A Person First:
A Workshop to Help Teens Support Friends with Mental Problems

By

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ABSTRACT

The author of this study, a First Nations teacher, has designed a culturally sensitive workshop for northern youth addressing mental health concerns. The ten hour workshop, entitled *A Person First!,* will encourage youth to consider the harmful impact of stigma on people who have mental health issues. The need for a workshop that appeals specifically to First Nations youth is evident in Yukon and in other northern communities, currently there is a lack of culturally relevant workshops that addresses mental health issues in remote northern communities. A Person First! Is geared towards First Nations learners and will be presented n the context of the cultural beliefs systems within their own communities. The author has presented a leader's guide for local facilitators that includes instructions for the use of video clips, circle discussions, and a self-reflection tool based on the Medicine Wheel. The workshop design, supported by research, recommends community education to promote youth resilience through stigma reduction and peer support. As community-based education, this workshop was designed to stimulate transformative change in youth thinking and behavior so that peers experiencing mental health issues will experience a supportive environment.

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Finally to my children and partner for their continual support through my personal journey in the entirety of my education, keeping me smiling, and feeling loved. I will be forever grateful to everyone involved.

GLOSSARY

I have provided this glossary so that readers will share my understanding of terms that have important and specific meanings relevant to this study. Although mental health can be considered a medical issue, I have not sought out technical medical definitions. Instead, I have defined terms and concepts so that they will be accessible to a general audience. Wherever possible, I have supported my definitions with references from the literature I have reviewed.

circle is an important concept in Aboriginal or First Nations cultures, as described by my late father:

> The circle has great healing power, because when in the circle no one is behind you. No one is in front of you. No one is above you. In the circle no one person is better or higher than you. Everyone is equal. That is why the First Nations People across the world use the circle whenever they can to explain, demonstrate, or perform daily functions in their lives. (Edzerza, 2008)

I have chosen to capitalize *Circle* and *Talking Circle* to show respect for the tradition of speaking in turn while passing an object of significance to identify the speaker. The Talking Circle is the main means of communication used by participants in this workshop.

coping "is one of the primary processes through which resilient outcomes are achieved" (Lerner & Steinberg 2004 p. 289).

constructivism Fosnot (2005) asserted that social constructivism is not a theory of teaching but a theory of learning with implications for teaching:

> Learning from this perspective is viewed as a self-regulatory process of struggling with the conflict between existing personal models of the world and discrepant new insights, constructing new representations and models of reality as a human meaning-making venture with culturally developed tools and symbols, and further negotiating such meaning through cooperative social activity, discourse, and debate in communities of practice. (Fosnot, 2005, Preface, location 85)

Fosnot also explained that an approach to teaching based on constructivism "gives learners the opportunity for concrete, contextually meaningful experience through which they can search for patterns; raise questions; and model, interpret, and defend their strategies and ideas" Fosnot, 2005, Preface, location 92).

dysthymic disorder is described by the medical profession chronic depression, regularly low moods. This type of depression is not as severe as major depression (A.D.A.M, 2012).

mental illness is a disturbance in thoughts and emotions that decreases a person's capacity to cope with the challenges of everyday life (TAMI, p. 47).

mental health support is the term that I use in this project to describe the positive attitudes and actions of peers as they interact with youth who have experienced mental illness themselves or in their families. As opposed to *stigma*, mental health support has a positive effect on the receiver, in terms of well-being.

mental health literacy combines knowledge of mental disorders with skills to recognize when to contact health professionals and how to manage the situation until professional help is received. This term is used in the Mental Health First Aid (MHFA) training programs that have spread internationally from Australia (Mental Health Commission of Canada, 2011).

An **outreach counselor** advocates for students and parents on an individual needs basis, and encourages and maintains positive communication between students, families, teachers, and staff within the school and other agencies as required.

A **peer** is "someone who is either a co-worker or a person who works in a similar organizational background, or someone of the same generation or cultural

background who has suffered the effects of mental illness" (Mental Health Commission of Canada, 2010, p. 1).

resilience has been defined as "the positive end of the development continuum that occurs for children who experience both acute and chronic exposure to stressors like poverty, abuse, war, violence, neglect, drug addictions, mental illness, disability, marginalization, racism, and myriad of other ways their well being is threatened" (Liebenberg & Ungar, 2009, p. 3).

stigma is a fear based response that comes from a lack of understanding and is damaging to the receiver. Hinshaw (2007). defined stigma as "a term conveying a deep, shameful mark or flaw related to being a member of a group that is devalued by the social mainstream" (p. xi).

traditional medicine wheel is a concept of health and wellbeing symbolized by a circular pattern that represents the four areas of life: physical, emotional, mental, and spiritual, originating with plains and western First Nations (National Aboriginal Health Organization, 2005, p. 20). The UMAY (2008) youth organization has described the medicine wheel as a self reflection tool that provides youth with a visual representation of their own attitudes, community values, and personal perceptions.

transformative learning: transformative learning is "a critical dimension of learning in adulthood that enables [learners] to recognize, reassess, and modify the structures of assumptions and expectations that frame…tacit points of view and influence …thinking, beliefs, attitudes, and actions" (Mezirow, 2009, p. 18). Transformative learning theory results in "an approach to teaching based on

promoting change, where educators challenge learners to critically question and assess the integrity of their deeply held assumptions about how they relate to the world around them" (Mezirow & Taylor, 2009, location 202). Although transformative learning was developed to describe the learning process for adults, Merriam and Bierema (2014) have suggested that transformative learning can be an alternate perspective of learning for children and youth, as it is in this study.

understanding: I use the word *understanding* to describe a combination of knowledge about a topic, such as a mental disorder, with developing empathy for what someone with that disorder might be experiencing. *Understanding* seems a more appropriate term than *knowledge* for a program that aspires to build empathy as the foundation of stigma reduction. Understanding is also a part of the constructivist, meaning making approach that Wiggins and McTighe (2011) identify in their term, *understanding by design.*

understanding by design: *Teaching for understanding*, like *backward mapping*, is a central premise of the approach to planning and instruction advocated by Wiggins and McTighe (2011) and known and trademarked as *Understanding by Design* or *UbD*. Students should be able to describe the goals or *big ideas* of a unit or course. They should understand how facts or knowledge items fit together to contribute to these big ideas, for example, in terms of the workshop designed in this study, how the experiences of a many different young people featured in the videos all contribute to the big idea that stigmatizing those with mental illness is harmful to their recovery.

CHAPTER I: THE NEED FOR COMMUNITY EDUCATION

> *I'm a person first and I'm a diagnosis second. And that's the message I wish I had been able to convey when I was younger, when I was very much being treated as a problem, not a person with a problem.*
>
> – *Stella Ducklow* (IWK Health Centre, 2012).

There is a growing need for community education, specifically for youth, about the stigma and discrimination related to mental health. Current research indicates that peer supports from friends, family, and relatives helps develop resilience – these relationships are important for regaining and sustaining mental health. For example, one study concluded that "peer support is an important element in the recovery of persons with mental illness" (Verhaeghe, Bracke, & Bruynooghe, 2008, p. 208). Someone experiencing mental illness with peer support and without stigma will be thought of *as a person first*, rather than as someone identified by an illness. It is particularly important to develop these attitudes in small, northern communities where supportive resources are lacking and culturally relevant mental health education is needed.

In this study I have designed a cross-cultural workshop to encourage Yukon youth in their mid to late teens to think about the harm that occurs when people with mental problems are stigmatized and how they might increase *mental health support* among their peer group. Ideally, this workshop would be delivered by local facilitators who know their communities well. My vision is that locally delivered workshops will contribute to a peer group that will support rather than stigmatize youth who have experienced mental problems or more severe mental illness.

I designed the ten hour workshop, entitled *A Person First!* to encourage self-reflection by youth participants at the beginning and end of the program, using a culturally appropriate Medicine Wheel activity. Other learning activities outlined in the *A Person First!* leader's guide (see Appendix A) are circle discussions, brainstorming, and small group collaboration in

response to YouTube video clips that portray the faces and voices of youth living with mental illness as well as those of parents and health professionals. There are also dramatizations that carry a message about the injustice of labeling people with disabilities with the name of their problem rather than thinking of them as *a person first.*

Participating youth will be encouraged to generate ideas for strategies that may help their peer group and community become more inclusive and stigma-free. At the conclusion of the workshop, the final medicine wheel self-reflection will invite youth who attend the workshop to notice how their thinking has changed over the ten hours. These self-assessments will be useful to group leaders, who can use them to consider the effectiveness, or transformative power, of each workshop. The workshop will be considered successful when the teens describe changes in their beliefs and attitudes that are likely to lead to more positive behavior toward peers and others with mental problems.

Purpose

This purpose of this study was to design a workshop to build more understanding and supportive peer groups for northern youth experiencing mental illness. My goal was to provide a culturally relevant and transformative learning experience for Yukon youth that could be delivered by community facilitators. The program that I have designed may be offered by teachers during school hours or as an extra-curricular activity. However, in small northern communities it is often the local residents who have unique understanding of community needs and may be ideal facilitators for this workshop, offered as a community resource. Therefore, I have presented the workshop in the form of a leader's guide. Ideally, I would gather a group of program leaders and work through this guide with them, actually viewing the videos recommended for the program and participating in the learning activities together. However, in

some situations, this pre-training for leaders may not be possible and so I have tried to write the leader's guide in clear language so that community facilitators could use it on their own. The qualifications necessary for group leaders, are that they have in-depth understanding of the culture and needs within the community, First Nations teaching of the medicine wheel, awareness of current mental health issues, experience working with youth.

The workshop has been based on three assumptions that I have drawn from the mental illness or mental health literature:

1) peer group education can be an important key to sustainable improvement for the mental wellbeing of Yukon youth and mental health consumers,
2) taking a proactive approach to educate youth on mental illness may reduce stigma and discrimination towards those requiring mental health services, and
3) having experienced mental health education, people may eventually become more comfortable speaking out about mental illness and protecting services that are needed for those living with mental illness.

Research Questions

I focused my design of the *A Person First!* workshop with a central research question: *What learning outcomes, instructional methods, and assessment strategies are appropriate for a mental health support guide/manual that has potential to contribute to stigma reduction for northern youth who have experienced mental illness?*

This overall question led to three more specific questions that I considered as I designed the workshop:

1. *What outcomes will describe the desired learning clearly?*
2. *What learning strategies will engage northern youth?*

3. *What assessment tools may reveal a resulting change in perceptions?*

Personal Connection to the Topic

My work as an educator has been in the public service sector, assisting underserved youth and families in both the justice and in the education systems. My duties have included advocating for families who require extra health care not covered under the public health care system, arranging supported living for people with fetal alcohol spectrum disorders (FASD), and working with youth who required alternative schooling or living arrangements. Part of my role has been providing education to families about the justice system supports available and about the education system. As a prior vice-principal and outreach counselor at an elementary school in Whitehorse, Yukon, I assisted with administrative duties and acted as an advocate for families, children, and adolescents. I worked directly with families that have children with cognitive disabilities and mental disorders as well as children who require extra support in the area of self esteem. I supported parents who are reluctant participants in the school due to their own historical experiences, for example residential schools. These experiences have made me well aware that a lack of education and understanding contributes to the fear that drives stigma and discrimination (Corrigan & Watson, 2002).

Recently, a member of my family experienced an episode of psychosis. At the time of the event I had no idea what was happening to him. I was inspired to research the topic of mental illness and adolescents at the *Kelty Mental Health Resource Centre* in Vancouver. This resource centre provides families with current mental health literature and mental health resources. I was fascinated by the topic and was driven to understand more. Since then, from personal experience, I have discovered that the Yukon lacks community support groups and educational resource centers for mental illness and that northern residents stand to benefit from locally-developed

resources. For example, in Vancouver there are parent support groups, evening youth groups, recreation groups for families supporting mentally ill members, programming for adults, and campaigns that focus on stigma reduction. This range of supports is not available in the Yukon, with its much smaller population and considerable distance from major treatment facilities.

Further, the higher proportion of First Nations people in northern communities makes it important to have culturally relevant support for families experiencing mental illness. Therefore, I recognized the acute need, in our northern city and in smaller communities in the territory, for additional mental health supports and resources for stigma reduction, particularly among youth. As a member of the Tahltan First Nation, I have woven my cultural understandings into the *A Person First!* workshop design, to make it suitable for a northern, cross-cultural environment.

I believe that my professional qualifications as well as the personal experience of mental illness in my own family have prepared me to contribute to the education of Yukon youth. I am eager to take steps to reduce the stigma and discrimination that individuals with mental problems or illness so often experience. I hope that this work will ultimately lead to additional resources and protection for underserved consumers of mental health services. As one of the six mindsets that Kaser and Halbert (2009) associated with change-oriented educational leadership, this *deep moral purpose* has given me the energy and commitment to initiate this solution to a local problem and see it through the planning stages. Throughout this process I have been inspired by the courage of my family member who has regained his mental health to become, as Fullan (2007) described it, an *agent of change* in our community.

The Need to Promote Resilience

In British Columbia, a study indicated a growing need for mental health services; for example, "Over 700,000 British Columbians, or 20% of the population of British Columbia, will

experience some form of mental illness in their lifetime" (Canadian Mental Health Association, 1999, p.1). And "of this number, approximately 70,000 people suffer from serious and persistent mental illness, which is profoundly disabling and requires extensive care" (Report of the Mental Health Monitoring Coalition of British Columbia, 2000, p.2). Across North America there is a growing movement in the community of professionals concerned with mental health to provide education to adolescents on mental health and mental illness issues.

Power (2010) reported that the National Research Council and the Institute of Medicine recently presented a road map to target interventions to strengthen individuals by building their *resilience*. Resilience has been defined as "the positive end of the development continuum that occurs for children who experience both acute and chronic exposure to stressors" (Liebenberg & Ungar, 2009, p. 3). It is important to distinguish between the terms *coping* and *resilience* to fully understand how peer support is a factor for youth experiencing mental illness. As Lerner and Steinberg (2004) stated, "the primary distinction is that coping refers to the process of and resilience is reflected in outcomes for which competence and coping have been effectively put into action in response to stress and adversity" (Lerner and Steinberg 2004, p. 289). Lerner and Steinberg concluded that "coping is an important process that can lead to resilient outcomes" (p. 276). Further, "coping efforts involve obtaining information, emotional support, tangible forms of help, and guidance from others. Sources of support for adolescents include parents, siblings, peers, teachers, and other significant adults in their lives" (Lerner & Steinberg, 2004, p. 276).

