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Sociocultural implications on the learning of youth with concurrent disorders: Factors that are perceived as necessary for student success in mainstream classrooms

by

Bonnie Belczowski

A Thesis
Submitted to the Faculty of Graduate Studies
through the Faculty of Education
in Partial Fulfillment of the Requirements for
the Degree of Master of Education
at the University of Windsor

Windsor, Ontario, Canada

2013

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Sociocultural implications on the learning of youth with concurrent disorders: Factors
that are perceived as necessary for student success in mainstream classrooms

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ABSTRACT

Research indicates that a significant proportion of adolescent students have a concurrent disorder that is significant enough to cause social or educational impairment. Thus the potential consequences of this condition on students as they progress through adolescence cannot be denied. The present study explored the factors perceived by teachers, administrators, and psychologists to be important in helping this population of students to achieve academic and social success in a mainstream classroom. The results of this study indicate that the number of adolescent students exhibiting symptoms of a concurrent disorder within the secondary school environment has increased in recent years. While a small number of students will need to access community services, many will remain within the classroom. There is a general consensus for a need for empirically-based classroom strategies, although there is a noticeable lack of consistency and confidence regarding the details and implementation of such strategies.

Keywords: Concurrent disorders; adolescents; teachers; perceptions; student success; mainstream classroom

DEDICATION

To Dad – I miss you

To Mom – for your encouragement and support

To Daniel – for your patience throughout this process

ACKNOWLEDGEMENTS

I would like to acknowledge my advisor, Dr. Geri Salinitri, who knew I would write this thesis before I was even enrolled in the program. I could never have done this without you.

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CHAPTER 1

INTRODUCTION

Research shows that 35-50% of individuals have concurrent mental health and substance abuse problems (Salvo et al., 2012; Rush, 2002). Moreover, 60% of youths who are substance abusers also have a comorbid mental health disorder (Armstrong and Costello, 2002). At the high school level in particular, some students experiment with illicit substances. It is important to realize that in some cases, drug use can be a symptom of a larger problem, and these two disorders co-occur in a number of individuals.

The term “concurrent disorder” is given to an individual that is experiencing any combination of “mental/emotional/psychiatric problems with the abuse of alcohol and/or another psychoactive drug” (Rush, 2002, p. v). It is important to remember that concurrent disorders are varied: any mental health problem can coincide with the abuse of any substance. Therefore, as the disorders are dissimilar, these individuals will demonstrate varied symptoms (often reflective of either component condition).

Although they can occur at any age, the natural onset of many mental illnesses occurs during late adolescence. Further, the majority of adolescents have used drugs or alcohol, with the median age at onset for both alcohol and drug abuse being 14 years (Swendsen et al., 2012). When a substance abuse disorder begins in adolescence, students are at an increased risk of developing additional dependencies, disruptive behaviour, and depression (Chan, Dennis, & Funk, 2008). Consequently, concurrent disorders are present in the population of high school students, and it is important that educators are cognizant of their presence. In many cases, individuals will try to hide their illnesses to fit

in with their peers. However, this is a tremendous burden for the person to bear, especially when the affected individual is an adolescent.

Consequently, these students encounter numerous barriers to their success in school, both in regards to academic standing and within social relationships. As educators, it is imperative that we are able to help all students reach their potential, including those that face the added difficulty of a concurrent disorder. We must be willing and able to help these students overcome obstacles in order to achieve success in school.

There is a noticeable paucity of research, both recent and dated, regarding concurrent disorders within the educational setting. Furthermore, the literature that is available does not address how the academic and social needs of this particular population of students can best be met within traditional classrooms.

I have an academic background in medicine, psychology, and education. Consequently, my research interests lie at the crossroads of physiology and behaviour in the classroom. While enrolled in a guidance course at the undergraduate level, I completed a project about students with concurrent disorders. This research endeavour piqued my interest in this area, and was the foundation upon which the current research emerged.

The purpose of this study is to investigate the personal, social and institutional (situational) factors that are perceived to increase the success of adolescent students with concurrent disorders in mainstream classrooms. The study addresses the following clusters of questions:

1. From a teacher's perspective, what strategies implemented within the classroom are effective for an adolescent student with a concurrent disorder in a mainstream classroom? What factors does a teacher perceive as being helpful for these students to achieve academic success (defined as achieving a passing grade in classes), and social success (defined as interacting appropriately with peers)?
2. From an administrator's perspective, what institutional plans are successful in supporting students with concurrent disorders when they study in a mainstream school?
3. From a psychologist's perspective, what personal factors help an adolescent student with a concurrent disorder achieve success in school (viewed objectively by the psychologist, including academic and social success)?

Theoretical Framework

In this thesis, three theoretical constructs weave through the fabric of the literature review and the analysis of the data. These theories influence the perceptions of the participants in the research:

1. Social learning theory (Bandura, 1977)
2. Social cognitive theory (Bandura, 1986, 2001)
3. Social representation theory (Moscovici, 1984, 2000)

Social Learning Theory

According to Bandura (1977), social learning theory is based on the principle that learning occurs through observation and modeling of behaviour. By this theory, individuals learn by acquiring symbolic representations of the modeled activities and not by stimulus-response interactions. The theory stresses the importance of observing and

modeling the behaviours, attitudes and emotional reactions of others because people learn from one another in a social context (Akers, 2009).

Social Cognitive Theory

Social cognitive theory arose from Bandura's social learning theory and was posited by Bandura in 1977. It provides a framework for understanding, predicting, and changing human behaviour. The theory identifies human behaviour as an interaction of personal factors, behaviour, and the environment (Bandura 1977; 1986; 1991). The interactions involve the individual's belief and cognitive competencies, which are modified by social and situational influences. Further, a person's behaviour determines the impact on the environment, while the environment also has an influence on behaviour.

According to Jones (1989), behaviour varies from situation to situation. That is, individuals may interpret situations differently provoking differing responses from different people, or different responses at different times. Thus, social cognitive theory is useful in identifying methods in which individual and group behaviour can be changed.

Social Representation Theory

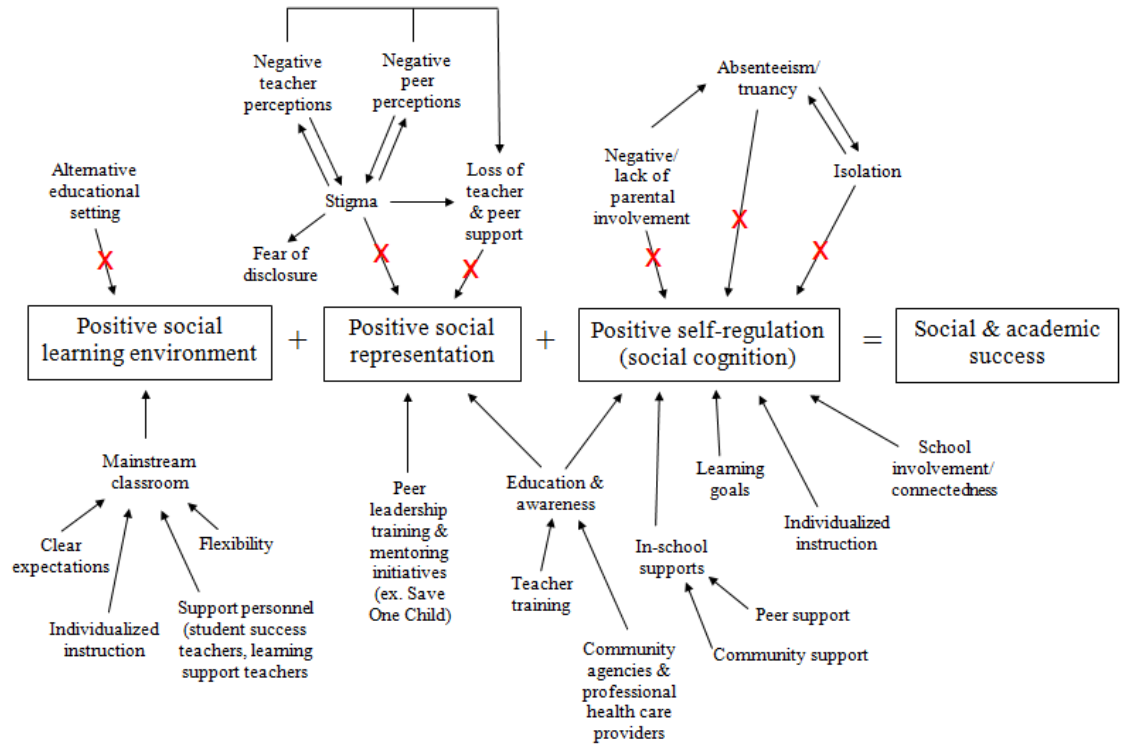
According to Höijer (2011), social representation could be described as "different types of collective cognitions, common sense or thought systems of societies or groups of people" (p.4). Moscovici (2000) also identified the individual's contribution to the formation of social representation through the interactions between social structure and the individual. Today the traditional social structures such as family, social class, and religion may not guide thinking or behaviour, and is therefore exposed to "a veritable open market of representations" (Moscovici, 1984, p.963).

Moscovici first defined social representation in 1973 as
...a system of values, ideas and practices with a twofold function: first, to establish an order which will enable individuals to orientate themselves in their material and social work and to master it: and secondly to enable communication to take place among members of a community by providing them with a code for social exchange and a code for naming and classifying unambiguously the various aspects of their world and their individual group history. (p xiii)

By 2000, Moscovici further identified social representation from “the dynamic point of view as a network of ideas, metaphors and images, more or less loosely tied together” (p.153). These representations are not always logical nor are they coherent thought patterns; instead, they may be thought fragments or contradictory ideas. Therefore, everyday thinking may be different, sometimes opposite, forms of thinking.

This theoretical framework connecting social learning, social cognitive and social representation theories will guide the literature review, the research questions, and the data analysis. Figure 1 shows the conceptual framework of the relationship between the theories and the potential effects of concurrent disorders on the academic and social success of adolescents.

Figure 1: A conceptual framework of the relationship between social learning theory, social cognitive theory, and social representation theory and social and academic success of students with concurrent disorders.



CHAPTER 2

LITERATURE REVIEW

This chapter begins with an overview of adolescent development, focusing on brain and cognitive development, and social maturation. This is followed by an introduction to mental illness and substance abuse in adolescence, focusing mainly on those disorders that are most commonly present in adolescence, either as continuations of a childhood mental illness or those that manifest symptoms for the first time during the adolescent years. For these disorders, symptoms and diagnosing criteria are described, as well as the etiology and association with coexisting substance abuse. Next, concurrent disorders are defined and the development of this disorder is discussed. The next sections outline obstacles that students with mental illnesses or concurrent disorders face to success in secondary school and factors that have been shown to promote success. Focus has also been given to the stigma associated with mental illness. Finally, the current adolescent mental health policy in Ontario is discussed.

Adolescent Development

The boundaries of adolescence are not clearly defined, although it is generally accepted that the period of adolescence begins with the physical changes of puberty and ends when the individual is able to function independently as an adult (Santrock, 2007). Consequently, the age range varies from individual to individual. During this period of time, individuals experience numerous changes, both physical and psychological.

Adolescent Brain Development

At the time of birth, individuals have the highest number of neurons that they will possess in their lifetime (Santrock, 2007). Brain function, therefore, is not a function of

the number of neurons, but rather, the quality of the connections (synapses) between them.

Following birth, neurons in the brain are “pruned,” that is, the connections between neurons that are stimulated by the individual’s environment are strengthened, and those that are not used, or not needed, disappear and are replaced by other, stronger, pathways (Paus, Keshavan, & Giedd, 2008). This process occurs in different regions of the brain at different times as indicated by early longitudinal MRI studies (Giedd et al., 1999; Thompson et al., 2000). The prefrontal cortex, the region of the brain involved in reasoning and thinking, is the last brain region to fully develop; this development is generally complete by the end of adolescent. Consequently, children and adolescents use different regions of their brains than adults when presented with similar situations (Dahl, 2004). In the case of adolescents, their behavioural responses are motivated by emotions rather than logical reasoning.

Furthermore, the limbic system, responsible for pleasure, is hypersensitive during adolescence (Bava & Tapert, 2010). This finding explains the increase in risk-taking behaviour that often characterizes adolescence. This sensitivity to reward within the brain also helps explain substance use and abuse by adolescents.

Adolescent Cognitive Development

The developments in brain structure affect the cognitive development seen during adolescence (Yurgelun-Todd, 2007). The prefrontal cortex is involved in goal-directed and future-oriented behaviour (Alvarez & Emory, 2006). Consequently, the cognition of adolescents reflects these developing regions of the brain.

Santrock (2007) summarizes the cognitive changes that occur during this period of development. As adolescents move into adulthood, they display increasingly realistic and pragmatic thinking, reflecting a shift from knowledge acquisition to knowledge application. Second, as the adolescent brain matures, adolescents are able to practice more reflective thinking by taking into consideration various perspectives of a given situation.

With the development of the pre-frontal cortex and its reasoning function, adolescents are able to improve in their ability to make generalizations from specific situations (inductive reasoning) and make specific judgements from general information (deductive reasoning). They are also faced with numerous decisions, including those pertaining to career choices, relationship and social choices, and health choices. As the brain develops, some adolescents are increasingly able to look to the future in order to anticipate consequences that will shape their decisions.

Adolescent Social Development

Adolescents are influenced greatly by those around them: teachers and peers at school, families and friends at home, the media and society in general. During this time, individuals begin to separate themselves from their parents or guardians, and peers take on a more significant role in the adolescent's social life (Santrock, 2007). However, research has found that adolescents who have positive relationships with their parents are less likely to engage in risk-taking behaviour, and are more likely to experience academic and social success in school (Steinberg, 2007).

The peer group, however, remains most important to an adolescent, and developing strong friendships is important for social functioning and self-esteem (Nelson

& Nelson, 2010). In order to gain favourable opinion, adolescents will often succumb to peer pressure and participate in activities that their social group deems acceptable.

Combined with the developing brain structure, a peer group can have a strong influence over an adolescent's participation in substance use or abuse. Contrastingly, a positive social group may influence an adolescent's decision to abstain from substance use.

Mental Illness in Adolescence

Adolescence is a period of significant change in the brain, thus it is not surprising that many mental illnesses first appear during this phase of development. The following section serves to introduce and define the mental health illnesses that most commonly develop during adolescence. Unless otherwise indicated, the information is taken from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) (2000).

Psychotic Disorders: Schizophrenia (Psychosis)

Schizophrenia is a disorder characterized by a combination of positive and negative symptoms (Barlow & Durand, 2002). Positive symptoms include irrational beliefs (delusions, often of persecution) and/or sensations in the absence of external stimuli (hallucinations, most frequently auditory), as well as disorganized speech and behaviour. Negative symptoms refer to the absence of normal behaviour, and include alogia (the absence of speech), anhedonia (the inability to derive pleasure from previously-pleasant activities), and affective flattening (the absence of emotionally-appropriate facial expression). In addition, schizophrenia often presents with additional disorganized symptoms, including disorganized speech, demonstrated by a lack of direct responses to specific questions. An individual must exhibit at least two symptoms for the

majority of time during a one-month period in order to meet the requirements of diagnosis (American Psychiatric Association, 2000).

