IMPROVING IMPLEMENTATION OF
MENTAL HEALTH LITERACY
IN A
MIDDLE YEARS CLASSROOM

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ABSTRACT

The purpose of this practical action research study was to improve my implementation of mental health literacy to middle-years students by using an inquiry-based approach with the intention of understanding how to engage with and address relevant mental health concerns alongside my students. In addition, I hoped to learn about the needs of my own practice related to mental health literacy in order to address my perception of ever-increasing mental health issues arising in my classroom. Twenty participants, both male and female from my homeroom classroom, took part in the study. Data was collected using initial and exit interviews, exit slips, as well as formative and summative assessments along with other student artifacts. As I progressed through the phases of the action research cycle to explore my implementation of mental health literacy within a middle-years classroom, four themes arose from the data. The first theme explores the needs within my practice and examines my instructional practices and my professional decisions. The second theme highlights the considerations and responsibilities that arise when teaching the unique topic of mental health. The third theme focuses on understanding the specific needs and requirements of teaching mental health to middle-years students. The period of adolescence requires special consideration related to unpacking students’ learning needs around mental health. Finally, the fourth theme discusses the need for mental health literacy within the Saskatchewan Health curricula and recommends having explicit mental health outcomes spiraled into the curriculum beginning early in students’ education.
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DEDICATION

I would like to dedicate this work to the late Mrs. Shirley Sim Owens who believed in me more than I believed in myself. I did not expect to become an educator, but I think of you often as I teach. I hope to inspire and believe in students as you did. Thank you for your investment in my life.
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CHAPTER ONE – INTRODUCTION

1.1 Situating the Research

Over the last fifteen years as a middle-years teacher of grades seven and eight students, I was responsible for implementing eighty percent of the curricula from all subject areas with the exception of French. While there were many areas I could choose with which to improve my practice, upon examination of my practice, I decided I wanted to focus on an area that would also have a direct impact on my students. Therefore, I started to investigate areas where I felt I lacked confidence and understanding as well as where I saw a growing need for my students.

As I reflected on my student population, I realized that in the last five years, my associations and interactions with mental health issues in the classroom had increased a great deal. More than ever before, I had students affected by mental health themselves or within their close circles of family and friends. Within the last few years, I have had students face challenges related to anxiety, depression, self-harm, eating disorders, suicide attempts as well as hospital admissions for mental health. I am sure there are many more issues concerning mental health within the parameters of my teaching that were not known to me.

Consistent with the literature, mental health issues permeate the middle-years classroom in a way that they did not at the beginning of my career (Bowers, Manion, Papadopoulos & Gauvreau, 2013; Whitley, Smith & Vaillancourt, 2012). While students seem to be experiencing a greater increase in mental health issues, they seem to lack the awareness and education to identify and recognize proper mental health, disorders related
to mental health, and how or when to get support (Tully, Hawes, Doyle, Sawyer &
Dadds, 2019).

In reaction to my experiences with increased mental health concerns, I decided to
teach an isolated, teacher-directed unit on mental health as a stand-alone health unit. It
was prescriptive and teacher driven during which I disseminated information. Students
interacted as they would with any other topic, but I drove the content and determined how
and what we should learn. Despite my belief that there was a need for mental health
literacy, there was little student engagement. Upon conclusion of the unit, I realized that I
had decided what students needed to know, but I had no idea what their real needs were
regarding mental health or if those needs were addressed within the unit.

Additionally, when I taught the unit, I did not find a specific place in the grade 7
and 8 Saskatchewan Health Curricula (Saskatchewan Ministry of Education, 2009) that
addressed mental health. Despite my perceived need for mental health literacy, there was
not a clear directive to teachers to teach the content which seems so necessary for our
youth. This was concerning because while the Health curriculum has not changed since
2009, the needs of the students seem to be.

