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Mental Health Policies and Practices: Student Services Leaders Connect the Dots

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Abstract

This research explored the perceptions of student affairs and services (SAS) leaders in relation to the effectiveness of policies and practices that assist students with mental health problems. Many students enter post-secondary schools with existing conditions that may or may not be clinically recognized. These mental health impairments and disabilities can manifest as permanent, sporadic, or temporary impairments. The emergence and magnitude of mental illness in early adulthood make post-secondary institutions key environments in which to intervene more proactively. Providing access to comprehensive mental health supports is vital for meeting students' increasing needs. To investigate how post-secondary leaders are responding to these needs, a qualitative single case study was conducted at one college in Ontario. Thematic analysis was used to examine transcripts and documentary evidence. Researcher notes served as a third source of data. Four participant-derived themes emerged in this study. They were (a) Developing Contextual Understanding: Complexity of Needs; (b) Developing the Culture: It Takes the Whole Community; (c) Developing People and Supports: On the Same Page; and (d) Developing the Organization: Connecting the Dots. These areas were viewed as chief priorities for ensuring learning, success & positive mental health. There were four major findings: (a) Students' mental health affected learning & success. Their needs were complex, growing & not being fully met; (b) Mental health policies & practices must be responsive to individual & collective needs & driven by a student-centred, contextually specific approach & shared commitment to success; (c) Some students & faculty misunderstood mental health. Student services leaders played a key role in filling this gap by initiating data-driven preventive & promotional measures; and (d) The lack

of a mental health policy acted as a barrier to meeting students' needs. The SAS leaders proposed three key areas for improvement at the college: (a) expanding students' awareness of mental health and the support alternatives; (b) building the faculty's knowledge of mental health, the accommodation process, and the available mental health services; and (c) introducing a college mental health policy centred on these knowledge-mobilization and capacity-building efforts. SAS leaders have been identified as important agents for introducing awareness-raising activities, reducing barriers, and providing resources that positively influence students' mental health. This research contributes knowledge to the mental health and student services disciplines. The goals were to inform policies and practices and provide guidance for developing and implementing services and supports that are devoted to college students with mental health impairments and disabilities.

Keywords: mental health impairments, mental health disabilities, psychosocial disabilities, student affairs and services leadership, post-secondary mental health policies, mental health and student success

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Chapter 1. Introduction

Mental health has garnered considerable interest worldwide. This is unsurprising given that mental illnesses rank fourth among the top ten causes of disability internationally (World Health Organization [WHO], 2001). Over the course of a lifetime, 43% of Canadians experience some form of mental health impairment or disability (Stockdale Winder, 2014) — one in five people are affected in any given year (Smetanin, Stiff, Briante, Adair, Ahmad, & Khan, 2011). Approximately 800,000 (14% – 25%) young Canadians have chronic mental health conditions (Canadian Institute for Health Information [CIHI], 2009). It is estimated that at least 70% of these conditions have an onset occurring in childhood or adolescence (Centre for Addiction & Mental Health, 2012; Statistics Canada, 2002). Despite the severity and disabling nature of mental health conditions, low detection rates have been reported in the medical literature (Grant et al., 2004; Vermani, Marcus, & Katzman, 2011). For example, a staggering 93% of those with bipolar disorders are improperly diagnosed (86% panic disorder, 66% depression) (Vermani et al., 2011). This has important implications for service providers because many students enter higher education with mental health impairments and disabilities that may or may not be diagnosed (Tellier & DeGenova, 2014). My research considers various policies and practices to assist those who have mental health conditions that disrupt learning and success.

According to Friedli and Parsonage (2007), “no other . . . condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact” (p. 6). Mental health impairments and disabilities can manifest as permanent, sporadic, or temporary conditions. In Ontario, there was a 67% spike in mental health disabilities from 2006 to 2011

(McCloy & DeClou, 2013). Holmes, Silvestri, and Kostakas (2011) found that 61% of students accessing college-based supports had multiple mental health needs. Many youth are driven to suicide, the second leading cause of death for Canadians aged 10 to 24 years (Centre for Addiction & Mental Health, 2012). Yet, the stigma of mental illness appears to prevent vulnerable people from obtaining professional help (Ontario Human Rights Commission [OHRC], 2014; Shrivastava et al., 2011) — nearly 40% have encountered the sting of discrimination (Mental Health Commission of Canada [MHCC], 2015). The emergence and magnitude of mental health impairments and disabilities among children, youth, and young adults necessitate proactive promotion and prevention within various contexts including post-secondary institutions (Canadian Association of College & University Student Services & Canadian Mental Health Association, [CACUSS & CMHA], 2013; Hunt & Eisenberg, 2010; MacKean, 2011; Schwean & Rodger, 2013).

Canadian post-secondary schools are welcoming more students with mental health impairments and disabilities to campus. Service providers are charged with delivering a continuum of timely supports to address their educational needs. Appropriate intervention strategies are essential because health is viewed as an integral variable in the learning equation (Basch, 2011). Researchers have argued that “education and health are interdependent and reciprocal, [and] . . . the efforts to promote both in collaboration are synergistic and mutually beneficial” (Ontario College Health Association, 2009, p. 13). Consequently, psychosocial factors such as motivation, self-confidence, social involvement, self-efficacy, and stress management can be predictive of success and retention (Chemers, Hu, & Garcia, 2001; Robbins,

Allen, Casillas, Peterson, & Le, 2006; Robbins, Lauver, Le, Davis, Langley, & Carlstrom, 2004). Facilitating growth in these areas calls on post-secondary leaders to establish a broader base of initiatives that are responsive to students' evolving needs. Thus, providing appropriate access to meaningful mental health services is crucial. This is a difficult task, however, because 15 to 24 year olds are the single largest group of Canadians touched by mental illness, but they are the least likely to seek assistance (Colleges Ontario, Council of Ontario Universities, College Student Alliance, & Ontario Undergraduate Student Alliance, 2012; Council of Ontario Universities & Government of Ontario, 2009). To promote proactive responses and behaviours, creative support measures must be instituted.

Student services leaders are predisposed to playing a catalytic role in facilitating outreach to affected individuals. Introducing preventive programs and policies that are compatible with students' idiosyncratic characteristics, help-seeking tendencies, and psychological needs is regarded as a necessary step (Eisenberg, Hunt, & Speer, 2012). The literature has indicated that post-secondary leaders can be instrumental in reducing access inequities, promoting inclusion, sharing information, and enriching teaching and learning (Braxton & McClendon, 2001; Krumrei-Mancuso, Newton, Kim, & Wilcox, 2013). As Hardy Cox and Strange (2010) have asserted, "Perhaps more than ever before, the ability of colleges to remain comprehensive, flexible, and responsive to diverse student needs may rest largely on their expanding expertise, and student-centred philosophy traditionally residing in student services" (p. 204).

The purpose of this study was to examine the perceptions of student affairs and services (SAS) leaders in relation to the effectiveness of policies and practices that assist college students

with diagnosed and undiagnosed mental health impairments and disabilities. This research can benefit service providers, stakeholders, and policy makers who are responsible for designing and implementing mental health approaches at the post-secondary level.

Statement of the Problem

Post-secondary institutions are seen as critical settings for encouraging positive mental health (Adlaf, Demers, & Gliksman, 2005; Hunt & Eisenberg, 2010; MacKean, 2011). Nevertheless, various investigative bodies and mental health advocates have suggested that additional research is needed to determine best practices for aiding higher education students with mental health conditions (CACUSS & CMHA, 2013; MacKean, 2011; Patterson & Kline, 2008). Studies have also shown that more individuals with mental health impairments and disabilities are reaching out to campus service providers for assistance (Cooke, Huntly, & Coordinating Committee of Vice Presidents, Students, 2015; Council of Ontario Universities, 2010; MacKean, 2011). This is significant given that the prevalence and severity of mental health conditions at post-secondary schools are projected to grow (Hunt & Eisenberg, 2010; MacKean, 2011; Storrie, Ahern, & Tuckett, 2010). The research has indicated that improved preventative, promotional, and early intervention activities are required.

Institutional policies and practices form a fundamental part of these responsive measures because they can cultivate behaviours and beliefs that enable or impede learning and success (CACUSS & CMHA, 2013; Olding & Yip, 2014). Researchers have argued that strategic policy development, on-site and external resources, and leadership also contribute to students' educational experiences and their mental health (Warwick, Maxwell, Statham, Aggleton, &

Simon, 2008). SAS practitioners serve as primary advocates in this process (Hardy Cox & Strange, 2010). Equally, they share a responsibility for fostering inclusive environments and delivering programs tailored to an increasingly more heterogeneous clientele (Hall & Belch, 2000; MacKean, 2011). Given this demographic variation, a constellation of mental health supports is needed to meet the mushrooming demand for services.

Although the academic community has reported some promising approaches, mental health policies and practices have been underexplored in the higher education literature. The Mental Health Commission of Canada (2012) has stipulated that “without building strong infrastructure to support data collection, research, and human resource development,” positive change will not be possible (p. 8). Patterson and Kline (2008) have also trumpeted “the pivotal role that [SAS] administrators can play in making the transition from a model of service focused primarily on the treatment of illness to [one] focused on the promotion of healthy [campuses] that support student wellness, learning . . . and a community-based approach . . . ” (p. 7). However, this role continues to be mostly unarticulated (Patterson & Kline, 2008). Few academic journals have included research about the perceptions and experiential knowledge of Canadian student affairs professionals who oversee, develop, and implement programming for those with mental health impairments and disabilities (MacKean, 2011; Patterson & Kline, 2008). Thus, there is some uncertainty about what policies and practices educational leaders should adopt. My qualitative single case study is built on these preliminary understandings but goes further by addressing deficiencies in the existing Canadian-based scholarship pertaining to college contexts.

Purpose of the Study

There is widespread agreement that gaps still exist in services devoted to higher education students with mental health impairments and disabilities (CACUSS & CMHA, 2013; MacKean, 2011). But before introducing improvements, a better understanding of current mental health support structures is necessary. My study describes lessons learned from student services practitioners at one college in Ontario. Specifically, I explored the perceptions of SAS leaders in relation to the effectiveness of policies and practices that assist college students with diagnosed and undiagnosed mental health impairments and disabilities. My intent was to further inform policy and practice at the post-secondary level. The purpose of this research was three-fold. First, I explain how the SAS leaders conceptualize mental health. Second, I highlight the policies and practices that the leaders perceived to be most effective. Finally, I describe the gaps in services and supports, as these professionals understood them.

Rationale and Significance of the Study

Higher education is a challenging system for all students to manoeuvre but more so for those who are less “psychologically robust” (Tinklin, Riddell, & Wilson, 2005). Many students are arriving at post-secondary schools with historic problems and need supportive mental health services. However, Ontario’s mental health “plan of action” at the policy and practical level remains at a relatively inchoate stage (Canadian Mental Health Association Ontario, 2014; Cooke et al., 2015). My study will help to fill this void. This research will guide policy and practice by providing new information for those who are driving change particularly in the college sector. Scholars, stakeholders, and other SAS practitioners will gain greater

understanding about how to implement interventions and create holistic mental health frameworks and approaches. New knowledge will also facilitate a shift in attitudes and behaviours and possibly lead to the introduction of more potent information-sharing, capacity-building, and stigma-reduction initiatives. Lastly, this study will confirm or disconfirm prior understandings, suggest improvements to practice, and inform mental health policy debates.

Research Questions

The perceived effectiveness of policies and practices related to students' mental health was explored through the eyes of SAS professionals. I chose to interview these leaders because they have been identified as instrumental agents for introducing awareness-raising activities, reducing barriers, and implementing policies and practices that positively affect students with mental health impairments and disabilities (Sandeem & Barr, 2006). The participants offered their personal interpretations of the college's responses, strategic plans, and future direction with regard to addressing a wide scope of related issues on campus. There were three study questions.

1. How do SAS leaders conceptualize mental health?
2. What policies and practices do the leaders perceive to be the most effective in terms of enhancing students' mental health?
3. What policies and practices need to be either refined or introduced to further enhance students' mental health?

Research Design and Methodology

This research undertaking began with a literature review, topic selection, and the choice of a theoretical paradigm and methodology that best addressed my research problem. I judged qualitative methodology to be suitable for exploring the policies and practices that SAS leaders perceived to be effective in improving students' mental health (Lincoln & Guba, 1985). The strengths of qualitative research derive primarily from its inductive standpoint and its focus on a unique social environment (Maxwell, 2013).

Thus, qualitative inquiry is understood as an interpretative act aimed at generating meaning from the perspective of individuals in a specific context (Snape & Spencer, 2003). This case study was founded on a constructivist-interpretivist philosophy. Determining my epistemological and theoretical perspectives was important for creating the research design and selecting the approach, methodology, data collection, and analysis procedures. This research provided a means for examining aspects of the SAS leaders' experiences and opinions and linking them to the study's constructs and questions. The methodology offered an appropriate instrument for documenting practitioners' thoughts about services aimed at students with mental health impairments and disabilities (Merriam, 1998). My goal was to analyze their understandings in a way that led to greater insight. To ensure methodological and analytical precision, I selected data collection and analysis techniques linked to my conceptual and philosophical preferences. Evidence was gathered from interviews, documents, and researcher notes over a six-month period. It was understood that triangulation of these sources would increase trustworthiness (Yin, 2003).

Positionality of the Researcher

The study is informed by my personal experiences as a graduate student, researcher, and special educator. I have always been interested in working with students exhibiting the most complex problems. Sadly, some have taken their lives. I have felt tremendous helplessness during these difficult moments. I did not fully understand their “lived experiences” and felt as though I had failed them in some way. More recently, I have noticed an enormous increase in mental health problems within the school system and our (my) inadequate responses to the most vulnerable among us. My study is founded, in part, on these personal experiences. I am hopeful that this research will not only strengthen my resolve to assist students more effectively, it will also illuminate promising policies and practices for reducing harm and suppressing some of the dreadful effects of mental health impairments and disabilities.

Context of the Study

The pseudonym, Resiliency Community College of Applied Arts and Technology (RCCAAT), was used to denote the study site. RCCAAT is located in a small city in Ontario. The college had approximately 7,500 students registered in a range of trades- and academic-based programs. There were about 1000 students with disabilities linked to RCCAAT student services in 2009 – 2010; almost 20% reported some type of permanent or temporary mental health concern (College Committee on Disability Issues, Ontario Community Colleges, 2010).

Definition of Key Terms

For the purposes of this study, I adopted the definitions related to mental health and disability as outlined in the *Ontario Human Rights Code* (OHRC, 2000, 2014). The *Code* describes a wide range of disabilities and provides criteria for mental health conditions in particular. The definitions are most defensible from a research perspective because they are consistent with how mental health, impairment, and disability were viewed at the study site. These fundamental understandings also informed mental health service delivery on campus.

Given the complexity of this topic, mental health lexicon can be quite diverse (e.g., mental health problems, challenges, disorders, illnesses, ailments, difficulties, etc.). To provide greater clarity for the reader and ease understanding of the nomenclature, I have restricted my usage of terminology. In this study, *impairment* refers to the genetic, biological, epigenetic, and psychological factors that are causal (medical model of disability); *disability* refers to the social response to individuals exhibiting various mental health issues (social model of disability); and *conditions* is the umbrella term used to refer to both impairments and disabilities.

Accessibility for Ontarians with Disabilities Act (AODA). The *Accessibility for Ontarians with Disabilities Act* (2005) addresses inclusion and the right to equal opportunity for people with all sorts of disabilities. The *AODA* is an important piece of legislation for improving accessibility. It complements the *Ontario Human Rights Code*, which has primacy over the *AODA*. The development and implementation of standards under the *AODA* must adhere to the *Code* and related human rights principles and case law, including issues faced by those with mental health impairments and disabilities. Organizations must follow guidelines outlined by

both the *AODA* and the *Code* (Accessibility Directorate of Ontario, 2014).

Accommodations for mental health disabilities. Within the context of the study site, accommodations are provided to students who experience temporary, intermittent, or permanent mental health impairments and disabilities. It is the functional limitations (real or perceived) associated with either a diagnosed mental illness or a “temporarily disabling” condition that drive the accommodation process. In other words, if a mental health issue impairs students’ ability to participate academically, they have the right to receive accommodations under the *Ontario Human Rights Code* (Government of Ontario, 1990). The Ontario Human Rights Commission (2014) has further invoked that “the focus should be on the effects of the distinction, preference, or exclusion experienced by the person and not on the proof of physical limitations or mental health status, the presence of an ailment, or the cause or origin of the disability” (p. 11).

Co-morbidity. Although classification systems exist, mental health problems do not fall neatly into distinct categories. Symptoms that are characteristic of one disorder often resemble those associated with other conditions. Mental disorders can accompany other disabilities; this is known as co-morbidity. Approximately 45% of children and youth with one mental health impairment or disability are likely to have another area of difficulty (Ontario Ministry of Education, 2013). Frequently, co-morbid conditions are under-recognized and not always treated effectively. Co-morbidity often “results in lower adherence to medical intervention, an increase in disability and mortality, and higher health expenditures” (WHO, 2003, p. 10). Substance

reliance is also common among people who are battling a mental health challenge (Anthenelli, 2010; MacKean, 2011; McCulloch, 2006; National Treatment Strategy Working Group, 2008).

Disability. According to Section 10(1) of the *Ontario Human Rights Code*, disability is defined as “any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness, . . . a condition of mental impairment or a developmental disability, a learning disability or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language, or a mental disorder, an injury, or disability” Therefore, “protection for persons with disabilities . . . explicitly includes mental illness, developmental disabilities, and learning disabilities. Even minor illnesses or infirmities can be ‘disabilities’ if a person can show that she was treated unfairly because of the perception of a disability” (OHRC, 2000, 2012).

Dual Continuum Model of Mental Health and Mental Illness. Corey Keyes (2002, 2007) has suggested that mental health and illness can be conceptualized along two continua (Figure 1). Accordingly, “mental health is best viewed as a complete state consisting of the presence and the absence of mental illness and mental health symptoms” (Keyes, 2002, p. 201). He describes the presence of mental health as *flourishing* and the absence of mental health as *languishing*. People who are flourishing exhibit positive emotions and high levels of psychological and social functioning. Those with “incomplete” mental health tend to languish and experience vacillating degrees of emptiness, stagnation, and despair (Keyes, 2007).

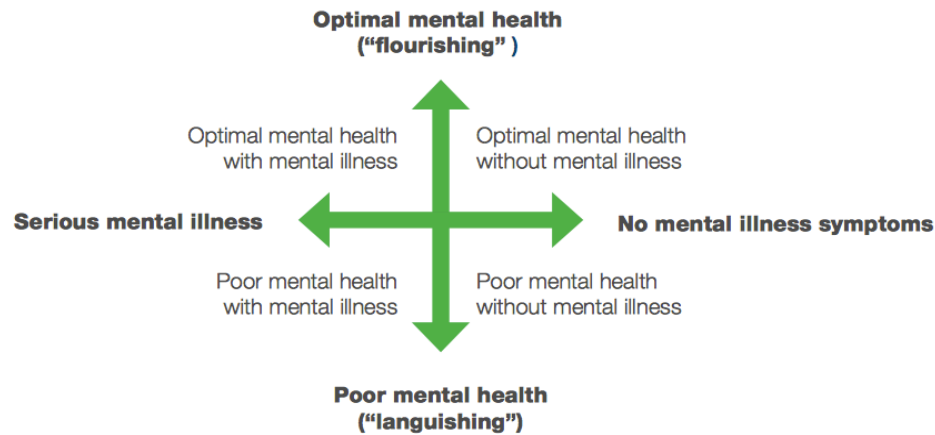


Figure 1. Dual Continuum Model of Mental Health and Mental Illness

Gatekeeper training. Gatekeeper training involves educating people who interact with students on a regular basis. Gatekeepers are taught to recognize and appropriately respond to warning signs for suicide (Isaac, Elias, Katz, Belik, Deane, Enns, & Sareen, 2009; Quinnett, 2007; Shtivelband, Aloise-Young, & Chen, 2015).

Medical model of disability. The medical model of disability focuses on the underlying genetic, biological, psychological, and epigenetic factors that result in mental health impairments. In this traditional model, the problem of disability is located within the person (i.e., disabled due to personal impairments) (Davis, 2014). Affected individuals are expected to “overcome” various environmental barriers imposed by their functional limitations (CACUSS, 1999). Disabilities are also viewed as defects or deficiencies that set individuals apart from “normal” people. The public policy response is to remedy or “care for” the disabled (Wolanin & Steele, 2004, p. xiv). This “intervention” model places individuals into diagnostic categories for medical convenience, labelling, and funding purposes (Davis, 2014; Tregaskis, 2002) and is a necessary part of a comprehensive support approach.

Mental health. As a rule, mental health is understood to be more than just the absence of a mental illness (CIHI, 2009; Keyes, 2002, 2007). Thus, “good health is not possible without good mental health” (MHCC, 2009, p. 9). It is determined by individual, social, environmental, cultural, and socio-economic characteristics (Public Health Agency of Canada, 2006). According to the Public Health Agency of Canada (2006), mental health is a multi-faceted concept defined as “the capacities of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face.”

Mental health disability. According to the Ontario Human Rights Commission, a mental health disability is defined as a “condition of mental impairment” and “mental disorder.” It may be permanent, sporadic, or temporary. Past and perceived disabilities are protected under Section 10(1) of the *Ontario Human Rights Code* (OHRC, 2000, 2012). Disability must be interpreted to also include its subjective component because discrimination may be associated with myths and stereotypes or the existence of actual functional limitations (OHRC, 2014).

Mental health literacy. The Canadian Public Health Association defines mental health literacy as “the ability to access, understand, evaluate, and communicate information as a way to promote, maintain, and improve health” (Rootman & Gordon-El-Bihbety, 2008, p. 11). Mental health literacy may also refer to the “knowledge and skills that enable people to access, understand, and apply information for mental health” (Canadian Alliance on Mental Illness & Mental Health, 2008, p. 8).

Mental health promotion. “Mental health promotion is about fostering the development of positive mental health by supporting resilience, creating supportive environments (Joubert &

Raeburn, 1998), and addressing the influence of broader [societal] determinants of mental health” (i.e., personal, economic, social, environmental factors) (Standing Senate Committee on Social Affairs, Science & Technology, 2006, p. 411). Mental health promotion entails developing policies, regulations, and contexts that are conducive to enabling optimal functioning in the community.

Social model of disability. The social model of disability focuses on changing the perceptions of those who engage in systemic discrimination against people with mental health impairments or disabilities and is part of a comprehensive support approach. Attitudinal barriers (e.g., stigma) and social, economic, or cultural disadvantages linked to intolerance and exclusion can negatively impact mental health (OHRC, 2014; Oliver, 2009) and lead to treatment avoidance (Jagdeo, Cox, Stein, & Sareen, 2009). This “sociological” model places responsibility squarely on the shoulders of society in terms of incorporating appropriate adjustments to accommodate the individual’s functional limitations (CACUSS, 1999).

Under-represented groups. This term refers to groups of people whose postsecondary participation rates are disproportionately low. These groups include students with disabilities; Aboriginal peoples; first-generation students; students from rural or remote areas; minorities; women; international students; lesbian, gay, bisexual, transgender, and queer students (LGBTQ); mature students; and those from low-income families (Hall & Belch, 2000).

Universal design for learning (UDL). The term universal design means that the context is organized to address the challenges of a smorgasbord of users. If physical environments are created to meet the needs of individuals with disabilities, then they will be accessible and useful

for the majority of people without further adaptation and without jeopardizing the quality of the product. UDL applies the principles of universal design to education settings as a means of increasing accessibility and inclusion (Fisher, 2006; Higbee & Goff, 2008).

Limitations of the Study

Qualitative research is interpretative in nature — it focuses on making meaning based on the perspectives of people in a particular social setting. Accordingly, I recognize that my findings and conclusions represent one interpretation of the research data. Furthermore, this case study involved an in-depth examination of a “bounded system” and demanded adherence to certain parameters (Stake, 1995). It facilitated the exploration of a phenomenon within a specific context, used a variety of data, and was designed to generate a body of “thick” descriptions for analysis (i.e., diverse perceptions) — these are the hallmarks of qualitative research. Although efforts were made to improve credibility by including an audit trail of my data collection methods, triangulation and member-checking techniques, peer and supervisor reviews of the analyses, and transparency about my personal biases (Merriam, 1998), it is plausible that other themes could have been uncovered. It is further stipulated that my epistemological positioning and theoretical beliefs affected the analysis of the collected evidence (Reicher & Taylor, 2005); qualitative research cannot be value-free (Snape & Spencer, 2003).

Hence, this qualitative research is not without limitations. It was a small-scale study exploring the variables identified by the selected SAS leaders employed at RCCAAT. Due to the limited sample size, my findings are neither generalizable to other post-secondary institutions, nor are they representative of all SAS professionals. Only two senior management leaders and

two middle management leaders were interviewed, whereas 13 front-line leaders were involved in the research. Five male and 12 female leaders participated voluntarily in this study, and as a result, the findings may have been influenced by the uneven distribution of gender and leadership position. It is conceivable that other SAS personnel at the college would have voiced different opinions about policies and practices related to students with mental health impairments and disabilities.

Summary

This chapter presented background information related to this research and defined the problem of practice, purpose, and significance of the study. It also included the research questions, design and methodology, my reasons for undertaking this project, and a description of the study site, key terms, and limitations. This case study was anchored in a constructivist-interpretivist philosophy. To ensure methodological rigour, I used a systematic approach for the research design, data collection, analysis, and presentation. Specifically, this study was conducted at one college in Ontario to further investigate how leaders were responding to the growing prevalence of mental health issues on campus. The objective was to construct meaning from the perspective of the participants. To increase trustworthiness of findings, I used data from three sources: interviews, documents, and researcher notes. My purpose was to produce substantive results, increase knowledge about the topic, link my interpretations to the current research, contribute to existing theory, and inform mental health policies and practices at the college level. Determining the effectiveness of policies and practices devoted to students with mental health impairments and disabilities is important for improving their learning and success.

Chapter 2. Literature Review

This chapter provides the theoretical underpinnings of my qualitative study. The section begins with a critical examination of the literature related to three key constructs: (a) students with mental health disabilities; (b) student affairs and services (SAS) leaders; and (c) mental health policies, services, and supports. Search techniques used to locate relevant literature and connections to previous research are provided. The chapter concludes with a description of the study's theoretical framework.

Students with mental health impairments and disabilities have an increasing presence at Canadian higher education institutions. Many require a continuum of supports from post-secondary service providers. Thus, mental health has become a central preoccupation because it profoundly affects students' academic performance and educational opportunities (MacKean, 2011).

The first part of this chapter explores the literature related to students with mental health disabilities. It includes detailed information about the increasing incidence and interventions designed to lessen the impact of mental health concerns among this particular sector of the population. Studies examining the links between student success and various mental health approaches are considered. This section also highlights research showing the key correlation between mental health and optimal learning, importance of an inclusive campus ethos for improving students' help seeking and self-advocacy, and need to alleviate access barriers and cultivate positive attitudes towards mental health.

To reach these goals, support services professionals must fulfill many responsibilities at their respective schools. These responsibilities have evolved as the anatomy of the student body has become more culturally and socially diverse. Notably, post-secondary leaders can have a significant impact on persistence and learning (Bailey & Alfonso, 2005; Braxton & McClendon, 2001; Krumrei-Mancuso et al., 2013) and are favourably positioned to improve the odds for many students (Hunt & Eisenberg, 2010; Sandeen & Barr, 2006; Warwick et al., 2008).

The second section in this chapter explores the literature related to student affairs and services (SAS) leaders. It includes detailed information about mental health accommodation practices aimed at improving participation and retention, the complications associated with diagnoses and medications, and strategies for counteracting the effects of societal taboos and discrimination. Studies exploring evidenced-based interventions and innovative uses of technology as support tools are elaborated. This segment also includes research investigating effective student outreach and information-sharing techniques, as well as faculty development and capacity-building practices. Part of the response effort involves the implementation and monitoring of a range of supportive resources that assist students with mental health impairments and disabilities. Appropriate mental health policies and practices are paramount for promoting learning and success (CACUSS & CMHA, 2013; Olding & Yip, 2014).

The third section of this chapter explores the literature concerned with mental health policies, services, and supports. It includes detailed information pertaining to resource shortages, streamlined mental health procedures, and collaborative relationships between student services

personnel and faculty members. Various studies examining how campus policies can be developed to more effectively meet students' mental health needs will also be discussed.

Search Methodology

The literature review included a number of strategies for locating relevant information. It began with a search of the online databases available at Western University's libraries. Qualitative and quantitative studies addressing post-secondary approaches to mental health, mental health impairments and disabilities, student services leadership, and policy development were selected. Educational Resources Information Center (ERIC), EBSCOhost, ProQuest, Dissertation Abstracts, and Google Scholar were used as search tools. Both peer-reviewed and grey literature sources were explored. The grey literature focused on reports and studies from Canadian, American, Australian, and British mental health agencies and research bodies. This literature review is based on material published primarily between 2000 and 2015. References represent original research from related websites and journals. Full articles were searched using various combinations of descriptive phrases and terms. These included: accessibility, accommodations, barriers and discrimination, disability support services, inclusion and equity, leadership and student affairs, mental health and Ontario, mental health and post-secondary education, mental health and college students, mental illness, mental health and addiction strategy, mental health and stigma, Ontario community colleges, mental health impairments, mental health disabilities, student services leadership, post-secondary and community colleges, and student support services. The nature of the articles was established from their abstracts, methodology statements, and content. Other sources were identified from the bibliographies of

these documents. A detailed search log was maintained and resulted in over 300 items being consulted, although not all were used in this study.

Literature Review of the Key Constructs

Students with mental health disabilities. Mental disorders are among the chief causes of disability throughout the world (World Economic Forum, 2012). An estimated 4.4 million Canadians have some form of impairment or disability; approximately 15.4% reside in the province of Ontario (Employment & Social Development Canada, 2014). The disability rate of Ontarians grew from 21% to 27% between 1999 and 2008, with one of the most common conditions tied to mental health impairments and disabilities for those between 15 and 24 years (MacKean, 2011). At least 70% of these conditions have an onset occurring in childhood or adolescence and eventually spill into early adulthood (Statistics Canada, 2002). Accordingly, the prevalence and severity of mental health impairments and disabilities have also risen at post-secondary schools over the last several years (Gallagher, 2012, 2014). A Council of Ontario Universities report (2010) revealed an astounding 320% upsurge of students tapping into accessibility services from 1991 to 2007. Gallagher's (2012, 2014) qualitative studies analyzed survey data collected from American and Canadian counselling services directors and found corresponding increases. Informants indicated that more students were experiencing anxiety disorders (89%), crises requiring immediate intervention (69%), psychiatric medication issues (60%), clinical depression (57%), alcohol dependencies (36%), self-harming (35%), and eating disorders (26%). The directors contended that for 8% of students requesting supports, problems were so severe that they had to withdraw from school because appropriate treatment was

unavailable. Results from the *National College Health Assessment Survey* (2013) completed by 34,039 students registered at 32 Canadian post-secondary institutions also showed that one in five respondents reported feeling so depressed or anxious that it was difficult to function (American College Health Association, 2013). Based on these findings, it is logical to surmise that young adults are highly susceptible to developing mental health impairments and disabilities that are becoming increasingly more challenging to address.

Aligning supports to match demographic changes. The evidence noted above suggests that Canadian post-secondary institutions need to focus more intently on aligning supports to students' unique needs, including those with mental health concerns. This heightened attention is justifiable because college-aged individuals are exposed to stressful circumstances that put them at greater risk for psychiatric disorders (Blanco, Okuda, Wright, Hasin, Grant, Liu, & Olfson, 2008; National Educational Association of Disabled Students [NEADS], 2010). As these numbers continue to swell, the demographic profile of post-secondary students has also become far more complex. Evidently, this wave of rising diversity and participation has prompted leaders to widen the access net and sphere of opportunity so that *all* students may be more fully included in the campus community (Braxton & McClendon, 2001; Krumrei-Mancuso et al., 2013; Ministry of Training, Colleges & Universities, 2013). In their comprehensive international review of tertiary education, Santiago and associates (2008) determined that “greater emphasis needs to be placed on equity of outcomes,” particularly for those with disabilities (Santiago, Tremblay, Basri, & Arnal, 2008, p. 66). Therefore, post-secondary institutions must not only facilitate access, they must also provide enough flexibility and consistency in the support process

to accommodate oscillating levels of impairment, disability, and need. Subsequently, services must follow students through to graduation to achieve optimal access, participation, and success.