The onset of schizophrenia occurs most frequently in late adolescence (Esterberg, Trotman, Holtzman, Compton, & Walker, 2010) with males tending to experience a slightly earlier age of onset than females (Erantil, MacCabe, Bundy, & Murray, 2013). Furthermore, the age of onset of psychosis is further decreased with substance abuse, notably with the use of cannabis (Large, Sharma, Compton, Slade, & Nielssen, 2011), and a metaanalysis of community-based research suggests that 7.5% of adolescents aged 13–18 years have experienced psychotic symptoms (Kelleher et al., 2012).

There is strong indication that schizophrenia has a genetic component, although a direct link with a particular gene has not been found (Sullivan, Kendler, & Neale, 2003). Further, there is believed to be a neurobiological component to the illness, as demonstrated by the effectiveness of medications that act by decreasing the levels of dopamine in the brain, as well as the appearance of schizophrenia-like symptoms in Parkinson's disease patients taking the dopamine-increasing medication, L-dopa (Birkmayer & Riederer, 1975).

Mood Disorders: Depression & Bipolar Disorder

Although it is normal for individuals, including adolescents, to experience changes of mood, prolonged periods of continual symptoms can indicate the onset of major depression. Symptoms of depression include both cognitive symptoms, such as subjective or objective feelings of sadness, decreased interest or pleasure in most daily activities, feelings of worthlessness or excessive guilt, and difficulty with concentration or thinking, as well as physical symptoms, including a significant change in weight and

alterations to sleeping patterns (either insomnia or hypersomnia) (Barlow & Durand, 2002). In order to meet the diagnosis of a major depressive episode, an individual must exhibit five or more symptoms over a two-week period. Furthermore, these symptoms must not be attributable to a life event (such as the bereavement following the loss of a loved one) (American Psychiatric Association, 2000).

In some individuals, periods of depression are separated by episodes of mania. The presence of these episodes of abnormally-exaggerated happiness characterizes bipolar disorder. During periods of mania, an individual may exhibit delusions of grandiosity and display excessive participation in pleasurable – though risky – behaviours (such as overspending or engaging in risky physical or sexual activities). The individual may also speak faster than usual, while describing racing thoughts and distractibility (Barlow & Durand, 2002). In the case of a manic episode, three symptoms must be present over a period of one week in order to meet the criteria for diagnosis (American Psychiatric Association, 2000).

The peak onset of major depressive disorder is in early adulthood, with a cross-national trend towards younger onset (Mezuk & Kendler, 2012). A younger onset of a major depressive episode is associated with a longer course of symptoms and poorer response to treatment (Klein, Taylor, Dickstein, & Harding, 1988; Klein, Schwartz, Rose, & Leader, 2000), and often has a stronger familial (genetic) component. Furthermore, research suggests that depression in adolescence is correlated with childhood poverty (Shanahan, Copeland, Costello, & Angold, 2011), as well as the female gender, a family history of mood disorders, history of childhood sexual abuse, anxiety disorder in childhood/adolescence, and poor general health (Klein et al., 2013). Further, it has been

shown that the recreational use of prescription medications during adolescence increased the odds of an individual experiencing an episode of major depression within the previous year, as well as lifetime prevalence (Schepis & McCabe, 2012).

The onset of bipolar disorder is earlier than major depressive disorder, with an average age of onset of 18 years. In a similar way to major depression, an earlier onset of the disorder is associated with a more severe course of symptoms (Coryell, Fiedorowicza, Leon, Endicott, & Keller, 2013), thereby making the adolescent population especially vulnerable to the effects of the illness.

Anxiety Disorders: Generalized Anxiety Disorder, Specific Phobia & Social Anxiety

With the significant academic and social pressures of secondary school, adolescents often have moments of anxiety. However, when anxious feelings of worry interfere with normal functioning, then a diagnosis of an anxiety disorder should be considered. Generalized anxiety disorder is characterized by cognitive disturbances (such as feelings of restlessness, irritability, and difficulty concentrating) as well as physical symptoms (including muscle tension and disrupted sleep patterns) (Barlow & Durand, 2002). In order for diagnostic criteria to be met, the symptoms must occur consistently over a six-month period, and must impede standard functioning in social or occupational areas of life (American Psychiatric Association, 2000).

Specific phobias are irrational fears that interfere with an individual's ability to function normally. While many individuals experience apprehension or fear of particular objects or situations, a clinically-diagnosed phobia represents a debilitating condition if the object or situation is encountered. Phobias involve anxiety over perceived subsequent

events, but can often be managed by avoiding fear-eliciting situation (Barlow & Durand, 2002). However, in the case of social phobia (social anxiety), especially in adolescents who are required to attend school, social situations are practically unavoidable.

The onset of generalized anxiety disorder most frequently occurs in early adulthood, while specific and social phobias may begin considerably earlier, as early as 11 years of age (Kessler, Demler, Jin, Merikangas, & Walters, 2005).

Marmorstein (2012) notes that, while substance use is unmistakably associated with anxiety disorders, the timing of these conditions varies from disorder to disorder. For example, the onset of generalized anxiety disorder tends to occur after the substance abuse, while substance abuse “overwhelmingly” (Marmorstein, 2012, p. 6) follows the onset of social phobia. The author speculates that the early adolescent-onset of social phobia may coincide with an adolescent’s opportunity to experiment with illicit substances, but acknowledges that a social phobia in adolescence may increase an individual’s susceptibility to peer pressure, leading to the development of a substance abuse problem. Other research supports the association between substance abuse and anxiety disorders, attributing the link to self-medication (Wolitzky-Taylor, Bobova, Zinbarg, Mineka, & Craske, 2012).

Attention-Deficit Hyperactivity Disorder and Behavioural Disorders

Although attention deficit hyperactivity disorder is generally diagnosed in younger children, the symptoms can continue into adolescence. Symptoms include physical manifestations, such as over activity, restlessness, and impulsiveness, as well as cognitive signs, such as problems sustaining attention and learning difficulties. The

disruptive behaviours of this disorder often serve to socially alienate the individual from others (Gelder, Mayou, & Geddes, 2005).

Behavioural disorders include conduct disorder and oppositional defiant disorder, both of which appear in youth. Conduct disorder is characterized by severe behaviour that opposes social norms. These behaviours include, but are not limited to, blatant disobedience of rules, lying, stealing, drug abuse, aggression, problems at school (including truancy). The boundary between meeting the criteria for conduct disorder and displaying normal rebellion is sometimes difficult to discern. Oppositional defiant disorder precedes conduct disorder, in some individuals, although evidence for this relationship is mixed (Rowe, Costello, Angold, Copeland, & Maughan, 2010).

Oppositional defiant disorder usually begins by age eight, and shares similarities with the symptoms of conduct disorder. These symptoms include anger and aggression, defiance of rules, arguments with individuals in positions of authority, and blaming others for mistakes and behaviours.

Research suggests that individuals who have co-occurring conduct disorder and alcohol abuse continue to exhibit exacerbated antisocial behaviour into adulthood (Howard, Finn, Jose, & Gallagher, 2011). The researchers suggest that the disorder leads to substance misuse in adolescence, which in turn lowers inhibitions and allows further drug use, disrupting the normal progression of adolescent brain development, which is essential for proper self-regulatory behaviours in adulthood.

The etiology of behavioural disorders is unknown. Attention deficit hyperactivity disorder is believed to have both a genetic and environmental component. Moreover, approximately one-third of individuals with severe attention deficit hyperactivity disorder

in childhood go on to develop conduct disorder (Beauchaine, Hinshaw, & Pang, 2010) or other behavioural disorders in adolescence and young adulthood.

Eating Disorders: Anorexia Nervosa and Bulimia Nervosa

In the adolescent population, many eating disorders are frequently overlooked since the individual displays a socially-accepted, and expected, body type. Furthermore, most individuals with eating disorders are within ten percent of their normal body weight.

Anorexia nervosa is most notably characterized by a refusal to maintain a healthy, normal weight, through excessive dieting and/or exercise. However, the disorder is also associated with cognitive symptoms, including an intense fear of gaining weight, and impaired perception of the individual's own body image. For example, despite the objective evidence to the contrary, an individual with anorexia nervosa will view themselves as overweight.

An individual with bulimia nervosa will use purging techniques, either vomiting or with the use of laxatives and/or diuretics, in an effort to reduce caloric intake. These episodes of purging are subsequent to a binge, in which the individual eats an abnormally-high amount of food in a correspondingly short period of time. During binge periods, an individual feels that he/she lacks the control to stop (Barlow & Durand, 2002). Symptoms must occur at least twice a week, over a period of three months in order to meet the criteria for diagnosis (American Psychiatric Association, 2000).

Eating disorders occur with greater frequency in females. Research shows a correlation between an eating disorder and substance use; Courbasson, Smith, and Cleland, (2005) found that the prevalence of eating disorders was higher in a population of substance abusers than in the general population. Several researchers attempt to

explain the frequent co-occurrence of substance abuse with eating disorders, and have noticed that genetics, personality traits (such as negative emotionality, low constraint, and neuroticism), and disturbances in brain neurotransmitters are evident in these populations (Harrop, & Marlatt, 2010), although definitive etiology cannot be ascertained.

Personality Disorders

Personality disorders fall into three categories, called clusters, under the DSM-IV. The first cluster includes odd or eccentric disorders. The three disorders found in this cluster are the paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder. These personality disorders share some similarities to schizophrenia, including pervasive suspiciousness of others, disturbances in emotional affect, or behaviours that distance the individual from normal social interaction and forming normal social relationships. The second cluster of personality disorders, the dramatic, emotional or erratic disorders, includes antisocial personality disorder, borderline personality disorder, histrionic personality disorder, and narcissistic personality disorder. All disorders in this cluster affect an individual's ability to form a healthy relationship with other people, due to their eccentric behaviours. The final cluster of personality disorders includes avoidant personality disorder, dependent personality disorder, and obsessive-compulsive personality disorder. These disorders are labelled as anxious or fearful disorders, since individuals alienate themselves socially due to feelings of inadequacy or a need for extreme control (Barlow & Durand, 2002).

Personality traits, and consequently disorders of personality, are intricately ingrained in an individual's self, and develop with the individual, thus it is difficult to establish a definitive onset of these disorders. Krueger, Caspi, Moffitt, Silva, and McGee

(1996) note that personality disorders are believed to originate in childhood and continue into adulthood.

Substance-Related Disorders

Individuals may use substances that have an effect on the brain or nervous system, such as alcohol or caffeine, without experiencing negative consequences. Substance use is the ingestion of these substances in a quantity that does not interfere with normal functioning. However, when a psychoactive substance is ingested in sufficient quantity, or with sufficient frequency, to interfere with an individual's responsibilities, such as school or work, or with an individual's relationships, then the term "substance abuse" is more properly applied. The amount of substance taken to meet the criteria of abuse will vary both for the substance and for the individual.

If an individual becomes "addicted" to a substance, he/she is said to have substance dependence. In this situation, the individual has both a psychological and physical response to the substance. Tolerance to a substance develops when an individual must ingest consistently greater quantities of the substance in order to gain the desired outcome. Physically, an individual with substance dependence will experience withdrawal symptoms if the substance is denied. Psychologically, the individual needs the substance, and will spend a large amount of time pursuing or obtaining it, including neglecting responsibilities in the process (Barlow & Durand, 2002).

Concurrent Disorders

According to Health Canada, concurrent disorder is the diagnosis given to an individual who is experiencing a mental illness and substance abuse problem simultaneously (Rush, 2002). It is important to note that concurrent disorders are

extremely varied in their manifestations. Since any mental health problem can coincide with the abuse of any substance, the symptoms may reflect elements of each disorder individually, as well as novel symptoms that appear due to their interaction.

Concurrent disorders are often referred to using alternative terminology. A more broad term, comorbidity, describes a situation where an individual experiences two disorders (of any type) simultaneously. In the United States, the terms dual diagnosis, dual disorder, or mentally ill chemical abuser are used interchangeably with concurrent disorder. However, in Canada, it is more common that the term “dual diagnosis” refers to someone with a mental disorder and a co-occurring developmental disability (Centre for Addiction and Mental Health, 1998).

Concurrent disorders occur with high frequency. Kutcher, Venn, and Szumilas (2009) note that in Canada, “approximately 15 to 20 percent of children and adolescents suffer from some form of mental disorder – one in five students in the average classroom.” (p. 44). Research from Health Canada shows that 40-70% of individuals have concurrent mental health and substance abuse problems (Rush, 2002). Armstrong and Costello (2002) report that 60% of youths who are substance abusers also have a comorbid mental health disorder; conduct disorder and oppositional defiant disorder were most common, followed by depression. DeMilio (1989) verifies this association. Earlier research including adolescents and adults reveals that over 28% have a concurrent disorder (Kessler et al., 1996).

It is important to note the presence of concurrent disorders, because this diagnosis often presents challenges to recovery. Concurrent disorders are often associated with “earlier onset, more chronic course, and lifestyle factors, such as less social stability

(including unemployment) that may lead to resistance to treatment” (Blanchard, 2000, p. 146).

The Etiology of Concurrent Disorders

Concurrent disorders can begin in various ways. Kessler, Nelson, McGonagle, Edlund, Frank, and Leaf (1996) find that in nearly all cases of concurrent disorders, there is at least one episode of the manifestation of a mental illness before the substance abuse appears. This is true for anxiety and personality disorders. For example, a substance, such as alcohol, can be used by an individual to compensate for the negative symptoms of the mental health disorder. Some authors believe that etiology of concurrent disorders is due to self-medication in response to a mental disorder (Christie, Burke, Regier, Rae, & Boyd, 1988, and Kendler et al., 1996). In this theory, substances are abused to compensate for a lack of personal coping skills or strengths necessary when facing a mental illness.

In contrast, for mood disorders, the substance abuse more frequently appears first. Thus, an individual experiences a mental health illness subsequent to abusing a substance. In this way, theory states that substance use or abuse can create symptoms of mental illness. With continued use over time, these drug-induced symptoms could eventually lead to an individual meeting the criteria of a mental disorder (Brook, Cohen, & Brook, 1998, and Bukstein, Glancy, & Kaminer, 1992).

Further, Caton et al. (2005), caution that the relationship between drug use and psychosis must be carefully considered: a wide variety of drugs, including alcohol, cocaine and amphetamines, can elicit symptoms of psychosis in an individual, regardless of the mental health of the user, mimicking the appearance of a mental illness. The

appearance of psychotic symptoms, regardless whether they are caused by a mental illness or if they are induced by the ingestion of a substance, can be disabling to an individual.

