Mental Health and Poverty in Young Lives: Intersections and Directions

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ABSTRACT

This paper provides a conceptual synthesis of literature that addresses intersections of mental health, poverty, and school. It is based on a research synthesis for the youth policy framework for Ontario, *Stepping Stones*. The paper addresses research on challenges involving income inequality, poverty, and mental health that impinge upon school, and examines the enduring ill effects of these issues and academic struggles on young lives. It suggests practices that show promise to support youth. Findings suggest that transitions through school involve multiple developmental negotiations and are a critical site of slippages and successes. The paper ends with a set of reflective questions around *age out* (of the child and youth services system), the need to address stigma by animating the abundant character of young lives (addressing the subtleties and nuances of the life stories, biographies, and narratives of young people and their communities), the need for authentic collaborations across health and education, and working *with* and *for* young people as they collectively and individually determine and negotiate their lives.

Keywords: youth, mental health, poverty, social inequality, young lives, education, school

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RÉSUMÉ

Cet article offre une synthèse conceptuelle des études sur les intersections de la santé mentale, la pauvreté et l'école. Il est basé sur une synthèse des recherches pour le cadre stratégique ontarien de la jeunesse, *D'un stade à l'autre*. L'article examine des données de recherche probantes sur les problèmes de l'inégalité des revenus, de la pauvreté et de la santé mentale en tant que ces problèmes touchent les écoles. Il suggère des pratiques prometteuses pour aider les jeunes. Les résultats suggèrent que les transitions à l'école contiennent plusieurs obstacles au développement et sont un site incontournable des réussites et des échecs. L'article se concentre en particulier sur les effets néfastes sur les jeunes de la pauvreté, de l'inégalité des revenus, des problèmes de santé mentale et des luttes scolaires. Il se termine par un série de questions de réflexion autour de la notion de « *age out* » (termination des services quand le jeune atteint une âge donnée) et de la nécessité de combattre la stigmatisation en animant le caractère abondant de la jeunesse, de promouvoir des collaborations authentiques à travers des services de la jeunesse éducatifs et de la santé et de travailler *avec* et *pour* les jeunes dans leurs traversées collectives et individuelles de la vie.

Mots clés : santé mentale des jeunes, pauvreté, inégalité sociale, vies des jeunes, éducation, école

Growing income inequality and mental health challenges for young people have now been termed the millennium morbidity to signal the ongoing problematic link between poverty and mental health. *The Mental Health Action Plan for Europe* calls for a scaled-up plan of investment, intervention, prevention, and policy (World Health Organization, 2008). The ongoing relationship between poverty and mental health is the most critical youth issue at both global and national levels. The *Oxford Handbook of Poverty and Child Development* (Maholmes & King, 2012) devotes an entire chapter to this topic as does the startling book *Childhood Under Siege* (Bakan, 2011). At present, nearly all Canadian provinces have new or emerging frameworks for child and youth mental health, and the focus on youth-specific issues is evident. For instance, *Evergreen: A Child and Youth Mental Health Framework for Canada* (Kutcher & McLuckie, 2010) provides a comprehensive listing of national and provincial child/youth mental health policy framework documents. In Canada the focus on youth specifically, however, is so far less obvious than it is in Australia. Australia has recently named addressing transitions experienced by youth aged 12–25 as the "weakest point" in the mental health system and is attempting to address this directly (McGorry, 2009). This paper provides a conceptual synthesis of research into the lives of young people in poverty and/or with mental health challenges as they make their way through school. We show how these experiences get under the skin of young people in the interactions of social and biological embedding processes (Evans, Chen, Miller, & Seeman, 2012; Keating & Hertzman, 1999; Wilkinson & Pickett, 2009) in their daily lives at school, and that disadvantaged youth are the most vulnerable to such imbalances between risk and protective situations in life (Tilleczek, 2012; World Health Organization, 2008).