Although student enrollment figures in Canadian institutions have climbed (Ferguson & Zhao, 2011), there was a higher dropout rate for college students with impairments and disabilities compared to their non-disabled peers — the percentage point difference (5.3%) was much larger in Ontario than in other regions of the country (Finnie, Childs, & Qiu, 2012). Thus, the Ontario government has specified that one of its main objectives for post-secondary education is “improving access, retention, and success for under-represented groups” (Ministry of Training, Colleges & Universities, 2013, p. 10). In their “rich empirical portrait” of higher education, Finnie and colleagues (2011) agreed, “Ensuring access to post-secondary education for all . . . is key to [the province’s] future competitiveness and . . . critical from an equity [and social justice] perspective” (p. 1). They also pinpointed a major trend: students from under-represented groups have much higher college participation rates compared to the rest of Ontarians (p. 19).

In addition, other researchers who oversaw two major investigations (*Towards Recovery and Well-being: A Framework for a Mental Health Strategy for Canada*, 2009; *Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy*, 2009) have recognized that flexible support measures targeting psychological factors are equally significant because mental health is a main determinant of educational success (Kirby, Howlett, & Chodos, 2009; Ontario Ministry of Health & Long-term Care, 2009). The Ontario College Health Association (2009) has gone one step further by acknowledging the crucial role played by universities and

colleges in fostering positive mental health on campus. Moreover, students' physical and mental health has been strongly correlated with the extent to which institutions respond to individuals' psychological problems and experiences (Kitzrow, 2009). The combined evidence supports conclusions reached by others; aligning mental health services to students' needs (especially for under-represented groups) is vital as this leads to improved persistence, retention, and success (CACUSS & CMHA, 2013; Finnie et al., 2012; MacKean, 2011; Parkin & Baldwin, 2009).

Improving accessibility and eliminating systemic barriers. The alignment of supports with specific needs is also necessary because students routinely identify mental health impairments and disabilities as negatively affecting their interactions and school experiences (MacKean, 2011). In a report commissioned by the Higher Education Quality Council of Ontario examining the impact of mental illness, Holmes and colleagues (2011) collected data from 15 of Ontario's 24 colleges. Following their descriptive analyses of evidence contained in 3,536 surveys, they determined that a definite relationship existed between students' learning challenges and their mental health. McCloy and DeClou (2013) established a parallel connection in their synthesis of research on students with disabilities attending post-secondary institutions in Ontario. Close to 67% of those utilizing support services encountered difficulties in their academic courses.

Similarly, people with mental health impairments and disabilities often tolerate attitudinal and environmental roadblocks that may cripple their ability to wholly engage in campus, academic, and community life (NEADS, 2010; OHRC, 2014; Oliver, 2009). Gaining access to appropriate services, however, can help to decrease these barriers and promote improved student

confidence, performance, and self-sufficiency (Martin, 2010). In one qualitative study examining the duties of SAS leaders, Patterson and Kline (2008) surveyed post-secondary staff and students and conducted focus groups across Canada. They affirmed that the development and provision of mental health services and an emphasis on prevention were primary contributors to student success. These results give credence to prioritizing mental health campus-wide because students' persistence, retention, and cognitive development are purposefully reinforced (Ministry of Education, 2014). The provision of proactive programs and mental health services can also diminish inherent risk factors (MHCC, 2015); indeed, these measures are integral precursors to success for students with mental health impairments and disabilities (Slade & Griffith, 2013).

The research points to the key role that post-secondary leadership plays in mitigating many of these risk factors (Eisenberg et al., 2012; Hall & Belch, 2000; Nicholls, Sheridy, & Li, 2012). Presumably, ongoing issues linked to equality, social justice, and inclusion have steered SAS professionals towards scrutinizing accessibility policies more carefully (Hartman-Hall & Haaga, 2002; Sweet, Anisef, Brown, Adamuti-Trache, & Perekh, 2012). However, simply delivering accommodations is insufficient because students still bear a tangle of faulty assumptions knotted in the mental health label (Martin, 2010); these individuals often abandon their studies prematurely (Parkin & Baldwin, 2009; Salzer, Wick, & Rogers, 2008).

Findings from other researchers confirm that structural, social, physical, and attitudinal hurdles remain stubbornly entrenched (Collins & Mowbray, 2005; Nichols & Quaye, 2009). In their study exploring various aspects of post-secondary service provision, Collins and Mowbray (2005) examined qualitative and quantitative data gathered from 275 American universities.

They established that the most predominant obstacles to service access were fear of disclosure (24%), students' poor understanding of their disability and current resources (19%), concern about stigmatization (19%), and the lack of adequate services (16%). Such barriers, punctuated by the intrinsic pressures of college, can put vulnerable students at greater risk for academic failure (Megivern, Pellerito & Mowbray, 2003).

There is accumulating evidence that attitudinal biases are particularly problematic for students with mental health impairments and disabilities — stigma represents an enormous deterrent to help seeking (Eisenberg, Hunt, Speer, & Zivin, 2011; OHRC, 2012; Storrie et al., 2010). This is significant because untreated students may exit early from school or engage in self-harming behaviours (Cook, 2007). Jenkins (2007) and others (Tinklin et al., 2005) have studied the challenges associated with eliminating these barriers. They have argued that institutions need to target awareness raising more aggressively and strategically deploy mental health supports to areas of greatest impact. Tinklin, Riddell, and Wilson's (2005) conclusions drew on findings from case studies involving five students with mental health impairments and disabilities (i.e., real-life experiences). Respondents noted that the educational environment exacerbated their problems due to a lack of knowledge among faculty members, unsatisfactory instructional support, poorly designed learning activities, and a culture that made disclosure of issues uncomfortable.

Once again, there are strong indications that funding and resource constraints, inadequate staffing and training opportunities, physical limitations, nebulous identification procedures, and destructive misconceptions may also interrupt access and attenuate academic progress (Mullins

& Preyde, 2013; Smith & Gottheil, 2011). These results suggest that higher education institutions must not only promote awareness to further dispel the myths associated with all forms of impairment and disability, they must also enhance service availability, match resources to students' exceptionalities, crystallize support procedures, and work towards creating a more inclusive learning atmosphere (Jenkins, 2007; Mullins & Preyde, 2013; NEADS, 2010; OHRC, 2014).

Promoting inclusive learning environments and help seeking. Mental health problems in post-secondary settings are not trivial. But in the absence of a genuinely inclusive climate, people with impairments and disabilities (25% – 50%) “suffer in silence” even when treatment alternatives exist (Centre for Addiction & Mental Health, 2012; Wynaden et al., 2014). A large body of research has underscored that many students are reluctant to self-advocate or seek professional help (Hunt & Eisenberg, 2010; Storrie et al., 2010; Vanheusden, Mulder, van der Ende, van Lenthe, Mackenbach, & Verhulst, 2008). Notably, Blanco and colleagues (2008) determined that only 25% of young people aged 19 to 25 obtained services. An equivalent rate of help seeking (25%) was found in a Canadian national survey of those 15 to 24 years of age (Bergeron, Poirier, Fournier, Roberge, & Barrette, 2005). Based on quantitative data gathered from 1092 youth with mental health conditions, Bergeron and colleagues (2005) also concluded that young men and those diagnosed with substance dependency or anxiety tended to under-use resources. Cheung and Dewa (2007) revealed that only about half of the individuals reporting suicidal ideation, suicide attempts, and major depression sought mental health assistance.

These results have found empirical support in prior studies — the World Health Organization (2003) substantiated, for instance, that an astonishing 44% to 70% of individuals with mental disorders, in developed nations, received no treatment of any kind. The evidence presented earlier implies that help-seeking behaviours are affected by multiple factors and remain disappointingly poor among this segment of the population, often resulting in disturbing consequences (Treatment Advocacy Center, 2015). Predictably, these issues, and the attendant stigma affixed to mental health impairments and disabilities, have captivated the research community for decades.

As defined by Martin (2010), “Stigma is a socially constructed mark of disapproval, shame, or disgrace that causes significant disadvantage through the curtailment of opportunities” (p. 261). Seminal work conducted by the Canadian Mental Health Association in the early 1960s effectively captured the general apprehension and prejudice associated with mental illness (Tyhurst & Canadian Mental Health Association, 1963). Some of these erroneous beliefs have remained virtually unchanged. As alluded to previously, research has demonstrated that students often delay requests for supports and accommodations because they fear being stigmatized (Gruttadaro & Crudo, 2012; Lightner, Kipps-Vaughan, Schulte, & Trice, 2012; Marshak, Van Wieren, Ferrell, Swiss, & Dugan, 2010). Unsympathetic peer or faculty reactions and confidentiality concerns further encumber students’ disclosure decisions (Hartman-Hall & Haaga, 2002; Salzer et al., 2008; Thornicroft, Rose, & Kassam, 2007). Research has shown that people opted to manage their problems independently, were unaware of support possibilities, or

felt that mental health services were ineffective or extremely hard to access (e.g., time, cost) (Eisenberg et al., 2012; Jagdeo et al., 2009; Salzer et al., 2008; Vanheusden et al., 2008).

In one exploratory study examining mental health services in higher education institutions, Warwick and colleagues (2009) interpreted data from interviews, surveys completed by 150 colleges, and five case studies of service provision practices at individual campuses. They observed that mental health approaches depended on the quality of leadership at the senior and middle management level, in-servicing opportunities, existing internal and external mental health supports, knowledge of the relationship between mental health and achievement, explicit policies and procedures, and the inclusive nature of the educational context. Most assuredly, inadequate resources and piecemeal delivery systems impede students' ability to obtain mental health resources. Indeed, a good deal of the published research has cited fragmentary supports, lengthy wait times, and underfunding as substantive obstacles to service provision (Davidson, Kutcher, Manion, McGrath, Reynolds, & Orrbine, 2010; Davis, 2014; Ontario College Health Association, 2009; Popovic, 2012). These findings are important because outcomes can be markedly enhanced once students access meaningful resources (CACUSS & CMHA, 2013). This is further borne out in other empirical evidence demonstrating that students who were linked to campus "disability" (accessibility) offices had greater success and interpersonal connection (Orr & Goodman, 2010) as well as a more satisfying college experience than those who did not apply for services (Jorgensen, Fichten, & Havel, 2009). This is relevant because other qualitative and quantitative studies exploring the experiences of post-secondary students with disabilities have

found that relationships with caring adults and students' use of accommodations and learning supports strongly correlated with academic progress (Orr & Hammig, 2009).

Although Salzer, Wick, and Rogers' (2008) research yielded ample data indicating increased awareness and access to mental health accommodations, a recent investigation executed by Young and Armstrong (2015) noted that students' mental health knowledge was relatively weak and tended to undermine help seeking. In their web-based survey of 2,783 university students using site-based mental health resources, Eisenberg, Golberstein, and Gollust (2007) confirmed that under-utilization of supports was related to unfamiliarity with service possibilities, a lack of perceived urgency, and skepticism about the benefits of counselling. Most of their study participants with mental health impairments or disabilities received no treatment even though free services were offered. The authors further hypothesized that reducing delays between onset of symptoms and intervention could lead to massive improvements in social, employment, and academic prospects.

These findings suggest that institutions should bolster their outreach efforts; available stigma-reduction programs, counselling services, and awareness-raising options must be more thoroughly publicized (Jenkins, 2007; Tinklin et al., 2005). This is noteworthy because many students with mental health impairments and disabilities continue to be "in the dark" when it comes to the resources specifically designed to remove "service-oriented" access barriers and facilitate their learning and success (Gruttadaro & Crudo, 2012; NEADS, 2010). Student services personnel, institutional leaders, faculty, and other education stakeholders must share in the responsibility of addressing these challenges to enable maximum participation and growth

(CACUSS & CMHA, 2013; Conway & Chang, 2003; Hindes & Mather, 2007). Research has shown that improving policies and practices prioritizing these areas is pivotal for addressing students' mental health needs (Hardy Cox & Strange, 2010; MacKean, 2011) — positive mental health should be a central goal campus wide (CACUSS & CMHA, 2013; Royal College of Psychiatrists, London, 2011; UK Universities & Standing Conference of Principals, Working Group for the Promotion of Mental Wellbeing in Higher Education [UUK/SCOP], 2015).

This section highlighted key insights related to students with mental health impairments and disabilities. Based on the evidence reviewed, one can wisely conclude that institutions should focus on (a) aligning supports to match demographic changes, (b) improving accessibility and eliminating systemic barriers, and (c) promoting inclusive learning environments and help seeking. This study builds understanding by considering how these factors affect college students' learning and success. More information is required given the ambivalence about what approaches are most helpful to this portion of the population and how SAS leaders should respond.

Student affairs and services (SAS) leaders. The student services profession is understood as a highly challenging and diverse role. Correspondingly, the duties associated with student affairs work have expanded dramatically over the last fifty years (Fried, 2011; Muncsh & Cortez, 2014; Sandeen & Barr, 2006; Seifert, Arnold, Burrow, & Brown, 2011). Student affairs and services are defined as all supports established by the institution to promote cognitive, emotional, and psychological development (Tait, 2000). Historically, “attending to the needs of the ‘whole’ person has been embedded in the core mission, values, philosophy, and literature of

the student affairs profession from the beginning” (Reynolds, 2011, p. 399). Therefore, these practitioners act first and foremost as custodians, teachers, and helpers who assist learners to cope with the inherent psychological and academic pressures of college (Reynolds, 2011). They have also figured prominently in devising policies and practices that boost academic and vocational skills (Hall & Belch, 2000; Hardy Cox & Strange, 2010; Kitzrow, 2009).

Research has suggested that SAS leaders often operate as critical “equalizers” for improving educational outcomes (Hardy Cox & Strange, 2010). Significantly, they have been recognized as indispensable assets in shepherding collaborative knowledge mobilization efforts; building inclusive, equity-specific policies; contributing to staff development and capacity building; evaluating program efficiency and impacts; personalizing services to students’ mental health needs; and reducing organizational inequities (Bailey & Alfonso, 2005; King & Baxter Magolda, 2011; McGrath, 2010). These pursuits are particularly important because many post-secondary students with mental health impairments and disabilities encounter bigoted attitudes and access issues that restrict educational opportunities and delay graduation (McCloy & DeClou, 2013; Woods, Cook, DeClou, & McCloy, 2013). In one exploratory study considering the effects of stigma, Martin (2010) conducted an anonymous on-line survey targeting students at one university. She noted that nearly 63% of the participants had not divulged their conditions to service providers (52% multiple diagnoses), even though they were undergoing academic strain — many were concerned that they would be seen as “telling lies” or “wanting extra privileges” (p. 65). Conversely, those who sought support enjoyed better results once the unique features of their impairments and disabilities were accepted and understood.

In other research, Holmes and colleagues (2011) argued that if institutional personnel possessed in-depth knowledge of mental health, students might be less apprehensive about self-identifying. The literature has also indicated that individuals frequently struggle with obtaining services partially due to the “invisible” or episodic nature of their impairment or disability (Mullins & Preyde, 2013; NEADS, 2010). Based on the findings from their longitudinal, mixed method study undertaken over a two and a half year period at two Ontario campuses, Tsagris and Muirhead (2012) concluded that post-secondary institutions have yet to meet the needs of all students on campus. Their results, along with those described earlier, suggest that SAS leaders have a responsibility in reversing these trends. However, given the many interrelated obstacles to educational success, this task is fraught with difficulty (Berger, Motte, & Parkin, 2009). Indeed, Sandeen and Barr (2006) believe that “dealing with the range and scope of psychological disabilities, and setting the parameters of response . . . will be among the greatest challenges facing the leadership in student affairs for the decades ahead” (p. 161).

Likewise, the increasing diversity of the student population, new accountability rules, accessibility legislation, consequent pressures to augment achievement and graduation measures, the role of technology, and adjustments to program and service delivery models have necessitated sweeping changes to the student services landscape. Given their duty in tending to the welfare of the “whole” student and strategic position in the institution, SAS leaders fulfill a multitude of supportive functions. These are linked to (a) academic accommodations, accessibility, and assessment; (b) services, supports, and the role of technology; and (c) information sharing and capacity building.

Academic accommodations, accessibility, and assessment. Students with impairments and disabilities have the right to access the same opportunities as their non-disabled counterparts (Government of Ontario, 1990; Hall & Belch, 2000; NEADS, 2010). To ensure continued accessibility and success, post-secondary leaders must establish a supple repertoire of institutional structures and programs that are responsive to students' diverse mental health needs (Drewes, 2008; Jenkins, 2007). According to the National Educational Association of Disabled Students (2010), "Accommodations refer to any service, adaptation, or support mechanism that enables students to participate fully in academic, campus, and community life" (p. 10). The intended objective is "to level the playing field." These supports are mandated by the *Accessibility for Ontarians with Disabilities Act (AODA)* (Ministry of Community and Social Services, 2011). They are also significant because students with mental health impairments and disabilities regularly confront performance obstacles. These are related to low self-esteem, poor attendance and motivation, self-regulation, engagement in group work and presentations, organization and planning, meeting deadlines, staying on task, recalling details, test anxiety, and coping with stigma (Collins & Mowbray, 2005, 2006; Megivern et al., 2003). Similarly, research has suggested that faculty and service providers may benefit from understanding the side effects of various medications especially when shaping accommodation plans (Holmes et al., 2011). For example, some psychotropic drugs may induce drowsiness and affect students' ability to concentrate in class. Equipped with this background knowledge, professors are more apt to provide alternative access to curriculum (e.g., copied notes, recorded lectures) so that learning is facilitated (Holmes et al., 2011).

Before any of these supports can be implemented, an assessment by an accredited health professional is commonly required. Transitioning and orientation programs and outreach to high schools can be effective for provoking students to self-identify so that the accommodation process can begin early. However, there are no guarantees that students will come forward even if they have a diagnosis (Ontario Ministry of Health & Long-term Care, 2009). Although documentation is often quite precise for certain disabilities (e.g., physical, learning) in terms of specifying the type of accommodation that is required, this is rare for mental health conditions. The challenge is that student services offices often receive proof of a medical disorder with no indication of how to best accommodate individuals academically (Ontario Ministry of Health & Long-term Care, 2009). In response, Condra and Condra (2015) made two recommendations. First, service providers should determine mental health accommodations based on students' functional limitations (not diagnoses). Second, institutions should use essential course requirements (i.e., Bona Fide Academic Requirements, BFARs) so that students can evaluate the impact of their "disability-related functional limitations" relative to a defined set of course expectations (p. 6).

The accommodation process can be further compounded because students' needs may fluctuate radically due to the unpredictable and intermittent nature of mental health impairments and disabilities (Ontario Ministry of Health & Long-term Care, 2009; UUK/SCOP, 2015). The literature has also signaled that mental health supports must be highly customized because accommodations that have been successfully used for one individual may be ineffectual for another (Ontario Ministry of Health & Long-term Care, 2009). In the event of an acute crisis,

accommodations may also need to be given retroactively and result in course withdrawals or petitioning for grades to be removed from official transcripts (Ontario Ministry of Health & Long-term Care, 2009).

Katsiyannis and colleagues (2009) have proposed that three additional factors can hamper accommodation procedures. Some faculty members misunderstand the policies and practices that have been adopted by the institution. Others believe that accommodations can jeopardize course integrity. Lastly, professors may not integrate relevant support practices because they cannot distinguish the telltale signs of incipient mental health conditions (Katsiyannis, Zhang, Landmark, & Reber, 2009). In another study examining faculty knowledge of students with disabilities, Vogel and colleagues (2008) surveyed 271 professors twice over a three-year period. They determined that targeted professional development, designed around faculty preferences and needs, resulted in “striking” changes to the learning milieu and their understanding of disabilities, legislation and policy, accommodation directives, and campus service options (Vogel, Holt, Sligar, & Leake, 2008). Specifically, instructors favoured access to expert advice, online information (available 24/7), and one-to-one consultations; followed by on-site seminars, speakers, and workshops; and finally distance education, tele-conferences, and credit or non-credit courses.

As noted previously, one of the more serious accommodation dilemmas is students’ low rate of self-identification. When individuals do not understand their own impairments and disabilities or refuse to self-disclose due to stigmatizing beliefs, they access no supports and risk academic failure (Jorm, 2000; Perry & Franklin, 2006). This evidence is important because

perceived negative attitudes have been isolated as one of the chief barriers to success (Kurth & Mellard, 2006; Wilson, Getzel, & Brown, 2000). Cook (2007) added that many students do not seek counselling services because they lack knowledge about mental health symptoms and resources or deny the severity of their problems. More alarming still is that if left unchecked, these problems may precipitate suicide attempts, grave injury, or fatalities (Cook, 2007).

Services, supports, and the role of technology. In response to these complex challenges, service providers offer a raft of interventions and programs aimed at addressing students' psychological, academic, social, personal, and accessibility needs (Coniglio, McLean, & Mueser, 2005; Crozier & Willihnganz, 2005). For example, two investigations, conducted by Porter (2011) and Turner and Berry (2000), explored how counselling centres contribute to retention and graduation. Archival records of students who sought support services were analyzed. Porter verified that counselled students in first year enjoyed a retention rate that was 7.6% higher than those in the general population. Turner and Berry's six-year longitudinal study found that retention outcomes, for students who participated in counselling, were 11.4% better than their peers. The results in both cases support the value of professional counselling as part of an institution's overall strategy to enhance graduation numbers. Others have indicated that SAS professionals can also serve a consultative and collaborative function and assist in mediation, appeals, risk assessments, tragic events response, and facilitate early warning or gatekeeper training (Lees & Dietsche, 2012). Nonetheless, the literature has demonstrated that existing supports do not adequately address all of the mental health impairments and disabilities that are surfacing on campus (Ontario Ministry of Health & Long-term Care, 2009).

Some researchers have argued that institutions should divert their attention towards introducing efficient triage systems, establishing stronger relationships and knowledge exchange with campus constituents and outside agencies, developing better protocols for those who transition back to school after hospitalization, and refining confidentiality practices for sharing personal medical information (Cooke et al., 2015; Ontario Ministry of Health & Long-term Care, 2009; Royal College of Psychiatrists, London, 2011; Storrie et al., 2010). Such approaches are essential because when students receive quality support, their emotional stability, persistence, and achievement can improve substantially (Gallagher, 2012; McCloy & DeClou, 2013; Porter, 2011; Turner & Berry, 2000). Yet, there continues to be immense pressure placed on support workers to do more and “be all things to all people” as demand for resources escalates and the system becomes increasingly stretched (Cooke et al., 2015). One of the issues is that institutions have been traditionally responsible for delivering educational programming, not health care (Ontario Ministry of Health & Long-term Care, 2009). But this is changing as post-secondary leaders recognize the clear links between student success and mental health. Notably, a number of technology-based approaches have been proposed to broaden access and opportunity.

Although the digital world offers many potential benefits to students with mental health impairments and disabilities and service providers alike, it can be a double-edged sword. On one hand, technology might be used to introduce cost-effective modes of support for online learners. Web-based tools facilitate easier access to training and information programs or tele- and e-mental health resources (e.g., *Good2Talk*), while encouraging help-seeking behaviours among those who would not typically ask for assistance (Cooke et al., 2015; Davidson et al., 2010;

Reavley, Cvetkovsky, & Jorm, 2007; Shaw & Shaw, 2006). On the other hand, technology can perturb students' mental health if it is misused (Kruisselbrink Flatt, 2013). In one study assessing Internet and cell-phone usage of college students, Jenero and colleagues (2007) gathered quantitative data from 337 people. They determined that 6.2% of students displayed tendencies matched to a compulsive Internet diagnosis; psychiatric disorders such as insomnia, social dysfunction, depression, and anxiety were more likely to materialize among excessive users. The results suggested that early detection of potential pathological behaviours deserves further exploration given the sizable emotional, educational, and social toll on affected individuals (Jenero, Flores, Gomez-Vela, Gonzalez-Gil, & Cabello, 2007). Unquestionably, mishandling of technology is a new problem that is magnifying the mental health crisis on many campuses (Kruisselbrink Flatt, 2013). It is reasonable to conclude that awareness-raising and outreach campaigns should form part of an institution's support arsenal to ensure that students are well versed about the effects of mental health and the variety of campus supports aimed at accelerating their learning and success (NEADS, 2010).

Information sharing and capacity building. Academic, social, environmental, and personality features must be carefully considered when planning these promotional and outreach programs. Such initiatives are valuable for raising awareness, facilitating successful transitions from high school, removing barriers to education, enhancing students' self-advocacy skills, and minimizing some of the hectic aspects associated with college (Nicholls et al., 2012; Ontario College Health Association, 2009; Smith Fowler & Lebel, 2013). Crucially, students who are unable to manage their stress are at greater risk for developing other personal and social

difficulties (Government of Canada, 2006). Stress has also been cited as the most common health-related ailment influencing academic performance (American College Health Association, 2013). Research has shown that the provision of proper supports can buffer the impacts of these problems before they balloon into larger issues that are less easily resolved (Armstrong & Young, 2015; Katsiyannis et al., 2009; NEADS, 2010). Others have also established a positive correlation between students' knowledge and use of supportive resources and graduation rates (Grayson & Grayson, 2003).

Similarly, faculty knowledge about mental health and campus supports is entwined with academic achievement — indeed, professors have a profound effect on students' learning experiences (Kurth & Mellard, 2006; Vogel et al., 2008; Wilson et al., 2000). In their review of disability services at one institution, Wilson and colleagues (2000) conducted telephone or face-to-face interviews with 49 staff and students and collected survey data from individuals who had requested help. They ascertained that faculty were generally uninformed about disability-specific resources and policies, course modifications, assistive technology, and accommodations. Accordingly, professors felt under-equipped to manage the growing demand for assistance. The results give credence to improving faculty training and preparedness because these elements directly affect learning and success. Previous research has also demonstrated that raising staff awareness fortifies commitment to supporting positive mental health on campus (CACUSS & CMHA, 2013).

To be effective, training must be readily available in multiple formats (e.g., online resources, handbooks, one-to-one support), include opportunities for collaboration between

service providers and faculty, and mesh with instructors' learning modalities and professional needs (Murray, Lombardi, Wren, & Keys, 2009; NEADS, 2010). This is important because the type and amount of staff development have been shown to positively influence students (Murray et al., 2009; Nicholls et al., 2012). Likewise, professors are more willing to assist learners with impairments and disabilities when they perceive that sufficient help from support personnel is nearby (Zhang, Landmark, Reber, Hsu, Kwok, & Benz, 2010). In one quantitative study examining the relationship between prior disability-focused seminars and faculty attitudes towards students, Murray and colleagues (2009) surveyed 198 full-time professors who engaged in targeted in-servicing. They determined that workshop participants scored higher (than non-participants) on measures linked to fairness, rudimentary knowledge of disabilities, personal investment in students, and willingness to provide exam accommodations. These results supply preliminary correlational evidence illustrating the value of disability-centred education for improving faculty mindsets, sensitivity, perceptions, and pedagogical practices (Murray et al., 2009). Others have championed professional development in areas such as differentiated instruction and universal design for learning (UDL) so that teaching approaches could be better aligned with learners' specific challenges (Fisher, 2006). UDL is significant because it coincides with mandated *AODA* legislation, supports the goals of inclusion, improves accessibility, and allows instructors to flexibly adapt programming and assessment techniques without diluting the quality of their courses (NEADS, 2010; Nicholls et al., 2012; Orr & Hammig, 2009). Therefore, a wide variety of faculty awareness-raising and information-dissemination mechanisms are needed to optimize knowledge and promote learning.

In summary, the roles and responsibilities of SAS professionals are broad and can be ill defined. Developing realistic expectations for service providers is not easy given the dynamic nature of post-secondary campuses and the realization that accommodating students with mental health complications requires more time and resources. However, many believe that mental health should be prioritized because it is one of the most powerful contributors to learning and success (CACUSS & CMHA, 2013; MacKean, 2011; Ontario College Health Association, 2009). SAS professionals can be influential for not only driving supportive activities, but also enabling service access.

The World Health Organization (2001) has estimated that almost two thirds of those affected by mental illness never seek professional help. Based on the literature reviewed beforehand, it is crucial that post-secondary institutions demystify mental health impairments and disabilities and mitigate the incendiary attitudes that often accompany them. Although there is no absolute blueprint for navigating these complexities, researchers have offered a number of useful suggestions for intervening responsively and increasing accessibility and participation for all students. This section highlighted the shifts that have occurred in relation to the student services portfolio. Based on the reported evidence, it seems reasonable to conclude that higher education institutions should emphasize several key areas. These include (a) strengthening accommodation, accessibility, and assessment protocols; (b) enhancing service efficiency and use of technology-based supports; and (c) promoting continuous information sharing and capacity building associated with students' mental health. Although prior research furnishes some direction about the role of student services in enriching response efforts, there is still some

ambiguity about what policies and practices SAS leaders view as most effective for supporting college students with mental health impairments and disabilities. This study fills some of the gaps in knowledge.

Mental health policies, services, and supports. Mental health intervention is an important part of the recovery process, but disentangling the web of issues that ease or deter access to resources is not simple. Mental illness can beset anyone at anytime (Canadian Mental Health Association, 2015) — roughly 28% of people aged 20 to 29 will exhibit a mental health impairment or disability in a given year (MHCC, 2013a). Surprisingly, one Canada–USA report established that the percentage of students taking prescribed psychiatric medications grew by 15% between 1994 and 2012 (Gallagher, 2012). Research has also reiterated that factors contributing to the onset of mental illness are prevalent in higher education settings (Andrews & Wilding, 2004). In these contexts, individuals are more likely to screen positive for psychological problems than the general population (Adlaf et al., 2005; Collins & Mowbray, 2005). Without prompt intervention, mental health conditions worsen and can follow youth into the workplace (Bartlett, 2014; Government of Ontario, 2009; MHCC, 2013a, 2016).

Despite the scope of programmatic initiatives aimed at supporting these students, many post-secondary institutions in Canada still do not have a well-articulated mental health policy (CACUSS & CMHA, 2013; MacKean, 2011; MHCC, 2012). Although problematic in itself, inadequate prevention and resource allocation have also been underscored as perpetual concerns. Mental health advocates have called for immediate action to address the scarcity of services (CACUSS & CMHA, 2013; Cooke et al., 2015; MHCC, 2012). Others agreed that “providing

timely access to high-quality health care by reducing wait times for assessment and treatment is . . . one of the top priorities for health care policy-makers in Canada” (Mental Health Table Forum, 2010, p. 3). In addition, research has strongly suggested that comprehensive promotion, illness prevention, and early intervention must form part of any mental health framework (Bartlett, 2014; Canadian Policy Network, 2011; CIHI, 2009; Friedli & Parsonage, 2007; Jané-Llopis, Barry, Hosman, & Patel, 2005; Smith Fowler & Lebel, 2013). Such programs could decisively cushion some of the deleterious effects of mental health impairments and disabilities if institutions were to act more swiftly and strategically (Dewa, 2010). Multiple strategies have been examined in the literature. These include areas related to (a) addressing resource shortages, (b) streamlining fragmented response strategies, and (c) promoting collaborative networks and mental health policy development.

Resource shortages. Ready access to counselling, psychological, and psychiatric services is a critical part of supporting students with mental health impairments and disabilities. Although higher education institutions are consciously interceding, service providers are unable to meet the accelerated demand for assistance (Cooke et al., 2015). This is understandable given that from 2007 to 2012, the full-time enrollment in Ontario colleges grew by 26%, but the number of counselling practitioners rose by only 4.5% (Lees & Dietsche, 2012). Hence, there continues to be a discernible shortage of counselling and suicide prevention resources on post-secondary campuses (Canadian Alliance of Student Associations [CASA], 2015). Data gathered from studies conducted in North American colleges have shown that, on average, there is a ratio of one counsellor for every 1600 students, resulting in at least 7.6% who cannot obtain assistance

(Gruttadaro & Crudo, 2012). Other statistics have indicated that at some Ontario institutions, the counsellor-to-student ratios vary from 1:2621 to 1:4350 (MacFarlane, 2012). Respectively, the MHCC's mental health indicators for 2015 revealed dire deficiencies in resources (CASA, 2015). Patterson and Kline (2008) further posited that such constraints (e.g., staffing, financial, etc.) thwarted service providers' attempts to fully meet all student needs.