Mental Health and Canada's Aboriginal Population

As background for this study, it is important to note that a high percentage of First Nations people live with mental illness and alcohol and drug addiction in Yukon and across Canada. Reports indicate that historical and cultural trauma has contributed to the mental health

issues faced by many Aboriginal people today. For example researchers Kirmayer and Valaskakis (2008) reported:

> The origins of the elevated rates of mental and social distress found in many Aboriginal populations are not hard to discern. Aboriginal peoples in Canada have faced cultural oppression and social marginalization through the actions of European colonizers and their institutions since the earliest periods of contact. Culture contact brought with it many forms of depredation. (p. 526)

Health Canada (2007) also reported that "historical determinants, such as the legacy of residential schools, are believed to have shaped the mental health of Aboriginal people" (p. 1). In 2003, the Aboriginal Healing Foundation reported the high rate and nature of mental health issues for residential school survivors: "based on mental health literature on residential school survivors, the most commonly diagnosed disorder is *post traumatic stress disorder* (64.2 per cent), followed by *substance abuse disorder* (26.3 per cent), *major depression* (21.1 per cent) and *dysthymic disorder* (20 per cent)" (p. 50).

In this study I am not focusing on First Nations people exclusively – non-Aboriginal youth are also members of peer groups in northern communities. However, out of respect for my culture, I believe that it is important to acknowledge that mental illness exists disproportionately in this Canadian population because of historical cultural traumas. This observation supports my rationale for a culturally relevant approach to stigma reduction education in a community-based program.

Mental Health Needs in Yukon

Mental Health Statistics in Yukon and British Columbia are consistent with the numbers reported by Health Canada in 2002: approximately 20% of individuals will experience a mental illness during their lifetime and the remaining 80% will be affected by an illness in family members, friends or colleagues. A recent study in Yukon depicted a relatively high number of

mental health consumers, considering the small population of roughly 34,000. Westfall's (2010) study concluded that "in 2008-09 Mental Health Services received 302 referrals and saw 387 individual clients. In the same period, Whitehorse General Hospital had 278 patient admissions for psychiatric reasons, as well as 514 emergency assessments (no admission)" (Westfall, 2010, p. 1). This data may not accurately reflect Mental Health Services required by all mental health consumers in Yukon – only those who accessed the service.

In addition, to this recent local study there have been numerous articles in the Yukon newspapers about mental illness and growing public demands for additional mental health resources and education. Keevil (2011) reported that in spite of public outcry, the Yukon Territorial government had reduced funding for Mental Health Services. Although, the funding was later reinstated, the interim was described as stressful for those in Yukon requiring mental health services and for their families.

Chapter Summary

In this chapter I have posed a problem – the need for a cross-cultural mental health support workshop that can be delivered by local facilitators in Yukon communities. I have provided data to confirm the existence of this problem and to support my proposed solution. I have stated the research questions that helped me to focus on various aspects of the workshop design, such as intended outcomes, content, instructional strategies, and assessment. I have described the cultural and professional background that has prepared me to design the workshop and facilitator's guide as well as the personal experience that fuels my moral purpose as an educator and curriculum designer (Kaser & Halbert, 2009).

The remainder of this study is reported in chapter two, a literature review, and chapter three, which contains a description of the actual design process for the workshop as well as my

final reflections. The leader's manual for the *A Person First!* Workshop is presented, in the form that I will share with community facilitators, as a large appendix to the academic document (see Appendix A).

CHAPTER II: LITERATURE REVIEW

I drew on the literature that I reviewed for this study to inform my design of a mental health support workshop for Yukon adolescents, including intended outcomes, content, teaching and learning strategies, and assessment tools. In light of the purpose of this study and of the workshop, a literature review of technical medical articles would not have been helpful. Instead, I focused my review on articles written for a general audience. The literature featured here provided accessible concepts and terminology to help community facilitators build understanding through peer group education.

First, I reviewed the literature related to the notion of *resilience*, particularly as it applied to youth experiencing mental illness. Next, I explored the topic of shame or *stigma* associated with mental illness. In a section on model programs, I reviewed information about programs elsewhere, including focused or comprehensive programs based in schools or communities. Considering the cross-cultural aspect of the workshop, in this section I included the First Nations *Medicine Wheel* teachings, particularly the *Circle of Courage* (Brokenleg, Brendto, Van Bockern, 2001) work that demonstrates how youth can be empowered to reflect on their own lives through these cultural teachings. I identified the study as coming from a *social constructivist* view of learning that aims to bring about lasting, *transformative* change in the beliefs and attitudes of participating youth. Finally, I noted the source of practical steps for planning this kind of learning: the *understanding by design* framework by Wiggins and McTighe (2011). I used this framework to plan the workshop by first choosing learning outcomes, then identifying content and acceptable evidence of learning, and finally choosing and sequencing activities.

Toward Resilience for Youth Affected by Mental Illness

Resilience is the outcome that occurs when a youth has coped well with setbacks such as mental illness and regained social, emotional, and mental health. Resilience has been defined as "the positive end of the development continuum that occurs for children who experience both acute and chronic exposure to stressors like poverty, abuse, war, violence, neglect, drug addictions, mental illness, disability, marginalization, racism, and myriad of other ways their wellbeing is threatened" (Liebenberg & Ungar, 2009, p. 3). Current research suggests that "resilient function is not a static condition that exists wholly within the individual but rather reflects a transactional, dynamic set of processes inside and outside the person" (Hinshaw, 2007, p. 172). Hindshaw explained that there are at least three variables that promote resilient functioning: a) personal virtues, b) relationships, and c) broader social environments. A study conducted with vulnerable youth in Vancouver, British Columbia, found that the development of required protective factors from the outside, including family support, a healthy relationship with an adult outside the home, and positive friends, "were the 3 main protective factors that increased the likely hood of healthy development." (Murphy, Saewyc, & Chittenden, 2006, p. 15).

Protective Factors and Peer Support

Peer support is a vital protective factor that contributes to building resilience. Two types of peer support include: a) the importance of friends as social agents, and b) peer groups in the context of social training. According to the Public Health Agency of Canada, "friends are a protective factor against emotional and behavioral problems and having friends to talk to promotes emotional wellbeing" (Health Canada, 2011, p. 83). Support from peer groups, families, and the medical community is also an important protective factor for sustaining mental

health because "resilience always encompasses more than the individual and always reflects a process over time" (Luthar, 2003, p. 249). It is important to recognize that mental illness can hinder development, personally and socially: "the onset of psychosis disrupts the psychological development of an adolescent or a young adult" (COPE, 2002, p.12).

Peer and social groups have been established as a component of recovery for those living with mental illness. According to Luthar (2003), developing resilience is a process that occurs over time and requires contributions from a range of people. Support from families and peer groups is essential because, "without help, young adults with a mental illness may not develop the life skills, independence and self-confidence that they need for not only at this point of their lives, but also in the future" (Mental Health Canada, 2006, p. 39). It is common for those living with mental illness to find it challenging to develop friendships with others and they may even struggle with close relationships.

Peer social training is an important strategy used in the mental health field for helping those who have experienced mental illness improve their relations with others. This method "involves teaching people new and more effective skills for interacting" (Morey & Mueser, 2007, p. 124). Social training is commonly held in a safe group setting where "group leaders demonstrate skills by role play and then engage participants in role play to practice the skills"(Morey & Mueser, 2007, p. 125). In addition to social training, Morey and Mueser described the frequent encouragement of peer support to provide opportunities for young people to exchange experiences and offer support to others. Some examples of peer support groups are *Alcoholic Anonymous* and *Narcotics Anonymous*. Finally, a strong statement of support for peer group education has been provided by Hinshaw (2007):

> A key to understanding resilience in the face of mental illness lies within the subgroup of individuals who, despite adversities related to mental illness and its frequently

> accompanying stigmatization, have succeeded in professional, personal, and family domains and grown in wisdom and compassion. (p.174)

The Stigma Associated with Mental Illness

Stigma is a fear-based response that is damaging to the receiver and occurs due to a lack of education. Hinshaw (2007) defined stigma as "a term conveying a deep, shameful mark or flaw related to being a member of a group that is devalued by the social main stream" (p. xi). Being stigmatized at any age is demoralizing and unfair. However, stigmatization is extremely challenging for adolescents because they are in a social developmental stage that includes "preoccupation with social image, peer acceptance, and identity consolidation" (Moses, 2010, p. 986). The effect of stigma for people with mental illness can be harmful and, at times, tragic. People who feel stigmatized tend to "remain quiet about their mental illness" and the "stigma often causes them to delay seeking health care, avoid following through with recommended treatment, and avoid sharing their concerns with family and friends" (Mental Health Canada, 2006, p. 41).

The Government of Canada (2006) has reported that "mental illness remains strongly connected with public fears about potential violence and with desire for limited social interaction. Yet very few people with mental illness are violent" (p.41). The fear-based response to mental illness is exhibited when those with mental illness are labeled as *crazy, loony, mental, schizo, wacko*, and so on. Research has largely focused on social stigma, namely the negative perceptions of youth toward peers with mental health disorders. According to studies, "youth with mental disorders are commonly viewed as less popular, aggressive, and more socially rejected" (Moses, 2010, p. 986; Connolly, Geller, Marton, & Kutcher, 1992; Hoza et al., 2005; Walker, Coleman, Lee, Squire, & Friesen, 2008).

Causes of Stigmatization

Youth stigmatization is caused by three primary factors: a) social conditioning in the home environment, b) lack of exposure to mental illness, and c) the media. The home environment is where children and youth learn how to treat others: "child rearing behaviors serve as a model upon which children base their behavior and expectations of future relationships" (Espelage & Swearer, 2004, p. 232). Lack of exposure to those with mental illness, coupled with the negative portrait of mentally ill individuals in the media, are two other factors. Considering youth as media consumers, the "media are the most frequent source of information about mental illness for people in this country" (Wahl, 1995, p. 539).

The media often depicts people with mental illness in a negative light; for example, "a study of 31 major U.S. newspapers over a period of two months during the year 2000 found that 64.7% of the stories about persons with schizophrenia had an association with violence" (Silver, 2001, p. 539). This number does not include all the other types of mental disorders. Further studies show that "television viewing averages approximately 31/2 hours daily in 11-14 year olds" (Heriken & Foehr, 2005, p. 539), which indicates how strongly youth may be affected by drama that is sensationalized to increase viewership. However, even these figures do not accurately reflect youth exposure to media because they do not include movies viewed as rentals or at the theatre or other media such as the internet, gaming, or music.

Addressing Stigmatization

There is no easy answer nor one set of standards for addressing stigma and discrimination against people with mental illness. Nessa and Johnston (2007) have suggested *education*, *protest*, and *contact*, as promising strategies. They recommend *educating* communities to dispel commonly held myths about mental illness. They advocate *protesting* to suppress discriminatory

attitudes and challenge community commonly held stigmatizing images. Finally, they recommend *contact* as a means of putting a human face on mental illness, whether that face belongs to a celebrity or to someone less famous (Nessa & Johnston, 2007).

Stigma is unfair and harmful to those stigmatized against and it continues to be "one of the most tragic realities of mental illness in Canada" (Mental Health Canada 2006, p. 41). It is worth repeating that stigma affects 100% of the population, "family, friends and the professionals who serve people with mental illness, as well as the individuals themselves" (Nessa, & Johnston, 2007, p. 5). Educating youth and the general public alike can be expected to help reduce stigma: "Addressing stigma about mental illness is one of the most pressing priorities for improving the mental health of Canadians" (Mental Health Canada, 2006, p. 42).

Evidence indicates that building knowledge of mental disorders among youth will reduce stigma, help support youth with mental illness build resilience, and provide them a better chance of continuing in recovery. For example, Martin and Johnston (2007) have suggested that mental health promotion and public education will reduce the stigma and discrimination that surrounds mental illness. Hinshaw (2007) spoke to the value of knowledge when he stated,

> if lack of awareness and understanding can be replaced by knowledge, such that the frightening, unknown aura and threat surrounding mental disorder dissipates, acceptance should emerge. From this perspective, ignorance is the key enemy (p. 194).

Model Programs

Given the need for community education that is so prominently featured in the mental health literature, I was pleased to discover several model programs for promoting stigma reduction and awareness of mental health issues. In this section I explore four programs, each of

which contributed to the design of my workshop for youth in a northern Canadian cross-cultural environment. I begin with the Canadian program, *Talking About Mental Illness* (TAMI) and then review two noteworthy Australian programs*: Mental Health First Aid* and *Mind Matters.* Finally I look at *Bring Change 2 Mind*, an American program with an interactive website full of accessible resources.

Talking About Mental Illness

Talking About Mental Illness (TAMI) is a Canadian program. This program attempts to reduce stigma by educating youth fifteen years and older in secondary schools. According to the *Center for Addiction and Mental Health* (CAMH), TAMI is based on a previous program developed by a nurse at the Clarke Institute of Psychiatry, which was essentially a two hour presentation for high school students focusing on factual information as well as personal experiences of mental illness. The TAMI program is designed to be delivered by health professionals or people who have experienced mental health issues themselves or with a family member.

The TAMI program ran in three Ontario communities – Hamilton, North Bay, and Kingston – and each modified the program to reflect local resources (Centre for Addiction and Mental Health, 2012). The specific goal is to reduce stigma against mental illness by providing support materials and bringing awareness to the community. When presenters who have been affected by mental illness talk about their experiences, participants often demonstrate a transformed perspective, expressed in comments such as "people with mental illness are just like everyone else" (CAMH, 2012, Background to the Problem, para. 2).

Some characteristics of the TAMI program that are relevant to my study are flexibility in response to needs of different communities. There is also an emphasis on developing

partnerships with local health care agencies and health care professionals. The curriculum itself has an emphasis on putting a human face on mental illness with presenters who have had personal experience.

Mental Health First Aid. I reviewed information on programs developed in Australia, including *Mental Health First Aid* (MHFA) (National Council for Behavioral Health, 2013). MHFA was developed in 2001 and has now been implemented in at least 18 countries, including Canada. The goal of the program is to provide people with the knowledge and skills to help themselves or their friends, family, or colleagues when early signs of mental health problems emerge. The program promotes *mental health literacy,* which combines knowledge of mental disorders with skills to recognize when to contact health professionals and how to manage the situation until professional help is received. MHFA training, like conventional first aid, does not replace professional health care but helps people recognize when it is needed and how to access it. MHFA aims to preserve life, prevent mental health problems from becoming more serious, promote recovery, and provide comfort (Mental Health Commission of Canada, 2011).

In 2010, MHFA programs came under the leadership of the Mental Health Commission of Canada and since then, training has been delivered to adults by trained facilitators in workplaces such as fire halls, hospitals, police stations, and public schools. Facilitators are carefully screened through the application process for instructor training. Facilitators may be sponsored by their organizations or they may be independent trainers who deliver training for a fee. Instructor training currently ranges from $3000 for five day courses for basic or adults who work with youth instructors to $4000 for a six day course to become an instructor for MHFA Canada for Northern People.

