

ETHICS WITHIN SCHOOL-BASED WELLNESS CENTRES

From Qualitative Case Study Research to Case-Based Pedagogy:

A Journey of Ethics within School-Based Wellness Centres

by

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Submitted in partial fulfillment of the requirements for the degree of

MASTER OF EDUCATION IN EDUCATIONAL LEADERSHIP

VANCOUVER ISLAND UNIVERSITY

We accept this thesis as conforming to the required standard.

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Abstract

“Are there circumstances when respecting a youth’s choice for privacy involves moral/legal conflict, and following legislation or law may not feel like the right decision?” Due to the distinct and sometimes differing professional policies, philosophies, and administrative structures between two sectors (health care and education) within a school-based wellness model, this dilemma is particularly relevant to the sharing of confidential youth information. A case study pedagogical approach reviews factors that impact student well-being and learning, particularly in communities where many families are experiencing poverty, and as a result have access to a school-based wellness centre. A student, her family, and professionals from each sector are incorporated into a case study that captures situations when students need support for their physical and psychological well-being from educational and/or health care professionals, and when “mature minor consent” conversations are most likely to occur. When a youth enacts their right to keep their health information private (a right associated with mature minor consent legislation) ethical challenges of cross-sector and family member communication may arise. *A Cross Sector Ethical Decision Making Support Tool* is applied as a teaching tool to guide learners through this ethical case study and decision making process. It is also provided as a template for professionals to take away and utilize if they are involved in an ethically difficult situation in their future. The commonalities and differences in approaching ethical problems and decision making from the perspectives of youth, families, educators and health care providers are identified and recommendations are put forward for future cross sector ethical decision making processes.

Keywords: ethics, mature minor consent, school-based wellness centres, sharing of information, youth, well-being

Acknowledgements

I would like to express my sincere gratitude to be living, learning, working and completing this thesis on the unceded territory of the Coast Salish Peoples and the traditional territory of the Snuneymuxw First Nation.

Thank you to my husband Bryun, and my sons Owen and Ronin. You are my world. I could not have done this without your love, sacrifice, encouragement, and random advice whenever I needed it.

To the rest of my family, thank you for your endless supply of positivity and faith in me.

Thank you to my close friends who have supported me with coffee/wine, quick running loops, laughter and reassurance when I needed them most.

Thank you to Dr. Phillips, I truly appreciate the inspiration and understanding you showed me during the first half of my master's journey.

Thank you to Dr. Priestman, your confidence and guidance during the final "pandemic stretch" of my master's journey reignited the spark I needed to get me through.

Thank you to my cohort classmates – my eyes were opened to the immense intelligence, compassion, creativity and humour (sometimes inappropriate) that educators hold – I so appreciate being included as one of you, even for a little while.

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Chapter 1: Introduction

Many communities across Canada are pursuing efforts to improve outcomes for youth through partnerships among education, healthcare, government, and social services agencies. These school-based, cross-sector collaborations bring individuals and organizational leaders together to develop shared goals and offer interventions to support vulnerable students. During the course of normal adolescent growth and development, a struggle exists between autonomy and attachment to parents / trusted adults (Lerner and Steinberg, 2009). This struggle can be compounded if vulnerabilities such as poverty, trauma, high risk behaviours, and/or health challenges are also part of a student's life story. Professionals who provide support within school-based wellness centres navigate these tensions when a youth enacts their right (through mature minor consent legislation) to keep their health information private. Due to distinct policies, philosophies, and administrative structures between health and education sectors within youth wellness centres, ethical challenges of cross-sector communication may arise. This leads to the question, "Are there circumstances when respecting a youth's choice for privacy involves moral/legal conflict, and following legislation or law may not feel like the right decision?"

This thesis uses a hypothetical case study analysis to illuminate some ethical considerations involved when youth choose to keep their health information private, particularly in environments such as school-based wellness centres. A review of literature and published stories informs the key challenges and characteristics of youth who have access to school-based wellness centre services, and the hypothetical story of "Emily" and her family emerges. The fictional information contained in her case study is designed to represent a true to life scenario for learning, discussion and reflection. Case study pedagogies support critical thinking of complex issues through encouraging skepticism, open-mindedness, recognition of alternate

points of view, and empathy (Herreid, Schiller, & Herreid, 2012; Heiney, Polyakova-Norwood, & DeGregory, 2019; McDade, 1995). The reasoning behind the selection of this case-based approach will be highlighted in the upcoming rationale, including the story of my initial attempt to proceed with qualitative research in this area during the first wave of a Covid-19 pandemic.

Background

As a nurse with a background in pediatrics, I have experienced a number of ethical dilemmas while caring for patients and their families which has resulted in a passion for clinical ethics. I have an interest in exploring opportunities for health care and education to partner in supporting youth to thrive - particularly in difficult situations when it is not always clear what the “right” decision or answer is. Supporting a vulnerable student/client and their family can be very complex and requires multiple partners and professionals working together. It is important to recognize that within this context every youth’s family looks different, including the dynamics of communication and sharing of information during this developmental stage (Coughlin, 2018; Lerner and Steinberg, 2009). The Canadian Mental Health Association of BC (2016) shares that schools are important to a family-centred approach because school counsellors, teachers, and principals spend time getting to know the students, are in positions to connect youth with additional resources, and provide a setting for early identification and promotion of positive mental health. When adolescents are “healthy” (which includes physical, psychological, and social well-being), they are better able to learn and develop the values, skills, and attitudes that will serve them well in their future (Blank, 2015; Dodge, Daly, Huyton & Sanders, 2012; Michael, Merlo, Basch, Wentzel & Wechsler, 2015). The case study presented in this project will challenge the reader to analyze the facts, beliefs, values, and ethical principles involved for all invested parties (youth, parent / caregiver, school counsellor, and health care providers) when

an adolescent's health and well-being may be at risk. My hope is for this critical thinking and conversation tool to be useful for both education and health care professionals.

Introducing the Youth: Students Attending Schools with Access to Wellness Centres

Young people in the world today are navigating a range of experiences that impact wellness in their lives. Dodge, Daly, Huyton & Sanders (2012) define well-being as “the balance point between an individual's resource pool and the challenges faced” (p. 230). This definition is explained by visualizing a see-saw, where an individual's wellbeing is safely balanced on the fulcrum when their unique physical, psychological, and social resources on the one side are able to meet the physical, psychological or social challenges they encounter throughout life on the other side (Dodge et al., 2012). A selection of impactful and personal stories told by three courageous youth have been selected from the *Stories Project* (Foundry: Stories & Articles, n.d.) to represent a sampling of potential situations facing students living in communities with access to school-based youth wellness centres.

“It seemed like everyone around me was able to handle things. Everyone around me seemed happy. They all seemed to me like they were in control of their lives, and it felt like I was the only person that was drowning in schoolwork and struggling to stay afloat.” (Nicole, Foundrybc.ca)

“I really didn't feel comfortable with myself. At the time I was very chubby and felt different because my family was economically marginalized,” Kyle recalls. *“Also, I was starting to have feelings towards guys instead of girls, which was really confusing too.”* (Kyle, Foundrybc.ca).

“The pain I felt got worse as I grew older. In high school, drinking became more acceptable and drugs started coming up at parties. I'm so impulsive and was just looking

for anything to take the pain away, so I started drinking and using drugs, which just made everything worse,” (Alexis, Foundrybc.ca).

These stories are reflections of personal challenges youth are experiencing in our schools today and informed key features of the representative case study created for analysis in this project.

Adolescent health is a key element of learning and achievement at school (Blank, 2015; Minkkinen, Lindfors, Kinnunen, Finell, Vainikainen, Karvonen, & Rimpelä, 2017). Students who are struggling with physical, mental health, and/or life challenges are at greater risk of struggling with school attendance, educational success, and high school graduation (Basset-Gunter et al., 2016; Blank, 2015; Havlik et al., 2017; Kraft et al., 2015).

Schools in British Columbia are currently implementing new changes to the curriculum, which includes updating the physical and health education content to “focus on well-being - the connections between physical, intellectual, mental, and social health” (BC’s New Curriculum, n.d.). This approach is meant to enhance the relationship between health and education with the philosophy that these two sectors are interdependent; meaning that “healthy students are better learners, and better-educated students are healthier” (DASH, Ministry of Health & Ministry of Education, n.d., p.5). This approach supports the well-being philosophy that each student’s unique physical, psychological, and social resources need to be fostered in order to meet any physical, psychological or social challenges they may face (Dodge et al., 2012). Four *BC Performance Standards for Healthy Living* have been developed to support the new curriculum and are titled healthy eating, active living, healthy relationships and healthy practices (B.C. Performance Standards for Healthy Living, n.d. and Healthy Schools BC, n.d.). These standard

titles (in addition to autonomy and mental and emotional health) will be used to capture the literature supporting the youth profiles in the next chapter.

Through seeking to understand health-related challenges to learning encountered by youth, we are better equipped to support positive changes in both their health and educational outcomes. This understanding is also critical when we are supporting students during difficult and personal circumstances and they choose not to have their confidential information shared.

Introducing the Context: School-based, Youth Wellness Centres

A number of communities in BC are recognizing the importance of pro-actively supporting the needs of vulnerable youth. The responsibility for youth well-being and educational success does not lie solely on one set of shoulders or in one area of focused support. For adolescents to learn, manage, and begin taking ownership of their own health and learning, they need partners. These partners include their counsellors, teachers, family, friends / peers, and other community partners such as health care providers. Through these community partnerships, wellness centres provide services within the walls of senior secondary schools to meet the health and wellness needs of youth, support them to stay in school and are particularly valuable when located within communities where many families are experiencing poverty (Legare & Associates, 2018; Lemkin, Walls, Kistin, & Bair-Merritt, 2019). This unique juncture of health and education support under one roof, situated in a community at high risk for poverty, provides the setting for the case study being presented.

Lemkin, et al. (2019) emphasize that developmental areas of the brain essential for school readiness and educational success are negatively impacted by poverty. Effective collaboration between healthcare and education professionals is necessary in the promotion of optimal health and educational outcomes for low-income youth (Lemkin et. al., 2019).

UNESCO (United Nations Educational, Scientific and Cultural Organization) and UNITWIN (University Twinning and Networking Programme) network (2018) have published their Global Health and Education goals rooted in the belief that education and health are universal and undisputable rights of all children around the world.

“Because education and health are inextricably linked, schools are considered an ideal setting for both health education and health promotion initiatives targeted at children and young people. In addition, there is a growing body of evidence that shows the close relationship between health, physical, mental and cognitive development, school participation, and educational achievement.” (UNESCO chair and UNITWIN network, 2018, p.2).

When addressing the diverse needs of students like Nicole, Kyle and Alexis, who access health services at school, the stories and experiences of the professionals who are committed to supporting them, are equally meaningful. There are times when students bring a level of uncertainty into the school environment and the experiences can be “intellectually, emotionally, and physically draining” on the professionals who support them (Kraft, Papay, Moore-Johnson, Charner-Laird, Ng & Reinhorn, 2015). If we include a student sharing private information and then through mature minor consent laws, enacting their right to object to the sharing of this health information, these circumstances increase in complexity within the cross-sector inter-professional care environment of a school-based wellness centre.

The school-based wellness centre in the hypothetical case study is modeled on a currently operating program and will be identified as Secondary School A (SSA) for the purpose of changing details to protect the confidentiality of students and interprofessional team members. The centre delivers a wide range of services to students in Grades 8 through 12. The model of the clinic is built on partnerships between the school district, health authority, the Division of

Family Practice and local pediatricians, First Nations community organizations, community youth mental health and substance use organizations, RCMP, and the city. Currently, students can walk in or make an appointment to address issues including injuries, illness, sexual health, or mental health and substance use.

Table 1.1 illustrates a general description of the students accessing the services and the reasons for doing so.

Table 1.1

Student Use of Wellness Centres' Services (September 2016 – June 2018)

	2016/17 School Year	2017/18 School Year
Total Number of Visits	1,182	1,537
New Students	16%	23%
Repeat Students	84%	77%
Female	82%	82%
Male	13%	17%
Physical Health Reason	47%	41%
Sexual Health Reason	29%	29%
Mental Health Reason	17%	21%

Source: Health Authority Administrative Data

Note: Physical health reasons = injury, illness, immunizations, other. Sexual health reasons = condoms, contraceptive management, pregnancy tests, sexually transmitted infections. Mental health reasons = mental, emotional and/or substance use issues (Legare & Associates, 2018, p.18).

While exploring interprofessional and interagency experiences, relationships, legislation, procedures and policies, this case study will focus on capturing a situation when a student seeks out support related to their physical and psychological well-being from the educational and/or

health care professionals, and when a “mature minor consent” conversation occurs. Ethical considerations and comparisons between the practices and policies of school and healthcare systems in the context of professionals sharing information while supporting the same youth in wellness centres will be highlighted.

Problem

The problem guiding this hypothetical case study analysis involves the complexities of collaboration and both the sharing and protection of confidential youth information across education and health sectors (during the enactment of adolescent rights of mature minor consent). With wellness centres in secondary schools in BC, there is a lack of research capturing if school staff/education professionals, are engaging with, and valuing, the health care services being made available to the students. Examination through research is not available in relation to effective interprofessional communication and partnerships being established between school staff and the health care providers in wellness centres, and if any improvements in student outcomes can be attributed to these experiences (Chow, et al., 2017; Legare & Associates, 2018).

Within the BC education system, the process of information sharing primarily includes school professionals, students, and their authorized parents / caregivers (BC Ministry of Education Governance and Legislation Branch, 2020). This is easily understood and is implicitly implied when a child/youth is registered to attend school. Additional consent documentation is required to share information out of that circle, such as additional learning support programs and/or community or health services (BC Ministry of Education Governance and Legislation Branch, 2020). Lemkin et al., (2019) share findings in their study of educator and pediatrician collaboration that protecting the relationship and trust between parents and educators became a

complex barrier to sharing student information with pediatricians. One teacher participant shared,

“You want to have a good strong relationship with your parents...and you don’t want to bring anything in that scenario that is going to weaken it...” (p. 304).

The Canadian Mental Health Association of BC (2016) had a similar finding to Lemkin et al. (2019) by recognizing on the one hand how important it is for service providers to build trusting relationships with youth and, on the other hand, how it grows in complexity when there are valued relationships with parents and other jurisdictions involved too.

Within the health care system, information sharing circles start with a service provider and the patient/client/youth being supported. Additional members may include parents, guardians or other team members involved in their care. As there is so much information to navigate in relation to the general protection of confidential information, it can be a confusing process to decipher when the desire to share information is in conflict with the need to keep it safe. The Canadian Mental Health Association of BC (2016) cautions that in the absence of clear guidelines supporting a greater understanding of legislation, the laws may be interpreted by service providers in the strictest and most literal form. This is also supported by Wadman, Thul, Elliot, Kennedy, Mitchell and Pinzon (2014) who state that “health care providers may have limited knowledge or misinformation related to the medical and legal requirements around providing confidential health care to adolescents and their families, ultimately doing a disservice to this population and impacting patient care” (p.11). This situation is an important factor I chose to highlight in the hypothetical case study created for this project.

Purpose

The purpose of this case study analysis is to explore the complex factors that influence student health and academic success, including the struggle of seeking autonomy while accessing school based wellness support. It is important to recognize the experiences, perspectives, and values of all parties while also considering any legal or practice obligations of the professionals involved when a youth enacts their right to keep their health information private. The research literature will begin with a youth “well-being profile” incorporating the four aspects of the BC Healthy Living Performance Standards: Healthy Eating, Active Living, Healthy Practices and Healthy Relationships within the definition of well-being selected for use in this project (Healthy Schools BC, n.d.; Dodge et al., 2012). The struggle between autonomy and attachment during the adolescent developmental period is an important consideration to follow the profile. This review of research will explore factors that impact student well-being and learning, particularly in communities where many families are experiencing poverty, and as a result have access to school-based wellness centres.

Further exploration of research related to school-based wellness centre services, will help to identify situations when students seek out support related to their physical, psychological, or social needs from the educational and/or health care professionals working at their school, and when “mature minor consent” conversations are most likely to occur.

A summary of information sharing practices and policies for “mature minors” across disciplines will follow. According to the Infants Act, a “minor” is defined as a child under the age of 19 (*Infants Act*, 1996). “A child who is assessed by a health care provider as being capable [having the necessary understanding] to give consent is called a "mature minor". A child who is a mature minor may make their own health care decisions independent of their parents’ or

caregivers' wishes. In B.C. there is no set age when a child is considered capable to give consent" (HealthLinkBC, 2018).

The story of a youth and family in crisis and the ethical challenges of professionals working in a school-based wellness centre (from both the education and the health care sector) in relation to a mature minor not consenting to share their personal information will follow. An ethical framework will be used to facilitate a deep inquiry into this representative case study.