Over the last few years, it has become evident to me that there is a need to bring
mental health literacy into the curriculum. As an educator of early adolescents, I have an
opportunity to educate and impact youth around the topic of mental health; however,
finding a place in the curriculum and authentically engaging young people to affect
change concerning mental health remains problematic. I believed that studying my own
implementation of mental health literacy may benefit both my professional practice as
well as support valuable learning experiences for my students.
1.2 Statement of the Problem

As previously noted, I’ve experienced a rise in mental health concerns within my own classroom. Research indicates that currently one in five children and adolescents experience mental health issues with a predicted increase to one in two by 2020 (Bowers, Manion, Papadopoulos & Gauvreau, 2012; Whitley, Smith & Vaillancourt, 2012). According to the literature and in my professional experience, students who are facing mental health issues are unable to devote their full attention to academics and learning due to focus, attendance, and pressures related to mental health concerns (Powers, Bower, Webber & Martinson, 2011; Wei, Kutcher & Szumilas, 2011).

As an educator, I believe that I need to address current issues facing youth in my classroom. If mental issues in adolescents are increasing, then I believe I have a responsibility to provide education for youth related to this issue. Furthermore, if mental health issues hinder learning, then I cannot fulfil my job as an educator without recognizing and addressing the impediment of mental health issues. I believe that providing mental health literacy is necessary to address the ever-increasing mental health issues within our youth. Many scholars note that since adolescents spend a large portion of time in school, it only makes sense that school would be a place to provide mental health education (Cushon, Waldner, Scott, & Neudorf, 2016; Flett & Hewitt, 2013; Kutcher, Wei, McLuckie, & Bullock, 2013; Manion, Short, & Ferguson, 2013; Meldrum, Venn & Kutcher, 2009; Reinke, Stormont, Herman, Puri, & Goel, 2011; Whitley, Smith & Vaillancourt, 2012; Wei et al. 2011). Research literature indicates that attitudes about mental health develop early and that early adolescence is a necessary time to educate youth and introduce programming (Kutcher et al. 2013). In addition, embedding mental
Health literacy into regular programming may create deeper learning and reduce stigma (Wei, Kutcher & Szumilas, 2011).

Hartman, Michel, Winter, Young, Flett & Goldberg (2013) recommend implementing global mental health promotion and anti-stigma initiatives for three reasons. First, young people generally have poor knowledge of mental health issues and stereotypes, however stigmatizing attitudes are developed early. Second, the most serious mental illnesses often peak during late adolescence. Early recognition and intervention can lead to better outcomes. Third, most young people do not seek appropriate help. Intervention and education will assist with the stigma of mental health as well as increase awareness of where to seek professional help.

Despite the increase of mental health issues, mental health outcomes are not explicit within the grade seven and eight Saskatchewan curricula. To address this issue, I chose to incorporate inquiry-based learning (IBL). IBL encourages students to investigate outcomes from multiple content areas while exploring the topic of mental health. In addition, inquiry-based learning provides opportunities for students to explore areas of personal interest which allows teachers to see where interests and possible knowledge gaps lie within the topic of mental health. I do not want to make assumptions about what students need or want to know related to mental health. I want their learning to be authentic and meaningful so that I can improve engagement of mental health outcomes.

As I began my study, I was focused on improving my implementation of mental health literacy by using an inquiry-based approach with the intention of understanding how to engage with and address relevant mental health concerns alongside my students.
In addition, I hoped to learn about the needs of my own practice related to mental health literacy.

1.3 Research Questions

The following question as well as two sub-questions guided my research:

1. How can I improve my implementation of mental health literacy to middle years students?

   a) Where can mental health be incorporated into the curriculum?

   b) What do students know and want to know about mental health issues?

I believed that improving my implementation strategies related to the topic of mental health literacy by focusing on the needs and direction of the students would afford me the ability to understand how to create a safe, welcoming environment that would deal with relevant issues arising for students regarding their mental health. If I could improve my practice, I believed I could better meet the increasing mental health needs of the students I encountered on a daily basis.