However, while the component conditions of most concurrent disorders can be separated with respect to the cause of their onset, in many cases, both conditions develop independently (Grant et al., 2004). In this instance, both disorders may share common risk factors (for example, genetic or environmental factors), and in some individuals, this may lead to the development of both conditions independently. Empirical evidence supports the theory that the two disorders (a mental illness and a substance abuse problem) share a common risk factor (genetic, environmental, or a combination of genetic and environmental factors) that increases the susceptibility of both conditions in a single individual (Markou, Kosten, & Koob, 1998). Therefore, it is possible that the structuring of the school environment can have an impact on the success of a susceptible student.

Obstacles to Student Success in Secondary School

Untreated mental illness can be the cause of abnormal tardiness and absenteeism. However, research shows that when treated, rates of absenteeism fall by 50% and rates of tardiness decrease by 20% (Gall, Pagano, Desmond, Perrin, & Murphy, 2000). Vander Stoep (1997) found that students with mental disorders were less likely to complete high school and achieve gainful employment. Specifically, Planty et al. (2008) found that 43% of students with a mental disorder received their high school diploma. It is logical to assume that students with concurrent disorders, of which one component of diagnosis is a

mental disorder, would experience similar difficulties if treatment or support is not received.

Clearly, achieving success academically is critical for attaining a high school diploma. This level of education is consequently important for achieving employment success into adulthood. Although not essential, a high school diploma is important for seeking gainful employment, and research suggests that individuals who attain a diploma earn more than their peers who lack such distinction (Martorell & Clark, 2010). While alternative traditional public education programs exist, not all provide the same completion document (Benz, Lindstrom, and Yovanoff, 2000). If future employers do not value alternative diplomas as highly as traditional ones, and students with concurrent disorders are unable to access the assistance needed to study in a traditional classroom, then the individual with a concurrent disorder may continue to have difficulties achieving success into adulthood. Thus, it is important to provide an environment that will support a student's academic and social success within a traditional classroom.

According to Richmond and Foster (2003), clinicians often hold negative attitudes towards individuals with concurrent disorders. Ross and Goldner (2009) support the findings of negative attitudes on the part of nurses. Consequently, this attitude can affect the quality of care that they receive. This finding has implications for the appropriateness and timeliness of treatment received. It is also possible that other individuals in an adolescent's life may share these negative attitudes, including teachers, which may affect the service (i.e., education) they receive in other situations.

King, Gaines, Lambert, Summerfelt, and Bickman (2000) found that adolescents with co-occurring mental illness and substance abuse experienced more behaviour

problems and functioning impairment than their peers. Clearly, this finding has important implications for their performance in a traditional classroom. Furthermore, these students require more resources (including teachers' attention, educational materials, or curricular modifications) than their peers. If these needs are met, the student has a favourable chance of success in the mainstream classroom. However, a failure to meet these provisions may augment a student's behavioural issues and derail any progress towards success in a traditional classroom.

Beyond education, school provides a place for students to develop their social skills. However, the social skills necessary to maintain positive relationships are identical to those that are affected by mental illness and substance abuse, thereby making it difficult to make a social connection with other individuals in the traditional classroom setting (Massey, 2004). Naylor and Cowie (2000) note the importance of having staff approval before a school can form a meaningful peer support system. Furthermore, it is necessary to train students about healthy relationship and strong social skills, and feedback should be regularly sought from students, teachers, and users of support programs in order to make changes that are perceived as necessary.

Peer relationships play a major role in the social coping mechanisms of adolescents. Umberson and Karas Montez (2010) outline the three general mechanisms by which social relationships benefit mental health. The first explanation is that social relationships promote healthy behaviours, including the adherence to prescribed medical regimes. The second theory is that social relationships provide a support network in which an individual can practice personal control. Last, there is a physiological connection between positive social relationships and a healthy immune system. Herman-

Stahl (1996) found that adolescents who had positive social relationships experienced less internalizing symptoms than those with fewer positive relationships. Furthermore, positive relationships within the family also contributed to an adolescent's well-being. Adolescents spend many hours in school; therefore they have the potential to form meaningful relationships with teachers and peers. It is evident that positive relationships can benefit a student's mental health, thereby contributing to the social success a student feels in a mainstream classroom. Bloemker (1998) further explains that emotional symptoms may appear when an individual experiences several failing experiences with empathy within self-object relationships. For an adolescent, these relationships may occur with friends and significant others. Thus, teacher-student relationships developed in the classroom, as well as peer relationships fostered within the school community, can have a significant effect on the success that an adolescent with a concurrent disorder can potentially achieve.

Umberson and Karas Montez (2010) noted the potential negative impact that negative social relationships can have on both mental and physical health. Stress in relationships can contribute not only to deterioration in mental well-being, but also in physiological health. Furthermore, relationships with risk-taking peers can contribute to increased substance use, potentially leading to abuse or dependence (Smith & Christakis, 2008).

Factors that Promote Student Success in Secondary School

Paul, Berriman, and Evans (2008) found that adolescents have strong, independent opinions regarding a decision to attend mental health services. In their study of English adolescent students' self-reported diagnoses and treatment, the researchers

found that less than half of the respondents would follow treatment recommendations made on their behalf, preferring to exert their autonomy. Furthermore, a minority of the students would change their minds if the recommendation was supported by their parents. Research suggests that students who learn from their peers, however, experience twofold benefits: they gain and practice practical life skills, and they experience an increase in academic and social success (Riese, Samara, & Lillejord, 2012; Reinke, Stormont, Herman, Puri, & Goel, 2011). These findings are supported by Paul, Berriman, and Evans (2008), who note that the majority of students surveyed (82.6%) believe that information regarding mental health should be presented to all students. However, the responses indicate that students prefer to receive this information during class time from health care professionals or other students with personal experience rather than from teachers.

Parental involvement plays an important role in a student's academic achievement throughout an individual's school years (Topor, Keane, Shelton, & Calkins, 2010; Fan & Williams, 2010). However, the involvement may take on different forms as an adolescent enters and progresses through secondary school. Further, the parents' roles may also be influenced by the characteristics of adolescent physical, cognitive, and social development (Hill & Tyson, 2009). This change may be due to an adolescent's increasing desire for autonomy, his/her ability to make informed decisions about his/her own education, and the modification of parent-child relationship from hierarchical to one involving more two-way communication. Research suggests that during adolescence, parental involvement is most beneficial to academic achievement when parents communicate expectations clearly and help students develop strategies to effectively succeed in the school environment (Hill & Tyson, 2009), although other forms of

involvement also show favourable results. The positive influence of parental involvement is also evident when other factors, such as social background, family structure, and academic capabilities, are controlled (Catsambis, 2001). Therefore, for a population of students with concurrent disorders to achieve success, parents or caregivers must make the effort to work with the student's teachers and administrators to promote and support this success.

Research shows that supportive relationships with teachers contribute meaningfully to academic success (Bernstein-Yamashiro & Noam, 2013a). Students who perceive a connection with their teachers are more likely to attend class, and to be engaged in the lessons. The natural consequence of this connection is improved academic performance. Further, positive student-teacher relationships foster socio-emotional success in students (Bernstein-Yamashiro & Noam, 2013b). Often beginning as an interaction about lessons, formal academic relationships can develop into mentoring relationships with a consequential positive effect on a student's success in school. Bernstein-Yamashiro and Noam (2013b) note that "students make clear that for them, learning and relationships are integrally intertwined and are pivotal to the success of schools, teachers, and students" (p. 28). While fostering student-teacher relationships is easiest in small class settings, it is possible, and important, to ensure that students feel accepted in all school environments.

Teachers can also promote success for students with concurrent disorders by creating a positive learning climate within the classroom (Johnson, Eva, Johnson, & Walker, 2011). It is beneficial to all students, including those with concurrent disorders that teachers maintain high standards of academics and behaviour, but to be clear and

explicit with the expectations for the students. Classroom routines should be consistent, although some flexibility regarding assignments is beneficial in situations when a student's symptoms intensify.

The modeling of respectful behaviour in the classroom by teachers has been shown to increase the pro-social behaviour of students with mental illness (LaRusso, Romer, & Selman, 2008; Johnson, Eva, Johnson, & Walker, 2011). In this situation, students feel that their contribution to the class is significant, and consequently, that they can approach the teacher with any difficulties they may be experiencing. Further, a classroom atmosphere of respect and trust encourages students to put forth greater effort towards personally-important goals, thereby contributing to increased feelings of accomplishment and self-esteem, which are often limited for students with mental illness.

Finally, a student's connectedness to his/her school positively predicts academic success (Osterman, 2000; Shochet, Dadds, Ham, & Montague, 2006). The success is attributed to increased academic motivation, in connection with positive attitudes towards school and greater feelings of self-esteem. In contrast, students with a low perceived connectedness with their school are more likely to experience difficulty with their social relationships, both with their peers and with their families. Further, students with a connection to their school community are less likely to participate in risky behaviour, including substance abuse (Maddox & Prinz, 2003). The lack of a school connection leads students to associate with peers who feel similarly disengaged, and results in an increased propensity towards deviant behaviour (Shochet, Dadds, Ham, & Montague, 2006).

Stigma

Stigma occurs when an individual is stereotyped or alienated because he/she is viewed as being different from society's norm (Ilic et al., 2013; Corrigan, 2004). Recognized instigators of stigma include a physical deformity, membership in a particular race or religion, or the presence of a mental illness. Mental illness carries a stigma that is not associated with other, physiological, illnesses. People who suffer from a concurrent disorder may experience bias because of their mental illness, but also because of their substance abuse problem. These individuals may have to deal with stigmatizing judgments on a daily basis; adolescents may face this stigma within the school environment. Data shows that stigma is one of the largest barriers people with mental illness experience to their living a satisfying life.

One reason that stigma surrounds most mental disorders is that our society has a distorted view of these conditions (Pescosolido et al., 2010). The media has contributed significantly to this misconception: in movies and on television, people with a mental illness are portrayed as aggressive, unpredictable characters, which are often dangerous or violent (Canadian Senate Committee on Social Affairs, Science and Technology, 2004). As a result, individuals with mental illness are not treated with sensitivity or compassion. Instead, they are labelled with degrading names and shunned from many situations. Since the media exploits rare violent events, society believes that these dangerous bursts are commonplace, and all mentally ill people suffer the consequences (Wahl, 2012).

Furthermore, it is human nature to make light of our fears in order to better cope with them. There are many jokes about the mentally ill, in which the terms "lunatic" or

“crazy” are often used (Ilic, Reinecke, Bohner, Röttgers, Beblo, Driessen, Frommberger, & Corrigan, 2013). The derogatory language and negative representations that have been typically associated with individuals with mental illness further the stigma associated with these labels (social representation). They also contribute to the distorted public view of mental health, and reinforce many of the inaccuracies about mental illness.

Negative Effects of Stigma

There are numerous negative consequences associated with stigma. In addition to the health challenge a person faces, he/she must also surmount the obstacles of discrimination and rejection. The effects of stigma are far-reaching, and include physical, emotional and social sacrifices.

People who suffer from mental health and substance abuse problems will often want to conceal their issues and illness for fear of the opinions of others. This often means that these individuals will forgo treatment in order to keep their disorder a secret and avoid the accompanying stigma (Corrigan, 2004).

Individuals with mental illness experience discrimination in various facets of life. Lyons, Hopley, and Horrocks, (2009) note that individuals disclosing mental illness faced difficulty finding gainful employment, a finding which is supported by other researchers (Pescosolido et al., 2010). Moreover, if employed individuals disclosed to a colleague that they were hospitalized for a mental illness, the information spread quickly and consequently perceived a difference in the way they were treated. The researchers also note that discrimination can occur when seeking medical help for unrelated issues. Respondents commented that many physicians attributed physical symptoms to be “all in

your mind” (Lyons, Hopley, & Horrocks., 2009, p. 504), rather than investigating the complaint thoroughly.

Further, individuals with mental illness, including those with concurrent disorders, often experience social isolation. Lyons, Hopley, and Horrocks, (2009) note that individuals with mental illness experience discrimination from their communities, as well as from family members. Because of the lack of education regarding concurrent disorders (as well as mental illness or substance abuse individually), individuals gather information from the media and base their subsequent opinions on these portrayals. Therefore, when a mental illness is disclosed, the individual is often shunned by others because of fear. Consequently, in an effort to avoid discrimination, people who suffer from mental illness, addiction or a concurrent disorder will sometimes choose to isolate themselves. This leads to further reduction of a person’s social support network – an essential component to recovery and a balanced life (Markowitz, 1998).

Over time, a self-fulfilling prophesy may develop. Individuals with mental illness are presented with the same negative images and characterizations of mentally-ill patients as are the rest of society. Moreover, they also experience the stigma of discrimination and isolation because of their condition. With repeated exposure, these individuals may start to believe the negative things that are being said about them (Canadian Senate Committee on Social Affairs, Science and Technology, 2004).

When subjected to continual stigmatization, people may develop depression (Menke & Flynn, 2009). This condition arises from the fact that these individuals feel that they are alone and helpless. Eventually, they may also lose hope of ever overcoming their situation. An individual with a concurrent disorder may already be diagnosed with

depression. Stigma can lead to worsening of both immediate symptoms and long-term prognosis. In extreme cases, feelings of depression, hopelessness and loss of self esteem can lead to suicide.

Mental Health Policies in Ontario

Various policies are in effect regarding the mental health of youth in Ontario. Not all policies are directed towards educators, but since adolescents are expected to attend school, the implications for educators are evident. The following sections outline the current policy framework for youth mental health in Ontario, representing various Ministries of provincial government.

Open Minds, Healthy Minds

Recently, the Ontario government, with the support of the Ministry of Health and Long-Term Care, the Ministry of Children and Youth Services and the Ministry of Education, outlined a comprehensive strategy aimed at improving the mental well-being of Ontarians. The document, “Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy” (Government of Ontario, 2011), describes four guiding goals: the improvement of mental well-being for Ontarians; the creation of resilient, inclusive communities; the early identification and intervention of mental illness and substance abuse problems; and the timely provision of appropriate treatments for those affected.

Recognizing that for “70 per cent of adults living with mental health problems, their symptoms developed during childhood or adolescence” (Government of Ontario, 2011, p. 20), the first three years of the policy’s implementation will focus on children and youth. The areas of focus will centre on providing faster access to high quality

services, early identification and intervention of youth with mental health issues, and closing services gaps for those living in remote communities.

Within the focus of early identification, educators are recognized as playing an important role in this strategy. In addition to changing the curriculum to include the promotion of mental health, the policy aims to educate teachers and administrators on the early signs of youth mental illness, and the actions they can take to help students access assistance through community resources. Lastly, this policy calls for the hiring and utilization of mental health workers and nurses in school to provide assistance within the school setting, as well as serving as a link to community-based mental health services.

Ontario's *Open Minds, Healthy Minds* program is based on several principles. The first standard is one of respect and understanding. Individuals live their own unique experiences, and each person deserves to be treated with dignity and respect. Many schools offer lists of curriculum ideas that strive to incorporate diversity into the curriculum, and many educators have access to professional development training for sensitivity and inclusion (Thornton, 2009). Similarly, a principle guiding this policy is diversity, equity and social justice. The treatment of individuals with mental health issues must reflect the cultural diversity and values of the population, and all members of this population must have equitable access to relevant services.