Finally, "Emily's story" will be presented and analyzed from an ethical standpoint, in the form of a sample decision making tool. By walking through a case study situated in a school-based wellness centre, I will explore the parallels of ethics within the education sector and health care to create a conversation and critical thinking tool that can be used by both education and health care professionals if a similar moral or ethical problem were to arise. The analysis will hopefully also shed light on the moral complexities involved in this kind of a case, and suggest ways in which one might interpret and apply fundamental moral commitments in light of these complexities and moral conflicts.

Primary Objective

Through the use of a representative case study, my aim is to provide an opportunity for readers to gain insight into varying (but not exhaustive) perspectives, values, and obligations of everyone involved during a complex circumstance or crisis that includes mature minor consent and the sharing of personal information within the context of a school-based wellness centre.

Secondary Objective

Identify resources available for youth, parents/caregivers, educators, and health care professionals when "consent conversations" or struggles with autonomy and sharing of personal information occur.

Third Objective

Share recommendations for future education and collaboration opportunities that have emerged from the exploration of information sharing, collaborative problem solving, and the recognition of differing and unifying perspectives within this project.

Rationale

Before diving into the current rationale for exploring this topic, it is important for me to share where it started. As a registered nurse embarking on an educational leadership program, I knew that I wanted to focus on the partnerships between healthcare and education while also recognizing the importance of including students and their family members. This led me to investigate the concept of “school-based wellness” and the successful implementation of a program in a local school district.

In 2018, Legare & Associates completed a report entitled “*Wellness Centres Evaluation Framework Initiative: Implementation Evaluation*” that captured student and staff data, experiences, and impacts resulting from the implementation of two wellness centres. This final report included praises and recommendations in relation to the implementation of these services for vulnerable youth.

One recommendation highlighted by Legare & Associates (2018) to improve the communication, collaboration, and sharing of knowledge between the school and wellness centre partners, prompted the start of my qualitative research. I became curious if youth consent (mature minor consent) to share personal information as defined, described, and understood in the public education sector, in contrast to within the health care sector, is one of the barriers hindering cross-sector connections for student well-being.

A qualitative research approach for this study was selected in order to investigate and understand the phenomena surrounding a social and human problem (Creswell, 2014; Loisel & Profetto-McGrath, 2011; Stake, 2010). The problem being explored was the “grey area” of discrepancy or conflict surrounding issues of mature minor consent in circumstances when one or more disciplines are supporting the same youth within school-based wellness centres.

I selected a qualitative case study research approach and design. Research data collected by way of individual semi-structured interviews with professionals from each sector may have uncovered unique perspectives or issues related to cross-sector communication in a youth wellness context. In the designing of my qualitative research questions, it was important to recognize the value in capturing both the subjective human experiences in addition to collecting objective information (Baxter & Jack, 2008; Stake, 2010; Yin, 2009). Based on the goal of learning from the experiences of both education and health care professionals through a qualitative case study approach, and ultimately sharing what is learned to facilitate inter-professional connections and mutual understanding, I identified the importance of the following research questions:

1. How is youth consent (mature minor consent) defined, described and understood in the public education sector in contrast to within the health care sector?
2. How do consent issues and the related practices and policies affect school staff and wellness centre staff when protecting the privacy and confidentiality needs of the students while also recognizing a need for cross-sector sharing of important information?

Why am I sharing a research design that never came to fruition? I am proud to have navigated the approval processes for two different research ethics boards, was eager to get started ... and then the Covid-19 pandemic hit. I received notice that my research could not

proceed as it could potentially add to the load or burden on professionals during the stressful and uncertain first wave of the pandemic. I was deflated on top of being seconded into new “pandemic related duties” at work that entailed many long hours. I just wanted to be done with it – almost two years of blood, sweat, and tears invested in a journey towards this research-based master’s thesis and I was now at a loss. This project is my way of salvaging past efforts and honouring the burning questions and issues that still remain unchanged. I will endeavor to connect readers to Emily’s story based on an amalgamation of real world examples. Through a case-based learning approach, the story will be accompanied by a support tool created to encourage analysis, problem solving, and addressing questions that have no single right answer (Queens University, n.d.). An ethical lens will also provide opportunities for readers to insert themselves into someone else’s shoes.

Students who are struggling with physical, mental health, and/or life challenges often struggle with school attendance, educational success, and high school graduation (Basset-Gunter et al., 2016; Blank, 2015; Havlik et al., 2017; Kraft et al., 2015). Many people are doing their own part to support students such as “Emily”, but what if barriers could be removed in the sharing of information amongst cross-sector inter-professional teams?

Students will benefit from a greater sense of community among the adults they trust. These newly enhanced partnerships can provide additional support, learning and job satisfaction for staff in both the education and health care professions working within youth wellness centre environments.

Guiding Question

To accompany the question posed in the introduction, “Are there circumstances when respecting a youth’s choice for privacy involves moral/legal conflict, and following legislation or law may not feel like the right decision?” an additional question will guide this project:

How can an ethical case study and support tool be designed to incite empathy, build understanding, and develop ethical decision making skills?

Definition of Key Terms

The World Health Organization (WHO)’s definition of *health* as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” was created in 1948 and is still widely used today (WHO Global School Health Initiative & World Health Organization, 1996). When this paper refers to the concept of health, the WHO definition will be used as the frame of reference.

Mature minor consent is an important concept to define. As outlined in the Infants act:

A child under the age of 19 is called a “minor”. ”Mature minor consent" is the consent a child gives to receive health care after the child has been assessed by a health care provider as having the necessary understanding to give the consent. A child who is assessed by a health care provider as being capable to give consent is called a "mature minor" (HealthLinkBC. (2018). The Infants Act, Mature Minor Consent and Immunization. para. 2).

A *vulnerable student* will be defined as a student enrolled in a school district with a high risk of poverty and who may experience personal, familial or educational challenges affecting their attendance, performance or behaviour at school (Kraft et al., 2015).

The definition for *well-being* selected for this project is the point of balance between an individual's psychological, social, and physical resource pool and any psychological, social or physical challenges they encounter. If they do not have enough in their resource pool to counter balance a challenge, they are at risk of tipping towards a state of distress (Dodge et al., 2012).

Summary

Chapter one highlighted the need to explore prevalent student health concerns and the impacts challenges may have on their learning. Once concerns are identified on a larger scale in a community, and a wellness centre has been developed, there are more considerations to explore. This chapter also highlighted the necessity of consistent and safe practices of sharing information – particularly in situations involving mature minor consent.

In order to provide an accurate profile of youth / secondary students accessing wellness centre services, chapter two will include a review of literature that illustrates the relationships between student health and education outcomes. Key areas associated with adolescent physical well-being (healthy eating, active living, and healthy practices), psychological well-being (mental and emotional health), and social well-being (healthy relationships) will be captured. Chapter two will also provide an overview of autonomy during adolescence and information sharing from the perspectives of youth, parents/guardians, the education sector, and the health care sector. It will continue with outlining the legislation, policies, and practices related to information sharing and mature minor consent. It will conclude with research and background information on school-based wellness centres and practice, in order to explore inter-professional opportunities to collaborate on information sharing and safe services for students.

Chapter three presents the case of “Emily”. This hypothetical, in-depth story, will include key characters, central issues, and intrinsic and extrinsic influencing factors for the reader to identify and reflect on.

Chapter four includes an ethical decision making support tool that has been partially completed as an example based on Emily’s story. A case study introduction handout based on Emily’s situation is provided in Appendix A and a blank template of the decision making tool is provided in Appendix B as a printable future resource.

In chapter five I reflect on my learning journey, share successes, and identify the limitations of switching to a case-based analysis approach. I will also include recommendations on the implementation of cross sector and collaborative approaches to ethical problems and decision making.

Chapter 2 – Background and Literature Review

The impact of physical health and lifestyle choices of adolescents on school performance has been widely studied and the outcomes of those studies demonstrate the important relationship between health and academics (Michael, Merlo, Basch, Wentzel, & Wechsler, 2015). A secondary school student profile will be presented thematically in the literature review related to key physical, psychological, and social factors that impact youth well-being. An overview of the developmental struggle between adolescent autonomy and attachment to parents / caregivers will follow. It is important to illuminate this developmental phase as an additional factor that impacts circumstances when a youth's well-being may be at risk and they choose to enact their right to not share their personal information with their parents, caregivers, and/or other service providers.

This research will differentiate between the sharing of personal health information for youth and parents / caregivers within the education sector and the health care sector. The literature review will highlight the relevant legislation, policies, and practices related to information sharing and mature minor consent.

This chapter will conclude with a discussion of how school-based wellness centres are situated to provide easy access for students to services that fall within the preceding focus areas such as physical, emotional, or mental health support. These students may present to the clinic with physical or sexual health concerns, mental health concerns such as anxiety or depression, or complex health and social challenges that will benefit from the opportunity of early intervention and support (Legare & Associates, 2018). The moral and legal dilemma occurs when a youth (under the age of 19 years) enacts their right of mature minor consent under the *Infants Act*, to not have their information shared outside of their interactions with the service provider

(Canadian Mental Health Association of BC, 2016). Within the environment of a school-based wellness centre, there are potential wide reaching complications that will be explored through the subsequent case study in chapter three.

Youth / Secondary Student Profile

Researchers in both the education and health sectors are identifying common areas of focus in the context of adolescent well-being (Dodge et al., 2012; Healthy Schools BC, n.d.; Kempf, 2018; Well-Being BC, 2020). These commonalities have been captured within the framework for well-being presented by Dodge et al. (2012) as an individual's unique process of balancing their physical, psychological, and social well-being needs. The youth profile to follow will provide a snapshot of health and life circumstances that impact youth / students accessing school-based wellness centres captured within the domains of physical, psychological, and social well-being.

Physical Well-Being

Healthy Eating. This first area of focus will outline research that validates the growing understanding that dietary behaviours and obesity can be linked with academic performance. In addition to involvement in physical activity (which will be discussed in the following section), good food choices and healthy weight range status (using Body Mass Index measurement), are linked with higher academic achievement (Kristjansson, Sigfusdottir, & Allegrante, 2010). Dietary behaviours are significant factors to consider, particularly during adolescence. This is a time in their growth and development where they are requiring the most nutrients. Burrows, Goldman, Pursey, and Lim (2017) identified that based on their systematic literature review they could make reasonable connections between regular breakfast consumption, lower intake of “junk / fast foods” (including sugary drinks), and good overall diet quality with better outcomes

of academic achievement. Faught, Gleddie, Storey, Davison, and Veugelers (2017a) found a positive link between early adolescents who consumed fruit and vegetables and academic achievement which further substantiate these connections. Similarly, they also found that consuming “junk / fast foods” (high sugar and fat) negatively affected academic achievement (Faught et al., 2017a). With reduced physical activity and consumption of foods with poor nutritional value, the prevalence of obesity among adolescents is growing, and an unfortunate outcome is that higher weights (increase of 50 to 60 pounds) are associated with an 8 to 10 % lower grade point average (Joe, S., Joe, E., & Rowley, 2018).

As articulated by Joe et al. (2018) in a review of educational research related to physical health, mental illness risks, and academic achievement in school-aged children, another important context to uncover when discussing physical health and healthy nutrition is socio-economic status. Health inequalities and food insecurities can be equally detrimental to both health status and academic achievement. Children who experience health challenges in their early years are at a higher risk of having compromised academic success and overall health in their adulthood (Joe et al., 2018). This is further evidenced by a cross-sectional analysis of data collected from a study conducted in Nova Scotia with students (aged 10 – 11 years) and their parents. The learnings from this study captured that children from low-income households and who had low food security resulting in poor diet quality, were more at risk for poor achievement at school (Faught, Williams, Willows, Asbridge, & Veugelers, 2017b).

Active Living. This section will expand on the importance of healthy eating to include the connections between physical activity and academic achievement. In honouring the balance our bodies need between activity and rest, the impact of hours and quality of sleep on learning will also be explored within this context.

In regard to the relationship between regularly moving the body and positive outcomes in learning, common findings in a number of articles have captured that greater physical fitness and activity were directly associated with academic success (Faught et al., 2017a; Ishihara, Morita, Nakajima, Okita, Yamatsu, & Sagawa, 2018; Kristjansson, Sigfusdottir, & Allegrante, 2010). Faught et al. (2017a) highlighted this connection through analysis of data from a study capturing self-reports from over 28,000 Canadian children (population-based sample of youth aged 11-15 from across all the Canadian provinces). The study found that when the students did not achieve the recommended amounts of physical activity (at least 60 minutes per day in a week) they had a lower chance of achieving a grade termed as “excellent” (marks as Mostly A’s or Mostly A’s and B’s). The interpretation of the results demonstrated a positive and direct relationship between being physically active and being academically successful (Faught et al., 2017a).

Through their study of parental questionnaires and academic data from 274 Japanese children (aged 12-13 years old), Ishihara et al. (2017) shared that the benefits associated with regular exercise and physical activity are improved learning ability and brain function. They emphasized that the benefits for children who achieve greater academic performance and greater physical fitness are twofold. The examination of gender differences throughout the findings was an area identified as a limitation in the research (Ishihara et al., 2017). Alternately, Kristjansson et al. (2010) identified gender, as a naturally dichotomous variable, as one of the significant variables to be considered when studying the connections between healthy behaviours and learning outcomes in their research and analysis. In addition to finding a positive correlation between participation in physical activity and higher academic achievement, Kristjansson et al. (2010) also shared that physical activity positively impacted adolescent self-esteem. This study of data from students aged 14 and 15 years old in all Icelandic secondary schools in the spring of

2000, demonstrated there are a multitude of complex variables that come into play when making connections between positive health and learning outcomes (Kristjansson et. al., 2010).

Sleep. Along with the potential to impact overall health, adolescent sleep needs such as hours of sleep, wake up times, and bedtimes, effect concentration, mood, academic performance, and health risk choices (Maume, 2013). Wolfson and Carskadon (2003) reviewed 14 studies that included preadolescents, adolescents, and college-age students to investigate if there was link between sleep patterns, sleep quality and adolescent school performance. A decreased amount of sleep, inconsistent sleep and wake schedules, late bedtimes, and poor quality of sleep (frequent waking) were strongly associated with negative impacts on adolescent academic performance (Wolfson & Carskadon, 2003). While Wolfson and Carskadon were able to report links between poor quality sleep habits and a reduced learning capacity and poorer academic achievement, they were also able to provide insight into certain limitations of the studies such as asking teens to self-report subjective information after the fact.

Wong, Lau, Wan, Cheung, Hui and MOK (2012) also demonstrated the relationship between poor sleep habits and impaired academic performance through a study of completed online, self-reported questionnaires from 930 Chinese students aged 18-25. There is a positive link between getting more than or equal to eight hours of sleep and an increase in grade point average (Wong, et al., 2012). Good quality sleep can be associated with greater motivation to learn and achievement at school whereas lack of sleep can cause impaired memory and recall (Wong, et al., 2012).

As researchers begin identifying the consequences that lack of sleep can have on cognitive, emotional, and behavioural health, an additional factor influencing sleep is becoming an increasing concern. The impact of social media and technology use is an area of interest in

both health care and education. Johansson, Petrisko, and Chasens (2016) concluded (from their study of the results from a National Sleep Foundation poll on 259 youth aged 13 – 21 years old in the United States) that screen time such as watching television and using cell phones, computers, video games, and tablets before bed is negatively impacting sleep needs and daytime functioning.

Healthy Practices. Of equal importance as the relationship between physical health and school achievement is the impact of adolescent lifestyle choices. Health risk behaviours such as tobacco, alcohol and substance use, and sexual activity can significantly impact educational and health outcomes (Joe, et al., 2018). Joe, et al. (2018), also identified the relationship between adolescents choosing health risk behaviours and the possible impacts such as lowered academic performance, potential to drop out of school, and long-term mortality.

Smoking / Vaping. In 2014, Stea and Torstveit identified that minimal research had been conducted in the area of making connections between lifestyle habits and academic achievement of adolescents. Through their study and analysis of questionnaires from over 2000 Norwegian youth aged 15-17 years old, Stea and Torstveit (2014) concluded that there is an adverse relationship between smoking and academic performance in both male and female adolescents. Stea and Torstveit also referenced a Canadian study by Morin, Rodriguez, Fallu, Maïano & Janosz (2012) that supported their findings in a positive perspective “by suggesting that adolescent students who attain high levels of academic achievement are less likely to smoke” (Stea and Torstveit, 2014, p.2). In following this train of thought, a new area of recent concern related to health risk choices, is vaping. At this point in time, there is not a great deal of information available about the long-term health effects or potential harms of vaping on

adolescents (Douglass & Solecki, 2017). This will be an area that healthcare professionals and educators alike may want to explore in the future.