Post-secondary mental health response plans have also been described as a “fragmented patchwork of programs and services” (MHCC, 2009, p. 13) that are largely one-dimensional and detached from local, provincial, and federal priorities (CASA, 2015). Models that stress only prevention or “symptom amelioration” tend to be individualistic in nature given their emphasis on reducing the incidence, prevalence, and severity of particular issues (e.g., mortality, etc.) (Barry, 2001; Jones, Brown, Keys, & Salzer, 2015). Furthermore, a literature scan performed by the Canadian Institute for Health Information (2009) confirmed, “The majority of mental health strategies continue to focus on illnesses and specific ‘at-risk’ or ‘vulnerable groups’ within the population” (p. 47). There appears to be consensus that this overly “medical” model of service delivery is “outmoded, narrow, and unsustainable” (Cooke et al., 2015; Davis, 2014; Ontario Ministry of Health & Long-term Care, 2009). Alternatively, a coordinated, holistic orientation targeting the overall health and wellness of everyone in the community has been widely recommended (CACUSS & CMHA, 2013; MacKean, 2011; Olding & Yip, 2014; Patterson & Kline, 2008). Canadian researchers, Schwean and Rodger (2013), have advocated a similar comprehensive approach for delivering children's mental health services.

Streamlining fragmented response strategies. Some experts have maintained that

“isolation and fragmentation, resulting from rapid growth in higher education during the last half century, are the greatest threats to successful student learning” (Frost, Strom, Downey, Schultz, & Holland, 2010, p. 45). Although isolated programs that enhance wait times, service delivery, and help-seeking initiatives are certainly valuable, the lack of cohesion can undermine the effectiveness of these “one-off” or stand-alone prevention, detection, and intervention programs (CASA, 2015; Health Canada, 2010). Ordinarily, these programs focus on individual support and accommodations but neglect the larger determinants of student mental health (Olding & Yip, 2014). Various researchers and investigative organizations have suggested a number of remedial steps. To achieve the objectives outlined in Canada’s *Mental Health Strategy* (MHCC, 2012), existing resources need to be more efficiently dispersed. No single sector can adequately address the complexity of students’ needs (Slade & Griffith, 2013) — greater interagency cooperation and collaboration must be nurtured (Health Canada, 2010; Mental Health & Addictions Leadership Advisory Council, 2015; MHCC, 2012; Storrie et al., 2010). To promote positive mental health and moderate disparities, committed leadership at multiple levels is equally vital (MHCC, 2012; National Treatment Strategy Working Group, 2008).

The mental health literature appears to be unequivocal; continued investment in areas related to prevention and promotion of mental health conditions is essential (Canadian Policy Network, 2011; CIHI, 2009; Friedli & Parsonage, 2007). For post-secondary schools, the challenge is to ensure that services are accessible to students, while also realizing that educational institutions are academic, not therapeutic, milieus (Cooke et al., 2015; UUK/SCOP, 2015). Based on the findings from her thorough literature and environmental scan, MacKean

(2011) suggested that leaders promote healthy mental health development at both a community and population level. The kind of systemic orientation advocated here sees the entire campus as a site for improving achievement and health (CACUSS & CMHA, 2013; Olding & Yip, 2014). Such an approach obviously includes individual-level programs but also entails organizational interventions that impact mental health such as infrastructure, policies, and practices (Olding & Yip, 2014). Critically, the Canadian Association of College and University Student Services (CACUSS) and the Canadian Mental Health Association (CMHA) have identified institutional policy as a key ingredient for reforming and streamlining response efforts. This is significant because these policies can influence students' ability to learn, connect, and flourish in ways that directly affect their mental health (CACUSS & CMHA, 2013).

Collaborative networks and mental health policy development. Without a comprehensive policy, students with mental health impairments and disabilities may “slip through the cracks.” Productive information-sharing practices and collaborative systems of communication are primary elements of any supportive approach (UUK/SCOP, 2015). In their qualitative study examining the role of student affairs and services in promoting success, Seifert and her fellow researchers (2011) used interviews and focus groups to collect data from 292 administrative and support personnel from 14 colleges and universities in Ontario. They found that professional partnerships, networking, and capacity were strengthened across departments and institutions when staff members could consistently liaise with others. By “collaborating broadly,” schools were better equipped to meet student needs (Seifert et al., 2011). Others have reported similar results. Frost and colleagues (2010) have argued, for example, that relationship and teamwork

between faculty and SAS professionals are prime determinants of student success. In some Canadian and British contexts, SAS divisions have been brought together into a central location (i.e., hub, “one-stop shop”) to reduce isolation (Seifert et al., 2011; UUK/SCOP, 2015). Technology has also been shown to play a definitive role for enhancing knowledge exchange (UUK/SCOP, 2015). Finally, evidence-based evaluation and planning have been cited as priorities so that the suitability of various services and interventions can be accurately assessed (Cooke et al., 2015; Wilson et al., 2000).

Supportive policies. In a recent study, Olding and Yip (2014) explored the links between institutional policies and student mental health and considered various configurations for service delivery. Generally, policies may be conceptualized in two ways: individual and universal. Policies on the individual side of the spectrum tend to be more reactive and zero in on the unique needs and vulnerabilities of each person. They encompass approaches that specifically support students who are experiencing challenges related to medical leave and re-entry, accessibility and accommodation, privacy and confidentiality, and responses to “at-risk” behaviours and crises. In contrast, policies at the universal end of the spectrum establish broader institutional processes, rules, and infrastructure that apply to all students, regardless of disability or mental health status (Olding & Yip, 2014). These policies are aimed at creating proactive, health-affirming campus cultures. They involve flexible grading and conflict resolution procedures (e.g., code of conduct), the reduction of institutional roadblocks and unfair practices (e.g., diversity, equity), and the promotion of inclusive curriculum and pedagogy (e.g., academic policies, UDL) (Fisher, 2006; Matthews, 2009; Smith & Buchannan, 2012).

Policy design. Mental health policies may be designed, implemented, and evaluated from two perspectives: consolidated and mainstreamed (Olding & Yip, 2014). Some post-secondary campuses assimilate all mental health policies and practices into one document or strategic plan. In the UK, for instance, consolidated policy development is overseen by student affairs and services and typically stresses accountability and assessment of mental health accommodations (Grant, 2005). Student feedback has been viewed as an integral component for creating and monitoring institutional mechanisms under the consolidation umbrella (UUK/SCOP, 2015). Roles, responsibilities, and procedures for responding to students' mental health impairments and disabilities are established and well defined (Olding & Yip, 2014). Importantly, consolidated policies are often interlaced with other priorities linked to retention, achievement, equity, and diversity (Warwick et al., 2008). Once again, individual students are supported on the basis of the functional limitations tied to their mental health. Lastly, a mainstreamed approach to policy design may also be embraced. In this case, designated senate committees are tasked with reviewing prevailing policies and practices and proposing modifications based on an inclusive or holistic orientation (Olding & Yip, 2014). The overarching goal is to embed a mental health lens into all institutional decision-making in order to better serve every student on campus.

In summary, there are a range of effective programs for supporting post-secondary students with mental health impairments and disabilities, yet substantial gaps still exist in terms of meeting their needs. Resource shortages (e.g., lack of specialized personnel, etc.) and splintered service delivery have been identified as persistent sticking points. The literature seems to suggest that these shortfalls adversely influence academic and psychological development;

they also hamper service providers from reaching each student. Streamlining the support process resonates with many in the research community who believe that a mental health policy should be developed at each campus (CACUSS & CMHA, 2013; Cooke et al., 2015; MacKean, 2011; Olding & Yip, 2014; Royal College of Psychiatrists, London, 2011). Research has corroborated that well-aligned, comprehensive institutional policies and theory-based practices that emphasize mental health dimensions can spur educational success (Zhao & Kuh, 2004).

This section highlighted a number of substantive issues related to mental health policies, services, and supports. Based on the evidence reviewed earlier, it is befitting for higher education institutions to pinpoint certain areas. These include (a) addressing resource shortages, (b) streamlining fragmented response strategies, and (c) promoting collaborative networks and mental health policy development. The present study considers these elements of practice but goes one step further to build understanding. It suggests possible avenues for developing mental health policies that are responsive to the needs of college students with mental health impairments and disabilities — an aspect that has not been fully elaborated in the theoretical scholarship.

Connections to Previous Research

This literature review has provided evidence that mental health remains a prevailing concern on Canadian campuses. Given the escalating presence of multiple problems, post-secondary institutions continue to wrestle with the challenge of stitching together an effective mental health plan. Prior studies considered students' mental health and intervention strategies in comparable settings; several limitations and recommendations were outlined. First, in

MacKean's (2011) investigation, respondents shared their understanding of the problems and suggested prospective courses of action but contributed little to describing "how" to institute a coherent mental health model. More in-depth interviews, internal document review, and policy analysis were advised. Second, Warwick and colleagues' (2008) exploratory study included only students 19 years and under. Nevertheless, they underscored the importance of leadership, school climate, awareness raising, and the need for improved mental health policies, practices, and support services. Third, Patterson and Kline's (2008) report included input from students and SAS administrators. Due to the small sample size, the results were not generalizable. Still, the authors urged constituents to adopt a campus-wide health and wellness focus and stressed the advocacy role of SAS leaders. Finally, Olding and Yip (2014) provided a detailed synopsis of mental health policy approaches based on discussions with key informants and extensive documentary evidence gathered from several educational institutions in Canada and the United Kingdom. However, their inquiry did not address the college experience or the practicalities of developing and changing campus mental health policies.

I have described previous findings and recommendations from the empirical research. This literature review has demonstrated that more studies are needed to determine best practices for assisting students who have mental health impairments and disabilities. It has also shown that the supportive role of student services remains relatively underexplored; few investigations have documented the perceptions of SAS professionals who oversee, develop, and implement programming for affected students. My study has addressed some of the identified gaps relevant to Canadian post-secondary settings.

Theoretical Framework

The theoretical framework anchoring this study is underpinned by an inclusive approach and human-rights perspective. My research is derived from a constructivist-interpretivist stance and arises from the themes showcased in the literature review. Accordingly, it is linked to student success, inclusion, and a holistic orientation. This study is built around three theoretical constructs: (a) students with mental health disabilities; (b) student services leaders; and (c) mental health policies, services, and supports.

Admittedly, service delivery is shaped to a large extent by personal beliefs and understandings of mental health impairments and disabilities (Davis, 2014). This study advocates a comprehensive, holistic approach and is therefore situated in both a medical (intervention) and social (attitudes) model of disability. Researchers have acknowledged that impairment in mental behaviour is caused by a combination of complex genetic, biological, psychological, and epigenetic factors, not defective character or individual “weaknesses” (Davis, 2014). They have also recognized that the social construction of disability includes a multiplicity of needless restrictions that inhibit people’s ability to function optimally in their communities. Oliver (1996) agreed that “disability is something imposed on top of impairments by the way [people] are unnecessarily isolated and excluded from full participation in society” (p. 22). Consequently, disabilities may result from attitudinal, environmental, or institutional obstacles. They may also be aggravated by social, economic, and cultural disadvantages tied to prejudice, inequity, and marginalization (OHRC, 2014). Jones, Brown, Keys, and Salzer (2015) have contended, for example, that “individual mental impairments may lead to social dysfunction, . . . but social

exclusion may also ‘disable’ an individual who could otherwise thrive with appropriate community supports” (p. 595). Importantly, the “social model” does not deny the reality of the impairment nor its causal factors or impact on individuals. Rather, it challenges the physical, attitudinal, and social environment to accommodate all “functionally limiting conditions” (WHO, 2013).

The medical and social approaches to disability have important implications for students with mental health impairments and disabilities. Both paradigms also have a significant effect on how post-secondary institutions respond to individual needs (Canadian Association of Disability Service Providers in Postsecondary Education, 1999). With respect to institutional accommodations, Tinklin and colleagues (2005) have argued that “tackling flaws in the higher education [context] is no mean feat, but . . . it would . . . help to alleviate demands on . . . support services . . . and improve the quality of the education experience for all students” (p. 511). For those with mental health conditions, in particular, it is essential to delineate environmental factors that exacerbate issues and then provide navigational strategies that help people overcome the challenges (Tinklin et al., 2005). There is an expectation that institutional leaders make the school setting as accessible as possible to lessen the need for accommodations (Dukes & Shaw, 1999). In her earlier work, Gill (1987) stipulated that for mental health interventions to be truly transformative, they have to be customized to students’ “lived experiences.” She further cautioned, “Misguided beliefs about what is ‘best’ for [people] must not supersede [their] own choices of equally beneficial alternatives” (p. 54).

Both models of disability relate directly to duties pertaining to the student services role. They also overlap with prescribed standards itemized in the *AODA* (Ministry of Community & Social Services, 2011) and the *Ontario Human Rights Code* (OHRC, 2000, 2012). Service providers, steered by a holistic approach to mental health impairment and disability, attempt to mitigate the unwanted effects of various barriers. These may be related to administrative bureaucracy, poorly applied regulations and accommodations, “attitudinal access” challenges, uninformed faculty, and inflexible programs. Finally, institutions that embody holistic principles support shared responsibility for learning and success, staff development that prepares faculty to meet learners’ academic and psychological needs, information sharing and collaboration, and commitment to enhancing inclusion and accessibility in the organization (Dukes & Shaw, 1999).

Summary

This chapter presented the literature review. It synthesized research related to students with mental health impairments and disabilities, SAS leaders, and mental health policies, services, and supports. Institutional policy affects the mental health and learning of all students, yet it remains an area of intervention that is not completely understood. Given the growing incidence, complexity, and prevalence of mental health conditions at Canadian campuses, more research is needed to investigate what policies and practices are effective for promoting positive mental health among college students in Ontario.

Mental health is understood as an essential part of an individual’s overall health (Raphael, Schmolke, & Wooding, 2005). Students’ social, emotional, and psychological fitness profoundly influences personal development and educational outcomes (Slade & Griffith, 2013).

Conversely, research has established that unsatisfactory psychological and social adjustment negatively influences quality of life and ability to thrive (Nichols & Quaye, 2009). By working collaboratively, sharing best practices, implementing empirically tested programs, and maximizing the use of resources, post-secondary schools can be responsive to a gamut of mental health impairments and disabilities (Cooke et al., 2015).

Patterson and Kline (2008) have contended that a campus-wide focus on health, the development and provision of mental health services, and an emphasis on preventive measures are major contributors to student success. Therefore, the institution's commitment to mental health should filter through all policy development efforts. This holistic, inclusive orientation towards service delivery has implications for researchers and provides opportunities for greater dialogue about the ways in which SAS leaders can help to create a positive learning climate and improve accessibility across the institution and community. Such an approach strategically dovetails applicable facets of both the medical and social models of disability.

In summary, this literature review presented current findings about post-secondary students who exhibit mental health impairments and disabilities. Although other investigators have conducted similar studies, there is a void in the research examining SAS leaders' opinions about policies and practices that directly affect students enrolled in Canadian colleges.

In chapter three, I describe how I addressed my research questions by outlining the methodology. The research design, epistemological assumptions, case study approach, trustworthiness, study questions, participant selection, data sources, data collection and analysis techniques, and ethical implications are explained.

Chapter 3. Methodology

The purpose of this single qualitative case study was to explore the perceptions of student affairs and services (SAS) leaders in relation to the effectiveness of policies and practices that assist college students with mental health impairments and disabilities. In this chapter, I discuss the research design, epistemological assumptions, case study approach, trustworthiness, study questions, participant selection, data sources, data collection and analysis techniques, and ethical implications. My data collection and analysis was aligned with the qualitative case study methodology — the goal was to maintain both methodological (good practice) and interpretive rigour (trustworthiness) throughout the study (Fossey, Harvey, McDermott, & Davidson, 2002).

Qualitative Approach

Scholars in the field of health and well-being have a time-honoured tradition of conducting qualitative research (Braun & Clarke, 2014). Qualitative inquiry is viewed as an interpretative activity that is designed to make meaning based on the perspectives of people in a particular social setting (Snape & Spencer, 2003). Since “interview data constitute the [study’s] empirical backbone” (Campbell, Quincy, Osserman, & Pedersen, 2013, p. 294), flexibility in design and data analysis are required to develop “deep” understanding and a justifiable representation of the participants’ experiences (Sidani & Sechrest, 1996). The way in which researchers conceptualize topics and organize their studies must also demonstrate methodological consistency and be congruent with their epistemological ideals and theoretical positioning (Reicher & Taylor, 2005).

This research undertaking started with topic selection and the choice of a theoretical paradigm and methodology that best addressed my study problem. The qualitative methodology was deemed to be suitable for exploring the policies and practices that SAS leaders perceived to be effective for enhancing students' mental health. Such an approach offered advantages because it was inductive in nature and allowed me to narrow in on a single context (Maxwell, 2013). The methodology also provided a flexible apparatus for recording the complexities of the SAS role and the leaders' thoughts about mental health services on campus (Stake, 2000); these were linked to the study questions and theoretical constructs. The key aims of my research were to contribute knowledge to the mental health and student services scholarship, inform policies and practices, and acquire greater awareness about college service-delivery models.

Epistemological Assumptions

This study was grounded in a constructivist-interpretivist philosophy, which led to the formulation of the research questions (Stake, 1995). Significantly, the constructivist paradigm assumes that knowledge is socially constructed. I was also guided by a holistic approach involving both the medical and social models of disability. Establishing these epistemological and theoretical perspectives was instrumental in forging the research design and reaching decisions about my approach, methodology, data collection, and analysis procedures (Creswell, 2003). To achieve methodological congruence, the data collection and analysis plan was rooted in the premise that reality and knowledge are situated in a specific social environment and co-created by the researcher and participants (Creswell, 2012).

As a constructivist researcher, I believe that “access to reality is through social constructions” (Myers, 2008, p. 38). My intent was to understand the topic through the meanings that were assigned by the SAS professionals and accurately depict these experiences. I recognize that my beliefs, values, and background as a special education teacher affected my understanding (Lincoln & Guba, 1985). In this way, I was a critical variable in the research equation. Thus, the codification and analysis of the data have been filtered through my personal lens. I am fully aware that researcher reflexivity (i.e., self-awareness, ownership of opinions) is an inherent component of qualitative research (Denzin & Lincoln, 2005). To reduce interpretive and epistemic bias, member checking was used. Leaders had opportunities to scrutinize transcript material and provide corrective feedback. Based on their requests, changes were made to conceal identities, thus conserving the substance of their words and respecting confidentiality.

Single Case Study

This study involved an empirical investigation at one college in Ontario. A case study is an in-depth examination of a “bounded system” and demands adherence to specific parameters (Stake, 1995). It facilitates the exploration of a phenomenon within one context, uses a variety of data, and ensures that the subject is examined through multiple perspectives (Yin, 2003). The approach is designed to generate a body of “thick” descriptions for analysis. Therefore, my rationale for using a case study was two-fold: (a) provide an opportunity for the SAS leaders to tell their “stories” and (b) generate a body of reliable, information-rich data for analysis (i.e., transcripts). I adopted reflexive, methodical coding, interpretation, and presentation procedures that permitted me to expose the essence of the data (Morrow, 2005).

Consistent with the case study approach, my research was exploratory in nature and contextually unique (Stake, 1995). I was able to answer the research questions, examine various aspects of the SAS leaders' experiences, and connect these to the study's theoretical constructs (Lincoln & Guba, 2005). Accordingly, my objective was to document, analyze, and comprehend the leaders' meaning-making process with respect to the college's mental health policies and practices (Lincoln & Guba, 2005; Merriam, 1998).

Trustworthiness

To increase trustworthiness, I applied established benchmarks suggested by Lincoln and Guba (1985) to my data collection and analysis: transferability, dependability, confirmability, and credibility. First, generating rich descriptions of the SAS leaders' insights that may have some application in similar post-secondary contexts improved transferability, albeit limited given the parameters of case study research. Second, I stressed dependability by including details about the specific data collection steps and offered a rationale for my choices. Third, confirmability was addressed through attempts to diminish bias by freely declaring that my background and experiences informed observations and interpretations (Lincoln & Guba, 1985). Finally, I adopted various strategies to build confidence in the "truth" of the research findings and enhance credibility (Mischler, 1990). I understand that interview data is subjective and selective; indeed, the methodology, data interpretation, and study outcomes were swayed by my underlying beliefs (Yardley, 2007) and positionality as outlined in the introduction. I also created major themes and patterns based on a comparative analysis of evidence contained in the three data sets: interview transcripts, documents, and researcher notes (Lincoln & Guba, 1985). Researcher notes were

particularly helpful for monitoring decision-making and modifications in study procedures and served as a reflexive device for interrogating my preconceptions and interpretations throughout this study (Lincoln & Guba, 1985). Finally, I used triangulation and member-checking mechanisms to enhance trustworthiness.

Triangulation. Lincoln and Guba (1985) believe that triangulation is the most powerful method for establishing credibility; data represent the lifeblood of case study methodology. I compared material gathered from the interviews, documents, and researcher notes to add richness and robustness to the evidence and further validate my conclusions. An audit trail of my efforts and behaviours was recorded so that readers of this study would fully understand the research process and be well placed to judge the fidelity of its outcomes.

Member checking. Member checking refers to the process of soliciting feedback from participants to confirm that the researcher's interpretations encapsulate a "recognizable reality" (Lincoln & Guba, 1985; Probst & Berenson, 2014). I viewed it as a quality control activity aimed at improving accuracy, credibility, and validity of evidence contained in the interview data (Lincoln & Guba, 1985), thus increasing authenticity and completeness of results (Cohen & Crabtree, 2006; Creswell, 2007). With these goals in mind, I emailed participants and asked for comments about my understanding of the interviews. Based on their preferences, full transcripts or summaries were made available to each person for verification. Participants confirmed that my interpretations adequately portrayed their perspectives. Once approved, verbatim quotes and excerpts were inserted into the final report to augment the precision of findings (Creswell, 1998).

Study Participants

I interviewed 17 student services professionals with various leadership responsibilities, experiences, and knowledge in relation to students' mental health. To obtain a clearer picture of the context, it seemed important to locate leaders with multiple perspectives and from different tiers of the leadership hierarchy at the college (i.e., senior leadership, middle management, front-line leaders). Based on the literature, my sampling decisions were justified and the numbers interviewed sufficient to yield a representative example of the SAS leaders' viewpoints (Creswell, 2007). According to Sandelowski (1995), "an adequate sample size in qualitative research is one that permits — by virtue of not being too large — the deep, case-oriented analysis that is a hallmark of all qualitative inquiry, and that results in — by virtue of not being too small — a new and richly textured understanding of experiences" (p. 183). To increase credibility, two sampling techniques were adopted. Purposeful sampling was used to select participants who possessed knowledge and experience linked to students' mental health and the various services available to them (Stake, 2005). The snowballing method was also employed to locate additional interviewees (Patton, 2002). Thus, I asked the initial pool of leaders to nominate other participants who met the eligibility criteria. I approached people who oversaw, developed, or implemented policies and practices designed to assist students with mental health impairments and disabilities and agreed to share information about their SAS work.

Key informants and selection criteria. Reaching the research goals is strongly linked to effectively executing the recruitment process and finding appropriate informants (Cyr, Childs, & Elgie, 2013). Recruitment demanded that I accurately describe the study to participants,

assemble an adequate sample tailored to its objectives, obtain written-informed consent, and adhere to the ethical standards defined by the review boards at the study site and Western University. I created a list of potential leaders based on information located on the college website. To generate reliable data, I included a cross section of individuals who “[represented] the richest and most complex sources of information relevant to the phenomena being studied” (Eide, 2008, p. 743). More specifically, I selected participants employed in counselling and accessibility, administration and management, adaptive technology, student success, and academic and learning support. I also spoke to leaders supervising Aboriginal and first-generation student outreach. Interviewing a mix of SAS practitioners provided a generous overview of the perceived challenges associated with policies and practices aimed at students’ mental health and development. My intent was to explore the impact of resources that these professionals understood to be most important for addressing students’ mental health needs.

Participant characteristics. A total of 17 SAS leaders were interviewed at Resiliency Community College of Applied Arts and Technology (RCCAAT). Only descriptors related to their gender, age range, and position were documented (Table 1). Five male and 12 female leaders participated in this research. Two senior management leaders (dean, etc.), two middle management leaders (director, etc.), and 13 front-line leaders (service providers) were involved in the study. Additional identifiers were omitted because these details could reveal participants’ identities. Thus, demographic information was intentionally excluded to protect the privacy and anonymity of the key informants.

Table 1

Demographic Characteristics of Study Participants

<i>Participants</i>	<i>Gender</i>	<i>Leadership Position</i>	<i>Age</i>
1. Participant B	F	Front-line	30-44
2. Participant BE	F	Front-line	30-44
3. Participant C	F	Front-line	30-44
4. Participant CH	F	Front-line	30-44
5. Participant D	F	Middle	45+
6. Participant DU	F	Front-line	45+
7. Participant E	F	Front-line	30-44
8. Participant EM	F	Front-line	30-44
9. Participant J	M	Front-line	30-44
10. Participant K	F	Front-line	45+
11. Participant L	F	Front-line	30-44
12. Participant M	F	Senior	30-44
13. Participant S	M	Middle	45+
14. Participant P	M	Senior	45+
15. Participant PH	F	Front-line	30-44
16. Participant V	M	Front-line	45+
17. Participant W	M	Front-line	30-44

Sample size. Sample size was an important consideration in this qualitative study. Sandelowski (1995) has underscored that "determining adequate sample size . . . is essentially a matter of [researcher] judgment and experience" (p. 179). Additionally, the concept of saturation is defined as "data adequacy" and involves gathering evidence to the point of redundancy or when no new themes are uncovered (Miles & Huberman, 1994; Morse, 1995). For this study, I engaged in continuous scrutiny of the transcription material so that subsequent data collection decisions could be made. I determined that data saturation was reached after 17 interviews — no variation appeared within the data. The collected evidence was comprehensive enough to answer the research questions (Creswell, 2003). I was also aware that it was not the quantity of data that was relevant but rather the details or "richness" of the leaders' narratives (Morse, 1995).

Invitation to participate. When ethics approval was obtained from the college and university, I connected with the SAS leaders from different departments through email. At that time, I elucidated study details (i.e., letter of information, informed consent) and responded to all of their queries. Once participants agreed to be interviewed, I emailed them to arrange appointments at a private location of their choice. A copy of the interview questions was shared in advance. No incentive for participation was offered.

Participants' privacy, anonymity, and confidentiality. All reasonable measures were taken to disguise identities and maintain the leaders' privacy. These measures were based on the ethical guidelines dictated by the university and college review boards. At no time were data linked to participants or the study site. Only pseudonyms were included in the interview transcriptions and study documents. Although participants' names appeared on the informed

consents, these forms were securely stowed in a location separate from the data at my workplace. Digital files were labelled with a corresponding pseudonym chosen by each participant and stored on my password-protected computer at work.

Pilot Interviews

The piloting phase was an indispensable part of my study design. To test the limits of the data collection methods and the appropriateness of the questions, I conducted pilot interviews with volunteers possessing traits similar to the college leaders. The trials assisted me in identifying minor weaknesses, managing logistical problems (i.e., scheduling, time, availability, feasibility, geography), and modifying my interviewing techniques (wait time) and use of recording devices. Only small modifications were made based on evaluative feedback from the pilot interviewees. To reduce ambiguity, I made slight adjustments to the wording, number, structure, and sequencing of the interview questions. During the piloting stage of this research, it was determined that the interviews were eliciting the necessary data to answer the study questions.

Interviews

The purpose of my interviews was to evoke the SAS leaders' personal stories and increase understanding of "[their] lived experience and the meaning they [made] of that experience" (Seidman, 2006, p. 9). The firsthand information included details pertaining to the leaders' daily activities and a descriptive narrative of their perceptions about policies and

practices that assist students with mental health conditions. The evidence provided me with greater awareness of the intricacies and challenges in serving this slice of the population.

My methodological design was guided by similar research that employed interviews to generate in-depth descriptions from post-secondary leaders, service providers, and students with disabilities (Agarwal, 2011; Castillo, 2007; Pietrus, 2013). These studies explored high-yield approaches that promoted awareness raising, anti-stigma initiatives, and student engagement. Like this earlier work, the bulk of my data were produced during the semi-structured interviews. The interview questions (Appendix A) were designed to dig deeper into the thoughts and beliefs of the SAS leaders. The structure of the questions was informed by seminal work conducted by Seidman (2006) — the objective was to obtain individual commentaries about the perceived effectiveness of mental health policies and practices.

Interviews were held at a private venue between May 2015 and October 2015. They were digitally recorded and took approximately 50 to 75 minutes to complete. Two recording devices were used to ensure that all information was captured in the event of technical difficulty. Before beginning data collection, leaders were asked to sign consent forms and create pseudonyms to be used in the written report. The interviews allowed them to reflect on their own understandings of the policies and practices that assist students with mental health impairments and disabilities.

Importantly, qualitative data “tell a story” from the participants’ viewpoint (Yin, 1984). Probing questions facilitated the disclosure of richer accounts that could not be acquired using other methods (Yin, 1984). The discussion and analysis of the interview data will bring readers

of the study closer to the leaders' experiences and provide some direction for college-based change initiatives in the area of mental health (Fossey et al., 2002; Harland, 2014).

Interview transcriptions. Each interview was transcribed verbatim. Due to the volume of data generated in the 17 interviews and significant time constraints, I hired a professional transcriptionist. She signed the confidentiality agreement as dictated by Western University. After several weeks, all transcripts were ready for coding and analysis. I coded line-by-line and included extensive details to faithfully reflect the SAS leaders' experiences and opinions about policies and practices that support students with mental health impairments and disabilities.

Documents

When studying a phenomenon, collecting and analyzing documents derived from a particular setting can stimulate understanding about specific issues and contextual realities (Cohen & Crabtree, 2006). Documents often serve as significant sources of social scientific data and can be seen as “conduits of communication that contain meaningful messages” (Prior, 2008, p. 230). Before starting the interviews, various documents were reviewed to obtain background information about the college and its approach to mental health. Documentary evidence included college-produced websites, videos, and paper-copy publications relevant to students with mental health impairments and disabilities. Thus, publicly available materials targeting a student audience included accessibility resources, the online health magazine, as well as SAS and student success information and school communications (e.g., posters, videos, brochures, accommodation handbook, etc.). Pertinent phrases and quotes were extracted from each of the selected documents. Later, this material was arranged in a chart and compared with various

themes uncovered in the interview transcripts. I teased out key messages referring to mental health and gained a clearer sense of the available supportive resources at the college. The documents were examined in tandem with other data from the researcher notes and interviews to increase the persuasiveness of my findings (Denzin & Lincoln, 2005).

Researcher Notes

Researcher notes were used as a third source of evidence and supplemented data collected from the interviews and documents (Lincoln & Guba, 1985). I wrote dozens of entries about my thoughts, reactions, and impressions, particularly during the data collection and analysis phases. I included interview details, methodological decisions and questions, and ideas associated with the study's organization and management. The notes also contained reflections, reactions, and realizations that surfaced over the course of the study (Gambold, 2005). I viewed the notes as a valuable "source of data because they "[became] a tangible way to evaluate . . . [my] experience [and] improve and clarify . . . thinking" (Janesick, 1998, p. 24). Ultimately, these reflections helped in the development and refinement of the key themes.

Data Analysis

Qualitative data analysis typically involves transcription, coding, categorizing, identification of major themes, conceptualization, and analysis (Miles, Huberman, & Saldana, 2014). The analytical approach for this study tightly corresponded with the data collection procedures and my constructivist beliefs. My intention was to seek out multi-voiced perspectives and compose thorough interpretations of the evidence.

Interview analysis. To make sense of the data, induction was used to locate, label, categorize, analyze, and record “repeated patterns of meaning” across the data set (Braun & Clarke, 2006). I developed themes based on the words and experiences of the participants. To expose patterns, I adopted a recursive, data-driven (rather than theoretical) approach and followed Braun and Clarke’s (2006) thematic analysis protocol. I reviewed the transcripts, developed initial codes, searched for themes, assembled various thematic maps, specified themes, and established connective threads between the participants’ narratives, the research questions, and the theoretical constructs. More specifically, I followed six steps.

1. Listened to recordings, reread typed transcripts, and wrote observations (*familiarization*);
2. Coded data, defined codes, and chose key excerpts tied to the study questions (*coding*);
3. Searched for coherent, meaningful patterns and built themes (*finding themes*);
4. Matched themes to extracts, blended themes, and uncovered thematic links (*reviewing*);
5. Analyzed and defined the themes (*conceptually defining*);
6. Wove the analyzed material into a report situated in the mental health literature (*writing*).