The research shows how social stigma, classism, and other forms of social marginalization are encountered by these young people, who might then disengage in education as a result of their life experiences and treatment by others. Some young people enter spirals of decline (Tilleczek & Campbell, 2013) and others are able to negotiate their multiple daily hassles (Seidman et al., 1994) and cultures of silence (Kutcher & McLuckie, 2010) with the help of flexible and supportive people working collaboratively *with* young people, their friends, and families. This research demonstrates the ways in which the structures and/or relationships

encountered in schools and other agencies can exacerbate and reproduce problems that already accompany relative impoverishment and mental health challenges that lead to academic failure. However, the research also demonstrates ways to alleviate some of these burdens for young people. Both premises will be explored in detail before discussing the policy, practice, and research implications arising from this conceptual synthesis. We conducted a meta-synthesis of a large collection of literatures for the purpose of explicating and integrating the findings (Evans, 2002; Glass, 1976). Both academic and grey materials were reviewed. Grey literature refers to research summaries, special publications, statistics, and other data that offer a more comprehensive view of a topic. The internet, government publications, fact sheets, statistical data, and so forth are all examples of grey literature.

CURRENT YOUTH TRENDS

There are social and economic reasons for the acute changes we are seeing in the lives and journeys of young people. Currently in Canada, four main types of youth trajectories exist in policy focus: (a) autonomy in relation to one's family of origin, (b) rapport with the world of work, (c) financial responsibility, and (d) development of citizenship roles and identities (Franke, 2010). Research (Furlong, 2006) shows how these transitions are compromised for poor youth, who have early entry into adult status and cannot take advantage of a period of exploration or the continued education of their relatively privileged peers: "Youth from poor families may not be experiencing the significant changes in demographic patterns that allow for this lengthier transition" (Berzin & De Marco, 2010, p. 279). Transitions to adulthood are becoming prolonged for most young people as they are requiring support at home to meet societal demands for more education and less available work. Youth "transition regimes" differ across countries and each is structured by complex social, economic, cultural, and institutional arrangements (Beaujot & Kerr, 2007). Canadian youth policy frameworks (Franke, 2010) identify sub-groups of vulnerable young people in every province and territory who experience more troubles due to these risk situations.

In addition, increasing gaps in income inequality lead to impoverishment and social marginalization. The distribution of income in society and the levels of relative income inequality have the greatest influence on health and social outcomes (Wilkinson & Pickett, 2009). Income inequality is measured as the proportion of income going to the richest and poorest members of society; the greater the income gap and disparity, the greater the income inequality (among the wealthiest nations with high levels of inequality are Singapore, USA, Portugal, and the UK with Canada about mid-way; Wilkinson & Pickett, 2009). The Organization for Economic Cooperation and Development (OECD, 2009) has shown that this gap in income has been *growing* for Canada in the last ten years. If the gap between the rich and poor is rapidly sending more families into poverty and more adults are vying for less available employment, where does this leave young people, especially those already marginalized by poverty?

> The gap between rich and poor in most OECD countries has widened over the past two decades. Children and young adults have borne the brunt of the change, and are now more likely to be poor than people around retirement age. But the trend to greater inequality is not inevitable: governments can close the gap with effective social policies. (OECD, 2009, p.2)

The OECD (2009) published its first report on the well-being of children in *Doing Better for Children: Country Highlights.* The country-by-country analysis shows that incomes at every level have risen over the

past two decades while the income gap between the richest 10% and the poorest 10% of the population has grown. The "Country Note for Canada" shows that "both inequality and poverty rates have increased rapidly in the past 10 years, now reaching levels above the OECD average" (OECD, 2009, p. 1). Canadian highlights demonstrate how governments should increase spending on early childhood and ensure that spending on youth is channelled toward the most disenfranchised young people. The OECD report states that the past 20 years have seen a significant increase in income inequality affecting more than three-quarters of OECD countries, with Canada, Finland, Germany, Italy, and the United States showing growing gaps between the rich and the middle class as well. Children and young adults are experiencing the change most profoundly as they are now more likely to be poor than are older people who are reaching retirement (OECD, 2009). Poverty is not distributed equally across all social groups; the 2001 Census in Canada demonstrated that 18.4% of all Canadian children were living in poverty. In 2007 the child poverty rate in Canada was 11% (Statistics Canada, 2009), and the 2006 Census indicated that the poverty rate among children aged 0 to 14 was 48% for recent immigrants, 41% for all immigrants, 36% for Aboriginal children, and 33% for visible minority children (Campaign 2000, 2009). It has been argued that such social inequality wastes the talents of youth (Wilkinson & Pickett, 2009), leading one to ask whether already disenfranchised youth are fast becoming the most marginal to society.