Alcohol. Another health risk and one of most commonly used substances in adolescents continues to be alcohol (Mochrie, 2012). A number of key messages regarding alcohol and substance use in BC's youth can begin on a positive note. In comparison to previous years, Smith, Stewart, Poon, Peled, Saewyc, and McCreary Centre Society (2015) highlighted that compared to 5 and 10 years ago fewer youth are trying alcohol and fewer are engaging in heavy drinking sessions. They based this conclusion on their analysis of the results from the 2013 British Columbia Adolescent Health Survey, which included responses of approximately 30,000 students in Grades 7-12 across 56 BC school districts. Smith, et al. (2015) captured that 45% of the youth (both male and female students) had tried alcohol (this is a reduction from 54% in 2008). With just under half of BC students still trying alcohol, it is important to be aware of the potential harms associated with adolescent alcohol use and the impacts on school performance. Joe et al. (2009) shared physical harms or health issues related to alcohol use that may develop such as liver disease, cancer, cardiovascular disease, neurological damage or psychiatric illness. Additionally, the effects on academic life could include a reduced connection to school, increased likelihood to skip school and lowered chance of planning to enter post-secondary education (Smith, et al., 2015).

Health Risk Behaviours. Unfortunately, when describing adolescent lifestyle choices and health risk behaviours, there is a relationship between early alcohol use and choosing to initiate additional health risks. These other health risks may be engaging in sexual activity (which includes higher risk of STIs and pregnancy) or making dangerous choices such as drunk or distracted driving, or not wearing a seatbelt (Smith, et al., 2015). To expand further, adolescents

may also choose health risk behaviours in response to the effects of social inequality such as living with a health condition or disability, identifying as LGBTQ+, having an unstable life at home, poverty, or exposure to violence, racism, or discrimination (Poon, Smith, Saewyc, & McCreary Centre Society, 2015; Smith, et al., 2015). In summary, as engagement in high risk activities puts adolescents in jeopardy for higher absenteeism and adverse health effects as shared by Basch (2011) this also means that they are jeopardizing their exposure to safe and supportive learning environments and knowledge growth to make more positive lifestyle and health decisions in their youth and ultimately for their lifetime.

It is clear that many facets of physical health and lifestyle choice impact the educational and health outcomes of adolescents. An important point to consider is that these factors are rarely single, isolated circumstances and that the adolescent experience is often complex with multiple factors influencing their health and learning.

Social Well-Being

Healthy Relationships. Through analysis of surveys completed by almost 8,000 Finnish children first at ages 12-13 years old and then again at 15-16 years old, Minkkinen et al. (2017) highlighted that health defined as a combination of physical, mental, and social well-being is a noteworthy influence on academic performance.

Peer Relationships. An interesting result of the Minkkinen et al. (2017) study revealed that in addition to individual health status impacting academic achievement, their classmate's health also impacted their learning. This outcome speaks to the significant level of influence that peers and fellow students have on each other and the benefit of developing a positive social and emotional climate in classrooms (Minkkinen et al., 2017). A quote captured from the 2013 BC Adolescent Health Survey and shared by Smith et al. (2015) powerfully articulates how social

experience has the potential to influence many areas of adolescent health, wellness, safety, and learning. When asked if she had ever tried alcohol, a fifteen-year-old girl responded:

“In my grade (9), many people are beginning to drink and get drunk. Almost 100% of the grade does. I do not want to and am not allowed...I may lose most of my friends because of this” (p.13).

Childhood Experiences. In the same way that peer relationships can influence adolescent health and educational performance, childhood experiences can also be linked to health, emotional well-being, and academic functioning (Balistreri & Alvira-Hammond, 2015). Adolescence is a time of transition where youth are trying to establish independence while still growing and maturing both physically and intellectually. If an adolescent has been exposed to one or more adverse experiences in their childhood, they may have difficulty navigating this developmental milestone. According to Soleimanpour, Geierstanger, and Brindis’s (2017) research on adverse childhood experiences (ACEs), their prevalence and lasting health effects is growing, but more focus needs to be paid to the impacts on adolescents and the subsequent supports they need. ACEs are described as acts of physical, emotional or sexual abuse, physical or emotional neglect, domestic violence in the home or neighborhood, parental substance use, separation or divorce, poverty, or having a family member in prison (Balistreri & Alvira-Hammond, 2015; Soleimanpour, et al., 2017).

Research completed in the United States has indicated that over 50% of their adolescent population has been exposed to at least one of these traumas, with over 25% experiencing two or more ACEs (Soleimanpour, et al., 2017). In Canada, statistics were hard to find specifically related to the adolescent population. In light of that challenge, the 2012 Canadian Community Health Survey – Mental Health provided some valuable insights. Approximately 24,000 people

were surveyed to create a representation of the Canadian population aged 18 years or older and 32% reported that they had experienced physical or sexual abuse and/or exposure to familial violence during childhood (Afifi, MacMillan, Boyle, Cheung, Taillieu, Turner, & Sareen, 2016). Despite the significant numbers of people being exposed to trauma, assessment methods to determine past traumatic experience have not yet been widely introduced into clinical practice (Bethell, Solloway, Guinosso, Hassink, Srivastav, Ford & Simpson, 2017; Soleimanpour, et al., 2017). The harmful effects of ACEs directly affect adolescent health and academic performance. These impacts look like a higher chance of being held back a year, increased risk for learning and behaviour challenges, suicidal thoughts, and early initiation of health risk behaviours (Soleimanpour, et al., 2017). Hare and Pidgeon (2011) also emphasize through their literature review that school experiences for Indigenous youth consist of too frequent occurrences of individual and systemic racism, which directly impacts their educational outcomes. Indigenous youth may experience verbal or psychological abuse at an individual level, and may struggle to find a connection to lessons that do not include or reference their histories, values, or worldviews (Hare & Pidgeon, 2011). The outcome of these challenges may look like lack of attendance, behaviour problems, or underachievement (Hare & Pidgeon, 2011; Stempel, Cox-Martin, Bronsert, Dickinson, & Allison, 2017). Exposure to ACEs (which includes racism), can be linked to decreased adolescent emotional and physical health and repeated exposure to stress can also impact impulse control or attention and decision-making processes (Balistreri & Alvira-Hammond, 2015; Hare & Pidgeon, 2011).

Resiliency. A valuable perspective highlighted by Soleimanpour, et al. (2017) is that there are strengths and protective factors that can defend against negative childhood experiences. Youth who build resiliency and coping skills and/or have trusted home, school, and / or

community supports may respond and recover more favourably from the effects of being exposed to ACEs (Bethell et al., 2017). Hare and Pidgeon (2011) describe one example of resiliency and strength in the face of adverse childhood experience. The example they share is that Indigenous families and communities and their knowledge systems (knowledge of their people, language, values, beliefs, and practices) empower youth to reach for their internal strength and their communities for sources of support to cope with challenges they face in school.

Psychological Well-Being

Mental & Emotional Health. An area that intersects the themes previously discussed related to healthy living is youth mental health. While transitioning to discuss mental health factors that impact wellness and academic performance, it is important to bring forward the linkage between ACEs and mental health challenges. Unfortunately, strong associations between child abuse and mental disorders, suicidal ideation, and suicide attempts exist (Afifi, MacMillan, Boyle, Taillieu, Cheung, & Sareen, 2014). It is essential for both educators and health care providers to gain a deeper understanding of the prevalence of childhood trauma and mental health concerns facing many vulnerable adolescents.

In their review of 150 peer-reviewed journal articles, books, and reports related to research on mental health, academic achievement, and mental health strategies in Australian secondary schools, Bowman, McKinstry, and McGorry (2017) shared a number of valuable conclusions. They outlined that the onset of mental health conditions such as depression, anxiety, or the first episode of psychosis, often occurs when the adolescent is in school.

Youth experiencing the negative effects of mental illness (including anxiety or depression) often have difficulties sustaining and completing high school education and many of

these adolescents will drop out (Bowman, et al., 2017). The conclusions drawn from the Australian review can also be validated with a study of Canada wide responses (pulled from a survey completed in 2008, titled Tell Them From Me) of approximately 119, 000 children in grades 6 to 12 by Tramonte and Willms (2010). While providing an important Canadian context, Tramonte and Willms (2010) were able to share that approximately 50% of mental health issues in adulthood begin in the mid-teenage years and unfortunately, the opportunity for treatment is often lost until they are out of school and into their adult years. With a focus on anxiety, Tramonte and Willms reported that anxiety impacts adolescent quality of life and their ability to benefit from the school experience while capturing a higher prevalence of anxiety in female students that was consistent across all grades. They also discovered that anxiety levels in general were universal across all schools with students in grades 6 to 12, which suggest that interventions created to support students with anxiety, could be also be universal across all schools. One self-identified weakness of this particular study was that they were not able to directly correlate students' mental health and wellbeing data to their academic performance data and this would require an additional study (Tramonte & Willms, 2010). While this research is only touching briefly on the relationship between mental health and school achievement, it is important to note that mental health concerns may be part of complex, comorbid disorders which mean that they are often not a singular problem and may have a variety of associated behaviours and symptoms.

In addition to the cognitive and behavioral effects of mental health problems, the symptoms can also be physical in nature such as shortness of breath, heart palpitations, nausea, numbness, dizziness, or trouble sleeping (Keeley & Storch, 2009). Mental health challenges such as anxiety disorders can cause a substantial amount of distress for adolescents that in turn widely impacts how they function at school, socially, and with family (Keeley & Storch, 2009).

To finish with a positive perspective on mental health and success at school, Mochrie (2012) reported her findings from an analysis of the results of the 2008 BC Adolescent Health Survey and provided a number of key influences related to school connectedness and positive mental health. Mochrie shared that the “more connected youth felt to family or school, the more likely they were to report excellent general health and high self-esteem, and the less likely they were to have considered suicide” (p.12). She also highlighted that “youth with mental health and substance use problems who reported that they had access to a supportive adult inside or outside their family reported better health and better health-promoting behaviours” (Mochrie, 2012, p.12).

Autonomy

At this development stage of a young person’s life, a struggle may exist between their need to express their autonomy and the attachment they may have to their parents / caregivers (Lerner & Steinberg, 2009; Soleimanpour, et al., 2017). This tension exists in both health care and education environments as the provision of care and education services for youth typically emphasizes parental involvement .Through the natural process of individuation from parents / caregivers, adolescents build their independence and personal responsibility for daily choices related to health, education, and relationships (Soleimanpour, et al., 2017). Adolescence is characterized as a time period of significant physical, psychological, and social development and is also a time when youth often have unmet physical and psychological needs (Dodge et al., 2012; Lerner & Steinberg, 2009; Soleimanpour, et al., 2017). This is further complicated if an adolescent has been exposed to trauma or adverse childhood experiences (Soleimanpour, et al., 2017). In fact, adolescents who have experienced a traumatic event will often require an opportunity to build a trusting relationship first, before feeling safe enough to disclose their

experience (Grant, Elliot, Di Meglio, Lane & Norris, 2008; Soleimanpour, et al., 2017). During a time when adolescents may engage in higher risk health behaviours while establishing their independence, they will also seek reassurance that any sensitive information they share with a trusted adult will be kept confidential (Soleimanpour, et al., 2017). Moreover, high school youth may forgo seeking health and care services for sensitive issues if they were concerned that their information would not remain confidential (Soleimanpour, et al., 2017; Wadman, Thul, Elliott, Kennedy, Mitchell & Pinzon, 2014). Both the principles of sharing youth information and the concepts related to mature minor consent (the recognition of a youth's personal autonomy) will be examined in the subsequent section.

Sharing of Personal Information Overview

All circumstances involving information sharing decision making, require authorization through legislation (Canadian Mental Health Association of BC, 2016; Coughlin, 2018; Office of the Information & Privacy Commissioner for British Columbia, 2015). Public sectors and their staff, in both education and health care, are guided by the *BC Freedom of Information and Protection of Privacy Act* (FIPPA) legislation (Office of the Information & Privacy Commissioner for British Columbia, 2015; Canadian Mental Health Association of BC, 2016; Coughlin, 2018). This legislation outlines how personal information may be used and provides guidelines for the sharing of that information.

Information Sharing Within the Public Education Sector

In addition to FIPPA, education professionals can access BC School Act legislation and Information Sharing Agreements which operate in compliance with FIPPA and are used when there are routine exchanges of personal information between public bodies (*School Act*, 1996; Canadian Mental Health Association of BC, 2016; Government of BC, n.d.). The *School Act*

ensures that the confidentiality of the information contained in the student records is protected and safeguards privacy for students and their families. In regard to the details of information sharing, “a parent of a student of school age attending a school is entitled to be informed, in accordance with the orders of the minister, of the student’s attendance, behaviour and progress in school” (*School Act*, 1996. Div2.7)

Information Sharing Within the Health Care Sector

Health care providers have the *Personal Information Protection Act* (PIPA) and the *Infants Act* along with FIPPA to support disclosure of information requirements (Canadian Mental Health Association of BC, 2016; Coughlin, 2018; Doctors of BC (BCMA), College of Physicians and Surgeons of BC (College) & Office of the Information and Privacy Commissioner for BC (OIPC), 2017; Downie, Caulfield & Flood, 2011).

PIPA applies to the private sector such as family physicians or specialists, the First Nations Health Authority, and non-profit organizations. “The purpose of this Act is to govern the collection, use and disclosure of personal information by organizations in a manner that recognizes both the right of individuals to protect their personal information and the need of organizations to collect, use, or disclose personal information for purposes that a reasonable person would consider appropriate in the circumstances” (*Personal Information Protection Act*, 2020, Part 1.2). The Doctors of BC et al. (2017) translate the legislation under PIPA to capture that in BC, consent for the “collection, use, and disclosure of personal information” for direct provision of health services works using the principle of “implied consent”. This framework reaches professionals who also provide care to the same person, becoming a member of that person’s “circle of care” (The Doctors of BC et al., 2017). A youth’s / patient’s expressed consent (written or verbal) is required prior to any of their personal information being shared

outside of that circle of care. A decision support tool is provided in chapter four to help team members navigate situations when expressed consent is not given by the youth to have their information shared.

Despite the fact that the legislation of FIPPA and PIPA is separate and serves unique purposes in each of the respective public and private sectors, when used together they function to support the sharing of personal information across both areas (Canadian Mental Health Association of BC, 2016; Doctors of BC et al., 2017).

When addressing the underlying ethical question related to when law or legislation may not be the right answer, these legal acts come into play during the moral and legal balancing act of interpreting the legislation to determine when it is in the best interest of a child/youth to disclose information to either parents and/or other inter-professional team members.

Mature Minor Consent. When highlighting the consent process for mature minors, the Canadian Mental Health Association of BC (2016) generalizes that in the majority of situations, parents and guardians can consent on behalf of an “infant or minor” (people under the age of 19 years). Nelson and Ogbogu (2018) expand on this point while emphasizing the important distinction that when parents or guardians do make treatment decisions on behalf of an infant / minor, it must be founded on the best interests of that infant / minor. The *Infants Act* dictates the right of children under the age of 19 (there is no specific age of consent in Canada) to consent to making their own medical decisions if the decision is in the child’s best interest and the child understands the information, risks, and benefits of the decision outcomes (Coughlin, 2018; Government of BC, 2019; Nelson and Ogbogu, 2018). The principles of mature minor consent within the *Infants Act* refer to circumstances when a person under 19 years chooses to make their own healthcare decisions without consent from their parent or guardian (Canadian Mental Health

Association of BC, 2016; Coughlin, 2018; HealthLinkBC, 2018; Nelson and Ogbogu, 2018). Minors, who voluntarily demonstrate the capacity to understand information that is relevant to their healthcare decision, acknowledge future benefits and consequences and reflect their understanding back to a healthcare provider (without coercion) may enact their right to an autonomous mature minor consent process (Canadian Mental Health Association of BC, 2016; Center for Practical Bioethics Children's Rights Task Force, 1999; Coughlin, 2018; HealthLinkBC, 2018; Nelson & Ogbogu, 2018).

As the ethical issues related to youth participating in decision making regarding their healthcare are explored in this project, the concept of assent is a vital component (Center for Practical Bioethics Children's Rights Task Force, 1999; Coughlin, 2018). Assent involves valuing a young person's capacity to participate autonomously based on their own knowledge and understanding in a healthcare decision and is important to recognize at this stage of their growth and development (Center for Practical Bioethics Children's Rights Task Force, 1999; Coughlin, 2018; Lerner & Steinberg, 2009; Soleimanpour, et al., 2017). Seeking out assent from adolescents during healthcare conversations can reduce anxiety, promote trust, and acknowledge their developing autonomy (Grant et al., 2008; Hart & O'Reilly, 2017; Jackson, Burns & Richter, 2014).