Individual, raw transcripts were approximately 20 to 35 typed pages in length. Initially, these were meticulously coded using manual, pencil and paper analysis. Original transcripts were then collapsed into cohesive, six-page summaries that retained the most salient information (i.e., codes, themes) — this facilitated further synthesis of the data. Creswell (2009) has argued that abridged transcripts are apropos. He further postulated that member checking is best accomplished using “polished” interpretations so that participants can focus on their key contributions. Full transcripts and polished versions were available to the SAS leaders. To ensure

that codes had not been distorted and were relatively free of researcher bias, a “critical friend” was asked to develop and review two transcripts (i.e., informal analyst triangulation) (Boyatzis, 1998). A fresh pair of eyes on the data strengthened the validity and integrity of the identified codes, rectified inconsistencies, and improved reflexivity (Stake, 2000).

Document analysis. As stated earlier, document analysis was incorporated into this project as a means for reviewing both print- and electronic-based resources. I examined how mental health was conceptualized and presented in the college documents using thematic analysis (Braun & Clarke, 2006). A chart was created to summarize the relevant codes, phrases, excerpts, and quotes. These were compared with the themes in the transcripts.

Researcher notes analysis. Researcher notes were employed to inform my data analysis activities. They helped me to build the themes based on the evidence collected during the interviews. I recorded ideas and insights about possible connections between the themes. I cross-referenced the themes within the documents and interview data, tracked all category and definitional changes to codes, developed hypothetical explanations, and engaged in comparative analyses. Various patterns, interpretations, relationships, categories, themes, hunches, and tentative conclusions were also underlined (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). The researcher notes were reviewed several times and served as a useful tool for documenting any bias and posing questions about my analytic process (Crabtree & Miller, 1999).

These notes undoubtedly reflect my experiences and tacit beliefs (Wolfinger, 2002), though I made every effort to correctly describe participants’ opinions and perceptions. Nevertheless, I acknowledge that personal biases, values, and attitudes likely emerged during the

study and influenced the analyses and conclusions (Lincoln & Guba, 1985; Malterud, 2001). My assumptions and analytical behaviours are further described in the final presentation of the findings to ensure that readers of the research will know how the conclusions were drawn from the data (Creswell, 1998; Sidani & Sechrest, 1996).

Ethical Implications

Informed consent. My study involved student services leaders at one college in Ontario. Written-informed consent was obtained before data collection began. The consent form described the purpose of the study, the leaders' involvement, the kind of information that would be collected, potential risks and benefits, confidentiality procedures, and participants' right to withdraw from the study without consequence. The leaders were informed that participation was completely voluntary. To preserve their spoken word, interviews were transcribed verbatim. Transcript details were omitted or modified if the information could reveal the leaders' or college's identities. The research plan included contingencies for participant withdrawal; this meant that data collected until the point of departure would be destroyed. None of the leaders withdrew from the study.

Impact on participants. To meet prescribed ethical standards, all reasonable measures were taken to protect privacy, as well as respect the dignity of the participants. In order to minimize harm, I ensured the scientific soundness of my study (i.e., supervisor and REB approval, empirically based), safeguarded confidentiality, obtained participants' informed consent, and adopted a transparent, reflexive, open stance (Richards & Schwartz, 2002). I held no supervisory power over the leaders and anticipated minimal risk to participation. Participants had

an opportunity to reflect on their experiences and share opinions. Information gathered will provide benefits to the SAS leaders for improving mental health policies, practices, and services.

Dissemination of results. Interview data were transcribed verbatim, examined for significant phrases, and clustered into themes. Once compiled, I made raw transcripts or six-page summaries available to the leaders (based on their preferences) for verification of correctness (Creswell, 2009; Lincoln & Guba, 1985). Approval was sought from the participants when direct quotes were used in the final report. After reconciling feedback, minor modifications were made.

Data storage and disposal. Data collection procedures, storage, and access were securely managed (i.e., locked cabinet, password-protected computer). The master list and signed consents were stored separately from the data. Destruction procedures conformed to data management regulations outlined by the college and university. Interviews were recorded using two digital devices and were downloaded to the hard drive of a password-protected computer at my workplace. All transcriptions and paper-copy study materials were securely stored in a locked cabinet in my office. With the assistance of the school division's Information and Technology (IT) department, all paper and electronic data will be destroyed after a seven-year period. The procedures adhere to ethics requirements authorized by the university and college.

Summary

This chapter described the methodology. The research was conducted at one college in Ontario to investigate how leaders were responding to the inflated prevalence of mental health conditions on campus. It was underpinned by constructivist-interpretivist principles. The purpose of this study was to explore the perceptions of student affairs and services (SAS) leaders in

relation to the effectiveness of policies and practices that assist college students with mental health impairments and disabilities. I discussed the research design, epistemological assumptions, case study approach, trustworthiness, study questions, participant selection, data sources, data collection and analysis techniques, and ethical implications. A flexible, yet disciplined approach to research design and data analysis was adopted to present an accurate interpretation of the leaders' opinions. Evidence from the interviews constituted the backbone of this study, although documents and researcher notes were also used to increase trustworthiness. I examined various aspects of the SAS leaders' experiences and tied them to the study questions and theoretical constructs. Although this research has limitations due to its narrow sample and may not be generalizable, it is instructive in terms of highlighting key insights about mental health policies and practices relative to the study site. My goals were to produce substantive results, increase knowledge about the topic, connect my analyses to the current research, contribute to existing theory, and inform mental health policies and practices at the college level.

The next section describes the study findings. In chapter four, I have organized the themes in a way that demonstrates methodological rigour and congruency with my constructivist-interpretivist perspective. The four key themes were derived from information shared by the 17 college leaders employed at RCCAAT.

Chapter 4. Findings

In this chapter, I present the results of the research. The purpose of this study was to explore the perceptions of student affairs and services (SAS) leaders in relation to the effectiveness of policies and practices that assist college students with diagnosed and undiagnosed mental health impairments and disabilities. This section includes a description of the four key themes: (a) Developing Contextual Understanding: Complexity of Needs; (b) Developing the College Culture: It Takes the Whole Community; (c) Developing People and Supports: On the Same Page; and (d) Developing the Organization: Connecting the Dots. My four major findings of the study are listed at the end of the chapter.

The central role that post-secondary leaders play in student success has been fully substantiated in the literature (Patterson & Kline, 2008). Seidman (2006) has also stipulated that “without context, there is little possibility of exploring the significance of experiences” (p. 17). To obtain a sharper picture of the study site, it seemed appropriate to locate individuals with multiple perspectives and from different tiers of the leadership hierarchy at the college (i.e., senior, middle management, front-line leaders). Thus, 17 SAS professionals were contacted. They had various responsibilities, backgrounds, and knowledge associated with students’ mental health.

SAS practitioners were interviewed because they are recognized as key agents for raising awareness, reducing institutional barriers, and introducing policies and practices that positively influence students’ mental health (Sandeem & Barr, 2006). Specifically, this chapter explains how the participants viewed mental health and their beliefs about policies and practices that are

needed to support students with mental health impairments and disabilities. Leaders' responses were grouped according to the four themes outlined earlier.

The chapter describes the results that were obtained following the analysis of evidence gathered from the semi-structured interviews, documents, and researcher notes. Most of the analyzed material originated from the interview transcripts, though some data were taken from the other two sources. Once the thematic coding process was completed, four participant-derived themes emerged — the identified themes related to the subjective experience of the SAS leaders.

Documentary Evidence

A variety of documentary evidence was examined (Table 2). College-produced websites, videos, and paper-copy publications pertaining to students with mental health impairments and disabilities were reviewed. After careful analysis, I found that these textual sources supplied concrete background about the college culture and its approach to mental health service provision across the various SAS divisions. Mental health messages were embedded in institutional documents dedicated to a student audience and appeared to be readily available in many forms (e.g., social media, institutional website, hard-copy materials, bulletin boards, etc.). Specifically, these included the online magazine, videos, signs, posters, and plasma screens; promotional events, campaigns, orientations, and wellness week; and numerous initiatives targeting Year One, Aboriginal, first-generation, and international students.

Table 2

Sample Documentary Evidence

<i>Items Reviewed</i>	<i>Key Messages and Excerpts</i>
Wallet Insert Counselling & Accessibility	Transitioning; Health; Anxiety; Stress; Grief; Autism; Mental health conditions; College can be stressful; Free, confidential counselling; Information in alternate formats; Equal access to learning (level the playing field); Accommodations
Website Student Success Advisors' Link	Your success matters to us! Worried about how to study and cope with learning lots of new material? Not sure who to talk to about finances? As your SSA, we provide support and resources to help you achieve your academic and personal goals; Have a positive learning experience; Adjust to college life; Find resources or a peer tutor; Develop skills that you need and more! Check us out!
Pamphlet Geared Up for Success?	Get to know new people; Introduce yourself to your coordinator, professors, and SSA; Take care of important business; Adjust to new routines; Get to know your college resources; Get organized; Orientation; Exercise; Sleep; Healthy eating habits
Card Student Services Start Here!	SSAs are here to help make your college experience the best it can be and help students have a positive and fulfilling learning experience; Study skills and time management; Test prep; Coping with anxiety; Note taking and organization skills; Study groups; Peer tutoring; Adjusting to college life; Balance; Resolving problems; Managing stress; Getting involved; Support for struggling students; Access to college resources and services
Handbill Student Social Club	Take a break! Student-run club supported by counselling and accessibility services; For students who self-identify as having a disability

Through thematic analysis of the documents (Braun & Clarke, 2006), I determined that many topics of interest to students were covered. The documents stressed that supports could be obtained by everyone (at no cost). Services were advertised under four broad headings: student success, accessibility, tutoring, and counselling. Evidently, campus supports were geared towards academic achievement, student development and learning, involvement in campus activities, stress management, and successful adjustment to college routines. Resources related to self-advocacy, rights and responsibilities, intake and documentation, and *AODA* regulations were available. Notably, services were framed around the notions of “leveling the playing field” and equal access to campus programs. The college’s stated commitment to increasing accessibility and reducing institutional obstacles was also commensurate with the principles underlying the social model of disability. Finally, one visible thread running through both the documentary evidence and interview transcripts was the college’s dedication to meeting individual needs and ensuring that all students could be successful.

Theme #1: Developing Contextual Understanding: Complexity of Needs

All study participants felt that mental health is a complex, multi-layered problem that had become a major preoccupation at the study site. The overall shared perspective was that mental health affects all aspects of students’ lives; it is directly connected to learning, success, and future opportunities. To promote optimal functioning and psychosocial development, several interdependent factors (e.g., personal, social, economic, environmental) must be considered in RCCAAT’s decision-making and support activities. To contextualize their views about mental health approaches, participants openly shared their understanding of the issues and provided

personal details about their experiences for helping students in crisis. Subtopics such as (a) incidence, diagnosis, and stress-related mental health issues; (b) the nature of mental health and its effects on students; and (c) gaps in understanding were discussed during the interviews.

Incidence, diagnosis, and stress-related mental health issues. The vast majority of participants repeatedly mentioned the prevalence of mental health needs at the college. There was near unanimity that there had been a “tidal wave of students with mental health issues arriving on campus.” The SAS leaders stressed the significant impact that mental health was having on students’ college experiences as well as the difficulties they were facing as service providers in meeting the needs.

Two participants indicated that roughly 15% to 20% of the students were accessing services in one form or another (CH31, W40). One leader felt that “students with mental health conditions [were] the number one sector of the population seeking supports” (CH32). Seven other participants agreed that there were substantially more mental health problems manifesting on campus and “[they were] not going away” (M97). Four leaders added that many students come to college with a variety of existing issues; the stresses associated with college life also tended to create additional mental health impairments and disabilities that were frequently undetected (and undisclosed) until courses were well underway.

Ten of the 17 study participants viewed the college as a stressful environment for students. The leaders noted key challenges linked to managing academic responsibilities, balancing priorities outside the classroom, and coping with the pressure to succeed. It was often during the first year, as early as October, that counsellors were inundated with appeals for help.

Students regularly reported historic mental health conditions that had been triggered or exacerbated due to the elevated level of stress at RCCAAT. One leader suggested that “college can be a . . . perfect storm for bringing out mental health issues” (W47). Participants also indicated that a large number of students lacked understanding of their disabilities, chose not to self-advocate, and were largely unprepared for post-secondary programs. The following comment illustrates how the hurried pace of school can aggravate mental health.

As things get heavier [and more stressful] after the first six weeks . . . emergencies pop up more often, and we have students coming and saying, ‘You know I’ve had this . . . issue, and I thought it was under control, but now with the stress of college, it’s just ballooned.’ So [we] tend to get a lot more [requests] for counselling appointments starting in October . . . [because] . . . students will break down in class or with one of the Student Success Advisors (SSAs). (W11–12)

Based on participant reports, the frequency and intensity of mental health-related incidents on campus had also increased; “schizophrenia [had] become a very big problem” (P152, B77, E13). Several references were made to students who were struggling with other long-term disorders and not receiving supports. The leaders indicated that there were more individuals who were waitlisted for services owing to the sheer volume of requests for resources (B63, EM27, V43). There had also been a rising demand for accommodation letters each year (L46). Although more students were presenting with mental health impairments and disabilities, participants believed that many continued to “suffer in silence” (P92).

One leader described mental health as “such an unknown beast” (CH59). This suggests that the issues and diagnoses were highly complex; some guessed that problems could be as varied as the college population itself. Specific mental health needs of LGBTQ, first-generation, Aboriginal, military, and international students were alluded to though only briefly. Still others deemed “mental health as an intractable problem that won’t be easily solved” (C51).

Another chief observation highlighted by the participants was that services were available to all students, not just those with recognized labels and diagnoses because many mental health impairments and disabilities are undiagnosed. Thus, supports were provided to students with both temporary and permanent conditions given their situational or biological origins. Some leaders emphasized that the “crisis is defined by the person coming in for services and what he or she wants” (S21). Therefore, a psychiatric condition is determined (in part) through self-reporting rather than a laboratory test.

Nature of mental health and effects. The interviews were peppered with comments about the countless snags associated with serving students with mental health impairments and disabilities. Fifteen of the 17 leaders spotlighted the severity, volatility, and impacts of various conditions. Such conditions could be “sporadic,” “unpredictable,” and “invisible” (D68, B52, CH38). In rare instances, people become aggressive, disruptive, and dangerous. Other participants emphasized related complications tied to the co-morbidity of needs; mental health difficulties often manifest with other disabilities. When students present with dual disabilities, the accommodation process becomes far more convoluted. If these individuals are not

appropriately supported, co-morbidity can undercut learning potential. One participant further elaborated this point.

The challenge for students is when they have more than one disability, they may have . . . ADHD [which] might be continuous, [and another] mental health condition that might be episodic. So, when the two of them come together, the student's productivity is going to be incredibly compromised (D192).

Consequently, the college's intake protocols had to be redesigned to accommodate students who had co-morbid disorders, particularly if they needed a psycho-educational assessment. As one leader stated, "We've shifted [our transitioning process] to include anyone with a self-identified disability [because there are] . . . a lot of students with learning disabilities and ADHD [who also present with symptoms connected] to depression or anxiety" (CH3-4).

Depression, ADHD, PTSD (post-traumatic stress disorder), ASD (autism spectrum disorder), as well as mood, panic, and anxiety disorders are all categorized under the mental health umbrella in the DSM-V manual (*Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., American Psychiatric Association, 2013). Accordingly, there is immense variability in terms of how mental health impairments and disabilities are expressed for each person. The diversity and scope of student needs and interventions are equally broad.

Twelve of the 17 leaders shared that they had spoken to various students who felt lonely, stressed, isolated, defeated, anxious, depressed, and even suicidal. Others submitted that mental health impairments and disabilities could be extremely debilitating and affect learners' ability to function academically and socially. One leader remarked that many individuals think that they

“don’t fit in” (EM20). Two participants also noted the pernicious effects of multi-generational trauma on Aboriginal students and the unique set of obstacles facing first-generation learners (34.5% of RCCAAT’s population). Others indicated that “PTSD [was] an emerging need” (CH11, B104) linked specifically to the increasing number of discharged military personnel who were resuming their studies following a traumatic event overseas.

In addition, some leaders contended that supporting individuals’ mental health needs was “like walking a tightrope” because many resist help and may withdraw entirely (DU33). It is the “students that hide and do not talk that we want to reach” before problems lead to disastrous ramifications (P92). Pulling withdrawn people out of isolation was depicted in this manner.

I do advisement, not counselling . . . because often times my students won’t go to a counsellor It’s a cultural disconnect I guess. They will talk to me or they will talk to nobody But, I always start with, ‘Would you like me to go down to counselling with you?’ Yet in six years, only two students have ever agreed to go So I always say, ‘If I sense that you are going to harm yourself or anybody else, then you have no choice. I’ll have to take you’ (DU8) So, [in terms of dealing with cultural differences and mental health,] it’s very difficult There are a lot of . . . students who are dreadfully depressed . . . and they’re quiet anyway, so it’s sometimes hard to draw them out. (DU33)

Study participants pinpointed other behaviours that could signal nascent mental health conditions. These included excessive time spent online, detachment from others, missed classes, and insomnia. Similarly, “improper use of technology and social media can have a negative

impact on students with depression and anxiety; this [was] a new dilemma for counsellors to manage” (S60). One participant speculated that “six out of ten times, mental health or some other disability [was] getting in the way of student success” (BE11). Although there were no data available specific to the study site, other SAS leaders inferred that students’ mental health “baggage” acted as a barrier to success, affected the learning environment and their quality of life, and often derailed graduation.

Gaps in understanding. Participants accepted that there is no “quick fix” or miracle solution for correcting all of the mental health conditions and gaps in services (D200). Still, enormous pressure had been placed on the college “to be all things” (L81). This means that much more work needs to be done to improve prevention-intervention activities and increase knowledge about the evolving problems (K13, S14, W51).

Many leaders argued that counselling must remain a priority because increasing demand for services continued to be problematic. Although some chronic issues could be addressed at the college, there was a lack of emergency and acute-care centres. “The most severe cases [were] sent to external agencies that [were] already overwhelmed” (W44). Likewise, one participant admitted that “there are some impairments that present some pretty significant challenges that we don’t have solutions for yet” (S17), though there are medications that help to stabilize students. The underlying belief for at least one leader was that, “We don’t think people are truly ever resistant [to therapy]. We just haven’t found what it is that’s going to help them to unlock things and . . . move forward . . .” (S24). Therefore, SAS leaders were still learning how to intervene and “figuring out [the college’s] mental health approach” (M53).

Given the noxious effects of mental health conditions and the increasing needs, a mosaic of awareness-raising programs for both faculty and students is required. The participants acknowledged that differentiated supports and flexible (fluid) accommodations must be strategically incorporated to address the many variables limiting students' capacity to function in the classroom. However, "accommodations are not enough; they do not remove all the hurdles" (C30–31). They must also be coupled with the principles of universal design for learning (UDL), meaningful mental health practices and stress-reduction initiatives, creative resource allocation, and a redoubling of efforts aimed at establishing a healthier campus community. Participants thought that the college was committed to improving mental health policies and practices and enhancing understanding of this perplexing problem.

Theme #2: Developing the College Culture: It Takes the Whole Community

All of the participants regarded mental health as a fundamental element of overall health that is affected by interrelated biological, social, and psychological determinants. As one participant professed, "Mental health is just health" (L52). Each SAS leader firmly believed that the college had a responsibility to detect, avert, and minimize students' mental health concerns and promote academic achievement. They also underscored that "it takes the whole community" (M87) to meet individual needs. Two key strategies driving this approach involved placing the student at the centre of the support process and tweaking intervention to match the identified learning challenges. One participant declared that "in our department especially, and in the college in general, we're quite flexible and accommodating" (PH18). Eight of the 17 leaders agreed that the impact of mental health impairments and disabilities was more effectively

mitigated by adopting a personalized rather than rigid, “cookie cutter” orientation (M99). One participant justified this opinion.

I think [our] college and . . . colleges across Ontario are trying to be open [and] . . . are making . . . pathways more individualized for students Every student doesn’t have to fit into a box and do everything the same way because it doesn’t work Then you have students dropping out and . . . it just spirals downward. (W54–55)

Though uncommon at RCCAAT, the leaders thought that stigmatizing attitudes towards mental health (e.g., “it’s a phase, you’ll get over it”) inhibited engagement and were detrimental to student success (D197). Many surmised that these misconceptions were rooted mainly in a lack of awareness and training. Thus, sharing information and reducing institutional barriers seemed to be uppermost in the minds of the participants. Related subtopics such as (a) promoting a positive climate and common vision, and (b) building relationships and connections were discussed during the interviews.

Positive climate and common vision. Eight of the 17 leaders highlighted the college’s responsibility in fostering an educational context that not only promotes academic excellence and school affiliation but also aligns services and supports with the most pressing student challenges. They noted that engagement and success were largely influenced by RCCAAT’s positive learning milieu and its targeted focus on students’ sense of belonging and individual needs.

When asked to describe their roles, the leaders displayed exceptional optimism, pride, and enthusiasm about their work, as well as remarkable commitment to students. Six of the participants noted that an affirming school climate was a necessary pre-condition to ensuring a

productive college experience, particularly for those who struggle with mental health impairments and disabilities. One participant attributed part of the success to the “positive energy” that permeated throughout the campus (PH51).

It feels like we’re all working for the student and [we’re moving] in the right direction . . . I don’t ever want to take that for granted We’re really lucky to have that kind of environment to work in It’s just part of the job I’ve often described it like a family atmosphere; [It’s] very warm . . . and people are approachable (M45–48)

Others underlined the “culture of care” philosophy and the college’s reputation for getting to know individuals on a personal level, responding to their needs, and helping them achieve their goals. Two participants stressed that “our students are valued and feel comfortable here.” Based on reports from seven other leaders, this was a result of diligent efforts “in [nurturing] a trusting, ‘homey’ ambiance or ‘family’ mentality” on campus. “We try to make sure that students know that we are here for them when they experience bumps along the way” (C2). One participant clarified this perspective.

The students [are not] just a number, they’re individually known In terms of overall success, I’d say that one of the huge things starts with the people that we have, the connections they form with the students (how they make them feel), and their willingness to support [their] success It’s a bit cliché, but so many of us talk about what a privilege it is to work at RCCAAT because you have the opportunity to make such a positive difference every day in the lives of so many people. There aren’t that many roles where you get that opportunity, right? . . . So the fact that our people believe in the

students is probably the number one success factor [along with] the supports that we have in place that are delivered under that umbrella. (P36–43)

To establish a learning atmosphere that was conducive to student success, there was a conscious focus on making programs relevant, engaging, and active (M110), as well as presenting “opportunities for achievement, growth, transformation, and change” (C50). Part of this process involved balancing a medley of personal needs with the safety and best interests of the larger group (M36). However, many of the participants contended that the nature of these needs (including those linked to mental health), students’ high expectations, and the diversity of the school population had a ripple effect that necessitated recalibrations to services, supports, and programming. As one leader noted, “We get who we get, and it is our responsibility to meet their needs” (M96). For two other participants, the college’s mandate was three-fold: engagement and support for the academics (L84), addressing individual needs (M19), and removing accessibility roadblocks to education (M8–9). Briefly, “it [was] all about giving students opportunities and second chances” (L86). Hence, the college had to determine the type of support that was required for each student to achieve success and reach vocational goals (S52, S68, L70).

According to six of the 17 leaders, part of this responsibility involved identifying at-risk learners (BE8) and connecting them to support services. Two participants insisted that this was particularly crucial due to the increasing severity and complexity of students’ mental health impairments and disabilities (e.g., schizophrenia, etc.). Likewise, there was consensus among five of the leaders about the significant impact that the campus environment could have on psychosocial growth and academic performance. Participants underlined the centrality of cultural

sensitivity in fully serving students (DU50) and benefits of a team approach for managing emerging conditions (V7). One leader indicated that “we strive to deal with issues constructively and [effectively] develop our counselling and mental health . . . resources” (P68, 90). Two others concurred that the college had a sincere desire to do the best it could to assist every person on campus (M56, P35).

Similarly, ten leaders spoke emphatically about the importance of building students’ connection to RCCAAT. Participants viewed this as a basic part of promoting success. One leader shared that “instilling a sense of belonging is the most important thing that I do” (DU27). Three others admitted that this was still a challenge given the college’s demographic diversity (e.g., cultural, gender, ability, sexual, interpersonal, ethnic, age) (EM16, EM26, L86, S67). Thus, the leaders suggested that more emphasis must be directed towards improving access, enhancing coordination and integration of services, and diversifying supports. Another stressed the college’s obligation to ensuring that “there are no artificial or unnecessary [access] barriers to education . . . and . . . the quality of our programs and our instructional delivery meet individual needs” (M8–10). This involved much more than just compliance with disability policies and regulations (S33). Two participants thought that to advance learning and success, RCCAAT personnel must continue to “create a real sense of belonging” (V47) and exhibit an unwavering belief in the students (P44). The college seemed to successfully achieve these goals by promoting an “open door policy” (P113, PH53), recognizing that everyone has special gifts (M11, S12, V48–53), and “demonstrating genuine acceptance [of all] students” (V47). In my review of various institutional documents related to services and supports, a similar inclusive,

“friendly” tone was reflected in many of the orientation, website, and printed materials. During my on-site visits, I noticed that numerous advertisements were posted throughout the campus. Mental health topics figured prominently in these promotional resources.

One participant believed that “everyone on campus is more conscious and knowledgeable; mental health is on everyone’s radar” (L48, 53). Others noticed that “mental health is part of our every day vocabulary” (L54); “so people are more open to talking about [it] than they were four or five years ago” (J17). Another leader signaled that “it’s not just the counsellors’ job to support positive mental health or ‘fix students;’ it takes the whole community and the whole institution to truly meet their needs” (M87). The challenge of engaging the school community and maintaining this accepting approach is exemplified in the following excerpt.

We have [people at the college] who are very accommodating, understanding, and accepting [Rather than] adopting a ‘lack of ability’ viewpoint, [they believe] that there are many ways that students can express their skill set [The challenge] is to acknowledge that there are hidden talents in all of us. (S12)

Another important piece of the college’s supportive approach was establishing relationships and connections with students.

Building relationships and connections. All of the 17 study participants argued that relationships are the root of any thriving community. Consequently, educational institutions that emphasize connectivity can stave off damaging influences, improve achievement, and act as “resilience-building” environments (L32). These benefits are very important for students who have mental health impairments and disabilities. Although the nature and effectiveness of

support programs were significant, the leaders sensed that a healthy, productive college experience also depended on the quality of relationships among students, faculty, support services personnel, and the community. The majority resolved that students benefitted from extra help and contact with trusted adults on campus. They also identified a number of relationships as key contributors to the success of individuals with mental health conditions. Three subtopics were highlighted in the interviews: (a) students' connections with college personnel; (b) SAS and faculty relationships, trust, and teamwork; and (c) outreach to the mental health community.

Students' connections with college personnel. All of the participants recognized that forming positive bonds with students was a vital part of the support process; the essence of all successful work with this clientele began with trust and relationship. Specifically, 13 of the leaders noted the importance of connecting with new students who had mental health conditions, though some expressed misgivings about the potential pitfalls for high school students who were acclimating to the college (CH85). As stated earlier, some individuals do not register with service providers on campus. Seven participants attested that the college made multiple attempts to ensure that the intake and transitioning processes were constructive experiences. Nonetheless, others conceded that improvements could still be made to streamline procedures so that each learner could be flagged and monitored more efficiently (CH2, 85). Although no data were referenced to support their beliefs, five of the participants stipulated that preventive measures and counselling supports were associated with better graduation and retention rates (P159, V42, S46, L15), especially among first-year students (D155, P109). As one leader contended, the

college had made laudable strides in terms of strengthening its orientation activities and building awareness about the available support options on campus.

The college does lots of different things to connect with Year One students in order to improve retention and success The counselling department is actually quite involved in trying to make [itself available] . . . to ensure that people know that [we] exist and are aware of [the] kinds of services we provide . . . [Counsellors invite students] to come in and just make sure that [they] have a good orientation to the college and to their services, which is, I think, a really nice personal touch . . . especially because a lot of those students might have increased anxiety about [starting school] . . . (PH32–36)

Ten of the participants mentioned the importance of knowing the students, “not just their accommodations” (P73). When asked by the college, students indicated that they valued “smaller classes and the fact that staff members knew their names . . . ” (M109). One leader pointed out that “caring professors are also able to link students to mental health supports” (D86) — many participants thought that this staff-student connection was essential (C24). Another suggested that “having respect [for] students’ . . . [who] seek help and a belief in their ability” were key to the support process (V24–25). By adopting a non-judgmental stance and keeping interactions positive (PH57), individuals “feel more comfortable about talking and opening up” (B54). One leader shared that “[it] was really interesting [that] I was getting referrals for students from other students. They were saying, ‘I brought my friend down. She really needs help; I think she needs to talk to you’” (PH55).

Others drew attention to the fundamental role of the Student Success Advisors (SSAs) and their capacity to build relationships with students, faculty, and the broader community (PH14–15, E27). They were responsible for leading efforts in areas such as making referrals to specialized support services, providing guidance about disabilities policies and procedures, sharing information with faculty, and facilitating transitioning to college. The SSAs' engagement with students and the connections they formed were viewed as being imperative to success (PH14, L31). Student Services Advisors are an “excellent resource for [the RCCAAT population] and are easily accessible” (B56–57). One leader made this observation.

One of the best policies, in terms of promoting success among students with mental health problems, is having the Student Success Advisors (SSAs) within each of the different schools or faculties They aren't focused just on academics but really adopt a much more holistic approach to meeting students' needs (E53–55).

Thus, reaching out to students represented a substantial chunk of the SSAs' professional responsibilities (C4, DU42). When individuals experienced learning obstacles due to mental health conditions, SSAs were able to intervene and guide them towards the services they required to achieve their personal, academic, and career goals.

We're sort of a GPS for students; we try to . . . keep them on track. If they're not sure where to go, we can send them where they need to be (L17). But faculty are probably our number one vehicle [for identifying at-risk learners] because they're in the classroom every day [Students will often say], 'my professor told me to come up and see you' or they'll say, 'you came to my class and you said that you could help' So for me,

my personal philosophy is that . . . [I'm] available, [I'm] visible, and [I'm] approachable . . . Being out there [and] being in their space, so that when they do have to cross that threshold of the door, I'm not a brand new face . . . (L17, 25–28)

Thus, developing rapport was central to identifying these vulnerable students and directing them to appropriate services (L26). According to another participant, “the special relationship between departments, managers, professors, and support staff” was a normal part of the college culture (M26). Others agreed that there was a “definite connection” (J24) and a “strong collaborative spirit between faculty and student services units” (L11). These relationships were regarded as crucial for flagging students as issues were beginning to surface.

Many of the leaders understood that mental health impairments and disabilities do not usually appear “out of the blue.” Sometimes, the stresses of college can reactivate or aggravate existing complications and be a “real trigger” (C42–43, W45). Being aware of these early warning signs and taking definitive action can be extremely important for changing outcomes. The leaders observed that one of the red flags was disconnection from others (EM15). Hence, developing those relationships with students and support personnel is fundamental to positive mental health and success (EM8, L31, C36, S25). One leader explained the association between student-staff relationships and retention.

I see it as the more engaged I am with them, the more they can be with me and the greater [chance that] they will come and talk to me because there's a connection . . . Hopefully there's a connection with the college too and that will make the difference long-term in the retention. (L31–32)

Many of the participants argued that without these relational ties to adults, students might become disengaged, unmotivated, and discouraged. For other leaders, a supportive and caring campus environment could spur active participation, a sense of empowerment, and stronger attachment to others (D130, P135). One participant provided a reason why connection and relationship should continue to be prioritized at the college.

We need to empower people up to their limit [We need to build] a culture where people recognize that it's through connection and understanding and kindness that we thrive as a community . . . so we just need to create that [but] it's a slow go In connection we thrive; in disconnection we wither and fade. (V45–47)

SAS and faculty relationships, trust, and teamwork. Eleven of the 17 leaders also cited the importance of connections between the SAS practitioners and the faculty. One participant remarked, “I would say the relationship between our student services . . . and counselling and that of our teaching staff is a source of pride” (P141). Another leader indicated, “One hand washes the other. That’s what we do here. Because everybody’s short on resources, we have to do the best we can” (V19). For many of the participants, this involved an intentional focus on teamwork (K23, J8, P6, P78) and the cultivation of trusting, collaborative relationships (V25, C36, S25, S55) and a sense of community (E25).

Therefore, trust and teamwork were viewed as desirable for supporting students’ achievement and psychosocial development. Fostering these key partnerships was a top priority, said two leaders, because they provided opportunities for professional dialogue, learning, and sharing among colleagues (P104, P146, S57). Others reasoned that “professors have to feel

comfortable asking for help” (D128) and “trust that counsellors are making reasonable accommodation requests” (CH28). The following quote illustrates this point.