Other principles stress healthy development, hope and recovery, excellence and innovation, and the need for accountability. It is important to recognize and remedy limitations within the school community that result in a disservice to students, and challenge those students to work for social change in their own lives.

Caring and Safe Schools in Ontario

The purpose of the policy document “Caring and Safe Schools in Ontario” is to help schools to create an environment that supports each student to learn, develop his/her potential, and complete their studies through graduation. The policy acknowledges that the behaviour of some students can make it difficult for them, or other students, to achieve these goals, and consequently, a progressive disciplinary approach to school management is offered.

Importantly, the document acknowledges that to “manage behaviour effectively, educators need to consider not just the behaviour itself – what the student is doing – but also the underlying cause(s) of the behaviour” (Ontario Ministry of Education, 2010a, p. 21). Underlying causes include disturbances in mental health as well as the abuse of substances. By acknowledging that students with mental illness, including those with concurrent disorders, have difficulty with standard tasks required for success in school, including maintaining concentration, dealing with time pressures and balancing multiple tasks, and interacting with others, the policy lays the foundation for helping students to receive help with their mental illness rather than being punished for the consequent maladaptive behaviours.

Further, the policy highlights the importance of early detection and intervention by including information about potential signs and symptoms that may be evident in the classroom, such as a negative change in the quality of work, missed deadlines, and excessive absenteeism). There is also advice for educators to become informed about mental illness, to build open and trusting relationships with students, to reach out to

parents to learn more about the unique needs of the students, and to work cohesively with parents and students to develop a strategy for success in the classroom.

A Shared Responsibility

The policy document of the Ministry of Children and Youth Services, “A Shared Responsibility: Ontario’s Policy Framework for Child and Youth Mental Health” (2006), outlines the Ministry’s vision that youth mental health is recognized by all Ontarians as an important component of overall health, and mental well-being is essential for an individual to reach his/her full potential. By understanding the relationship between mental health and individual success, government and community partners take on different, though equally important, roles in providing mental health support and services to youth: government agencies set policy and community agencies provide quality, evidence-based services that meet the needs of the community. Furthermore, responsibility also lies with youth and their families or caregivers to make use of community resources effectively.

The policy framework requires that government and community agencies work together to enhance the mental well-being of youth. In order to do so, mental illness, as well as risk factors that may lead to mental illness, must be identified early so that proper interventions may occur. Moreover, the interventions and support programs must be individualized to the unique needs of each community, and efficient access must be prioritized.

To reach the goal that has been set, the policy framework stresses services that are age-appropriate and family-centred. It is recommended that services be accessible, and provided as close to an individual’s home as possible. Further, the mental health supports

and services provided must be evidence-based, and service providers must be educated and trained within their disciplines. Although the education sector is not mentioned directly in this document, the implications and challenges of other community agencies can be applied to all adults working with students: it is necessary to be educated, and to practice evidence-based methods of helping students to achieve success and to reach their full potential.

CHAPTER 3

METHODOLOGY

Research Approach

The methodology of this study follows a phenomenological approach to qualitative research. The purpose of this research method is to uncover specific phenomena through examining the perceptions of those involved (Lester, 1999). Creswell (2007) notes that studying lived experiences will expose “contexts or situations that [affect or influence the individuals’] experiences of the phenomenon” (Creswell, 2007, p. 61).

In this technique, individual experiences with a phenomenon are reduced to a “description of the universal essence” (Creswell, 2007, p. 58), that is, by gathering data from lived experiences, generalizations can be made about the experiences others may have with the same phenomenon.

This study examines the phenomenon of working with students with concurrent disorders. Through the perspectives of teachers, administrators, and psychologists who have worked closely with this population of students, the factors needed for these students to achieve success in a traditional classroom setting are exposed.

Participants

The phenomenological approach can be applied to single cases, but the strength of inference can be increased with additional participants (Lester, 1999). Further, it is appropriate to deliberately select samples based on the participants’ experience with the studied phenomenon. “People involved in a phenomenon may have insights that would

not otherwise be available to the researcher, and it is the quality of the insight that is important, rather than the number of respondents that share it” (Wainwright, 1997).

This study involved eight participants stemming from three subgroups: secondary teachers (grades 9-12), administrators working within secondary schools or with secondary school populations, and psychologists who work with adolescents aged 13 and older. Creswell (2007) cites Dukes’ (1984) recommendation of a sample size of three to ten subjects for a phenomenological study.

To personalize the research, an online random name generator was used to generate pseudonyms for the participants (<http://random-name-generator.info/>).

Secondary teachers from a public secondary school board in a city in Southwestern Ontario were sent a single email inviting them to participate in a research study involving students with concurrent disorders. Eight individuals responded to this invitation. At the time of data collection, there was a political dispute between the Ontario government and the teachers’ unions, during which time teachers were discouraged from participating in extracurricular activities. I believe that this situation contributed to the small number of responses. Of the eight individuals who responded, three teachers were randomly selected (by choosing names from a hat) to participate. Teacher 1, Marlene Cushman, is in her 40s and has over ten years of teaching experience. Her current position involves dividing her time between teaching in a traditional classroom and working as a student success teacher. Teacher 2, Judith Doering, is in her 20s and is a novice teacher. Her current position involves a full timetable of teaching students in applied-level science classes. Teacher 3, Lynn Faraci, is in her 30s and has

over ten years of teaching experience. Her position also involves dividing her time between a science class and working as a student success teacher.

Administrators were similarly contacted via email invitation to participate in the research. Only two individuals responded to the initial invitation, and were consequently selected as participants. Teresa Wayne is in her 40s with less than ten years experience as an administrator. Her current role is as principal of an urban secondary school. The other participant, Greg Sotelo, is in his 40s with more than ten years experience as an administrator. Mr. Sotelo is principal of a suburban high school. In order to increase the pool of participants, a third individual was purposively selected to this subcategory of participants. Christine Bibeau is a superintendant within the same school board as the other participants, with experience acting as both vice-principal and principal at the secondary level.

This study takes place in an area that is underserved by psychologists trained and experienced with working with youth. Consequently, it was necessary to purposively select participants within in the psychologist subgroup. Individuals were selected based on their professional experience working with adolescents (aged 13 to 19) in an educational setting, either at the high school or university level. Three psychologists were invited to participate, but only two responded to the request. Psychologist 1, Adam Eckler, is in his 40s, and has over ten years experience working with older adolescents at the university level. The second psychologist, Nora Hirst, is in her 50s, with more than twenty years experience working with both children and adolescents at the elementary and high school levels.

Subsequent to initial contact, all participants self-identified as having experience working with students with concurrent disorders, either in current teaching educational settings or in past experiences. Before beginning the interview, each participant was informed of the purpose of the research, and any clarifications regarding terminology was made. Each participant was given a letter of information and gave informed consent to participate.

Since multiple individuals in each role were interviewed, the reliability of the sample is increased. Using individuals in different positions with respect to student success helps to establish a more well-rounded view on students' integration into the classroom and serves to triangulate the data via the perspectives of three different roles of participants reflecting on the same questions. Triangulation is a qualitative research method used to "check and establish validity by analyzing research questions from multiple perspectives." (Guion, Diehl, & McDonald, 2011, p. 1). To secure validity, research findings must reflect the situation and create certainty supported by evidence. Patton (2002) argues that any inconsistencies in the data should be viewed as opportunity to uncover deeper meaning.

Data Collection

First, a content analysis of related government, school board, and academic literature and policy documents was conducted. Research topics included mental health and substance abuse disorders, obstacles to success for students with mental illness, and mental health policy for schools and other community agencies.

Lester (1999) suggests that research collected for a phenomenological study follow the principle of "minimum structure and maximum depth" (Lester, 1999, p. 2).

However, acknowledging that research must often occur within the constraint of time, partially structured interviews are acceptable alternatives to open-ended questioning. In addition to interviews, other data collection methods may be used, including participant observation, conversations, and the use of personal texts.

“The success and validity of an interview rests on the extent to which the respondent’s opinions are truly reflected ... [in] communicating their responses” (Newton, 2010, p. 4). For this study, participants were interviewed using a semi-structured interview technique. Interview questions can be found in Appendix A. In addition to questions designed to elicit the unique perspective of each participant group (such as the teacher’s perspective on classroom factors of student success), each interviewee was asked their perspectives on the roles of the other participant groups (for example, the teacher’s perspective on an administrator’s role).

Interviews were arranged through email contact, and occurred in March and April 2013 at the time and location selected by the participants. All teachers were interviewed after school in their respective classrooms. Administrators were interviewed in their offices, either during the school day or after school. Psychologists were interviewed in their offices. Prior to the start of the interview, each participant gave written consent for audio-recording. Interviews ranged in length from forty to sixty minutes. All interviews were audio-recorded and then transcribed. Each transcription was reviewed by its original interviewee for member-checking. The approved transcriptions, as well as the original interview recordings, were secured on the researcher’s password-protected personal computer.

Following the initial interview, participants were asked to generate a concept map using the factors that had been discussed in the interview (see Appendix B). The goal of this research component was twofold. First, the concept map encouraged participants to consolidate their thoughts and to examine the connections that the participant perceives to be present among the areas investigated through the interview (Lester, 1999). This technique shows the relative importance of ideas. In most cases, the respondents added additional data to their concept map that was not included in the interview. Secondly, the concept map provided the researcher with another source of data. A sample concept map structure, unrelated to the research topic, was provided as a guide for participants, although the guidelines of this exercise were intentionally left unstructured, to allow for individuality of the responses. Four participants (two psychologists and two teachers) chose not to complete the concept map following their interview, due to time constraints. In these cases, the interview data was collected, without the accompanying concept map.

Data Analysis

Following careful reading and rereading of transcripts, codes were attached to phrases and sentences of the data. Basit (2003) notes that coding helps a researcher to create categories that will “[trigger] the construction of a conceptual scheme that suits the data” (p. 144), ultimately helping the researcher to order the categories and compare them across the data. In this study, various codes were used to link the data to other ideas, and to facilitate interpretation.

The categories were analyzed for recurring themes regarding the participants’ perspectives of essential strategies for student success using the constant comparison method (Thorne, 2000). In this strategy, individual pieces of data (such as particular

statements or themes) were compared “with all others that may be similar or different in order to develop conceptualizations of the possible relations between [them] (Thorne, 2000, p. 69). Further as suggested by Miles and Huberman (1994), a provisional ‘start list’ was developed from the conceptual framework, analysis of the literature, research questions and key variables addressed in the literature. The themes are described in detail in the following chapter.

Researcher Bias

According to Wainwright (1997), researchers should adopt a reflexive perspective on their own work in order to increase the validity of the qualitative research study. It is important to note that a qualitative researcher cannot fully detach from the research process. Consequently, it is important to acknowledge oneself within the research. My academic experience lies in the fields of science (biology), medicine, psychology, and education. I am currently working as a secondary school teacher, teaching locally-developed compulsory science courses. My interest in the area of adolescent students with concurrent disorders was piqued through an informal research project conducted during my Bachelor of Education studies. Results gathered from this study will inform my future teaching practice.

In qualitative research, validity is based on the inferences generated from the research (Rajendran, 2001). Research is a human endeavour that is subject to interpretation, which comes from the lived experience of the researchers. Because of my educational and experiential background, I relate to the teachers and psychologists more than the administrators, and I look for biological implications in addition to the social and educational implications.

To reduce researcher bias and triangulate the data, my supervisor also examined the data, and each interview transcription was reviewed by the interviewee for signs of bias on behalf of the researcher. Since each individual would have their own unique bias, the potential for skewed data is diminished.

CHAPTER 4

RESULTS

The purpose of this research was to investigate the personal, social and institutional (situational) factors that increase the success of adolescent students with concurrent disorders in mainstream classrooms by examining the perceptions of teachers, administrators, and psychologists who have experience working with this population of students.

Through a series of semi-structured interviews, I strove to address the following questions:

1. What factors does a teacher perceive as being helpful for these students to achieve academic success (defined as achieving a passing grade in classes), and social success (defined as interacting appropriately with peers)?
2. From an administrator's perspective, what institutional plans are successful in supporting students with concurrent disorders when they study in a mainstream school?
3. From a psychologist's perspective, what personal factors help an adolescent student with a concurrent disorder achieve success in school (viewed objectively by the psychologist, including academic and social success)?

Several themes emerged from the data. Several responses were found to overlap, and the following themes were found to closely address the research questions.

Disclosure/Stigma

Kutcher et al. (2009) find that “approximately 15 to 20 percent of children and adolescents suffer from some form of mental disorder” – one in five students in the mainstream classroom (p. 44).

Marlene Cushman, a teacher in her 40s who works in an urban school pondered on the question of awareness and stated, “I don’t know if I was aware of it that much in the beginning of teaching. I don’t know if it’s something that may not have been there or it wasn’t something that I was as aware.” In the past 4 years Ms. Cushman has taken the role of Student Success Teacher¹ which has changed her understanding. “I’m more knowledgeable of some of the mental health issues of students because of my role and that’s not always made aware to the classroom teacher.” Ms. Cushman would notice behaviour changes and question “what’s going on with this student?” It appears that Ms. Cushman had to seek out information regarding students from the vice principal or from personnel from the guidance department, and would have rather been appraised of the situation for earlier intervention.

Students are often reluctant to share information with teachers. Lynn Faraci, a teacher in her 30s, spoke of the stigma impacting disclosure of mental illness.

So he’s addicted to marijuana and other things as well as medication for his mental illness. He’s reluctant to share with me specifics because I think it’s the stigma that still comes along with having mental illness, more so than the addictions. Most students won’t even admit that they are addicted

¹ Student Success Teacher: teacher assigned by principal to develop positive relationships exclusively with students who are struggling or who need extra attention to help them graduate; monitoring attendance, developing work and study skills; working with teachers on strategies for student improvement; working with teachers to create behaviours/improvement plans for student...providing the necessary supports so that every student has the potential for academic and personal success. (Toronto District School Board).

to marijuana, they think that it's acceptable and that it's the norm...but my concern is that coupled with the mental illness and the medication can be very detrimental.

According to the Canadian Mental Health Association in Ontario (<http://ontario.cmha.ca/mental-health/mental-health-conditions/stigma-and-discrimination>), individuals with a mental illness are faced with “multiple, intersecting layers of discrimination as a result of their mental illness and their identity” (para. 2). There are great consequences to the social representation (Moscovini, 2000) of people with mental illness. They are depicted as dangerous, violent and unpredictable. Due to the stigma associated with the illness, youth have found that they lose their self-esteem and have difficulty making friends. The stigma may be so pervasive that these youth refuse to seek help.

Judith Doering, a teacher in her 20s, has found that there are ADHD students identified in her grade 10 applied-level class. One student in particular has related issues of drug use.

I find that they tend to self-medicate – they tend to take drugs until they feel better. Or if the drugs maybe aren't the right thing for them, you find that they...we have one girl she becomes a problem because she feels gross about the drugs for ADHD...the drugs are making her feel controlled and different, she feels like she's not herself... so what happens is after that week she starts using marijuana quite heavily. She is very well known in our school for marijuana use and she uses it to treat – to self-medicate.