“Healthcare decision making involving minors must include recognition of the developing capacity of minors for rationality, autonomy, participation in decision making, and their evolving sense of self and life story.” (Center for Practical Bioethics Children's Rights Task Force, 1999, p.1)

Autonomy, beneficence, non-maleficence, and justice are four foundational principles in bioethics (Beauchamp & Childress, 2001). The incorporation of these principles and the value of

building a common language within educational ethics and “wherever we pursue ethical truth” is important to explore (Maxwell, Tanchuk & Scramstad, 2018). The case study presented in the next chapter will identify assent as an expression of a mature minor’s “informed free will” within a healthcare decision making process, in the context of a school-based wellness centre and the ethical challenges that arise when this autonomy holds more personal value for some than others. The four ethical principles of bioethics will be utilized as the framework for discussion, analysis and learning throughout the remaining chapters.

Information Sharing for Youth

Confidentiality and trust are integral to adolescent care relationships and they are at great risk of foregoing services if they do not feel safe disclosing private information (Canadian Mental Health Association of BC, 2016; Grant et al., 2008; Hart & O’Reilly, 2017; Jackson et al., 2014). The importance of confidential health care is emphasized by Grant et al. (2008) who summarize that “the number one reason given by teenagers for not accessing health care is confidentiality” (p.16). Furthermore, it is important to explore with a young person who they are comfortable sharing information with and what information is kept private (Canadian Mental Health Association of BC, 2016; Hart & O’Reilly, 2018). The comfort level with disclosing personal information to others is unique to every individual, including youth. There are youth who may decide not to access particular health care services if they believe that their private information will be shared with their parents, while other youth may find their family a source of support and request parent or caregiver involvement (Grant et al., 2017; Jackson et al., 2014). The upcoming case study is set in an inter-professional care environment of a school-based wellness centre. This setting adds complexity to decision making about sharing information if a young person and / or parent does not want health-related information shared with school staff -

which could hinder responsive and coordinated support (Canadian Mental Health Association of BC, 2016; Hart & O'Reilly, 2018). As discussed previously, this is a time when youth are seeking out ways to exert autonomy in their lives. Youth who meet the legislated criteria of mature minor consent under the *Infant's Act*, can be “respected as persons primarily responsible for their own health and well-being” (Center for Practical Bioethics Children’s Rights Task Force, 1999, p.14). Through the creation of healthcare relationships founded in trust, adolescents will learn and develop independent decision making about their private information based on their unique life circumstances and preferences (Canadian Mental Health Association of BC, 2016).

Information Sharing for Parents/ Caregivers / Families

During a time when youth are struggling between autonomy and still needing support, the dynamic relationships between parents/caregivers and youth can present ethical challenges for healthcare providers (Wadman et al., 2014). Service providers universally recognize that in the majority of circumstances, family involvement is key to providing wholesome support. It is a learning curve for some parents to understand that there is confidentiality legislation that applies to their child, a mature minor, and to feel comfortable fostering their child’s autonomy (Canadian Mental Health Association of BC, 2016; English & Ford, 2007; Soleimanpour, et al., 2017). Parents or caregivers may feel frustrated or helpless when they are navigating the tension between needing important information about their child and honouring their child’s wishes to keep information private (Canadian Mental Health Association of BC, 2016; Hart & O'Reilly, 2017). The laws around sharing information with families are complex, ambiguous, and difficult to interpret at times. This confusion is often at the core of ethical challenges related to youth privacy and information sharing (Canadian Mental Health Association of BC, 2016; English &

Ford, 2007; Grant et al., 2008; Wadman et al., 2014). Because they encourage a consultative level of parental involvement in decision making, Grant et al. (2008) commend the Canadian Paediatric Society for their family-centred care approach “that prepares youth to participate in medical decision making, and assists families of youth to move from primary decision makers to consultants” (p.17).

For everyone involved in decision making around the sharing of youth information, it is vital to establish a common understanding that there are circumstances when information must be shared. When someone believes that a youth or someone else may be harmed or is in danger in situations such as abuse or suicide, personal information must be shared (Canadian Mental Health Association of BC, 2016; Coughlin, 2018; Doctors of BC et al., 2017; Downie, Caulfield & Flood, 2011). Additionally, personal information may be shared within a youth’s circle of care, such as any other health care providers also involved (Canadian Mental Health Association of BC, 2016; Doctors of BC et al., 2017).

Moral and legal dilemmas occur when a youth (under the age of 19 years) enacts their right of mature minor consent under the *Infants Act*, to not have their information shared outside of their interactions with their healthcare provider. Within the environment of a school-based wellness centre, this has wide reaching complications.

Upon concluding their best practice guide (which has been generously referenced throughout this literature review), the Canadian Mental Health Association of BC (2016) shares an impactful message to support the navigation of complex legislation alongside complex human interactions.

“Privacy should not be a barrier to health, safety or the provision of high-quality care. In fact, appropriate and effective information sharing is an important ingredient to a family-

centred mental health and substance system. And above all, we all need to remember that “life trumps policy.” (p.19)

School-Based Wellness Centres (SBWC)

School-based health centres have been established in the United States since the 1970's with the goal of reaching those students who could not afford primary health care and in turn, a strong connection with higher academic performance has been documented in research (Chow, Hollenberg, Lowndes, Kovacs, Dion, & Cumner, 2017). A wellness centre is meant to be located in a centralized and safe place where students can access a number of health services for mental, sexual, and physical health needs in addition to health promotion support. Although a positive correlation has been determined between accessing school-based centres and increased academic performance in the United States, there is a lack of data supporting this practice in Canada (Chow et al., 2017). From an international perspective, Stewart-Brown (2006) completed a systematic review of controlled trials of school-based health promotion initiatives based on the World Health Organization's health promoting school guidelines and concluded that further research is needed that includes measureable outcomes and evaluations to determine what is working and what is not in relation to promoting health in schools.

In light of a lack of Canadian data, Chow et al. (2017) conducted a study in a wellness centre within a school for boys in Grades 3 through 12 in Toronto. Over a period of five years, the purpose of this study was to examine the number of students accessing the wellness centre services, the reasons for their visits and amount of school time missed. Through their analysis of the metrics, Chow et al. (2017) shared that their findings aligned with American research studies and showed a positive relationship between visits to the centre and academic success through a reduction in absenteeism.

In search of Canadian based information on this topic, Legare and Associates' (2018) published a final report and evaluation of three BC school-based wellness centres on during the 2016 to 2017 school year. They captured a number of key services provided in the wellness centres that supported the youth to stay in school. These services included support for an array of physical, mental, emotional, and sexual health concerns. They drew their information for analysis from student surveys and discussion groups and interviews with educators and health care providers. Students shared through their participation in the focus groups that the wellness centre has helped them in areas such as managing anxiety and depression, or dealing with the impacts of bullying which has made them less likely to skip individual classes or school entirely (Legare & Associates, 2018). To summarize the impact of this collaborative approach on adolescent wellness and education, Legare and Associates (2018), captured a significant message from the interviews:

A strong theme running through this study is the recognition of the strength and resiliency of students, particularly those who maintain their school connectedness and academic pursuits through difficult personal circumstances. Increasing school connectedness through strong relationships to staff helps students to feel that they matter, and maintain their link to school attendance, academic success, and graduation (p.32).

The positive outcomes connected to relationship building and connectedness can be applied to the interprofessional relationships within the schools as well. To expand on the importance of strong connections and communication, the Legare & Associates' (2018) report provided the following recommendation for improvement:

Work with school staff to address privacy and policy concerns regarding student health records; clarify information-sharing boundaries with school agencies and counsellors;

develop a shared understanding between school and wellness centre staff to address school staff concerns regarding students' use of the wellness centre lounge areas; develop shared approaches to support student access to the wellness centre. (p.59)

As the establishment of school based wellness centres is a new initiative and in its early stages of growth, these specific and actionable suggestions for improvement of cross sector processes in wellness centres operating within BC schools provide clear direction for future research. Pulling from recently published recommendations for interprofessional collaboration across sectors within a local school-based wellness centre to create the case study, will provide valuable and realistic learning moments for the reader.

Key Findings from Literature

As a mutual understanding of the key factors that influence both health and learning outcomes in adolescents develops, collaboration between health and education leaders is important. A greater appreciation of the complex and varied influences that adolescents experience while navigating their health and education journey emerged from the literature and provides valuable insight. Struggles with attendance and academic performance, are often related to health issues. Additionally, school connectedness and access to school-based wellness supports can greatly benefit students and require future commitment, expansion of health and education partnerships and further study. Limitations of a number of studies shared within this paper are related to a lack of Canadian data.

What is needed in current Canadian research is an insight into the perspectives of interprofessional and cross-sectoral teams who are working in communities with vulnerable youth and in schools that house wellness centres within their walls. As students may often reach out for help or show up needing support at a school environment first, it is important to consider

the expertise of the professionals who are regularly supporting and interacting with them, while also recognizing there may be times of moral or ethical stress.

Lisa mentioned, “I think this a general problem in many schools and teenagers in general but... I’ve never experienced the volume of kids, who are cutting in school and have blood dripping on the floor” (Furey, 2014, p.78).

Nancy agreed that family stress is a contributor, stating, “They come from a not-so-tight family and they’re just struggling to live their everyday life” (Furey, 2014, p.80).

Either of the student experiences (witnessed in a counsellor’s practice) shared above, could have been examples of student stories from a school-based wellness centre. What if the students are deciding not to share their personal health information with anyone else? How will a shared understanding of ethical principles, legislation, and standardized student safety measures across the school and wellness centre alleviate barriers to sharing information? These are areas of interest and future research that would be important to explore.

Blank (2015) offers a few points to keep in mind when building and growing relationships between sectors for the benefit of the youth in our communities, such as continually examining how they are working together, what is working, and what needs improvement. Vass (2017) shares a culturally responsive schooling practice that captures the interdependent relationship between health and education by encouraging us to “understand that test scores and grades are symptoms, not causes”. The literature is clear that there is an undeniable link between health and educational outcomes. It is equally apparent that both education and health care sectors have prioritized this connection. What has not been demonstrated well in research is how these systems are successfully partnering together using common language and strategies to support adolescents and each other.

Chapter 3 – Case Study Analysis Process and Rationale

This project starts by highlighting the complex challenges that impact students' well-being and learning, particularly in communities where many families are experiencing poverty, and as a result have access to school-based wellness centres (Legare & Associates, 2018; Lemkin et al., 2019; Poon, Smith, Saewyc, & McCreary Centre Society, 2015; Smith, et al., 2015). Further exploration identifies situations when students may seek out support related to their physical, mental, or emotional needs from the educational and/or health care professionals working at their school, and when “mature minor consent” conversations are most likely to occur. Now in chapter three, a deeper inquiry through case study analysis will dive into Emily's¹ story of choosing to keep her private health information confidential, and not consenting to have any information shared with her parents or school staff. Finally, based on the information presented, reviewed, and analyzed from the perspectives of all parties involved in Emily's story, a learning tool will be presented. This affective learning style and ethical decision making framework will build a greater understanding of the facts, values, attitudes, and behaviours that emotionally impact the youth, parents, school staff, and care providers (Dutra, 2013; Heiney, Polyakova-Norwood, DeGregory, 2019 & McDade, 1995).

Case Study Pedagogy

In alignment with my original approach of qualitative case study research, I re-engaged in this work by selecting a case study analysis approach for this project that can still investigate and understand the phenomena surrounding a social and human problem (Creswell, 2014; Loiselle & Profetto-McGrath, 2011; McDade, 1995; Stake, 2010). The problem I am exploring is the “grey

¹ The Emily in this case study is a fictionalized character, a composite of challenges and characteristics of youth who might seek out school-based wellness centre services.

area” of discrepancy or conflict surrounding issues of mature minor consent in certain circumstances within school-based wellness centres. The people I am capturing on this exploratory journey are Emily, her parents, and the educational and health care professionals involved in her care as they navigate the social and human considerations of consent related decision-making.

Case study pedagogy has been in existence for as long as the First Nations, Inuit, and Metis storytellers have been passing on knowledge from generation to generation through oral traditions (First Nations Pedagogy, 2009). Just as early storytellers would use stories or “cases” to foster survival instincts, wisdom, and understanding of the world around them, case study analysis has evolved to allow the learner to dive into complex real-world situations, explore solutions to problems, and reflect on their thoughts and ideas (First Nations Pedagogy, 2009; Heiney et al., 2019 & McDade, 1995). Working from the belief that people learn through experiences and reflection, the theoretical framework for case study pedagogy is grounded in constructivism (Dutra, 2013; Grundy, Hamilton, Veletsianos, Agger-Gupta, Marquez, Forssman & Legault, 2016; Wright & Grenier, 2009). The constructivist case-based learning approach is used across a myriad of disciplines to develop critical thinking skills and encourage reflection while the learner is learning to problem solve on their own (Dutra, 2013; Grundy et al., 2016; Heiney, 2019; McDade, 1995; Queens University, n.d.; Wright & Grenier, 2009). By walking through a case study situated in a school-based wellness centre, I explore the parallels of youth and family related ethical challenges within both the education and health care sectors to create a conversation and critical thinking tool that can be used by both education and health care professionals. Critically evaluating, learning, and identifying individual and professional values from complex social phenomena based on realistic and applicable constructs ... and applying

them to real-life situations, are valuable skills developed through case study analysis (Dutra, 2013; McDade, 1995; Queen's University, n.d.; Valiga, 2003).

Considerations

Now that an overview of case study analysis has been presented and applied to the context of this project, the next step is to dive into the specific case. As the literature review captured the complex student profiles that may be factors in consent related circumstances within the school-based environment of the study, the case study approach supports the search for deep and empathetic understanding of this real world situation while also recognizing the pertinent contextual and ethical considerations (Dutra, 2013; Heiney et al., 2019; McDade, 1995; Queen's University, n.d.).

Case Study Guiding Question

Before sharing Emily's story, it is important to articulate the problem that the case study is presenting for analysis (Grundy et al., 2016; McDade, 1995). The question guiding this project is, "Are there circumstances when respecting a youth's choice for privacy involves moral / legal conflict, and following legislation or law may not feel like the right decision?"

Through using a case-based approach to tell a story that resembles a real-world example, my role in sharing Emily's story is to support the reader / learner to identify, analyze, and examine problems, empathize with other perspectives, and attempt to solve ethical questions that have no single right answers (Queen's University, n.d.). The selection of the problem for Emily's story is based on the realistic context of what is happening in many Canadian communities today. McDade (1995) and Grundy et al. (2016) both stress the importance of growing practice through theory and theory through practice. Regardless of the discipline, for this growth to be successful, the learning has to be relevant and authentic to current or future experiences in order

for it to resonate and support connections between practice and theory. I source my professional experience and research publicly available “true cases” to design a case study that can be used for information and resources, self-directed learning, or as a discussion and collaboration tool (Dutra, 2013; Grundy et al., 2016; McDade, 1995; Queen’s University, n.d.).

Theoretical Constructs

Concepts from Information Processing Theory (IPT) and Herreid’s (2007) rules for case based learning will inform the framework of the case study (Dutra, 2013; Ormrod, 2003; Queen’s University, n.d.). These two theoretical constructs were selected due to their learner-centred approaches that encourage critical thinking, which are vital to case study pedagogy (Dutra, 2013; Herreid, 2007; McDade, 1995; Ormrod, 2003; Queen’s University, n.d.). A brief summary of the seven factors I considered when building Emily’s story are as follows:

Part 1. Create a compelling story that grabs the learner’s attention with a current (within the last five years) and thought provoking “hot topic” (Herreid, 2007; Queen’s University, n.d.).

Part 2. Generate a case that is relatable and applicable to current knowledge and practice with intention to inform future learning and professional growth (Dutra, 2013; Herreid, 2007; Ormrod, 2003; Queen’s University, n.d.).

Part 3. Draw from literature, personal experience and publicly available data to develop a list of key characters that the learner can connect with and gain empathy towards. Include quotes from each person in order to capture their voice and have their position and / or perspective better understood (Herreid, 2007; Queen’s University, n.d.). Table 3.1 captures an example of my initial list of key characters generated in this phase.

Table 3. 1*List of Key Characters*

Role	Name
Mature Minor:	
Indigenous youth who identifies as female, and accesses school-based wellness centre	Emily
Family:	
Parent – Single Mother	June
Sibling – Younger Sister	Elizabeth
Education Sector:	
School Counsellor in same school as wellness centre	Mr. Crane
School Educator / Coach in same school as wellness centre	Ms. Pointer
Health Care Sector:	
Public Health Nurse working at school- based wellness centre	Julie
Family Physician working at school-based wellness centre	Dr. Paige

Part 4. Maintain alignment with principles of case study pedagogy and keep material organized (Dutra, 2013; Herreid, 2007; Ormrod, 2003; Queen’s University, n.d.). This will allow the learner to follow the story and sustain their engagement in the learning and problem-solving process.