Sometimes accommodations and making those changes in the classroom put [additional] stress on the faculty We have a lot of part-time people who are coming in teaching one or two classes and they’re like, ‘All of a sudden I’m [being asked to do more] I don’t know what to do. I don’t know if I can do this,’ and that can . . . [cause a lot of confusion]. But . . . in my years here, the faculty have been really wonderful once you [have established those relationships] That’s why getting permission [from the students] to talk to [the professors] on their behalf is really important because once you have one or two conversations with them, they become very open to [accommodating], especially when they [understand] the problems that students are facing, where they’re really at, and that students are not trying to manipulate or take advantage, then the staff become very helpful (W24–25)

Hence, collaboration with others was understood as essential for unravelling the complex issues that normally arose at RCCAAT (BE38). Networking and connecting allowed student services, counselling, faculty, and SSAs to all “have a voice” (M37) and problem solve together. When student services and academic personnel joined forces and built bridges, their collective expertise led to more creative decision-making. One leader described the team approach for tackling crises as follows.

[In a case conference,] there’s counselling, security, academic and student service representation, and the Student Success Advisor [who might be] all working around a

single student [who is in crisis] All of those departments have a voice in the situation. I think [that this is] just an example of how we live and breathe it every day, . . . that all of those components [and people] are necessary to solve the problem. (M37–38)

Another participant vividly recounted an episode indicative of the need for collaboration when resolving acute mental health cases.

The coordinator of one of the test centres called me [because] a student was . . . threatening to kill herself because the test she was supposed to write wasn't there. We called our associate director of counselling . . . and he took care of it So there are some very serious mental health concerns here. I've spent years building a relationship with [counselling], . . . and working very closely together to try and build that relationship because I'm constantly saying, 'I'm not a counsellor.' When I have [students sharing], 'I hear voices and the voices are bullying me,' that's beyond [my expertise] So again, . . . building that relationship [and reaching out to my colleagues] are really critical [for dealing with the more serious situations]. (BE37–39)

A wide range of connections and networks had been formed at the college and in the broader community. These were found to be invaluable for assisting such a diverse and needy population. In other words, the leaders viewed relationship building on campus as an absolutely indispensable part of the support process (BE13).

Connections with community agencies. The study participants frequently articulated the value of strong college-community relationships. They thought that positive mental health was largely dependent on the existing supports and the students' ability to access them. Eleven of the

17 leaders spoke about the importance of community liaisons, especially for individuals requiring intensive care. One of the participants also added that resource sharing was an inescapable reality during periods of austerity when services were being consolidated and budgets were shrinking (B91). Subtopics related to community partnerships and specialized support services were further elaborated in the interviews.

One leader acknowledged that “we are generally very busy throughout the year, but there are some months when we can’t manage [everyone] . . . and provide the level of support we feel is required” (W61). To fill these gaps and handle the more serious mental health issues, “we work closely with our community partners” (CH78, P154, M72). Another participant confirmed that “we have strong community alliances that are working for us, but there’s no formal structure in place” (P172). Others propounded the advocacy role that counsellors played in expanding these relationships (M72, P34, C22). As one leader stated, “With us being the centre point of that support, directing students where to go, [we are] . . . always trying to reach out to community organizations” (W48). This was particularly vital when students had significant, potentially life-threatening mental health needs.

One participant noted that counsellors complete threat and suicide assessments to determine the gravity of problems (W17). Some students must be admitted to the hospital, though many are referred to community mental health service providers (W15). Hence, individuals can access campus and outside agency supports in psychiatry (V18) where “a student can be assessed in a matter of days” (P168). One leader provided an example of the kinds of “crises” that have been reported.

A crisis is self-defined So [a student] could be in crisis because [he or she] got 48% on a test worth 5%, yet someone else [could be] in crisis because they think there are bugs crawling on their arms and they're actively psychotic; so we have to respond to both But we're not a crisis centre We can't be seen as that, [though] we definitely do see students in . . . emergency situations, [so we] then work with . . . people from community mental health [who] sometimes come to the college and help us assess [or] accompany [students] to the hospital (CH78)

Although two leaders judged that there was considerable coordination among the campus health clinic, counselling services, and external mental health agencies (E69, DU24), another participant supposed that more needed to be done to solidify relationships with hospitals to ensure that expedient and appropriate follow up by professional staff was undertaken (D166). Specifically, one leader felt that a seamless continuum of care and a clear transitioning process were mandatory for serving students who had been hospitalized and returning to school (D167).

All participants articulated a solid belief that the relationships among students, faculty, support services personnel, and the community determine the quality of students' college experience and the level of support that is available. Connectedness and shared responsibility were viewed as prime ingredients for creating a learning environment conducive to promoting positive mental health. The leaders subscribed to the idea of building deeper alliances and harnessing the input of all stakeholders to competently handle the escalating mental health needs on campus.

Theme #3: Developing People and Supports: On the Same Page

All of the 17 study participants extolled the institution's steadfast dedication to addressing students' mental health impairments and disabilities. Although the college continued to grapple with how best to operationalize their mental health strategies and plans and respond to the varying challenges, common areas of focus were identified. Promoting positive mental health, creating barrier-free learning spaces, and facilitating student success were recognized as areas of collective responsibility. To fulfill these goals, "mental health literacy" (knowledge) and service delivery models must be improved. Three subtopics linked to developing people and supports were discussed. These included (a) attitudes, beliefs, and misconceptions; (b) knowledge mobilization; and (c) capacity building.

Attitudes, beliefs, and misconceptions. Throughout the interviews, the leaders described how mental health was variously understood (or misunderstood), the decisive role of the faculty, and the influence of stigma and organizational barriers on students' participation and post-secondary experiences. All study participants praised the college's inclusive, student-centred approach to service delivery. Numerous examples were provided that demonstrated earnestness in not only changing attitudes but also improving accessibility and achievement. One leader proclaimed that [student success] is "one of our big things; it's a key part [of our strategic plan]; everyone on campus is focused on the same goal" (J26). Another participant reiterated that the college was "very much about . . . improving access, meeting [students'] needs, and helping each individual to be successful" (M19–21).

Two areas related to attitudes, beliefs, and misconceptions were mentioned. These included faculty knowledge of mental health as well as stigmatization and attitudinal barriers.

Faculty knowledge of mental health. Several participants underlined the importance of understanding constituents' perceptions of mental health. Five of the 17 RCCAAT leaders conceded "that it [was] very difficult to [deal with] the misconceptions surrounding mental health" (BE25, CH81). "Some people still think that a mental health [problem] is a 'scam' or something that you . . . fabricate . . ." (D190, K18). This is significant because how others judge students may affect their willingness to access mental health services and supports (S30). One participant made this observation.

In the broader perspective, we need to just take a minute [and realize that] we shouldn't be excluding anybody. That's why I always tend to lean back on acceptance, accepting the people in front of you. If they say they're in pain, they're in pain Many people with chronic mental health problems talk about their physical issues, and they're not listened to because they have a mental health condition The judgment piece gets in the way . . . of people receiving [the help] that they require (S29–30)

Throughout the interviews, these gaps in knowledge and mistaken beliefs were recurrent concerns. One participant suggested that faculty attitudes and misplaced fears could complicate the accommodation process (D23). These misconceptions stemmed primarily from a lack of knowledge. According to one leader, a small number of professors felt that they should just "deliver the curriculum" (B73) — mental health was not seen as part of their responsibilities (B71). Nevertheless, the vast majority of the faculty were eager to broaden their understanding

so that they could better serve students who were encountering difficulty (B72). As one participant revealed, “There is definitely an appetite to learn among many [professors]” (B102) with respect to introducing tools that would improve program accessibility and facilitate learning. Others highlighted that the accommodation process could unfold very smoothly depending on the faculty’s prior knowledge; however, most had accessed little or no professional development (D22–24). According to one leader, “If [training] is not mandated, [and instructors] don’t know what they’re supposed to do . . . , how do they meet best practice standards . . . ? So, it’s a real barrier for students” (D140).

One participant contended that “some professors . . . [bent] over backwards to accommodate physical problems” (D187) but [were] less apt to do the same for students exhibiting mental health conditions (D188). Another presumed that students spoke more frankly with teachers (B13); others were reticent about their mental health needs (D144) and chose to mask any struggles from instructors (BE46). A participant also confessed that impairments and disabilities could be misconstrued.

A person with mental health issues, who isn’t attending class, may be perceived as being lazy. But really, they’re [trying to cope] with a mood or anxiety disorder (e.g., social phobia) [For that individual], it’s hard to come through the front door [of the college] We see quite a few students with obsessive-compulsive disorders, and their compulsions prevent them from getting to class on time So, it’s an enormous [problem]. (CH81)

Stigmatization and attitudinal barriers. Although opinions were somewhat mixed, all 17 participants expressed unease about the stigma attached to mental health. One leader stated that there was seemingly less stigma (L36); another proposed that “we’re still trying to break down all those stereotypes” (CH38). A participant speculated, “In the past, students were afraid to ask for help, dropped out, or failed to recognize their mental health problems, so they suffered through [alone] . . . Having [students] knowing about things and asking for help is great, but we also need to meet that demand and ensure that supports are [readily] available . . .” (PH43–45). Another leader concluded that “a lack of awareness about our services, stigma, or attitudinal barriers prevent students from making [an] appointment” (CH32). This was particularly evident for those who were enrolled in the skilled trades (CH32).

One participant also found that some new students concealed the fact that they had Individual Education Plans (IEPs) in high school because they were embarrassed or ashamed (BE45). A leader shared, “We depend on students to self-identify, so we don’t know exactly how many people are walking around with psychosocial disorders who are not getting assistance” (CH32). Another voiced concern about students’ own stigmatizing beliefs and societal attitudes that are bound to the mental health label because these could adversely affect their use of support services. He further asserted, “We need to move away from that. There’s not a lot of utility in a label” (S76). One other participant had a similar outlook.

We still have to [get the message out that] there’s nothing unusual about people going through rough patches in relationships, emotionally, or psychologically . . . It just means [that like anybody], they’re experiencing a really difficult time . . . I think that half the

stigma is that there is a culture for all of us to be so secretive about our fears and our weaknesses and our worries. Everyone's supposed to be just so We're supposed to be stressed and the unspoken [expectation] is 'get 'er done anyway' (V51)

One leader maintained that additional "awareness-raising and anti-stigma work needed to be done to dispel myths and reduce persistent attitudinal barriers" (CH65). Eleven others deemed that this was essential because flawed thinking and misguided presumptions could limit students' ability to learn and dissuade them from obtaining services. Another participant remarked, "You know what the major barrier is for our students with mental health disabilities? Is it things like a lack of resources? Is it family support? No The biggest barrier, according to students with mental health disabilities, is not being believed" (D65, 191).

Knowledge mobilization. Overcoming these hurdles, meeting the needs of the "whole" student, and ensuring access to education involved a multi-pronged or holistic approach at RCCAAT (M24, E18, C39). Several of the leaders suggested that knowledge mobilization should include efforts linked to prevention and early warning protocols. Every participant agreed that all members of the campus community needed opportunities to increase their awareness and use of available mental health supports and services. Specifically, leaders underscored the merits of sharing information. Two areas were further explored to illustrate their viewpoints. These entailed communication among college personnel and the dissemination of information to students.

Communication among college personnel. To promote positive mental health, the participants believed that it was necessary to create a supportive school environment and provide

equitable, clear routes of access to services. Four of the leaders reasoned that response initiatives and programs must be based on locally developed, student-centred goals and learners' individual strengths and needs (W42, M27–28, DU26, P146). Efficient communication between the various sectors of the campus community was understood to form the heart of this support process.

Another participant added that cordial, collaborative relationships were also a fundamental part of the college's strategic plan and priorities (M28). Thus, senior leadership, from the president on down, emphasized consistent messaging and dialogue (M27).

A participant indicated that one of her primary responsibilities was “to keep the lines of communication open” (DU26) among outside agencies, faculty, and other service providers on campus. Although this kind of collegial exchange was crucial throughout the institution, one leader noted the importance of sharing and interaction within each of the departments (C23). Another mentioned that physical proximity facilitated spontaneous conversations with faculty and student services personnel (BE14) and allowed everyone to “be on the same page.” None of the participants discussed the existence of departmental barriers at RCCAAT.

Three of the leaders assumed that ongoing contact enabled a more proactive orientation to service delivery (B90, BE13, C20). They supposed that this approach was preferable because the longer problems go unchecked, the more negatively they affect students' mental health and ability to learn. One participant provided an example of how members from various programs stayed in touch and carefully monitored students' progress.

I would say that actually there was a fair amount of communication in the [departments that] I travelled in [but] to varying degrees. [We] were typically asked . . . to give a list to

the program coordinator of the students [that were] at risk That could be for academic reasons, but there could be other things going on too By week five, that's kind of the time to flag somebody, and say okay, there's something going on here And then at that point, either the coordinator or the Student Success Advisor would reach out and try to track that person down and see what was happening So, [to stay in the loop,] . . . [we] met weekly . . . or once a month For other [programs,] I just submitted a list [to the coordinator]. (B21–25)

Four of the participants held that discourse and collaboration were invaluable tools for supporting students who exhibited severe mental health impairments and disabilities (P14, P21, P146, DU26, M27–28, W42). Evaluating the level of risk and conveying concerns with colleagues were regarded as crucial (e.g., early alert signs) for preventing students from “falling through the cracks” (E60, V13) or engaging in self-harming behaviours (CH77, PH16). Therefore, distilling information, communicating with the faculty, “trying to bring all those pieces together to fit that individual student's needs, . . . and knowing about the [available] resources [were] a big part of the job” (W42). One participant contended that it was “the communication that we have between [our staff] that's really the difference maker” (P146). This focus on information sharing was viewed as imperative for both college employees and students.

Dissemination of information to students. Five of the 17 participants indicated that disseminating information about mental health and the various support options was a principle thrust on campus (CH37, W33–34, D80, PH45, J35). Two others acknowledged that the college

employed multiple strategies to reach the student body and mobilize knowledge but conceded that many individuals remained oblivious (D80, PH45).

According to ten of the leaders, SSAs played a pivotal role in circulating positive mental health messages to build greater awareness. These support personnel spearheaded various campaigns and participated in promotional activities to connect with students and increase their knowledge about mental health services. Thus, there were numerous mechanisms, practices, and programs to steer vulnerable people towards appropriate supportive resources. Mental health materials designed for student audiences were “all over the place” (W34). However, several participants claimed that some individuals who might benefit from accessing these resources were inadequately informed even though the college had taken considerable steps to publicize its services (CH37, W33–34, D80, PH45, J35). “For every orientation, we send out packages to all students who accept; it’s all over our website Yet, some still don’t hear it” (W34). Another leader described comparable glitches.

Colleges and universities don’t have information available for students [about] the top three mental health conditions: anxiety, depression, and eating disorders. [It’s] not getting to them Students also pointed out that they get [so much information all] at once and they don’t remember [it] until they run into a crisis themselves and don’t know what to do A number of students indicated that they were in third and fourth year before they realized that they were entitled to be accommodated because it’s not widely known, and so that is a huge problem Unless they have really caring professors who say,

‘Look, I think you need to go to disability and accessibility services; I’m sure you can get some help,’ . . . the student is at the mercy of the system. (D80–87)

One participant insisted, “I know that the college has made a lot of improvements in mental health promotion” (e.g., online resources, *Good2Talk*, workshops, etc.) (J33), but there were still many students who did not know their rights (EM50) and lacked the necessary self-agency and information-seeking skills (E59). Frequently, “we’re depending on students stumbling across us on the . . . website” (CH35). Another leader divulged that many people arrived at disability services mid-semester, unaware that they could have accessed mental health accommodations and resources (W33). Based on participant reports, this lack of awareness often compromised the efficiency of the support process.

Sometimes students come in here in the wintertime and say, ‘I didn’t know these services were available.’ And they’re like, ‘I need this.’ And now we’re halfway through the year and trying to implement [things]; ‘we could have done [something] for you in August and September and most likely you wouldn’t be in this position, right?’ And that’s a lot of the stuff that we see in November, students coming in and being like, ‘I’m dropping out. I can’t do this.’ And so you have to start saying, ‘you know, we haven’t discussed these services we have available. We can do this and that with accommodations.’ And all of a sudden they’re like, ‘Oh my gosh! This is so much better; this is so much more manageable.’ But we can’t get to them all. (W33)

In response to some of the identified gaps, one participant recommended that “a ‘blurb’ be inserted into the email that is sent to each first-year student from the recruitment or

admissions office; that would be helpful” (CH73). Others felt that mental health material should be incorporated into course syllabi and distributed more broadly using electronic venues (D83, CH69). One leader elaborated, “We’re looking at how technology can support students with mental health difficulties, particularly about the effects of medication on attention and recall” (CH53). In short, “mental health information should be included in everything” (D82).

Although all students receive a welcome package (DU37), it does not contain details about the supports and services that are available to those with mental health impairments and disabilities.

We do a lot of outreach to the high schools . . . and we’re trying to get a [counselling] note in the acceptance package . . . which is problematic because it’s a barrier. For example, students get their acceptance letters, . . . [but] . . . there’s nothing . . . that tells them how to contact us and that we exist. Last year, [the package] mentioned accessibility, but [not counselling]. So what we’re talking about is an information-communication barrier So [students] may have a mental health disability and we don’t know how to contact them. That’s a huge issue. (CH69–71)

Despite these deficiencies, all the participants concurred that RCCAAT strove to widely disperse information. The leaders provided possible solutions and examples of user-friendly methods and devices designed to reach every learner who might be struggling with a mental health condition. Based on my review of the documentary evidence, the on-site visits, and participant comments, mental health messages seemed to be infused in many college documents and student communications in both print and electronic formats. These included campaigns,

promotional events, wellness week, and orientations; videos, plasma screens, texting and emailing, the online magazine, posters, and signs; as well as various programs aimed at Aboriginal, Year One, international, and first-generation students. In addition, participants noted that the college used online tools, social media, and the campus website; follow-up phone calls and face-to-face meetings; and in-class introductory presentations. A handbook for students with mental health impairments and disabilities had also been recently published. One leader cautioned, however, that “information must be repeated many times because if it’s provided only once, it will be quickly forgotten” (D84).

I think that for the most part, students know what they need but how to express that can be challenging or it can be tough on their confidence to go ahead and say, ‘I need some extra time.’ They may be particularly hard on themselves or this may be a new diagnosis or they’re not fully comfortable or they don’t really understand what it means to have an anxiety disorder. So we try to do our best [to assist them]. I think there’s room for us to do more training on self-advocacy and effective . . . communication with faculty and what’s ‘reasonable’ [in terms of accommodations] . . . (CH30)

This participant believed that students remained unsure about how to self-advocate and obtain mental health or accommodation information. Similar gaps in knowledge existed among college instructors.

Capacity building. As stated earlier, a recurring theme cited throughout the interviews was the professors’ lack of understanding about assisting students with mental health impairments and disabilities (B48, D114, L55). Ten of the 17 study participants agreed that

capacity building was necessary in terms of filling this vacuum. According to two of the leaders, the college employed various strategies to mobilize knowledge and raise the profile of mental health but admitted that many professors were uncertain about the available resources and their teaching obligations for supporting students who were struggling (D80, PH45). Better training vehicles were seen as important for stimulating knowledge exchange and increasing faculty's use of mental health accommodations and effective teaching practices. The study participants highlighted the following areas in the interviews: capacity-building challenges and capacity-building response efforts.

Capacity-building challenges. Five of the 17 participants thought that most professors were open minded about mental health (L43) and willing to modify programming to meet student needs (L67). However, some faculty members did not possess the rudimentary skills and educational background to appropriately respond (B48, D114) because they had obtained little in the way of professional development (D24, C47, B46). One leader deduced that some instructors continued to feel ill prepared in handling serious mental health behaviours.

Education is a huge part I think 90% or even more faculty and staff want to help but don't feel that they are informed and are not sure what the [accommodation] policies are. So that's where that professional development comes in, giving them information . . . and doing it in a way that is easy for them is a significant piece because they have to have an understanding of [mental health] and then what their responsibilities are or what's out there. Then [professors] are a lot more comfortable because we're taking away that 'fear'

. . . . ‘Okay, what do I do when a student comes into my classroom and I feel like they’re having a mental health crisis? What is my responsibility?’ (L55–57).

One participant added that there was also a tremendous amount of confusion among the faculty about how mental health accommodations work. For example, accommodations are related to students’ functional limitations not the diagnosis or medical label (BE48). Some professors acknowledged that they did not know how to support an individual without having the diagnosis (D49). One leader provided an example to illustrate this point.

[In some workshops], people had a knee-jerk reaction . . . and asked, ‘How are we going to accommodate if we don’t have a diagnosis?’ But that makes the assumption that if you have a mental health disability such as depression, everybody manifests the same symptoms and that’s just not true (D49–50).

Still other participants stated that professors were often unfamiliar with accommodation policies (L57) and the rationale behind the services that were requested (CH38). In many cases, the referral and support process and the principles of differentiation were equally unclear (D30, BE27). Another leader specified that there was some ambiguity about confidentiality procedures and protocols for accessing the testing centre (BE21). The majority of the participants surmised that instructors were “desperate” for accommodation-skills training and referral information. One leader offered this perspective.

If professors don’t receive training then . . . it’s a chance experience for a student. So I think that the faculty-training piece is [important] for helping to remove barriers for students, and it’s not necessarily on mental health because the faculty member will never

know that a student has a mental health disability [due to privacy legislation]. The faculty member will only know that the student is accommodated. So from the faculty member's perspective, they need to know that it is an institutional responsibility to accommodate a student and their role in that. And if the student exhibits behaviour in the class that the professor is concerned about, then the faculty member needs to know: 'Who do I refer to? What kind of help do I get?' and that's a huge piece that's missing (D25–30).

The same leader argued that "it's a real barrier for students seeking mental health supports when you . . . have faculty [who are uninformed] about the accommodation process" (D142). The bulk of the study participants suggested that capacity building was part of the college's strategy to correct this shortfall, but as one leader announced, "There is no mandated training for professors on how to respond to students with disabilities, so there's an information gap there" (CH17). Another submitted that "it would be nice in the future for everyone to have the same [mental health] training, to be on the same page, and know exactly what to do" (J40). The overall consensus was that additional in-servicing, time, and resources should be available to not only increase understanding among the faculty (E81, B38, B95, P25), but also prepare them for extreme mental health incidents on campus (L10).

As explained previously, crises were occurring more frequently at the college (P170, D98, E12, B49), but capacity-building efforts had not kept pace with the need for information. One of the key challenges was the difficulty in reaching every professor, particularly those holding part-time positions (B94). Another major obstacle was that support staff were so

preoccupied with “direct client services and putting out fires” that there was little time left for outreach and awareness-raising endeavours (CH14).

Capacity-building response efforts. According to many of the leaders, the college was wholly committed to enhancing accommodations protocols and broadening training opportunities that could be widely applied to supporting students with mental health impairments and disabilities (M56). Nonetheless, the study participants pinpointed several areas that required greater focus. These included counsellor training, faculty supports, assistance for part-time professors, and specialized early-alert programs.

Some leaders had concerns about professional development in the counselling unit. The increasing diversity of the student population, the role of technology, and changes to program delivery models demanded the use of a more sophisticated and nuanced set of counselling tools (P149). Therefore, counsellors required training to effectively deliver the kind of culturally sensitive, online supports that were needed (S65, V30, EM54).

Things have changed with the introduction of technology. [It's] a huge avenue of support for distance ed. students and for [those] with disabilities . . . that they would never have had otherwise [For] the growing online environment . . . nobody really has a handle on that yet. How are we going to provide counselling and support to distance students? How are we going to provide accommodations? That's something that we'll be tackling this year as a project How are we going to change our service? What infrastructure do we need? What training do we need? So for online counselling, . . . Do you do it in Facetime? Do you do it via email? Do you do it via Skype? How do you ensure security?

What level of security? It poses other challenges too Distance students [are entitled] to support services, . . . but what if you're a student [from] Dubai and you want counselling? [Can] a registered psychotherapist in Ontario provide services to [that individual]? . . . Or . . . for an Indigenous population, . . . many students have said, 'I don't want culturally sensitive support I'm not interested in seeing an Elder or using my local services' We need to be trained to ask the right questions. But at the same time, we need [to accept that] the counselling role keeps expanding (S63–67)

Faculty training was also a dominant theme considered by the 17 study participants. Many claimed that RCCAAT offered numerous (mandated and voluntary) opportunities and resources aimed at increasing professors' mental health knowledge and awareness. Two leaders held that the accommodation handbook and faculty reference guide simplified the support process and accommodation procedures (e.g., legislation, policies, etc.) and provided tips for incorporating universal instructional design into academic programs (BE29, L60, W29). Others felt that UDL was especially useful because accessibility enhancements for one individual or group of students were often beneficial for the whole class (e.g., electronic texts). One participant spelled out some features of the new manual.

We just finalized a faculty guide We don't really get into the nature of the disabilities and what accommodations suit what disorder It's more about how [professors] respond to the accommodation request. [It] breaks down every accommodation [and includes] a faculty awareness piece There's [also] an information sheet. It is crucial. But it's not something they have to read upon hire; . . . it's

just something that's a resource to them. But there's no real expectation that it's read, even though it would [make the job easier] especially for the part-time faculty

(CH61–63)

Another leader stipulated that the counselling department had also developed a script for non-counselling staff to use when a student was experiencing an intense mental health episode in the classroom (BE40). Despite these initiatives, two others stressed that ancillary training was still “urgently required” across multiple areas (B70, D25, D159). One participant suggested that professors must be technologically savvy to fully engage students and meet all of the individual needs (L66). However, two leaders thought that faculty members were generally ill at ease with technology (D124, K15). In response, specific professional development had been designed to accommodate their divergent levels of competency and comfort (K15). For example, professors often required extensive support in producing accessible documents and converting legacy materials into digital products that complied with UDL guidelines (D126, K32, W69). The campus technology centre was one mechanism that provided ongoing accessibility information to assist professors in adapting their programs using an assortment of training formats (K31). Though useful, one participant stated that from the students’ perspective, the most significant barrier continued to be the faculty’s lack of awareness about mental health accommodations (D143).

One leader pointed out that professors preferred facilitated or face-to-face training rather than online alternatives (D120), although RCCAAT’s information videos served a worthwhile function for helping faculty to interact with students in crisis (D112). Still others acknowledged

that instructors are curriculum experts, not mental health specialists (B47); there are limitations in how they can intervene. One participant described the dilemma that faculty faced in managing their teaching responsibilities with regard to students who had various mental health conditions.

I think that because professors are so often the ones who see the students first, it's really important for them to know this information and have some basis of understanding in terms of what to do. On the other hand, I can see that it [means] taking on a lot more [than just teaching] It's a bit of a tough dilemma I feel that personally, . . . I would benefit from knowing more about how to deal with [mental health issues] and I'm fine with taking that on I'm interested in that, but I do recognize that there will be people who will be like, 'Listen, I was just hired to teach [one class.] I was not hired to counsel students or deal with this kind of stuff' I think teaching is a dual role . . . and it changes [from one year to the next]. I mean you have a class where there are no issues . . . and then you have one where it's a total nightmare So, just when you think you've got something figured out, some new situation presents itself . . . and [there have been] some . . . difficult challenges, strangely, a fair number of them, at least two or three in the last year, so you know it's happening; there are more students [with mental health issues] So [professors] need training, but there's only so much that [they] can do. (B71–80)

Seven of the 17 leaders also expressed concern about the level of professional development that part-time faculty received. One participant singled out the challenges encountered by these professors particularly in light of the resources and time that were assigned for education purposes (L77). Another felt that “it would be [useful] to have training for part-

time faculty about how to respond to mental health problems in the classroom” (J39). Such opportunities would increase understanding of instructional and support processes, policies, and professional duties and boundaries. The college had also offered optional training for faculty about accommodations but the “the uptake [had] not [been] very high” (CH22). Part-time professors were invited to participate in the semester-planning sessions (K24). In addition, faculty meetings were viewed as advantageous for promoting collaboration and information sharing between new hires and the more seasoned instructors (B36). Yet, many part-timers remained hazy about program accommodation techniques (W24).

The difficulty was that the bulk of the seminars were offered during the day; attending these sessions presented a problem for some part-time workers. They might be on campus for only a few hours in the evening. Some commuted long distances to reach the college or were employed full-time in other jurisdictions. One leader thought that the summer orientation must be supplemented with more intensive, accessible programs to build knowledge about mental health impairments and disabilities (L59). Others also questioned whether there was adequate inservicing for part-time professors in noticing early indicators and facilitating outreach to service providers.

Participants agreed that professors who regularly interacted with students were well positioned to identify atypical behaviours (L25) and connect learners with supportive resources. Therefore, “broader capacity for recognizing the warning signs” (M64) and assessing students’ level of risk were seen as essential, particularly for employees occupying front-line positions (L10, W17). In response, the college had presented *ASIST* and gatekeeper tutorials (suicide

prevention) to various groups in the campus community. One leader believed that everyone at the college should have the “basic skills to intervene when students are in crisis” (M65). Two others also acknowledged the value of offering training to students and the need for increasing student-mentor and leadership initiatives (M67, J32). Participants signaled that the college had plans to introduce a new early alert course to share information, promote staff development, and strengthen preventive measures.

In summary, knowledge exchange and capacity building, communication, and a common understanding of mental health were identified as significant to improving the quality of services and supports. It was noted that no official structures existed between the college and community service providers. As a whole, the leaders affirmed that developing people and supports must continue to be a chief focus campus wide.

Theme #4: Developing the Organization: Connecting the Dots

All of the participants viewed leadership as an integral part of the mental health support process. Many also shared the belief that current policies and practices must be coordinated and clearly defined to more effectively address students’ needs. Several leaders specified that the college was moving closer to producing its own strategic mental health policy; this was deemed to be a high priority. Three subtopics related to developing the organization were discussed during the interviews. These included (a) inclusive leadership and organizational change; (b) policies, practices, and institutional structures; and (c) a comprehensive approach to mental health.

Inclusive leadership and organizational change. Study participants repeatedly verbalized RCCAAT's commitment to promoting positive mental health and reducing attitudinal, accessibility, and structural barriers to success. Based on leader responses, achieving these objectives required development across four domains: contextual understanding, the college culture, people and supports, and the organization. Leadership plays a formidable role in not only advancing these objectives but also building opportunities for change. Participants commented on two related areas. These involved college leaders and mental health as well as identifying "champions," role models, or catalysts for change.

College leaders and mental health. Seven of the 17 participants emphasized the influential role of leadership in fostering a mutually inclusive, responsive learning milieu and promoting positive mental health. The process of reconstituting structures and policies that boost both psychological health and academic achievement were described in the interviews. Some of the leaders argued that a mental health lens should be embedded more broadly into policy development efforts (i.e., mainstreamed policy design). One participant commended the college's dedication to supporting the mental health portfolio, "I know that we've made a lot of improvements this year; we're definitely heading in the right direction" (J33–34). Two others characterized the deans as very supportive and accessible; many had an open door policy (C19, C35, BE2). Evidently, this amicable approach "[started] from the top." One participant portrayed the president as follows: "The president will come through the building and knock on people's doors just to say 'hello' . . . on a regular basis . . . He's always present and very . . . friendly . . ." (M51).

Similarly, others spoke about the impressive steps that RCCAAT leaders had taken to promote positive mental health and accessibility (V40). Middle management was regarded as instrumental for vigorously reinforcing the mental health agenda. Two participants thought that these managers exemplified the “culture of care” philosophy by demonstrating genuine concern for the health of both the employees and students. Another leader agreed that “they [were] cognizant of the wellness of the staff” (BE35). For example, some had added flexibility into counsellors’ schedules to not only accommodate personal commitments, but also meet the needs of students taking evening classes (EM35, V17, BE35). One participant discussed team-based mental health initiatives aimed at mobilizing resources and establishing alliances with the community, although there were no clear structures to inform how these collaborations were enacted (P178). SAS leaders’ drive to incite needed change on campus has provided the impetus to work with these partners and other institutions.