Teresa Wayne, an administrator working in an urban secondary school, reflects on similar situations in her school. She notes that, because of a lack of disclosure, the adults in the school are often left unaware of a mental illness until the compensatory drug use is discovered.

“[I]t’s never a real formal process of how we find out, it’s just kind of random or you’ll suspect that a student has some sort of a mental health issue or an illness and then three weeks later, you’ll have them under the influence of marijuana at school. So then you make the connection that the two together. It’s not a nice little scientific that they come in with the OSR [Ontario Student Record] with a flag on it that says...”

Consequently, there is a need for information disclosure and understanding as a way to combat the stigma associated with mental illness and drug abuse. Dr. Christine Bibeau, PhD, a superintendant with the school board, comments about the difficulty of implementing strategies to help students without being aware of their individual needs.

“When a kid goes to a hospital,...but because of their disclosure they don’t want anybody to know at the school [the reason for their hospitalization], I don’t know what this is, and the teacher wouldn’t know, and the principal won’t know this either, so it’s important to make sure that people feel comfortable stating that this is what I – and I’m thinking high school particularly – this is what I need in order to have a safe environment for me to learn. And if they don’t self-advocate – if they’ve already said “no, I’m not going to disclose to the school,” it makes it really tough for us.”

Dr. Bibeau continues to explain the disconnect between a student's outward appearance and internal struggles, by noting that "people are still struggling with if you look "normal" that they have a certain expectation of you...[and] if you don't meet that, then some people take it personally...instead of recognizing that it could be the disorder that's causing that." A similar sentiment was echoed by Ms. Wayne.

Again, I think it's just that sometimes people will stereotype. So they'll avoid the student who behaves differently and just write it off as, "Oh, they're a behaviour problem" or "Oh, they don't care about school" or "They're lazy 'cause they don't do things the way I do things." So we write them off too quickly.

Within the framework of social representation, characteristics or behaviours of the adolescent with a concurrent disorder are taken out of context and compared to the normative criteria of the social group. Thus, the student's behaviours are "separated from the field to which they belong to be appropriated by groups who, by projecting them into their own reality, can control them more easily" (Rateau, Moliner, Guimelli, & Abric, 2011, p. 482-483).

From a professional perspective, psychologists stress that the onus is on the student to advocate for themselves through disclosure. Dr. Adam Eckler, PhD, a psychologist working in a University Student Counselling Centre says,

"It's being able to talk to your professors, based on their comfort levels... So one is individualization, but two, is just dialogue...with the professor, again, with whatever they're comfortable divulging. By law, they don't have to say anything, they can just say "here are my accommodations, period". But

usually, when you foster dialogue with professors, when you promote understanding about what's going on with you, you build in flexibility.”

Social learning theory (Bandura, 1977) posits that an individual's behaviour is learned through observation of the consequences experienced by others in similar situations. The choice to not disclose, then, is influenced by witnessing the stigma faced by other students. According to the Canadian Mental Health Association (Ontario), “Experiences of stigma and discrimination is one of their greatest barriers to a satisfying life” (para. 6). This potential stigma is a stronger motivating force against disclosure than the potential help that may result from divulging a diagnosis to an educator.

The educators interviewed, both teachers and administrators, overwhelmingly expressed frustration about their students' choices not to disclose their mental health issues, and cited this choice as a significant barrier to establishing the necessary accommodations for success in the classroom. As Ms. Wayne ponders, “how do you save them all when you don't know who all of them are?” Psychologists, possibly because they are privy to this classified information, note that students must be made to feel comfortable enough to willingly choose to disclose to their teachers. All individuals interviewed agree that education is a necessary first step towards eliminating stigma. The school board represented by this study is increasingly promoting mental health within the system and the broader community. Dr. Bibeau comments that, while the initiative began with small numbers of interested individuals, “they keep growing now that we keep talking about it,” with the ultimate goal of reducing or eliminating the fear and misconceptions that surround mental illness. However, students must be made to feel safe

within their own schools (Ontario Ministry of Education, 2010), and educators play an important role in establishing this environment. As Ms. Wayne explains,

I'll say to kids, "Why are you worried? If you have diabetes, you take insulin. If you can't see, you wear glasses or contacts. It's not a problem. It's just something you need support with." And until as a society we become accepting of it, then I think it's not going to be as accessible for people to get to because the money isn't put into that area.

Academic Success Strategies

The Ontario Ministry of Education sets the requirements for graduation. To successfully complete secondary school and receive the Ontario Secondary School Diploma [OSSD], a number of fixed criteria must be met (<http://www.edu.gov.on.ca/extra/eng/ppm/graduate.html>). Consequently, there was a general consensus among the teachers and all other participants in the program that the expectations for academic success are the same as those for students in the mainstream. As Greg Sotelo, an administrator of a suburban high school, states that academic success is "achieving a credit."

However, most interviewees, both teachers and administrators, agreed that for some students, academic success involves more than a passing grade. Like Ungerleider's (2008) findings on the Student Success program, the success of these students in mainstream classes can be measured more in their greater attendance and general engagement than in improved grades. For many, academic success is intricately linked to class attendance. Mr. Sotelo notes the link between attendance, passing grades, and ultimately, self-esteem: academic success is "having them come to school, each and

every day, as consistently as they can, and achieving that credit so that they can get a diploma and feel good about themselves.”

Research shows that school refusal is associated with numerous mental disorders, including anxiety and depression (McShane, Walter, & Rey, 2001). Ms. Wayne describes the relationship of academic success and attendance using an extreme example:

I’ve had a student who initially was so debilitated that they couldn’t attend school...who was in and out of hospitals; last semester was on home instruction the entire semester, and is back at school one period a day. To me that’s academic success. She was successful – got all of her credits last semester not even being in the mainstream high school – and now is still doing three credits on home instruction but one credit back in school. And then hopefully to continue with this success rate, she would go to two periods until she could integrate back in.

The ultimate goal, it follows, is to encourage students to return to a mainstream classroom setting, a view echoed by Nora Hirst, a school psychologist who oversees both elementary and secondary schools. Following treatment, it’s “very likely” that students will return to their regular classrooms. She continues:

There’s follow-up, there’s re-entry meetings – we have a very close relationship with [community treatment agencies] so when students are discharged, we have a one-day grace period that gives us a chance...to prepare for the child’s re-entry. We work very hard to reintegrate students back into the classroom.

When students are in a positive classroom environment, Bandura's social learning theory (1977) posits that all students will be able to capitalize on the constructive socializing effects of peers and teachers. Further, this placement should help a student to increase pro-social behaviour by providing a safe environment in which modelling and reinforcement can be provided.

Just as social representation theory proposes that "there is a greater degree of choice concerning alternative ways of living and of strategies for how to get there" (Höijer, 2011, p. 4), the pathway to academic success may differ considerably between students with concurrent disorders and their non-affected peers. As Ms. Cushman states,

So when you're talking about someone with a concurrent disorder, their path may veer off many times...I think some of them do the same things for different reasons. I think that they kind of get there at different rates.

There is a lack of consistency with respect to classroom or school-wide strategies that have been found to be effective for helping students with concurrent disorders achieve success in the mainstream classroom. In general, the interviewed teachers focused on strategies that they could implement within their classrooms. Acknowledging the generally-poor attendance record of this population of students, the teachers noted that clear expectations and routines are helpful to a student returning to class after an absence. Ms. Doering describes how her class website helps her student (who has a concurrent disorder) stay current with the coursework. "I update the website at the beginning of the week, so if she knows she isn't up for coming to class that week, she will download all the lessons for the week." The expectation – that the student must keep up with the rest of her class – is clear.

However, Ms. Cushman stresses flexibility when working with a student with concurrent disorders. When referring to missed work, she says:

I try and come up with plan B, and when plan B doesn't work, then plan C – and we just keep working together on the next plan: So what are we going to do? Where are we at? What can you do?

Research suggests that maintaining clear expectations, while providing the flexibility needed to successfully complete course requirements, is helpful for students with mental illness to achieve academic success (Johnson, Eva, Johnson, & Walker, 2011). When asked about other strategies that she thought would be helpful, Ms. Cushman reiterated the importance of “being really explicit, really explicit with the student in terms of what the expectations is. Very explicit and very available. This is what you need to do be successful.” The teachers in this study, however, had difficulty coming up with additional strategies that could be used to support this population of students, though Ms. Cushman was the only one to recognize this shortcoming:

I think this is probably the one area where we could use more, as classroom teachers; more support and more information on how to do that in the classroom and how to help the student because they really need both.

In contrast to the teachers' responses, the administrators attributed academic success to school-wide supports. Mr. Sotelo describes the factors within his school:

We have our learning support teacher, for those kids with concurrent disorders who also have an exceptionality. Our credit recovery program is there, our student success teacher is there, our guidance counsellors – so the structures are in place to try to catch all the students.

Ms. Wayne also describes similar programs, such as “student success programs, learning support teachers, guidance, a crisis team, all of those things are structures that are there,” within the urban secondary school. This reflects a consistency among the implementation of policies set forth by the Ontario Ministry of Education (student success², credit recovery³, and learning support⁴), but not those that are specifically initiated through the board (crisis team). Dr. Bibeau describes this school board initiative:

[W]e’ve got the crisis team, which is new this year. ...Within the social workers we have a crisis team now – so if a kid is in imminent...risk...then we can call upon this team and they come and immediately make those partnership connections...so it’s easier for everyone.

Overall, all interviewees expressed a desire to help all students achieve academic success despite the inconsistencies in suggestions for implementation. Thus, while some strategies are being implemented to assist students with concurrent disorders to achieve academic success, there is a noticeable lack of direction about specific strategies that can be used within the classroom.

Individualized Attention

According to Health Canada’s “Guide for Best Practices in Concurrent Mental Health and Substance Use Disorders” (Rush, 2002), the term “concurrent disorder” describes an individual that is experiencing any combination of

² Student Success/Learning to 18 is a strategy which gives educators, parents, employers, college and university partners, students and others the necessary tools to create an engaging school experience for all teenagers. (<http://www.edu.gov.on.ca/eng/teachers/studentssuccess/strategy.html>)

³ Credit-recovery programs help students earn the credits they have previously failed to achieve, as they develop the learning skills needed for academic success. (<http://www.edu.gov.on.ca/eng/studentssuccess/learning/files/strategies.pdf>)

⁴ Learning support teachers work collaboratively with students, parents and teachers to accommodate a student’s specific learning needs as stated in the student’s Individual Education Plan and to develop strategies to help compensate for learning differences. (<http://www.tvdsb.ca/Glendale.cfm?subpage=81996>)

“mental/emotional/psychiatric problems with the abuse of alcohol and/or another psychoactive drug” (p. v). Because the symptoms of a concurrent disorder can reflect the underlying mental illness, the effects of the substance being abused, or a combination of both conditions, the appearance of a concurrent disorder will vary from student to student, and the factors that will affect his/her success will also differ. Harre (1984) notes that “social representations are not *social* in the sense of belonging to the group, they are *individual* representations, each of which is similar to every one of the rest” (p. 930). However, individual students are not like all the rest. Dr. Eckler, familiar with the non-uniform appearance of students with concurrent disorders advises:

From my perspective, and maybe this is the bias of talking to a psychologist, is that it really has to be individualized. So accommodations – you can’t have blankets – I don’t think there is a blanket accommodation for students with concurrent disorders. What’s going to work for John isn’t going to necessarily work for Mary. So you really have to see what’s going on with the person.

Ontario’s Ministry of Education has a policy regarding differentiated instruction for all students, recognizing that students have different strengths and needs, and that all students are entitled to an opportunity to demonstrate their learning and achieve success (Ontario Ministry of Education, 2010b). By “offering [the] student a learning experience that responds to his or her individual needs,” (Ontario Ministry of Education, 2010b, p. 146), students with concurrent disorders are simultaneously able to assimilate and modify the social representations assigned to them (Höijer, 2011).

Ms. Cushman suggests a strategy for constructing individualized strategies with the students themselves that can then be shared with the teachers:

Are there any additional factors that could be implemented school-wide to help students with concurrent disorders? I think that [forming] intimate programs,...very targeted, very individualized, small groups, [of] students that are dealing with the same issues and sort of supporting them and then coming up with ideas and strategies, telling them what some of them are. I think that comes back to being very explicit with them, here are some strategies you need to cope with the issues you are dealing with, and now we are going to share that same strategies with your teachers who are going to try and implement them in your classroom, as well, to support you.

From a constructivist theoretical framework (Cunningham, & Duffy, 1996), students are able to take ownership of this learning activity, thereby making it more personal and salient. Further, working with other students facing similar challenges, in the presence of an understanding adult, offers the opportunity for students to model appropriate, pro-social behaviours, such as goal-setting and problem-solving.

It is important to realize that students, whether or not they are affected by a concurrent disorder, have unique abilities and enter the classroom with their own unique histories. Bandura's social cognitive theory (1991) acknowledges that an individual's behaviour is an interaction of personal factors, behaviour, and the environment. Consequently, when addressing such behaviour in the classroom, a teacher must consider

each student's individual needs. As Dr. Bibeau challenges, it is the responsibility of the teacher "to teach the whole child."

Teacher-Student Relationship

DeWit, Karioja, Rye and Shain (2011) found that emotional support from classmates and teachers is a powerful protective factors in preventing or reducing student mental health problems. Social comparison theory (Festinger, 1954) or social representation theory (Moscovini, 2000) explain student perceptions of the loss of classmate and teacher support in the transition from elementary to secondary school may increase mental health problems occurring in the transition from elementary (middle) school to high schools (DeWitt, et. al., 2011).

This theory is supported by Ms. Wayne's belief that it is "the caring adult; that's what it comes down to." As she reflected on a comment by one of her teachers, "you know, we don't know the student's stories, we don't know what they come with" she addressed an unspoken thought that "you should know what they come with. If you don't know anything about the student, [how can you teach him or her]?" The mission of the school board involved in this research confirms that teachers need to teach the whole child and help them reach their full potential academically, emotionally and socially.

So how do we address the gap between expectations as per mission statement and priority goals and what really happens between secondary school teachers and their students? DeWit et. al.'s (2011) findings of strong correlations between declining teacher support and diminishing mental health suggest that teachers play a significant role in the prevention of student mental illness and that all stakeholders implement policy on

improving the quality of the interpersonal relationships between high school students and their teachers.

Mr. Sotelo justifies the role of relationships in academic success, and in working with students with concurrent disorders, by describing the structures that are in place in his school.

As a school we have adopted the “save one student” philosophy. We look at student marks and staff reflects on where the students are with respect to success. What can we do to ensure successes? We have our learning support teachers for those with concurrent disorder with exceptionalities. We have the structures in place – Student Success teachers, guidance counsellors – so structures are in place to capture all the students. The difficulty comes when a student completely disengages, refuses to come to school or they come to school and treat it like a mall.

