Secondary Teachers’ Experiences with the New Health and Physical Education Curriculum: Shifting Towards Mental Health Literacy

By

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Abstract

This qualitative study explored teachers’ experiences and reported delivery of the new 2015 Health and Physical Education (HPE) curriculum, particularly in relation to its new emphasis on mental health. Previously in the 1999 curriculum, mental health was only introduced to students who pursued HPE courses in grade 11. With mental health issues affecting one in five Canadians it is important to support all students in acquiring mental health literacy, so that they may apply these skills in their future or use them to help navigate current experiences.

Semi-structured interviews of three Ontario Secondary teachers were conducted, and findings included strategies for the promotion of student mental health literacy, the importance of developing student-teacher relationships, addressing mental health stigma, a lack of resources and direction received during the implementation of the new curriculum, and structural constraints. This study sheds light on the importance of student mental health literacy and affirms the need for the recent curriculum shift. Recommendations for further research are given in order to improve and enlighten HPE teacher practices related to mental health.

Key Words: mental health literacy, curriculum, Health and Physical Education, mental health, secondary students, stigma
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Chapter 1: Introduction

1.0 Introduction: Research Context and Problem

We are all balancing our own mental health on an individual continuum. According to the Mental Health Commission of Canada (2012), one in five Canadians experience the onset of mental health problems during childhood and adolescence, specifically between the ages 14-25 (Friedman, 2006). A recent review of Canadian studies found that most mental health problems are detected prior to the age of 24 (Min, Lee, & Lee, 2013, p. 308), and 50% of these difficulties can surface before the age of 14, in which most children will not receive treatment (Kessler, Berglund, Demler, Jin, & Walters, 2005). Children and adolescents spend a substantial amount of their day within schools and therefore school communities can become a natural and important venue for the delivery of mental health services, the understanding and reduction of stigma, and allow for the promotion and maintenance of student mental health (Kelly, Jorm, & Wright, 2007). When students enter high school at roughly 13 and 14 years of age, they are beginning to change physically and mentally, and are able to develop and understand coping mechanisms to maintain their own mental health (Miguel-Hidalgo, 2013). According to the Canadian Coalition for Children and Youth Mental Health, the mental health of students is the “number one issue facing schools today” (Brown, 2011, p. 1). Thus, the concepts of mental health are very relevant to Grade 9 and 10 students who are participating in their first years of secondary school.

In 2015, the Ontario Ministry of Education (OME) incorporated mental health into the Health and Physical Education (HPE) curricula. Prior to this, the Health and Physical Education program was to promote physical literacy, healthy active living, the enjoyment of regular and enthusiastic participation in physical activity, and an understanding of personal actions and
decisions that will affect their health, fitness, and well-being (Ontario Ministry of Education, 1999). Strands were imbedded into the curriculum to breakdown different components of the course. The Healthy Active Living Education courses from Grade 9 to 12 introduced 4 strands: Physical Activity, Active Living, Healthy Living, and Living Skills. This allowed students to develop the knowledge, skills, and attitudes required to enjoy a healthy lifestyle, build a life-long commitment to physical activity, and to promote responsible, personal and social behaviours regarding physical activity settings. In grades 9 and 10 the healthy living strand introduced only healthy growth and sexuality, substance use and abuse, personal safety, injury prevention, and healthy eating (Ontario Ministry of Education, 1999). According to the curriculum, the healthy living strand must address, “knowledge and skills that students need to make informed decisions related to healthy growth and sexuality, mental health, and personal safety and injury prevention” (Ontario Ministry of Education, 1999, p. 6). Mental health, however, was not introduced until grade 11. Students who chose not to participate in Health and Physical Education courses after completing their mandatory grade 9 or 10 credit, were therefore graduating without an introduction to mental health. In response to this issue, the new 2015 OME HPE curriculum integrated topics of mental health in Grade 9 and 10 to promote mental health literacy, which has been supported positively by several researchers (Loreman & Earle, 2007; Voltz, 2003; Woloshyn, Bennett, & Berrill, 2003).

The 2015 revision of the Health and Physical Education program is “based on the vision that the knowledge and skills students acquire in the program will benefit them throughout their lives and enable them to thrive in an ever-changing world by helping them develop physical [literacy] and health literacy as well as the comprehension, capacity, and commitment they will need to lead healthy, active lives and promote healthy, active living” (Ontario Ministry of Education, 1999).
Education, 2015, p. 6). Not only are students required to develop physical literacy, they are now encouraged to develop health literacy. “Health literacy involves the skills needed to get, understand and use information to make good decisions for health” (Ontario Ministry of Education, 2015, p. 7) The Canadian Public Health Association on health literacy defines it as the “ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course” (Rootman & Gordon-El-Bibbety, 2008). Jorm and colleagues (1997) suggests mental health literacy as an extension of health literacy that will provide context to a wider and more diverse audience. The public usually responds to physical diseases, while simultaneously ignoring mental health illnesses. The objective of promoting mental health literacy is to help fill in the gap of citizens who are misinformed about mental health and illness (Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, 1997). Overall, for students to attain health literacy, they must demonstrate a comprehensive understanding of mental health. Research by Lincoln and colleagues (2006) found low health literacy to be related to poorer mental health outcomes, more specifically, worsened depressive symptoms. Mental health literacy is an essential and foundational component for mental health promotion, prevention, early detection, intervention, and is a component of health literacy (Whitley, Smith, & Valliancourt, 2013). Whitley, Smith, and Valliancourt suggest that teachers need to be equipped with sufficient mental health literacy to promote mental health literacy within their class. For this specific research, I suggest that for students to achieve health literacy, they require mental health literacy in order to meet all curricular expectations emphasized on mental health.

All Healthy Active Living Education courses from Grade 9 to 12 are now composed of 3 strands: Active Living, Movement Competencies (Skills, Concepts, and Strategies), and Healthy
Living. Physical Literacy is developed through the Active Living strand and the Movement Competencies Strand. Where Health Literacy, and therefore Mental Health literacy are developed through the Healthy Living strand.

In the new 2015 curriculum, mental health is incorporated in the Healthy Living strand. The strand promotes and maintains knowledge of mental health, “building an understanding of mental illness, and reducing stigma and stereotypes” (Ontario Ministry of Education, 2015, p. 42). Positive mental health and emotional well-being are closely related to the development of psychological and emotional resilience, which is the ability to recover from difficulties and/or change (Ontario Ministry of Education, 2015). “A person with good mental health is able to think, feel, act, and interact in a way that permits him or her to enjoy life while being able to cope with challenges that arise” (p. 42). Although understanding mental health is not always correlated to the prevention of mental illness due to biological components, “learning about mental health and emotional well-being helps students understand and manage the risk and protective factors that are in their control so that they will be better able to build and maintain positive mental health” (p. 42). This is an extremely important characteristic for Grade 9 and 10 students who have recently changed schools and environments. The HPE curriculum (2015) encourages teachers to move away from defining mental health as the absence of mental illness and connects mental health to cognitive, emotional, social, and physical development, while expressing the importance of positive mental health. The curriculum has been made specific and appropriate for the needs of intermediate students, helps promote students to live a life committed to mental health literacy, and betters the quality of society and its understanding of mental health.

As of yet, there is little to no research on the impacts and implementation of the new HPE
By Interviewing Grade 9 and 10 HPE teachers, this study will explore the impact of the inclusion of mental health in the curriculum.

1.1 Purpose of the Study

The purpose of this study was to explore the experiences of the first wave of Ontario secondary HPE teachers who implemented the new 2015 HPE curriculum in the 2015-2016 school year, and who are therefore required to teach and support the development of student mental health literacy. To explore this topic, I interviewed a sample of these teachers about how they conceptualized the importance of mental health in theory and practice, how they adjusted to the new emphasis on mental health, how they assessed their students on mental health literacy development, and the resources, challenges, and supports they faced throughout the implementation of the new curriculum.

With this study, my aim was to report and share the practices that Ontario intermediate teachers have been using to help students achieve mental health literacy. These practices can influence and inform other educators on how to use these instructional practices when implementing the new 2015 HPE curriculum. In the promotion of teaching mental health concepts, and allowing future Canadian citizens to be mental health literate, we are generating a more caring and effective society. Research has shown that people who were considered to have high-standing mental health have fewer absences in the work force, fewer cutbacks, have the lowest levels of health limitations, fewest chronic diseases/conditions, lowest health care utilization, and highest levels of psychosocial functioning (Keyes, 2007, p. 100). By investigating the new mental health teacher practices required to promote the newly introduced HPE curriculum, this study aims to inform teacher education so that future generations of
Ontario students come to understand the importance of mental health literacy and fulfill the new HPE curriculum’s full potential.

1.2 Research Questions

The central question which guided this study: how are Ontario intermediate HPE teachers experiencing and reportedly delivering the new mental health content in the 2015 HPE curriculum? The following sub-questions furthered the inquiry:

- How do these teachers conceptualize the importance of mental health, in theory and in practice?
- How did these teachers reportedly adjust to the new emphasis on mental health? What experiences prepared them for this work?
- How do these teachers reportedly assess mental ‘health’ literacy for short and long-term development?
- What resources and challenges support or hinder these teachers in teaching the new curriculum?

Another objective of this study was to raise awareness of the importance in long-term student knowledge of mental health, and straying away from mental health stigmas. It was also expected to encourage teachers to include best practices in their pedagogy. Thus, being mindful of their own beliefs through the introduction of mental health concepts, as mental illnesses are most likely to develop during student’s secondary education.

1.3 Background of the Researcher

The topic of mental health is particularly interesting to me and was thoroughly introduced in my undergraduate studies, where I majored in Human Kinetics at the University of Guelph. I participated in many human development and psychology courses, emphasizing the importance
of mental health. Due to my background in the sciences, I was able to study the genetic chemical imbalances, development of biological responses, and integration of environments implicating mental health. Moving away from home and adjusting to a new lifestyle at times was overwhelming, sometimes stressful, and ultimately challenged my ability to maintain a healthy state of my own mental health during my undergraduate studies. Although I am not diagnosed with a specific mental illness, I still feel that I have experienced times at which my mental health has been altered or considered unwell.

During my entire high school career, I participated in HPE courses, and graduated knowing some of the basic mental health concepts introduced in the HPE 1999 curriculum before entering university. Mental health signs were posted all over the University of Guelph campus, promoting awareness and educating students on some of the symptoms identified with specific mental illnesses. As adolescents who moved away from home into changing environments, we can become fragile in terms of mental health. During my time at OISE I began comparing the 2015 to the 1999 curriculum. I realized that many Ontario secondary students were graduating with no knowledge of mental health and mental illness, therefore lacking the mental health literacy skills required for optimal functioning in society.

Through further contemplation I began to realize the importance of promoting student mental health literacy, and was excited to see it incorporated into the new HPE curriculum. I began to wonder if the new curriculum, and the goal of health literacy are of value to intermediate students, and how secondary teachers are addressing it in their teaching practices. It brought me to question matters of: How are teachers going to be able to present and teach mental health to students? How are teachers going to ensure that students graduate health literate?
As a future HPE secondary teacher, I am extremely motivated to decrease the stigma held against mental illness, and promote mental health. I am specifically interested in supporting teachers’ practices that can allow students to achieve health literacy upon graduation. I want to continue research in developing the HPE curriculum to better students’, and society’s overall mental health literacy.

1.4 Overview

To respond to my research questions, I conducted a qualitative research study using purposeful sampling to interview three Ontario intermediate HPE teachers about their experiences and instructional strategies when teaching the new emphasis on mental health from the revised 2015 HPE curriculum. This Masters of Teaching Research Project (MTRP) is broken down into five chapters. In Chapter 2, I review literature in the areas of mental health among intermediate students, life-long mental and health literacies, teacher ability to adapt to new curriculum, and the integration of the new HPE curriculum in other courses, the school, and community. Next, in Chapter 3, I elaborate on research design and methodology. In Chapter 4 I report my research findings and discuss their significance in light of the existing research literature. Finally, in Chapter 5 I identify the implications of the research findings for my own teacher identity and practice, and for the general educational research community. Moreover, I consider my research and articulate a series of questions raised by the research findings, and point toward recommended areas for future research. References and a list of appendixes are found at the end.
Chapter 2: Literature Review

2.0 Introduction

In this Chapter, I review research literature in the areas of mental health, mental illness, and how teachers are now addressing such topics to secondary students in hopes of them developing mental health literacy. Secondly, I review research literature on teachers’ responses to curriculum changes, as currently Ontario Secondary Teachers are experiencing a new Health and Physical Education Curriculum that involves a huge emphasis on mental health. More specifically, I define the evolving definition of mental health and review research on global mental health initiatives, in which all are guided to promote mental health literacy especially in adolescents who are more susceptible to the onset of mental illness. I discuss the prevalence of diagnosed mental illnesses in Canada, and focus on the main barriers, such as self and public stigma that dissuade people from seeking health services and treatments. I then go on to address school-based mental health initiatives to reduce stigma, as well as school-based mental health curricular initiatives. I have provided an overview of the resources available for teachers as well as their perspectives. Finally, I further review literature on the process of how and if teachers respond to curricular changes, and explore gaps in the research provided.