The basic MHFA course addresses mental health problems including mood disorders, anxiety disorders, psychosis, and substance abuse disorders. Information on responding to crisis situations includes providing initial support in cases of suicidal behaviour, overdoses, panic attacks, reaction to traumatic events, and psychotic episodes. There is nothing mentioned in program descriptions about the instructional approach or how participants or local communities might be involved. However, instructors are urged to deliver MHFA programs with fidelity, which means following the prescribed program. When programs are shown to be effective, it is important to maintain fidelity so that effectiveness is also maintained. However, Caza (2010) noted that it is important to have a balance between fidelity and local relevance.

There is a special MHFA course available for adults who work with youth aged 12 – 24. Again, the focus is on early intervention and harm reduction but with additional focus on problems that are common in youth, such as eating disorders, anxiety disorders, and deliberate self injury. The need for this course occurs because "mental health problems often first develop during adolescence or early adulthood, with half of all mental disorders beginning by age 14, and 75 percent beginning by age 24" (Mental Health Commission of Canada, 2011, MHFA Course for Adults Who Interact with Youth, para. 3).

Recently, the Mental Health Commission of Canada (2014, June), funded by Health Canada and collaborating with the governments and stakeholders of Nunuvut, Northwest Territories, and Yukon, announced a Mental Health First Aid course for Northern Peoples. The three day course is designed to help people develop skills and acquire knowledge to help them manage emerging or existing mental health problems. The program

> focuses on determinants of health as they relate to the north, such as Aboriginal wellbeing and holistic approaches to health, Seasonal Affective Disorder and supports specific to the north (i.e. Land-based healing centres). The course also addresses certain mental health factors unique to the north such as isolation, limited number of health care

> professionals, fewer supports and services, high turnover of healthcare staff, and high medical travel costs. (Mental Health Commission of Canada, 2014, para. 3)

As part of the program announcement, Minister of Health and Social Services Glen Abernethy (as cited in Mental Health Commission of Canada, 2014, para. 4) emphasized the value of the program to overcome the stigma associated with mental issues by starting conversations that mobilize people to work together for change. It is not clear from the brief course outlines posted on Mental Health Commission of Canada websites what strategies, other than increased knowledge, will mobilize people or where reducing stigma is addressed in the curricula.

Evaluation of the MHFA program in Australia has shown evidence that the program is effective for: a) improving knowledge of mental disorders, reducing stigma, and c) increasing the amount of help provided to others (Mental Health Commission of Canada, 2011, Evaluation). Rigorous evaluation in of the programs in Canada is ongoing. Of particular interest is an evaluation of MHFA training in First Nations communities in Alberta (Caza, 2010), that examined data for programs delivered in 25 communities to 302 participants between May, 2008 and August, 2009. Evidence was consistent with the results of other evaluations, with participants reporting increases in mental health literacy, first aid skills, and reduction of stigma. The author of the report noted that the program had been adapted for the Canadian context but not for First Nations. An important recommendation was that the curriculum be revised with the advice of experts in Aboriginal mental health to increase relevance to this community, which was already underway in Alberta.

The MHFA training is for adults, including adults working with youth and in northern communities. Although my study is focused on youth in northern communities, much of the knowledge about mental illness from MHFA would be valuable background knowledge for

facilitators of *A Person First!* Evaluations of the MHFA program indicate that increased knowledge can contribute to stigma reduction. It is encouraging to know that the governments of Canada's northern territories are recognizing the need for mental health education and collaborating with the Mental Health Commission of Canada to develop relevant programs for the north. The cost of instructor training, however, may prohibit the spread of the program unless fees are covered by government agencies or organizations.

Mind Matters

A second Australian program, *Mind Matters*, is an innovative national program that is school-based and associated with the country's *Health Promoting Schools* initiative. This program is based on the assumption that "schools bear the weight of the youth mental health promotion agenda" (Wyne, Cahill, Holdsworth, Rowling, & Carson, 2000, p. 595). That is, attention to mental health is not something to add to the existing curriculum but it is part of the core purpose of schools. An increasing need for mental health support for young people is acknowledged and policy makers believed that a school-based program will make these resources more accessible to a wider audience.

A corresponding program in the preceding grades, *Kids Matter* (Institute for Positive Education, 2014), helps to ensure that early intervention occurs and continues through secondary school. Both programs are based on a pyramid of intervention model proposed by the World Health Organization (as cited in Wyne et al., 2000) but specific interventions are built on a broad foundation of community-building and belonging: the goal is for all students to feel as though they belong to a supportive community.

In this respect, *Mind Matters* is more than an insertion of mental health material into the school curriculum – it is a comprehensive framework for whole school commitment to enhance the

health and well-being of all students. The program is comprehensive in that it blends preventative or wellness education for all students, in academic and extra-curricular activities, with targeted intervention and support for a small number of students with specific needs.

Mind Matters was developed by a team of academic and health education professionals who consulted with mental health experts. It was piloted in 1998 in 24 Australian secondary schools, including some that were rural and remote and may experience the lack of services that are common in smaller Yukon communities. The program was then adjusted and distributed nationally, as reported by Wyn and associates in a peer-reviewed psychiatry journal in 2000. The goals of the program were to facilitate exemplary practice in mental health education, to create teaching resources including unit plans, and to offer teachers up to date knowledge through professional development and supportive structures. The program was designed to build on a foundation of partnerships that connect students, teachers, and parents with community health agencies whenever possible.

The *Mind Matters* curriculum is flexible so that schools can choose the priorities and focus areas relevant to their own communities. Suicide prevention appears to be a cornerstone of the program and resources are provided in four additional areas: a) enhancing resilience, b) dealing with bullying and harassment, c) grief and loss, and d) understanding mental illness. The community-building nature of the program as well as the areas for enhancing resilience and understanding mental illness address the need to develop a supportive peer network for stigma reduction, which is the focus of my study. *Mind Matters* program designers focused on the importance of the social environment to promote wellbeing, as I do in my workshop design.

The pedagogy of these model programs is as important as the content. In the *Mind Matters* program, lessons are experiential and interactive, so that the learners are actively

engaged with the concepts. Student activities require them to communicate and cooperate so that they can construct personal meaning and develop a sense of interdependence. Guided discussion is used frequently to move students from an experience to reflection on the impact and meaning of that experience. Learning is expressed through technology and the arts, including dramatic presentations and video. The overall goal of this kind of *social constructivist* teaching is personal and school-wide change. Such change is similar to descriptions of *transformative learning* (Mezirow & Taylor, 2009) in the adult learning literature, where learners examine and revise their beliefs and behaviours irreversibly.

Wyne and associates (2000) studied the early success and sustainability of the *Mind Matters program* and identified key features for success: a) support from the school principal, b) professional development and curriculum resources, c) links with community health agencies, and d) contact with other schools doing similar work. It appeared that facilitator workshops and ongoing support were also important. A concern raised by teachers in rural and remote schools was their lack of access to health service agencies or personnel.

A current conference website (Institute for Positive Education, 2014) indicated that both the *Kids Matter* and *Mind Matters* programs continue in Australian schools, although a relaunch and new advances were mentioned. The website also emphasized the importance of ongoing professional development and support for teachers, noting online learning options. More than a decade of examples from a variety of schools contribute strategies for implementation and teaching to share at conferences such as this one.

The *Mind Matters* program is school-based, nationally mandated, and comprehensive in contrast to the community-based, optional program focused on stigma reduction that I have designed. However, there are applicable lessons from the *Mind Matters* initiative. Mental health

programs for youth are an international concern and maintaining wellbeing for young people should be an important focus for community agencies as well as for schools. Programs are most effective when partnerships are established within the community and services are coordinated and adapted to local priorities. Facilitators are most effective and committed to the program's goals when they receive professional development in advance and teaching or workshop resources are provided; ongoing support is also helpful to keep knowledge current and to encourage revision as needed. Learning in caring communities is compatible with a social constructivist approach that invites participants to create personal meaning and commitment to new beliefs and behaviours. Students who are actively and creatively engaged with their learning are contributing to their own wellbeing as well as to their ability to support peers. When peer support has been embedded in the local culture, transformative and sustainable change has occurred.

Bring Change 2 Mind. Bring Change 2 Mind (BC2M, 2014) is a national anti-stigma campaign founded by the actress, Glen Close, who has family members with bipolar disorder and schizophrenia. The extensive and well-designed BC2M website provides a range of information and invites viewers to participate in anti-stigma community activities, such as walkathons, documented in an appealing photo gallery. The home page invites viewers to commit to the cause personally by taking a pledge against stigmatization, sending a donation, or sharing a story. There is also a *Get Help* button that leads to numbers to call in case of an emergency or for phone support. A Fact section identifies some prominent myths about mental illness and explains that stigma is harmful because it prevents people from seeking help when they need it.

People who have experienced mental illness themselves or have been affected by the illness of someone close to them are also invited to submit their stories in 400 words or less.

Personal stories are posted by category, including self-harm, bi-polar disorder, schizophrenia, depression, anxiety, and so on. A recent story, in response to the death of actor Robin Williams, thanked him for bringing courage and laughter to the world and noted that: "now with your final living act, you bring the tragedy and reality of untreated or inadequately treated depression into the spotlight in a way that no one else could possibly do" (BC2M, 2014, Kathy's Story).

A video section of the BC2M (2014) website contains professionally-produced Public Service Announcements (PSAs) that feature the faces and voices of those affected by mental illness describing the harm that occurs as a result of stigma and inviting public support. Photos, stories, and videos feature people of a variety of ethnicities and ages; youth and young adults are prominent. A resource section listed books, often first person accounts or memoirs, organized again by categories of mental illness.

There was also a section for research, where I found a peer-reviewed empirical study that compared the effects of filmed stories of mental illness with the effects of personal contact to reduce stigma in student nurses (Clement, S., NIeuwenhuizen, A., Kassam, A., Flach, C., Lazarus, A., de Castro, M., McCrone, P., Norman, I., and Thornicroft, G., 2011). Relevant to this study was the assertion that "direct social contact interventions are known to reduce mental health stigma" and the finding that "filmed social contact may be equally effective and have practical and cost advantages" (p. 1). The study also found that lectures were the least effective of the three intervention types to reduce stigma. These findings support an approach to teaching that blends lectures to transmit information with personal stories to make them real and activities to build ownership and translate new understanding to action. When personal contact is not possible, as in isolated communities, it is encouraging to know that videos featuring the faces

and voices of young people who have experienced mental illness are likely to be effective for reducing stigma.

Overall, the benefits of the BC2M (2014) website for this study are many. The site has an action orientation that appeals to young people and may give *A Person First!* participants ideas for projects in their own communities. The website makes a wealth of accurate information accessible, from brief comparison of myths and facts to compelling personal stories, polished videos, published books, peer-reviewed research papers, and links to a wealth of supportive organizations. This website would be a valuable source of background information for facilitators and could provide stories or videos as discussion starters. Workshop participants could be encouraged to browse the site on their own and some may be inspired to share their own stories of anxiety, depression, or response to trauma on the website.

The Aboriginal Medicine Wheel

There is emerging interest in the traditional Aboriginal teachings of the Medicine Wheel (Bopp, Bopp, Brown, & Lane, 2012; Brendtro, Brokenleg, & Van Bockern, 2001) for youth programming in Youth Centers and Friendship centers across Canada. These traditional Aboriginal teachings have been used by facilitators to teach youth about self-awareness and stigma reduction. For example, the *Brandon Aboriginal Youth Activity Centre*, with the assistance of Dr. Martin Brokenleg, used the medicine wheel concept to "teach youth that they are connected to everything" (UMAYC Online, 2008, p. 1). Dr. Brokenleg is nationally known as teacher and promoter of traditional methods to support positive youth development, which builds resilience. In workshops for teachers, as in his writing, Brokenleg describes how the traditional teaching of the Medicine Wheel can become a holistic *circle of courage* for a young person: "The youth is taught to make independent decisions and to respect the wisdom and

advice of adults. Achievement and mastery empower acts of greater service" (Brokenleg, Brendto, &Van Bockern 2001, p. 66).

The *White Bison* (2014) organization in Colorado Springs has developed three programs that focus on youth development, using the traditional teachings from the Medicine Wheel: *The Path of Wellbriety, Personal Enrichment*, and *The Medicine Wheel and the Circle of Life*. The goal of White Bison is to bring understanding of the purpose of life to Native youth but this program is inclusive and accepts non-Native participants. The teachings of the traditional medicine wheel seemed an appropriate fit for the cultural diversity of the Yukon and offered learning strategies consistent with an Aboriginal worldview (Bopp, Bopp, Brown, & Lane, 2012). Battiste and Barman (1999) confirmed the value of this approach for teaching Aboriginal youth: "Medicine Wheels can be pedagogical tools for teaching, learning, contemplating, and understanding our human journeys" (p. 51).

As I designed the mental health support workshop to include this approach, I drew on the teachings of my late father, a prominent elder and political leader in the Yukon community. Another resource that was helpful was *The Sacred Tree: Reflections on Native American Spiritually* (Bopp, Bopp, Brown, & Lane, 2012). This book synthesized the traditional teachings and worldview of Aboriginal Elders from across North America and presented them as a potential means to return Aboriginal youth and their communities to wellness.

Constructivist Learning

The literature on constructivist learning theory and practice is relevant to this study because, to design the workshop, I needed to determine what learning outcomes were needed to fulfill the goals of the program and what activities would help participants achieve those outcomes. Constructivism

> is an approach to teaching and learning based on the premise that cognition (learning) is the result of *mental construction*. In other words, students learn by fitting new information together with what they already know. Constructivists believe that learning is affected by the context in which an idea is taught as well as by students' beliefs and attitudes (NCREL, n.d., para. 1).

Jonassen (2013) explained further that learners construct knowledge "as a function of... prior experiences, mental structures, and beliefs that are used to interpret objects and events" (p. 217).

Fosnot (2005) made the distinction that constructivism is not a theory of teaching but a theory of learning:

> Learning from this perspective is viewed as a self-regulatory process of struggling with the conflict between existing personal models of the world and discrepant new insights, constructing new representations and models of reality as a human meaning-making venture with culturally developed tools and symbols, and further negotiating such meaning through cooperative social activity, discourse, and debate in communities of practice. (Fosnot, 2005, Preface, location 85).

However, any theory of learning has implications for teaching and for choosing methods that are likely to provide opportunities for learning. Fosnot also explained that an approach to teaching based on constructivist learning theory "gives learners the opportunity for concrete, contextually meaningful experience through which they can search for patterns; raise questions; and model, interpret, and defend their strategies and ideas" (Fosnot, 2005, Preface, location 92).