As for the student’s social success, the relational piece also emerges. However, there is no link between the emotional and the academic piece. Mr. Sotelo brings up the save one student philosophy, “those interpersonal skills, not beating on the student and interpersonal: yes, you can get the credit, don’t give up, I will count it as a double assignment, providing opportunities not giving up on them.”

He tells the staff to be the kind, caring, compassionate adult since they may be the only one in the student’s life. “We want respect, responsibility, citizenship for all our students...it’s a school for everyone...everyone is accepted, included and valued.” With this said, students are being suspended daily in all schools.

Dr. Bibeau affirms that teachers need to take the responsibility and need to develop good interpersonal relationships. Accordingly, this reduces classroom management issues, attendance problems, and disengagement. “It is a power base of teaching style, that the kids will retain more when there’s that connection piece.” When thinking of students that commit suicide, Dr. Bibeau wonders, “did they have that person that they could go to?” According to the Society for the Prevention of Teen Suicide, Inc., suicide is still the third leading cause of death among teen and second among college students; almost 9% of high school students reported a suicide attempt in the past year and 25% report suicide ideation. The suicide rate is increasing for youth age 10-14 (<http://www.teachervision.fen.com/education-and-social-issues/mental-health/57131.html>).

As a novice teacher, Ms. Doering believes that some of the issues are beyond an interpersonal relationship, and there is a need for medical health support. “I am diligent in watching behaviour changes and in staying a consistent support; however, some students need higher levels of intervention”.

At the university level, dialogue is necessary to create a safety net between health professionals. Dr. Eckler believes that interaction is totally the responsibility of the student. At this level, although the stigma and bias exist, students need to be encouraged to seek help. With large classes it is difficult to develop interpersonal relations with professors. There is an onus on the student which really makes it a challenge for those with poor social skills.

Han and Weiss (2005) found that high teaching efficacy⁵ is directly related to successfully implementing strategies to help students with mental illness and addiction. Therefore teachers who struggle with teacher-student relationships report greater stress in their careers, including issues with management of disruptive student behaviour, and disengagement. Many of these behaviours are linked to student mental illness and addiction (Perfect & Morris, 2011). Along with dealing with the stresses, teachers need what Bandura (1977) coins as “personal agency” or the ability to direct their actions towards their ultimate goal – student success.

Research shows that a positive student-teacher relationship plays a significant role in helping students achieve academic success in the classroom (Bernstein-Yamashiro & Noam, 2013a; b). Further, this relationship enables the modeling of socially-acceptable behaviours that students with concurrent disorders often find challenging (Bandura, 1977). However, there is a lack of accountability in this area of teaching; while the task of meeting curricular expectations is measurable, the student-teacher relationship remains unmonitored. As Dr. Bibeau astutely notes, “if a kid is hearing voices, and they’re sitting there, they’re not going to be learning math, or social science, or whatever,” and it is up to the observant, compassionate teacher to notice the change in the student, and to initiate dialogue.

Awareness and Knowledge, More Professional Support

A consistent theme permeating the answers of all interviews was the need for education, both for students and for the adults that work with them. Research supports the role of information in reducing the stigma associated with mental illness (Atkins,

⁵ Teacher efficacy is defined as a teacher’s confidence in his/her ability to promote students’ learning (Hoy, 2000). Derived from Bandura’s social cognitive theory.

Hoagwood, Kutash, & Seidman, 2010), but there is little consensus on the optimal way to integrate mental health awareness into the curriculum or into extra-curricular programs. Mr. Sotelo recalled that “when we can, bring outside people from the community to talk to the students” about mental health. However, Dr. Eckler proposes that “it’s got to be – I think the stuff that is most effective is done by students, for students.” By acquiring information from peers, students have the potential to gain unbiased, accepting models of behaviour, supported by social learning. Research suggests that peer learning has positive effects on student achievement while helping students practice various skills that are needed for future employment (Riese, Samara, & Lillejord, 2012), and Reinke, Stormont, Herman, Puri, and Goel (2011) note that school-based prevention programs effectively reduce the negative impact on learning and social development associated with mental health programs. Thus, there is a significant connection between mental health education for students and positive effects on academic and social performance.

However, teachers, since they spend numerous hours in a classroom working closely with students, have the opportunity to recognize changes in their students’ behaviours. As Dr. Bibeau notes, “teachers have to take the responsibility and have to know that that’s part of their job in order to foster really good interpersonal relations” so that when there is a change in a student’s behaviour, the teacher may intervene, as appropriate. Without accurate, accessible knowledge, though, teachers may not see their place in early intervention, and may not feel comfortable fulfilling their role. As Ms. Faraci noted about her colleagues,

I don’t think we’re there yet entirely with all staff...I think that it needs to be more information and we need to become more knowledgeable and embrace it.

Some teachers are very critical to early intervention. We need to be able to communicate with them.

The teachers and administrators interviewed, though, overwhelmingly expressed a desire for more strategies to help students with concurrent disorders within their domain of responsibilities. Teachers such as Ms. Cushman noticed the lack of classroom strategies for students with mental illness and wished for more information about tactics that would help them succeed.

When you have a student who is struggling academically, and they don't know algebra and they can't get the algebra, there are a few strategies you can use to try and teach them how to do algebra. We have strategies for literacy. If you can't do an open response question, here are a couple of strategies to teach that student. It would be great if there were strategies for helping students socially and saying, "here are three things that you can do in your classroom to support your student socially." Great! I will try those things! Some may work for me, some may work for that student.

That's what I would like. Ideally.

Administrators also noted the need to help teachers further their own knowledge, enrich their teaching practice, and implement strategies to help students with concurrent disorders achieve success in the classroom. As Ms. Wayne noted:

I think part of that is training. So how can we find other ways that staff can become more knowledgeable about it so that we as administrators are... confident in knowing what [teachers] should do, where you go to next, what's the next plan, without making it – and I don't want to use the word

“extra work” – but without making it extra work? Because you’ve already got so much as a classroom teacher in terms of curriculum and marking and lesson planning and all of that. How do you make [strategies] just a part of what you do and know how to do it just as well as you know how to teach the curriculum? And I don’t know how I would support you to do that, but it would be good if we knew how.

In a study by Reinke, Stormont, Herman, Puri, and Goel (2011), 75% of teachers surveyed acknowledged teaching a student with a mental health problem, and believed that schools have a responsibility to support the mental health of their students. However, only 34% of teachers felt that they had the necessary skills to support this population of students. When a mental health awareness training program is implemented, however, teachers’ knowledge about the illnesses increases, stigma is reduced, and teachers feel more confident in their ability to provide help for their students (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010). Clearly, there is a need to educate the educators in this situation. As Dr. Bibeau expresses, “it’s my firm belief that teachers do the best things for kids,” and consequently, they deserve to be provided with the necessary tools needed to optimize their teaching practice.

Parental Involvement

According to the Concurrent Disorders Ontario Network (2005), living with youth with concurrent disorders has a profound effect on the family. As well, college students under emotional duress find parents as a major source of stress. The Centre for Addiction and Mental Health suggest that families need help to deal with the impact of concurrent disorders, but families are also a key to finding effective solutions. According to

Tannenbaum (2005) parents represent the central dimension of the system of care. The importance of involving families is being recognized as a best practice in providing quality services to youth with mental illness (Chovil, 2009).

All participants in the research affirmed the need for parental involvement when providing the best directions for youth with concurrent disorders. Ms. Doering was frustrated with the lack of response from a parent with a struggling teen in her class that is experiencing a concurrent disorder:

They've washed their hands of it. Her parents – we did communicate several times – nothing has come of it. They do not return my calls. I think at this point they are frustrated with their daughter, which is understandable, but they are still a necessary part in her education.

Ms. Cushman believes that family support is important for all students.

I think the key is finding how strong it is. If there is any kind of substance abuse with the family unit then their ability to support is much less than another family. As a Student Success teacher, we find things from the schools in terms of what the parent support is because until you call [community agencies], some parents won't be proactive.

Frustrations with parental support appear to impact teachers' efficacy to help the student both academically and socially.

From Ms. Wayne's perspective, it is important to engage all parents.

Consequently, she finds it unfortunate that parents are not made aware nor invited to the workshops on mental health for educators. When talking to her parent council, Ms. Wayne suggested that all parent councils in the region be invited to a Mental Health

Seminar hosted by the school: “We need to do more with families and sometimes the families just don’t know where to go”.

According to Ms. Faraci,

...parental/family involvement is huge. They need to be in communication with teachers and administration on a regular basis. They need to be accepting, flexible and cooperative and they need to work with their child and helping them understand that without the assistance they will not every get on that road to seeing academic or social success.

Affirming Tannebaum’s (2005) statement describing parents as the central dimension, Dr. Bibeau suggests, “parents are the ones that are going to drive where treatment is available,” and “because school is not 24/7 and school counseling is not available during the holidays or in the summer between June 28 and September 3”, students need a consistent level of involvement to become mentally healthy.

Dr. Eckler agrees that parental support is a huge component of improving the mental health of the student with concurrent disorder.

We have the caring adult model. Sometimes the parent is just as at-risk as the student. The parent is unemployed, looking for a job...some are not well kept. Parent doesn’t engage, student doesn’t engage. Some parents don’t want to recognize that their child has a problem...we try to set them up with supports like [a local academic/treatment facility]...you really do need to get your son assessed by the doctor for refusal....parents don’t have the benefits through work, or they just chose to ignore it until it’s too late...parental influence is huge...some wealthy parents provide material

things but may lack quality time with their child...it's a growing issue.”

Basically, family engagement is a “huge” piece of the mental health issue.

According to Chovil (2009), “there is more than sufficient evidence that demonstrates the necessity to engage with families...as families, children and youth are intrinsically woven together, as are their mental health needs.” (p. 32).

Alternative Settings

The Ontario Ministry of Education allows for supervised alternative learning environments to meet the needs of students who, for various reasons, leave school before graduation. Within the policy document, it is explained that one reason students leave school early is for personal reasons of “mental illness, or problems with substance abuse” (Ontario Ministry of Education, 2010c, p. 4). Emphasis, however, is placed on prevention; the ideal environment for students is the traditional school setting. In order for all students to experience success, certain accommodations must be made for students who have specific needs. Ms. Hirst describes a successful resource for students who may have difficulty dealing with some aspects of a regular school day.

In some of our high schools, they have what they call a transition room. It functions, in some ways, like a drop-in centre, although most of the time they try to have it organized so [classroom] teachers will let teachers in the transition room know “tomorrow I’m going to be working on this assignment. It’s probably going to be challenging for so-and-so, so can I have them work with you in the transition room?” or “Can they write their test in the transition room to avoid some stimuli in the regular classroom that may be a trigger for this child to have difficulty?”

While acknowledging the need for preventative measures and strategies, a few students can best be served by participating in programs that meet their needs outside of a traditional classroom. Within the community researched in this study, there are several such agencies that can treat students with concurrent disorders. Many interviewees, including Ms. Wayne, acknowledged the importance of these resources: “So I think part of [a student’s success] is having an opportunity for home instruction for students that need it. I think having the agency schools...as a partner is really important for students.” In some situations, these agency schools provide the only environment in which a student can succeed. However, without the opportunity to interact with a larger number of individuals, both adults and peers, students miss the potential learning experience that arises from this social situation; their behaviour cannot be shaped by the traditional secondary school environment unless additional accommodations can be made. Mr. Sotelo described examples of these accommodations which are successfully implemented in his school.

We do [make special arrangements]. Sometimes they’re shared students. They may be going to [an alternative academic/treatment facility] for half the day, and then coming to us for the remainder. So sometimes those academic considerations are met. It may be for a full semester where they go half a day there and half a day here, or it may be one semester there then they come here for the second semester.

In order to reach more students, a balance must be reached between general preventative measures and a more extreme withdrawal from school. The Ministry of Education (2010c) suggests school-based alternative education settings that provide

students with an opportunity to model skills both in a traditional classroom as well as non-traditional settings. Mr. Sotelo describes that

We've expanded cooperative education⁶ opportunities for kids, so that they can see the fruits of their labour. Whether it's the home builders program that we have, or whether it's the foods program that we just set up – you know, different kinds of opportunities for kids – it's not just sitting in the classroom, writing notes, and listening to a teacher, so they're more engaged and active.

Thus in this situation, students are able to learn in an environment that is outside of the school while simultaneously remaining a part of the school community. Research suggests that school connectedness serves as a predictor of future mental health problems (Shochet, Dadds, Ham, & Montague, 2006), therefore striving to meet the needs of all students, including those with concurrent disorders, within the traditional classroom should be a priority within schools.

Summary

Teachers, administrators, and psychologists agree that there are a significant number of secondary school students experiencing the symptoms of a concurrent disorder. Furthermore, there is consensus that, in addition to being able to access community mental health resources, it is essential to have structures and strategies in place within the traditional school to support the academic and social needs of these students. However, there is a noticeable lack of consistency, as well as a lack of

⁶ Cooperative Education is a ministry-approved program that allows students to earn secondary school credits while completing a work placement. The program consists of a co-op course monitored by a cooperative education teacher, a related curriculum course in any subject and a work placement. (Ontario Ministry of Education Co-op Factsheet: <http://www.edu.gov.on.ca/morestudentsuccess/coopFact.pdf>)

confidence, regarding the details of such strategies. While several empirically-supported strategies are being implemented to meet the individual needs of students, there is a lack of information and direction regarding the universal implementation of such interventions across the school or school board.

CHAPTER 5

DISCUSSION

Research indicates that concurrent disorders are prevalent in the general population, with nearly half of all individuals diagnosed with a mental illness exhibiting a concurrent substance abuse disorder (Blanchard, 2000). Further, adolescents are at a significant risk of an early onset of mental illness or substance abuse, and the U.S. Department of Health and Human Services (2002) notes that 10% of students with mental illnesses experience distress that is significant enough to cause social or educational impairment (Trussell, 2008). Thus the potential consequences of concurrent disorders on students as they progress through adolescence cannot be denied.

There are no clear results from this study. Findings from this research do indicate that teachers, administrators, and psychologists are aware of students with concurrent disorders within the mainstream secondary school population, and have experience working with this population of students. There is general consensus that the number of adolescent students exhibiting symptoms of a concurrent disorder within the secondary school environment has increased in recent years, and that these students have special needs that may or may not be met successfully within the classroom, however there is no clear consensus about strategies or factors that can help increase the success of this population of students.

Stigma and discrimination represent major barriers to reaching goals that individuals with mental illness may set for themselves (Canadian Mental Health Association, <http://ontario.cmha.ca/mental-health/mental-health-conditions/stigma-and-discrimination/>). Social representation theory (Moscovici, 1984; 2000) posits that

individuals create a system of naming and classifying various aspects of their world in order to make sense of them. Consequently, negative stereotypes arise from the fear of the unknown – from the classification of individuals with mental illness as “different.” From the results of this study, it is evident that stigma within the schools prevents students from disclosing their needs to teachers and administrators, thereby denying themselves access to resources and services that may increase their potential for success. There is some disconnection between the implementation of school board-directed initiatives regarding mental health awareness and their impact on classroom practices. There is, however, a general consensus among participants that further education about mental wellness is necessary to decrease stigma.