2.1 Defining Mental Health

The definition of mental health has made substantial progress with respects to moving away from the conceptualization of mental health being a state absent of mental illness (Galderisi, Heinz, Kastrup, Beezhold, & Sartorius, 2015, p. 231). This prior definition raises several concerns and promotes misconceptions, as mental health includes positive feelings and functions. According to the World Health Organization (WHO) (2004) mental health is, “a state
of well-being in which the individual realizes [their] own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community” (as cited in Galderisi et al., 2015, p. 231). Although the definition is more specific, it is hard to interpret the term well-being, since our well-being is influenced daily. Research by Keyes (2007) identified two types of well-being: hedonic, referring to feelings of happiness and satisfaction, and eudaimonic, referring to one’s self-realization or self-potential (p. 98). Together they provide the definition of positive mental health (Keyes, 2007, p. 98), a combination of feeling good and functioning well in life (Gilmour, 2014, p. 3) People are capable of multiple emotions, which include sadness, anger, frustration etc. However, a person with positive mental health will still experience these emotions in a dynamic life span (Galderisi et al. 2015, p. 232). Furthermore, Galderisi et al. (2015) defines mental health as:

A dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one’s own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind respect important components of mental health which contribute, to varying degrees, to the state of internal equilibrium. (pp. 131-132)

The definition helps to further hedonic and eudaimonic definitions by including the continuous need for harmonious interactions between body and mind to avoid psychotic disturbances, eating disorders, self-harm, or poor physical health (Galderisi et al. 2015, p. 232). Mental health is often confused with mental illness. Research shows that mental health and mental illness are present on a two continua model, in which they are separate and correlated to one another (Gilmour,
Mental health is a complete state between the two phenomena, in which improvements made to one’s mental health have been associated with lower odds of mental illness (Gilmour, 2014). Research continues to define mental health in ways for society to best understand, but universally the definition has explicitly made it clear to stray away from defining mental health as the absence of mental illness. Strategies have been aimed to promote the proper definition of mental health, as the prevalence of mental illness has increased, in which 1 in 5 Canadians are experiencing a mental illness of mental health concern (Friedman, 2006’ Mental Health Commission of Canada, 2012).

2.2 Mental Health Literacy as an Aid to Conquer Mental Illness

Over the past decade(s) mental illness has been a contributing factor to one of the top leading causes of death. However, many mental health initiatives/programs have been developed globally to help promote mental health awareness and reduce mental health stigma. Some examples are, the World Psychiatric Association came out with the document Open-the-Doors in 1996 to help educate people about Schizophrenia (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012), and the Mental Health Global Action Programme (2001) came out with Stop Exclusion Dare to Care to provide strategies on effective and available mental health services. Additionally, the National Depressive Initiative in Australia came out with the BeyondBlue campaign and the Compass Strategy to help improve the public’s view on depression and promote mental health literacy, and encourage those who are experiencing depression to seek helpful treatment opportunities (Kelly, Jorm, & Wright, 2007). The Mental Health Commission of Canada came out with Changing directions, changing lives: The mental health strategy for Canada (2012) and the School-Based Mental Health and Substance Abuse Consortium (2013b) to help integrate and promote mental health initiatives for all students and not just those affected.
Other documents have been made such as *Open Minds, Health Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy* (Ontario Ministry of Health and Long-Term Care, 2011), and *Supporting Minds* (Ontario Ministry of Education, 2013), which acts as a guide for educators to promote student mental health and well-being. In addition, the new 2015 Ontario Health and Physical Education curriculum was updated to help further promote mental health among students. Many of these initiatives have been implemented for some time and far more exist. Every year more and more individuals around the world are effected by mental illnesses. Furthermore, the United Kingdom, Australia, and Canada have recently become invested in promoting mental health literacy due to the increasing numbers of those affected (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012).

The Canadian Alliance on Mental Illness and Mental Health [CAMIMH] (2007) defines mental health literacy as “the knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems” (p. 4). According to Wei and colleagues (2013), mental health literacy “encompasses knowledge and skills that address the biological, psychological and social aspects of mental health to increase the understanding of mental health and mental disorders, reduce stigma, help recognize and prevent mental disorders, and facilitate help-seeking behaviours in youth along the pathway to mental healthcare” (p. 110). It has been shown that individuals who have higher mental health literacy are more likely to understand the complexity of mental illness, see through falsified stigma, and understand the importance of disorder-specific treatments (Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013). Within the last few years, Canada, and more specifically Ontario, has become invested in addressing and implementing mental health initiatives designed to promote resilience and improve attitudes towards mental illness. According to the Ministry of Child and Youth Services they identified
one of their primary goals to be enhancing the levels of resilience in Canadian children and youth (Flett & Hewitt, 2013, p. 22). The Canadian National Dialogue on Resilience in Youth (2008) therefore came out with a specific and initial assessment that addressed what was to be known about resilience and what had to be done to improve resilience among Canada’s children and youth (Flett & Hewitt, 2013, p. 22). In addition, it was concluded that “resilience must be promoted and developed to help young people succeed in school and in life” (Flett & Hewitt, 2013, p. 22). Jorm (2000) suggests that if greater gains aim towards “prevention, early intervention, self-help and support of others in the community, then we need a ‘mental health literate' society in which basic knowledge and skills are more widely distributed” (p. 399).

2.3 Frequency of Mental Illness in Canada

Although there is a large focus on promoting mental health literacy using world-wide mental health initiatives, the prevalence of mental illness continues to escalate and is currently a leading cause of Canada’s disability (Institute for Health Metrics and Evaluation, 2015; Lim et al., 2008 & Mental Health Commission of Canada, 2014). Mental illness can frequently lead to death, and unfortunately this includes young children and adolescents. Although statistics on mental illness vary, it is suggested that 1 in 5 Canadians experience a mental health or addition problem, and by age 40, 1 out of 2 Canadians have – and or have had – a mental illness (Smetanin et al., 2011). In addition, 34% of high school students have a moderate-serious level of psychological distress, and 14% have a serious level of psychological distress (Boak et al. 2016). 75% of mental health problems onset between ages 14-24, and 50% of these onsets occur before the age of 14 in which most children will not receive treatment (Min, Lee, & Lee, 2013, p. 308; Wei, McGrath, Hayden, & Kutcher, 2015, p. 1). Age 14 is consistent with children entering Ontario secondary schools. Research suggests that adolescents are more susceptible to mental
illness because they are still undergoing brain development in the prefrontal cortex, explaining why adolescents are often impulsive, emotional, and frequently participate in risky behaviours. (Cullen et al. 2009; Miguel-Hidalgo, 2013; Min et al., 2013). Adolescents experience dramatic hormonal, neural, and behavioural changes, and although the brain gives ample room for plastic changes to adapt to social and natural environments, the brain is still more susceptible to manifest psychiatric or neurological changes (Miguel-Hidalgo, 2013, p. 245). The adolescent brain is more vulnerable during adolescence, especially when establishing new social and personal relationships while reaching reproductive success and independence (Min et al., 2013).

According to the Mood Disorders Society of Canada (2002), mental illnesses are “characterized by alterations in thinking, mood or behaviour (or some combination thereof) associated with significant distress and impaired functioning over an extended period” (p. 7). Symptoms of mental illness vary from mild to severe, depend on the type of mental illness, the individual, the family and the socio-economic environment (Mood Disorders Society of Canada, 2002, p. 7). Types of mental illnesses include anxiety disorders, eating disorders, mood disorders, and personality disorders (Mood Disorders Society of Canada, 2002). Research has shown that the most common problems among adolescents are anxiety, behaviour, mood, and substance use problems (Merikangas et al. 2009). Evidence from Merikangas et al. (2009) has also shown that adolescent rates of mood and anxiety disorders are higher in girls, while rates of behaviour disorders are higher in boys, however both showed equal rates of substance use disorders. The most alarming suggestion by Whitley, Smith, & Vaillancourt (2013) is that the number of children and adolescents suffering from mental illnesses is expected to increase by 50% by 2020, in which currently the prevalence of mental illness ranges from 15-30%.
Not only is the increase of mental illness upsetting, approximately 60% of Canadians lack the capacity to obtain, understand, and act on health information and services, or make appropriate health decisions (Visscher & Hutnik, 2011). Furthermore, an increase of mental illness and inadequate understanding of mental health literacy are likely to negatively and largely impact the Canadian economy especially in terms of productivity losses and health care costs (Mood Disorders of Canada, 2002). In 1993 the economic cost of mental illness in Canada was 7.3 billion dollars, and it has consistently increased (Mood Disorders of Canada, 2002). Approximately 51 billion dollars is spent yearly, if not more (Lim et al., 2008). According to Merikangas (2011) 36.2% of Canadians receive treatment, and only 50% of children and adolescents receive treatment. In 2010 the Mental Health Commission of Canada created a study to fill the gap in pan-Canadian information about the number of people living with mental health problems and illness today and the associated costs. The study built a unique model based on a wide range of existing studies in Canada and internationally and its findings share some important reasons for investing in mental health, in which the document, *Making a Case for Investing in Mental Health in Canada* (2013a) was created. Furthermore, it showed that the cumulative cost of providing treatment, care, and supportive services over the next 30 years is expected to exceed 2.5 trillion dollars (Mental Health Commission of Canada, 2013a). If all Canadians suffering from mental illness were to seek treatment, the Canadian economy would be spending even more money. Adolescents are more susceptible to mental illness, and therefore the Mental Health Commission of Canada (2013a) suggested that “indirect costs such as reduced income and taxation associated with diminished career options [are] arising from [students] leaving school prematurely, and costs of undiagnosed mental illnesses [have] an effect on productivity” (p. 19). The most common and recognized forms of mental illness in secondary
schools are Attention Deficit Hyperactive Disorder (ADHD) and behavioural disorders, in which 45-60% of adolescents receive treatment (Merikangas et al., 2011). However, less than 1 out of 5 adolescents with eating disorders, anxiety disorders, or substance abuse disorders receive no treatment at all because of less observable symptoms (Merikangas et al., 2011). Mental health problems and illnesses are prevalent among adolescents regardless if they are diagnosed or undiagnosed, as such access to supports must increase in Canada and around the world. If research suggests that mental illness will double by 2020, and our mental health services continue to decline, the future Canadian economy and people will be at a disservice (Flett & Hewitt, 2013).

It is important to note, that if mental illnesses are left untreated the affected individuals are at risk of developing a chronic mental disorder, or other mental illnesses, and are more likely to participate in self-harm which can lead to suicide (Flett & Hewitt, 2013). In Canada, suicide is the second leading cause of death among 15-19 year olds (Skinner & McFaull, 2012, p. 1029). More specifically, in 2012 suicide accounted for 17% of deaths among youth aged 10 to 14, 28% among youth aged 15 to 19, and 25% among young adults aged 20-24 (Centre for Addiction of Mental Health, 2015). 12% of high-school students report having seriously contemplated suicide in the past year, and 3% reported having attempted suicide in Ontario (Boak et al., 2016; Ialomiteanu, Hamilton, Adlaf, & Mann, 2014). It is important to recognize that not all people with mental illnesses commit suicide, however more than 90% of those who die from suicide have a diagnosable mental illness (Nock et al., 2008). Often these people are not receiving treatment or help from health care services. For example, between January 2000 and November 2006 Ontario did an analysis on 370 adolescent suicides overlooking previous attempts and history of psychiatric treatment, in which only 66 adolescents had prior interventions (Soor et al.,
According to Flett & Hewitt (2013) “[it] is likely that a very substantial proportion of the 82.1% of adolescents who killed themselves had a suicide without any apparent warning signs” (p. 14). Although some mental illnesses have observable symptoms, some mental illnesses do not and therefore many of those people do not receive treatment.

According to Flett & Hewitt (2013), they have suggested that many mental illnesses in adolescents are undetected due to personality styles, in which they are extremely unwilling to let others know about their levels of distress (p. 16). Furthermore, this is a result of adolescents having elevated levels of self-consciousness (Flett & Hewitt, 2013). In addition, a follow up study focusing on social phobia by Burstein et al., (2011) found that 1 in 10 adolescents suffer from social phobia and only 10% of those received treatment. Moreover, it is evident to Flett & Hewitt (2013) why adolescents do not seek help opportunities. In addition, these adolescents also have elevated levels of self-concealment and self-perfectionistic traits which hinder them from disclosing even when experiencing psychological pain (Flett & Hewitt, 2013, p. 16). This condition is also known as smiling depressions or disguised depression, in which they falsify positive behaviours and emotions to ensure that no one identifies symptoms that can be associated with them having a particular mental illness (Flett & Hewitt, 2013). Flett & Hewitt (2013) also have suggested that often these adolescents are not only ashamed of themselves via self-stigma, but feel this way because they are hindered by mental health public stigma. These barriers will be discussed in greater detail.

### 2.4 Mental Health Literacy Barrier: Stigma Among Adolescents

One component of mental health literacy is overcoming the barrier of stigma. Stigma is the most frequently cited barrier that dissuades people from seeking treatment (Hartman,
Mental illness stigma has been distinguished by two relevant dimensions: self-stigma and public stigma (Corrigan & Shapiro 2010; Hartman, Michael, Winter, Young, & Flett, 2013). Stigma is similarly known as stereotypes, which “are general beliefs about characteristics, attributes, and behaviours of people who are categorized as a member of a particular social group” (Corrigan & Shapiro, 2010, p. 908-909). Public stigma occurs when large segments of the general-public agree with the stereotypes and thus individuals distant themselves from them as well as disrespect their human right (Corrigan & Shapiro, 2010). For example, people who experience mental illnesses are usually stigmatized as dangerous, unintelligent, and incapable of recovery (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). In contrast, self-stigma is when people with mental illnesses internalize stereotypes, apply the stereotypes to themselves, and suffer diminished self-esteem and lessened self-efficacy (Corrigan, Watson, & Barr, 2006). Although research suggested that the public lacks knowledge on mental health and continuously reinforces its negative stigma, a study by Hartman and colleagues (2013) suggested that one in eight students experience self-stigma. Hartman and colleagues (2013) examined the effectiveness of a single session anti-stigma intervention on five secondary schools. It was found that a classroom-based presentation which incorporates contact with a mental health service recipient can produce significant reductions in self-stigma, reduced social distance and improved students comfort level around people with mental health concerns (Hartman, Michael, Winter, Young, & Flett, 2013, p. 39).