We’ve got a champion and a staunch advocate in the health needs of our students, including mental health Our director of student services . . . has been very purposeful in taking advantage when funding . . . [comes] along to do special projects and . . . to really go after those opportunities and develop things that will help with respect to counselling, mental health, health, and well-being [One] project . . . involves a partnership between Resiliency Community College of Applied Arts and Technology (RCCAAT) and the university [Together, they] . . . developed guidelines for helping students with mental health issues to transition to post-secondary and [promote success] There was a lot of grey area there . . . and issues arising around what faculty needed

to know about [students] other than the nature of their accommodations So they've done a lot of excellent work that, in the process, . . . has given us more visibility and . . . more access to other opportunities So the buzz that surrounds proactive action allows and grows itself, I think, in visibility. Certainly being partners with other institutions . . . is helpful as well. (P65–77)

Three of the leaders emphasized the significance of these “champions” or role models for increasing awareness and instigating attitudinal and behavioural transformation. As explained earlier, many faculty members lacked information about supporting students with mental health impairments and disabilities (C47, B46, EM45). The sharing of promising practices and tacit knowledge was regarded as an obligatory antecedent for assisting these professors in nurturing inclusive, learning environments that were accessible to all students.

To capitalize on RCCAAT's rich local wisdom, the participants asserted that trusting, collaborative relationships must be built first (BE5, B22, S36, J24). Augmenting the college's combined expertise stirred professional growth and generated opportunities for staff to meaningfully contribute to students' post-secondary experience. One leader announced that “there are many great faculty at the college” (D149); champions are found in every department or school (D78). These individuals demonstrate a positive attitude towards accommodations (D152, B44), emulate best practice standards (L66, S50, D147), and act as fierce advocates for students in areas such as accessibility and inclusion (K3, K10, P66, P102). They also serve a supportive function for their colleagues (D77, B44).

Every college and university has . . . champions and they are the people in the know. If they are respected, things change That's my experience. If there's somebody who's a real communicator and who is doing really neat things and [facilitating] presentations, others say, 'Oh, how do you do that?' They feel comfortable asking. I think we should also ask, 'Who are the champions? Who did an amazing job with the accommodation process?' because those people should be acknowledged; those are the people you need to go to when training needs to happen You have to cascade out from this group to everybody. If you have leadership from the top, that will happen (D129, D147)

Although participants mentioned the presence of competing priorities on campus (L66, S50), some still recognized the importance of role models for assisting others and promoting a positive approach to mental health (L66, S50, D147).

Policies, practices, and institutional structures. Many participants had strong opinions about the college's approach to mental health. Eleven leaders posited that RCCAAT was progressing towards the creation of a site-based mental health policy; clearer directives would soon emerge (S40). The common theme was that mental health policies, practices, and support mechanisms needed to be further evaluated, reconfigured, and expanded (CH89, L39, S44, P121). To contextualize their interpretations, participants identified organizational issues and proposed possible action steps germane to enhancing mental health services. Two related areas were discussed during the interviews. These included (a) effectiveness of services and structural gaps and (b) accessibility and accommodation policies.

Effectiveness of services and structural gaps. Most of the study participants believed that gradual shifts in societal attitudes and human rights legislation were reflected in the college's policies, practices, and organizational structures. As a result, RCCAAT had made tangible gains in managing mental health, working collaboratively with staff, and sharing resources and information (M98, BE34–35). Notably, there was widespread recognition among the participants that mental health and student success are interconnected.

One leader stressed that “we start where students are and advance them along the continuum. It is our responsibility to adjust methods and delivery to keep them moving forward” (M16–17). Thus, a critical piece for several participants was the focus on restructuring and repackaging programs to improve accessibility and success (D179, M101, CH72, L39, S6). In other words, college leaders must continue to adapt pathways to match students' needs by incorporating options such as reduced course loads and medical withdrawals (W56, M4). Another suggested that by defining the essential requirements (i.e., Bona Fide Academic Requirements - BFARs) of various programs, RCCAAT would be able to better align students' skill sets to course expectations and career aspirations (D218). In this case, accommodations are tied to core prerequisites of the trade or vocation (D216, S54). Although support models differ across contexts and there is no accepted standardized format (S41), the leaders presented specific ideas to improve the efficiency of service delivery processes.

Participants acknowledged that considerable budgetary constraints had imposed limits on resources devoted to mental health and service provision. Various challenges, associated with channelling institutional supports towards those areas of greatest need and potential impact, were

emphasized. One leader reflected on the college's attempt to reshuffle services and divert funding towards programs that had proven to be most fruitful.

I would be one of the first to say that we can't continue with a sort of shotgun approach to student services. [The student services division] is working with limited resources We have these very good, but sporadic . . . strategies happening throughout the organization. [These represent] the best efforts on the part of all [those who] are involved, but there comes a time when we can say, let's consolidate, let's look at what's most effective and let's resource that, so we can have more benefit overall for everyone. [We have] gone through the service inventory and looked at: what are the services that we provide to students and where are they provided? . . . [This has allowed us] to identify the gaps and redundancies That continues to be a work in progress. To the notion of, why might we be successful? Because in part, even if we're not there in terms of structure and strategy, it's an ongoing dialogue and people are aware. (P121–129)

Five other leaders also recognized the importance of using evidence-based monitoring routines to gauge the effectiveness of interventions (W64, S44, BE50, M85, J12). One participant confided, "We have been a culture of giving accommodations . . . without knowing if they are working" (BE50). Another admitted that "we're still busy trying to figure out a system where we can identify students in need and those who received counselling services and verify if the service helped them to reach their goals" (S44). In an effort to further streamline and appraise these delivery models and inform decision-making, a new data collection instrument will be

introduced to elicit student feedback. One participant clarified how the evaluation tool will be deployed and its intended purposes.

We are just developing our services evaluation processes [One idea] is a random survey [of] individuals utilizing our services [We are] trying to keep that anonymity because . . . without anonymity you can't get [accurate] feedback But at the same time, it's got to provide an opportunity for students to get in touch with whoever might be in charge, and . . . voice their concerns on a higher level; that's the intent Students can fill out [the form] . . . and then we can take a look at our service I think we need to sort of [view] that as constructive feedback [about] . . . the changes that we can make I don't want people to feel burdened, but I also don't want things to get missed. I worry about students exiting early out of the college [because] nobody got to them on time or no one was able to answer their questions in time (S69–72)

Generally, participants reported that services and supports tended to be cobbled together and disjointed (P123, M99, D175). Nonetheless, some thought that “one-off” programs were very worthwhile for assisting some students (B17). One leader remarked, “We don't have an overarching policy; [rather], we have bits and pieces and we're working away at it and making improvements all the time” (M57). Thus, the participants believed that RCCAAT must continue to judge the effectiveness of mental health practices and make changes that provide the greatest benefit to the student body.

Accessibility and accommodations policies. All 17 leaders recognized that it was incumbent upon the institution to improve access and provide accommodations for students with

mental health impairments and disabilities (D59). Two leaders established that RCCAAT's mental health structures and approaches were linked to Ontario's *Human Rights Code* (D33) and formed an essential part of the dialogue around student success (P129). Others revealed that accommodation protocols could be imprecise and extremely complex. One leader illustrated the challenge of co-determining relevant mental health supports.

Students direct the counselling services, if we're doing our job well. We don't build the parameters, the student does. But if you want buy-in from the student, you want that alliance built You want them to trust that you are there in their best interests to see them succeed; they need to define the problem; they need to have a hand in defining what they think some of those solutions might be and then [counsellors] have to go okay, 'Is this reasonable or unreasonable given what they're describing . . . and what should I be offering up?' There are certainly some challenging issues or diagnoses that require certain accommodations that are difficult to put in place. [For example], we know that people who suffer from depressive symptoms or anxiety . . . can also develop some executive functioning challenges, which can impact on things like short-term or working memory abilities and [the skill] to follow a series of steps. So, should students be entitled to a memory aid without a psycho-educational assessment? How do we determine if they are being honest . . . or what's helpful and not helpful and then you get to . . . the education of the faculty [about what] is a legitimate accommodation (S55–57)

Accordingly, counselling remained a fundamental component in the college's mental health approach (P131, S3, S45). Counsellors engaged in monitoring and assessment of needs,

referrals, and triage. The number of students accessing supports was tracked, caseloads were measured, and an inventory of services was tabulated. Hence, accountability and documentation “[were] a huge part of the job” (W19, V1). One of the reasons was that the allocation of monetary and staffing resources and ministry funding were based upon defined needs (CH7). Crucially, there were a fixed number of psychological visits allowed even if problems persisted (i.e., six-appointment policy). A participant shared one consequence of this policy and the ensuing impact of resource shortages when attempting to meet individual needs.

A student of mine . . . has been in a couple of programs She’s only got so many [counselling] appointments left, and after that she doesn’t know what to do and she’s anxious about that . . . and she still needs [support]. So I don’t know . . . that is a tricky one. I think that there’s some pretty big picture stuff that I feel the college has been quite proactive in addressing, but I think there are constantly more issues [and] a limited amount of resources to be able to . . . help everyone (B88–92)

Many leaders suggested that more guidelines and in-servicing were needed to assist those who were working directly with students who presented with mental health conditions (P70). Although RCCAAT had several supportive structures designed to assist professors (P143, PH31) and provided a helpful accommodation handbook (BE20, L62), procedures continued to be poorly understood and inconsistently applied (D29). This was a major concern because accommodations are a code-compliant issue — professors should understand their teaching obligations and duties (D117). Thus, accommodations must be given to the point of “undue hardship” (i.e., excessive costs, health and safety risks). The faculty manual includes some

direction about how students can obtain accommodations and the teacher's role in terms of implementation (CH40–41) but does not fully unravel the confusion about how different mental health accommodations are granted (e.g., interim, good faith, etc.) or the appropriate response at the institutional level (E29, E80). Another emerging issue was associated with retroactive accommodations (D55–56). One participant confessed that “this [was] causing a lot of grief” for post-secondary schools because students may request an accommodation if they have failed to meet performance expectations (e.g., missed exam) due to a mental health impairment or disability (D176). Similarly, compassionate accommodations are determined based on the professor's discretion (D184) leaving students with no recourse if they are denied (D176). One leader argued that these decisions should not be left up to one faculty member (D185), otherwise the process could be “hit and miss” for both the student and the professor (D139–140).

Likewise, one participant agreed that obtaining accommodations could be a “daunting” and needlessly laborious and inefficient experience for students (D20). For example, the accommodation letter must be given to each professor individually (D137). Although provisional accommodations can be delivered without documentation (CH74), formal assessments are required for chronic conditions. This can be problematic because students often arrive at school without any assessment information at all (DU66). Funding restrictions can also add another layer of red tape, particularly for those with undiagnosed mental health impairments and disabilities (V22). Importantly, monies are attached to accommodation and disability labels (D36–37, S22). A leader noted that, in some cases, student associations absorb the cost of psychological services in their student fees so that supplementary supports and therapy can be

available to anyone (D171–172). As far as one participant was concerned, however, funding and accommodations should be completely separate entities (D38). Another challenging aspect of the accommodation process related to students who were on placement in the community (M41). One leader communicated that the college had developed some parameters to support these learners (CH42), but it was sometimes difficult to effectively adapt accommodations to industry-based programs (e.g., nursing) (BE28, W58). Overall, participants concurred that RCCAAT needed a more straightforward system for requesting and rolling out accommodations (D182). Finally, the concept of universal design for learning was discussed by various leaders. Some sensed that it might eventually become common practice (S53). Others suggested that, in classes where it had taken hold, UDL had alleviated the need for accommodations and offered advantages for both professors and students (W26–28). Another participant expressed this opinion.

Universal design for learning is great in the sense that it allows the student to have multiple means of representation [and] multiple means of expression, but it's never going to eliminate . . . accommodations. For example, there's always going to be [students who require] an accommodation for flexible deadlines When a student has to write a test in a private space, that [must] always . . . be accommodated. (D71–72)

Such an approach provides a partial solution but does not totally remove the need for accommodations (CH90, D71). Rather, a series of holistic interventions is required to fully address students' increasing mental health needs.

Table 3

Student Services at RCCAAT Linked to Mental Health

<i>Sector</i>	<i>Services</i>
Campus Health Services	Resources for all students: Mental health counselling (e.g., depression, health issues, eating disorders, emotional stress, sexuality issues); Physician on site: appointments, allergy injections, birth control, First Aid, emergency assistance, immunizations, prescriptions
Online Mental Health Resources	Resources for all students: Academic accommodations and mental health disabilities, research, information videos for students and faculty
Accessibility Services	Resources for students with impairments and disabilities ([un]diagnosed): Academic accommodations, learning strategies, and adaptive technology services
Transitioning Services for Students with Disabilities	Resources for students with disabilities: Transitioning, online self-help resources, workshops (e.g., stress reduction), semester start-up activities, connect with students, staff, mentors, service providers, and faculty, campus tours and orientation, learning strategies, and adaptive technology
Counselling Services	Resources for all students: Academic accommodations and IEPs (documentation for mental health diagnosis - depression, anxiety, ADHD, ASD, etc.); Adjustment to disability- and health-related concerns (anxiety or mood issues, stress, conflict, grief/loss, relationships, self-esteem, sexuality, substance use; temporary disability or illness may be eligible for supports); Transitioning
Student Success Services	Resources for all students: College resources (mental health, learning, note-taking, presentations, study and test taking skills, tutoring, budgeting, online learning, time management); Transitioning
Aboriginal Services	Resources for Aboriginal students: Referrals to college services and resources (mental health), connect with college staff and community services, transitioning and application processes, social and cultural events, employment opportunities, bursaries, scholarships, and band funding; Meeting new students and mentors; Addressing concerns and celebrating success; Monthly Elder visits

Comprehensive approach to mental health. The 17 study participants recognized that the college had a host of valuable services and supports to assist students (Table 3). However, they recommended that more coordinated, deliberate action was necessary to meet the burgeoning mental health needs at RCCAAT. All college constituents could play a positive role in this process and help to cultivate a healthier campus community. Two related areas were explored in the interviews. These included challenges in mental health policy development and the key gap in the college's mental health approach.

Many in the college community conveyed a distinct interest in formulating a comprehensive mental health framework in the future. Senior management, in particular, was making a concerted effort to ensure that there would be a strategic plan available for everyone to consult (CH44, L65). It was hoped that RCCAAT's policy would be co-constructed by multiple stakeholders, including a panel of student representatives (CH49) — student input was viewed as “most important” (D42) with regard to discussions centred on the accommodation experience (D46, D136). One participant added this caveat: progress could be interrupted by conflicting institutional priorities or a lack of government backing (CH43). Others echoed that “to really make change, it needs to be policy-driven at the provincial level” (P188). Thus, financial support, strong leadership, and community involvement were fundamental to establishing a robust mental health strategy on campus (P182, D207). One leader underscored some of the concomitant snarls associated with policy development.

There is no particular policy for students with disabilities. We make reference to disabilities in terms of course load, . . . but there is no policy or procedure for how

students connect with [accessibility and counselling] . . . Maybe there might be a one-liner under general faculty responsibilities about implementing accommodations as granted, or something like that. There's not much; it's minimal. But we are currently . . . updating the placement accommodation policy because that's really important when students are off campus, working in the field and we support them . . . obviously, but there's a challenging piece there. There's that third party, that outside party, that agency supervisor. So if [a student] is in a [particular] program and [doing a placement], how do we ensure that the agency supervisor who is . . . assessing [the student] helps to accommodate [and] has the information he or she needs? So a policy is something that we are lacking. I know it's on the mind and on the list of my director, but there are just so many other things; so we're constantly . . . in reactive mode and not proactive, preventative mode. It's hard to get ahead. But we are making some serious efforts at this time to make sure there is a policy, to ensure that there is something in place that students, faculty, everyone can refer to and know what their rights are, what the process is, and how [to] connect with us. There are a lot of practices, but no policies. (CH44–46)

Hence, many of the essential elements of a comprehensive mental health approach already existed at RCCAAT, but the “full spectrum of mental health resources, services, and supports” (S19) had not been organized into one all-encompassing document or directory (D165). Two leaders stated that the college should adopt a consistently proactive or preventive response to student needs (D178, CH43). In addition, clearer policies and procedures needed to be introduced that could be easily understood and implemented by the faculty. Others stipulated

that RCCAAT's mental health plan must involve coordinated programs and services, adequate infrastructure, creative resource allocation, and further training and support to ease the transitioning or change process (P171, S14–15, CH79).

Two study participants stressed that “the biggest gap” at the college was the lack of a concrete, cohesive mental health strategy (CH82, B83) — “We don’t have a college policy and that is a problem” (CH47). A senior management leader explained how a streamlined mental health plan would assist the college to more proactively support students’ mental health needs.

I think in some respects, we have pieces in place out there; it’s being able to connect the dots and have a more comprehensive approach . . . Perhaps we should spend more time intervening specifically with those at-risk groups because those . . . groups are the least likely to walk through that open door . . . and find the counselling [that they need]. So we [must] connect those dots and have a more comprehensive approach . . . The work is in the planning and the linkages . . . and [more effectively coordinating and using the resources] we already have . . . (P112–117).

One participant indicated that it was “the right time” for post-secondary institutions to move ahead and develop their own mental health framework (D201). Another reached this conclusion.

I don’t think we have it all figured out. I think we have a lot of work to do and it’s something that . . . we still very much struggle with, but I think it’s more like an attitude . . . [It] is one of our strengths . . . it’s that attitude and a lot of awareness. At least we

know that it [mental health] is an issue . . . and that we should be doing something, or the best we can to help students and that we have a desire to make it better. (M52–56)

All participants believed that a broad range of services and supports is required to assist students with mental health impairments and disabilities. Efficient use and scarcity of resources were noted. Participants also acknowledged that current mental health practices must be reviewed and evaluated to inform decision-making and policy planning. Many leaders emphasized that the development of a college mental health policy should be prioritized. To realize this goal, leadership at multiple levels must be provided.

Conclusion

This chapter presented the results of the research. The bulk of the data originated from the 17 interview transcripts, though some evidence was chosen from college documents and researcher notes. The purpose of this single qualitative case study was to explore the perceptions of SAS leaders in relation to the effectiveness of policies and practices that assist college students with mental health impairments and disabilities. Specifically, the intent was to understand the views of SAS professionals who oversaw, developed, and implemented programming designed to meet the needs at one college in Ontario: Resiliency Community College of Applied Arts and Technology (RCCAAT). This section included details about the four key themes: (a) Developing Contextual Understanding: Complexity of Needs; (b) Developing the Culture: It Takes the Whole Community; (c) Developing People and Supports: On the Same Page; and (d) Developing the Organization: Connecting the Dots.

The chapter examined the most salient aspects of the participants' opinions. Theme One

dealt with the development of contextual understanding. All the leaders posited that students' mental health needs were complex, growing, and not being fully supported (i.e., tidal wave of students). Mental health impairments and disabilities were negatively affecting learning and success. The participants also underlined the role of context and the assorted subtleties of learners' challenges. Theme Two described the development of the college culture. All the participants specified that a student-centred approach facilitated the process of addressing various mental health conditions; the whole community shared in this responsibility. The leaders highlighted the importance of reducing institutional barriers, strengthening relationships and partnerships both inside and outside the school, and promoting student engagement and connection. Theme Three explored the development of people and supports and the notion of common understanding (i.e., on the same page). Participants suggested that some students and faculty misunderstood mental health. The SAS leaders iterated the significance of increasing knowledge exchange, raising student awareness, and introducing multiple training opportunities to augment staff capacity in providing accommodations, noticing warning signs, and directing students to service providers. Finally, Theme Four considered the development of the organization. Many participants indicated that the lack of a mental health policy acted as a barrier to meeting students' needs. The leaders articulated the value of a college strategy and the institution's efforts to synchronize resources more efficiently (i.e., connect the dots). They suggested that policies and practices must be aligned with both the college's primary goal of student success and the provincial mental health strategy. A streamlined continuum of meaningful, well-defined response options must be available to faculty so that they can

effectively support students' functional limitations while enhancing accessibility. The leaders pinpointed some gaps in RCCAAT's mental health approach and offered a number of worthwhile insights that could contribute to the college's policy development and planning process. Four major findings are proposed based on the evidence presented in this chapter. These include:

Finding #1. All the participants indicated that students' mental health affected learning and success. Their needs were complex, growing, and not being fully addressed at the college.

Finding #2: All the participants indicated that mental health policies and practices must be responsive to individual and collective needs and driven by a student-centred, contextually specific approach and shared commitment to success.

Finding #3: Many participants indicated that some students and faculty misunderstood mental health. Student services leaders played a significant role in filling this void by introducing preventive and promotional measures that were empirically based and determined through local evaluation and accountability procedures.

Finding #4: Many participants indicated that the lack of a cohesive mental health policy acted as a barrier to meeting students' needs.

The next section provides a detailed analysis of the findings relative to the research questions that were posed. Linkages between the literature and the constructs outlined in the theoretical framework are drawn. The chapter concludes with a summary of the interpretation of findings.

Chapter 5. Discussion

This chapter presents an analysis of the results based on the study questions. The purpose of the study, the research problem, and a discussion of outcomes are included. The intent is to provide interpretative insights and build on the major findings of my research.

Discussion of the Study Results and Links to Previous Research

Although the themes identified in this research are unique to RCCAAT, similar issues have been broadly examined in other mental health investigations applied to higher education. To strengthen my claims, evidence from the present study and prior work were incorporated into the discussion. The results reinforced the argument that an inclusive, streamlined mental health policy will help to not only eradicate some institutional obstacles but also enable psychosocial development and student success. This assertion resonates with key tenets of both the medical and social models of disability.

The discussion considered the literature linked to students with mental health disabilities; student affairs and services (SAS) leaders; and mental health policies, services, and supports. It is anticipated that my findings will bring deeper clarity and understanding about the perceptions of SAS professionals in relation to the effectiveness of policies and practices that assist college students with mental health impairments and disabilities.

Question #1: Leaders' Understanding of Mental Health

The first research question sought to determine the leaders' perceptions about students' mental health. In accordance with past results in the empirical literature, this discussion includes

participant observations associated with contextual understanding. Closely akin to many in the research community, SAS leaders at Resiliency Community College of Applied Arts and Technology (RCCAAT) adopted a perspective that embraced the “whole” student (Cooke et al., 2015; Reynolds, 2011; Sandeen, 2004; Slade & Griffith, 2013; UUK/SCOP, 2015). They seemed to recognize that the mind and body work in concert and are needed to facilitate learning and personal growth. This approach is well founded given that the current generation of college students has been described as one of the “sickest” on record (Kitzrow, 2009). Unmistakably, post-secondary institutions provide fertile ground in which mental health problems can multiply (Adlaf et al., 2005; Andrews & Wilding, 2004; Collins & Mowbray, 2005; MacKean, 2011).

The American College Health Association (2009) indicated that 90% of its subjects, all of who attended one of six Ontario post-secondary institutions, experienced stress, which led to mental health issues (62%), reduced academic achievement (60%), and ill health (57%). This finding is startling because even with consistent efforts to foster an inviting and responsive learning climate, approximately 60% of the RCCAAT study participants were concerned about the corrosive effects that stress was having on many learners, both academically and psychologically. Similarly, students’ unpreparedness and their difficulty in balancing personal responsibilities and the pressure to succeed were also observed. This pressure placed students in a vulnerable position for developing mental health conditions. This is worrisome because research has suggested that there is greater risk for mental illness when anxiety and stress are present (Bartlett, 2014; CIHI, 2009). Thus, both RCCAAT leaders and other researchers have recognized that factors contributing to the onset of various conditions are predominant in higher

education settings (Adlaf et al., 2005; Andrews & Wilding, 2004; Collins & Mowbray, 2005; Mowbray et al., 2006). The combined evidence makes a compelling case for more fully supporting students who may be predisposed to developing mental health impairments and disabilities, particularly within stress-inducing contexts (i.e., post-secondary schools).

But locating all those in need of support is close to impossible. According to the study participants, mental health conditions were ubiquitous at RCCAAT. Eighty-eight per cent of the leaders conveyed uneasiness about the “tidal wave of students with mental health issues arriving on campus” (D177). This is unsurprising given that more students with mental health needs are able to enter higher education due to enhanced accessibility, improved therapeutic interventions, and advances in psychiatric medications (Collins & Mowbray, 2008; NEADS, 2010). Still, many continue to languish. The considerable prevalence and breadth of mental health concerns among students at post-secondary institutions in Canada are also well documented (Cooke et al., 2015). Studies have shown that the incidence and severity have markedly soared in the last decade (Cranford, Eisenberg, & Serras, 2009; Gallagher, 2012, 2014). My study data, and earlier literature, provide a persuasive argument that mental health presents considerable challenges for campus service providers. Two strategies used at RCCAAT to address these challenges were nurturing an inclusive, learning-rich environment and focusing on student success.

This had become increasingly more difficult, as one leader remarked, because incredible pressure was placed on the college “to be all things” (L81). A similar conclusion has been amply reflected in the educational research. Not only are students making greater demands on service providers (Elam, Stratton, & Gibson, 2007), they are also becoming a more discerning and

diverse group (Berger et al., 2009). Subsequently, colleges are charged with boosting enrollment, preparing workers for the labour force, and ensuring that their institutions are inclusive, innovative, and responsive to individuals' specific learning preferences and modalities (Cooke et al., 2015; Hardy Cox & Strange, 2010; McGrath, 2010).

These are not easy tasks given the enormous variability of mental health needs at RCCAAT. The participants suggested that depression, anxiety, and stress were substantial issues. Autism, panic and mood disorders, PTSD, and ADHD were mentioned less often (< 30% of the leaders), but they were still viewed as problematic. Although the statistics differ slightly from those identified at RCCAAT, studies have proven that mood- and anxiety-related complaints are among the most common (Holmes et al., 2011) and can affect learning potential and graduation (Eisenberg, Downs, Golberstein, & Zivin, 2009; Gallagher, 2012, 2014). Unexpectedly, schizophrenia was highlighted by 76% of the study participants. This was an unforeseen finding because schizophrenia affects only 1% of the Canadian population (Public Policy Forum, 2014). Nonetheless, it was unsettling for the leaders because, as cited in the literature, this illness is connected to pronounced stigma and elevated rates of suicide (Schizophrenia Society of Canada, 2013).

Participants maintained that educational outcomes were further complicated when students displayed co-morbid conditions. This finding was anticipated given that mental health problems often manifest with other disabilities (Ontario Ministry of Education, 2013). For example, investigators have found that more students are struggling with addictions and mental health (MacKean, 2011; OHRC, 2014). Equally troubling is the large degree of co-occurrence

among depression, PTSD, and alcohol dependency (Anthenelli, 2010; Cranford et al., 2009; McCulloch, 2006; OHRC, 2014; Ontario Ministry of Health & Long-term Care, 2009). The SAS leaders at RCCAAT also commented that when students presented with dual disabilities, the support process was more arduous for service providers. Evidently, the intricacies associated with these conditions had imposed additional stress on college personnel who were already overwhelmed.

The same SAS leaders also perceived an unprecedented influx of students requesting support. They surmised that this might be due to shifting attitudes and the increased frequency of mental health episodes and crises at the college. The empirical literature has supplied varied explanations for these changes (Gallagher, 2012, 2014; Hunt & Eisenberg, 2010). On one hand, research conducted by the Mental Health Commission of Canada (2013c) claimed that there has been a decrease in stigmatization across the country. On the other hand, others have postulated that the "silence" surrounding mental health and the concurrent stigma still pervade post-secondary campuses (Davis, 2005; Wynaden et al., 2014). Nevertheless, RCCAAT leaders calculated that up to 20% of their students were accessing resources, the majority of who had mental health impairments and disabilities. They believed, however, that these figures understated the actual need for assistance; many affected individuals tended to shun support services.

This may be due in part to students' poor level of mental health literacy. I have made this assumption based on reports from the RCCAAT study participants that deficiencies linked to knowledge exchange and awareness continued to exist. Analogous concerns have been examined

in the literature (Hardy Cox & Strange, 2010; MHCC, 2012). Most notably, an influential body of work published by Tyhurst and colleagues (1963) asserted that people's understanding of mental health was "apt to be incomplete, negatively structured, and rigidly held" (p. 11). Contemporary researchers have insisted that deficits in mental health knowledge still endure — they lead to unfounded beliefs and misconceptions, poor service access, and unsatisfactory health outcomes (Armstrong & Young, 2015). In response, the Standing Senate Committee on Social Affairs, Science and Technology's (2006) landmark report recommended sweeping changes to Canada's mental health approach including the promotion of mental health literacy nation-wide. Although the SAS leaders at RCCAAT granted that many questions remain unanswered, they agreed that the responsibility for advancing positive mental health must be assumed by everyone at the institutional, community, provincial, and federal level.

Participants italicized that there was "no quick fix" for tackling all of the problems on campus. Successfully negotiating the college's mental health terrain would not be accomplished using prescribed approaches. Rather, programmatic decisions and mental health plans must be tailored to specific needs, observable gaps, and the distinctive qualities of the educational setting. Researchers ascertained early on that "planning for mental health services demands a comprehensive diagnosis of local needs and conditions" (Tyhurst & Canadian Mental Health Association, 1963, p. 43). The RCCAAT leaders shared several examples of initiatives, programs, and practices that had been trialled, evaluated, and adopted (and in some cases discarded). Once more, my study findings paralleled those uncovered in the theoretical scholarship. The Mental Health Commission of Canada (2012) declared that "there will never be

a ‘one size fits all’ approach to the complex task of transforming the mental health system . . . [or] universal agreement on everything that needs to be done” (p. 12). For an institution to achieve its mission, it must cultivate a healthy physical, psychosocial, and emotional climate. Thus, responding to students’ mental health needs was a conspicuous goal at RCCAAT: “it [continued] to be a work in progress.” The results imply that the leaders in my study were still grappling with fully defining their roles and responsibilities with respect to advancing the mental health portfolio on campus.

Question #2: Effective Mental Health Policies and Practices

The second research question sought to determine the leaders’ perceptions about which policies and practices were effective for assisting students with mental health impairments and disabilities. This discussion includes RCCAAT participant insights related to mental health services and resources that were available to both students and faculty. My observations are also based on a holistic approach and prior results found in corresponding literature.

As I mentioned earlier, the participants indicated that RCCAAT was pledged to creating a learning context that was inclusive, responsive, and accessible. These values were viewed as essential for developing informed policies and practices that promote success for students with mental health conditions. Importantly, the overarching principle at RCCAAT was that “mental health is just health” (L52). This all-embracing conception is mirrored in the work of different researchers who have suggested similar linkages. For example, the World Health Organization (2016) proposed, “Mental health is an integral part of health; there is no health without mental health.” Others agreed that physical and mental health cannot exist independently; the

interrelationship between physical, mental, and social functioning is indisputable (Raphael et al., 2005). This foundational understanding is important because unresolved mental health issues can pose a sizable threat to health and well-being (Manion, 2011) and affect the emergence, nature, and outcome of similar conditions (Raphael et al., 2005). Likewise, others have considered the symbiotic link between education and health. The Ontario College Health Association (2009) has hypothesized that “education and health are interdependent and reciprocal, [and] . . . the efforts to promote both in collaboration are synergistic and mutually beneficial” (p. 13). This vision was clearly illustrated in RCCAAT’s policies and practices, institutional documents, and website. It is against this backdrop that research question two will be answered. To frame the discussion, the identified strategies, policies, and practices for supporting positive mental health are grouped into four categories: (a) inclusive, accessible learning environment — a shared responsibility, (b) faculty awareness and training, (c) student mental health awareness, and (d) early indicators — identification of vulnerable students.

Inclusive, accessible learning environment: A shared responsibility. RCCAAT study participants believed that meeting the needs of all students began with shared, earnest effort to build an inclusive, accessible learning environment. This is an ambitious goal given the increasing diversity of the population and the mounting complexity (e.g., severity, co-morbidity) of the needs on campus. The leaders viewed the student-centred philosophy and creation of a sense of belonging as fundamental tools for improving accessibility and removing barriers to learning. This multi-pronged orientation has been broadly recognized as necessary for helping post-secondary students achieve success, cope with unexpected adversity, and adjust to the

feverish pace of college life (CACUSS & CMHA, 2013; Cooke et al., 2015). The literature has demonstrated that a responsive, inclusive campus climate not only contributes to positive mental health and success, it also benefits students in under-represented groups (Collins & Mowbray, 2008; Fried, 2011; Wiggers & Arnold, 2011). This finding is noteworthy because 34.5% of RCCAAT's student body falls into the first-generation classification. The need for designing welcoming, healthy environments is also significant because "isolation and interpersonal rejection plague disabled people" (Gill, 1987, p. 51) — individuals with mental health conditions are often susceptible to social exclusion (MacKean, 2011; Standing Senate Committee on Social Affairs, Science & Technology, 2011). First-generation students, in particular, have reported greater levels of depression and stress, poorer ratings of belonging and engagement, and lower use of services compared to other student groups (McFadden, 2016; Stebleton, Soria, & Huesman, 2014).