The kind of teaching described by Fosnot (2005) seems to correspond to the Aboriginal tradition that encourages learners to make personal meaning of cultural stories (Bopp, Bopp, Brown, & Lane, 2012). A constructivist approach engages learners in discussions with each other, so that they can think out loud and learn from each other as they grapple with whether they will choose new ways of understanding the world. Social interaction that builds a community of practice or a community of support among youth in a small northern village may be sustainable and effective in a way that change for one youth alone would not.

The goal of *A Person First!* workshops is for participating youth to change their thinking regarding peers who have experienced mental illness and for them to support each other in this new approach. When the workshop is successful, participants will not simply acquire information about the effects of mental illness but come to new understandings that are powerful enough to change their behaviour. Experiential and reflective learning activities based on a constructivist theory of learning seem most likely to bring about this transformative change, at least for some participants.

Transformative Learning

Transformative learning is a concept that emerged from the adult learning literature (Mezirow & Taylor, 2009) but I believe can be applied to creating the conditions for personal and social change for youth as well. Transformative learning is "a critical dimension of learning in adulthood that enables [learners] to recognize, reassess, and modify the structures of assumptions and expectations that frame…tacit points of view and influence …thinking, beliefs, attitudes, and actions" (Mezirow, 2009, p. 18). Transformative learning theory results in "an approach to teaching based on promoting change, where educators challenge learners to critically question and assess the integrity of their deeply held assumptions about how they relate to the world around them" (Mezirow & Taylor, 2009, location 202). Although transformative learning was developed to describe the learning process for adults, Merriam and Bierema (2014) have suggested that transformative learning can be an alternate perspective of learning for children and youth, as it is in this study.

I have designed the workshop so that experiences and activities will invite participating youth to construct their own understandings and so that the assessment tool will reveal transformative changes in their thinking. The intention is that increasing understanding will

enable workshop participants to contribute to a more inclusive and stigma-free environment for family members, friends, and classmates experiencing mental illness. The Medicine Wheel assessment will reveal whether participants see a change in their own thinking and whether they anticipate their behaviour toward those who suffer with mental illness to be different in the future. Although not all participants will describe transformative change, all participants will have more information that may cause them to reconsider their participation in stigmatizing behaviour in the future.

Understanding by Design

I chose Understanding by Design (UbD) as a practical approach to designing a constructivist and potentially transformative workshop for youth. My goal was to develop a workshop that would help students apply new knowledge and attitudes to sustainable community development. The Wiggins and McTighe (2011) emphasis on teaching for understanding seemed to be an appropriate basis for planning the outcomes and activities of this workshop.

Wiggins and McTighe (2011) have traced the roots of their popular approach to curriculum design:

> In 1948, Ralph Tyler advocated this approach as an effective process for focusing instruction; Bloom's Taxonomy – and its recent revision by Anderson and Krathwohl (2001) – lays out the different types of educational aims and what they require of assessment; Robert Gagné (1977) and Robert Mager (1988) have long taught people how to analyze different outcomes and what they require of learning; more recently, William Spady (1994) popularized the idea of "designing down" from exit outcomes. (Wiggins and McTighe 2011 p. 7).

The UbD approach follows the advice of leadership guru, Stephen Covey (2004) to *begin with the end in mind* – that is, to start planning by identifying learning outcomes rather than by choosing activities first. This approach was so unfamiliar to teachers that it was called *backward mapping* or *backward design.* The procedural for this kind of planning begins with identifying

desired results or learning outcomes as big ideas or long term goals, then deciding what evidence of learning will show that outcomes have been achieved, and finally choosing or designing the learning activities that correspond with outcomes and assessments.

Another new aspect of the UbD framework is the purposeful focus on teaching to develop personal meaning, so that learning will be evident in changed behavior that is supported by changed thinking. Appropriate assessments are an important part of this approach, so that learners become aware of how their thinking has changed. In contrast, traditional curricular design focused on the transfer and retention of knowledge items, often without attention to organizing them into concepts. There was also little attention paid to having students apply new information to real world problems or to building the personal and collaborative skills to support learning. In UbD, "understanding is revealed when students autonomously make sense of and transfer learning through authentic performance" (Wiggins & McTighe, 2011, p. 3). In this way, a UbD approach to curriculum planning seems coherent with both constructivist and transformative learning theories.

Chapter Summary

In this chapter I have explored the central concept of *resilience* as well as its enemies, *shame and stigmatization*. I have reviewed information on model programs that informed my design of a cross-cultural, made-for-Yukon workshop, including current use of traditional Aboriginal *t*eachings. I have described my approach to workshop design as grounded in constructivist and transformative learning theories and guided by the practical steps of teaching for understanding and backward mapping. This is the body of literature that contributed to my workshop design, including its content, learning strategies, and the medicine wheel as a self-reflection for youth and program assessment for leaders.

CHAPTER III: WORKSHOP DESIGN AND REFLECTIONS

The method for this project can be described as *design research* (Kelly, Lesh, & Baek, 2008; McKenney & Reeves, 2012), which is focused on identifying educational problems and creating innovative solutions that will be tested and refined in real life situations. This study is limited to the initial design of a leader's training for community workers (for example, First Nations Band employees) or volunters who are interested in facilitating a ten hour mental health support workshop for youth. I expect to revise the leaders training as well as the youth workshop after I have delivered them and received feedback from participants. However, delivering the workshop and refining the curriculum accordingly is beyond the scope of this study, which focuses on the initial *design* of the workshop. To help readers visualize the workshop as I discuss my design steps, I have provided an overview of the six parts or lessons in the workshop, along with the purpose or content and the learning activities each part (See Figure 1).

This overview shows the main assessment for the workshop as an individual Medicine Wheel reflection in the first session that will be compared with a similar reflection at the end of the workshop. Other lessons contain group exercises to teach participants to match their thinking from Circle Talk sessions to the Medicine Wheel quadrants. Each lesson or workshop part has interactive components that encourage participants to respond to what has been presented or to engage in learning activities with each other. Videos that feature young people who have experienced mental illness play a prominent part in the workshop.

Parts or Lessons	Purpose	Learning Activities
Part 1: A Strong Circle of Support	- introductions - Strong Circle of Support workshop goals - circle protocol & respect, confidentiality - introduce Medicine Wheel	1. Two Truths and a Lie in the Circle 2. Brainstorm Mental Health/Mental Illness 3. Medicine Wheel Reflection
Part 2: Mental Illness Types and Treatment	- Understand that it is difficult to live with mental illness - chemical causes - types of disorders - risk factors - treatments	1. Auditory Hallucinations 2. Function of Neurotransmitters Video 3. *Downside of High* video Excerpt 4. Reading & Discussion
Part 3: Learning About Stigma	- Hear the voices of those who have been stigmatized - Understand stigma and silence as harmful - Connect learning to the quadrants of the Medicine Wheel	1. *Stigma and Mental Illness* video 2. *Ending the Stigma of Mental Illness* video 3. Circle Talk 4. Matching Circle Talk points to Medicine Wheel
Part 4: Removing the Labels	- See stigma as a heavy burden - Understand the courage it takes to define yourself in spite of labels - Realize how many ways there are to stigmatize through labels and name calling	1. *Carry the Load* video 2. *I Define Me* video 3. ABCs of Stigmatization 4. Medicine Wheel Reflection
Part 5: What If Your Friend Needed Help?	- Relationships are based on what people have in common - Strategy for suicide prevention - Advice for someone thinking of suicide	1. Five Things in Common game 2. Discussion 3. *Teen Suicide Prevention* video 4. WALT Strategy sort 5. Role Play 6. *For Those Considering Suicide* video 7. Circle Talk
Part 6: Personal Growth and Community Action	- Gratitude as a strategy for mental health - Mental illness is treatable and people can recover and live a normal life - Community action can reduce isolation, improve mental health - Celebrate steps toward a stronger circle of support in this community	1. Medicine Wheel Group Reflection 2. Think Tank Circle 3. *Mental Health: A Conversation that Matters* video 4. Circle Talk 5. Community Plan Discussion 6. Review Strong Circle of Support Goals 7. Celebration 8. Final Medicine Wheel Reflection (individual)

Figure 1. *An overview of the workshop parts or lessons, purposes, and activities.*

Another step toward delivery of the youth workshop by leaders other than me will be to adapt these materials, such as the video descriptions and the Medicine Wheel Reflection sheets, into handouts. That work is also beyond the scope of this project because I may see a need to modify the handouts when I pilot the leaders' training.

Because the facilitators are not likely to be professional teachers, I chose to focus on designing the leaders' training. I believe that the best way for non-professionals to learn to lead a workshop is to have the complete workshop modeled for them and to participate in the program as a participant.. Having workshop leaders go through the youth workshop activities from start to finish will enable me to demonstrate teaching strategies and behaviours more efficiently than if I simply told workshop leaders how to do it. Modeling will also provide the leaders an overall picture of the information and activities before they start to plan their own workshop, which should reduce their preparation time, and would also put then in direct contact with youth in a facilitator role.

Although I would follow the six parts or lessons presented here with a planning session for leaders, I chose not to include guidelines for that specific, community-based planning as part of the study. Planning a timeframe and reminding leaders to gather workshop materials in advance will be important for successful workshop delivery but my focus in this study is the design of the workshop's outcomes, assessment, and learning activities.

Design Research

Design research can be "*descriptive*, *explanatory*, *predictive*, or *prescriptive* allowing for improving or studying the effectiveness of an existing program or product. The flexibility of this research method also allows for further development of interventions "(Mckenny & Reeves, 2011). I intend to use the materials designed here in both descriptive and explanatory ways. In a leaders' workshop to prepare adults to lead workshops for youth in communities throughout Yukon, I will describe and explain what the youth workshop will consist of and why these activities are important. The schedule of activities will also be offered as somewhat prescriptive

for leaders who are unfamiliar with this topic, although adaptations may occur, depending on each leader's skills and knowledge.

As a type of qualitative research, design research requires a systematic process as well as public sharing of the results. In this chapter, I describe my design and target audience. Then I review the backward mapping (Wiggins & McTighe, 2011) that I used as a planning guide. Next I outline the specific steps that I used to design the workshop and describe some of the design decisions that I made to address my research questions related to outcomes, assessment tools, and learning strategies. I conclude with final reflections and a chapter summary.

Initial Design and Target Audience

This workshop is designed to be delivered in a ten hour time frame. Ten hours is a reasonable length for a weekend workshop that would have a two hour session on Friday evening and four hours each on Saturday and Sunday or five hours on Saturday and three on Sunday. Alternately, the workshop could be delivered with some evening sessions and a Saturday or just evenings over a two or three week period. In my experience as a classroom teacher and youth workshop facilitator, this is an appropriate length. Ten hours will allow the ample time for presentations and discussions without being too long to maintain interest. A longer time frame could increase the risk of youth losing interest in the topic or missing part of the workshop.

Five sessions of up to two hours each would fit my plan for a ten hour workshop. However, I realized that the workshop needed a specific session on suicide prevention and so the workshop grew to six sessions. Although it is not as easy to fit six sessions into ten hours, I think the timing could be adjusted to make it work. Extending the workshop to twelve hours could make it a bit too long to deliver in a weekend. I will be better able to adjust the pacing of the

sessions after I have piloted both the leader's training and the teen workshop after this design study has been completed.

I also realized, as I struggled with what to include in this limited time, that this workshop can only provide a very basic introduction to mental health knowledge. I decided that an emphasis on reducing stigma by learning about the personal harm that it does, as described by youth in videos that workshop participants will watch, would be the most effective way to invest ten workshop hours. Although I had planned to have participating youth learn more about specific types of mental illness and their treatments and make presentations to the group, time constraints made this an unrealistic goal.

I was also not sure that the youth would have the skills to research and prepare an accurate presentation on their own, which would fit more with an engaging constructivist approach to learning than simply presenting them with the information. Perhaps more emphasis on acquiring knowledge through research and presentations could be added if the workshop were delivered as part of a school curriculum with the support of a professional teacher. However, I hope the workshop, in the current state, will inspire youth as well as their community-based leaders to look for opportunities to learn more about maintaining mental health and about the types of mental illnesses and treatments that most affect their family, friends, or community. With numerous YouTube videos and credible online resources, the workshop introduces the vast amount of trustworthy information that is accessible, even for people in rural and remote Yukon communities.

The teen workshop described in this leader's training is designed specifically for youth aged 15 years and older. Although the program may be adapted at some future date for younger groups, where stigmatization is also a problem, the sensitive nature of the subject matter makes it

important for facilitators to gain experience with older teens. In addition, I have chosen this age group to correspond to the audience intended for the model programs that have informed my design.

A Person First! workshops may have the most power to mobilize communities of peers if they are open to any interested youth of the appropriate age. However, if the program is offered to a school population, a suggested audience is students who are enrolled in alternative education programs. From my professional experience, I believe that this group is more likely to have faced some form of stigma in their lives and to have had difficulties in the school setting or with peer groups. Additional work to be done for this kind of delivery would be to match workshop goals with the prescribed outcomes of a school curriculum. The workshop may have to be adapted or expanded to address curriculum goals.

Backward Mapping

Wiggins and McTighe (2011) have had a great deal of influence on educational planning processes with their concept of *backward mapping.* Simply put, they have urged educators to plan curriculum by first focusing on the intended outcomes and then considering what acceptable evidence of that learning might look like. Finally, instructional strategies and learning activities are selected to achieve the learning and to demonstrate the quality of learning that has occurred.

The backward mapping approach to planning helped me to design my youth workshop and leaders' training in logical steps. First I identified the learning outcomes I hoped participating youth would achieve, based on my literature review about the power of other programs to reduce stigmatization and build a more supportive community. Then I planned assessment that could reveal to participants themselves what learning had occurred for them, notably the Medicine Wheel Reflection at the start and finish of the workshop. As a final step in

the backward mapping sequence, I chose learning activities that I thought would engage participants in a constructivist way and could lead to transformative learning, at least for some participants.

In addition to the design of a workshop, I considered the eventual need for program evaluation. I have included a formal workshop evaluation form at the end of the workshop leader's guide. Baseline datamay then be collected from the first delivery of the youth workshop, to support possible funding applications or rationale for additional delivery. Perhaps a next step would be to adapt the questionnaire for the leaders' training, specifically, to gather data about whether adult participants feel prepared to lead a workshop themselves and if not, what further help do they feel they need.