Another study, consisting of two respondent groups, one group having mental health concerns and the other having none, each containing 49 Canadian students age 13-20, 47.8% of all participants perceived stigma as the number one barrier to not accessing mental health services and 23.1% of the adolescents who had a mental health concern reported that they did not
know where to go for help (Bowers, Manion, Papadopoulos, & Gauvreau, 2013). Despite the number of mental health services provided, many individuals do not seek treatment because of public and self-stigma influences and one-third of the people who accessed mental health services felt stigmatized and therefore became significantly less involved in treatment and services (Corrigan & Shapiro, 2010; Bowers, Manion, Papadopoulos, & Gauvreau, 2013). It was found that very few young people discuss mental health with their friends and family, and when they do it was done through secrecy (Bowers, Manion, Papadopoulos, & Gauvreau, 2013). A study by Patten and colleagues compared surveys from 2002 to 2012 on people who suffer major depressive episodes in Canada in hopes of addressing some of the changes specific to prevalence, treatment, and impacts and therefore suggested that approximately one third of Canadians who require mental health services/treatment receive them. They found that approximately only half of the Canadians who experience depression receive potentially adequate care (Patten et al., 2016). It was also suggested that in Ontario there is approximately a six-month to one-year wait list for children and youth who require mental health services (Children’s Mental Health Ontario, 2016) and are therefore left untreated. According to Jorm and colleagues (2000), “the prevalence of mental disorders is so high that the mental health workforce cannot help everyone affected and tends to focus on those with more severe and chronic problems (p. 399).

Unfortunately, children have adopted discriminating stereotypes against people with mental illnesses, and therefore many children avoid interactions with those who experience mental illnesses (Corrigan et al., 2007; Wahl, 2002). Fortunately, the current generation of adolescents appears to have less negative attitudes on mental illness compared to previous generations. Moreover, recent adolescents indicated that they would not fear a person with a
mental illness, and felt that all people should be treated with respect even if they experience a mental health concern (Wahl, Susin, Lax, Kalpan, & Zatina, 2012). However, Wahl and colleagues (2012) also found that adolescents tend to adopt negative views about mental illness. Wahl and colleagues (2012) surveyed 193 students at four different middle schools about their knowledge of and attitudes towards mental illnesses. According to the surveys, 15% of students agreed that only students who are weak and sensitive are affected by mental illnesses, 27% said they would feel embarrassed if they had a mental illness, 29% agreed that people with severe mental illnesses do not get better, and approximately 42% would not invite someone with a mental illness to their home or work on a project with them (Wahl, Susin, Lax, Kalpan, & Zatina, 2012). Moreover, an environment filled with negative mental health views can contribute to children and adolescent participation in public and self-stigma stereotypes. However, self-stigma on its own can negatively influence help-seeking opportunities and treatment options for those affected (Vogel, Wade, & Hackler, 2007). Vogel, Wade, and Hackler (2007) found public-stigma to be difficult to change, and therefore concluded that knowledge on self-stigma is a more practical and efficient intervention. They also suggested that people should encourage counseling to overcome internalized stigma, and that it should be done via out-reach and educational programs. Next, I will examine ways to target these goals in adolescents and integrate the objectives within schools.

2.5 School-Based Mental Health Initiatives to Reduce Stigma

Because public and self-stigma are a major barrier towards students seeking help, especially if faced with a mental health concern, many schools have welcomed mental health initiatives to promote mental health and overcome stigma within their school. “Schools are an ideal venue in which to embed mental health literacy at both the individual and population level
because schools are where most young people can be reached and classroom-based educational activities are familiar to students” (Mcluckie, Kutcher, Wei, & Weaver, 2014, p. 379). Research by Mcluckie and colleagues (2014) had teachers implementing mental health into their classrooms by using *The Guide* from February to June 2012 in four different Canadian school boards and found that when integrating mental health into everyday secondary classrooms, students’ mental health literacy was positively influenced because of improved knowledge and attitudes on mental health and illness. Research by Hartman and colleagues (2013) reviewed social psychological literature and identified two promising approaches that are generally used to combat stigma within schools. These approaches are known as education and contact, and are shown to affect and improve students’ mental health literacy.

Education is a proactive strategy that involves challenging the myths of mental illness with factual information to enhance mental health literacy and has been found to be fairly effective (Hartman, Michael, Winter, Young, & Flett, 2013, p. 31). Research suggests that people who are educated with proper information on mental health and mental illness are less likely to stigmatize individuals who experience mental illnesses (Faulkner, Irving, Boak, & Adlaf, 2010). Pinfold and colleagues (2003) assessed the effectiveness of an educational intervention with young people aimed to increase mental health literacy and challenging negative stereotypes associated with severe mental illnesses. 427 secondary students participated in 2 mental health awareness workshops and completed pre-and post-questionnaires, in which they found short based educational workshops to produce positive changes in student’s attitudes on mental illnesses (Pinfold et al., 2003). Six months after the educational workshops most students remembered the sessions, in which 37% remembered the activities and 15% remember the video (Pinfold et al., 2003, p. 343). Corrigan and Shapiro (2010) suggested that adolescent’s views on
mental illnesses have not fully developed compared to adults, which is why adolescents are more responsive to educational approaches. However, research also shows that education about biological roots sometimes worsens and offsets responsibilities such as views about disease prognosis in which people assume that because the mental illness is “hardwired” people are less responsive to treatment (Corrigan & Shapiro, 2010, p. 910).

Contact involves dispelling negative beliefs about mental illness through direct in vivo interactions with mental health consumers and appears to be the most promising approach (Hartman, Hartman, Michael, Winter, Young, & Flett, 2013, p. 31). Corrigan & O’Shaughnessy (2007) have shown contact to be most effective when it involves mental health service recipients sharing with their personal experiences with their illness to others, and demonstrating their success in treatment. According to Hartman and colleagues (2013) national and international studies of brief school-based educational workshops have shown that contact can increase mental health literacy and produce lasting positive changes in the reported attitudes of youth towards mental illness. Ke and colleagues (2015) studied the effects of a 1 hour classroom based workshop, led by medical-students, on the topic of mental illness stigma among 279 British Colombia secondary students aged 14-17. Furthermore, a questionnaire was administered directly before, immediately after, and 1 month post workshop (Ke et al., 2015). Thus, stigma reduced by 23% directly after the workshop, which sustained to approximately 21% 1 month post workshop (Ke et al., 2015). Ke and colleagues (2015) researched that “combinations of education with direct contact or video-based contact with persons with mental illness have all been effective in reducing stigmatizing attitudes among children and youth (p. 330).” Rickwood and colleagues (2005) also suggested that educational approaches which include contact have been shown to reduce prejudice attitudes towards people with mental illnesses as well as increase
help seeking opportunities. However, when mental health stereotypes match a person who has a mental illness, this can strengthen participants’ attitudes on stigmatizing people with particular mental illnesses, therefore having an adverse effect (Corrigan & Shapiro, 2010, p. 910).

However, a recent Canadian survey on educators’ perspectives of school mental health demonstrated that they considered mental health to be extremely important, but lacked confidence in addressing it due to a lack of knowledge (Mental Health Commission of Canada, 2012). This is interesting as many school boards have integrated mental health initiatives in curriculum.

2.5.1 School-based mental health curricular initiatives

In response to the school-based mental health initiatives, schools and research projects have also looked at incorporating curricular mental health initiatives. Currently, there is limited evidence regarding the impact of curriculum-based interventions within high school settings. Current school-based mental health literacy programs follow one or two approaches: programs addressing specific conditions and programs for general understanding of mental health and mental illnesses (Mcluckie, Kutcher, Wei, & Weaver, 2014; Merritt, Price, Mollison, & Geddes, 2007). A systematic review, conducted by Wei and colleagues (2013) identified 15 reviews that examined the outcomes of high school-based general mental health literacy programs. Majority of these programs were found to be associated with no, or only minor, gains in the students’ knowledge and/or attitudes towards mental illnesses. This review revealed that only one study, by Pinfold and colleagues (2005) has reported on a mental health literacy intervention in Canadian high school students (Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013). However, Mcluckie and colleagues (2014) examined the effects of a high school mental health curriculum,
The Guide, in enhancing mental health literacy by surveying 265 Grade 9 Canadian students in multiple school boards during Health classes. The Guide is a mental health literacy resource designed to inform junior high and high school curriculum. It was developed in collaboration between mental health experts, educators and the Canadian Mental Health Association (CMHA), and a national mental health non-governmental organization. The Guide has been endorsed by the Canadian Association for School Health, is certified by Curriculum Services Canada, and is embedded in the Provincial grade nine school curricula in Nova Scotia, and is currently being used in hundreds of additional schools across Canada (Kutcher, Wei, & Morgan 2015). Before teachers implemented The Guide they had access to a teacher study guide and website, and underwent only a single training day. The effect of this implementation on teachers’ own mental health literacy has been examined and has shown significant and substantial positive impact on their knowledge and attitudes (Kutcher, Wei, Mcluckie, & Bullock, 2013). Furthermore, after implementing The Guide, knowledge on mental health significantly improved between pre- and post-student surveys, and was maintained during the follow up, while attitudes towards mental health and illness significantly improved pre- and post survey, and was significantly higher at follow up than base line (Mcluckie, Kutcher, Wei, & Weiver, 2014). Moreover, this was the first study to demonstrate a positive impact of a curriculum-based mental health literacy program in Canadian high school population.

2.6 Teacher Resources and Supports on Mental Health Curricular Initiatives

According to the Canadian Teachers’ Federation (2012) over two-thirds of teachers reported they had not received any professional development on knowledge acquisition and or skills training to address student mental health and mental illness. This gap in knowledge further justifying some teachers’ lack of confidence in teaching mental health or reaching out to those
experiencing mental illnesses (Mental Health Commission of Canada, 2012). Also, virtually 96% of teachers reported an important need for additional knowledge and skills training on mental health (Canadian Teachers’ Federation, 2012). Research by Wei and Kutcher (2011) suggests that when implementing curricular mental health literacy, the school community must have skilled and trained teachers in mental health. Through the curricular program/school-based pathway, the program goal begins with the application of curricula to improve mental health literacy in students, teachers, and parents. However, a major component of this program is implementing *Gatekeeping* Training. The gatekeeper training program is for specific teachers in the school community in which those teachers would be the go-to teachers in suspecting and supporting a child with a mental health concern, and was implemented in Nova Scotia (Wei & Kutcher, 2011). Providing teachers with resources and training on how to foster mental health literacy during their usual teaching activities, such as *The Guide*, can help improve the knowledge and attitudes of both teacher and student on mental health (Mcluckie, Kutcher, Wei, & Weaver, 2014). Research by Kutcher, Wei, and Morgan (2015) suggests that *The Guide* may enable and empower teachers and students to have better communication with mental health service providers while also promoting students to seek health care services if in need.

### 2.7 Teacher Responses to Curriculum Changes

Because this research also explores teachers’ experiences with the new 2015 HPE curriculum, this report will include a review of literature concerning teacher responses to curriculum changes. The Ontario College of Teacher Standards of Practice requires teachers to remain in their professional knowledge and recognize its relationship to practice, and learning theory (Ontario College of Teachers, 2006). It is the teachers’ responsibility to update their teaching pedagogy when curricula standards change, which requires substantial time and
commitment. There have been many studies (e.g., Ryder & Banner, 2013) on ‘failures’ of school curriculum change which have shown that teachers may not implement new curricula as intended. Studies (e.g., Gray, Anderman, & O’Connel, 2011) have shown that even teachers with appropriate knowledge and pedagogical expertise do not necessarily implement successful curriculum reforms. For example, when sexual education was added into the curriculum, a study by Carrion & Jenson (2014) found that some educators chose to disregard the curricular expectations on sexual education due the societal and political controversies, despite students’ inadequate knowledge on the topic. Although, this study was not on mental health, it is hoped that the outcome of the curricular reform follows a better path. However, other studies (e.g., Scholtz, Watson, & Amosun, 2004) have found that teachers’ pedagogical practices are influenced by curriculum innovation, and teachers may adapt in response to the interaction between the new curriculum and the situation in which they work. Resources and textbooks are often recommended for educators to use, but teachers interpret their content differently, leading to different student experiences (Heckley, 1995). Therefore, although curricular reforms may be considered innovative for teachers and students’ needs, this does not mean teachers will implement the expectations (Sherin & Drake, 2009). In sum, researchers have not tried to identify and understand the interactions between teachers and the curriculum material they use, but find these difficult to predict as many factors contribute and influence teacher’s practices. It is possible for teachers to change over time, in response to new ideas, curriculum reforms, and teaching practices; however, the degree of change depends on whether the teachers are initially convinced that the innovation has something special to offer them specifically (Scholtz et al. 2004).

More specifically Han and Weiss (2005) review literature on the factors that influence the
sustainability of teachers implementing school-based mental health programs, to further understand the complexities of the program under real-world circumstances. Research by Han & Weiss (2005) found four factors to be crucial when sustaining mental health programs in schools. The program must be accepted by the teacher and school, effective, feasible, flexible and adaptable and all characteristics are required to sustain the programs implementation (Han & Weiss, 2005). Thus, it is important to lay the ground work to cultivate institutional understanding, readiness, and support for the program at the school. Han & Weiss (2005) researched that sustainability in teachers’ implementation is enhanced through provision of teacher training and performance feedback. Furthermore, research by Han & Weiss (2005) found that, “it is incumbent upon program developers and evaluation researchers to identify effective methods for training teachers on program implementation, so that teachers achieve program fidelity and also develop an in-depth understanding of the program” and was extremely effective when role-playing and active modeling (p. 677). However further research incorporating assessments of both student and teacher outcomes over multiple years that cover the supported implemented phase and sustainability phase are required (Han & Weiss, 2005). A study by Ha and colleagues (2004) did a study in Hong Kong on teachers’ perceptions of in-service teacher training to support curricular changes in physical education, in which 183 primary school teachers participated in a questionnaire based on their receptivity and views on the effectiveness of the teacher development program. Ha and colleagues (2004) found that participants felt they needed the in-service training to equip themselves in implementing the curriculum changes and that almost all participants had a positive attitude going into the change. However, participants felt that the curriculum was a proposed guideline rather than a mandatory policy, and was unlikely to be implemented in the absence of a highly interactive infrastructure of pressure and
support, suggesting that the principal plays a huge role in influencing the change (Ha, Lee, Chan, & Sum, 2004).