The research has also theorized that education involves a collective response to addressing students' needs (Canadian Association of College and University Student Services [CACUSS], 2011). RCCAAT leaders frequently spoke about the value of shared ownership in supporting students' interpersonal, academic, vocational, physical, and psychological growth. As one participant avowed, student success is "one of our big things; everyone on campus is focused on the same goal" (J26). This unified, mutual understanding appeared to permeate the campus from top to bottom. Having everyone "on the same page" was regarded as a key component of the college's supportive process for enhancing students' psychosocial and academic development. All of the leaders advocated beliefs and language that were congruent with those

described in the website and the selected documentary evidence. In short, the same vision and ideals were espoused by all participants and seemed to guide RCCAAT's actions, policies, and practices. Many "champions" working throughout the campus were also celebrated for their concentrated efforts in responding to students' mental health needs and promoting collaboration (e.g., Student Success Advisors, etc.). Crucially, participants acknowledged that "it takes the whole community and the whole institution to truly meet [students'] needs" (M87). Other researchers have acknowledged that "health is vital to learning . . . and shouldn't be thought of as auxiliary or ancillary to the mission of [the] institution [Thus, all stakeholders are responsible for] creating an atmosphere that enables and magnifies the potential of every student" (Silverman, Underhile, & Keeling, 2008, p. 11). According to MacKean (2011), "if student mental health remains on the periphery, viewed as the responsibility solely of student services professionals, a tremendous opportunity will have been missed to integrate mental health . . . into academic structures, policies, and processes" (p. 8). Thus, RCCAAT study data and the literature make a strong case for collectively pursuing positive mental health throughout the campus.

In a similar vein, participants repeatedly cited teamwork and relationship as basic building blocks for promoting a positive approach to mental health and addressing individual needs. The deliberate emphasis on collaboration and collegial exchange seemed to enable far greater sensitivity to students' academic and mental health concerns and their accommodation requirements. This is salient because fragmentation is often referenced in the research; the gap between faculty and student affairs is well documented (Hirsch & Burack, 2002). Apparently,

RCCAAT had managed to strategically build campus community by bridging this historic “gap” or disjuncture (Frost et al., 2010; Schuh, 1999). Team building, trust, and “the special relationship among departments, managers, professors, and support staff” were an innate part of the culture (M26). Working with college associates and other institutions had also been a focus for student services managers wishing to drive needed change at RCCAAT. This is important because these relationships are forerunners to enhancing retention, student learning, accountability systems, and quality of services (Frost et al., 2010). Moreover, approximately 60% of the RCCAAT leaders underlined the fundamental role of the Student Success Advisors (SSAs) and their influential relations with students, faculty, and the community at large. These connections were regarded as absolutely critical for ushering at-risk students to appropriate mental health supports and enabling success.

Faculty awareness and training. RCCAAT participants also recognized that faculty knowledge and awareness of mental health and the accommodation process were integral to learning. This finding was expected, as studies have confirmed the vital role that professors play in promoting student success (Cooke et al., 2015; NEADS, 2010). Although faculty-training opportunities were not without limitations, the leaders stressed RCCAAT’s commitment to working collaboratively with instructors to ensure they had the tools to facilitate access and optimize students’ achievement. This was viewed as essential because faculty expertise, attitudes, and behaviours are considered to have the most powerful impact on academic progress (Kurth & Mellard, 2006; Vogel et al, 2008; Wilson et al., 2000). Thus, the RCCAAT leaders thought that building professors’ currency of knowledge, skills, and practice through ongoing

professional development should be a main priority. Other studies have demonstrated that accentuating staff awareness strengthens efforts to support positive mental health on campus (CACUSS & CMHA, 2013). Previous research has also shown that student outcomes substantially improve when disability-focused training is accessible on a regular basis in multiple platforms (Murray et al., 2009; NEADS, 2010).

Accordingly, RCCAAT had introduced many knowledge- and capacity-building resources that were readily available to full-time faculty. These resources were needed because instructors usually held no mental health credentials; others had not earned a teaching degree. Therefore, staff development in areas such as differentiated instruction was understood as crucial for helping professors to match their pedagogical approaches to individual learning challenges (Fisher, 2006; Nicholls et al., 2012). This is notable because classroom experiences have a significant impact on student retention (Tinto, 2006). Similarly, one study participant sensed that universal design for learning (UDL) might eventually become common practice (S53); some RCCAAT leaders felt that it reduced the need for accommodations and afforded benefits to both the professors and students (W26–28, D71). Importantly, UDL coincides with the *Accessibility for Ontarians with Disabilities Act* (Ministry of Community & Social Services, 2011) and is intended to “level the playing field.” It also corresponds with the central precepts of inclusion and the social model of disability, allows instructors to flexibly adapt teaching and curriculum based on needs, erases obstructions to learning, and maintains course integrity (Matthews, 2009; NEADS, 2010; Oliver, 2009; Orr & Hammig, 2009). Ultimately, UDL has been touted as a versatile strategy for delivering necessary supports to higher education students with mental

health conditions (Matthews, 2009; Nicholls et al., 2012). Thus, professional development that is informed by the *AODA* and the social model of disability might also provide other avenues of training, instill greater awareness, and lead to improved access and learning. Both the literature and my study findings have suggested that given the emphasis on accessibility by governments, advocacy groups, and service providers and UDL's broad application, it is valuable for faculty to understand how it can be widely implemented.

Researchers have also urged post-secondary institutions to develop user-friendly faculty guides that explain the main challenges in assisting students with disabilities (NEADS, 2010). Correspondingly, RCCAAT published an informative faculty handbook that supplemented other staff development materials. To facilitate access, this resource was produced in both hard-copy and digital versions. Additionally, the college encouraged professors to consult with counselling staff and the accessibility advisor. The literature has indicated that these kinds of one-to-one consultation opportunities are beneficial for diffusing information, curbing frustration, answering questions, and responding proactively to escalating concerns (NEADS, 2010). New RCCAAT faculty were also advised to connect with the learning strategist, adaptive technologist, assigned mentor or faculty coordinator, and attend department meetings. This was vital because previous research has found that faculty members were more willing to assist students when they perceived that sufficient help was available from support personnel (Zhang et al., 2010). The RCCAAT study participants also pointed out that training videos had been developed according to best practice standards for accommodating and referring students with mental health impairments and disabilities. Similarly, the literature has recommended that online resources

tailored to the needs of professors should be close at hand (NEADS, 2010). In keeping with these recommendations, a wide variety of faculty mental health awareness-raising protocols were in place at RCCAAT. Research has also endorsed a comparable set of information-dissemination algorithms to increase students' familiarity with mental health resources on campus (Armstrong & Young, 2015).

Student mental health awareness. The RCCAAT leaders agreed that students' awareness of mental health, support options, and accommodation process was indispensable for extending access to academic programs. Indeed, studies have demonstrated that this knowledge has a direct impact on learning and success (NEADS, 2010). The weight of mental health conditions on post-secondary students, coupled with their insufficient levels of mental health literacy (Kelly, Jorm, & Wright, 2007), seems to indicate that information sharing among this population must be amplified. This is valid because such strategies have been found to bolster prevention efforts and ward off discriminatory attitudes (Canadian Alliance on Mental Illness & Mental Health, 2007).

RCCAAT participants reiterated that support services were delivered to all students at the college, not just those with clinical labels because many mental health conditions are undiagnosed. Evidently, a support process grounded in a strengths-based (rather than a "lack of ability") perspective had been adopted at RCCAAT (S12). The college had also oriented its mental health practices around an inclusive approach to disability. Subsequently, purposeful attempts had been made to introduce accommodations that increased access and removed barriers sabotaging success. Thus, to promote positive mental health on campus and appropriately support affected students, the leaders listed many bold initiatives targeting specific

areas. These included: improving access to services, enhancing early identification, minimizing stigmatizing attitudes, augmenting students' help-seeking behaviours, and propagating mental health knowledge.

The RCCAAT study participants indicated that educating students about mental health and the service alternatives was a key part of the college's support process. For this reason, there were numerous mechanisms, programs, and practices devised to increase understanding and link students with appropriate help (e.g., social media, Facebook, Twitter, online tools, college website, face-to-face meetings, presentations, handbook, etc.). Researchers have advocated similar schemes to fortify outreach and knowledge mobilization, as well as ensure optimal service responsiveness, diminish information gaps, and expand awareness of campus resources (Jenkins, 2007; Shaw & Shaw, 2006; Tinklin et al., 2005). Hence, these types of knowledge-distribution routines are advantageous because students with mental health impairments and disabilities are often unfamiliar with existing college services (Armstrong & Young, 2015; NEADS, 2010).

RCCAAT participants also noted that equivalent knowledge deficits frequently characterize first-year students. Therefore, a number of resources (e.g., online self-help, orientation events, workshops, etc.) were geared towards facilitating a smooth entry into the college. Two of the leaders believed that connecting students with these supportive and preventive services was also positively associated with better graduation rates (D155, P109). Research has confirmed, for example, that orientations remove access hurdles and encourage self-identification (Grayson & Grayson, 2003; NEADS, 2010). All the same, there was one

potential stumbling block. Like other services within RCCAAT, students with mental health conditions were required to seek out and initiate the accommodation and counselling processes themselves (i.e., self-advocate) before they were able to realize the various benefits.

But self-advocacy and help-seeking activities can be stymied due to stigma, time constraints, privacy matters, lack of awareness, and resource shortages (Hunt & Eisenberg, 2010; Megivern et al., 2003). These were concerns for the RRCCAT leaders because when students are left untreated, mental health can deteriorate dramatically. In some cases, individuals must be hospitalized. My findings also correlate well with recent investigations that chronicle the struggles of those with chronic mental illnesses who receive no services (Ontario Ministry of Health & Long-term Care, 2009). The more sobering consequences of non-treatment may include incarceration, homelessness, violence, victimization, and suicide (Treatment Advocacy Center, 2015). Reinforcing ties and knowledge exchange with external agencies has been recommended to decrease some of these calamitous repercussions (Storrie et al., 2010). Although RCCAAT's awareness campaigns certainly raised the profile of mental health on campus, the leaders felt that many students and faculty still lacked information about the symptoms and early warning signs of impending problems.

Early indicators: Identification of vulnerable students. Throughout this report, I have highlighted RCCAAT's broad range of mental health response plans. Several training and awareness-raising opportunities were already in place to assist students with mental health impairments and disabilities. The SAS leaders extolled the value of improving professional development, accommodation procedures, and mental health information-sharing initiatives.

Respectively, early, as well as crisis, intervention had also been recognized as principal components of RCCAAT's support strategy.

It is widely understood that crises, such as imminent risk of harm to self and others, not only have a profound impact on students' mental health and academic success, they are also inherently complex (CACUSS & CMHA, 2013). RCCAAT leaders determined that responsive efforts must be equally nuanced and well coordinated. For this reason, enhanced skills and practical knowledge for all those who provide services are imperative because mental health incidents can affect the campus community and potentially endanger the safety of others (CACUSS & CMHA, 2013). The study data indicated that RCCAAT was committed to providing a safe place for everyone on campus — the college had distributed information for responding to threats and crisis situations. Although not specific to mental health, security and emergency communiqués were readily available to campus constituents. It was also interesting that some of the leaders felt that one of their primary functions was identifying at-risk students. This is significant because noticing red flags and taking definitive action can be pivotal for changing future outcomes (CACUSS & CMHA, 2013).

Furthermore, additional training, early alert, and suicide prevention programs had been introduced at RCCAAT (i.e., *ASIST*, gatekeeper training). The literature has confirmed that these courses are helpful and have been used extensively across Canada (Isaac et al., 2009; NEADS, 2010; Shtivelband et al., 2015). But students' need for mental health support has risen substantially, leaving campuses scrambling to meet the demand (MacKean, 2011). Still, the RCCAAT participants maintained that information diffusion and collaboration were especially

useful for serving students who experienced serious mental health outbursts. Networking among student affairs, counselling, faculty, SSAs, and external mental health services was fundamental to intervening early and directing students to relevant resources. Consequently, it was extremely important to create these alliances so that students could be quickly linked to community organizations if necessary (NEADS, 2010). This is noteworthy because if unheeded, mental health conditions may result in increasingly risky behaviour or premature death (Cook, 2007; OHRC, 2015). These current research findings and the extant literature offer a cogent argument for continuing to build cooperative, communicative knowledge-exchange structures into the support process so problems can be flagged and timely referrals made. To fill service gaps and address the more severe mental health conditions, a certain amount of service outsourcing was needed at RCCAAT, though no formalized partnerships had been established. Outside agencies were tremendously critical when students were facing major crises that required hospitalization or longer term, specialized therapies.

In summary, students' mental health is influenced by many factors in both the college and the community. Maintenance of positive mental health is predicated on the level of shared commitment, insight, and vigilance in formulating opportunities for all students to be successful. The RCCAAT leaders believed that everyone had a role to play in this process. Researchers have also confirmed that better information-dissemination and awareness-raising projects should be launched to improve students' access to supportive resources (Health Canada, 2010; MHCC, 2012, 2014).

Question #3: Gaps in Mental Health Policies and Practices

The third research question sought to determine RCCAAT leaders' perceptions about what policies and practices needed to be either refined or introduced to enhance students' mental health. This discussion includes participant observations related to developing people, supports, and the organization that align with past research. Significantly, the overarching philosophy undergirding RCCAAT's approach was that positive mental health is intrinsic to learning. In keeping with this perspective, the participants indicated that an array of services designed around the characteristics of the population was provided. Thus, RCCAAT's primary focus was student success. To achieve this goal, meeting learners' diverse needs and ensuring equal access to educational opportunities were designated as priorities. RCCAAT's approach was inclusive, rights-based, and founded on the notion that mental health factors could be predictive of academic growth (Krumrei-Mancuso et al., 2013). This positive vision seemed to be infused throughout the organization. Similarly, policies and practices were reflective of a belief in students and a collective responsibility in developing an equitable, accessible environment that allowed them to reach their potential. Shared understanding, knowledge mobilization, and capacity building were intentionally endorsed. Collaborative exchange among colleagues was also a key ingredient in the college's approach. This warrants mention because collaboration was viewed as a core tool for identifying and assisting individuals who were suffering through intense periods of mental health distress.

Given the substantial burden of mental illness throughout the lifespan and prevalence of conditions in early adulthood, many have argued that post-secondary institutions are ideal venues

in which to incorporate promotional and prevention programs (Hunt & Eisenberg, 2010; Kutcher, 2011; MacKean, 2011). With this in mind, RCCAAT has continued to wrestle with how to implement mental health strategies, reduce barriers, and address students' multi-dimensional needs. Many of the participants expressed pride in the college's efforts to respond to these needs but also admitted that three key issues have eroded progress to varying degrees: (a) students' poor understanding of mental health and the support process, (b) faculty's insufficient training and mental health knowledge, and (c) most prominently, the lack of a cohesive mental health policy on campus. The impact of these gaps should not be underrated. If students' do not receive the services and supports that they require, their learning and success can be undermined. They may exit early from their classes or experience life-changing mental health episodes. Under the worst circumstances, individuals may lose hope and engage in self-injury or suicidal acts.

Key refinement #1. The first key refinement, identified by the RCCAAT leaders, relates to students' poor understanding of their own mental health and the services that were available to assist them. Although there were already a great many information-sharing instruments used at the college, the leaders still proposed a few refinements that might heighten student knowledge. Many of the study participants determined that "mental health information should be included in everything," service options should be more widely publicized on campus, and areas such as prevention, stigma, and warning signs should be specifically targeted. This perspective mirrors those recommended by accessibility advocates and researchers. For example, Armstrong and Young (2015) have contended that campaign efforts must emphasize topics of interest to students, such as symptoms of mental illness and stress management. It is important to realize,

however, that promotional initiatives may inform students about campus and community services and also dispel myths, but there are no assurances that the effects will be continuous (Ontario Ministry of Health & Long-term Care, 2009). Unfortunately, investigators have been unable to firmly establish that awareness-raising programs help students to cope with chronic conditions; study results must be cautiously interpreted. The implication of these findings is that more research is needed to reliably predict the effectiveness of certain interventions, chiefly those allied with stigma reduction.

RCCAAT leaders acknowledged that stigma played a major role in the help-seeking process. Unexpectedly, participants' opinions were mixed with regard to the prevalence of negative attitudes on campus. Be that as it may, all of the leaders were concerned about the stereotyping and shame fastened to the mental health label. Coupled with other barriers, stigma can have long-term effects, lead to alienation, and inhibit some students from requesting accommodations or speaking with their professors. It can also make the identification process erratic and inexact — the problem was that RCCAAT depended on individuals to self-identify. Thus, the number of unsupported students was unknown. The primary implication of this finding is that the system did not permit SAS professionals to methodically flag those in need. This put RCCAAT service providers in a tenuous position. Although they were committed to helping everyone, the existing structures made it impossible to locate each person that required assistance. The college continued to trial different approaches that would fill this hole. Still, various administrative and programmatic issues must be further confronted to render support programs more efficient, accessible, and effective.

As noted before, stigma often prevents students from reaching out for mental health services (Eisenberg et al., 2011; OHRC, 2012, Storrie et al., 2010). Stuart (2004) and others (Hartman-Hall & Haaga, 2002) have confirmed that help-seeking behaviours can be affected by both public stigma and self-stigma. According to RCCAAT participant accounts, many students chose not to obtain assistance because they worried that it could lead to unwarranted judgments. This is a thorny puzzle to solve because mental illness is one of the most stigmatized conditions in society (Alexander & Link, 2003). Incredulous responses from professors to the disclosure of mental health conditions have been documented (Collins & Mowbray, 2005). Other confirmatory data have shown that some higher education environments can be inflexible and non-accepting of differences (Tinklin et al., 2005). Undeniably, greater attention must be focused on stigma reduction and awareness raising in post-secondary settings, but once again, the research offers no clearly marked road map. For instance, there is little evidence to dependably estimate the effect of using printed materials to distribute information. More concerning still is that promotional campaigns have not been uniformly correlated to decreases in suicidality (Dumesnil & Verger, 2009). Nonetheless, more anti-discrimination strategies need to be introduced across individual, institutional, and societal levels. Crucially, any effort to abolish stigma must involve people who know it best, those with personal experience (Mental Health Commission of Canada, the Canadian Human Rights Commission, the World Psychiatric Association Scientific Section on Stigma and Mental Health, & the Public Health Agency of Canada [MHCC, CHRC, WPA, & PHAC], 2012). Research has shown that direct contact with individuals who live with mental health conditions leads to positive changes in public attitudes and behaviours (Durham Talking

About Mental Illness Coalition, 2007). Efforts to improve research, communication, resource leveraging, and synergy between post-secondary institutions and communities have also been applauded (MHCC, CHRC, WPA, & PHAC, 2012; UUK/SCOP, 2015).

Fortunately, there are some signs that a shift is underway in how people with mental health impairments and disabilities are perceived. Stigma is an issue that has seized the attention of the international community (MHCC, CHRC, WPA, & PHAC, 2012). Mental health has also been named as a government priority both provincially and federally. Likewise, the U.N. Convention on the Rights of Persons with Disabilities (United Nations, 2006) has redirected the emphasis on these individuals “from recipients of charity to holders of rights.” Through ratification of this convention, Canada shares a responsibility in eliminating prejudice and enhancing accessibility for all citizens. Ontario is also doing its part to advance mental health literacy because a “lack of knowledge leads to fear and therefore lack of opportunity” (OHRC, 2012, p. 39).

In summary, mental illness results in poor outcomes and considerable burden on both the individual and community if untreated. The present research and related literature have indicated that deficits in mental health expertise are contributing factors to both stigma and low service access. Given RCCAAT’s dedication to student success and positive mental health, it is well situated to support those in need and guide them towards appropriate resources. It is important that promotional and preventive activities are aligned with the diverse needs of the college population. These initiatives are necessary to not only offset the negative impacts of stigmatizing attitudes, but also strengthen outreach to students who tend not to seek assistance.

Due to the sparse research evidence on effective programs and policies, it would be presumptuous to draw definitive conclusions about how RCCAAT should proceed. What is clear, however, is that steady effort on the part of post-secondary institutions is needed to improve mental health interventions and supports. Above all, progress depends to a large extent on leaders' commitment to building the organization's people capacity (Lowe, 2005).

Key refinement #2. The second key refinement relates to the faculty's lack of knowledge about mental health and appropriate accommodations to promote student success. As referenced earlier, there were several programs, as well as print and online materials, available to aid professors at RCCAAT. Yet the leaders argued that supplemental capacity-building efforts were still required in areas such as support procedures, mental health literacy, professional responsibilities and boundaries, and access to service providers. This is important because it is widely accepted that faculty members play a pivotal role in both the learning and support process (Burgstahler & Doe, 2006; Dukes & Shaw, 1999; NEADS, 2010; Ontario Ministry of Health & Long-term Care, 2009). Specifically, staff training is instrumental for stimulating understanding of the issues, increasing faculty's use of mental health accommodations and potent teaching practices, and creating a wholesome school environment (CACUSS & CMHA, 2013; MacKean, 2011; Vogel et al., 2008; Warwick et al., 2008).

Several of the study participants agreed that professors who regularly interacted with students were ideally placed to identify unusual behaviours and connect learners with resources. RCCAAT leaders thought that most faculty members were quite open about mental health and willing to modify programming to meet students' needs but were often unacquainted with

disability policies and the rationale behind the accommodation and referral process, UDL and differentiation, and confidentiality regulations. The literature has described similar deficiencies. Professors often lack basic information about impairments and disabilities, their legal responsibilities, and the provision of reasonable instructional supports (Dona & Edmister, 2001; Kurth & Mellard, 2006). However, when educational opportunities are tied to instructors' professional needs, accommodations are more consistently applied and learning is enhanced (Fisher, 2006; NEADS, 2010; Ontario Ministry of Health & Long-term Care, 2009). If RCCAAT is going to achieve its goals of addressing student needs and ensuring success, it must develop clearer mental health accommodation policies that are easily understood by professors. More research is also needed to evaluate the effectiveness of approaches for managing "extenuating-circumstances" and unconventional support options (Cooke et al., 2015; Kurth & Mellard, 2006; UUK/SCOP, 2015).

As stated beforehand, many RCCAAT leaders voiced reservations about the level of professional development that part-time faculty received. Another key challenge was the difficulty in reaching every professor. This is noteworthy because it has been estimated that the ratio of full-time to part-time college faculty is approximately one to three (MacKay, 2014). Thus, many institutional leaders have indicated that educating part-time instructors should be a priority, but this presents complications due to heavy workloads, time and monetary restrictions, attitudinal interference, and unfamiliarity with professional duties and available resources (Fisher, 2006; Ontario Ministry of Health & Long-term Care, 2009). RCCAAT study participants also revealed that faculty members often felt under-prepared to handle acute mental

health behaviours. This concern is well founded because these incidents could quickly derail a classroom and place people at risk. Hence, the provision of relevant mental health in-servicing is needed to give faculty the tools to fulfill their responsibilities in helping and referring fragile students (Colleges Ontario, Council of Ontario Universities, College Student Alliance, & Ontario Undergraduate Student Alliance, 2012; NEADS, 2010).

Leaders at RCCAAT agreed that professors must learn how to cope with mental health crises in their classrooms. Appropriate reactions to emergencies are critical to prevent explosive situations or further escalation (Ontario Ministry of Health & Long-term Care, 2009). The majority of the participants suggested that capacity building was part of the college's strategy, but "there [was] no mandated training for faculty on how to respond to students with disabilities, so there [was] an information gap there" (CH17). Interestingly, Cooke and colleagues (2015) have recently recommended that training should be compulsory for all new hires at the post-secondary level.

Similarly, the literature has shown that gatekeeper programming for suicide prevention has positive effects on the attitudes, skills, and acumen of trainees (Isaac et al., 2009). Other researchers have argued that all employees should be able to discern signs of mental health distress and connect individuals to relevant services (Eisenberg et al., 2011; MHCC, 2012). RCCAAT had adopted a similar stance. It offered *ASIST* and gatekeeper training to various sectors of the campus community. Some of the leaders believed that "broader capacity for recognizing warning signs and assessing students' level of risk [was] needed" (M64), particularly for front-line workers (V28–29).

In conclusion, RCCAAT provided a breadth of print- and web-based material, optional seminars and orientations, and campus contacts who could be accessed on a voluntary basis by the faculty. Still, the overall consensus was that more professional development should be available to promote greater understanding of mental health among the professors. Additional time and resources should be earmarked to fully support part-time faculty, especially with regard to accommodation practices. The leaders felt that the college must continue to focus on dispelling myths, dispersing knowledge more adeptly, and creating a culture of acceptance and openness. To achieve these objectives, training opportunities and mental health information must be readily accessible to all constituents.

Key gap. The key gap, identified by the RCCAAT study participants, relates to the lack of a concrete mental health policy on campus. Although fragmentation in service delivery was underlined by many of the leaders, there was a definite desire to “connect the dots.” In other words, many agreed that the creation of a comprehensive mental health policy would improve the support process and should be prioritized. While multiple access points to mental health support and services are beneficial, a lack of coordination often fuels confusion and creates unnecessary duplication. This makes the system unsustainable, inefficient, and difficult to navigate (Cooke et al., 2015; Mowbray et al., 2006). The primary implication of this finding is that RCCAAT’s mental health approach could not fully respond to students’ needs (e.g., counselling, accommodations, etc.). Service providers were left in an undesirable position because the fundamental value of the college revolved around assisting individual students, but existing structures did not allow them to offer the requisite resources. Cooke and colleagues

(2015) give credence to this perspective. They have warned that “demand for student mental health services is outstripping capacity; . . . there are significant policy gaps that must be addressed” (p. 4). Others have speculated that there may be substantial support deficits (unmet needs) for college students with mental health impairments and disabilities (Cranford et al., 2009). The literature has implied that many post-secondary leaders are abiding the same resource discrepancies and are therefore, unable to provide students with adequate services (CASA, 2015; Cooke et al., 2015; Gruttadaro & Crudo, 2012).

Similarly, there is irrefutable evidence suggesting that the complexity and prevalence of mental health conditions on post-secondary campuses have increased immensely (Ontario Ministry of Health & Long-term Care, 2009). Subsequently, institutions must be mindful of many related phenomena when planning response efforts. First, the timing of the initial episode of several psychiatric disorders often occurs at an age that overlaps with entry into post-secondary schools (Choy, Horn, Nunez, & Chen, 2000). Second, a contributing factor to this pattern is that situations associated with the emergence of mental health conditions are common in higher education (e.g., financial pressures, loneliness, relational conflicts, etc.) (Andrews & Wilding, 2004; Bartlett, 2014). Third, the presence of a mental health disorder appears to interrupt academic persistence and graduation (Holmes et al., 2011). Fourth, Canadians, aged 15 to 24 years, are the most likely demographic to display mental health conditions such as mood, anxiety, and personality disorders; substance dependence; schizophrenia and psychosis; and suicidal propensities (Statistics Canada, 2003). Lastly, there is a paucity of information about how universities and colleges are putting evidence-based approaches into practice at their own

institutions (MacKean, 2011). Both the RCCAAT study participants and the literature furnished some direction in these areas.

These challenges cannot be overcome, said the RCCAAT leaders, unless everyone is “on the same page.” In many ways, the college seemed to have the prime attributes and structures for formulating a cohesive mental health policy. It had taken great pains to nurture a healthy campus ambiance. Shared responsibility, collaboration, and informal community alliances were solidly embraced. The college had also begun to evaluate the effectiveness of various policies and practices to promote a more data-driven decision-making process. Locating RCCAAT champions who modelled positive attitudes towards skill development and possessed extensive knowledge about campus services had also been highlighted as a worthwhile strategy. To further improve awareness and alter professional behaviours and attitudes, the college must more intently train potential “change agents.” Finally, the study participants imparted the virtues of working with community agencies but acknowledged that formalized partnerships had not been cemented.

Although a comprehensive mental health policy involves many moving parts, forming seamless linkages between post-secondary institutions and external mental health organizations has been recognized as one of the main tactics for removing service barriers (Cooke et al., 2015; Davidson et al., 2010; Royal College of Psychiatrists, London, 2011; Storrie et al., 2010). Others have argued that policy development might be augmented through “a ‘mental health-in-all-policies’ approach that consistently and systematically crosses sectors” (Canadian Policy Network, 2011, p. iv). As one RCCAAT participant stressed, “To really make change, it needs to

be policy driven at the provincial level” (P188). The literature has corroborated that “strong partnerships with government stakeholders and community mental health service providers are required . . . to support and enhance [interventions] for students with mental health issues” (Ministry of Health & Long Term Care, 2009, p. 19).

Another piece of policy development entails the delineation of a set of clear principles and preventative measures. More specifically, RCCAAT participants submitted that an effective mental health approach must include coordinated programs, adequate infrastructure, creative resource allocation, information dissemination, and suitable faculty training. This also involves expanding the focus to encompass the health of the entire campus community.

As outlined in Chapter 2, Olding and Yip (2014) organized mental health policies into two primary categories. Both have implications for serving post-secondary students with mental health impairments and disabilities. The two types are (a) policies that support individual students experiencing mental health issues (i.e., individual basis - accommodations, etc.) and (b) policies that broadly promote positive systemic mental health (i.e., universal basis - UDL, etc.). Notably, RCCAAT had developed a series of initiatives to address these aspects, but all of the relevant information had not been merged into one, comprehensive, all-inclusive document (i.e., consolidated policy or compendium of best practices). It is understood that any mental health policy must have a general structure but also be fashioned around the idiosyncrasies of the specific location. Given the diversity challenges in college contexts, it is doubtful that a single approach to improving mental health is the answer (MHCC, 2012). Nevertheless, mental health policy developers must recognize the key elements of an effective, comprehensive approach: the

interplay between achievement and mental health, the need for an inclusive campus philosophy, leadership and commitment for change, the provision of professional development experiences, increased information sharing aimed at a student audience, as well as the availability of internal and external mental health resources (Warwick et al., 2008). Based on my study findings and related literature, I believe that a college mental health policy at RCCAAT would galvanize its commitment to positive mental health, enhance an already very optimistic learning environment, and create boundless opportunity for student success. The college had many of the major “bits and pieces” already in place.

Summary of the Interpretation of Findings

The previous section included an interpretation of the results based on the study questions. The purpose of the study was to explore the perceptions of SAS leaders at RCCAAT in relation to the effectiveness of policies and practices that assist students with mental health impairments and disabilities (diagnosed and undiagnosed). The study participants identified three key areas for improvement at the college: (a) expand students’ awareness of mental health and the support alternatives; (b) build faculty’s knowledge of mental health, the accommodation process, and the available mental health services; and (c) introduce a college mental health policy centred on these knowledge-mobilization and capacity-building objectives. The study findings suggest that the RCCAAT leaders viewed the development of contextual understanding, the college culture, people and supports, and the organization as chief priorities for ensuring student learning, success, and positive mental health.

Finally, the present research upholds the idea that Canadian post-secondary schools must anticipate and adapt to the ebb and flow of inevitable change, particularly in the area of mental health (MacKean, 2011). Participants in this study seemed to embody this flexible orientation. RCCAAT's leadership and institution-wide dedication to creating an inclusive culture where all students could succeed were obvious. This is essential given the steeply growing challenges. Acknowledging the severity of the problem, enhancing students' mental health literacy and knowledge about relevant resources, improving faculty proficiency in supporting students, strengthening links to community agencies, and devising a comprehensive mental health policy were regarded as necessary steps.

One unexpected result in this study related to the universality of the leaders' perspectives about RCCAAT's vision for students and its approach to mental health. I had wrongly hypothesized that that opinions among the three types of leaders (i.e., senior, middle, front-line) would differ. This assumption was based on Kouzes and Posner's (2009) work indicating that a fundamental determinant of success in any large-scale school change initiative, and the most difficult to achieve, is the "thoughtful creation and formal acceptance of a shared vision." What I discovered at RCCAAT was a group of participants who professed an unflinching commitment to its key goal: student success. Without exception, every participant acknowledged the college's continual attempts to build an educational atmosphere wherein all students could be successful, including those with mental health impairments and disabilities.

Chapter 6. Conclusions

The chapter presents the conclusions of the study. I provide a brief summary of the purpose, research problem, results, and links to previous literature. This section includes final conclusions, recommendations based on the findings, suggestions for future research, and implications. The challenges associated with case study and researcher reflections are also described.