Design Process

In this section, I explain how I drew on the literature and model programs I have reviewed to a) identify intended outcomes and the content related to that learning, b) plan to assess intended outcomes, and c) choose instructional strategies and learning activities. The main outcome that I hope for is a reduction in stigmatization of youth who have experienced mental illness, through changes in the attitudes and behaviours of their peers. However, this outcome is too complex and long-term to assess at the time the workshop is delivered. Therefore, I needed to set more immediate goals for this workshop, to provide participating youth with the knowledge, beliefs, and skills that could make them more likely to provide positive support for peers who have experienced mental illness. I see design research as an early stage in a spiral of inquiry (Kaser & Halbert, 2009) that could include program evaluation studies at a later stage.

Outcomes

The outcomes that I developed began as four statements of overall purpose. For the leaders' training and youth workshop, I translated these purposes to brief, clear statements about what we wanted to do in our workshop in order to create a strong circle of support for people with mental health problems or mental illness. My teaching experience with formative assessment made me want to share intended outcomes with workshop participants so that everyone could understand them and help to achieve them. Workshop and training participants could also provide feedback about how well these goals were achieved, which would be helpful information for improving the workshops.

However, I thought that *outcomes* sounded too much like teaching jargon for a community workshop led by local people. Instead, I described these outcomes simply as steps to achieving a strong circle of support in the community. At the end of the workshop, when these steps are reviewed, I intend to them specifically as workshop goals. However, I am not sure if my goals are worded in a way that Wiggins and McTighe (2011) have described as ideal; my goals for this workshop still seem to be quite activity based – describing what participants will do more than what they will learn.

Drafting and revising outcomes for the workshop gave me opportunities to think clearly about what I wanted participants to accomplish, how it could be assessed, and which activities could lead participants to positive assessments. Further, as I wrote instructions for watching each video, I noticed that these instructions seemed to function as learning outcomes that are more specific but still correspond to the overall workshop goals. For example, instructions for watching the first stigma video describe the learning related to stigma in detail. But it is then up to participants whether they identify their learning in the *Circle Talk* that follows.

I had three main goals for the design of this workshop: a) to provide youth with enough understanding of mental illness for them to gain empathy, reduce stigma, and increase support for peers experiencing mental health problems, b) to be culturally relevant for Yukon youth, and c) to invite youth to explore changes in their own knowledge and beliefs through self-reflection. As a result of a successful workshop that would achieve these three goals, I hoped that participants would begin to apply their changed thinking to action plans for building a healthy and supportive community for people who live with mental illness. I believe these broad goals or outcomes are represented in the steps to building a strong circle of support that I have planned to share with leaders in their workshop (see Figure 2).

How Can We Build a Strong Circle of Support?

- By creating a circle where everyone belongs
- By learning about *stigma* and the harm that it causes
- By gaining knowledge about mental health issues
- By understanding how people with mental health problems feel
- By practicing support skills – what to say and do
- By reflecting on our own thinking and behaviour
- By planning community action to share what we've learned

Figure 2. Workshop goals, outcomes, or steps in building a circle of support.

Teaching for understanding, like *backward mapping*, is a central premise of the approach to planning and instruction advocated by Wiggins and McTighe (2011) and known and trademarked as *Understanding by Design* or *UbD*. Students should be able to describe the goals or *big ideas* of a unit or course, which is why I have summarized them in plain language to share at the beginning of the workshop. Workshop participants, the learners, should understand how facts or knowledge items fit together to contribute to these big ideas. For example, in this workshop, participants should understand that the experiences of many different young people featured in the videos all contribute to the big idea that stigmatizing those with mental illness is harmful to their recovery.

To check that these outcomes are likely to be effective, I remembered recommendations from Nessa and Johnson (2007) that effective stigma reduction has occurred through *education*, *contact,* and *protest*. My *A Person First!* workshop has been designed as culturally relevant education, so that northern students will be open to the learning that is offered. In rural and remote communities, contact with young people who have experienced a variety of mental health issues is not likely to be available. Therefore, to address the *contact* criterion for northern communities, I have built learning activities around videos in which young people speak about their mental health experiences. For *protest,* I have designed the workshop to challenge youth participants to identify what is needed to build a strong circle of support in their own communities.

Assessment

This workshop addresses a complex topic and the videos and other activities carry a wealth of information. Rather than assess discrete and possibly meaningless pieces of knowledge, such as whether participants remember definitions of a variety of mental illnesses or disorders that they have never encountered, I have followed the advice of Wiggins and McTighe (2005) to focus assessment on the outcomes that I identified as important when I began to plan the unit. Further, in the traditions of First Nations teaching styles (Brendtro, Brokenleg, & Van Bockern, 2001; Bopp, Bopp, Brown, & Lane, 2012). I have chosen to invite participants to self-assess their learning and to share that assessment with the leader and other youth in the group, if they wish.

Through the learning activities, participants will be encouraged to construct their own understandings of stigma, the harm it causes, and ways to provide peer support. Their self-assessment of learning will occur when they compare their Medicine Wheel reflection from the beginning of the workshop to a second Medicine Wheel Reflection at the end. Workshop participants will be encouraged to identify their learning as changes in knowledge and understanding, skills, and attitudes or values that occurred as a result of the workshop. Workshop leaders, having gone through this exercise themselves to compare their own first and last Medicine Wheel reflections, will better understand how to help youth participants see growth. I expect that there will be changes in both the quantity and the quality of participant understandings about mental health issues and stigma. The second reflection will contain much more information and because of the references to the Medicine Wheel throughout the workshop, participants will have an idea where their learning fits within the quadrants.

With this approach to learning and assessment, I believe that youth participants will gain awareness of the effects of their attitudes and behaviours on others, so that they may change

them if they choose. The freedom to choose whether to change, as the learner sees fit, is the essence of the First Nations concept of respect (Rattray, 1997) and a foundation of the *mastery* quadrant on the Medicine Wheel. To me, a constructivist approach to assessment using the Medicine Wheel framework is compatible with Yukon First Nations' ways of teaching through stories. In this way of teaching, the message of a story is not explicit or even the same for everyone; listeners are expected to consider how the stories apply to them and to determine personal meaning for themselves.

Therefore, assessment of the learning from this workshop will not be captured in a grade to be reported, such as in a unit of study at school, but will be identified as growth by the learners themselves. The cultural relevance of this approach is confirmed in the literature on Aboriginal education:

> In Aboriginal education systems, learning is seen as individual's lifelong responsibility. Traditional teaching stresses personal responsibility and relations. Teachers model competent and respectful behaviour. A specific product or grade is not as important as the process of learning and living. (Alberta Education, 2005, p. 24).

In keeping with a traditional First Nations teaching style, youth participants in *A Person First!* workshops will be trusted to make good decisions for themselves, once they have information about how their actions may affect others. To honour the First Nations view of respect as well as constructivist principles, it is important that participants identify for themselves what has changed and who they want to become because of it.

Assessment for this program has a function beyond the personal development of participants. A second function is to inform facilitators as to whether the intended learning was achieved so that the program can be improved for future groups. For this more conventional kind of program evaluation to occur, there needs to be a more objective focus on whether the goals of the program have been achieved. Careful attention to what is shared by participants in the

Talking Circle after the final Medicine Wheel reflection may provide useful anecdotal feedback to inform revisions to the workshop. Even more concrete information for revision will be available from the *Workshop Evaluation Forms*, which are included at the end of the leaders' workshop (see Appendix A). Evaluation forms from a number of workshops may be compiled in the future as a formal evaluation of the effectiveness of the program (Caza, 2010).

Although the overarching goal of this workshop is stigma reduction, it will be more difficult to assess the outcome of supportive thinking and willingness to change. I believe that formative assessment would be appropriate assessment approach as it will provide students with positive teacher interaction and continuous feedback, Tomlinson and McTighe (2006) stated that " formative assessment…provides students with opportunities to revise and improve the quality of their thinking and understanding" (p. 174). Therefore, I expect that formative feedback from the leaders, modeled for the leaders by me, will encourage youth to reflect on their thinking and identify changes as they occur.

Learning activities

According to Wiggins and McTighe (2011), the learning activities for a unit of study flow naturally from the intended outcomes and the assessment strategies that have been identified. For A Person First , outcomes are related to identifying supportive attitudes and behaviours and developing personal and community action plans. This workshop was designed to optimize learning with interactive and engaging activities, offered within a safe environment. I wanted to help workshop leaders create a setting where youth could explore the meaning of mental health, learn about types of mental illness, and discover the importance of decreasing stigmatization for their peers.

Therefore, in the workshop design, the content and learning activities flowed from what I hoped to see on the medicine wheel assessment I planned to have students complete. Several of the workshop parts have a repeated routine of taking notes during Circle Talk and later sorting these points about what participants have learned to emphasize connections to the quadrants of the medicine wheel. Activities were also informed by the literature, particularly the Ness and Johnston (2007) framework of methods for reducing stigmatization. I was mindful, in choosing and ordering activities, that I wanted to facilitate both cognitive and affective learning with potential to transform thinking and behaviour. I knew that youth participants would need both kinds of learning to reconstruct or transform their identity and increase participation as caring people in the community. It would not be enough just to know about mental illness; participants would have to learn to care about it, too.

Following the example of the TAMI (2001) program, I kept my workshop focused on the goal of stigma reduction, although I thought the workshop would not be complete without a section on suicide prevention, as it is reported that "People who die by suicide are frequently experiencing undiagnosed, undertreated, or untreated depression" (depts..washington.edu 2012. AMI (2001) teaches that people with mental illness are not violent or incompetent, and that, in one student's words, "they are just like everybody else." (p. 8). I adapted sections from the TAMI teachers' guide that teach what stigma is, why people stigmatize, and how it affects others as well as a basic overview of what mental illness is. The section on suicide prevention is meant to complement that material.

I used videos and follow-up discussions to engage workshop participants and to allow them to have contact with youth who had experienced mental illness, at least through film. I searched for videos from credible sources that would emphasize this anti-stigma message with

the voices of youths who had experienced stigma themselves. I reviewed many videos but selected those that were produced by credible organizations, contained accurate information, and included the voices and faces of youth who had experienced mental illness. Some of the videos were dramatizations, which I thought would hold the interest of young workshop participants.

Reflections

This experience of completing this study was challenging, rewarding, and thought provoking. It was personally meaningful to me because of experience with the mental illness of my own family and because I realized that the resources for his healthy recovery may not be available in our own community. As I completed my research and the workshop design, I realized that stigma reduction is important for the health of both individuals and communities. The backward mapping approach to planning resonated with me as culturally appropriate and I delighted in this opportunity to apply the teachings of my late father, who saw the Medicine Wheel as compatible with traditional Yukon First Nations beliefs.

Personal meaning

My journey toward designing a culturally relevant stigma reduction program for northern youth began when my own family member became ill. During his treatment, I spent three months with him in Vancouver, British Columbia, away from my home in Yukon. I pondered on how people he knew would react when he returned home. Would his friends see him as different now? If so, how could we re-engage them? I wondered if it was my task to educate them or if it was his. Should I teach my family member to talk openly about mental illness, in the hopes of reducing the stigma he would experience? It took some time but I discovered the answers to my questions by reading research: education could decrease stigma and peer support could bring hope of long term recovery, renewed self-worth, and acceptance in the community. However,

that kind of education and peer support might not be available or culturally accessible in our northern community. I saw the lack of culturally relevant, stigma reduction education for Yukon youth as an opportunity for me to take a leadership role and design it.

As I started digging deeper into the history of mental illness, mental health, and stigma reduction programs of the past and present, I wondered how stigma reduction could apply to Yukon culture. What could a workshop for Yukon youth look like, and what should it contain to make it engaging and relevant for them? What would have to be in place to resonate with Yukon youth's feelings, emotions, understanding, of mental illness? Finally, when the teachings had been shared, how could they be adapted and sustained to honor the uniqueness of each Yukon community?

Because I was born and raised in Yukon I understand that it is a unique place and each community in the territory has its own cultural values. Having this knowledge convinced me that a successful workshop would need to be culturally relevant to each location. Attention to Elders as well as place, history, and value systems would be important. Because of the sensitive nature of the topic, facilitators would benefit from an in-depth understanding of the community that can only develop over time as a person lives there. In order to meet these needs I have planned for the leaders of this workshop to be from each community where the workshop is offered. With encouragement to do so in the leader's training, local workshop leaders will intuitively adapt the workshop to their own communities.

The importance of stigma reduction

During my initial research, I realized quickly how naive I was about the level of stigma that surrounds those living with mental illness. The historical accounts that are on record of mental institutions in Canada are astounding. Mentally ill patients have been treated in a

shameful manner, tossed from society and locked up, unaccounted for. Thankfully, our societal approach to people with mental illness has moved beyond that way of thinking. However, today people with mental illness are often tossed from society through stigma, which is evident in the name calling and social exclusion that may be as harmful as locking them up.

Stigma reduction is vital to community health and sustainable funding for future programs that offer support for those living with mental illness. A lack of education about mental illness and mental health jeopardizes the whole community, not only the person who lives with mental illness and his or her family. Without adequate support and resources in smaller communities the mentally ill are often removed out of their natural environments to receive treatment. However, the family and community is the natural environment and it is where people belong. Providing family members the opportunity to be involved in treatments and care, in turn, increases the chances for long term recovery.

I have come to believe that stigma will continue to fester in our society if families continue to be excluded from the treatment and recovery process. Community members excluded from the recovery process will only remember what the mental illness looked like, rather than envisioning recovery. Community empowerment could occur if the whole community was aware of or had a role to play in the recovery process of one of its members.

Community relevance

This summer I facilitated Mental Health First Aid training in Yukon communities, for the Council of Yukon First Nations.. This provided me the opportunity to see what resources were in the communities for youth, mental health support, and what general attitudes were held by Yukon community members towards those living with mental health issues. From my observations members in Yukon communities are very interested in learning more about mental

health and mental illness and what supports are needed. Youth would benefit from an education program that targets youth and stigma reduction. If there was more training about mental health issues within Yukon, community members may be able to identify the exact resources required for the uniqueness of their community rather than trying to implement the one-size-fits-all approach that may be recommended by Health Canada and the territorial government.

From my perspective as a teacher I see the youth of today as our leaders of tomorrow. If we plant the seeds of stigma reduction and educate youth about mental illness, communities will, in future, have knowledgeable members to develop or obtain sustainable resources to support people living with mental illness, in addition communities also gain members that are role models and serve as outreach support. If we in Yukon continue to send people away somewhere when they are ill, they will always be someone else's problem. On the other hand, if we learn more about how those suffering with mental illness develop resiliency, we may find that community education and support can contribute to resilient responses.

Cultural connections

As I designed the workshop, it occurred to me that the backward design concept to designing learning is not new but in many ways resonates with traditional First Nations ways of teaching. The idea of *beginning with the end in mind* is how Aboriginal people in Yukon taught our young. For example, when a boy was identified by a family member or Elder as a hunter, he was given to his uncle or another coach to train him for that role. This training process often took years to complete but after many lessons of watching, listening, and learning respect for animals and for the land, the boy would learn the skill of hunting. The goal was clear and learning activities were focused purposefully on that goal.