2.8 Limitations to Research

Although mental health education initiatives are increasing within schools, such as the updated 2015 Ontario HPE curriculum and its emphasis on mental health, studies on school-based strategies aimed to increase student’s mental health literacy are still relatively new. Current research literature suggests that findings concerning the effectiveness of school-based mental health strategies on promoting student mental health literacy lack validity and reliability. For example, a study by Wei and colleagues (2013) reviewed 27 articles, including 5 randomized controlled trials, 13 quasi-experimental studies, and 9 controlled before and after studies found that although school-based mental health literacy programs improve knowledge, attitudes, and help-seeking behavior, almost all studies had a risk for bias. Wei and colleagues (2013) assessed the potential biases and found 17 studies met the criteria for high risk of bias, 10 for moderate risk of bias, and no studies were found to have low risk of bias. Wei and colleagues (2013) also indicated that they were not able to use meta-analysis to synthesize and evaluate the levels of confidence for any of the results.

Additionally, more research needs to focus on the comparative effectiveness of individuals implementing school-based mental health initiatives or curriculums. Wei and colleagues (2013) suggested research has considered integrating mental health, but the concept of integrating mental health literacy is still relatively new. Research Lindley et al. (2012) said that, “there has been a tendency to overlook the importance of the pedagogical structure of anti-stigma education,” and while educators may share the objective of integrating mental health
literacy into their schools, research has not yet made substantial progress in establishing a consensus on the most effective strategies required to incorporate mental health education into the school curriculum.

2.9 Conclusion

In this literature review I examined research in mental health, mental illness prevalence in Canada and Canadian adolescents, initiatives in developing mental health literacy and overcoming the barriers of stigma through school-based mental health initiatives. Secondly, I provided literature review on teacher experiences with curricular reforms. This review provides an understanding of the commitment geared to promoting, preventing, and integrating mental health into curriculums, and focusing on the importance of students achieving mental health literacy to better societal outcomes regarding mental health. It also raises concerns regarding teachers implementing new curricula, and adjusting their teaching strategies to further promote the new reform, and reviews gaps demonstrated in the literature. Furthermore, this present study explores this gap by interviewing current HPE secondary teachers in Ontario who are experiencing the new 2015 HPE curriculum and its emphasis/curricular expectation toward students achieving mental health literacy. If teacher practices, experiences, ideas, and concepts towards the new curriculum can be identified, this knowledge can provide a better understanding of the process required for students to become literate in mental health, through the implementation of effective and positive attitudes towards curricular change.
Chapter 3: Research Methodology

3.0 Introduction: Chapter Overview

In this chapter, I will cover the research methodology used, identifying the methodological decisions I have made and outline my rational for these decisions, given the research purpose and questions. To begin, I will explain the research approach and procedures, and then continue to describe the main instrument of data collection. I will identify the participants of the study, list the sample criteria, and describe the sample procedures. Then, I will describe the data analysis, and address [description] ethical considerations. In conclusion, I have listed some of the methodological limitations and strengths of the study.

3.1 Research Approach & Procedures

This study was conducted using a qualitative approach. It includes an overview of the existing literature relative to the research questions and purpose of the study and includes semi-structured, face-to-face interviews with three Ontario Health and Physical Education teachers. Semi-structured interviews are also known as in-depth interviews.

According to Irving (2006), research on education should take a quantitative approach to maintain objectivity. Therefore, qualitative approaches were not an accepted method in educational and social science research. In response, Litchman (2013) proposed that research in education should be qualitative because it requires in-depth understandings. Either approach is acceptable, but for this study it was most beneficial to conduct a qualitative study to focus on the experiences and perceptions of the teachers interviewed.

Qualitative research incorporates a holistic approach, is reflective and process driven, and produces culturally situated and theory-developed knowledge through an ongoing interplay between methods and theory (Litchman, 2013). It focuses on depth of knowledge rather than
breadth. Qualitative research promotes deeper understanding of a phenomenon “as it is experienced in a particular setting rather than draw broad conclusions” (Neuman, 2014, p. 71). Qualitative research focuses on human behaviours and experiences, interactions, and social contexts without the use of statistical procedures (Fossey, Harvey, McDermott, & Davidson, 2002; Litchman, 2013). It adopts a humanistic perspective to understand human-lived experiences. The researcher focuses on the experiences from the participants’ perspective, and therefore adds uniqueness to the data collection and analysis (Creswell, 2007).

Qualitative research is most appropriately used in a non-experimental setting with a specific group or population. A natural setting allowed participants to share personal stories instead of addressing the cause and effect relationships (Creswell, 2007). A considerable amount of time is invested in qualitative research, in which the researcher observes any changes the participants report in their communities (Hays & Singh, 2011, p. 6).

Because qualitative research does not rely on numerical data (Litchman, 2013, p. 16), it provided an excellent opportunity to explore the lived experiences of Health and Physical Education (HPE) secondary teachers who have been implementing the mental health emphasis. Quantitative research establishes how one variable causes another, whereas qualitative studies explore description, understanding, and interpretation (Litchman, 2013, p. 20). A qualitative approach allowed for the exploration of teachers’ experiences implementing the mental health focus in their classes.

3.2 Instruments of Data Collection

There are many data collection methods for qualitative research. However, Hays and Singh (2011) suggest individual interviewing as the most widely used qualitative data collection method. Interviewing was used in the early theory of education and mental health, and continues
to be the preferred option for unexplored and underexplored social phenomena (Hays & Singh, 2011, p. 237). There are different types of interview methods which include, structured, semi-structured, and unstructured. Distinction is based on a “continuum ranging from relatively structured to relatively unstructured formats” (Brinkmann, 2013, p. 18). Brinkmann uses the term ‘relatively’, because he argues that there is no such thing as a completely structured or unstructured interview.

Semi-structured interviewing is also known as in-depth interviewing. According to Brinkmann (2013) semi-structured interviewing has the purpose of obtaining objective descriptions of the interviewee. An interview protocol is used to serve as a guide. The interviewer is not obligated to ask every single question (Hays & Singh, 2011, p. 239). Moreover, the pace of the interview may be changed and additional questions may be asked. The interviewer is allowed to cater to the interviewee’s experiences and perceptions, while still maintaining structure and preparedness (Brinkmann, 2013, p. 21). This is advantageous because it may bring up certain questions or areas of concern, which may further benefit the study and provide meaningful information.

According to Irving (2006) unstructured interviews are friendly conversation with interviewees (Brinkmann, 2013). This is prominent when the interviewee tells a life story, in which the interviewer cannot prepare specific questions (Brinkmann, 2013, p. 20). During the interview, it is important to listen in hopes of discovering and developing unexpected themes between the interviewees perspective and the qualitative research (Edwards & Holland, 2013).

According to Edwards and Holland (2013) structured interviewing is more commonly used in quantitative interviewing. Structured interviews are usually in a survey format and include standardized close-ended questions (Irving, 2006). The protocol cannot be deviated from.
I was interested in HPE secondary teachers’ experiences of the new mental health emphasis in the 2015 curricula. HPE secondary teachers who have implemented both curriculums, will yield the most relevant information. Based on the research above, semi-structured interviews were used to collect data. Having structure and flexibility through semi-structured interviews are the best instrument for data collection of this study, due to the collaborative interaction between the interviewer and interviewee. The only data collection method used in this study is, semi-structured interviews, and most semi-structured interviews are typically the singular source of data used (DiCicco-Bloom & Crabtree, 2006). Lastly, by using these face-to-face interviews I was able to observe and interact on a more personal level, and add uniqueness to each interview (Creswell, 2007). Complete objectivity is deemed impossible in qualitative interview research, but is the best data collection method for this topic.

The organized protocol (Appendix B) was fashioned into four sections, starting with the participant’s background information, followed by questions addressing their encounters with implementing the new emphasis of mental health in the HPE curricula, then addressing their experiences and beliefs about the new curricula, concluding with questions regarding challenges, supports, and future steps for teachers. Examples of interview questions include:

- How does your previous teaching and knowledge of the 1999 curricula help or hinder your experience with the 2015 curricula?
- What does mental health literacy mean to you?
- Can you tell me of a time in which a student demonstrated mental health literacy skills?

3.3 Participants

It is not logistical to study an entire population, which is why sampling is an essential part of research methods. It not only looks at people, but takes settings, events, and processes
into consideration (Maxwell, 2012, p. 96). It is important for these parameters to align with the research questions (p. 96). My participants were not randomly selected. Below I address the methodological decisions made towards the research participants.

3.3.1 Sampling criteria

The following criteria was applied to each teacher participant:

- Teachers who are currently teaching intermediate/senior HPE in the Greater Toronto Area. Specifically grades 9 and 10.
- Teachers who have implemented the previous 1999 HPE curriculum for a minimum of five years, and will have implemented the new 2015 HPE curriculum in their own classes.

Since the nature of the research is so specific and in-depth, qualitative studies usually have a relatively small and specific sample (Emmel, 2013). In order to address the main research question, the participants I interviewed must have met the sampling criteria. They must have demonstrated proper training in HPE, as well as have experience implementing the old and new curricula. This is because my focus was in learning about their experiences with the adjusted curricula and new emphasis on mental health literacy. Furthermore, I wanted to maintain a geographical focus and have all participants teaching in the Greater Toronto Area. As this was such a small study, I did not select participants by gender, age, or experience.

3.3.2 Sampling and recruitment procedures

There are two sampling procedure methods that were used in this qualitative study, which include convenience and purposeful sampling. Convenience sampling reduces cost and time, as it selects a sample based on accessibility and proximity (Maxwell, 2012). I interviewed HPE teachers within the Greater Toronto Area (GTA) to support my research because I have
networked with teachers in this district through my experience as an OISE student. Purposeful sampling is when “particular settings, persons, or activities are selected deliberately to provide information that is particularly relevant to your questions and goals” (Maxwell, 2012, p. 97). These participants are able to provide you with information needed for your research questions, and is deemed the most important consideration in qualitative sampling decisions (Maxwell, 2012, p. 97). Each participant had to meet the sampling criteria in order to collect proper and accurate data. I used snowball sampling by asking participants to recommend other teachers appropriate and interested for my study (Hays & Singh, 2011). I contacted teacher associations, school boards, and Principals and provided them with an overview of my study for potential participants. This ensured that my participants volunteered their time, and were not pressured or coerced.

### 3.3.3 Participant biographies

I interviewed 3 HPE teachers, all within the GTA, to support my research and gather appropriate findings. All were interested in my research and eager to participate in a semi-structured interview.

The first participant/interviewee was with Kinley Greasly from BlueBoard Secondary School (all pseudonyms). For the past 5 years, he has been the head of the HPE Department. He teaches grades 9 to 12. Specifically, teaching activity and fitness courses, kinesiology, and all healthy active living courses, including grades 9 and 10. Kinley is head of the concussion protocol at BlueBoard Secondary School, coaches and helps many extracurricular programs within the school, and has just recently received his principle qualifications.

My second participant/interviewee was Rogan Brody from ParkStone Secondary School (all pseudonyms). He has been teaching for almost 20 years, in which 11 have been at ParkStone
Secondary School. He has science qualifications, but has been teaching full-time HPE, specifically grades 9 and 10, with a few exceptions to teaching grade 11 and 12 healthy active living courses. Teaching was Rogan’s second career, as he was previously a professional lacrosse player. Because of his athletic background, and knowledge of concussion protocol, he also has a role within the development of the concussion protocol. Rogan participates in many extra-curricular programs, and is very passionate about mental health.

My third participant/interviewee was Nicco Mitchell from LeeBram Secondary School (all pseudonyms). He has been at this school for almost 20 years, and has qualifications in science and HPE. He teaches grade 9 HPE, as well has recently received grade 11 healthy active living courses. Certain semesters he teaches sciences to grades 9 and 10, but for the most part has maintained a career in full time HPE.

3.4 Data Analysis

Creswell (2007) describes analyzing data as a challenging task for qualitative researchers. Researchers must prepare and organize data for analysis, reduce the data into themes through transcribing interviews, coding, and further represent the data into tables, figures, or a discussion (Creswell, 2007, p. 148). Coding is the “process of noting what is interesting, labeling it, and putting it into appropriate files” (Irving, 2006, p. 125). This is the general process used to understand the phenomenon being studied, and lastly incorporates meaning and making analysis (Irving, 2006). Meaning and making analysis is, “the very process of putting experience into language” (Irving, 2006, p. 19) in which the interviewee and interviewer are both involved in the process of highlighting meaning throughout the interview.

In this study I transcribed interviews by using the guided research questions, and coded transcripts individually to identify categories of data and themes. Furthermore, I read the
categories side by side to develop deeper themes between each interview. The last stage of data analysis included my analysis on meaning-making process where I developed themes (my findings) and compared them with what previous studies have already found. I also considered null data, which highlights what interviewees did not speak of, and why this was important and relevant to the study.

3.5 Ethical Review Procedures

There are several significant aspects to be considered concerning ethical review and procedures. Hays and Singh (2011) argue qualitative interviewing to be more intense compared to clinical interviews, due to the possibility of emotional responses. There are four major ethical issues which DiCicco-Bloom and Crabtree (2006) caution researchers to be wary of. These include: reducing the risk of unanticipated harm, protecting the interviewee’s information, effectively informing the interviewees about the nature of the study, and lastly reducing the risk of exploitation. In this study I was aware of these potential issues, and incorporated ethical principles to minimize these occurrences.

Since the research questions focus on mental health, participants may have experienced extreme sense of emotion, causing the interviewee to feel vulnerable. I minimized this risk by sending the interview questions to participants ahead of time. I also notified all participants and restated throughout the interview and in the consent letter (Appendix A) that they had the right to withdraw from the study or refuse to answer any question they did not feel comfortable with. It is “recommended that interviewees verbally consent to participate in on-going interviews several times during the research process” (DiCicco-Bloom & Crabtree, 2006, p. 319).