The publication *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addictions* (Kirby & Keon, 2006) demonstrated the urgency of engaging Canadians in the mental health of children and youth. The rates of mental health disorders are significant, ranging from 15% (Waddell & Shepherd, 2002) to approximately one-third (30%) of students who indicate psychological distress (Paglia-Boak et al., 2010). Only a minority of these youth receive formal supports (Costello, Egger, & Angold, 2005). *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health* (Ontario Ministry of Children and Youth Services, 2006) states that 15% to 21% of children and youth (approximately 467,000 to 654,000) are affected by mental health disorders that cause significant symptoms or impairment. Youth populations aged 14–19 years bear the largest burden. Overall, 15% of Ontario youth enter hospital with a mental disorder as the main diagnosis (Tilleczek, 2008). This figure increases to approximately 21% when including all noted patient diagnoses and developmental or emotional issues as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) (American Psychiatric Association, 2000). Tilleczek (2008) also reports that approximately 61,200 Ontario youth aged 12–19 have spoken to a health care professional regarding their mental or emotional health in the past year. This amounts to 5.2% of that youth population. Given that access to mental health service is limited in Northern Ontario (Boydell et al., 2006), this figure is likely an underestimation of those who are waiting to do so.

INTERSECTIONS AND CONNECTIONS: POVERTY AND MENTAL HEALTH

The trends above demonstrate that poverty and mental health are two of the most crucial emerging markers of contemporary young lives. Research and policy have begun to make use of interdisciplinary and ecological models to examine the multiple levels of social and biological influences and map the range of risk or protective factors in each. The complex cultural nesting model (Tilleczek, 2011, 2012, in press) is one such interpretive framework for studying young lives. Young people face many challenges within and across interconnected spheres of life (home, school, work, family, community, etc.). Young people and those closest

to them are inseparable from, and nested within, cultures, biographies, and bodies. It is at these intersections that most progressive research and policy take place. Cumulative deprivations for many young people make it necessary to map these trajectories over time if the severity is to be understood.

The World Health Organization (2008), for instance, is now squarely addressing the effects of income inequality on youth well-being in the last century, known as the new morbidity and characterized by emotional and social problems and learning difficulties. The millennium morbidity is the new term for the pervasive and enduring connections between growing income inequality, mental health, and physical health outcomes for young people. Youth mental health is a burgeoning focus and concern in Canada, Europe, and Australia (see, for example, McGorry, 2009; World Health Organization, 2008). The World Health Organization (2008) is calling for "an urgent need to scale up policies, interventions and investments" (p. 3) for child and youth mental health promotion and provision. An extensive review of socioeconomic status and child development in Europe (World Health Organization, 2008, p. 31) demonstrates that there is "substantial evidence that low SES children more often manifest symptoms of psychiatric disturbance" with evidence that socioeconomic inequalities in early childhood become more pronounced in middle childhood and adolescence. Evidence supporting the association comes from the U.S. National Longitudinal Study of Youth showing a lower prevalence of depression and emotional disorders associated with higher socioeconomic status. Willms (2009) has also demonstrated these links in Canada such that young people from lower socioeconomic status families had much higher rates of self-reported depression and anxiety than did their wealthier peers.

While it is known that low family income affects children, "we know relatively little about the form of the relationship between family income and children's behavioural and cognitive outcomes" in school (Willms, 2009, p. 12). One of the difficulties of researching poverty's role in educational attainment is that many of the correlates of income are also probable determinants of child development (Duncan, Yeung, Brooks-Gunn, & Smith, 1998). Low income co-exists and intersects with other factors such as region, culture, compromised mental health of parents, or the poor physical condition of the home; therefore, relational direction is unclear. This is also the case for the links between poverty and mental health. There are strong, stable, and consistent relationships found in the literature between poverty and mental health at both the family and neighbourhood levels, but the mechanisms by which the connections occur in the biological or social embedding process are less well understood (Lipman & Boyle, 2008).