Part 5. Keep content brief and concise. Reflect the core messages and only share information that is important to the story (Dutra, 2013; Herreid, 2007; Ormrod, 2003; Queen’s University, n.d.).

Part 6. Capture the “controversial narrative” that will humanize the material and introduce meaningful conflict that supports a return to the case study question (Herreid, 2007; Queen’s University, n.d.).

Part 7. Prompt the reader to make their own decision or recommendations. This will enhance the consolidation of learning (Dutra, 2013; Herreid, 2007; Ormrod, 2003; Queen’s University, n.d.).

Due to the diverse experiences and expertise of each person involved in the care and consent related conversations in this case study, I will draw from a constructivist foundation while attempting to understand the phenomena of mature minor consent from the perspectives of each of those directly involved in Emily's story (Dutra, 2013; Grundy et al., 2016; Heiney, 2019; McDade, 1995; Queens University, n.d.; Wright & Grenier, 2009).

Case Presentation

This case study will be sharing a moral problem facing Emily, her family members, and the educators and health care providers supporting her.

Disclaimer

Emily's story is fictional and the information contained in her case study is solely for the purposes of learning and discussion. Aspects of actual, published stories were used to inform some of the details to provide a realistic picture of a current day Canadian youth accessing care within a school-based wellness centre. No names used in this case study were taken from real-life cases and any similarity to an actual case is not intentional. The opinions and questions framed throughout the process are intended to instigate rich and diverse discussions.

Emily

Emily is a 16 year old girl who identifies as Indigenous and attends senior high school in a community with a high risk for poverty. She lives with her single mom and younger sister. Emily's mother June, works two jobs that are shift work, which keep her away from the home for long periods of time. Emily has a close relationship with her 12 year old sister Elizabeth, and often takes on the role of her sister's caregiver when her mom is at work. Emily and June's relationship has been close until recent tensions arising out of Emily seeking more independence and autonomy. Emily's mother and father never married and due to her father's struggles with

alcohol abuse, he has not been in their lives since Emily was three. Elizabeth has a different father who is also not involved in their lives.

Emily is a high-achieving, quiet girl who performs well academically with straight A's and a mastery level in most concepts. She is also an avid volleyball player who plays on the school team at a competitive level with hopes of getting a volleyball scholarship to university. Earlier in the year while training for a new volleyball season, Emily badly injured her knee. After being seen in the emergency department, she was provided a prescription for Tylenol 3 to manage her pain while slowly introducing physiotherapy.

While waiting to be cleared to return to the volleyball court, Emily began spending time with some new friends at school and met her first boyfriend. Now, a month into her relationship with Trey, Emily accesses care at her school-based wellness centre.

Family

Emily's mother June contacted the school counsellor and expressed concerns about Emily hanging around with new kids that are a "bad influence on her daughter". She shared that she is also concerned that her daughter has become sexually active and is "making bad decisions". June asks if she can be informed of what Emily shares during the counselling appointment and asks for Ms. Pointer, Emily's teacher and volleyball coach to be informed as well. She states she is so proud of Emily and "does not want her daughter to throw everything away that she has worked so hard for".

Education Sector

Ms. Pointer became concerned about Emily after her injury and the pressure she was putting on herself to heal quickly and get back on the court while maintaining her grades. She is seeing Emily making "risky choices" in new friendships and behaviour with her boyfriend in the

school hallways. She told Emily she is worried about her and asked if Emily would be open to meeting with one of the school counsellors. Emily agreed to meet with Mr. Crane, a part-time educator who also works in the school counselling program. Emily sought out support at the wellness centre first, before her counselling appointment that was booked for the following day.

Healthcare Sector

On the day of Emily's wellness centre visit, Julie, a registered public health nurse meets with Emily and completes an intake interview and clinical assessment. In this wellness centre, the family physician and registered nurse work closely together to support students' needs. With Emily's consent, Dr. Paige completes a further assessment and examination, and she is diagnosed with a sexually transmitted infection (STI) requiring antiviral treatment. Emily appears emotional, nervous and fidgety. When asked about how she is feeling, Emily shares that she has been "stressing out a lot" about this situation because she is worried that her boyfriend will break up with her when he finds out about the infection. When asked if she has experimented with any alcohol or drugs to deal with her stress, she said that she will never try alcohol because "it is the reason she doesn't have a dad". She hesitantly disclosed that she was taking Tylenol 3 for her knee pain but she ran out of pills. Because she was still in pain, worried about what was wrong with her body, and had to get an "A" on a big exam coming up, she subsequently shared that she has tried using her boyfriend's Ritalin and occasionally smokes weed with her friends. Emily states, "It's been a brutal couple of weeks - now that I will have medicine and the exam is over, I won't need to take anymore pills". Emily states that she does not have suicidal thoughts or a plan.

Emily chooses this time to share that she absolutely does not want her mother, volleyball coach, or new school counsellor to be informed of her circumstances. She pleads with the doctor

and the public health nurse, “Please do not tell anyone, especially my mom about any of this – it would make her so upset and she already has enough to deal with.”

Dr. Paige determines that Emily is competent to make this decision and that she is making it with the full understanding of the immediate and future consequences of her decision.

Case Overview

Emily has disclosed to the clinical team that she is sexually active, she occasionally smokes marijuana with her friends, and that she has also been taking her boyfriend’s Ritalin after finishing all of her prescribed Tylenol 3s. She does not want her mother to know that she is sexually active or that she is being treated for a STI. She also does not want her marijuana use or experimentation with Ritalin to be shared with anyone. In summary, Emily as a mature minor is choosing to have her private health information kept confidential.

After identifying the facts, the next step is exploring the moral and ethical principles, values, and considerations that are relevant to each of the affected parties in this problem. The final step includes seeking out solutions and justifying why a final recommendation is the most “morally preferable action or response” (Priestman, 2005).

Relevant Considerations

Trust. As outlined in the literature review, if high school youth trust that their private information will remain confidential, they are more likely to seek health and care services for sensitive issues, return for follow up visits, and feel safe to disclose information about high risk behaviours (Canadian Mental Health Association of BC, 2016; Grant et al., 2008; Hart & O’Reilly, 2017; Jackson et al., 2014; Soleimanpour, et al., 2017; Wadman, et al., 2014).

Law. Mature minors such as Emily, who voluntarily demonstrate the capacity to understand information that is relevant to their healthcare decision, acknowledge future benefits

and consequences, and reflect their understanding back to a healthcare provider (without coercion) may enact their right to an autonomous mature minor consent process (Canadian Mental Health Association of BC, 2016; Center for Practical Bioethics Children's Rights Task Force, 1999; Coughlin, 2018; HealthLinkBC, 2018; Nelson & Ogbogu, 2018).

As the primary focus of enquiry for this project alludes to, interpreting “the law” with the best interests of a mature minor in the forefront is not always easily done. There are circumstances when confidentiality may be overridden if there is a risk of harm to the health or safety of youth themselves or to others (Canadian Mental Health Association of BC, 2016; Coughlin, 2018; Doctors of BC et al., 2017; Downie, Caulfield & Flood, 2011). The ethical and moral challenges arise when weighing the risks of keeping important youth information confidential versus breaking confidentiality and disclosing important information to family members and / or other professionals (Canadian Mental Health Association of BC, 2016; Wadman et al., 2014).

Adolescents must be told if their private information is being shared and why. If confidentiality must be broken, only those with an absolute need to know should be provided with the information, and only key information that is needed to prevent harm should be disclosed (Canadian Mental Health Association of BC, 2016; Doctors of BC et al., 2017).

In summary, the former Privacy Commissioner of BC, David Loukidelis, was quoted by the Canadian Mental Health Association (2016, p.14) stating, “Individual cases can be fuzzy. But if someone uses common sense and in good faith discloses information, my office is not going to come down on them. Privacy is important, but preserving life is more important.”

Ethical Principle Analysis

Maxwell, Tanchuk and Scramstad (2018) suggest that the four principles of autonomy, beneficence, non-maleficence, and justice within the bioethics framework have direct applicability in educational ethics. These principles can be used to bring people into conversation with each other using universal terms and a “common moral language” to support inter-professional ethical decision making (Gillon, 2015; Maxwell, Tanchuk & Scramstad, 2018). Furthermore, Shapiro and Stefkovich (2016) propose that by utilizing more than one ethical paradigm, such as those that resonate on professional or personal levels, a richer understanding can be reached when analyzing complex ethical challenges. There are valuable consistencies across ethical decision-making and leadership in education and in health care. These parallels are evidenced by the educational paradigms of the ethics of care (concern for others, trust, and consequences of decisions and actions), justice (rights, law, fairness, equity, and equality), critique (examining power, privilege, race, gender, and voice) and profession (balancing requirements of profession, community, and individuals) being useful to draw from during the analysis of an ethical health care dilemma (Shapiro & Stefkovich, 2016).

The analysis of Emily’s story will follow a contextual ethics framework in order to outline the complexities of her situation, analyze the ethical considerations, and come to a recommendation. Contextual ethics involves the inclusion of judgment and context in the framing, evaluating, and resolving of real-life moral problems (Hoffmaster, 2018). The four principles of autonomy, beneficence, non-maleficence, and justice within the bioethics framework will guide the analysis of the differing perspectives within Emily’s healthcare dilemma. The applicability of principles based in bioethics also being used in education, is

demonstrated through a universal understanding of bioethics as the “ethics of finite, fallible human beings who inhabit complex, dynamic, and contingent worlds” (Hoffmaster, 2018. p.7).

The key question in Emily’s situation, “Should the health care team maintain strict confidentiality of Emily’s private health information and not disclose her information to anyone?” identifies the conflict and provides a place to start the analysis.

This case documents four distinct perspectives regarding Emily’s problem: that of the Emily as the client, June as the parent, Julie and Dr. Paige as the health care team, and Ms. Pointer and Mr. Crane as the educational professionals in her school. In many cases involving patients, families, and cross-sector collaboration, viewpoints may hold very little difference, but on some occasions the greatest challenges arise when two or more of these perspectives hold strongly opposing beliefs.

The four bioethical principles will be used to capture the values and considerations relevant to each of the affected parties in response to Emily’s wishes, the key question guiding this situation, and the decision making process.

Principle One: Autonomy

Autonomy is defined by Beauchamp & Childress (2001) as “independence from controlling influences and capacity for intentional action” (p.58).

Emily wants to keep her health information private and self-manage her own health and care decisions. From a legal perspective, Emily must be capable of understanding the nature and consequences of her choice for privacy (Canadian Mental Health Association of BC, 2016; Coughlin, 2018; HealthLinkBC, 2018; Nelson and Ogbogu, 2018). It is important to her that her decisions are respected. Once Emily meets the legislated criteria of mature minor consent under the Infant’s Act, as outlined in the previous chapter, she can be treated as a capable individual

who is responsible for making decisions related to her own health and well-being (Center for Practical Bioethics Children's Rights Task Force, 1999). She has the right to refuse the disclosure of her health information, even if her parent, her health care providers and / or her educators believe the sharing of information could be beneficial.

June, as Emily's parent would like to maintain her locus of control over her daughter's health and care. She is worried about her daughter's independent choices and is struggling with Emily's growing personal autonomy within the constructs of parental autonomy. Added to June's discomfort is learning that there is actually a law that applies to her child, as a mature minor that transfers decision making power to Emily instead of her as a parent (Canadian Mental Health Association of BC, 2016; English & Ford, 2007; Soleimanpour, et al., 2017). June may be conflicted while needing important information about Emily and at the same time trying to honour her daughter's wishes to keep information private (Canadian Mental Health Association of BC, 2016; Hart & O'Reilly, 2017).

Julie and Dr. Paige as health care providers respecting autonomy, or respecting an adolescent's emerging self-determination, it calls for them to respect Emily's wishes to keep certain sensitive details of her life confidential. The primary concern for this team is deciding whether or not Emily has the capacity to understand her healthcare issues and therefore keep her information in confidence (Jackson, Burns & Richter, 2014).

The care team may feel that they will be disrespecting and betraying Emily's trust if they were to decide to "share her private information without her permission" (Beauchamp & Childress, 2001). On the other hand, providers have the right to not provide services or perform tasks that they deem to be more harmful than beneficial. An additional consideration for the health care team making a decision about Emily's private information is one of paternalism. An

unintentional risk of taking a stronger paternalistic approach based on judgement and stereotyping may exist (Maxwell, Tanchuk, & Scramstad, 2018). Frankly stated, it is important to identify if decisions being made are influenced by beliefs that there is higher risk of Emily coming to harm based on generalizations or assumptions about her age, race, culture, and / or socio-economic circumstances.

Ms. Pointer and Mr. Crane as education professionals are connected to Emily and her mother through a different relationship. The ethical principles may remain the same, but how the educators interpret them may be where a significant difference comes to light. If an information sharing agreement is in place between the education staff and the health care staff, certain key “need to know” details could be shared across disciplines, but only if Emily were to consent to the sharing of this information. Choosing to respect Emily’s right to self-determination and maintaining the privacy of her health information rather than supporting her mother’s need for key information about her child is a challenging position for her volleyball coach and school counsellor to be in. Alternately, as Emily has not yet had her school counselling appointment, these education professionals need to be prepared and supported to safely navigate the sharing of serious health / mental health related information if it were to occur (Hart & O’Reilly, 2018).

Principle Two: Beneficence

Beneficence can be simply defined as “doing good” and in the medical field, duty to act in the best interest of a patient (Beauchamp & Childress, 2001; Maxwell, Tanchuk, & Scramstad, 2018). An educator view of beneficence is highlighted by Maxwell, Tanchuk, and Scramstad (2018) as, “At the core of every educational act then, is a question of beneficence at the heart of human action more generally: we are called to ask what is best for our students and the profession to pursue” (p. 86).

Emily believes that her own best interests are to keep her information confidential, that no one needs to know other than her boyfriend, and that she can move on from this experience with no harm coming to others.

June believes that having the support and understanding of her family could hugely benefit Emily. June is concerned that Emily's choices and behaviours are not going to change overnight and that there are ongoing issues that still need to be resolved. She is worried about Emily's academic performance, her physical health, and her mental well-being. She wants trusted adults at Emily's school also involved in supporting her daughter.

Julie and Dr. Paige are in a challenging decision-making situation. If Dr. Paige determines that Emily has the necessary capacity to make her own autonomous decisions, are they failing to protect her best interests if they believe there is a risk of future harm to Emily if her mother and/or her school supports are not informed? Do they believe that the risk is high enough and of significant harm to Emily that they would not honour her choice to keep her information private?

Ms. Pointer and Mr. Crane have a duty to ask themselves "what is best for our students?" (Maxwell, Tanchuk, & Scramstad, 2018). From an ethical and educational philosophy perspective, they might believe including the family in the information sharing circle and respecting the family as a moral unit is beneficence (Maxwell, Tanchuk, & Scramstad, 2018). They are also feeling conflicted that although Emily would not agree, it might be in her best interests for Emily to share her private information with her mother. According to the *BC Freedom of Information and Protection of Privacy Act* (FIPPA) and the *School Act* legislation, a parent or authorized guardian may request access to their child's school file/record through a school principal request (Office of the Information & Privacy Commissioner for British

Columbia, 2015; School Act, 1996). If this situation was reversed, and Emily sought out support from her teacher or counsellor first and asked one of them not to share her private information, what would their perspective be?

Principle Three: Non-maleficence

Non-maleficence means “doing no harm” and in the medical field, duty to protect from harm (Beauchamp & Childress, 2001; Maxwell, Tanchuk, & Scramstad, 2018).

Emily wants to avoid suffering in a number of ways. She does not want her information to be shared in case it might prevent her from seeing her boyfriend. She also wants to keep her information private in order to protect her mother from suffering. She believes that the news would cause her mother distress and worry.

June believes that, as Emily’s mother, it is her duty to still protect Emily from “any potential harms out in the world” and is struggling with her daughter’s newly developing autonomy.

Julie and Dr. Paige are in the position of causing Emily harm if they do not honour her autonomy. Many youth would not reach out for particular healthcare support if they believed their information would be shared with their parents (Jackson, Burns & Richter, 2014). If Emily’s trust in the system protecting her confidentiality was broken, she could be at risk of more serious problems in the future by not accessing necessary care for fear of disclosure. This is also termed as harming the therapeutic relationship between Emily and the wellness centre care team. Furthermore, if the health care team chooses not to disclose Emily’s private information, they are avoiding Emily’s immediate suffering, but how significant are the unknown risks of the long term consequences and family impact? The question they will ask themselves is if a higher risk of harm is prevented by breaking Emily’s confidentiality or by protecting it.