Trust is a very important factor between the interviewer and interviewee, and a safe and comfortable environment should be made for the participant (DiCicco-Bloom & Crabtree, 2006).
With that being said, the interviewee may share information that could jeopardize their position (DiCicco-Bloom & Crabtree, 2006), and therefore must remain anonymous. To overcome this ethical issue, confidentiality is kept throughout the entire research study in which any identifying markers related to their school or students have been excluded. All participants have been assigned a pseudonym. All data will remain private; password protected and will be destroyed after five years. Each interviewee was provided with a summary of the purpose of the study, associated ethical issues, and expectations required of the participant within a consent from they have sign, giving permission to be interviewed and audio recorded (Appendix A).

Lastly DiCicco-Bloom and Crabtree (2006) explains how interviewees should not be exploited for personal gains, but the outcome of interview should enhance the freedom of participants more than the researcher’s career. Hays and Singh (2011) suggest that the researcher is the expert in the field, and may use this as an advantage when interacting and collaborating with the participant. Since I am a student in a teaching program and lack employment in a teaching context, I was able to minimize the power imbalance between the interviewees, and myself, as they are established teachers within the school boards.

3.6 Methodological Limitations and Strengths

There were many limitations within the study, given the ethical parameters I was approved for. The MTRP can only involve interviews with teachers, and it was not possible to interview parents or students, administer surveys, or observe classroom dynamics. Lichtman (2013) describes one of the main limitations of a study to be the lack of variety within data collection methods. The study was also limited to a very small sample size of three teachers, and therefore could not report generalizations of the population of secondary HPE teachers across Ontario on a broader scale. Emmel (2013) describes sample sizes to be relatively small, due to
the limited number of participants to meet the sample criteria, and larger samples of qualitative studies are still rather small.

Another limitation of qualitative interviewing and research is that it has a humanistic approach, in which it is impossible for the research to remain unbiased throughout the interview, and it may allow for different interpretations between the interviewer and interviewee, known as rational considerations (Creswell, 2007). Litchman (2012) explains the importance of reducing subjectivity of the qualitative research. However, Emmel (2013) explains how qualitative studies can be more valid based on the non-experimental environment created in comparison to quantitative research.

Although semi-structured interviewing does not ensure consistency between data collection and experience of all participants, “it makes up for this disadvantage by including more participant voice, as appropriate, to provide a richer picture of a phenomenon under investigation” (Hays & Singh, 2011, p. 239). The significance of interviewing teachers through a semi-structured interview demonstrates strength within the study, as it encouraged teachers to share experiences and tell stories through their perspectives of what they felt was important to the study. This allowed for greater depth of understanding compared to a survey, which would not reveal anything personal of the participant (Hays & Singh, 2011). Teachers provided meaning from their lived experiences, and this allowed them to reflect on their practices and articulate how they approach conceptualizing particular topics in theory and in practice.

Lastly since this focused on the implementation of the 2015 HPE curriculum, little research is provided and participants are specific and few, as teachers have only implemented the curriculum as of 2015. This research opens a brand new scope of research in the educational
world, as teachers are implementing a new curriculum which had previously not been updated since 1999.

3.7 Conclusion: Brief Overview and Preview

In this chapter I explained the research methodology. I started by describing the research approach and procedure, highlighting the rational and significance of qualitative research compared to quantitative research. After this I explained the instrument used for data collection, in which I addressed interviewing. I addressed the different types of interview methods, and explain how this particular study used semi-structured interviews for optimal results. I continued to explain the characteristics of the participants of the study, listing the sampling criteria, and provide a brief introduction of the selected participants. I explained how the study used convenient and purposeful sampling to obtain data, and explained the use of snowball sampling in my research study. Furthermore, I described the method used to analyze the data, through transcribing and coding interviews individually and in sequence of one another creating meaning based on previous literature. I examined ethical issues including consent, risk of participation, right to withdraw, data storage, and ways to address these possible issues. Lastly, I discussed limitations and strengths of my qualitative, semi-structured interview research study. In the next chapter, I report on the findings of my research.
Chapter 4: Findings

4.0 Introduction to the Chapter

As previously explained, the HPE curriculum now includes topics of mental health as early as grade 9 in hopes of students achieving mental health literacy. Research has suggested that mental health is exponentially increasing on a global scale, and therefore promoting mental health literacy within schools can have positive effects on society. However, more research is needed on best practices and their results. The purpose of this qualitative study is to explore the first wave of Ontario Secondary HPE teachers who have implemented the new 2015 HPE curriculum, through three semi-structured interviews.

This chapter presents and discusses the findings that emerged from the analysis of data from the research interviews. Throughout the analysis, I was constantly mindful of my research question: how are Ontario intermediate Health and Physical Education (HPE) teachers experiencing and reportedly delivering the new mental health content in the 2015 HPE curriculum? In the discussion that follows, I examine connections between all interviewees’ experiences and perceptions, specifically between strategies and barriers, and relate it to the literature reviewed in Chapter Two. The three HPE educators that I interviewed are Kinely Greasly from BlueBoard Secondary School, Rogan Brody from ParkStone Secondary School, and Nicco Mitchell from LeeBram Secondary School. Findings are organized into five main themes:

1. Previous Strategies for Promoting Student Mental Health Literacy
2. Relationship Building
3. Reducing Stigma
4. Lack of Resources and Direction
5. Structural Constraints

All themes address how the 2015 HPE curriculum transition has reportedly affected the teachers, students, school and/or classroom with regards to the new mental health emphasis. For each theme, I describe it, report on the data, and discuss the significance of each theme based on the participants and within the context of previous literature. Finally, I summarize my findings and transition to Chapter Five where I will make recommendations for next steps.

4.1 Previous Strategies for Promoting Student Mental Health Literacy

The first theme presented was that interviewees perceive that mental health was insufficiently integrated into the old grade 9 HPE curriculum; all interviewees had somewhat previously integrated mental health within their school, whether it was curricular or co-curricular. Moreover, interviewees were comfortable in addressing the mental health emphasis of the new curriculum because of their previous experience. I will first explore how Rogan and Kinley both reportedly integrated mental health into their grade 9 curricula prior to the curriculum change, and then I will briefly touch on how all interviewees’ schools participated in mental health co-curricular activities.

4.1.1 Previous curricular mental health integration

Rogan and Kinley expressed that, prior to the 2015 curriculum, in their HPE classes they identified the various mental illnesses as well as explored symptoms, treatments, and strategies one would use to support themselves if faced with a mental illness. Furthermore, since HPE was only mandatory for grade 9 students, it was important for the grade 9 and 10 students to access mental health education. The HPE teachers at ParkStone Secondary School address characteristics of well-being and resilience in grade 9. Rogan, from ParkStone, described his department’s teaching philosophy with these factors already in mind:
we really focus on supporting the students through their growth and development and to be in tune with their emotions, feelings, and thoughts. I’m a gym teacher so I want my students to move and get sweaty, but at the end of the day these are kids who are growing up and racing to become adults. We need to slow them down. We focus on how to adapt and react. You fall once, you try again. You fall twice, you try again. You fall a third time and you ask for help. We teach students how to problem solve, balance their emotions, and we try new things. Kids go through so much change you know? And so we teach them how to be resilient. We get rid of the elephant in the room and we always talk about mental health.

As explained above, the ParkStone Secondary School HPE department felt mental health to be an integral part of the grade 9 HPE curriculum. Additionally, Rogan described mental health as relevant for grade 9 students, mainly because children in grade 9 are transitioning from children to adults and therefore require mental health literacy skills. Previous research by DeSocio and Hootman (2004), Miguel-Hidalgo (2013), and Min, Lee and Lee (2013) found that mental illness often becomes prevalent during adolescence. Furthermore, the research found that preventative education among adolescents can help decrease the negative impacts mental health can have on school performance, peer relationships, participation in risky behaviour and can promote treatment seeking opportunities to maintain one’s health, supporting their justifying of incorporating mental health into the curriculum.

Secondly, Rogan explained that the ParkStone department previously integrated mental health and stigma units in the Grade 9 curriculum, prior to the 2015 curriculum change, in hope of students developing mental health literacy. To achieve mental health literacy Rogan stressed the importance of firstly “creating a working definition of mental health and then [exploring] and
[identifying] the factors of mental illness.” They used a YouTube clip and Pamphlet from Dr. Condra at Queen’s University, as well as the YouTube clip, Black Dog, which helped students define characteristics of mental health, mental illness, and the role stigma plays in both. This was congruent with the research by Pinfold and colleagues (Pinfold et al., 2003; Pinfold et al., 2005) which found that short videos can produce significant effects on student attitudes and beliefs towards mental illnesses; videos are also described as an integral resource for promoting mental health literacy by Jorm (2011).

In addition to grade 9 ParkStone students learning about mental health from HPE teachers, students reportedly received an interactive workshop from their school’s social worker. The social worker was a representative of many schools in the GTA and was only involved with ParkStone on certain days of the week. Rogan made it clear that students recognized him and said, “Hey that guy, I know that guy” and further developed an understanding of his role within the school community as well as gained an immediate resource. Rogan explained the department’s collaboration with the social worker and the Grade 9s HPE experience as follows:

no one told our department to collaborate with the school’s social worker or to add topics of mental health in our grade 9 curriculum, but you know we did it on the fly and it worked … We talk about substance use and abuse, eating disorders, relationships, which can all cycle back to mental health and mental illness, right? … so when the social worker came in students were listening … He did a great job of making it authentic and he didn’t single anyone out. He talked about strategies on how to be resilient, how to cope, and where to go for help … now that mental health is part of the curriculum, it’s finally catching up to our teachings and our student needs.
Based on the initiative ParkStone’s HPE department took to collaborate with the school’s social worker to promote student mental health literacy, Rogan felt comfortable with the new curricular expectations and successful in their implementation. Rogan also addressed that he was reassured that mental health was now being incorporated across all Ontario secondary schools. He also believes that it is almost impossible to ignore mental health and illness when talking about substance use and abuse, relationships etc. as often these can be influenced by the onset of mental illness.

Like ParkStone, Kinley reported that BlueBoard had previously integrated mental health within their school’s grade 9 and 10 HPE curricula through a culminating assignment. Kinley developed this assignment as the department head for the past few years, in which all HPE students were required to set up a station and collaborate in groups to build a mental health awareness symposium for the entire school during lunch. Many of the stations promoted awareness, shared coping mechanisms and supports, and addressed common misconceptions. This symposium runs every semester and all students and staff are welcomed to participate. Kinley described the assignment and results as followed:

it’s an inquiry type of assignment. We give little guidance and students never seem to fail … Students create posters, videos, kahoots, songs, they become so invested in learning about mental health … you know, it’s really effective having the students relay the information to their peers and that it’s not always coming from me. Its student based and relevant … and as teachers we assess their work and the delivery of the material. But what we really notice is the change of the school’s atmosphere. Students are responding to what they are seeing and hearing, which is new information, and it gives us educators
feedback as to what they are tracking and absorbing. And so, we really haven’t felt the impact of the curriculum because we’ve been on that track for a while now.

Through this response, Kinley described that for other schools the shift of curriculum was needed and beneficial for students. As a result of the culminating task, Kinley reminds us that students in grades 9 and 10 are interested and curious about mental health. Due the previous mental health assignment Kinley had incorporated, he felt the curriculum change as reasonable for his entire department and for students entering secondary school.

Although it was not a huge emphasis during Nicco’s interview, he mentioned that the school and administrative system prompted HPE teachers to further support and guide students who were at risk of experiencing mental health issues due to previously school incidents in which the entire school community was affected. Thus, Nicco felt that he was indifferent towards the curriculum shift based on the school’s previous commitment to addressing mental health across all grades and because this initiative then translated into his teaching practices through teacher-student conversations.

4.1.2 Previous co-curricular mental health integration

Additionally, LeeBram also previously integrated mental health awareness activities within the school. However, unlike ParkStone and BlueBoard it was not integrated into the formal curriculum but developed through staff and student lead co-curricular activities such as clubs for anxiety and stress, and through events and presentations. Unfortunately, LeeBram has experienced multiple student suicides, and therefore these activities and events were aimed to promote mental health literacy and reduce stigma within their community in hope of supporting students and staff. Nicco felt that these particular school activities and events helped with the
curriculum’s new mental health emphasis because the content was relevant to students’ experiences and the school’s culture.

Kinley also mentioned that BlueBoard promoted activities and events such as healthy eating clubs and the Specialist High Skills Major in Health and Wellness to promote healthy and active living, mental health literacy, and foster a sense of school community and interconnectedness. Aside from clubs, Rogan at ParkStone, and Nicco at LeeBram previously were largely involved with promoting national initiatives like Bell’s Let’s Talk Campaign and Stop the Stigma. Rogan described that “kids were texting, and re-tweeting. They made donations and it really brought the whole thing [mental health] home.” Interviewees explained that several students took advantage of the clubs, events, assignments, and the opportunity to learn and share some of the mental health obstacles they had faced, or began to share stories of other people’s experiences. National and international studies have shown that school-based educational workshops/events have been found to increase the effectiveness of mental health education, to further promote mental health literacy, and to encourage positive changes towards mental health (Pinfold et al. 2003; Pinfold et al. 2005).