It is known that youth mental health status can foreshadow outcomes in later life but not always in easily predictable fashion (Howard, Galambos, & Krahn, 2010). Depressive symptoms have been shown to decline in young people with more-educated and professional parents than those from working-class families, and low academic achievement and negative life events in childhood predict growth in depressive symptoms from age 15–24 (Stoolmiller, Kim, & Capaldi, 2005 ; Howard et al., 2010). Mental health trajectories for young people are therefore diverse but tied to social class background and gender; they are moving targets wherein mental health status at one point during transitions may not perfectly reflect later coping ability (Howard et al., 2010). With regard to gender, variation in prevalence and timing has also been found. While there are no gender differences in the rates of onset and prevalence in depression and anxiety disorders for young children (Nolen-Hoeksema & Girgus, 1994), qualitative reviews show prevalence of depressive symptoms increasing for females into adolescence (Twenge & Nolen-Hoeksema, 2002; Breton, Bergeron, Valla,

Berthiaume, & Gaudet, 1999; Nolen-Hoeksema & Girgus, 1994). In adolescence, females have higher rates of depression and anxiety than males, and older females have higher rates than their younger counterparts (Breton et al., 1999). For example, the Quebec Child and Mental Health Survey shows that older girls have higher rates than boys in two age groups: 9–11 and 12–14 (Breton et al., 1999). Also, at the age of 13–14 years, girls consistently display higher rates of depression than girls who are younger (Nolen-Hoeksema & Girgus, 1994). Similarly, a meta-analysis of the Children's Depression Inventory suggests that at age 13, girls have significantly higher depression scores than boys (Twenge & Nolen-Hoeksema, 2002).

In contrast to higher levels of female adolescent depression, males have higher rates of ADHD than females. Reported by teachers and parents, males have higher rates of ADHD than females, and younger males have higher rates of ADHD than males in adolescence. Additionally, oppositional/conduct disorders and hyperactivity are more prevalent in boys than girls (Breton et al., 1999). A study of incarcerated youth found rates of a mental health diagnosis were higher in females than in males. In examining 169 incarcerated youth intake and assessment interviews, an estimated 84% of females suffered from mental health disorders in contrast to 27% of males (Grande, Hallman, Underwood, Warren, & Rehfuss, 2012). Various suggestions have been made to account for the gendered etiology of mental health in young lives. Some explore whether physiological changes in puberty, gender-linked personality traits, or sex-related innate coping strategies produce the biological changes to provide the variance (Nolen-Hoeksema & Girgus, 1994; Twenge & Nolen-Hoeksema, 2002), while others explore gender differentiation in socialization, risk factors, and coping strategies and community supports (Nolen-Hoeksema & Girgus, 1994; Twenge & Nolen-Hoeksema, 2002). Gendered disparities also exist in medication and service use. Psychotropic medication is commonly associated with children and youth who are seeing a mental health specialist to treat ADHD and/or disruptive, mood, or anxiety disorders. Studies have found that boys are more likely than girls to be prescribed psychotropic medication (Robest, Armstrong, & Dollard, 2009) and that children aged 6–12 and males were more likely to take medications, have more days with medication, and have more months of adherence to antipsychotics. For ADHD, the rate of service use did not differ by gender but factors associated with service use did (Graetz, Sawyer, Baghurst, & Hirte, 2006). The predictors of service use for males are indicated by problems with schoolwork, low grades, and number of ADHD symptoms. For females, however, the presence of a depressive disorder was the main predictor (Graetz et al., 2006).

Overall, almost all types of mental illness are elevated with poverty, and youth from impoverished backgrounds are three times more likely to have a mental health challenge (Lipman & Boyle, 2008). The main risk factors for poor mental health include poverty, learning difficulty, abuse, neglect, inconsistent support, isolation, and lack of access to decent health care and education (Lipman & Boyle, 2008). The importance of good mental health for development and the complexity of youth mental health journeys make it an ongoing and pressing research and policy need.

THE LIVED EXPERIENCE AT SCHOOL

School plays an increasingly important contextual role for young people as a result of the heightened demands for education in contemporary society (Furlong & Cartmel, 2007). For example, most young people in Canada pass through the educational system whether they leave early, leave and return, become incarcerated, enter the child welfare system, graduate and attend post-secondary school, or graduate and enter

the work force. Many young people experience social or academic challenges when transitioning to high school (Tilleczek, 2007, 2012): a range of 25% to 80% of young people leave high school before graduation, Aboriginal youth being most likely to leave early (Tilleczek, 2008); close to 40% of young people are not being intellectually engaged in school (Willms, Friesen, & Milton, 2009); many marginalized young people are under-represented at colleges and universities (Canadian Council on Learning, 2010); and high rates of youth unemployment remain the norm in modern society (Furlong & Cartmel, 2007).