As a final thought, I want to say that it was an honor to include my knowledge of the traditional Medicine Wheel teachings, which I learned from my late father John Edzerza, in the design of this workshop for Yukon youth. The Medicine Wheel focus will bring youth together by providing an experience of sharing learning and ideally will bring a sense of community awareness about Yukon First Nations culture of the past, present, and of future. Even though this workshop is a small contribution to large issues that surround mental illness, it is my goal to start conversations about what kind of programs and support systems could be put in place by members of Yukon communities for Yukon communities.

Chapter Summary

In this chapter I have presented a brief rationale for my chosen method, *design research*, informed by the design strategy of *backward mapping* (Wiggins & McTighe, 2011). I have provided an overview of the initial design of the six part, ten-hour workshop, including outcomes and activities, for a target audience of youth aged 15 years or older. I have described my thinking or design decisions pertaining to outcomes, assessment, and activities, following the backward mapping sequence. To conclude the chapter, I have shared my final reflections on the importance of stigma reduction education and community involvement in healing. The complete leader's manual for the *A Person First!* workshop follows (see Appendix A).

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APPENDIX A: A PERSON FIRST! LEADER'S MANUAL

Welcome to the Leader's Guide

For

A Person First!

A Workshop to Help Northern Youth Support Friends with Mental Problems

Welcome! Thank-you for your interest in leading a workshop to help young people in your community support family and friends with mental problems. One in five Canadians will have some mental illness in their lifetime and most will not get the help they need. Caring friends can help people with mental illness regain their health or at least keep this problem from ruining their life. The value of good friends for regaining mental health after a problem is especially strong for youth, who naturally depend so much on their friends to help them learn who they are as they grow into adulthood.

As a leader of ***A Person First!*** workshop, you will gather a group of youth and lead them through about ten hours of community education. The videos, discussions and activities that are described in this guide will encourage teens from 15 to 19 years of age to think about what happens when people are criticized and excluded for having a mental problem or more serious mental illness. They will learn about the harmful effects of this kind of stigma and plan ways that they can support instead of stigmatize anyone they know who is suffering from mental health problems.

Your job as a workshop leader is very important because you know your community well. You know how people have suffered as a result of mental problems and you are aware of the kinds of cultural practices that can bring healing. I have tried to write this leader's guide as clearly as possible, so you will have confidence in your ability to do this important job.

Because some of the things the group will be talking about are painful, it is a good idea to invite other local people to help you with this workshop, maybe an Elder or a nurse, someone from the school, or an adult that young people know and respect.

Thanks again for your willingness to take on this important work for your community.

Debra Edzerza

How to Use this Guide

- If you are attending a leader's prep session, we will go through the activities that you will use when you lead your *A Person First!* workshop.
- If you are getting ready to lead a workshop on your own, read through this manual stopping to view each of the videos and think about the discussion questions and other activities.
- It is important for you to be familiar with the information and activities in the workshop before you begin sharing them with youth.
- It is important to fully understand the traditional circle protocol outlined in part 1:A. and have participant sign the contractual agreement.
- Recognizing that the topic of mental illness is a sensitive subject for some, clearly explain that the Elders are there to offer support, if someone in the group feels they need space or break they are welcome leave, an Elder or group leader will check on them immediately.

The Group Leader

- ✓ *Welcomes each person as they arrive*
- ✓ *Offers pop, water, or juice*
- ✓ *Invites everyone to the circle*
- ✓ *May ask an Elder to begin the workshop with a prayer*
- ✓ *Introduces himself or herself first and explains his/her reasons for leading this workshop*

Part 1: A Strong Circle of Support

Welcome: <u>Two Truths and a Lie</u>

How well do we know each other?

1. Everyone is seated comfortably in a circle.
2. Passing a talking stick or feather clockwise, each person tells two truths and one lie about themselves.
3. The group has one chance to guess which one is the lie.

4. The person speaking admits when a correct guess is made.

> *"The circle has great healing power, because when in the circle no one is behind you. No one is in front of you. No one is above you. In the circle no one person is better or higher than you. Everyone is equal. That is why the First Nations People across the world use the circle whenever they can to explain, demonstrate, or perform daily functions in their lives. Some examples of this are: sweat lodges, circle sentencing, medicine wheel, celebration, circle of life, and so on."*
>
> *- John Edzerza, 2008*

Why Are We Here?

- To build a strong circle of support for people who have mental health problems

How Can We Build a Strong Circle of Support?

- ***By maintaining confidentiality***
- By creating a circle where everyone belongs
- By learning about *stigma* and the harm that it causes
- By gaining knowledge about mental health issues
- By understanding how people with mental health problems feel
- By practicing support skills – what to say and do
- By reflecting on our own thinking and behaviour
- By planning community action to share what we've learned

These are the goals of this workshop – the outcomes that we want group members to leave with.

A Strong Circle is About Respect

1. Each community has traditional circle protocol.
2. Circles are used to explore issues of significance.
3. The circle must be complete – people must not be left out.
4. An object – a stick, feather, rock or other object that has meaning – is passed around. If no object is

Talk to an Elder in advance about circle protocol in your community. You may also invite an Elder to speak to the group about the importance of the circle.

It is important that this workshop be culturally relevant and respectful of our traditions.

Traditions of respect and inclusion will be valuable resources for these youth as they move into leadership in the community.

available, ask someone to lend something that is meaningful, for example, a bracelet.

5. Everyone listens to the person holding the object without interrupting. If the person talking is in pain, body language from the group sends a message of support. People nearby may touch the person's arm or give a comforting pat on the back.

6. Everything about the circle shows respect for individuals and what they have to say: what is said in the circle remains confidential.

Circle Agreement

I agree to follow circle protocol. I will show respect for others in the circle.

_____
Signature

Mental Health, Mental Illness Brainstorm

1. Have a flip chart or white board with two columns – Mental Health and Mental Illness.
2. In the circle, invite people to share what they know about kinds of mental illness, symptoms, treatments, and difficulties.
3. People may choose to pass without speaking.
4. Note that it is important not to mention anyone's name – just what you have learned from their experience.
5. You can write a few of your own ideas to get things started.
6. Write down everything – there are no bad ideas in a brainstorm.

A brainstorm will get group members thinking about the topic and the words for talking about it.

You will also get to know your group and understand what knowledge they have or what their concerns are.

Flip Chart Tips

- *Use new markers*
- *Double space*
- *Print clearly*
- *Use point form*
- *Save charts to review*

Mental Health	Mental Illness
• is connected to physical health – e.g. exercise, drug free • Healthy people have good relationships • Some depression, anxiety, sadness or grief is expected in life and is healthy	• Interferes with a person's ability to maintain relationships and to deal with day to day life

What is the Medicine Wheel?

"Traditionally, the Medicine Wheel is meant to make sense of the world and bring order to it, without isolating or compartmentalizing our different understandings....It celebrates both the diversity and unity of our spiritual, mental, physical and emotional experiences....It represents healing, humanity, inclusion, diversity and unity."

-ACIC, Medicine Wheel Evaluation Framework

How can we use it for this workshop?

The UMAY (2008) youth organization has described the medicine wheel as a self-reflection tool that provides young people with a visual representation of their own attitudes, community values, and personal perceptions. We will use it to think about our thoughts and feelings about people with mental illness at the beginning of the *A Person First!* workshop and again at the end. We will invite workshop participants to think about how their knowledge, skills and attitudes have changed as a result of the workshop.

The Medicine Wheel...

- Deepens understanding
- Encourages participation
- Fosters storytelling

- *Medicine Wheel teachings came from outside the Yukon but many First Nations people here have adopted them. Using the Medicine Wheel as a way of thinking about our own actions fits with traditional Yukon First Nations ways of learning and healing.*
- *Ask the group to share their knowledge of the Medicine Wheel.*

An Introduction to the Four Quadrants of the Medicine Wheel

North (Generosity)

An important virtue Elders instilled in the young was to be generous and unselfish. Children were taught generosity by helping others. They learned self-respect and kindness by experiencing the value of making positive contributions to others.

South (Mastery)

Children were taught to carefully observe and listen to those with more experience. A person with greater ability was seen as a model for learning. Young children would sit and watch Elder sew, or watch and listen to stories on how to make preservatives, lessons taught were season dependent.

East (Belonging)

Children were taught to treat others as family, such relationships of respect ensured the survival of the culture. Even if parents died or were not responsible, the community supports would be in place to care for the next generation. Even today in Yukon communities and First Nations people are referred to as auntie, uncle, brother sister, cousin, yet they may not be blood related.

West (Independence)

Traditionally to First Nations independence meant to build respect and teach inner discipline. From childhood, children were encouraged to make decisions, solve problems, and show personal responsibility. Adults in communities modeled, nurtured, taught values, and provided feed back to them. In Yukon and other northern First Nations communities, young boys were often assigned to an uncle to learn hunting skills, and to

be independent. Young girls were often mentoring under their aunties, or Grandmothers learning how to cook, sew, and process food and hides, essentials for nomadic society.

First Medicine Wheel Reflection

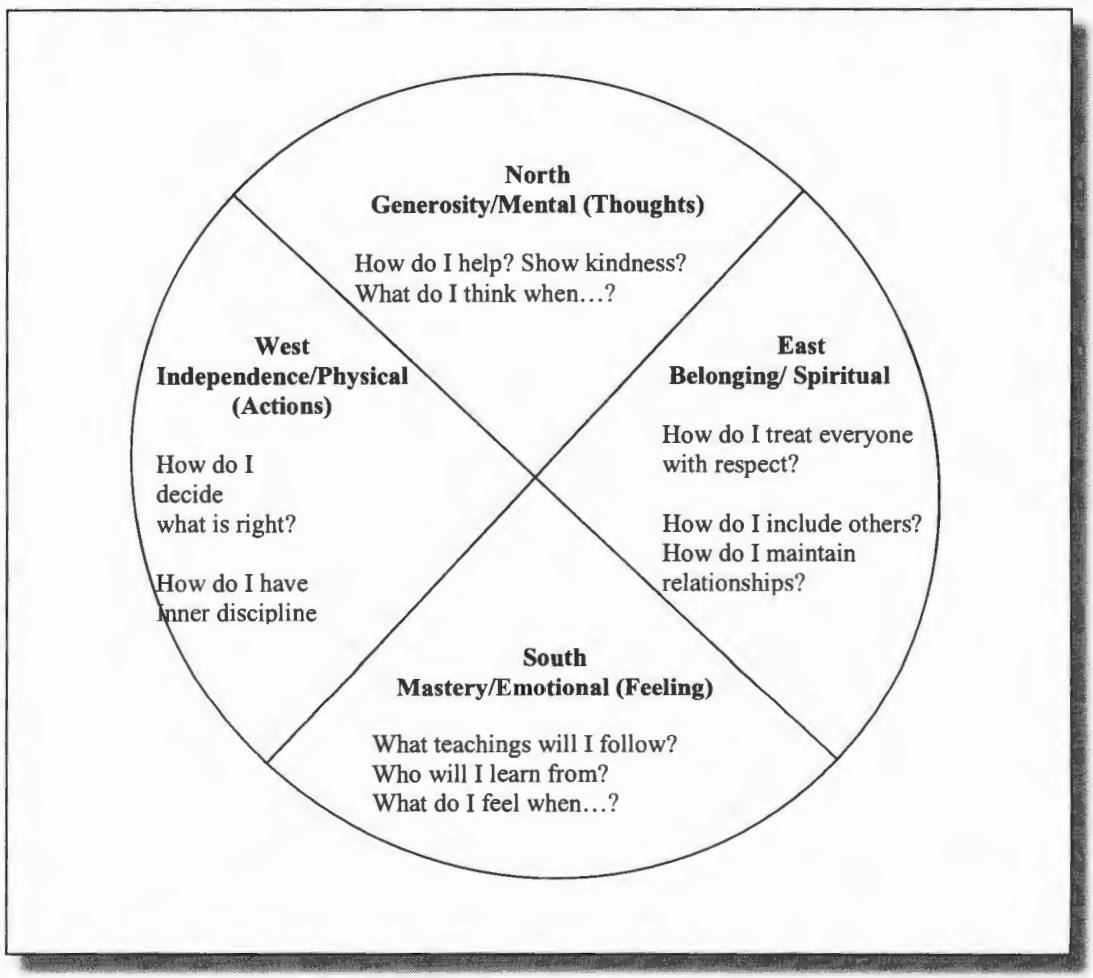
- Use a symbol (see below) and a key word or phrase to describe your thoughts, feelings, and actions toward people with mental problems or mental illness.

✓ **Successes** are positive things you already do.

★ **Goals** are things you want to do in the future.

? **Questions**: I need to think/learn more about this.

Remember that failure has no place in Medicine Wheel teachings.



- Talk with a partner about what you have recorded on your Medicine Wheel.
- All through this workshop, think about how these thoughts, feelings, and actions might change as a result of what you learn.

Part 2: Mental Illness Types and Treatments

Auditory Hallucinations

1. Invite students to organize into groups of three or four.
2. Two students will have an everyday conversation.
3. The third student will be the inner voice (auditory hallucination) of one of the people talking. He or she will sit behind that person and whisper the script while he or she is trying to carry on the conversation.
4. Group members change roles so that everyone has an opportunity to experience the exercise

This exercise is to help students gain understanding about how difficult it is to cope with symptoms of mental illness.

Caution: this exercise can be disturbing for some people.

Remind the group that it is always ok not to participate if you feel uncomfortable.

Script for Auditory Hallucinations

(Person reading the script can choose a voice – suspicious, distracting, hostile or amusing. These are some of the ways that people suffering from auditory hallucinations describe their voices.)

For female partner:
You are stupid, she doesn't want to talk to you, you're ugly, you're useless, she doesn't want to look at you, she lies, don't listen to her, she's evil, she knows that you're no good, she knows you're lazy, she's laughing at you, don't listen to her, she knows what you're thinking, everyone is looking at you.

***For* male partner:**
You are stupid, he doesn't want to talk to you, you're ugly, you're useless, he doesn't want to look at you, he lies, don't listen to him, he's evil, he knows you're no good, he knows you're lazy, he's laughing at you, don't listen to him, he knows what you're thinking, everyone is looking at you.

Discussion

- Share your feelings about this experience.
- What would you do if someone you know was experiencing auditory hallucinations?

(Tell an adult. Get them to see a nurse or doctor as soon as possible.)

How Do People Become Mentally Ill?