Overall, it is fair to report that interviewees adapted to the curriculum change well since they were already being pro-active on integrating mental health into the HPE curriculum. Interviewee’s had a hard time commenting on the transition of the curriculum because it was already reflective in their teaching practices. It was also established that mental health was included based on interviewees feeling that it was an interest of students and a topic that students require. Additionally, interviewees suggested that the updated curriculum and emphasis on mental health was a positive addition to HPE.
4.2 Relationship Building

Rogan, Kinley, and Nicco each expressed the belief that teachers play a crucial role in the development of student mental health literacy through building strong teacher-student relationships. Interviewees agreed that teachers should not act superior towards students when trying to develop mental health literacy skills, and should remember to treat students as people first. After the suicide incidents at LeeBram, Nicco explained that

I always ask students “how was your weekend” and I take the time to listen … I try to make sure I do that for every student and every class. That’s my goal, for students to value our relationship and for them to want to come to my class and not skip it … I try to connect and communicate with the students, and show them I care and that they can trust me. I don’t belittle them, we are equals and we work together as a team. If they come to my class consistently late, I make sure to ask them how things are before lecturing them on tardiness. We are all human, and I like to show them that I make mistakes too.

Based on this statement, Nicco perceives that student-teacher relationships cannot be built without communication and care, and that students are more responsive when they feel comfortable within the class and are acknowledged as equals.

In addition, Kinley described the importance of teachers being a trusted adult for students when trying to promote student mental health literacy. Kinley described a particular situation:

This year I had a student come up to me after we had talked about a couple of the different mental illnesses and she was very up front with me in that she had a couple … when students open-up to me it indicates that they are learning … As a teacher, you begin to value student rapport … you want to be the trusted adult for them and help in any way
possible. In order to stop the stigma, students need to know that they are not going to be judged by you. I think developing that relationship is key.

When assessing students on mental health literacy, here Kinley suggests that when students share mental health stories, teachers can be reassured that they are gaining mental health literacy skills and reducing stigma. Additionally, if students do not feel trusted by their teachers, it can be difficult to incorporate topics about mental health as well as positively encourage mental health literacy skills.

All interviewees mentioned that it takes courage for students to talk about mental health amongst their peers. Previous literature has shown that many adolescents often conceal their difficulties due to elevated levels of self-consciousness as a result of being influenced by mental health stigma (Flett & Hewitt, 2013). Rogan expressed that when teaching mental health, you as the teacher sometimes must be the first to share mental health obstacles. It was suggested that when teachers model and share personal experiences about mental health, students are more likely to share and describe their classroom as a safe space, which aligns with existing research on the relationship between contact with people who have mental health problems and attitudes towards mental health and stigma (Corrigan & O’Shaughnessy, 2007; Couture & Penn, 2003; Rickwood et al., 2004). Rogan admitted that he felt comfortable and had a sense of preparedness when it came to developing student mental health literacy and promoting conversations within the class through his strategies of sharing his own personal experiences with mental health. Rogan expressed that his previous career as a professional lacrosse player was terminated through ignored concussion treatments which resulted into a severe coma and almost death. As a professional athlete Rogan was devastated by his regression in athletics where he had to re-learn how to walk. As a result, he experienced severe depression. Rogan elaborates:
sharing my history with the students comes naturally … All of a sudden I become a person to them and I’m no longer just the teacher. I show them that I’m not ashamed of my past. I learned, you know? As a kid my coach kept asking, ‘Can you play?’ And I’m thinking yea, meanwhile I can’t remember my dog’s name. So as a class we have an open discussion about my past, and without asking, [they] start sharing their own stories. Through this example, it shows that students can be more intrigued when teachers show a sense of vulnerability within the class, and once again demonstrate that they are equals among the class. Additionally, when teachers are vulnerable, students may be more inclined too as well. However, it is important to recognize that it is not a requirement for teachers to share personal mental health stories, or to have experienced something traumatic in order to be effective in developing student’s mental health literacy. Rogan has just shed some light as to what has successfully worked for him in terms of relationship building and promoting student mental health literacy.

All interviewees expressed the importance of building relationships with students due to the vast amount of time teachers have with them, which relates to findings from previous literature (Kelly, Jorm, & Wright, 2007; Wei, Kutcher, & Szumilas, 2011). Although there are principals, vice principals, guidance counsellors etc. Nicco perceives that the kids are most comfortable with me… but you know just because I teach mental health doesn’t mean they are going to come to me for that reason. They are going to come to me because I talk to them and connect with them … to me that is part of the development of positive mental health or at least maintaining it … I don’t have to say mental health, mental health every day because I’m already role modelling the skills by showing students the importance of human interaction, and that you are never alone.
Nicco believes that when teachers are actively and consistently checking in with students, their teacher-student relationships can strengthen. As a result, students who are struggling with mental health are more likely to approach teachers for guidance. Research has shown that when adolescents facilitate help-seeking behaviours they are demonstrating aspects of mental health literacy (Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013). Human interaction and communication can act as an easy segue for teachers to address aspects of the mental health literacy within their class.

Each interviewee described their school as highly academic and university-driven. It was expressed that; many students reportedly face anxiety and stress. At ParkStone the HPE department encouraged HPE teachers to offer students assistance inside and outside of the gym. Rogan explained that they are “trying to create a support net for these students, because you don’t want any of them falling through the cracks”. As a former science teacher, Rogan often assists students with their science homework to help minimize the pressure and stress students experience in other subject areas, teachers, and parents. This form of commitment to building teacher-student relationships is extra work for teachers, but it can sometimes help students who are experiencing anxiety or stress. There is no guarantee that this strategy will ensure students in developing mental health literacy, but in Rogan’s experience it has helped with relationship building and has positively influenced classroom discussions when trying to promote mental health literacy.

Based on Rogan, Nicco, and Kinley’s experiences teachers should model communication skills for students to adopt skills of mental health literacy, in hopes of promoting the likelihood of students seeking mental health information (Jorm, 2011). This can be an impossible task if students do not feel like they have a significant relationship with their teacher, and thus these
students more likely to not attend class. Participating in class is a huge contributing factor in developing mental health literacy in the eyes of all participants.

In sum, all teachers believed that building a strong student-teacher relationship as well as classroom environment positively contributed to student’s development of mental health literacy. Furthermore, I can report that teachers should first develop classroom/student’s relationships before integrating mental health topics, otherwise the content may be hard to deliver. It was suggested that through these conversations and development of relationships that students are practicing skills involved with mental health literacy.

4.3 Reducing Stigma

All interviewees expressed that stigma is still a barrier with regards to students learning mental health literacy in their schools. However, by promoting mental health literacy in the HPE curriculum, interviewees believed that stigma was slowly beginning to reduce because of students and staff speaking freely about mental health and mental illness. Kinley believes that stigma exists for teachers and students “who are not informed” and therefore having the goal of mental health literacy we can reach out to those people. Providing students and staff with factual information that challenges or disproves myths concerning mental illness has been found to decrease stigmatizing attitudes (Faulkner, Irving, Boak, & Adlaf, 2010; Hartman et al., 2013). Nicco at LeeBram also expressed the increase of professional development gatherings that focused on mental health in hopes of decreasing the stigma across all departments. It was suggested by Kinley, that more often it’s the older teachers who have a hard time understanding mental health and enable the stigma, while students are more willing to explore the topic before making a concrete judgement about it. Additionally, we should correct these views to ensure adolescents are not being influenced. This was also supported by previous literature by Corrigan

Furthermore, Rogan described some of the stigma questions and concerns he had addressed with his students in class as:

What is normal? What is stigma? And why don’t people talk about it? Why are people scared to say ‘I have to go to the psychologist?’ You and I can both say ‘I have to go to the dentist after school, but why do I get funny looks when I say I have to go to the psychologist?’

Rogan observed student’s breaking down the stigma. Students began to share stories about their uncles, their fathers, and began reflecting on how it has affected their own personal mental health journey in front of the class. Rogan explains “that’s a beautiful part of the whole process, when students understand that there are ways to cope and treat mental illnesses, and that’s part of mental health literacy, right?” These type of questions reportedly sparked lots of interesting discussions and conversations according to the teachers perception of the classrooms dynamics.

Many of the interviewees mentioned the importance of using appropriate language in hopes of reducing stigma. Kinley shared that

There will be stigma attached to certain words and terms that they hear … It’s our job to model appropriate language when we introduce mental health into the classroom. We teach students to address people first. For example, you don’t say the ‘down syndrome’, you would say a person with down syndrome. And so you use examples they already know, and you simply re-direct the lesson. We don’t say the ‘schizophrenic’ or ‘manic’, we say a person with schizophrenia or a person experiencing anxiety. … And so I have students using appropriate terminology and using words that they would have never used and I’m gaining insight as to what they are fully absorbing.
When students are use appropriate language, it demonstrates respect, helps reduce stigma, and according to Kinley it is part of his assessment when reflecting on students achieving mental health literacy. By focusing on the person first and illness second, Kinley believes that we can diminish the idea of people being viewed as different and/or abnormal.

Nicco also reported that students used inappropriate language casually in class, and described it to counteract the progress that has been made in terms of reducing mental health stigma. Nicco described one incident, saying that

I know they mean no harm by calling another kid ‘crazy’. But you still have to watch out for that language … I try to squash that language as best as possible at the beginning of each semester. I let them know that it is not tolerated in the class. It’s a non-negotiable and I don’t have many kids defy me after that.

Through this example, because of his students no longer being able to use inappropriate language in his class, Nicco feels that his students no longer felt the need to communicate in such a way and therefore it was perceived that students understood the use of appropriate language when it comes to mental health and illness. However, Corrigan et al. (2012) found that taking a reactive approach in trying to reduce stigma can be ineffective and further have a rebound effect and cause an increase of prejudice.

Also, interviewees agreed that ensuring students have accessible supports was a critical factor in trying to reduce the stigma. As Rogan stated,

I want all my kids coming to class, but you know often it’s the kid who isn’t coming to class who is probably struggling with a divorce, a break-up, a mental illness and that’s the hard part. Because if they don’t come to class, it’s hard for them to learn about all the supports we have. Instead they feel alone and everything just gets worse.
In this example, it is suggested that the classroom can be a powerful venue to help students gain information on supports/resources, which can be extremely beneficial for students who are experiencing mental illness. Interviewees expressed the importance of teachers taking the time to talk about the supports within the school community, as well as outside. Rogan mentioned that students are encouraged to talk with the school’s social worker and to use the kids-help line. Rogan enjoys telling the students about the advances of the help line, through which children are now able to log into help chatrooms. Kinley also mentioned that the school community plays a large role in providing students with stress-managing supports. Therefore, teachers who believe and therefore provide students with immediate resources are more likely to have students who are more responsive in tracking their own mental health as a result of knowing where to seek for help. This echoed findings from previous research, by Bowers and colleagues (2013) in which participants completed a survey/interview, in which found that a greater portion of young people compared to service providers reported stigma as the largest barrier to accessing mental health services (p. 1). Moreover, it was found that it is important that young people get involved in mental health initiatives, such as teachers providing students with helpline numbers, and the resources within their school/community (Bowers, Manion, Papadopoulos, & Gauvreau, 2013, p. 5).

However, although the school can act as a great venue for students dealing with mental illness, Nicco cautioned that “when a student approaches me about mental health I always ask ‘are you currently getting support and does your family know?’ … I’m not a doctor so I have to know when and where I should refer.” After the LeeBrams school suicide incidents relate by Nicco, the school communicated the importance of referring people as well as advertised all the supports and resources the school community had to offer. Schools that lack resources of support
face extreme challenges that lead to higher student dropout rates, especially for those who are struggling with mental health (McEwan, Waddell & Barker, 2007; Saluja et al., 2004).

Thus, the interviewees expressed stigma to be a barrier when introducing mental health concepts into their class. However, the interviewees expressed that they believed and perceived a reduction of stigma present in their classroom as a result of helping students develop mental health literacy through exposing students to the resources and supports in their communities.

4.4 Lack of Resources and Direction

Each interviewee expressed concern that there is a lack of direction and inadequate resources for implementing the 2015 curriculum. Interviewees felt that the approach of the updated curriculum was up to the HPE department themselves in context of their school. All interviewees report meeting with their HPE department and planned the year accordingly. Rogan even felt that the Ministry of Education wanted to see how the different departments managed the new curriculum before giving additional resources aside from the curriculum document itself. All interviewees had mentioned they are waiting for the Ontario Health and Physical Education Association (OPHEA) to come out with supports, but there were not received going into the first year of implementation.

Although the curriculum has placed a major emphasis on mental health in the grade 9 and 10 units, interviewees reported receiving no resources on how to teach the material. Kinley stated that

I’m using the curriculum document itself … as a basis for conceptualized knowledge and then I’m investigating and inquiring on top of it … but we are really on our own for the most part right now because everything is new … we have to fill in the blanks whereas other curricul[a’s] will specifically tell you what to do … so we have to beg, borrow, and
steal … When it comes to a new curriculum it’s usually a 3-year process … and now I’m doing some projects and creating some resources … I think [the OPHEA document] will be a huge stress relief on some classrooms for teachers right now.

Kinley perceives that HPE teachers are having to do additional work and research in hope of delivering the curriculum accurately. Since the curriculum is new it may take some time for teachers to fully achieve all of its expectations and will further require specific resources instructed on how to best teach the curriculum.

Based on their own previous integration of mental health as explored in the first theme section, interviewees reported feeling confident in guiding the material, but still wanted to gain resources from the board during this monumental change in curriculum. Over the past few years the goal of student mental health literacy had moved up on the priority list of education which is why ParkStone and BlueBoard started to address it on their own. However, Rogan was particularly concerned about how other schools would cope with the inadequate direction and resources provided as a result of the new HPE curriculum:

my department head really stressed the benefit of adding mental health before the curriculum change. He got a sense of the mental health push over the years … But the rumor is that some schools are opting to do partial mental health or no mental health … which is kind of sad and a lot of it comes back to the Board not giving enough resources, or overloading us with resources, and giving no solutions on how to teach this stuff … Teachers are gonna do what they want to do. It’s a lot of work, especially if they have no resources to pull from or help from their department. So I guess some teachers will ignore the changed curriculum until they are given more guidance.