Ms. Pointer and Mr. Crane are experienced with language as education professionals, that schools are set up to avoid any circumstances that could involve physical, psychological, or sexual harm to students (Maxwell, Tanchuk, & Scramstad, 2018). Ms. Pointer is concerned that Emily is making harmful choices and is hopeful that a connection can be made between Emily and Mr. Crane. Adding another trusted adult into Emily's support network may help mitigate the risk of her not having a safe space to turn if she experiences more serious problems in the future.

Principle Four: Justice

Ethical justice can be described in the education sector as the fair distribution that “benefits, burdens, relations, rights, and responsibilities ought to take, first in the classroom and later in society” (Maxwell, Tanchuk, & Scramstad, 2018. p.88.). The formal principle of justice in health care requires that a health care practitioner provides care and services fairly and equitably and treats equal cases equally. For example, two patients with the same medical need should not be treated differently (Beauchamp & Childress, 2001).

Emily is trusting in justice and fidelity from the health care team to act in her best interest. She is investing in the healthcare team living up to the trust relationships built and respecting her rights as a capable mature minor to make her own health and care decisions. She is entitled to the same treatment and ethical decision making process as any other adolescent, in similar circumstances, accessing care and services at the wellness centre.

June is also trusting in fair and equitable treatment of her daughter in school and in society; an environment that is free from unfair bias and judgement.

Julie and Dr. Paige are responsible for lifelong learning through building cultural competency and awareness of ethical differences often associated with growing up in an Indigenous family or community. Before coming to a final decision regarding the disclosure (or

not) of Emily's personal health information, the healthcare team needs to reflect on any personal or professional biases regarding Indigenous youth that they may have. Are any biases influencing their decision and / or assessment of risk? Are their final decisions based in truths and not assumptions?

Ms. Pointer and Mr. Crane are familiar with the struggle of justice in their day to day practice. An example of this is working within a high risk community and needing to decide how to share their time, energy, and resources equally across all their students. Do they believe Emily's situation should be treated differently because she is Indigenous?

Case Summary

Emily's case captures how a particular ethical problem can generate the converging and diverging of perceived values related to a youth's individual autonomy. Each viewpoint from Emily herself, her mother, the healthcare team, and education staff, aligned with some aspect of ensuring that Emily's best interests were always considered.

The challenge for the wellness centre physician is to make an information sharing decision that demonstrates professional and responsible care for Emily while recognizing the value in parental involvement and interprofessional collaboration. This ethical decision making process clearly highlights the compassion, compromise, and genuine care involved in coming to a solution considering Emily's best interests. The healthcare team's responsibility is to Emily who is asking for help. They need to honour the therapeutic relationship while managing the conflicting needs of other people and unknown risks of Emily's future lifestyle choices.

Presentation of Possible Solutions

Two responses and potential solutions to the key question of "Should the health care team maintain strict confidentiality of Emily's private health information?" will be summarized in

Table 3.2. Both the values and the positions of favouring or rejecting the courses of action will be explored. When there are ethical principles or values in conflict with each other, hence the need to compromise, this demonstrates the moral struggles that may be experienced by everyone involved. In keeping with Shapiro and Stefkovich’s (2016) recommendation to pull from a variety of ethical paradigms, additional theoretical perspectives from ethics in education will be applied when further analyzing potential solutions to Emily’s problem.

Table 3. 2

Case Study Analysis: Conflicting Responses and Solutions to an Ethical Question

Should the health care team maintain strict confidentiality of Emily’s private health information?

Responses:	First = No	Second = Yes
Solutions:	Time should be dedicated to support Emily to discuss her physical and emotional well-being with her mother	Time should be dedicated to providing Emily with all of the information she needs to understand her health condition and the potential outcomes of each of her decisions
	Emily’s mother should be informed of her sexual health condition and her drug/medication use	Emily’s autonomy should be respected and her wishes for the sharing of her information be followed
	Emily and Julie / Dr. Paige should meet with her mother together to disclose the information that Emily decides can be shared	A follow up appointment and care conversation should be scheduled to ensure Emily receives ongoing support and monitoring if required
	If Emily is connected to a school counsellor – key information that Emily authorizes should be shared to align support across disciplines	Emily should be encouraged to talk to her mother herself without pressure or coercion
	If Emily does not agree, she is not acting in her own best interest and the health care team should disregard her autonomous decision for privacy and disclose the information in any way that they feel will benefit Emily	

Table 3.2 Continued

Should the health care team maintain strict confidentiality of Emily’s private health information?

Responses:	First = No	Second = Yes
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Values:	Emily will experience loss of trust and autonomy	Therapeutic relationship of trust between Emily and health care team / wellness centre services will be maintained
	Health care team determines there is higher risk to Emily related to future harms than current harm of not honouring her autonomy	Emily's growing autonomy and ability to make her own health and care decisions is honoured
	Educational ethical perspective - good reasons to support Emily to disclose information to her mother and trusted counsellor as they may be additional support system, particularly if she has ongoing health and/or emotional issues to resolve in the future	June, Emily's mother will be morally obligated to acknowledge Emily's personal perspective and decision-making – even if she does not agree
Compromises:	Current harm to Emily is chosen over higher risk of future harm	Emily's current need for confidentiality and autonomous decision making outweighed the potential risk of future harm
	Has coercion been used to guide Emily towards disclosing her health information?	Family and education team will not be included transparently to provide Emily support with current challenges
	Is additional future harm created by Emily perceiving that sharing her private information is a condition of accessing care ... and will she avoid seeking help with reproductive health care and/or psychological /emotional support moving forward?	Conflict between the "adult's" notion of what is best for Emily versus her own view of what is best for herself
Rationale:	First and foremost duty is to protect Emily from future harms and prioritize the importance of family involvement and support system	First and foremost duty is to respect Emily's wishes to make her own informed and autonomous health and care decisions

The first response to be examined is the action of the healthcare team opposing Emily's autonomous choice to keep her health information private. At a glance, this means that the care team is placing more importance on protecting Emily from the unknown future harms of risky

life choices without parental knowledge versus supporting her current wishes for autonomy and non-disclosure of her private information.

This action could be interpreted as a “good one” for a number of reasons. When addressing autonomy, the need for June to maintain her locus of control over Emily’s health and care falls within the constructs of parental autonomy. From an ethic of care perspective such as coming from a place of care and concern, this option would be a compassionate response to a worried and distraught parent. The ethic of justice supports the law factor. Emily is under the age of 19 which means that in British Columbia she is considered a minor. This gives her health care team opportunities to pursue options that they feel believe are in her best interests to improve her health and well-being (beneficence), and/or prevent harm (non-maleficence).

Response number one could also be viewed as a “bad choice”. Even though Emily has been previously identified as a mature and capable adolescent with the knowledge and ability to make informed medical decisions, her voice and right to autonomy are not being considered equal to that of her parent. This inequality and removal of autonomy could also be viewed as failing to respect Emily’s well-being as a person. There are two sides to consider when looking at risk of harm. Anything that decreases Emily’s chance for survival such as withholding information can be viewed as inflicting harm but the traumatic experience of disclosing private information against her wishes can also be viewed as inflicting harm. In this instance, Emily has articulated which response is more harmful to her. The moral principle of non-maleficence not being met comes into play here. Finally, when looking at the “bad” side of this option, are the healthcare team members considering the ethic of critique and how personal and/or professional biases, judgements, and inequities may be impacting their decision to disclose Emily’s private information against her wishes?

The second response to be explored is the action of supporting Emily's decision and prioritizing her growing autonomy. This means that Emily's decision making capacity is respected and the health care team is willing to honour her wishes.

This response could be seen as a "good one" for a number of reasons. The ethic of justice also supports the legal aspect in this course of action. A child who is assessed by a health care provider as being capable to give consent is called a "mature minor". In B.C., a mature minor may make their own health care decisions independent of their parents' or guardians' wishes. A health care provider can accept consent from Emily and honour her health care choices without getting consent from her parent or guardian if the health care provider is sure that Emily understands three components. These include Emily understanding her health and care information, demonstrating that she can make decisions on her own, and that she understands the potential outcomes of her decisions (Canadian Mental Health Association of BC, 2016). This response demonstrates that Emily is being respected by upholding the importance of her ownership in decision-making and her sense of autonomy. From the care team perspective another "good" aspect of option two is related to the principle of fidelity and the ability to protect a trusting therapeutic relationship between Emily, Julie and Dr. Paige. The ability to follow through with Emily's wishes and avoid the potential harm of her refusing to access any reproductive or mental health services in the future may help to decrease the risk of moral distress on the care team members.

This second option can be a "bad choice" simply due to the fact that it is extremely difficult when parents are not included in decision making regarding their child – especially when a child such as Emily is choosing health risk behaviours. This second response of honouring Emily's right to privacy carries a lot of unknown factors that can make the decision

more difficult. This challenging ethical situation brings the critical question at the core of this project to light. “Are there circumstances when respecting a youth’s choice for privacy involves moral / legal conflict, and following legislation or law may not feel like the right decision?” When focusing on beneficence and what is in Emily’s best interest along with her legislated rights, what if the health care team is not comfortable with following the law and keeping all of Emily’s information private? What if honouring Emily’s current wish is the “right answer for today” but a devastating outcome in the future could be prevented (non-maleficence) if this wish was denied? Even in times when health care team members are resigned to / confident in their decision as professionals such as within the ethic of their profession, it is important to reflect on the ethic of care. The need for care, empathy, and respect is equally important for everyone involved in complex ethical dilemmas that have no “right answer”.

Recommendation

Now that two different responses to this moral dilemma have been discussed with competing rationales, the next step is to provide a recommendation for resolving the problem. The case study analysis of Emily’s situation provided a high level overview of the ethical perspectives that may exist for each of the affected parties. The information provided was meant to stimulate thought and self-reflection and generate more questions than answers. Even though Emily’s experience is centred around her visit to a wellness centre within her secondary school, because she sought medical treatment and disclosed personal information in the context of that therapeutic relationship, the responsibility for the final decision lies with the health care team.

This second response of honouring Emily’s autonomy and following through with protecting the privacy and confidentiality of her health information is a “good” moral response. It is keeping Emily at the centre of her health and care decisions and respecting her “mature

minor” status. It is providing an opportunity for Emily to be supported in an ongoing capacity through the creation of a safe space and therapeutic relationship. Through the establishment of a trusted and safe environment and support network, future risk of harm to Emily if she were to choose high risk behaviours can be mitigated. This response allows Emily to be supported at her own pace to identify key personal information that she is willing to share with her family and/or trusted educational professionals. This option is taking into account the many experiences and needs of all who are being impacted by Emily’s choice and moving towards a form of shared acceptance related to her independence. It is allowing the care team to feel comfortable in their roles moving forward in providing safe care to Emily under the guiding bioethical principles of autonomy, beneficence, non-maleficence and justice.

Summary

This chapter provided an overview of case study analysis and the case based approach selected for this project. The creation of Emily’s story utilized seven key factors important to case study pedagogy that were pulled from Information Processing Theory (IPT) and Herreid’s rules for case based learning (Dutra, 2013; Herreid, 2007; McDade, 1995; Ormrod, 2003; Queen’s University, n.d.). Concepts from these two theoretical constructs were used to inform the framework of Emily’s case study to promote critical thinking and independent learning (Dutra, 2013; Ormrod, 2003; Queen’s University, n.d.).

Emily’s story was created to explore meaning behind instances when “laws may bind us or support us” and to illuminate both successful and challenging experiences (in their own words) of youth, family members, and education and health care professionals supporting mature minors (Leavy, 2017). Emily’s case study was connected to areas of focus within the literature review, while ensuring it also aligned with the overarching ethical question of the project.

Through case study analysis, the goal was to explore the legal context of mature minor consent, the experiences of youth and their parents or guardians, and the education and health care professionals working within school-based wellness framework to meet the secondary students' complex health and education needs.

The case study analysis, responses, solutions, and recommendations shared in chapter three were meant to challenge perspectives and encourage deeper thinking. Following this chapter's overview of the case based approach to Emily's story, chapter four presents a cross sector ethical decision making support tool that has only been partially completed in order to further challenge the reader to self-reflect and identify their own priorities and values. A blank ethical decision making tool is also provided in Appendix B to support any future complex ethical decision making processes that may occur in either sector.

Chapter five will highlight the insights gained in relation to the complexities of supporting vulnerable youth within "consent-related circumstances". This final chapter will share the benefits and limitations of transitioning to case study pedagogy instead of qualitative case study research. The conclusion will provide recommendations for practice and policy review in both healthcare and education and encourage further research in the area of cross-sector collaboration in youth wellness centres in order to enhance services for adolescents in BC.

Chapter 4 – An Ethical Decision Making Tool

Based on reviewing literature, preparing for case study research and subsequent investigations into real-life and published cases, a need to address a universal ethical decision making process in schools with wellness centres was clear.

Both healthcare providers and educators require knowledge of professional expectations, the ability to recognize ethical dilemmas as they arise, and be able to participate in ethical analysis and decision making in response to challenging circumstances (Gillon, 2015; Maxwell, Tanchuk, & Scramstad, 2018; McDonald, 2001; Warnick & Silverman, 2011).

A case-based pedagogical approach was discussed in chapter three and Emily's story was presented. Furthermore, an ethical principle-based synopsis provided insight into the different viewpoints of the people involved in addressing Emily's situation. The process of understanding Emily's case, examining the different perspectives, and working through how decisions can have negative or positive consequences depending on the individual, provides a learner with the opportunity of seeing theory put into practice (Dutra, 2013; Grundy et al., 2016; McDade, 1995; Queen's University, n.d.). Chapter three provided the narrative to inform utilization of the *Cross Sector Ethical Decision Making Support Tool* created for this project (Appendix B).

By walking through Emily's hypothetical case study situated in a school-based wellness centre, the parallels of ethics within the education and health care sectors were explored to inform a conversation and critical thinking tool for use by both education and health care professionals. Through the guided use of this tool, learners will be able to grow their analytical skills and acquire ethical competencies. Inter-professional learners will reach their own conclusions regarding whether or not a framework based on bioethical principles equally addresses the unique moral considerations and / or goals in their respective sectors. They will

also be reflecting on their own experiences, identifying solutions, and by evaluating risks, benefits and consequences will reach conclusions that they can apply to future situations (Dutra, 2013; Gillon, 2015; Maxwell, Tanchuk, & Scramstad, 2018; McDade, 1995; McDonald, 2001; Queen's University, n.d.; Warnick & Silverman, 2011).

Maxwell, Tanchuk, and Scramstad (2018) share a statement that is also true for healthcare professionals working within school environments. "Processes that incorporate critical reflection, open dialogue and utilize the actual lived ethical challenges of educators can be catalytic forces for fostering ongoing ethical formation and for nurturing ethical cultures within schools and school systems" (p. 45).

Competency in recognizing ethical principles and dilemmas associated with circumstances, relationships, policies, and practices is valuable for all professionals supporting vulnerable youth. Developing this skill enlightens both educators and health care providers to the ethical threads that are intrinsic throughout their personal and professional life experiences. Finally, strengthening this ability enables team members to address challenging and ethical situations with an empathetic and compassionate approach. My plan is to share a tool that will address these competencies as well as other aspects of interprofessional communication and teamwork necessary when a diverse team is supporting the same adolescents.

Learning and Teaching Approach of the Tool

When searching for a pedagogical approach to explore the challenges of ethics, interprofessional collaboration, and person and family-centred care, the answer for me was case study analysis. Four professional attributes were identified by Kantar and Massouh (2015) as outcomes of case-based teaching. The four emerging qualities they discovered were knowledge growth, opening up to different ways of thinking, positive self-worth, and a caring attitude

(Kantar, & Massouh, 2015). In line with case-based teaching methods used in nursing education, case study pedagogies also support critical thinking through scenarios of complex challenges, dilemmas, or tensions and encourage personal and professional growth (Herreid, Schiller, & Herreid, 2012; Heiney, Polyakova-Norwoord, & DeGregory, 2019; Kantar, & Massouh, 2015; McDade, 1995).

Emily's narrative seeks to draw emotion from the learner and contextualize her situation so that the complex experience can be better understood. It is important to recognize that ethical decision making is a skill that must be learned and developed over time. It is not mastered once someone has gone through a case study and completed the support tool. It is also important to identify that this approach may not be comfortable for many learners, as some will not be familiar, or have experience with navigating ethical dilemmas, nor be comfortable with "no right or perfect answers" at the end of ethical decision making processes.

It is my hope that when professionals encounter "circumstances when respecting a youth's choice for privacy involves moral / legal conflict, and following legislation or law may not feel like the right decision", they will demonstrate an increase in comfort and competency when addressing these complex ethical situations.