Many students enter post-secondary schools with mental health conditions and require a continuum of resources to promote learning and success. It is generally accepted that there are gaps in services devoted to helping these individuals (CACUSS & CMHA, 2013; Cooke et al., 2015; MacKean, 2011). Therefore, a better understanding of existing mental health support structures, procedural flaws, and redundancies is imperative before meaningful improvements can be introduced.

The purpose of this single qualitative case study was to explore the perceptions of student affairs and services (SAS) leaders in relation to the effectiveness of policies and practices that assist college students with diagnosed and undiagnosed mental health impairments and disabilities. I spoke to professionals who oversaw, developed, and implemented programming for students at one college in Ontario: Resiliency Community College of Applied Arts and Technology (RCCAAT). Specifically, my research covered three primary areas. First, I examined how the SAS leaders conceptualized mental health. Second, I probed the policies and practices they perceived to be most effective. Finally, I considered the gaps in services and supports, as these professionals understood them. This research was guided by a constructivist-

interpretivist paradigm and an inclusive, holistic approach to disability. Lincoln and Guba's (1985) benchmarks were applied in data collection and analysis to strengthen trustworthiness. Both the data generation and analyses processes were filtered through my personal lens and experiences. Accordingly, I recognize that my interpretations may be biased.

Final Conclusions Drawn from the Findings

The conclusions drawn from this study revolve around the research questions and the findings. The study participants highlighted numerous interrelated features and intervention strategies that could positively affect mental health and academic performance. Notably, there were visible connections between the effectiveness of various institutional structures and development in four core areas: (a) contextual understanding, (b) the college culture, (c) people and supports, and (d) organizational factors. Based on my findings, several conclusions can be drawn. These key considerations give rise to the recommendations that are detailed later in this section.

The first major finding of this study was supported by all of the participants. The RCCAAT leaders felt that they were unable to meet all student needs due to the increasing complexity and prevalence of mental health conditions. Put simply, the college could not do it alone. The diversity of the population, coupled with improved accessibility for under-represented groups, had created additional stress on both campus and community support personnel who were already overextended (e.g., counselling wait lists, etc.). Inadequate staffing, under-resourcing, and fiscal strains had also magnified the shortfall. It was expected that this trend would continue. Thus, the existing institutional structures were insufficient in terms of detecting

students in difficulty and then meeting their demand for assistance. Based on this finding, it can be concluded that RCCAAT service providers must adopt a different approach to handle the intensification of mental health needs on campus. This conclusion is well founded given the cluster of risk factors associated with the higher education experience. First, students have reported that mental health issues unfavourably affect their learning and success (Holmes et al., 2011). Second, many individuals with mental health impairments and disabilities are attending post-secondary schools (Bartlett, 2014; Gallagher, 2012, 2014). Third, psychotropic medications are being prescribed to more young adults (Gallagher, 2012). Fourth, students are reaching out to service providers with greater frequency (MacKean, 2011). Fifth, college-aged learners are subjected to taxing conditions that contribute to vulnerability for psychopathological disorders (NEADS, 2010). Lastly, without timely support, students may dropout, engage in unsafe activities, or possibly take their own lives (Cook, 2007; Gruttadaro & Crudo, 2012). It can be further presumed that increased focus on improving service provision is vital because the number of those requiring supports is projected to swell. My study findings suggest that SAS leaders had a genuine desire to better align mental health resources with the emerging needs at RCCAAT. Early identification of at-risk students and proactive intervention could significantly reduce potential harms for affected individuals.

The second major finding of this study was supported by all of the participants. The leaders agreed that mental health policies and practices must be responsive to individual and collective needs and driven by a student-centred, contextually specific approach and shared commitment to success. These assumptions were based on the understanding that learning,

health, and the campus climate are all intertwined. A conclusion that can be drawn from this finding is that the creation of a healthy environment, that is conducive to both psychological and academic growth, requires concerted effort from all college constituents. Similarly, an effective mental health approach must be holistic, jointly promoted, and include planning and decision-making that balances the needs of individuals and the campus at large. It can be further surmised that student success cannot be fully achieved without the active participation of multiple sectors of the school community who are all fixed on a common set of goals. Given the dynamic nature of mental health and rising pressures on the support system, an expansive, flexible repertoire of strategies must be developed to purposely funnel limited resources to areas of greatest need. It can be further reasoned that RCCAAT students are most appropriately assisted when service providers use an inclusive, proactive, coordinated approach that removes obstacles and increases access to a level of support matched to their specific learning challenges.

The third major finding of this study was supported by most of the RCCAAT participants. They indicated that some students and faculty demonstrated poor mental health literacy. SAS leaders can play a significant role in filling this void by introducing preventive and promotional measures that are empirically driven and determined through local evaluation and accountability procedures. Based on this finding, the conclusion that can be drawn is that some institutional barriers were evident in a small fraction of the RCCAAT community. To diminish the negative impacts, SAS professionals must continue to introduce rigorous awareness-raising, anti-stigma, and outreach campaigns; enhance the efficiency and use of technology as an information-sharing source; and advance knowledge mobilization and capacity building through

diverse, accessible platforms. It can be further argued that an expanded approach to disseminating information is needed to develop students' mental health literacy. Therefore, the college should engage in more robust initiatives using tools that appeal to learners' information-seeking preferences. Students must be adequately informed about the effects of mental health conditions and the variety of campus resources that are designed to facilitate their learning and success. It is logical to conclude that the advocacy role of SAS professionals lends itself well to correcting these areas of concern by monitoring the effectiveness of academic accommodations, accessibility, and assessment protocols; services and technology; and information-sharing and capacity-building endeavours. Redundancies and gaps must be identified to ensure skillful use of scarce mental health supports.

Based on the RCCAAT study findings, it was also suggested that some professors lacked understanding of the mental health accommodation process and how to meaningfully respond to acute crises in the classroom, even though assorted in-servicing opportunities were within reach. The conclusion that can be drawn from this finding is that current staff development and awareness-raising programs were not fully aligned with instructors' needs; some faculty were ill-equipped to teach students who had mental health conditions. More time and resources should be allocated to assist part-timers in particular. The leaders felt that the college must also continue to focus on dispelling myths and imparting knowledge efficiently and consistently. To achieve these objectives, training experiences and mental health materials should be re-engineered to improve access for both target audiences (i.e., students, faculty).

The fourth major finding of this study was supported by most of the SAS leaders. They

indicated that the lack of a cohesive, comprehensive mental health policy acted as a barrier to meeting students' needs. A conclusion that can be drawn from this finding is that, in the absence of a clearly articulated policy, "things will be missed" and some individuals will be adversely affected. It can be further assumed that despite the many good practices and projects on campus, RCCAAT's response inventory had obvious gaps. The college was still grappling with fully defining its role and responsibilities, yet seemed ready to propel the mental health agenda forward. Most of the study participants recognized that without a campus policy, processes would continue to be fractured and only partially understood. Therefore, students' mental health needs could not be sufficiently managed under the present conditions.

According to the RCCAAT leaders, the development of a comprehensive campus policy would curtail fragmentation and streamline the support process. Research has confirmed that an effective mental health framework must contain several key components to facilitate academic, social, psychological, and emotional growth (CACUSS & CMHA, 2013). Hence, RCCAAT's policy should include clear directives in the following areas: (a) student and faculty knowledge of mental health services and accommodation procedures; (b) identification of vulnerable students transitioning into the college; (c) formalized partnerships with external agencies to support acute mental health needs; (d) efficient deployment of mental health resources, (e) access to counselling; (f) coordination between college, community, and government mental health goals; (g) use of technology in the support process; and (h) mechanisms to measure the effectiveness of programs so that initiatives that are most helpful to the entire student body can be adequately resourced. The institution's commitment to mental health should also infuse all

policy development efforts. I believe that RCCAAT's holistic, inclusive orientation towards service delivery and its "culture of care" philosophy definitely provide the foundation upon which a comprehensive mental health policy could be built.

Based on the study findings, one could speculate that communication, knowledge exchange, and common understandings of mental health are fundamental elements for improving student participation and access to services and supports. Similarly, students' needs at RCCAAT cannot be proficiently addressed unless greater attention is cast on building internal capacity, particularly for part-time faculty. The roles and responsibilities of support personnel must be explicitly delineated to strengthen preventive and promotional programming. Community partnerships and research were also viewed as important adjuncts for pursuing additional staff development and information-sharing opportunities.

Recommendations Based on the Findings

I have concluded that mental health impairments and disabilities are very common — many students arrive at RCCAAT with existing conditions. This is significant because mental health is an integral variable in learning and success. But there are other issues that slow efforts to meet students' academic, psychological, and social needs. These include stigma, resource shortages, fragmented service delivery, inadequate information dissemination and capacity building, ill-defined community alliances, poor help seeking, and the lack of a cohesive mental health policy. SAS professionals play a decisive role in helping to tackle these deficiencies.

Service providers will be unable to meet students' escalating needs unless changes are made to RCCAAT's support processes. As a whole, the leaders acknowledged that developing

contextual understanding, the college culture, people and supports, and organizational structures must be further pursued. Development in these areas will promote increased learning, success, and positive mental health. I believe that a comprehensive mental health policy would streamline college services and add to an already very constructive approach to serving students in the RCCAAT school community.

The following recommendations are based on the findings, analyses, and conclusions of the study. The research results indicate that a broad menu of policies and practices is required to deal with the rising incidence and complexity of mental health problems on campus; students' needs are not being fully met. Though not exhaustive, several suggestions are provided to rectify this gap. I propose that RCCAAT's leaders should continue to build mental health programming around inclusive, student-centred approaches, uphold accessibility to college programs and services as a key priority; and promote relationship and team building among faculty and SAS professionals. Given the study findings, these areas may be worth exploring more extensively.

Capacity building and knowledge mobilization. College leaders should:

- Consistently spread the message campus wide that mental health is part of overall health
- Improve information dissemination mechanisms targeting the student population
- Consider introducing mandatory mental health in-servicing for all new professors
- Institute more accessible training vehicles for part-time faculty
- Systematically identify “champions” on campus to build capacity (e.g., SSAs, etc.)
- More aggressively promote UDL as a tool that benefits everyone
- Continue to engage in research projects with other institutions and share knowledge

Preventative measures. College leaders should:

- Systematically flag at-risk students by developing or refining existing screening tools (e.g., Year One, first-generation, Aboriginal students)
- Provide additional stress-reduction programs as part of the orientation process
- Include mental health information more broadly in college communications
- Prioritize preventive activities (e.g., improve help-seeking and stigma-reduction programming; increase availability of *ASIST* and gatekeeper training)

Use of technology. College leaders should:

- Continue to more fully explore the benefits of technology as an information-sharing and support mechanism (e.g., online counselling, communication, networking, awareness raising, screening instrument, etc.)
- More deliberately elicit the perspectives and opinions of students (with lived experience) about mental health in general and their interactions with service providers and faculty

Resource allocation and monitoring program effectiveness. College leaders should:

- Engage in ongoing monitoring and evaluation of existing services (e.g., consolidate if appropriate, reduce redundancy, funnel resources to areas of greatest impact)
- Reconfigure existing resources and increase supports devoted to counselling in particular
- Continue to pursue government funding opportunities (*Mental Health Innovation Fund*)

Community alliances. College leaders should:

- Solidify partnerships with community service providers to ensure that resources and expertise are shared and coordinated more efficiently

Policy development. College leaders should:

- Spearhead the development of RCCAAT’s mental health policy (e.g., clarify mental health accommodations and services, coordinate and streamline processes, etc.)
- Consider adopting a case manager model to oversee situations involving students with acute care needs (e.g., hospitalization)
- Consider the possibility that the student association defray costs of intensive therapy in the school fees so that support can be universally accessed by anyone in crisis

Suggestions for Future Research

Given the findings and limitations of this research, a number of topics could be considered for future study. One area that warrants further exploration relates to the mental health needs of certain student groups. Only a few participants mentioned the challenges associated with servicing those who were affiliated with the following populations: LGBTQ, new Canadians (i.e., immigrants, refugees), Aboriginal, military, first-generation, and international students. The literature has suggested that these learners present with unique mental health conditions and trauma-based anxieties that may require alternate support measures (CACUSS & CMHA, 2013; Daniels & Geiger, 2010; Hyun, Quinn, Madon, & Lustig, 2007; Queen & Lewis, 2014; Standing Senate Committee on Social Affairs, Science & Technology, 2011).

The design of this study precluded the identification of difficulties relative to those with “lived experience.” Nevertheless, the Mental Health Commission of Canada (2012) has stipulated that involving these individuals in research is particularly relevant for upgrading anti-

stigma programming. Quantitative and qualitative research should be conducted to elicit the viewpoints of college students who have accessed mental health services to determine the perceived effectiveness of the accommodation process, supportive resources, and knowledge mobilization mechanisms that are employed on campus.

This study explored the opinions of only 17 SAS leaders. Thus, I cannot rule out the possibility that some issues were disregarded. To obtain a fuller picture of the mental health landscape at RCCAAT, it would be advisable to determine the views of faculty and other campus constituents for comparative analysis. This data, blended with evidence collected from students, would provide researchers and post-secondary leaders with a far more complete appraisal of the services and supports devoted to those with mental health conditions.

As noted herein, several participants spoke about the challenges linked to accommodating students with schizophrenia and co-morbid disabilities. The literature has indicated, for example, that there is a sizable degree of co-occurrence among alcohol dependence, PTSD, and depression (Anthenelli, 2010; Cranford et al., 2009; McCulloch, 2006; OHRC, 2014; Ontario Ministry of Health & Long-term Care, 2009). This may be an area of research that should be pursued because more students are struggling with addictions and mental health. There is also a higher prevalence of alcohol abuse on college campuses (Hunt & Eisenberg, 2010; MacKean, 2011; OHRC, 2014). In addition, schizophrenia was mentioned as a key concern by 76% of the RCCAAT participants. Focused awareness raising and training may be necessary to more adequately support this specific demographic.

Lastly, given the dearth of empirical evidence about how Canadian post-secondary schools are developing their own mental health policies, it would be interesting to participate in a large-scale, multi-site study involving all the colleges in Ontario. Although policies must reflect the special properties and circumstances of each institution and be based on a thorough diagnosis of local needs, it is possible that knowledge gained from one location could have some value to other policy developers, college leaders, and mental health advocates.

Implications

Mental disorders are a leading cause of disability in Canada (MHCC, 2014). Likewise, an increasing number of students are enrolling in post-secondary schools with historic mental health conditions and require supportive services. Ontario's prescription for action, however, at the policy and practical level is insufficiently developed (Canadian Mental Health Association, Ontario, 2014; Cooke et al., 2015). Moreover, research about the perceptions of Canadian SAS leaders in relation to the effectiveness of mental health policies and practices is still in its infancy.

My research will guide policy and practice by providing new information to those who are driving change at the college level. Scholars, policy makers, and other SAS practitioners will acquire greater understanding about how to implement interventions and establish inclusive, holistic mental health frameworks and approaches. Additional knowledge will translate into changes in attitudes and behaviours and facilitate the creation of innovative awareness-raising, stigma-reduction, and capacity-building programs that make a difference for students. This study has suggested enhancements to practice and will further inform mental health policy debates.

These findings will be of value to the study site because the recommendations for improvement originated from some of RCCAAT's student services leaders. SAS professionals have been recognized as playing a pivotal role in accentuating the urgency of mental health problems in post-secondary settings (Patterson & Kline, 2008). They are also regarded as collaborative "bridge builders," change agents, and advocates who zealously advance the interests of students from various under-represented groups.

Therefore, this study will be of benefit to those who are responsible for implementing policies and practices aimed at students with mental health impairments and disabilities. Insights garnered from this research will help to fill some of the gaps in the Canadian-based literature and provide tangible direction for devising mental health programs and campus policies designed around the needs of college learners. On a broader scale, the findings from this case study suggest that mental health should remain at the top of the political agenda and be collectively pursued by multiple stakeholders at the institutional, community, provincial, and national level. More emphasis should also be placed on expanding knowledge-exchange and data-collection practices, heightening understanding of the social determinants of mental health, and formulating health-based policies that bestow the greatest advantage to the population as a whole.

Challenges of Case Study Research: What I Learned

For this case study, my goal was to document, analyze, and understand participants' perceptions in a way that led to a greater appreciation of the challenges linked to assisting RCCAAT students with mental health impairments and disabilities. Several problems had to be disentangled to appropriately address the study questions. First and foremost, I learned that case

study research is complex — it is not a neat and tidy process. Rather, it involved a steep learning curve and required a tremendous amount of intellectual effort, organization, and planning. The success of this study also depended on my ability to manage a large volume of data and ensure that pertinent information was not overlooked. It was difficult to analyze and interpret the evidence from the three sources and then weave the findings into a unified, convincing argument. This required considerable energy, perseverance, and dedication; it was labour intensive, time consuming, and fraught with angst, ambiguity, and missteps. Although my research was well planned, a high degree of flexibility was required throughout the life of the study. I realized that it was unrealistic to foresee all the twists and turns that would occur as the project unfolded and fully anticipate the outcomes — I had to accept that it was impossible to ascertain “ultimate truths.” It was also important for me to support my claims with sufficient evidentiary data and add something new to the mental health field. Notwithstanding, the results should be understood in the context of some limitations. I explored only those variables identified by the 17 leaders from RCCAAT. The findings and conclusions represent one interpretation of the collected evidence. Given the small sample size, my results are neither generalizable to every college, nor are they representative of all SAS personnel working in post-secondary schools.

Researcher Reflections: Personal Connection

As stated in Chapter 1, I have a personal connection with my topic. By undertaking this research, I wanted to know how post-secondary leaders were responding to the mounting challenges surrounding mental health among college students. Many lessons were learned through my interactions with the participants. I am incredibly appreciative that I had the

opportunity to speak with such a devoted and knowledgeable group of people. Their generosity, expertise, and candor contributed immeasurably to this study and my understanding of the difficulties that service providers confront in their attempts to support those who suffer with mental health conditions. Although I gleaned many insights about mental health and the various policies and practices that are designed to assist vulnerable students, I acknowledge that some questions have been left unanswered. Perhaps these will be addressed in future studies.

Ultimately, the SAS leaders provided a great deal of practical information that will help to guide others who are interested in more effectively supporting post-secondary students' mental health needs. It continues to be my hope that this research has faithfully reflected the participants' views, as well as spotlighted promising policies and practices for reducing harm and reversing some of the devastating effects of mental health impairments and disabilities.

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Appendix A. Interview Questions

1. How did you decide to come to the college?
2. What does your job entail? (*Probe: And your key responsibilities?*)
3. What things relate to mental health? (*Probe: Why are these important?*)
4. How do the departments work together to tackle mental health issues?
5. How do you get (mental health) information out to students? (*Probe: How do you get them to walk through your door?*)
6. Can you tell me about a mental health program on campus? (*Probe: Are there others?*)
7. How do you know that this program is making a difference? (*Probes: What helps students? What gets in the way? Are evaluation reports available?*)
8. What supports are needed to help students struggling with mental health?
9. Given the challenges that you mentioned, where do you see things going in the future? (*Probe: What should the college do?*)

Appendix B. Letter of Information and Informed Consent



Project Title: Mental Health Policies and Practices: Student Services Leaders Connect the Dots

Principal Investigator: Melody Viczko (Assistant Professor), Faculty of Education, Western University

Co-PI: Vicki Schwean (Dean, Professor), Faculty of Education, Western University

Student Investigator: Laurie Dodson (EdD student)

Letter of Information

You are being invited to participate in this research study about the perceptions of student affairs and services (SAS) leaders in relation to policies and practices that assist college students with mental health impairments and disabilities because, as a leader, you play a key role in facilitating student learning and success.

The purpose of this letter is to provide you with required information for you to make an informed decision regarding participation in this research.

The purpose of this study is to explore factors that SAS leaders perceive to most profoundly impact students with mental health conditions. SAS leaders' insights may help to identify policies and practices that not only enhance the psychosocial development and success of students, but also identify barriers that impede their participation. In order to gain a fuller picture of SAS leaders' perceptions and experiences, individual, semi-structured interviews will be conducted with various college professionals who provide a range of supports and services.

Individuals who meet the following inclusion criteria are eligible to participate in this study.

- Participants are involved in overseeing, developing, and/or implementing programs/services/policies for students with mental health conditions
- Participants agree to be audio recorded during the interviews.

Individuals will not be eligible to participate if they do not meet the criteria outlined above.

If you agree to participate, you will be asked to take part in one semi-structured interview. You must agree to have the interview audio recorded in order to participate in this study. It is anticipated that the entire task will take 50 to 75 minutes. The interviews will be conducted at the college site in a private location of your choosing. There will be up to 20 participants in this research. Each participant will be interviewed separately.

There are no known or anticipated risks or discomforts linked to participating in this study.

You may benefit from having the opportunity to reflect on your own practice and to provide input into a study that may benefit the college and society. The information gathered in this study may enhance understanding of policies and practices that assist college students with mental health impairments and disabilities. Your contributions may be of value to scholars, stakeholders, and other SAS practitioners in Ontario who work in student services and student success.

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions, or withdraw from the study at any time without consequence. You will not be compensated for your participation in this research.

All data collected will remain confidential and accessible only to the investigators of this study. If the results are published, neither your name nor the college's name will be used. If you choose to withdraw from this study, your data will be removed from the database and destroyed. All data collected in the study will be stored in a secure location to which only the research team may have access.

You will be provided with a copy of the transcript or summary from the recorded interview for your review in order to ensure that the information captures your intended meaning and that any identifying material has been removed from the document. This will be your final opportunity to withdraw from the study. Personnel, who will agree to abide by a confidentiality agreement, may transcribe interview transcripts. Representatives from the Western University's Non-Medical Research Ethics Board may contact you or require access to your study records to monitor the conduct of the research.

Although your college and the University of Western Ontario have granted approval for this study, you are under no obligation to participate. Refusal to participate will have no impact whatsoever on your employment status. You may withdraw from the study at any time.

If you require further information regarding this research project or your participation in the study, you may contact the student investigator, Laurie Dodson, [REDACTED]
[REDACTED] EdD supervisors Melody Viczko (Assistant Professor), Faculty of Education,
[REDACTED] Vicki Schwean (Dean, Professor), Faculty of
Education, [REDACTED]@uwo.ca.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact the Office of Research Ethics (519) 661-3036, email ethics@uwo.ca.

If the results of the study are published, your name will not be used. If you would like to receive a copy of any potential study results, please contact Laurie Dodson [REDACTED]
[REDACTED]

If you wish to participate in the study, please sign the attached Consent Form.

This letter is yours to keep for future reference.



Consent Form

Project Title: Mental Health Policies and Practices: Student Services Leaders Connect the Dots

Principal Investigator: Melody Viczko (Assistant Professor), Faculty of Education, Western University

Co-PI: Vicki Schwean (Dean, Professor), Faculty of Education, Western University

Student Investigator: Laurie Dodson (EdD student)

I have read the Letter of Information. The nature of the study has been explained to me. All questions have been answered to my satisfaction. I agree to participate.

Participant's Name (please print): _____

Participant's Signature: _____

Date: _____

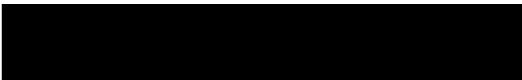
Appendix C. Email Script

Subject Line: Invitation to Participate in Research

You are invited to participate in a study that I, Laurie Dodson (student investigator), am conducting under the supervision of my co-advisors: Dr. Melody Viczko and Dr. Vicki Schwean. Briefly, the study involves a 50 to 75 minute interview. Please see the attached Letter of Information describing the research. If you would like more information, please contact the researchers listed below.

Thank you,

Researcher's name: Dr. Melody Viczko
Affiliation: Western University



Dean, Professor: Dr. Vicki Schwean
Affiliation: Western University



Student investigator: Laurie Dodson
Affiliation: Western University



Appendix D. Western University Ethics Approval



Western
Research

Research Ethics

Western University Health Science Research Ethics Board NMREB Delegated Initial Approval Notice

Principal Investigator: Prof. Melody Viczko
Department & Institution: Education, Western University

NMREB File Number: 106561

Study Title: Student Services Leadership: Perceived Effectiveness of Policies and Practices Targeting the Psychosocial Well-being of Students with Disabilities

Sponsor:

NMREB Initial Approval Date: April 24, 2015

NMREB Expiry Date: April 24, 2016

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Recruitment Items		2015/03/22
Instruments		2015/03/19
Revised Western University Protocol		2015/04/14
Revised Letter of Information & Consent		2015/04/14

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the above named study, as of the NMREB Initial Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.



delegated board member

Ethics Officer to Contact for Further Information

Erika Basile ebasile@uwo.ca	Grace Kelly grace.kelly@uwo.ca	Mina Mekhail mmekhail@uwo.ca	Vikki Tran vikki.tran@uwo.ca
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This is an official document. Please retain the original in your files.

Appendix E. College Ethics Approval

May 5, 2015

Principal Investigator: Laurie Dodson, Western University
Research Study: Student Services Leadership: Perceived Effectiveness of Policies and Practices Targeting the Psychosocial Well-being of Students with Disabilities [REDACTED] REB #2015-127LD

This application was subject to:

☐ Full Board Review ☒ Delegated Review

Dear Laurie:

I am writing to advise you that the Research Ethics Board (REB) of [REDACTED] has granted **Approval** to the above-named research study. Your research may now begin.

You have one year to complete the project from the time of approval. Should you require more time to complete your project, you will be required to submit a [Request for Continuation \(or Amendment\) of an Approved Project Form](#), in order to obtain ongoing ethics approval for your project. This must be submitted prior to REB approval expiry.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Both a Request for Amendment of an Approved Project form and [REDACTED] application must be submitted to the research office for review by the REB.

Any adverse or unanticipated events should be reported to the REB as soon as possible. The REB reserves the right to review your file at any time to ensure that research is being conducted in accordance with [REDACTED] policies.

Once your project is complete, you are required to complete a [Project Termination form](#). This form must be submitted as a final report about your research to the REB.

Best wishes for the successful completion of your project.

[REDACTED]
Alison Tucker
Chair, Research Ethics Board

Appendix F. Western University Continuing Ethics Approval Notice



Western University Non-Medical Research Ethics Board NMREB Annual Continuing Ethics Approval Notice

Date: April 20, 2016

Principal Investigator: Prof. Melody Viczko

Department & Institution: Education, Western University

NMREB File Number: 106561

Study Title: Student Services Leadership: Perceived Effectiveness of Policies and Practices Targeting the Psychosocial Well-being of Students with Disabilities

NMREB Renewal Due Date & NMREB Expiry Date:

Renewal Due -2017/03/31

Expiry Date -2017/04/24

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed the Continuing Ethics Review (CER) form and is re-issuing approval for the above noted study.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), Part 4 of the Natural Health Product Regulations, the Ontario Freedom of Information and Protection of Privacy Act (FIPPA, 1990), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Ethics Officer, on behalf of Dr. Riley Hinson, NMREB Chair

Ethics Officer to Contact for Further Information: Erika Basile ___ Katelyn Harris ☒ Nicole Kaniki ___ Grace Kelly ___ Vikki Tran ___

CURRICULUM VITAE

EDUCATIONAL HISTORY

Doctor of Education Thesis

Title: *Mental Health Policies and Practices: Students Services Leaders Connect the Dots*

Master of Education Thesis

Title: *The Effects of Using Technology to Enhance Student Ability to Read, Organize and Write Informative Text*

Doctor of Education	Western University	2016
Master of Education	University of Manitoba	2000
Bachelor of Education	Université Laval	1985
Bachelor of Arts	Université Laval	1984

Special Education Teacher's Certificate	Manitoba Education and Training	1994
Post-Baccalaureate Certificate in Education	University of Manitoba	1994

Additional Qualifications

AQ: Librarianship Part I	Nipissing University	2005
AQ: Special Education Part III	Nipissing University	2004
AQ: Computers in Classroom Part I	York University	1987

AQ: New Teacher Induction Program	College of Teachers	2006
AQ: Guidance Part I	College of Teachers (equivalency)	2002
AQ: ESL Part I	College of Teachers (equivalency)	2002
AQ: Special Education Part I	College of Teachers (equivalency)	2001
AQ: Special Education Part II	College of Teachers (equivalency)	2001

UNIVERSITY TEACHING

Instructor - Additional Qualification Courses	University of Ottawa & Queen's University	2002-08
<ul style="list-style-type: none">• English as a Second Language Part II• Reading Part I• Reading Part II• Reading Part III• Special Education Part I• Special Education Part II• Special Education Part III		

Instructor - Undergraduate Courses: University of Manitoba		1999-01
<ul style="list-style-type: none">• Reading in the Elementary - Faculty of Education• Reading in the Elementary - Faculty of Continuing Education		

PRESENTATIONS AND WORKSHOPS (2006-2011)

I received grants from the Ministry of Education and HPEDSB to facilitate the following projects:

- Assistive Technology Project - Initiative Based on the Principles of Universal Design: Making Textbooks Accessible to All Students
- “Think Indigenous” Two-Year Project - Initiative Aimed at Raising Awareness and Increasing Collaboration
- “StEEDS” - Learning with Horses Project - Initiative Targeting Learning for Special Education and COOP Students
- School-Community Yoga Project - Initiative Targeting Wellness for Students, Staff, and Community
- Assistive Technology Teacher Workshop - Implementing and Evaluating Classroom Use
- Professional Learning Community Initiative - Implementing and Evaluating Classroom Strategies for Students with Special Needs
- Special Education Learners and Instructional Practice - Establishing Effective Classroom Procedures
- Tailoring Individual Education Plans (IEPs) - Workshops for Teachers
- Continuous Assessment: Informing Our Practice - Workshop for Teachers
- Team-Building Workshop for Teaching Staff, Child and Youth Counsellor and Special Education Department
- Special Education Department Head and Child and Youth Counsellor – Grade 8 Transition-Home Visits
- Staff-Selected Topics - Professional Development Workshops for Teachers and Educational Assistants:
 - Autism Spectrum Disorders
 - Inclusion of Special Education - Student-Credit Accumulation
 - Blind/Low Vision - Instructional and Assessment Adaptations
 - Test Development and Test Taking Skills
 - Hearing Impairment and Learning
 - Language Disorders and Auditory Processing
 - Mild Intellectual Disorders
 - LD Learners and Academic Success
 - Differentiated Instruction and Accommodations/Modifications
 - Behavioural Disorders and Anxiety (Self-Esteem and Mental Health Considerations)
 - Overcoming Reading Disabilities
 - Overcoming Writing Disabilities
 - Assistive Technologies as Tools to Support Learning

CAREER HISTORY

- | | |
|------------|--|
| 2005-2016 | Hastings-Prince Edward District School Board (HPEDSB) - Bancroft, Ontario <ul style="list-style-type: none">• Interdepartmental Special Education Head (Grades 9-12) |
| 2001- 2005 | Ottawa-Carleton District School Board (OCDSB) - Ottawa, Ontario (K-12) <ul style="list-style-type: none">• Teacher-Librarian• General Learning Program (GLP)• Special Education Resource Teacher |

- 1993-2001 Assiniboine South School Division No. 3 - Winnipeg, Manitoba (K-12)
- English as a Second Language
 - French Immersion/English Resource Teacher
 - Counsellor
 - Reading Specialist - Modified & Individualized Programs
- 1992-1993 Winnipeg School Division No. 1 - Winnipeg, Manitoba (K – 6)
- English as a Second Language
 - Language Arts
 - French Immersion Resource Teacher
- 1991-1992 Avon Protestant School District No. 5 - St. Paul, Alberta (Grades 5-9)
- Core French
 - Special Education
 - Visual Arts Teacher
- 1987-1991 Victoria County Board of Education - Lindsay, Ontario (K - 8)
- Core French
 - Special Education Teacher
- 1985-1986 Thibault Roman Catholic Public School District No. 35 - Morinville, Alberta (Grades 7-12)
- Core and Immersion French
 - Physical Education
 - Social Studies Teacher
- 1983-1985 Tilly Regional School Board - Ste-Foy, Quebec
- English as a Second Language Monitor

VOLUNTEER EXPERIENCE

- Bancroft Switchyard Youth Centre
- Bancroft Food Bank Board
- LINC Program (ESL for adults), Ottawa-Carleton District School Board
- Project Overseas, Canadian Teachers' Federation, In-Service Training Workshop (St. Vincent, West Indies)
- Adult ESL Centre - Winnipeg #1 School Division
- Volunteer English Practice Program, International Students' Centre, University of Manitoba