Simplistic interpretations of income-related effects on mental health and/or schooling as "problems" with "poor" people must be avoided as this approach demonizes, essentializes, and narrows the range and "effectiveness of prevention and intervention efforts" (Schonert-Reichl, 2000, p. 4), a point also made by others (Ferguson et al., 2010; Tilleczek, 2010a; Wilkinson & Pickett, 2009). We need to better understand the ways in which these problems actually play out in young lives and avoid easy categorizations that miss the nuances of how poverty and mental health operate in educational and social lives. As Tilleczek (2010b) states:

> Since the beginning of compulsory public education, Canadian schools have done well by some young people and much less well by others. New understandings about the nuances in young lives are showing us that we cannot draw a simple conclusion about who is marginalized, how, or what should be done. One student's coming out as gay or lesbian may be celebrated in one school but lead to shunning in another. One Aboriginal community's young people live with a host of positive inspirations while another continues to mourn the loss of its young. The daily hassles experienced by some youth living in poor families or by newcomers to Canada are met with concern by one teacher, but not by another. (p.1)

The pervasiveness of the socioeconomic gradient of income inequality on many learning outcomes, such as literacy and numeracy, has now been documented in detail across countries (Keating & Hertzman, 1999; Wilkinson & Pickett, 2009). Just as in Canada, New Zealand researchers found that students in schools in low income areas did less well in mathematics, social studies, and literacy skills (McGee, Ward, Gibbons, & Harlow, 2003).

As youth approach secondary school, moreover, self-esteem and access to a confidant decline such that 9% of Ontario youth report low self-esteem, with a significant plunge occurring among first-year high school students (Tilleczek, 2008). Willms (2003) has reported that all measures of school engagement show a marked decline during middle and secondary school, which correlated to declines in a sense of social engagement and belonging. Many students also reported high levels of anxiety and depression, 11% and 65% respectively, and some young people reported a range of physical symptoms such as panic and dizziness. Students with low levels of intellectual engagement at school were 1.2 times as likely to experience anxiety as those with higher levels of intellectual engagement. Those reporting low levels of a sense of belonging were about 4.1 times as likely to experience anxiety and 6.6 times as likely to experience depression compared to their peers who felt they belonged at school (Willms, 2003). Of course, the direction of the relationship is not always clear, but the findings and size of the effect are important to note.

It is clear that young people from impoverished backgrounds continue to bear the burden of struggle in schools and that youth mental health challenges are exacerbated by poverty for youth. Indeed, this is a youth policy alarm. If we countenance the rich corpus of research that shows clearly how socioeconomic status relates to the differing ways that youth are treated and taught in schools, and the emerging research that makes connections between socioeconomic status and mental health for youth, then the school's daily structures (rules, regulations, etc.) and student–teacher relationships (teaching styles, expectations, etc.)

must be further considered. Human relationships are the cornerstone to school success, but it is often in high school that student–teacher relations can become less personal, less positive, less supportive, less caring, and teachers were found to trust students less (Eccles et al., 1993). The perceived change in student–teacher relations and student support in high school significantly explains changes in levels of academic, personal, and inter-personal functioning achievement (Barber & Olsen, 2004). Teachers believe themselves to be less effective with students who are struggling academically, and students struggle more with less efficacious teachers (Eccles et al., 1993). Disengagement from school can become a coping strategy, with too many young people displaced and dislodged.

A *School-Based Mental Health and Addictions Consortium* has been developed in Canada to review best practices and policy considerations (Santor, Short, & Ferguson, 2009) and a *Canadian Joint Consortium for School Health* (JCSH) has completed a further review (Morrison & Kirby, 2010). These important reports suggest the need for a closer examination of the impacts and experiences of mental health on schooling. Some youth disengage from school due to the stigma attached to mental health, they circle into other spheres and eventually *age out* of the child and youth services sector. Student attitudes toward class mates with mental illness show patterns of social distancing associated with age and with knowledge about schizophrenia (Faulkner, Irving, Paglia-Boak, & Adlaf, 2010). Stigmatizing attitudes increase with age, solidify by adolescence, and continue into adulthood (Hinshaw & Stier, 2008; Faulkner et al., 2010). Such attitudes can develop into prejudices and discriminatory behaviours that come with negative social consequences (Adlaf, Hamilton, Wu, & Noh, 2009). Faulkner and colleagues' (2010) study of social distancing toward people with schizophrenia concludes that "32.8% of students reported that they would not want to make friends with someone who had schizophrenia, and 26.2% reported that they would be afraid to talk to someone who had schizophrenia" (p. 937).