Further, while there is agreement among all participants that strategies should be implemented within the classroom, and other initiatives should be taken within the school, there is a definite lack of information regarding the type of intervention that should be followed. There is no board-wide policy or recommendation to guide teachers or administrators, thus each individual must develop his/her own classroom strategies based on his/her own experience. Some strategies used by the teachers interviewed in this study are supported by empirical evidence, such as the consistent application of clear expectations, while providing the flexibility needed to successfully complete course requirements, and is helpful for students with mental illness to achieve academic success (Johnson, Eva, Johnson, & Walker, 2011). However, the fact that teachers were unable to name other, varying strategies, reflects the need for additional training in this area. Evidence-based practices exist with respect to teaching students with mental illness and substance abuse (Reinke, Stormont, Herman, Puri, & Goel, 2011; Johnson, Eva, Johnson,

& Walker, 2011). Descriptions of effective strategies must be consolidated and shared among educators.

Participants reflect that the current practice of individualized instruction is beneficial for the academic and social success of students with concurrent disorders. Regardless of the role of interviewee, the importance of the uniqueness of each student, whether or not they are affected by a concurrent disorder, is of utmost importance for a successful academic or social experience. Teachers felt comfortable implementing strategies of differentiated instruction, being familiar with this policy set forth by the Ontario Ministry of Education (2010b). The concept of individualizing instruction is supported by Bandura's social cognitive theory (1991), as the student's outward behaviour will reflect the interaction of his/her personal factors with the classroom environment. Consequently, if the classroom environment can be altered through specific teaching strategies, or the personal factors modified through appropriate treatment for the concurrent disorder, appropriate behaviour (including academic and social success) can follow suit.

Further training and education is required for teachers to gain confidence in their ability to help students with concurrent disorders achieve success in the classroom. Research confirms that, while students with concurrent disorders are present in mainstream classes in significant number, teachers lack confidence in their ability to effectively teach this population of students (Reinke, Stormont, Herman, Puri, & Goel, 2011; Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010). Education and support for teachers must be widespread. It is important, but not enough, to simply provide teachers with a list of classroom strategies to use with students with concurrent disorders. School-

wide support, including the need for interventions or programs targeting stigma reduction, is required for social misrepresentations to be eliminated, and for students with concurrent disorders to feel fully included in the school environment.

In order for any classroom interventions to be effective, teachers must first establish significant, positive relationships with their students. Research shows that the student-teacher relationship plays a significant role in helping students achieve academic success in the classroom (Bernstein-Yamashiro & Noam, 2013a; b), and the social learning theory (Bandura, 1977) supports the development of social skills through the modelling and practice of these skills with, or under the supervision of, a caring adult. Participants unanimously agreed that teachers have the unique opportunity to know students both on an academic and extracurricular basis, and this relationship enables them to identify early warning signs of concurrent disorder within their students. This challenge for early intervention is set forth by the various Ontario mental health policies (Ontario Ministry of Children and Youth Services, 2006; Government of Ontario, 2011), and reflects the positive impact of timely treatment on an adolescent's potential for success.

However, while the positive teacher-student relationship was universally recognized as important by the respondents in this study, it was also recognized to be an inconsistent feature in practice. Despite its significance, there is a lack of accountability in this area of teaching. The Ontario Ministry of Education sets forth explicit, measurable guidelines for meeting curricular expectations, but the student-teacher relationship remains unmonitored. Assessing curricular standards is a straightforward task; however, assessing the student-teacher relationship presents a much more challenging obstacle.

Other relationships are also important for both academic and social success in secondary school. Research undeniably supports the association between family engagement in the school with academic success (Bernstein-Yamashiro & Noam, 2013a, 2013b; Tannebaum, 2005; Chovil, 2009). The results of this study confirm this association, with participants reflecting both on positive instances, as well as cases that were complicated by a lack of family support.

Thus, the factors that affect the academic and social success of adolescent students with concurrent disorders are numerous and complicated. However, research suggests that a student's perceived connection to his/her school connectedness serves as a predictor of future mental health problems (Shochet, Dadds, Ham, & Montague, 2006). The participants in this study acknowledged the need for community agencies and alternative academic settings for students with extreme symptoms, though the resources available within the school environment were also favourably noted. Striving to meet the needs of all students, including those with concurrent disorders, within the traditional classroom should be a priority within schools

Implications

This study adds to the research concerning the education of adolescents with concurrent disorders. The findings of this study indicate a significant gap between evidence-based practices emerging in the literature, and the familiarity of teachers with strategies to encourage student success within a population of students with concurrent disorders. While there is a desire on the part of teachers for increased education, there is limited availability of resources that can be accessed from governing bodies. There is a need for practical, classroom-based strategies that encourage inclusion of all students.

Future research gathering evidence-based strategies that promote the success of students with concurrent disorders should include the use of teacher focus groups to facilitate idea-sharing and dialogue regarding the practicality and/or effectiveness of suggested strategies.

In the current study, it was shown that teachers with more experience had more strategies that they could draw upon to support the students in their classes. Furthermore, it stands to reason that they will have more opportunities to practice various strategies with a larger number of students with concurrent disorders, simply based on the fact that they have taught a larger number of students over the years. Consequently, the results of this study indicate that it would be beneficial for teachers to learn strategies from one another through focus groups or professional learning communities. In an informal collaborative learning environment, teachers will be able to share their classroom strategies, both effective and ineffective, to generate additional ideas that can be implemented in their classrooms to enhance the success of all students, especially those with concurrent disorders.

However, while the informal sharing of knowledge and experiences is important, it is essential that educators – both teachers and administrators – receive formal professional training with respect to concurrent disorders. In order to ensure that misconceptions and inaccurate social representations are not propagated, training should be led by professionals. Psychologists from community agencies, familiar with the needs of adolescents with concurrent disorders, are the most appropriate facilitators of such teacher training. Ideally, training in mental health should be a requirement of the teacher education program; if new teachers are expected to meet the needs of all students in the

classroom, it is imperative that they have the appropriate foundation of knowledge to do so. Such training should include not only information about the basic signs and symptoms of mental illness and concurrent disorders, but also information regarding therapeutic strategies pulled from psychology. While teachers are not expected to take the place of professional therapists, they must be aware of effective therapeutic techniques that will help them communicate with their students. The teacher-training program would also be an ideal environment to introduce a formalized plan of strategies that can help students with concurrent disorders achieve success in a mainstream school setting.

Further, the importance of the teacher-student relationship, supported by empirical evidence, is noted but unmeasured. Additional research into factors or qualities affecting this relationship, both positively and negatively, would serve to qualify (and/or quantify) this critical component of student success. Such research could also have implications for teacher education programs, which stress the academic (curriculum) piece of teaching, while deemphasizing the humanistic (social) piece of teaching. In an ideal educational setting, smaller classes would help teachers develop more meaningful relationships with their students.

Last, this study suggests a top-down model for the development and implementation of classroom strategies to help students with concurrent disorders to achieve success (i.e. the strategies would be prepared as guiding policy from the school board). Further research should compare this approach with a bottom-up strategy, whereby students with concurrent disorders, working with peers or their teachers, identify their unique needs and co-create a strategy that could be used in the classroom.

Limitations

Although care was taken to maximize the validity of the study through triangulation of the participants' perceptions, as well as data analysis, the small sample size of this study is a notable limitation. Further research is needed to assess whether the themes that emerged from this study are applicable to a larger sample of participants, and to build upon, or create additional, themes regarding the factors affecting success for students with concurrent disorders.

The interview structure was selected to be semi-structured because of the constraints of time associated with the completion of the thesis. Consequently, the depth of information gathered is less than could be collected with an unstructured interview format (Lester, 1999). Subsequent research is necessary to build upon the data generated in this study.

Further, it is beyond the realistic scope of this research study to interview students with concurrent disorders about their personal experiences. It was also impossible to address the perspective of the parent/guardian within the framework of this study, although it would be important to investigate this area in future research. Subsequent research would be required to obtain data from these populations.

Last, this research was conducted within a single public school board, covering a region in Southwestern Ontario. All data presented in this study applies directly to schools within this school board and/or schools within this region. Further studies, involving participants from a broader geographic area, would be beneficial to increase the potential to generalize the results.

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APPENDICES

Appendix A: Interview Questions

Questions for Teacher Interview

1. Please describe, in general terms, your experience with students with concurrent disorders in your classroom (i.e., have you taught students with concurrent disorders in the past, how many, when, etc.)
 - a) Were you aware of the student's condition?
 - b) If so, who informed you? How were you told?
2. How confident were you in your ability to help a student with a concurrent disorder achieve success in your classroom?
 - a) What gave you confidence?
 - b) Did you have any training (professional development seminars, workshops, etc.) regarding concurrent disorders or a related topic?
3. How do you define academic success for students with concurrent disorders?
 - a) How does this differ from the mainstream student population?
4. Thinking about the student's academic success (i.e., passing marks):
 - a) What classroom *structures or strategies* (classroom routines, assessment techniques, teaching strategies, agreements between the teacher and student for leaving the classroom, missing tests/assignments, etc.) were in place to make this success possible?
 - b) What *materials* (curricular or supplemental) helped the student achieve success?
 - c) What *interpersonal* interactions (between the student and his/her teachers, support staff, other students, etc.) enabled him/her to achieve success?
5. How do you define social success for students with concurrent disorders?
 - a) How does this differ from the mainstream student population?
6. Thinking about the student's social success (i.e., socially acceptable interactions with peers):
 - a) What classroom *strategies* were in place to make this success possible?
 - b) What *materials* (curricular or supplemental) helped the student achieve success?
 - c) What *interpersonal* interactions (between the student and his/her teachers, support staff, other students, etc.) enabled him/her to achieve success?
7. What types of administrative support are available for the student? Please describe them with respect to their accessibility and feasibility.

8. Thinking back to your experience teaching students with concurrent disorders:
 - a) Is there anything you would do differently within your classroom to help the student achieve *academic* success?
 - b) Is there anything you would do differently within your classroom to help the student achieve *social* success?
 - c) Is there anything that administrators within the school could do to help *you* to help the student within your classroom?
 - d) Are there any additional factors (programs, campaigns, support, etc.) that could be implemented school-wide to help students with concurrent disorders achieve success?
9. What additional administrative support should there be?
10. From your perception, is there anything else within the school system that can help a student with a concurrent disorder achieve success academically or socially?
11. Please describe the importance of parental/family support on student success (academic or social) in this population.
12. Do you have anything to add?

Questions for Administrator Interview

1. Please describe, in general terms, your experience with students with concurrent disorders in your school (i.e., how many, when, etc.)
 - a) How were you informed of the student's condition?
2. Speaking in general terms, were you asked to make any special arrangements within the school for these students?
 - a) If so, what were they?
3. How confident were you in your ability to provide an environment that could help a student with a concurrent disorder achieve success?
 - a) What gave you confidence?
 - b) Did you have any training (professional development seminars, workshops, etc.) regarding concurrent disorders or a related topic?
4. How do you define academic success for students with concurrent disorders?
 - a) How does this differ from the mainstream student population?
5. Thinking about the student's academic success (i.e., passing marks):
 - a) What school-wide *structures or strategies* (routines, programs or initiatives, support systems, etc.) were in place to make this success possible?
 - b) What *materials* (curricular or supplemental) helped the student achieve success?
 - c) What *interpersonal* interactions (between the student and his/her teachers, support staff, other students, etc.) enabled him/her to achieve success?
6. How do you define social success for students with concurrent disorders?
 - a) How does this differ from the mainstream student population?
7. Thinking about the student's social success (i.e., socially acceptable interactions with peers):
 - a) What school-wide *structures or strategies* were in place to make this success possible?
 - b) What *materials* (curricular or supplemental) helped the student achieve success?
 - c) What *interpersonal* interactions (between the student and his/her teachers, support staff, other students, etc.) enabled him/her to achieve success?
8. What other types of support are available for the student? Please describe them with respect to their accessibility and feasibility.
9. In your opinion, did the procedures in effect in the school help the student with a concurrent disorder achieve academic success? Social success?

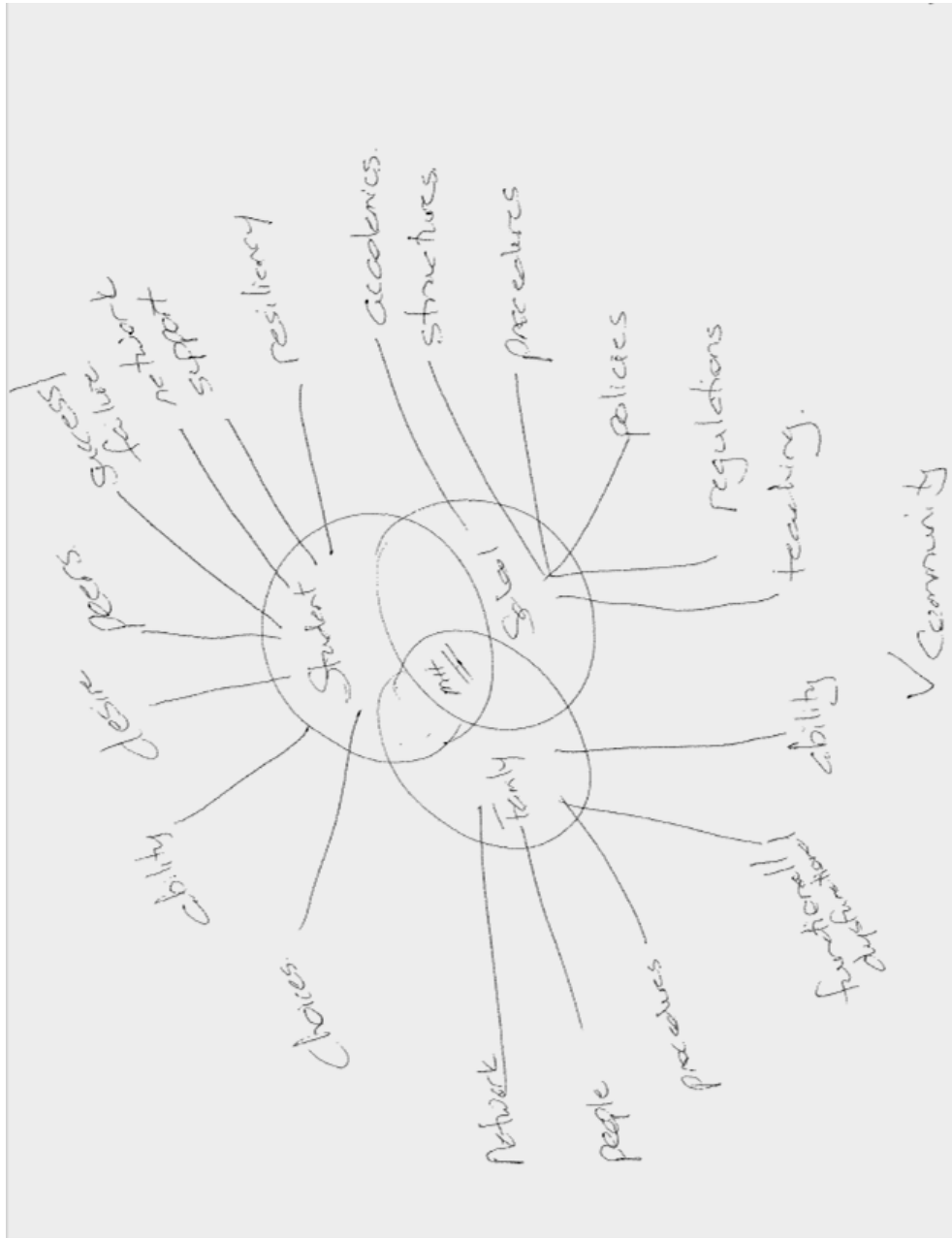
- a) Is there anything you could do differently to help the student achieve *academic* success?
 - b) Is there anything you could do differently to help the student achieve *social* success?
10. From your perspective, what role does the classroom teacher play in helping a student with a concurrent disorder achieve academic and social success?
 11. How can the administration support teachers in helping a student with a concurrent disorder achieve academic and social success?
 12. From your perception, is there anything else within the school system that can help a student with a concurrent disorder achieve success academically or socially?
 13. Please describe the importance of parental/family support on student success (academic or social) in this population.
 14. Do you have anything to add?