- **Watch this video to learn about the chemical causes of mental illness.**

Function of Neurotransmitters
http://www.youtube.com/watch?v=haNoq8UbSyc

We now know that communication between the neurons in our brains is powered by electricity. Neurostransmitters carry messages about pain and pleasure, sadness and joy, and stress and relaxation. Our brains contain tiny molecules of mood, including serotonin, substance P and endorphins. One of serotonin's many jobs is to inhibit violent tendencies. Substance P carries messages about pain. Endorphins are pain killers.

It is easy to disrupt our chemical equilibrium or balance. Mood disorders and mental illness can result.

- **Watch this short video to understand that chemical balance and mental health can be disrupted by drug use.** (The full 45 minute video can be viewed at http://www.cbc.ca/natureofthings/episodes/the-downside-of-high.)

Downside of High (from CBC, The Nature of Things)
https://www.youtube.com/watch?v=MQyO3YmS4Gk

Mental Illness Types, Risk Factors and Treatments

- There are many kinds of mental illnesses or disorders. Medical professionals often group mental disorders in categories.
- The most common are depression and anxiety it is common for people suffering from depression and anxiety to self medicate often leading to substance abuse..
- Cutting is a behaviour, also known as self-harm or self-injury, that is common for youth who are feeling extreme emotional pain. It may be related to depression or anxiety but it is not listed as a disorder.

Types of Mental Disorders (from teenmentalhealth.org)

- **Circle** the types that have had an impact in your community.
- **Underline** the types that you most interested in learning about.

This activity gives the group leader an understanding of group interests.

Leaders can gather more information on the types of mental disorders that have had an impact in the community.

Mood Disorders: Disturbances in usual mood states
- major depressive disorder
- persistent depressive disorder (dysthymia)
- bipolar disorder

Psychotic Disorders: Disturbance of thinking/perception/behaviour
- schizophrenia
- delusion disorder

Group members can be encouraged to learn more about the disorders that interest them and share what they learn in the next session.

Personality Disorders: Maladaptive personal characteristics
- dramatic, emotional or erratic disorders
- anxious or fearful disorders

Eating Disorders: Disturbances of weight and feeding behaviour
- anorexia
- bulimia

Developmental Disorders: Early disturbances in brain development
- autism spectrum disorders
- attention deficit hyperactive disorder
- learning disorders

Behavioural Disorders: Persistent disturbances in expected behaviours
- Oppositional defiant disorder
- conduct disorder

Addictions: Disorders of craving
- substance use disorders

Obsessive Compulsive and Related Disorders
- obsessive compulsive disorder

Risk Factors (from www.mayoclinic.org)

Exact causes of mental illness are hard to pinpoint. Risk factors may increase the chance that mental illness will occur. It is important to note that mental illness may not occur even though risk factors are present. That is, if

you have a family member with mental illness, it doesn't mean that you will become mentally ill. It does mean that you need to take good care of yourself so that the risks are not increased.

Mark the risk factors that are beyond our control with an X.
Mark the risk factors that we can do something about with a ✔.

- Having a close relative with a mental illness
- Exposure to viruses, toxins, drugs or alcohol before birth
- Stressful situations, such as financial problems, death, family break up
- A chronic medical condition, such as cancer
- Brain injury
- Traumatic experiences, such as violence
- Drug use
- Abuse or neglect in childhood
- Having few friends or few healthy relationships
- A previous mental illness

Discussion

Question: What can people do to strengthen their circle of support and reduce mental health risk factors in their communities?

Possible Answers: support mothers who do not drink or do drugs during pregnancy; support each other when there is a death or family break up; visit and encourage those with cancer, brain injuries, mental illness; work toward a sober, drug-free community; report child abuse or neglect or help care for children in need; organize community gatherings, social events.

Treatment

- Treatments vary according to the type of illness and severity.

- a combination of medication, therapy and family or community support is often the most effective

- In Yukon communities support may come from Elders, healers, sweat ceremonies, and extended family

Medications

- Antipsychotics
- Antidepressants
- mood stabilizers
- anxiolytics or anti-anxiety medication

Psychotherapy

- talk with a therapist is often used along with medication
- therapy relieves distress by changing negative attitudes, behaviours, and habits and promoting constructive ways of coping
- types of therapy include short-term, long-term, individual and group
- requires a supportive, comfortable relationship with a trusted therapist

Self-help groups

- run by clients of the mental health system and their families
- provide an important part of
- informal meetings with others with similar issues and challenges
- groups with a specific focus do not exist in small communities
- support from family and friends may be more available
- An alternative is for people to travel to Whitehorse to attend groups

Family support

- informal relationships with friends, family, and others play a vital role in supporting and maintaining mental health.
- family and friends of people need as much information as possible so they can provide support as well as deal with their own feelings

Community Support (services available in each community varies)

- People with serious mental illness may need access to social services, education, public housing, social support and family services
- Some considerations: Is housing provided by the First Nations band? Is support available through the school? Do counselors or mental health professionals from Whitehorse visit once a month? Are there work programs, culture camps? Are Elders available?

Begin to Plan Community Action

- What information can be gathered and shared to build a strong circle of support for those with mental illness in your community?

Part 3: Learning About Stigma

- **Watch to learn about stigma, the harm that it causes, and how to prevent it.**

Stigma and Mental Illness (from IWK Heal Centre)
https://www.youtube.com/watch?v=LTIZ_aizzyk

This video shows us the faces of those who live with mental illness. We meet Stella Ducklow, a young woman who wants to be thought of as *a person first* and not just an illness or a problem. Stella and others talk about the way nurses and doctors have treated them with discrimination and prejudice because their illness is mental and not physical. They feel bullied and gossiped about. This is the *stigma* of mental illness – when people judge and reject someone without understanding what they are going through.

This video describes the harm that can be caused by stigma. Mental illness can be fatal – the cause of death can be listed as anything but the real cause – hopelessness. Everyone needs to know that mental illness can be managed and people can live normal lives.

Circle Talk: What did you learn? What did you feel? How can we help?
(Group members can talk about any of these questions. A leader or volunteer writes main points on chart paper while people talk.)

- **Watch this video to learn more about stigma and what we can do about it.**

Ending the Stigma of Mental Illness (from Bring Change 2 Mind)
https://www.youtube.com/watch?v=ZdUz0tlKZ78

People in this video talk more about stigma – prejudice and discrimination equal stigma. Stigma comes from fear and a lack of knowledge. Stigma is when members of a group are despised, ignored or isolated. People who have mental illness often feel that other people exclude them and treat them unfairly.

Silence about mental illness and suicide helps keep the stigma going. The best way to stop stigma is to talk about these issues without fear. A young woman says that she will be part of the generation that will make a difference. At the end, many people tell us that life is good now – because they got the right help. (Friends and family can be part of that help!)

Circle Talk: What did you learn? What did you feel? How can we help?
(Group members can talk about any of these questions. A leader or volunteer writes main points on chart paper while people talk.)

Medicine Wheel Group Reflection

What did we learn? What did we feel? Where does it fit?

1. Review the list of things we felt and learned as we watched the videos.
2. Look again at the Medicine Wheel. Where do some of the things we learned fit on the wheel? (Generosity, Belonging, Mastery, Independence)

There are no wrong answers – this is a chance to review the meaning we made from the videos and to think more deeply using the Medicine Wheel as a guide.

Here are some examples:

- People can die of hopelessness if nobody helps them.
- Stigma comes from fear.
- Even nurses can stigmatize people they are supposed to be caring for.
- Don't give up on a person with mental health problems.
- It does not help to say, "You should have tried harder!".
- It is important to believe people when they tell you something is wrong.
- Mental health problems are very common – they can happen to anyone.
- I felt happy when the people said that their lives were better now.
- I wanted to help that girl who said we have to be the generation to make a change.
- Mental health problems can happen to anyone.
- We should not be afraid to talk about mental illness.
- Gossip is a kind of stigma.

- *Belonging – we can help them belong.*
- *Mastery – we can learn what to do to help.*
- *Mastery – Knowledge helps to get rid of fear.*
- *Independence – Even nurses can make harmful choices.*
- *Generosity – give them your time and patience.*
- *Belonging – respect someone enough to listen to what they need.*
- *Belonging – respect*
- *Generosity – give them your full attention*
- *Belonging – people are more the same than different*
- *Generosity – want good things for other people.*
- *Independence – make a decision to help*
- *Mastery – learn what to do*
- *Belonging*
- *Independence or Mastery – Do it even if it is hard for us.*
- *Independence or Mastery – Have the inner discipline to stop yourself from saying or doing something that will hurt someone.*

Part 4: Removing the Labels

In Our Own Words: What is stigma?

- Record contributions. Add/revise until everyone in the group is happy with the definition.

- **Watch this video to learn about how stigma becomes a heavy burden.**

Carry the Load (from Change the View, 2011)
https://www.youtube.com/watch?v=jrCtODVKSKo

A young man in a school hallway carries a heavy backpack. The weight that he carries is the stigma of mental health issues – he has depression but he tries not to make his condition obvious because he gets singled out by his friends. Other young people talk about their conditions – Obsessive Compulsive Disorder (OCD), Eating Disorder, and Bipolar Disorder. All of them try not to make their conditions obvious because they get singled out by their friends. One person explains that the best a friend can do is to be patient and non-judgmental. The final message from all the young people who have spoken is "We all carry this weight on our shoulders. Help break the stigma."

Circle Talk: What did you learn? What did you feel? How can we help?
(Group members can talk about any of these questions. A leader or volunteer writes main points on chart paper while people talk.)

Being "singled out" may mean that you are called names that make you feel like you are different from everyone else.

- **Watch this video to think about how labels are part of the heavy load of stigmatization for people with all kinds of disabilities – physical or mental.**

I Define Me (from Proud To Be Disabled, 2007)
https://www.youtube.com/watch?v=opgUMJTXTYY&list=PL45B1637ABEF55593

A young man sits in a wheelchair in a busy mall. People who walk by put sticky labels on him to show what they are thinking – words like "victim", "helpless" and "incapable". He takes the labels off and crumples them on the floor. When his friend arrives and waves to him, he smiles and wheels toward her, leaving the labels behind. "I define me", he says.

ABCs of Stigmatization

1. In groups of two or three or in the whole group, write the alphabet.
2. Brainstorm labels, names, and descriptions that begin with each letter and discriminate against those living with mental illness, such as C - crazy, R - retarded, L - loony, P - psycho.
3. Challenge: complete the whole alphabet within a time limit (5 minutes?).
4. Review the ABCs together. Does this long list surprise you?
5. An adaption to this exercise is to divide the alphabet in to groups 1st group has A – M and the 2nd group N-Z.

This activity gets people working in teams or as a team to meet a challenge.

It also builds awareness about how many harmful labels are attached to those who live with mental illness.

Discussion Question

- **Question:** How do you think these discriminating words affect those living with mental illness?
- **Possible Answers:** make them feel bad, gives them a bad reputation, harder time getting places to live, work, go to school, make friends, etc.

Have a discussion in the circle or ask the group if they would rather discuss in small groups and report back to the group.

Medicine Wheel Group Reflection

What did we learn? What did we feel? Where does it fit?

1. As before, review the points made in Circle Talk and decide where they fit on the Medicine Wheel.
2. There can be some discussion about the best fit for each point but there are no wrong suggestions, as long as a person can give a reason for his/her choice of quadrants.
3. Not every point has to be discussed – invite students to look at the chart and pick a few important ones to match to the Medicine Wheel.

This group activity reviews the learning so that the group will remember it more easily.

It also helps people get ready to do the final Medicine Wheel Reflection for themselves.

Part 5: What If Your Friend Needed Help?

Five Things in Common

1. Group members choose a partner.
2. Each pair will have 30 seconds to find five things they have in common.
3. Each pair finds another pair and has one minute to find things that all four have in common.
4. Each group of four presents the list of things that they all have in common.
5. Ask: How did you feel when you found things in common?

This pair activity is a fun and friendly way to begin a session.

It also shows that the things we have in common are the basis of our relationships.

Discussion Question

- **Question:** Something everyone has in common is that we do things every day to take care of our mental health. What are some of those things?
- **Possible Answers:** do things we enjoy, eat well, sleep enough, spend time with friends, think positively about ourselves, etc.

Discuss in the circle or in small groups, with each group reporting highlights of the discussion back to the larger group.

This discussion links the Five Things in Common activity with the need to look after our own mental health and to recognize when friends may need help.

When your friend is not doing these things, use the WALT strategy!

1. **Watch for Warnings** – Know the warning signs of suicide.
2. **Ask** – Know what to ask to see if there is immediate danger.
3. **Listen** – without judgment but with understanding.
4. **Tell** – your friend how to get help. Tell an adult who can help.

- **Watch this video to learn more about WALT**

WALT is not mentioned in the video – but there is information for each of the steps: watch, ask, listen, tell.

Teen Suicide Prevention (from the Mayo Clinic, 2014)
https://www.youtube.com/watch?v=3BByqa7bhto

A group of young men and women stand together to share instructions about what to do to prevent teen suicide. The video is meant for parents but it has important information for friends as well. First, know the warning signs of suicide. Then know what NOT to say and what to say and the questions to ask. There are some helpful tips, such as insisting that the person make a list of people they can talk to and keep it in their wallet.

What do we remember/know about WALT?

Warning Signs **Don't wait until you are sure! Trust your gut.**	**Ask** **It never hurts to ask!**	**Listen** **Show them you care! Is it an emergency?**	**Tell** **Never promise to keep suicidal thinking a secret!**
• Acting different/down • Crying/getting mad • Not sleeping/always sleeping • Shutting friend out • Giving stuff away • Acting reckless	• What's wrong? • How can I help? • Have you thought about hurting/killing yourself?	• Take what your friend says seriously. • Listen calmly without interrupting, without judging • Listen for clues about what to do – is it an emergency?	• **Non-emergency:** Tell your friend to write down and save names/number of people to talk to and a suicide hotline number. • Tell your friend that he/she can get through this (without alcohol or drugs!) • Tell your friend that you will stay connected • Encourage physical activity • Encourage him/her to get help – talk to a doctor, nurse, counselor, minister, teacher **Emergency:** • Call 911! • Do NOT leave the person alone

Advice for friends of teens who show warning signs of suicide is offered on websites from trustworthy organizations:

- http://kidshealth.org/teen/your_mind/friends/talking_about_suicide.html#
- http://www.mayoclinic.org/diseases-conditions/suicide/in-depth/suicide/ART-20044707?pg=2

Let's Try It – Role Play or Discussion

Imagine that either Amanda or Andrew is your friend. What are the *warning signs*? What would you *ask*? *Listen* for? What and who would you *tell*?