Mental health influences schooling via sets of feelings, stigmatizations, isolation, and disengagements. For instance, feelings of competence, coherence, autonomy, and agency were often compromised for young people with mental health challenges at the very time when they are required for social and academic negotiations. The sense of coherence model (Antonovsky, 1979) was used to test the suggestion that medical well-being may be enhanced by a well-developed sense of self (Hart, Wilson, & Hittner, 2006). Disengagement was identified as a coping style and significant predictor of depressive symptoms for young women (Votta & Farrell, 2007, p. 126). The engagement/disengagement coping style framework (Carver, Scheier, & Weintraub,1989; Compas, Davis, Forsythe, & Wagner, 1987) shows how "cognitive and behavioural responses to stress are directed either toward or away from the source of the stress or negative emotions, thereby affecting the impact of a stressor on an individual" (Votta & Farrell, 2007, p. 127). As stigmatization often happens at school, young people with mental health issues have to cope with additional feelings of isolation and being made marginal. These feelings of isolation and loneliness may culminate in an overall sense of helplessness and a feeling that there is no way out (Kidd, 2006).

Stigma must be directly addressed through mental health literacy, as this young person suggests:

> More children and adolescents need to learn about how mental disorders work, so that they know . . . I am a real human, with feelings . . . We desire life. To get married. Have children. Working a job we love doing. The better educated the kids of today are, the less likely they are to be prejudicial." (Kutcher & McLuckie, 2010, p. 19)

Anti-stigma initiatives, mental health literacy, and mental health promotion activities are best focused on school-based and youth organization–based activities (Kutcher & McLuckie, 2010). Reducing the stigma associated with mental health problems/illnesses results in greater community support and timelier access to needed services (Ontario Ministry of Children and Youth Services, 2006). The young people participating in the *Evergreen Project* recognized the difficulty in accessing help through various systems, suggesting that "efforts should be made to decrease stigma so that when mental health issues are identified, children, youth and their families do not feel ashamed or discouraged to seek support" (Kutcher & McLuckie, 2010, p. 19). The report also suggests that stigma brings with it a "culture of silence" with the lack of education regarding mental health forcing youth "to go through everything alone" (Kutcher & McLuckie, 2010, p. 20). The lack of education and culture of silence results in "only meeting one other person with [the] illness" not because others didn't experience mental health problems but "because no one feels comfortable discussing their illness" (Kutcher & McLuckie, 2010, p. 20).

Kirby and Keon (2006) concur with these findings and note that educators are in a unique position to offer help and recommend "that mental health services for children and youth be provided in the school setting by the school-based mental health teams . . . that teachers be trained so that they can be involved in the early identification of mental illness . . . [with] practical resources and supports necessary to take on this new role" (p. 140).

Taking Mental Health to School (Santor et al., 2009) suggests the need for school-based programs, mental health literacy, and service provision within and across schools and social agencies. Policy and practice recommendations include the establishment of an inter-ministerial leadership body; professional development and guidance to self evidence-based programs for local use; research, social service, and school board collaborations to implement good programs; and a provincial research presence moving forward. Research recommendations include the inclusion of socioeconomic and regional difference in understanding the size of effects and influences on youth mental health, developmental differences in understanding mental health literacy, and understanding the extent to which youth coping skills are being acquired and could prevent later symptoms (Santor et al., 2009).

In Ontario, the Ministry of Children and Youth Services is responsible for mental health services through the age of 18 years, after which time service and care are transferred to the Ministry of Health and Long-Term Care. This creates problems for young people, such as running out of service provisions as they reach 18 (*age out*), fragmentation of services, and the process of transferring across silos, that become acute for young people who are transitioning both through and between services. A familiar call is made for continued enhanced collaboration across service sectors to help young people and their families avoid fragmented care and navigate their local system. The Ontario review suggests that "to prevent children and youth from 'falling through the cracks,' we need to strengthen linkages, collaboration, coordination, and most importantly, a commitment to shared responsibility for child and youth mental health, both within and beyond the child and youth mental health sector" (Ontario Ministry of Children and Youth Services, 2006, p. 3).