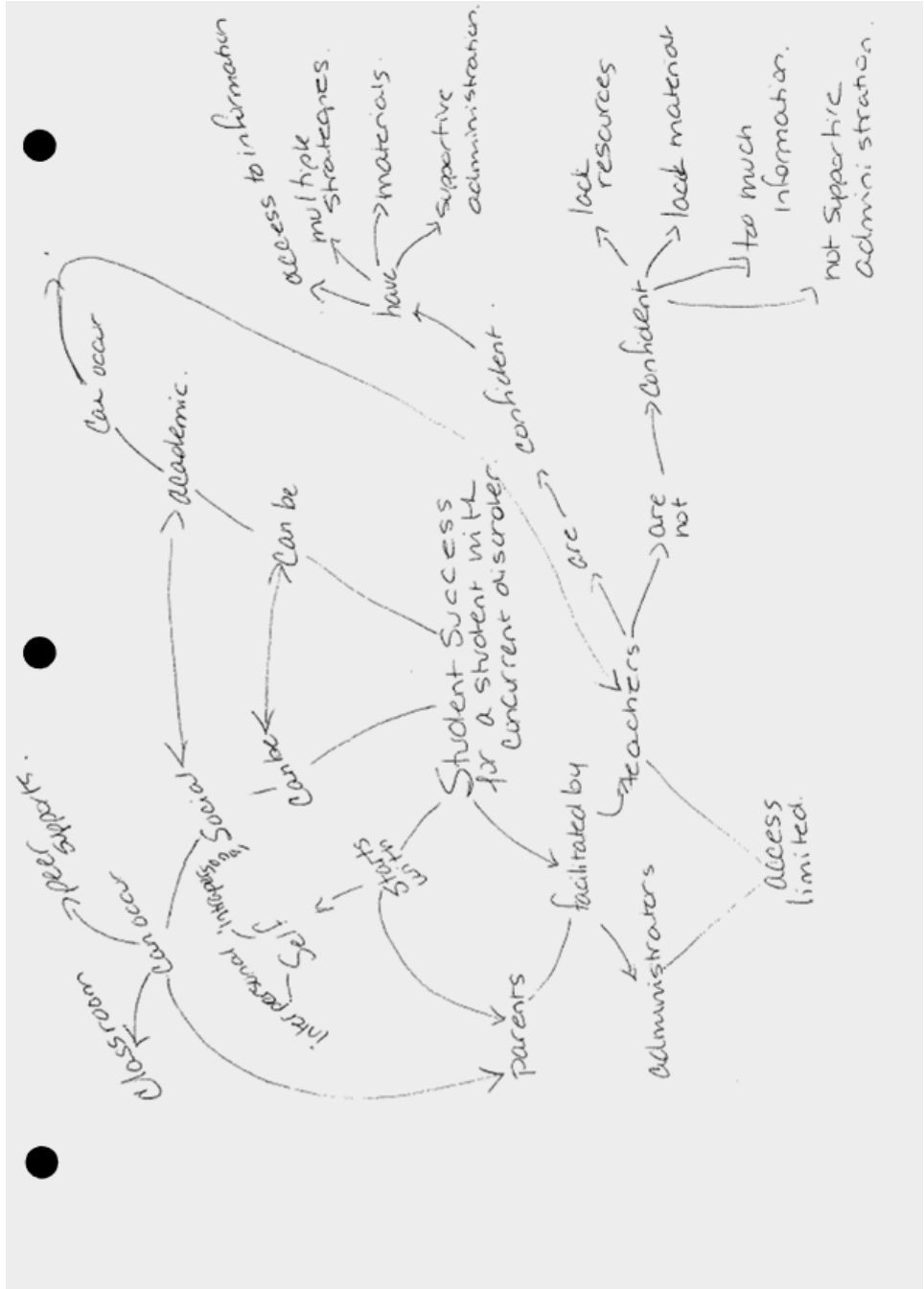
Questions for Psychologist Interview

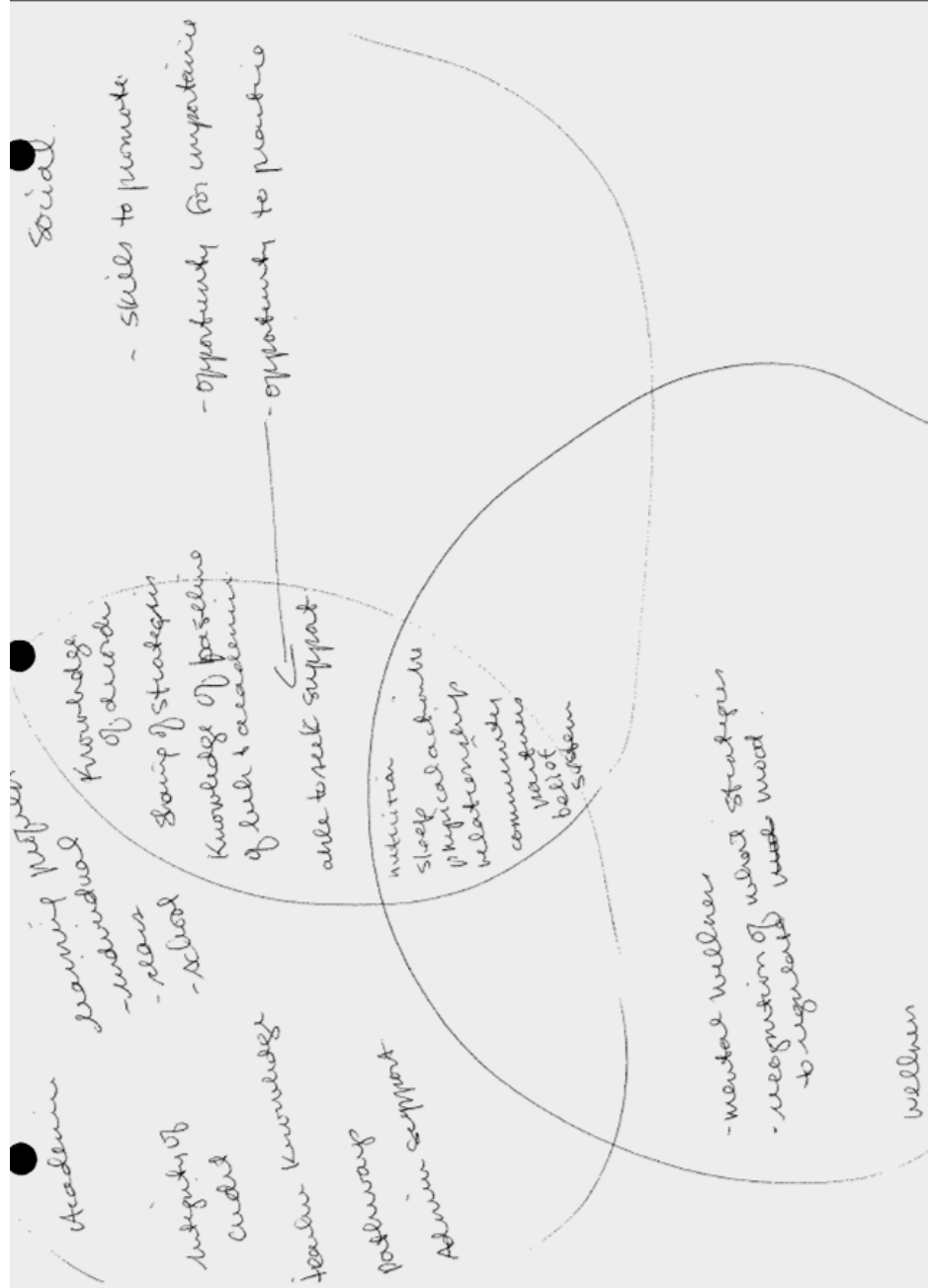
1. Please describe, in general terms, the experience you have working with students with concurrent disorders who are studying in mainstream classrooms (i.e., how many, when, etc.)
2. In your experience, are most students with concurrent disorders studying in mainstream or alternative classrooms?
 - a) What does this distinction depend on? How likely is it for a student to return to a mainstream classroom?
3. How do you define academic success for students with concurrent disorders?
 - a) How does this differ from the mainstream student population?
4. Thinking about the student's academic success (i.e., passing marks):
 - a) What classroom *structures or strategies* (classroom routines, assessment techniques, teaching strategies, agreements between the teacher and student for leaving the classroom, missing tests/assignments, etc.) should be in place to make this success possible?
 - b) What school-wide *structures or strategies* (routines, programs or initiatives, support systems, etc.) should be in place to make this success possible?
 - c) What *materials* (curricular or supplemental) can help the student achieve success?
 - d) What *interpersonal* interactions (between the student and his/her teachers, administrators, support staff, other students, etc.) can enable him/her to achieve success?
5. How do you define social success for students with concurrent disorders?
 - a) How does this differ from the mainstream student population?
6. Thinking about the student's social success (i.e., socially acceptable interactions with peers):
 - a) What classroom *structures or strategies* should be in place to make this success possible?
 - b) What school-wide *structures or strategies* should be in place to make this success possible?
 - c) What *materials* (curricular or supplemental) can help the student achieve success?
 - d) What *interpersonal* interactions (between the student and his/her teachers, support staff, other students, etc.) can enable him/her to achieve success?
7. What types of classroom support should be available for the student? Please describe them with respect to their accessibility and feasibility.

8. What types of administrative support should be available for the student? Please describe them with respect to their accessibility and feasibility.
9. What do *teachers* need (resources, support, etc.) to best help their students with concurrent disorders achieve academic and social success?
10. What do *administrators* need (resources, support, etc.) to best help the students with concurrent disorders in their school achieve academic and social success?
11. From your perception, is there anything else within the school system that can help a student with a concurrent disorder achieve success academically or socially?
13. Please describe the importance of parental/family support on student success (academic or social) in this population.
14. Do you have anything to add?

Appendix B: Participant Concept Maps







STUDENT SUCCESS FOR STUDENTS WITH CONCURRENT DISORDERS.

- COMMUNITY SUPPORTS**
- AGENCY SCHOOLS
 - CAN. MENTAL HEALTH ASSOC.
 - TEEN HEALTH CENTRE
- (AVAILABILITY OF THESE PROGRAMS)

SCHOOL PROGRAMS/SUPPORTS

- SCHOOL PHILOSOPHY AROUND STUDENT SUCCESS, ~~THE~~ SUPPORTS FOR STUDENTS & PROGRAMS.

PHILOSOPHY

- RESPECT
- RESPONSIBILITY
- CITIZENSHIP
- INCLUSION
- "SAVE 1 STUDENT"

SUPPORTS

- ADMIN
- GUIDANCE
- LST
- STUDENT SUCCESS
- SPECIAL WORK/ATTENDANCE
- PSYCH. SERVICES

PROGRAMS

- CREDIT RECOVERY
- LDCC COURSES
- CO-OP
- EXPERIENTIAL LEARN.
- OYAP

STUDENT IDENTIFICATION WHO ARE THEY?

- WHAT IS THEIR PROFILE? CONCERN?
- SUICIDAL THOUGHTS →
- STRESS →
- DEPRESSION ANXIETY →
- SUBSTANCE ABUSE →

STUDENTS ABILITY TO COPE WITH ISSUES

- RESILENCY
- MATURITY
- ENGAGEMENT (VS) DISengagement
- ABIL FOR HELP BEFORE CRISIS

PARENTAL INFLUENCE/SUPPORT

- SOCIO/ECONOMIC STATUS.
- RELATIONSHIP TO CHILD (LOVING/NURTURING?)
- PARENTS RELATIONSHIP TO SCHOOL, ADMIN/STAFF.

Appendix C: School Board-Wide Mental Health Strategies/Interventions

(taken from the ***SB school board website – address withheld to protect anonymity)

- Piloted secondary mental health curriculum in two schools.
- One trained teacher from each of our secondary schools will facilitate implementation of the new curriculum in September 2012.
- Principal baseline survey of school-based mental health programs was conducted at schools throughout the system.
- The Student Support Leadership Initiative (SSLI) introduced and implemented the systems of care with community partners; worked toward integrating mental health services within the community; created a DVD and distributed it to all principals and school councils; held a Mental Health forum for the community in May.
- Mental health champions (one from each work location) engaged in 1.5 days of professional learning.
- Partnered with the System Student Success School Team to provide an awareness workshop on mental health issues.
- Wellness education through Disability Management Attendance Support, WSIB [Workplace Safety & Insurance Board] and JEAP [Joint Employee Assistance Program] programs for staff continued to be an on-going priority. Our JEAP program provided information about wellness activities over the course of the year, along with encouragement to increase levels of activity. Our Disability Management program was implemented and our Attendance Support Program was created.
- We are in compliance with legislation regarding health and safety, and emergency response.

- Mental health curriculum will be introduced and implemented in all grade 11 physical education classes.
- Development of system plan will begin for roll out of a mental health elementary curriculum pilot.
- Emphasis will be placed on building an information network beyond mental health advocates.
- Student Support Leadership Initiative will continue to align community services.
- Plan to build on survey results and tri-ministry documents to develop our mental health strategy.
- Continue to develop resources to assist our staff in their work with students with mental health illnesses/issues.
- IT Department to review automated call out systems for safe arrivals and recommend alternatives.
- Supervisors, managers, principals and vice-principals to be trained in Attendance Support Program in anticipation of piloting the program for all employee groups. The Attendance Support policy will be presented to trustees for approval by June 2013.
- Work on compliance relative to Bill 160 (Ontario Health and Safety Act – OHSA), particularly with regard to staff training, will continue once more direction from the Ministry of Labour (MOL) is available.

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