Introducing the Tool

The support tool reflects a constructivist case-based approach and learner-centered guiding framework (Dutra, 2013; Grundy et al., 2016; Heiney, 2019; McDade, 1995; Queens University, n.d.; Wright & Grenier, 2009). It was developed with the intention to provide all learners with a simple and common language to build on during their "ethical decision making experience" (Gillon, 2015; Maxwell, Tanchuk, & Scramstad, 2018).

The step by step process of the support tool framework is divided into two sections. The first section involves an algorithm to determine if the problem is a true ethical dilemma such as involving a conflict between ethical principles and law/policy and/or a conflict between ethical principles and values (Maxwell, Tanchuk, & Scramstad, 2018; McDonald, 2001; Warnick & Silverman, 2011). The second section captures seven steps with guiding questions to support the ethical decision-making process. These steps were selected as they are all significant factors to consider when walking through a complex ethical scenario, especially those situations involving youth, privacy laws, and autonomy. In an interprofessional work environment, it is often easy to default to working within “sector silos” in a complex or emergent situation. This tool may identify communication, team dynamics, and a person and family-centred approach to decision making as equally important considerations.

Based on what has been learned from Emily’s case study analysis in chapter three, the support tool will be completed as an example for reflection and discussion. The demonstration will begin with the circling of the responses to the algorithm in the first section that correspond with Emily’s dilemma, and which also indicate that an ethical decision making process is necessary to determine the best option moving forward. Section two will follow with information added to the seven steps.

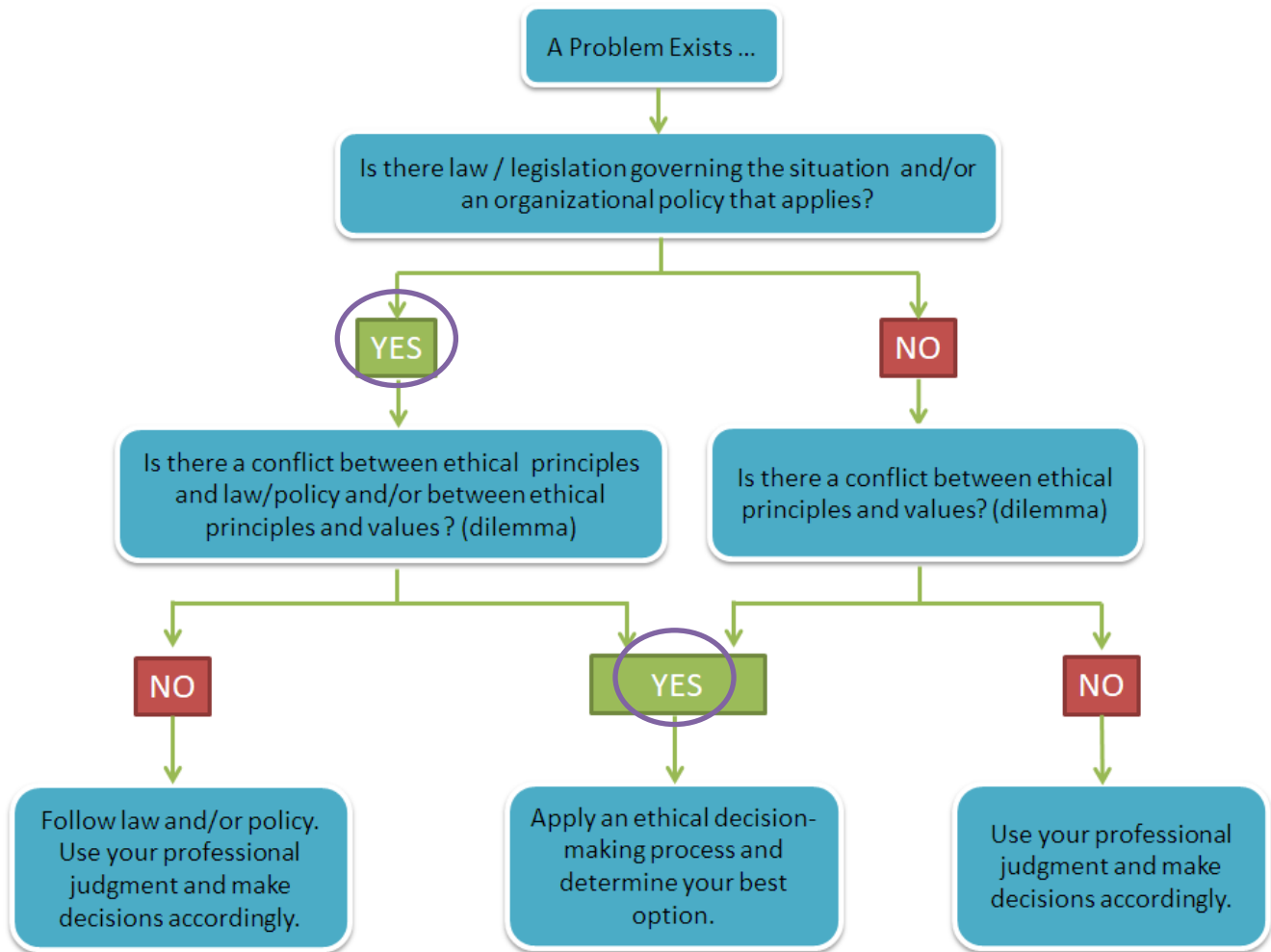
What this completion exercise will also highlight is that further and deeper conversations may be necessary to reach the best course of action for Emily. Some information may be added to encourage controversy and critical thinking. As a reminder, the blank and printable support tool template is found in Appendix B.

Cross Sector Ethical Decision Making Support Tool

This ethical decision making framework can be used along with professional codes of ethics to collaborate with youth, families, and other inter-professional team members when faced with ethical problems requiring decisions to outline a “best course of action”

Through thoughtful examination of facts, values, beliefs, principles and professional standards the objective is to make the “best” choice with what is available – there will never be a “perfect decision” (Maxwell, Tanchuk, & Scramstad, 2018; McDonald, 2001).

This tool consists of an algorithm and seven steps with guiding questions to support you through the ethical decision-making process.



<p>1.</p>	<p>What is the problem?</p> <ul style="list-style-type: none"> • What is your interpretation? • How do others perceive it? • Summarize the dilemma in a clear statement. 	<p>Emily is a mature and capable young adult and wants her autonomous wishes to keep her health information private honoured.</p> <p>Others believe that Emily is a vulnerable, Indigenous teenage girl who is lacking insight into the risks she is taking through unprotected sex and experimenting with drugs.</p> <p>Emily's right to privacy and confidentiality of personal information versus the duty to warn (parent/educators) of a risk and thereby prevent harm.</p>
<p>2.</p>	<p>What are the facts?</p> <ul style="list-style-type: none"> • What information do you know for sure? • What information is missing? 	<p>Emily has visited the school-based wellness centre seeking services.</p> <p>Emily has been diagnosed with a STI requiring treatment .She has also disclosed that she has used up her prescription medication (Tylenol 3s) from a previous injury, she has tried her boyfriend's Ritalin and she occasionally smokes marijuana. She does not want any of this confidential information shared with her mother, her volleyball coach or her soon to be school counsellor.</p> <p>Dr. Paige has assessed Emily as capable under the mature minor consent act to make her own health and care decisions.</p> <ul style="list-style-type: none"> • Physician has made sure that Emily does not intend to harm herself or place someone else at risk of serious harm –otherwise, the information would need to be shared
<p>3.</p>	<p>Who is involved?</p> <ul style="list-style-type: none"> • Who else needs to be included? • Who else should be consulted? • What resources are available to help? 	<p>Emily, Julie (Public Health RN), Dr.Paige (Family Physician)</p> <p>... Can anyone else be consulted if Emily has made the choice to not have her information shared?</p> <p>...Does this need to be revisited once a "best possible solution" has been decided?</p> <p>Professional Codes of Ethics, Standards of Practice, Legal and Risk Depts. (Mature minor consent legislation), Ethics team consult</p>
<p>4.</p>	<p>What is really important to those involved?</p> <ul style="list-style-type: none"> • What are the personal or professional values guiding the decision-making? 	<p>Level of Importance:</p> <p><input type="checkbox"/> Important <input type="checkbox"/> Very Important <input type="checkbox"/> Critical / Essential</p> <p>Emily- autonomy, trust (she wants her decision respected)</p> <p>Emily- non-maleficence (she doesn't want to upset her mom)</p>

	<ul style="list-style-type: none"> • What roles/ responsibilities need to be considered? • Which ethical principles are being prioritized? <ul style="list-style-type: none"> <input type="checkbox"/> Autonomy <input type="checkbox"/> Fidelity <input type="checkbox"/> Beneficence <input type="checkbox"/> Other? <input type="checkbox"/> Non-Maleficence <input type="checkbox"/> Justice 	<p>June-parental autonomy & non-maleficence (she wants to protect Emily from harm)</p> <p>Julie & Dr. Paige- maleficence (protecting Emily from risk of harm)</p> <p>Julie & Dr. Paige- beneficence (respecting Emily's wishes)</p> <p>All- justice (want Emily to be treated fairly & without structural racism)</p> <p>Ms. Pointer-has expressed desire to protect Emily from harm</p>
<p>5.</p>	<p>What are the possible solutions?</p> <ul style="list-style-type: none"> • What is the rationale behind each answer? • What are the risks and benefits of each option? 	<p>1/ Emily is not acting in her own best interest and the health care team should disregard her autonomous decision for privacy and disclose the information to those who can help her:</p> <ul style="list-style-type: none"> • Rationale: First and foremost duty is to protect Emily from future harms and prioritize the importance of family involvement and support system • Risks: Current harm (loss of autonomy, trust, respect, connection to services)to Emily, potential risk of coercion if encouragement to share information with others is misinterpreted • Benefits: Emily's mother (primary support) is informed about her health and lifestyle choices, wrap around support can be established for Emily with both health and education teams sharing information <p>2/ Maintain strict confidentiality of Emily's private health information:</p> <ul style="list-style-type: none"> • Rationale: First and foremost duty is to respect Emily's wishes to make her own informed and autonomous health and care decisions ... of not having her information shared • Risks: potential risk of future harm if Emily makes similar or more harmful lifestyle choices in the future, family and education team will not be included transparently as support for current challenges • Benefits: therapeutic relationship of trust between Emily and healthcare team is maintained – for now and future needs, dedicated time providing Emily with all of the information she needs to understand her health condition and the potential outcomes of each of her decisions, caring approach without coercion can be attempted at a future appointment to encourage Emily to include her family and educators to support her
<p>6.</p>	<p>What is the “best course of action”?</p> <ul style="list-style-type: none"> • Which solution / action has the best overall consequences and mitigation of risk? • Who will be responsible for this final step? 	<p>Best course of action is - honouring Emily's autonomy and following through with protecting the privacy and confidentiality of her health information. It is keeping Emily at the centre of her health and care decisions, respecting her “mature minor” status and protecting the safe space and therapeutic relationship within the wellness centre.</p> <p>Dr. Paige will be responsible for having this conversation with Emily and discussing opportunities for follow up care and visits.</p>

7.	What has been learned? <ul style="list-style-type: none"> • What was successful? • What went wrong? • What insights were gained? • Would you take the same approach in the future? 	<p><i>Emily's trust and relationship with the wellness centre has been maintained and she has been back for two follow up visits.</i></p> <p><i>Educators are still worried/concerned about Emily and her behaviour at school – they see her go into the wellness centre and struggle with not being informed - it appears that Emily gets “to enter those special doors within the school and gets a cone of silence privilege – regardless if we are concerned or not”.</i></p>
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Discussion

What this exercise is meant to facilitate is an understanding that ethical problems often generate more questions than answers. Participants can be surprised by their reactions either in favour or opposition to another's viewpoint or priorities.

- Do you have any surprise reactions to the content presented?
- What information is missing?
- Is anyone's voice or perspective missing?
- What principles or values would you prioritize if you placed yourself in this story?
- What potential solution or third option is missing?
- What is your choice as the best course of action?

As the decision making algorithm reaches the seventh step entitled lessons learned, it is interesting to explore the impacts after the decision. Another ethical principle, fidelity, comes into play which asks us, “Are we being faithful to institutional and professional roles and are we living up to the trust relationships that we have with others?” (McDonald, 2001. p.3). Has the trusting relationship between the education staff and the wellness centre staff been compromised by this decision? Is upholding a professional responsibility to act in the best interest of Emily, and abiding by legislation, negatively impacting interprofessional relationships? In reference to

professional judgement and decision making, lists of professional standards and codes of conduct have been provided in Appendix C.

While there is value in the case study exercise of using a common language of ethical principles to walk through the process of coming to an agreed up final course of action, it is not meant to be an exercise of placing people involved in the dilemma into just “four principle boxes or labels” (Gillon, 2015; Maxwell, Tanchuk, & Scramstad, 2018). What this exercise has actually highlighted, is that based on the decision of not sharing Emily’s information, the decision making group is small and does not allow for cross sector collaboration. What if an information sharing agreement between the school and the wellness centre was in place for all students accessing services? If an agreement was disclosed to every student who needed support (i.e.: “Before we proceed, we need to ask if any of your health information may be shared with educators within your circle of care?”), would students such as Emily continue to access services? That agreement would still not affect her right as a mature minor to keep her information private – both from her educators and her mother. For the purposes of guided learning and not making things too complicated for an introductory case study, Julie, the Public Health RN and Dr. Paige the Family Physician held the same beliefs and values about the right course of action for Emily. What if Julie did not agree and felt strongly that Emily’s mother should be informed immediately?

Recognizing that the “Government of Canada is working to advance reconciliation and renew the relationship with Indigenous peoples, based on recognition of rights, respect, cooperation, and partnership”, there are a number self-reflection questions that are important to include as part of this ethical exercise (Government of Canada, 2019):

- Do you feel your decisions and/or perspectives would be different if Emily was not Indigenous?
- Do you feel she automatically needs more protecting because of her culture, gender and/ or race?
- What are your own personal values of culture?
- What are your biases?
- What are your privileges?
- Are you familiar with racism as a social determinant of health?

Conclusion

Emily's case represents how a particular ethical dilemma can have differing perspectives amongst people in a complex situation, while at the same time, everyone believing they are acting in the central person's best interest. Each person in the story, starting with Emily and the crucial importance of her autonomy, her mother valuing non-maleficence and protection, the healthcare team supporting Emily's legal rights, and the educators wanting to both protect and share information, holds a different vision or belief of what is in Emily's best interest.

The responsibility of the healthcare team in this case is to make a final decision that honours their therapeutic relationship with Emily and aligns with her right to choose not to have her information shared; even if they are concerned it may not support any of her additional needs and may not be received well from other people involved.

Caring for youth during complex situations is stressful for both health care providers and educators. As demonstrated throughout the literature review and as evidenced by school-based wellness centres being placed in vulnerable communities, there is an increasing need for supports and services for adolescents. The people providing health and education services and who are

committed to supporting these growing youth needs are also in need of support. Learning opportunities to build competence in the skills and knowledge required to manage ethical problems are a valuable addition to ongoing training and professional development in both sectors. By creating both a case study and a decision making tool, I hope to offer this as an option for independent growth in practice and self-reflection or as group exercise for teams encountering ethical problems

Chapter 5 – Final Thoughts

Reflections

What I have learned through transitioning from qualitative case study research to case study pedagogy and case-based analysis is that I did not lose touch with my original objectives. I originally sought to provide a deeper understanding of the experiences of the education and health care professionals supporting the same youth in the context of school-based wellness, through complex circumstances involving mature minor consent and the sharing of their personal information. While I did not get to learn from real-life professionals and capture their true experiences, I was still able to identify the challenges that exist in both education and healthcare disciplines when needing to solve ethical questions that have no single right answers (Queen's University, n.d.).

Furthermore, I was also able to maintain my focus on answering the guiding question of “Are there circumstances when respecting a youth’s choice for privacy involves moral/legal conflict, and following legislation or law may not feel like the right decision?” Through creating Emily’s case study, generating a case study analysis, and finally developing an ethical decision making support tool, I feel that I am able to confidently answer that question as “yes”. Our human nature and conscience guide us to ask “what if” as a natural method of decision making. In Emily’s scenario, the “what ifs” can be the impetus for someone feeling like the law may not be the best answer. What if she continues to make risky lifestyle choices, continues to experiment with drugs, and develops an addiction? What if she tries a drug laced with fentanyl and dies? What if any of these potential future risks could be prevented by looping more people into her information circle? Feeling like it may not be the best answer does not mean that the answer is wrong; it means that the decision maker is human.