Rogan perceived that promoting student mental health literacy is extremely hard when there is no
foundation. Rogan suggested that schools and teachers may lack the ability in successfully teaching mental health, which aligns with previous findings in which teachers were surveyed and reported lack of knowledge and preparedness when implementing mental health and supporting those with mental health needs, as well as felt it was the school psychologist’s role to teach social emotional lessons rather than themselves (e.g., Reinke et al., 2011).

In sum, the interviewees believe that the Ministry gave inadequate guidance, curricular resources and documents, specific directions on implementation and therefore it served as a barrier across students consistently achieving mental health literacy among Ontario secondary schools.

4.5 Structural Constraints

Structural constraints were reportedly faced by all interviewees as obstacles when implementing and promoting student mental health literacy. Some of the obstacles shared were time, large class sizes, access to classrooms, and finding a balance in how the curriculum should be delivered. Speaking to all of these constraints, Kinley stated that

Time is a huge factor. Especially when we when get to mental health. It’s a big piece and sometimes you have a class of 30. And so it takes a lot of time and you don’t want to rush some of those heavy discussions. And the kids are sometimes nervous to speak up in class, so you want to take you time in hopes that they’ll feel comfortable asking those burning questions. And so sometimes I think our teaching is compromised, especially if we can’t get scheduled into the health room and were forced to teach on the bleachers. In those instances, you cross your fingers and hope all 30 were paying attention. It’s just too much.
Furthermore, it is apparent that quite possible that the goal of all students achieving mental health literacy by the end of grade 9 is unrealistic when classes are so large, and when there is no appropriate place for teachers to address these discussions. Nicco and Rogan also expressed that they do not have a lot of time in the health room to cover all the topics due to scheduled classroom times and lack of space. Rogan further explained how

We have approximately eight units to cover in health, and that includes mental health, right? But how do we do that if we have the exact same amount of time in the health room? … So what are teachers chopping out? Or are we doing it super-fast? … And so you have to find a balance between all the topics so you aren’t going from healthy relationships, to suicide prevention without talking about mental health first.

Rogan suggests that teachers must plan their lessons accordingly to ensure that all students are readily able to absorb the following information presented. It was also suggested that teachers have to select the topics to cover, which can be a challenging task when the curriculum is very integrated. Planning requires additional work, and teachers must be flexible and creative when they do not have access to a classroom and still are required to teach mental health.

Furthermore, all interviewees stressed that their school was very fast-paced, highly academic and competitive, and that many students cannot afford to take HPE courses past Grade 9, due to mandatory credits they need to acquire in order to apply to universities. Nicco suggested the benefit of making HPE mandatory from grades 9-12 in order for students to fully achieve the goal mental health literacy. It is therefore suggested that students are probably not achieving mental health literacy by the end of grade 9 due to the vast amount of topics to cover. It may be more plausible if students are mandated to enroll in HPE courses throughout their secondary school education.
4.6 Conclusion

Through the analysis process, five main themes emerged. The most important factor influencing teachers experience with the new 2015 curriculum was their previous experience and initiative towards integrating mental health within their curriculum, or through non-curricular activities. This was supported by teacher’s belief in mental health being an integral and relevant component of secondary student’s education. Moreover, these particular teachers were prepared for a curriculum change, and were able to reuse previous lessons and assignments. While the implementation of the new curriculum is relatively new, it seems as though these teachers are relatively comfortable with the change and therefore eager to share their strategies in promoting mental health literacy among secondary students.

Secondly, I found that teachers stressed the important of building student-teacher relationships in order to successfully get students involved in the curricular emphasis of mental health. By modeling characteristics of proper communication and care, teachers were reportedly able to strengthen teacher-student relationships. As a result, teachers believed that students were more likely to participate in class if relationships were strong, and therefore develop factors that contributed towards the development of their mental health literacy. In being a trusted adult, it was suggested that students who are experiencing mental health issues would be more likely be inclined to share, and seek second-hand additional supports. Teachers perceived that by building strong relationships it allowed students to further deepen discussions on mental health topics.

Thirdly, I found that teachers believe that stigma was still a barrier among students and staff. However, through the implementation of mental health literacy, they also believe that stigma was slowly reducing. Some of the obstacles mentioned were inappropriate language among students, lack of knowledge with regards to the school communities supports and
resources, and addressing all common misconceptions about mental health in a factual way to students and staff.

Next, all interviewees shared that many of their colleagues, including themselves at times, felt misguided and lacked the resources to adequately achieve the new curriculum expectations and emphasis on mental health. Although the participants felt confident in the delivery of the material, many were concerned about how other schools were addressing the new curriculum or if they even were. Inadequate resources left interviewees and their departments deciding whether or not to incorporate all aspects of the new curriculum. Not only is there a problem with teachers who are not including mental health throughout the HPE curriculum, but for the teachers who are, how can we ensure meaningful activities are regularly being used to promote student mental health literacy within the class?

Lastly, I found that these teachers are reportedly faced with structural constraints when addressing the new curriculum. Lack of time, large class sizes, and inadequate classrooms became a recurring and common theme. Although these teachers were reportedly successful in starting to develop student’s mental health literacy, it was apparent that the goal of achieving mental health literacy, with only a short amount of time can be somewhat unrealistic. Teachers felt that it might be attainable if students were enrolled in HPE courses throughout their secondary education.

Overall, my findings suggest that Ontario intermediate HPE teachers are somewhat readily experiencing and reportedly delivering the new mental health content emphasized in the new 2015 HPE curriculum. I have interviewed three teachers who have pro-actively addressed mental health concepts to their grade 9 and 10 students prior to the curricular update, as their departments believed in the importance of mental health integration. With that being said, the
interviewees had indicated that a curriculum update takes time, and they continue to update their teachings and co-plan with their department their grasp on the curriculum and achievement of student mental health literacy will improve. Since, all participants were passionate about mental health, pro-active in their teaching methods, it would be interesting to further research teachers who may have felt overwhelmed by the curriculum and how they managed to re-wire their pedagogy in HPE, as participants still shared concerns about supports, guidance etc.

Next in Chapter 5 I discuss broad implications for the educational community and narrow implications for my professional identity and practice based on findings previously stated. Next I give recommendations and note potential areas of further research.
Chapter 5: Conclusion

5.0 Introduction to the Chapter

This chapter concludes the present study on how Ontario intermediate HPE teachers are experiencing and reportedly delivering the new mental health content in the 2015 HPE curriculum. First, I provide an overview of the key findings and their significance according to previous literature. This is followed by a discussion on the broad and narrow implications that effect the educational community as well as my own personal identity and practice. I then offer recommendations based on the previously stated implications, which ultimately help to explore further research areas. Finally, I bring this entire research study to a close.

5.1 Overview of Key Findings and their Significance

The purpose of this research was to explore the experiences of the first wave of Ontario secondary HPE teachers who implemented the new 2015 HPE curriculum in the 2015-2016 school year, and who are therefore required to teach and support the development of student mental health literacy. Overall, after interviewing Rogan, Kinley and Nicco, the key findings were categorized into five emerging themes, which indicated that participants were actively investing and integrating the new curriculum and its focus on mental health. Teachers were reportedly addressing characteristics of mental health literacy explicitly and implicitly towards their students. However, teachers still addressed common barriers. The five main themes presented when delivering the new curriculum were teacher’s previous experience and initiative towards integrating mental health within their school’s curriculum or non-curricular activities, the value they emphasized on building strong teacher-student relationships within their classes, educating students towards a stigma-free environment, and lastly teachers felt they had
inadequate guidance from the Ontario Ministry of Education as well as faced structural constraints when trying to promote student mental health literacy.

Moreover, because Kinley, Rogan, and Nicco, had previously integrated mental health within their curriculum and throughout their school, they felt comfortable in delivering the new curriculum’s content on mental health. Mental health was reportedly integrated within these schools, because their school community agreed that the content was relevant to secondary students’ education, especially during grade 9 where they are transitioning from elementary school and approaching adolescence. This aligns with research ON WHAT? as it showed that during adolescence, at approximately 14 years of age, the body undergoes extreme hormonal, neural, and behavioural changes in which the brain is more susceptible to psychological and neurological changes that may onset mental illnesses (Miguel-Hidalgo, 2013).

Additionally, participants’ previous knowledge of and exposure to lesson, activity, and assignment design, allowed participants to lead discussions that were congruent with the mental health curriculum expectations of promoting mental health literacy. The co-curricular and curricular mental health initiatives ParkStone, LeeBram, and BlueBoard implemented support recent literature, suggesting that the promotion of mental health literacy through education and contact are effective ways in reducing stigmatizing attitudes (Hartman et al., 2013). As mental health continues to increase in Canada, and is expected to double by 2020 (Flett & Hewitt, 2013), schools and teachers should begin to understand and justify the need and importance of mental health education within the adolescent community. All participants perceived success in breaking down the stigma within their classes when promoting mental health literacy. Research has shown that providing students with factual information on mental health, challenges and disproves misconceptions, and simultaneously decreases stigmatizing attitudes more effectively
(Faulkner, Irving, Boak, & Adlaf, 2010; Hartman et al., 2013). More specifically, Rogan and Kinely claim that when they implemented mental health literacy in grade 9 they perceived reduced amounts of stigma within their school. This was consistent with previous findings in literature on school-based mental health programs, as instructed by Pinfold and colleagues (2003; 2005). Pinfold (2003; 2005) found that even short videos and educational workshops can produce significant effects on student’s attitudes towards mental health and illness, suggesting that ParkStone and BlueBoard’s efforts in designing symposiums, seminars, and workshops are effective ways in promoting mental health literacy and reducing stigmatizing attitudes. The perceived decrease in stigma and increase in help seeking opportunities observed by all participants, was justified by participant’s ability to share personal information in hopes of developing stronger student-teacher relationships. Moreover, this aligns with existing research by Hartman and colleagues (2010), Ke and colleagues (2015), and Rickwood and colleagues (2005). School-based educational workshops have found contact [approaches] to increase mental health literacy, and produce lasting changes in attitudes of youth towards mental illness (Hartman et al., 2013), and when combined with educational approaches that include video-based contact with persons who have mental illness these stigmatizing attitudes drastically reduce (Ke et al., 2015). The inclusion of contact approaches in school-based mental health curriculum appears to be a promising strategy for the promotion of mental health literacy, and decrease of stigma. As ParkStone, LeeBram, and BlueBoard continue to promote mental health literacy through the updated curriculum, their experiences and delivery of instruction is supported by existing research. Although contact is still an effective way of teaching, educational approaches are supported as well. Mainly because research suggests that adolescent’s beliefs about mental
illness are not firmly developed compared to most adults, and therefore curriculum may influence students positively (Corrigan et al., 2012).

During the first year of implementation of the new HPE curriculum, teachers felt that more supports and guidance from the ministry would have been appreciated in helping them successfully address the new curricular expectations on mental health. However, because the curriculum covers many topics, teachers had to plan effectively and try to balance all the topics cohesively for students. It was apparent that mental health initiatives were most successful when the department and school valued mental health. Without a strong support system, it would be extremely hard for HPE teachers to teach especially when little guidance and resources were given on how to implement the new curriculum. Rogan was particularly concerned with other schools not addressing the new mental health curriculum and felt some would regard it as a proposed guideline rather than mandatory policy. Research has agreed, and shown that curriculum is unlikely to be implemented in the absence of a highly interactive infrastructure of pressure and supports (Ha, Lee, Chan, & Sum, 2004).

Teachers also expressed structural constraints that inhibited student’s ability to achieve mental health literacy, such as time, class sizes, classroom availability etc. Participants felt that the goal of student mental health literacy might be more realistic if students were mandated into taking HPE courses throughout their secondary education, and therefore expected to practice, further understand, and achieve life-long skills of mental health literacy over an extended period.

5.2 Implications

This section discusses the implications that emerged through answering the interview questions guided by the fundamental research question of this study. First, I begin by outlining the broad implications of my findings as they relate to the educational community. Secondly, I
begin to outline the narrow implications that affect my own professional identity and practice.
The implications discussed further begin to suggest recommendations that will appear in the next
section.

5.2.1 Broad: The educational community

Through the analysis of research findings and the previous research discussed in this study, a variety of broad implications have been suggested, which reinforce ideas and practices that should be encouraged within the HPE community and their duty to promote the new 2015 HPE curriculum.

Firstly, some teachers may feel that prior to the 2015 HPE curriculum update, there were not enough teacher educational programs, resources, guidelines, supports etc. to prepare current teachers who were expected to update their teacher practices away from the 1999 curriculum, for the 2015-2016 school-year. As previously found, all participants had been incorporating mental health topics within their HPE pedagogy and throughout their school community, and have been therefore practicing the implementation and promotion of student mental health literacy prior to the curriculum change. Research suggests that some teachers may fail to teach according to the changed curriculum as a result of not being entirely convinced of the initiative (Scholtz et al. 2004). Although these participants were confident in addressing the new mental health curricular expectations, they still faced obstacles in which resources were not readily available when planning the year with department colleagues. As a result, it is apparent that without standard resources and supports given to teachers prior to planning the implementation of the new curriculum, that the content on mental health may not have been fully delivered to the first wave of Ontario secondary students. Teachers were expected to re-plan lessons, activities, presentations, without the ability to pull from standard resources, in which they had to seek
supports themselves. Research suggests that to promote mental health literacy, the school community must have skilled and trained teachers in mental health (Wei & Kutcher, 2011), and that providing teachers with resources and training on how to foster mental health literacy during their usual teaching activities can help improve the knowledge and attitudes of both teacher and student on mental health (Mcluckie, Kutcher, Wei, & Weaver, 2014).