Amanda is in your grade but she has been missing a lot of school lately. When she is there, she is not hanging out with anyone and she has her hoodie up all the time. She gets mad when anyone speaks to her. She seems to be losing weight and when you see her at parties, you notice that she has been drinking more than usual. Now you hear that Amanda is using drugs, which is not normal for her. Every time you call her house her brother says that she is sleeping.

Andrew is the same age as you are. You aren't close friends but you've known him since Kindergarten and sometimes you shoot baskets in the schoolyard. Since his girlfriend broke up with him he seems to be drinking heavily and picking fights wherever he goes. At a bush party, you hear Andrew bragging about playing chicken with his truck on the highway. He talks about what it would be like to wait just a second too long and splatter his brains on the windshield.

Role play is a powerful way to practice new skills.

Some people love role play so ask for volunteers for the parts of Amanda and Andrew and of friends who watch, listen, care and help.

But many people are uncomfortable doing a role play – if there are no volunteers, discuss the WALT strategy for Amanda and for Andrew as a group.

- **Watch this video to think about important messages for someone who is thinking about suicide.**

For Those Considering Suicide (from Wellcast, 2013)
https://www.youtube.com/watch?v=IqqIV8x82Qc

First, if this is an emergency, call for help, right now! (A phone number is given.)

Then a voice speaks while animated illustrations emphasize the message. You are loved and valued and you would be missed forever. If you are having suicidal thoughts, seek support. Express your feelings in a poem, song, or art work. Share it with someone. Face the fear! Certain people or events my trigger dark thoughts – bullying, abuse, death of a friend or loved one. But death is NOT the only way to end this pain. In fact, these thoughts may be caused by a mental health problem such as depression, bipolar disorder, anxiety, schizophrenia, or substance abuse. These conditions are treatable and treatment can lift you out of your dark thoughts. Find out where you can get help.

Remember to care for yourself. Life is hard but you don't have to bear it alone.

Circle Talk: What did you learn? What did you feel? How can we help?
(Group members can talk about any of these questions. A leader or volunteer writes main points on chart paper while people talk.)

Part 6: Personal Growth and Community Action

Medicine Wheel Group Reflection from Part 5
What did we learn? What did we feel? Where does it fit?

1. As before, review points made in Circle Talk and decide where they fit on the Medicine Wheel.

2. Choose points that are different than those already recorded.

Thank Tank

- "Thank Tank is all about the stuff that happens in everyday life that gives us a bit of a buzz. It's about writing down the random moments that make you feel a little bit awesome so you don't forget them." *(from www.biteback.org.au)*

- Thinking of things you are grateful for each day or each week helps maintain mental health.

Thank Tank Circle

- In the Circle, share something this workshop has made you grateful for.
- **Watch this video to see that there is hope: It is possible for people with mental illness to be successful.**

Mental Health: A Conversation that Matters (from Vibewire)
https://www.youtube.com/watch?v=g4zVW4Ar0Qk

Young adults describe what happened to them when they began to have mental health problems as teens. A young man said that things started falling apart in grade seven. Soon he was thinking about death all the time and he eventually lost hope that it would get better. A young woman remembers that her best friend just left her because her depression made her too negative. She looks back on different periods of depression in her life and she sees now that it comes and goes. Both mention that suicide is a big problem that needs to be talked about.

The mood lightens as these young adults begin talking about their lives now. Both are working on online projects to support those living with mental illness. The woman works on a creative space called *This Place is Yours* and the man works on *Bite Back*, a website to help young people get the most out of the life they live.

They say that it is important to get people with mental illness to seek help early on. There are things you can do every day to improve your own wellbeing – eat well, exercise, take time to connect with people. Their final message is: Have the courage to be vulnerable. You will get through it.

Circle Talk: What did you learn? What did you feel? How can we help?
(Group members can talk about any of these questions. A leader or volunteer writes main points on chart paper while people talk.)

Community Plan

- Now that we have some understanding of mental health and mental illness, how can we build a stronger circle of support in our community?

Questions for Small Group Discussion

1. Groups discuss and list supports that exist in their communities, such as peer groups, nurses/doctors, teachers, youth programs, activity centers, culture camps/hunting/fishing. If they have to see the doctor do they have to travel to Whitehorse? Is there an Elder in community or a person that everybody sees if they need to talk to someone?

2. Imagine that your community could become a stigma-free, mentally healthy community in five or ten years. What would that look like?

3. What changes would bring this new vision of your community to life?

4. What will be your first step?

5. Who can help? (principal and teachers, Chief and Counsel, MLAs, Elders, nurses)

If your group is small, it could work well to discuss these questions as a whole group.

For larger groups, small group discussion will get the conversations going so that more people will contribute ideas.

Rather than interrupt the groups to share each question, move among the groups to hear their good ideas.

Circle Talk: Invite a person from each small group to share the highlights of their plans. Encourage them to start with manageable steps – things they can do themselves or with others in this group.

Reviewing Our Workshop Goals

Reviewing the goals of the workshop together may help group members get ready for the final Medicine Wheel Reflection and also the workshop evaluation .

We Can Build a Strong Circle of Support...

1. By creating a circle where everyone belongs
2. By learning about stigma and the harm that it causes
3. By gaining knowledge about mental health issues
4. By understanding how people with mental health problems feel
5. By practicing support skills – what to say and do
6. By reflecting on our own thinking and behaviour
7. By planning community action to share what we've learned

Discussion

- Which goals did we meet well?
- Which goals could we have spent more time on?

Celebration Break

The workshop is almost finished – just the final Medicine Wheel Reflection and Workshop Evaluation. If time permits, break for a snack and a bit of social time before these final activities. Celebrate the Circle that has become stronger.

Final Medicine Wheel Reflection

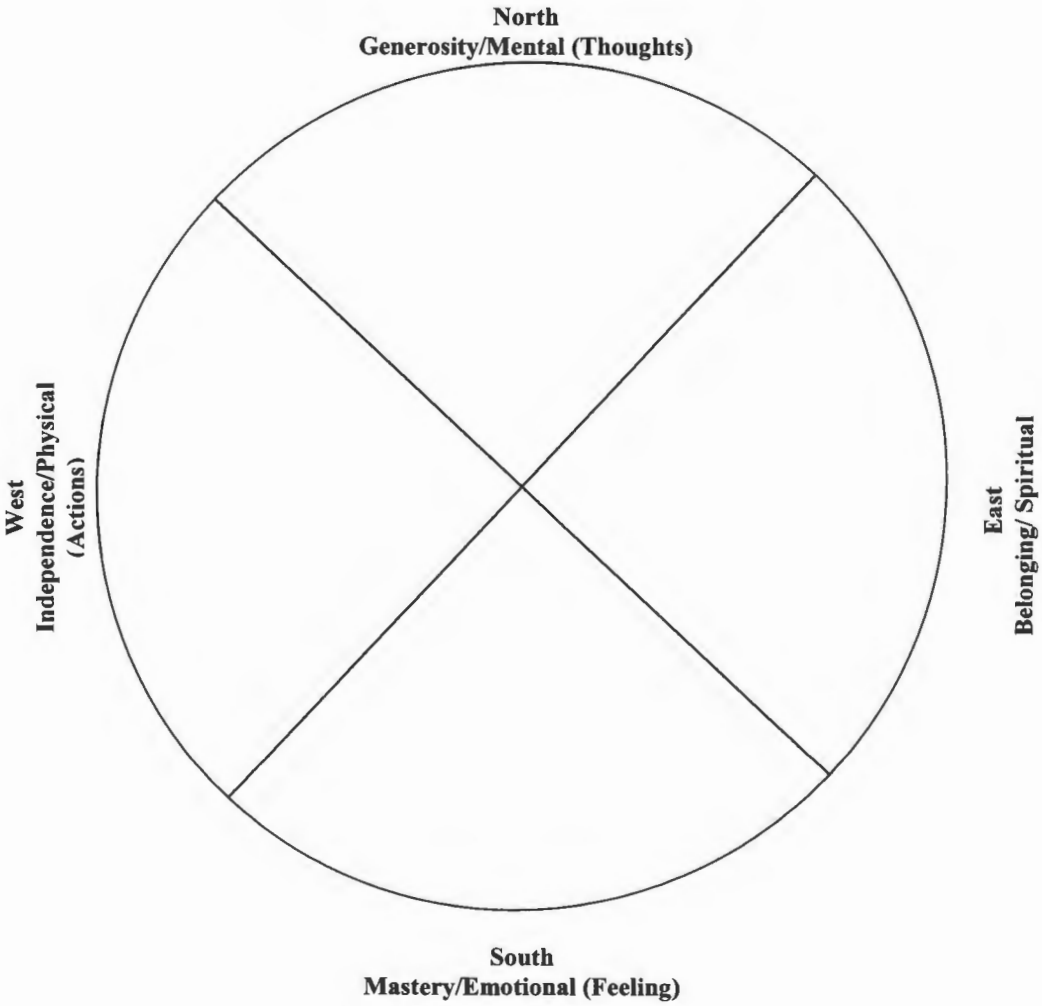
- Use a symbol (see below) and a key word or phrase to describe your thoughts, feelings, and actions toward people with mental problems or mental illness.

✓ **Successes** are positive things you already do.

★ **Goals** are things you want to do in the future.

? **Questions**: I need to think/learn more about this.

Remember that failure has no place in Medicine Wheel teachings.



- Compare with your first Medicine Wheel Reflection. What has changed? Describe the changes to a partner.

This is the last Circle Talk. Record these answers carefully to help you see the effectiveness of the workshop.

Circle Talk: How has this workshop changed our thinking? How do we think it will change our actions?

Youth Workshop Evaluation

Date _____ Location of Course: _____

Yukon Community: _____ Instructor: _____

Part A

1. How new to you were the Medicine Wheel Concepts?

☐ Very new

☐ Somewhat new

☐ Some parts were new

☐ Not at all new

Explain:_____

_____

1. How new to you was the information about mental illness?

☐ Very new

☐ Somewhat new

☐ Some parts were new

☐ Not at all new

Explain:_____

_____

3. How new to you was the information about the causes of mental illness?

☐ Very new

☐ Somewhat new

☐ Some parts were new

☐ Not at all new

Explain:_____

Part B

4. I found this course easy to understand

☐ Strongly disagree

☐ Disagree

☐ Agree

☐ Strongly Agree

Explain:_____

_____

5. I learned a lot about types of mental illness

☐ Strongly disagree

☐ Disagree

☐ Agree

☐ Strongly Agree

Explain:_____

_____

6. I understand more about supporting people with mental illness?

☐ Strongly disagree

☐ Disagree

☐ Agree

☐ Strongly Agree

Explain:_____

_____

7. I learned useful information about stigma reduction

☐ Strongly disagree

☐ Disagree

☐ Agree

☐ Strongly Agree

*Explain:*_____

Part C

8. I found this course easy to understand

☐ Strongly disagree

☐ Disagree

☐ Agree

☐ Strongly Agree

Explain:_____

_____

9. I found the activities fun and educational

☐ Strongly disagree

☐ Disagree

☐ Agree

☐ Strongly Agree

Explain:_____

_____

10. People my age should learn about mental illness

☐ Strongly disagree

☐ Disagree

☐ Agree

☐ Strongly Agree

Explain:_____

_____

11. Would you recommend this course to your friends?

☐ Strongly disagree

☐ Disagree

☐ Agree

☐ Strongly Agree

Explain:_____

_____

12. What is your overall response to this course?

THANK - YOU

Circle of Respect Confidentiality Agreement

This group exercise is completed before the workshop proceeds. Have the group in a circle formation, on large chart paper, have group participate in laying the ground rules out, be clear that the rules of the circle are to create an environment that is a safe learning space that includes respect for all, confidentiality, what happens here and said here stays here. Once the circle protocol is written and agreed to by all the participants have the group sign it. Including the leaders.

Why Are We Here?

- To build a strong circle of support for people who have mental health problems

How Can We Build a Strong Circle of Support?

- ***By maintaining confidentiality***
- By creating a circle where everyone belongs
- By learning about *stigma* and the harm that it causes
- By gaining knowledge about mental health issues
- By understanding how people with mental health problems feel
- By practicing support skills – what to say and do
- By reflecting on our own thinking and behaviour
- By planning community action to share what we've learned

A Strong Circle is About Respect

7. Each community has traditional circle protocol.
8. Circles are used to explore issues of significance.
9. The circle must be complete – people must not be left out.
10. An object – a stick, feather, rock or other object that has meaning – is passed around. If no object is available, ask someone to lend something that is meaningful, for example, a bracelet.
11. Everyone listens to the person holding the object without interrupting. If the person talking is in pain, body language from the group sends a message of support. People nearby may touch the person's arm or give a comforting pat on the back.

Everything about the circle shows respect for individuals and what they have to say: what

Circle Agreement

I agree to follow circle protocol. I will show respect for others in the circle.

Signature of participants _____

MENTAL HEALTH RESOURCES

School Psychology Resources On-line: http://www.schoolpsychology.net

Study Web: Links for Learning: http://www.studyweb.com/science/ment_toc.htm

Changing directions, changing lives: The Mental Health Strategy for Canada Addresses Northern and First Nations Priorities http://strategy.mentalhealthcommission.ca/media/

Canadian Health Network: http://www.canadian-health-network.ca/1mental_health.html

Canadian Mental Health Association, National Office: http://www.cmha.ca/

Internet Mental Health: http://www.mentalhealth.com

Health Canada, Mental Health Web site: http://www.hc-sc.gc.ca/hppb/mentalhealth/index.html

Bipolar Kids Homepage: http://www.bpkids.org

Facts about youth suicide: http://www.emh.org/acadia/su.htm

Warning Signs, Information, Getting Help: http://www.focusas.com/Depression.html

Suicide Awareness Voices of Education: http://www.save.org/

National Depressive and Manic Depressive Association: http://www/ndmda.org

Bipolar National Foundation for Depressive Illness: http://www.depression.org/

Wing of Madness Depression Community: http://www.wingofmadness.com/

Treatment of Bipolar Disorder: A guide for patients and families:

http://www.psychguides.com

Schizophrenia Society of Canada: http://www.schizophrenia.ca/

The World Psychiatric Association program to fight stigma due to schizophrenia:

http://www.openthedoors.com/

Art Exhibitions by the Mentally Ill: http://www.naemi.org/

The Down Side of High:

http://www.cbc.ca/documentaries/natureofthings/2010/downsideofhigh/

For additional documentaries

The National Film Board of Canada, Sales and Customer Service, D-10 PO Box 6100, Station Centre-Ville

Montreal, Quebec H3C 3H5 www.nfb.ca

The Whitehorse public library may have some of the titles and if that is the case you can obtain them from the school library. A school teacher maybe have free access to some of the NFNC titles through the internet

NOTES