Evaluation

One area that I feel my project is limited, is the ability to measure if the case study and ethical decision making support tool are effective teaching and learning approaches. While designing the materials I kept the project's second guiding question in mind, "How can an ethical case study and support tool be designed to incite empathy, build understanding, and develop ethical decision making skills?" There will be no formal assessment of learners and their knowledge and skills in ethical decision making will be most likely tested "in the moment" when they are next faced with a difficult ethical situation in their practice. I hope that by reading Emily's story, practicing and reflecting on the completion of the decision making support tool provided, they will be more confident managing challenging situations in their future.

Who Can Use the Support Tool?

My intent is to share this thesis in part or whole (such as just the support tool), with anyone working in healthcare or education who might benefit from this introductory level information. As I was permitted to visit a local school-based wellness centre and attend their steering committee meetings for the second half of my master's program, I will offer to share my project with their team. Before sharing the *Cross Sector Ethical Decision Making Support Tool* more widely, I plan to ask a small group of team members from the wellness centre to test it and provide feedback on the tool. I am interested in whether the process is easy to follow and if the tool is relevant to their practice. Once validation and testing of the tool has happened, I will make it available to colleagues in my health authority and the local school district while inviting them to share the ethical decision making support tool with their networks.

How Can the Tool be Used in the Future?

The finalized version of the tool will be available electronically for interested programs to have on their internal webpages for easy access to print. I would also be willing to adapt it into an electronic form if that need was identified. My wish for future development of this case study is to create a self-paced and interactive “e-learning or web-based” learning tool. For instance, the clinical rheumatology program at the University of Birmingham in the UK developed a “problem-based learning tool to promote student-centred active learning with focus on questioning, critical thinking and problem solving” (Wilson, Goodall, Ambrosini, Carruthers, Chan, Ong, Gordon, & Young, 2006). This approach aligns well with ethical decision making as problem based learning involves the learner starting with an issue, figuring out what they need to learn to be able to solve the problem and then applying that knowledge to their solution (Wilson et al., 2006). Exploring case studies in this way can provide a stronger connection to the patient [or student] as a person, which enhances skills in communication and critical thinking

In recognition of the current pandemic circumstances in which I am completing this project, I am drawn to the problem-based, e-learning approach highlighted by Wilson et al., (2006) as it provides a greater opportunity to offer accessible adult education. Finally, what is most exciting to me (in addition to supporting physical distancing) is that this platform allows learners to walk through a scenario such as Emily’s, make choices based on their professional and personal judgement and safely practice various “what if” situations and consequences (Wilson et al., 2006). In addition to new technological ways of learning and engaging with educational materials, there is still great value in a healthy debate and difference of opinion. This educational approach could be further enhanced if opportunities were also provided for teams to meet virtually to share and discuss their personal insights, perspectives, and responses to the

content presented; particularly in areas where their opinions or values differed or conflicted with each other (Dutra, 2013; Herreid, 2007; Ormrod, 2003; Queen's University, n.d.).

Recommendations

Although the focus of this project was ethical decision making in circumstances when a youth enacts their right to keep their information private, it is important to acknowledge that this is not the only ethical challenge in youth health and education that exists. Mental illnesses in children and adolescents are becoming increasingly common in our communities and schools. “Approximately one in seven young people in BC—or 14%—will experience a mental illness at some point. Many mental illnesses—between 50% and about 70%—show up before the age of 18, so they can have a huge impact on a child’s development” (Canadian Mental Health Association, 2014). I could have changed the case study to capture Emily disclosing self-harming behaviours – minor with no immediate risk, but again, if she does not want anyone to know, is there a future risk of her harming herself more seriously in a potential future attempt?

In regard to future research, I see great value in “renovating” my previous qualitative research attempt with a stronger ethical focus to explore the real-life challenges that interprofessional teams are experiencing as they support vulnerable youth in secondary school. While I have been able to provide a glimpse at codes of ethics and practice standards in Appendix C, it would also be interesting to explore deeper into the commonalities and differences between practices and policies in education and healthcare that may help or hinder the cross-sector collaboration in youth based wellness centres. Through better understanding the interprofessional and interagency relationships, procedures and policies, the research could then begin to focus on discovering how sharing successful and established practices could support aligning the services and safety measures for all students accessing support.

Lastly, I strongly encourage professional development across health and education sectors in support of training focussing on navigating difficult conversations and ethical decision making. Endorsement for the creation of web-based and interactive ethical case study learning tools would benefit educators and healthcare providers alike. In a time of increasing moral distress for people in positions (both healthcare and education) of supporting children and youth, the offer of a compassionate and guiding conversation and an ethical decision making support tool may be able to make a difference in to their practice, and ultimately to the children that they serve.

During his opening message at a United Nations Educational, Scientific and Cultural Organization (UNESCO) Chair Global Health & Education Event, Dr. Tedros Adhanom Ghebreyesus, the Director General of the World Health Organization (WHO), spoke of “Health and education as the two cornerstones of human development, and the two best investments in human capital.” (Ghebreyesus, 2018). I have been privileged as a nurse to be welcomed into the education community through this master’s journey. I passionately agree with Dr. Ghebreyesus when he stresses the significant impact both healthcare providers and educators have on the world’s developing humans – the children, patients, and students we mutually care about. The positive relationships between health and education that support the promotion of healthy development in youth, also promote favourable outcomes over their lifetime (Bassett-Gunter, Yessis, Manske, Gleddie, 2016; UNESCO chair and UNITWIN network, 2018).

Creating a new path forward with this project required determination and patience. It has also provided me with time to reflect on my own “leadership learning” over the past two years. Importantly, the First Peoples’ Principles of Learning have taught me valuable lessons (FNESC, 2015). In my final musings, it is important for me to highlight the three principles that have

connected the most with me as I took on a new direction. The first gift is to remember that “learning involves patience and time”, the second insight is that “learning is embedded in memory, history, and story” and thirdly “learning involves recognizing the consequences of one’s actions”. Over the course of this thesis, I have required both patience and time. I have also relied on the importance of personal and professional history to walk through a case study analysis. On a final note, the most important outcome of this work is to have readers identify their own values related to complex situations involving vulnerable youth, empower them to share and discuss the ethical principles that influence their problem solving and help them to use those insights as they weigh the consequences of their final decisions.

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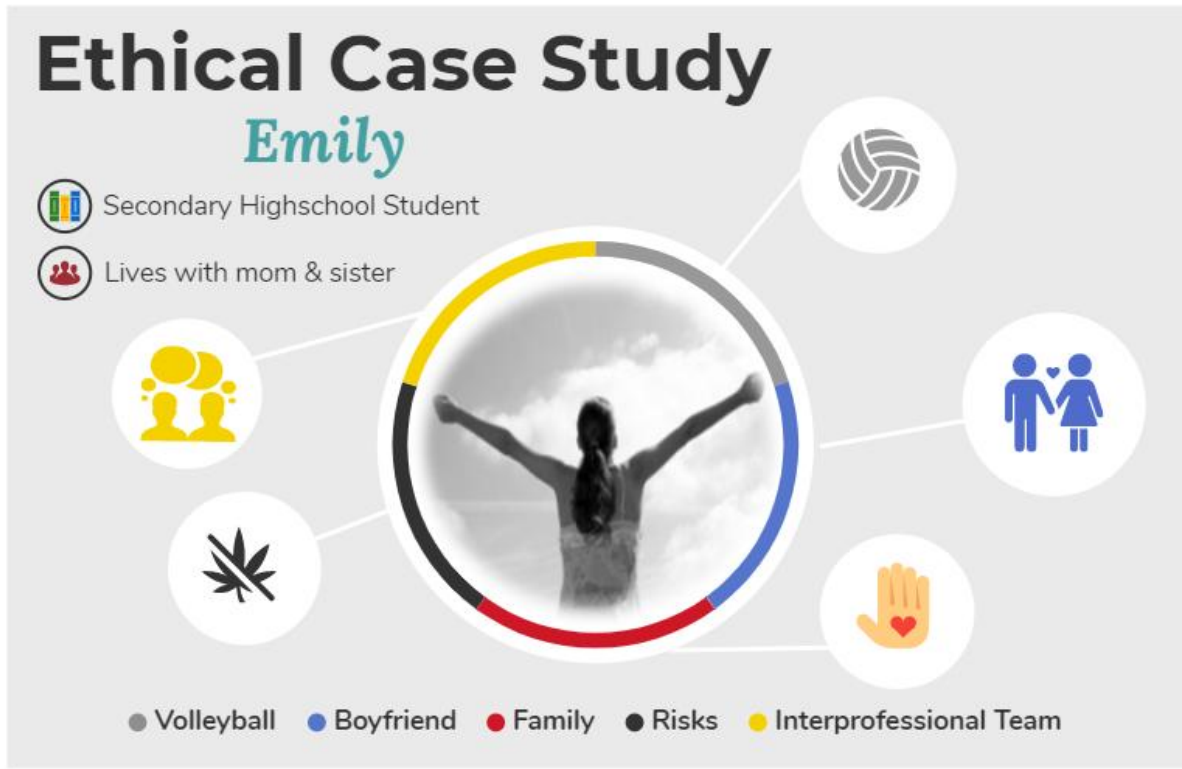
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Appendix A – Case Study Introduction Tool



Case Overview

Emily has disclosed to the clinical team that she is sexually active, she occasionally smokes marijuana with her friends and that she has also been taking her boyfriend's Ritalin after finishing all of her own prescribed Tylenol 3's. She does not want her mother to know that she is sexually active or that she is being treated for a sexually transmitted infection. She also does not want anyone to know about her marijuana use or experimentation with Ritalin. In summary, Emily as a mature minor is choosing to have her private health information kept confidential.

How Important are the Ethical Principles?

Important → Crucial

Autonomy	●	●	●	●	●
Beneficence	●	●	●	●	●
Non-Maleficence	●	●	●	●	●
Justice	●	●	●	●	●
Fidelity	●	●	●	●	●

Guiding Questions

1. What is the problem?
2. What are the facts?
3. Who is involved?
4. What is really important to those involved?
5. What are the possible solutions?
6. What is the best course of action?
7. What has been learned?

Notes:

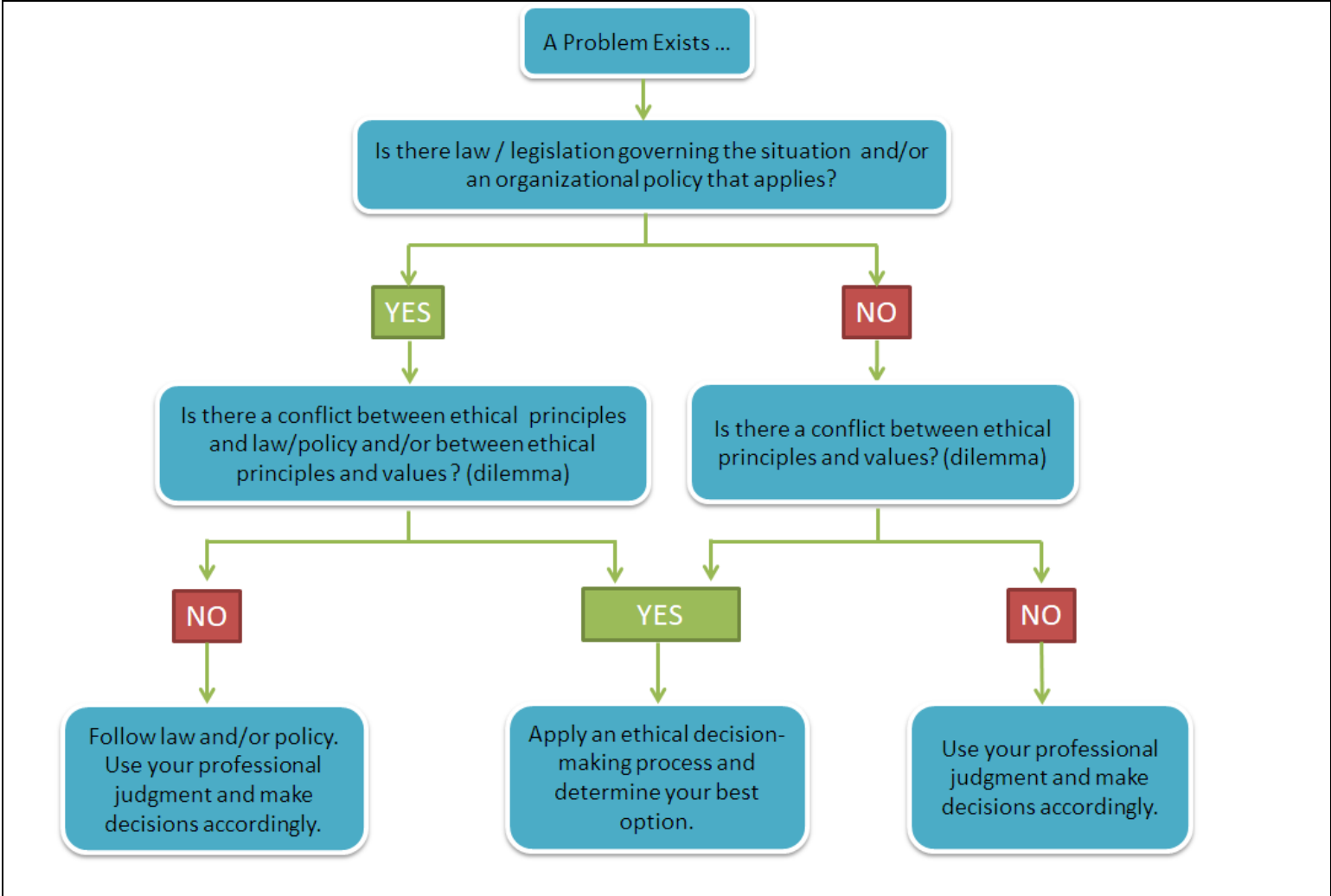
Appendix B – Cross Sector Ethical Decision Making Support Tool

Cross Sector Ethical Decision Making Support Tool	2020
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This ethical decision making framework can be used along with professional codes of ethics to collaborate with youth, families, and other inter-professional team members when faced with ethical problems requiring decisions to outline a “best course of action”

Through thoughtful examination of facts, values, beliefs, principles and professional standards the objective is to make the “best” choice with what is available – there will never be a “perfect decision” (Maxwell, Tanchuk, & Scramstad, 2018; McDonald, 2001).

This tool consists of an algorithm and seven steps with guiding questions to support you through the ethical decision-making process.



This ethical decision-making framework is adapted from a framework for ethics in teacher education found in the Professional Ethics & Law for Educators (2018), as well as a modified Warnick & Silverman (2011) ethical model and a bioethical Framework for Ethical Decision Making Framework by McDonald (2001).

Guiding Questions:

1.	What is the problem? <ul style="list-style-type: none"> • What is your interpretation? • How do others perceive it? • Summarize in a clear statement. 	
2.	What are the facts? <ul style="list-style-type: none"> • What information do you know for sure? • What information is missing? 	
3.	Who is involved? <ul style="list-style-type: none"> • Who else needs to be included? • Who else should be consulted? • What resources are available to help? 	
4.	What is really important to those involved? <ul style="list-style-type: none"> • What are the personal or professional values guiding 	Level of Importance: <input type="checkbox"/> Important <input type="checkbox"/> Very Important <input type="checkbox"/> Critical / Essential

	<p>the decision-making?</p> <ul style="list-style-type: none"> • What roles/ responsibilities need to be considered? • Which ethical principles are being prioritized? <ul style="list-style-type: none"> <input type="checkbox"/> Autonomy <input type="checkbox"/> Fidelity <input type="checkbox"/> Beneficence <input type="checkbox"/> Other? <input type="checkbox"/> Non-Maleficence <input type="checkbox"/> Justice 	
5.	<p>What are the possible solutions?</p> <ul style="list-style-type: none"> • What is the rationale behind each answer? • What are the risks and benefits of each option? 	
6.	<p>What is the “best course of action”?</p> <ul style="list-style-type: none"> • Which solution / action has the best overall consequences and mitigation of risk? • Who will be responsible for this final step? 	
7.	<p>What has been learned?</p> <ul style="list-style-type: none"> • What was successful? • What went wrong? • What insights were gained? • Would you take the same approach in the future? 	

Appendix C – Professional Standards and Codes of Ethics

Healthcare Sector

Canadian Medical Association (2018). CMA code of ethics and professionalism. Retrieved from:

<https://policybase.cma.ca/documents/policypdf/PD19-03.pdf>

Canadian Nurses Association (2017). Code of ethics for registered nurses. Retrieved from:

<https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive>

Education Sector

BC School Counsellors Association (n.d.). Legal and ethical guidelines. Retrieved from:

https://www.bcschoolcounsellor.com/legalethicalguidelines?_

BC Teachers Council (2019). Professional standards for BC educators. Retrieved from:

https://www2.gov.bc.ca/assets/gov/education/kindergarten-to-grade-12/teach/teacher-regulation/standards-for-educators/edu_standards.pdf