Secondly, school administrative systems might not recognize the challenges and pressures HPE teachers face when trying to promote mental health literacy to large classes without access to classrooms, as well as lack of funding. Rogan had allowed outside mental health services to come into the classroom and educate his students on a deeper level. Having service workers, community members, etc. requires extra funding for the HPE department, as well as requires them to have a space in which they can lead presentations outside of the gymnasium. Research has found that a classroom-based presentation which incorporates contact with a mental health service recipient can produce significant reductions in self-stigma, reduced social distance and improved students comfort level around people with mental health concerns (Hartman, Michael, Winter, Young, & Flett, 2013, p. 39). Moreover, these are all characteristics of developing mental health literacy in students. It is also a way to reach out to students who often hide their experiences with mental health. Research suggests that contact is most effective when it involves mental health service recipients sharing with their personal experiences with their illness to others, and demonstrating their success in treatment (Corrigan & O’Shaughnessy).

Lastly, some students may not be achieving mental health literacy by the end of grade 9. The barriers that manifest in HPE can impact student’s perspectives on mental health and can lead to an unhealthy lifestyle if ever faced with a mental health concern. Some of the barriers are not mentioned in the literature, as the new curriculum of promoting mental health has just been
implemented. Teachers made it apparent that although students are gaining insight on mental health, it is perceived that students are not fully able to grasp all the content in such a short amount of time. Moreover, there are some barriers at the curriculum level. Many students do not have time in their schedule to enroll in HPE courses past grade 9. Students who want to take HPE courses, or students who would benefit from them are prevented from doing so due to university and colleges requiring specific courses.

5.2.2 Narrow: Professional identity and practice

As a future teacher, I am now more aware of the barriers that teachers may face when implementing the new mental health emphasis of the HPE curriculum. I am conscious that the topic is relevant to intermediate students, and that mental health literacy is an integral part of the Grade 9 HPE curriculum. Firstly, I recognize that I can plan lessons and activities that allow for multiple opportunities for students to gain insight on mental health, promote an inclusive classroom environment in which students can share experiences and feel comfortable in seeking supports/treatment, as these are all characteristics of becoming mental health literate. Some students may be experiencing mental health issues or may be helping a family member or friend. Thus, I am more reflective and understanding of situations and realize the importance of delivering the mental health emphasis via education and contact approaches, as explored in previous literature. Because mental health literacy is characterized of mental health promotion, prevention, early detection, and intervention (Whitley, Smith, & Vaillancourt, 2013), I plan on using curriculum as an educational tool, and seek members of the community to come in and speak to students about mental health. I plan on bringing community members in to show student’s that resources can also extend away from the school community and are readily
available to them 24/7. With that being said, I also plan to integrate the mental health curriculum throughout the year, in which students can practice how to monitor their own mental health.

Secondly, I plan on working with colleagues of the HPE department and other school professionals to share successful strategies when promoting and teaching student mental health literacy. The curriculum is still new and therefore feedback is necessary for teachers to implement the mental health emphasis accordingly, and to further improve the delivery of the new 2015 HPE curriculum year after year.

5.3 Recommendations

Teachers can create yearly, monthly, and weekly meetings for planning the HPE curriculum and its emphasis on mental health within their department, and further share with other school communities. Moreover, they can exchange activities, lessons, workshops, collaborate classrooms and seek strategies that have been successful when addressing the mental health content, and where teachers have perceived student’s development of mental health literacy. Additionally, teachers can share experiences that were unsuccessful and work together to see where improvements can be made. Planning should be collaborated, and after each year lessons should be reviewed to further benefit the next year of HPE students.

School administrative workers can consider offering teachers more opportunities to seek professional development, which focuses on implementing mental health within the new HPE curriculum. Strong administrative staff can help ensure that curriculum is being implemented, and can help motivate teachers during the shifting curriculum. Additionally, their support will help student’s development of mental health literacy. The school administrative team can also advertise their HPE program to new students, and promote that the course will help students foster mental health literacy skills that they can use for life, in hopes of more students
participating in HPE courses passed grade 9. Ultimately, some schools can mandate that all students must take HPE courses throughout their 4 years of secondary education. Administration can also provide more funding for the HPE department, which should positively influence the entire school community and all of its subjects if students are successfully able to monitor/understand their own mental health, the mental health of others, and seek further supports.

Lastly, policy makers within the Ministry of Education can consider implementing smaller classroom sizes, especially in the mandatory grade 9 HPE course. This will help teachers develop a more focused and intimate class when expected to teach the physical education curriculum, along with the new health and mental health focus recently added. HPE teachers have the same amount of time to teach all the content within the semester, and therefore over filled classes may require more attention to classroom management and building student-teacher rapports. Additionally, teachers may not have enough time to conduct in depth conversations and activities about mental health, in which students will not be achieving the goal of mental health literacy.

5.4 Areas for Further Research

This study focused on Ontario secondary teachers who first experienced and delivered the mental health emphasis of the new 2015 HPE curriculum. For future studies, it would be beneficial to research successful strategies and resources teacher had used after the first year of implementation, and underline ways in which teacher were unsuccessful when implementing mental health. Furthermore, research can help improve teaching within the HPE department, specific to students gaining skills of mental health literacy, and how to authentically assess these skills throughout the year. Additionally, research should also consider student’s perspectives of
the mental health content, and how it has helped the promotion, prevention, and intervention of the students within the school community.

After concluding this study, I still wonder how teachers effectively design pedagogical strategies to assess students understanding and development of mental health literacy through the implementation of the new HPE curriculum. Studies on school-based strategies aimed to increase student’s mental health literacy and integrate it within curriculum are still relatively new (Wei et al., 2013). According to Lindley et al. (2012) there has been a tendency for teachers to overlook the importance of the pedagogical structure of anti-stigma education, and while educators may share the objective of integrating mental health literacy into their schools, research has not yet made substantial progress in establishing a consensus on the most effective strategies required towards incorporating mental health education into the school curriculum. According to Ontario secondary teachers it would be beneficial to research the common pedagogical strategies used throughout the first few years of implementation and which strategies have been most successful and unsuccessful.

5.5 Concluding Comments

As Ontario teachers, we have the role of supporting all students in their journey toward success. More specifically HPE secondary teachers must now strive to support students through the expectations of the new 2015 HPE curriculum, which focuses a great deal on student’s ability to gain mental health literacy. This research is specific to the teachers who have first handily delivered the new HPE curriculum, and for teachers who are continuing to improve their practices on delivering the mental health content. It is my hope that teachers can relate and learn from my research literature, and reflect on some of the participant’s experiences with the new HPE curriculum. Mental illness continues to increase, and therefore the school community can
become a great venue to educate, promote, prevent, support, and create a society that understands the implications of mental illness and the maintenance required to maintain mental health.

Although I have not been diagnosed with a mental illness, maintaining my mental health was an integral part of experiencing and successfully completing my secondary and post-secondary education. Through my time at OISE, and with my HPE background, it became apparent that I wanted to explore the new curriculum and its emphasis towards mental health, in hopes of inspiring teachers, and to further understand my own future pedagogical strategies to create an environment where student mental health is valued and supported through the development of mental health literacy. The transition of the 1999 to 2015 HPE curriculum has made exceptional head way in the HPE community, in terms of positively supporting students, and it is my hope that researchers will continue to provide more insight as to how HPE teachers can improve and provide a more meaningful experience for secondary students and their mental health.
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Appendices

Appendix A: Letter of Consent for Interview

Date:

Dear Participant,

My name is Shannon DeGroot and I am a student in the Master of Teaching (MT) program at the Ontario Institute for Studies in Education at the University of Toronto (OISE/UT). A component of this degree program involves conducting a small-scale qualitative research study. My research will focus on teachers’ experiences of implementing the new 2015 Ontario Health and Physical Education curriculum, particular its emphasis on mental health. I think that your knowledge and experience will provide insights into this topic.

Your participation in this research will involve one roughly 60 minute interview, which will be transcribed and audio-recorded. I would be grateful if you would allow me to interview you at a place and time convenient for you, outside of school time. The contents of this interview will be used for my research project, which will include a final paper and informal presentations to my classmates. I may also present my research findings via conference presentations and/or through publication. You will be assigned a pseudonym to maintain your anonymity and I will not use your name or any other content that might identify you in my written work, oral presentations, or publications. This information will remain confidential. Any information that identifies your school or students will also be excluded.

The interview data will be stored on my password-protected computer and the only person who will have access to the research data will be my course instructor. You are free to change your mind about your participation at any time, and to withdraw even after you have consented to participate. You may also choose to decline to answer any specific question during the interview. I will destroy the audio recording after the paper has been presented and/or published, which may take up to a maximum of five years after the data has been collected. There are no known risks to participation.

Please sign this consent form, if you agree to be interviewed. The second copy is for your records. I am very grateful for your participation.

Sincerely,
Shannon DeGroot
Consent Form

I acknowledge that the topic of this interview has been explained to me and that any questions that I have asked have been answered to my satisfaction. I understand that I can withdraw from this research study at any time without penalty.

I have read the letter provided to me by Shannon DeGroot and agree to participate in an interview for the purposes described. I agree to have the interview audio-recorded.

Signature: ______________________________________

Name: (printed) ______________________________

Date: ______________________________________
Appendix B: Interview Protocol/Questions

Thank you for agreeing to participate in this research study, and for making time to be interviewed today. This study aims to explore how secondary Health and Physical Education teachers are experiencing the new 2015 Health and Physical Education Curriculum, particularly its new emphasis on mental health. This interview will last approximately 60 minutes and consists of approximately 22 questions. This interview protocol has been divided into 5 sections, beginning with your background information, your teacher perspectives and beliefs, teacher practices, supports and challenges, and lastly your next future steps. I want to remind you that you may refrain from answering any question, and you have the right to withdraw your participation from the study at any time. As I explained in the consent letter, this interview will be audio-recorded. Do you have any questions before we begin?

Section A: Background Information

1. What is your teaching philosophy and how do you implement it into your lessons?

2. a) What grades do you currently teach?
   b) Which grades have you previously taught?

3. In addition to your role as a HPE teacher, do you have any other roles within the school? (i.e. coach, advise a club, tutor etc.)

4. a) How long have you taught at this school?
   b) Can you describe the school’s emphasis and importance it puts on HPE programs?

5. Can you tell me about the school culture you are currently teaching in?

6. a) Can you describe your school’s climate in terms of mental health? (Culture, environment, atmosphere, etc.)
   b) To what extent would you say mental health and illness are stigmatized there? (Under diagnosed, misunderstood, lack of recognition etc.)
   c) Why do you think this is the case?
   d) Can you tell me of a specific time in which the school intentionally sought to raise awareness of mental health?

Prompts: (i.e. Bell lets Talk, School Tragedy, News etc.)
Has the school ever come together for an assembly about mental health, or made an announcement for the entire school to raise awareness?

Possible Prompts: If so, how did…
  i) the entire school react
  ii) students’ respond
  iii) teachers’ respond
  iv) colleagues respond
  v) it help HPE curriculum
  vi) parents’ respond

8.  a) Can you tell me about a time when your students showed particular interest in mental health in your classes?

b) From experience, and through the implementation of the new curriculum, how has their interest changed from previous years?

9.  a) Do you have any training or personal experiences relevant to mental health that you wouldn’t mind sharing?

b) If so, how does it support your teaching philosophy and students?

Section B: Teacher Perspectives and Beliefs

10. a) Can you describe your initial response to the changes in the HPE curriculum?

b) How did your department initially react to the changes? What did you do?

c) Do you feel that the curriculum was in need of a change? Why/not?

Prompts:
Curriculum Change: 1999 curriculum compared to the 2015 curriculum

11. A significant change in the curriculum is its strong emphasis on mental health. Can you give me your own definition of mental health literacy?

Prompts:
Mental Health (2015 Curriculum): More than just the absence of mental illness, but the well being of a person.
Literacy:
  i) Life long learning
  ii) Complete clear understanding

12. a) In your experience, attitudes and behaviours are indicators of your students becoming mental health literate? In other words, what does ‘mental health literacy’ look like in students?
b) What does its ‘opposite’ look like?

c) Do you feel as though your students understand mental health, and portray skills related to mental health literacy?

13. Can you tell me of a specific time this past year when you saw a student demonstrate mental health literacy in your classroom?

Possible Prompts: What behaviours had you observed? How did you interpret their behaviour? What did their actions look like? Did behaviours or actions change?

Section C: Teacher Practices/Experiences

13. a) Can you describe some of the topics you have covered in your HPE classes with regards to mental health?

b) Can you tell me of a specific time where the students successfully grasped a topic on mental health?

Possible Prompts: Substance use and abuse, diet and nutrition, mental wellness etc.

c) Are there any challenges you face as a teacher, when implementing all the mental health topics?

Possible Prompts:
   i) Time
   ii) Students ability to understand
   iii) Curriculum resources

14. How do you assess and evaluate student learning based on the goal of students achieving life long skills regarding mental health?

Possible Prompts: assessment of learning, assessment as learning, assessment for learning etc. How do you track progress?

15. Can you tell me how you prepare to run activities within the HPE class, and what the ultimate learning goal for each HPE student?

Possible Prompts: What activities have you run? Did it influence student learning and/or their behaviour?

16. In addition to teaching the mental health strand, are there other ways in which you incorporate mental health into your practice?

Prompts: What is the ultimate goal of your class? What do you want students to take away from each lesson? How does it improve student mental health literacy?
17. In your experience, what are students’ responses to the new curriculum?

Section D: Supports and Challenges

18. a) What kinds of supports and resources are available to you with regards to the implementation of the new curriculum and its emphasis on mental health?

b) What do you think about the supports and resources that are available?

19. a) What challenges and barriers do you continue to face in the classroom when addressing mental health?

b) What do you think needs to be done to manage these challenges and barriers?

20. a) Can you tell me of a specific experience you had where you had a hard time implementing the new curriculum?

Prompts: Why was it challenging? What did you find was missing from the curricula? Have you ever been offered resources to provide support for teaching mental health?

b) How did you manage this obstacle?

Prompt: Did you use resources? Were you able to gain support from other colleagues? If not, what are you looking to improve for the next time you teach?

Section E: Next Steps

21. As a future HPE educator, what advice do you have for me entering the profession?

22. Do you have any final thoughts?

Thank you for your participation and time in this research study.