SUMMARY AND DIRECTIONS

Theory and research on young lives has evolved over the last 15 years. Adolescent development was once the nearly exclusive domain of psychology and biology, but important interdisciplinary research is now

available from sociology, anthropology, cultural psychology, and the emerging field of youth studies (for a current review see Tilleczek, 2011; in press). Research from these fields demonstrates that youth mental health research must acknowledge (a) the importance of strength-based, ecological, and pathway metaphors; (b) that research, policy, and practice attend to intersections of social, cultural, and biological influences; (c) that narrative, journey and life story are gaining momentum as valid and valuable research and practice tools; (d) the importance of fundamental social processes of being, becoming, and belonging; (e) an important heterogeneity of young lives and transitional pathways; and (f) that there is no "normative" youth journey. Perhaps this last point is the most salient for the exploration of intersections of poverty, mental health, and school. These emergent trends should guide policy guidelines and frameworks in youth mental health.

Sorting out the importance and influence of poverty, income inequality, and mental health on school experiences of young people is daunting. On one hand, there is a simple and enduring story that poverty and income inequality relate negatively to mental health and school outcomes. Inequality in society gets under the skin and into the daily lives of people via processes of social comparison and the resultant experiences of vulnerability, anxiety, discrimination, and threat (Wilkinson & Pickett, 2009). Apparent in the daily experiences of young people at school, this effect is organized socially in the structures, practices, and treatment of poor students (especially in poorer schools) and students struggling with mental health challenges relative to their peers. On the other hand, there is important theoretical and empirical work detailing the complexity of these situations. This work points to possibilities for resilience within responsive schools and supportive communities and families. It shows us how interventions matter and how best to make them. But, this is not happening regularly or in profound and enduring ways to date in public education. Why is this so and what is happening in schools to reproduce rather than alleviate these struggles for young people? What could be done?

Lessons for better policy and practice in youth mental health are beginning to detail the long known call for stronger partnerships, new policies, and better integrated services. As outlined in the 2008 report from the Government of Canada on its *Healthy Transitions to Adulthood: Moving to Integrated Mental Health Care,* the most pertinent recommendations for youth were that research and service address the importance of interactions between social, psychological, and biological factors in the lives and mental health of young people and a related call for further evidence bases and multi-departmental policies and programs. Clearly, in the case of young lives at school, and especially for young people struggling with the intersections of mental health and/or poverty, the collaboration of education, youth services, and health is critical. One such move has been to focus on mental health within schools and work to connect schools in and across other youth agencies. If schools are the place of last coordinated social contact for many young people, better coordination between systems and breaking down resistances at individual and organizational levels is required (Barwick et al., 2005).

The Declaration of Accountability on the Ethical Engagement of Young People and Adults in Canadian Organizations (Alderman, Balla, Blackstock, & Khanna, 2006) provides a useful direction. Its strength-based and youth-centred approach builds on the importance of youth self-determination with the assistance of others. Dignity, safety, balance, accountability, shared voice, and dialogue are among the principles put forward, most of which are also reflected in the literature reviewed here. The ongoing need to work *with* and *for* youth across educational, health, and youth welfare personnel has never been more intense. There is scarcely a research report or policy document relating to youth that neglects to mention the need for

integrated and collaborative services and working across silos, especially since we now know how young lives defy easy categorization.

In summary and to address implications in community mental health, we suggest the following directions:

1. We must take seriously growing income inequality and youth poverty in Canada and come to examine how it is changing the character of poverty at the level of community.
2. We must better attend to the subtleties and nuances of the life stories, biographies, journeys, and narratives of young people and their communities. What could they tell us that we do not already know about the daily hassles of young people, breaking spirals of decline, and recognizing cultures of silence? What is the place of friends, families, teachers, and self-determination in the stories?
3. We must **"**take mental health to school" without losing the insights in community mental health research of the last ten years that address social and biological interaction. How could school-based mental health and mental health literacy become an important part of prevention and early intervention? How could we extend efforts across families of schools to close gaps between schools and address continuities in services in the communities? How could educators and other youth services collaborate at the community level? Could youth narratives be useful in records keeping and sharing case stories?
4. We must continually address youth desires for social fit as they negotiate belonging, being, and becoming. Could we enhance a timely and collaborative assessment of social fit for young people and provide services when/where/if social fit falters? How could friends and peers play a role in this?
5. We must re-position and treat young lives as more than simply biological categories (age, grade). When we must address age, how could we fully embrace social context and environmental influences on biology to avoid "age gaps" and "age out" in youth supports?

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