1.4 Summary of Chapter One

This chapter discusses the parameters with which I recognized my need to implement and improve my teaching of mental health literacy to middle-years students. I recognized ever-increasing mental health issues within my homeroom classroom and yet a lack of teaching or learning surrounding that topic. I understood that my prior implementation of mental health literacy was ineffective, yet the topic remained relevant.
1.5 Overview of Thesis

In chapter one, I outline the questions and concerns I have related to myself and situated myself in the research. I included background information about my experiences with students and instruction related to mental health and described the need for research in this area.

In chapter two, I provide a literature review that focuses on mental health related to adolescents. The perspective is largely Canadian with a focus on the rising concern regarding mental health issues and youth. There is a focus on information about mental health related to the role of schools and the incorporation of mental health literacy. Additionally, it reviews literature related to Canadian Policy around mental health and includes discussion around Comprehensive School Health. The use of inquiry-based learning related to mental health is examined as well as some of the barriers to learning. Finally, the chapter ends with implications and recommendations for implementing mental health literacy with adolescents.

Chapter three discusses the practical action research methodology used within the study. It also outlines components of participant recruitment and describes the choices made concerning data collection and data analysis as well as the processes used.

Chapter four presents the data collected within the action research study which I refer to as the Holistic Action Cycle made up of the first three components of the action research cycle: planning, acting, developing. The chapter begins by addressing my research question including the two sub-questions. The rest of the chapter is a chronological discussion of the study which includes data from the planning stage, the acting stage which is made up of four mini-action cycles through to the developing stage.
of the action cycle which includes the post-data. In addition, at the end of each stage and mini-action cycle, I present a reflection of my thoughts from that section based on the data presented.

In chapter five, I discuss the analyzed data that was collected over the course of the study. Within the holistic action cycle, this chapter serves as the reflecting stage as it reflects on my findings and indicates implications and recommendations for my practice. I present my findings by deconstructing my research question into four themes. The chapter concludes with implications and recommendations for mental health literacy.
CHAPTER TWO – LITERATURE REVIEW

2.1 Introduction

The Mental Health Commission of Canada defines mental health as a “state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community” (2012, p.6). It is more than simply an absence of mental illness.

Increasingly, adolescents are affected by mental health issues as outlined in this review. As such, it is important to understand the mental health of students related to the role of the school. This review provides a largely Canadian perspective on mental health and schools highlighting the current state of mental health and adolescents including teachers’ perspectives and the role of the school. In addition, this chapter discusses Canadian mental health policy, a comprehensive school health model of approaching mental health as well as barriers, implications and recommendations for addressing adolescent mental health needs in Canada.

2.2 Mental Health of Children and Adolescents in Canada

In 2000, studies reported one in ten children and adolescents experienced mental health problems (Trussell, 2008). More recent research indicates that now one in five children and adolescents experience mental health issues with a predicted increase to one in two by 2020 (Bowers, Manion, Papadopoulos & Gauvreau, 2013; Whitley, Smith & Vaillancourt, 2013). Mental health disorders are common in young people and make up one-third of the global disease issues related to adolescents (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005; Kutcher, Wei, McLuckie & Bullock, 2013). Manion, Short and Ferguson (2013) indicate that the majority of mental health disorders develop
in childhood with 50% originating before the age of 14 and 75% by the age of 24. Tully, Hawes, Doyle, Sawyer and Dadds (2019) concur with this finding and indicate that intervening in childhood is critical to prevent chronic pathways of mental health disorders.

In addition, research indicates that most children needing interventions do not receive them. Only one in five of those needing treatment actually receive it (Flett & Hewitt, 2013; Wei, Kutcher, & Szumilas, 2011). These statistics point to the increase in occurrence of mental health conditions in adolescents as well as the need to address intervention and promotion of mental health at an early age. The mental health needs of children and adolescents in Canada are not being met (Flett & Hewitt, 2013; Mental Health Commission of Canada, 2012).

2.3 Early adolescence and mental health studies

Most research regarding mental health revolves around older adolescents. Early adolescence has received far less attention despite the fact that this period of life is a critical time for physical, cognitive, emotional and social development as well as development of beliefs and attitudes (Chandra & Minkovitz, 2007). Younger adolescents are at a stage where they are beginning to gain independence from parents, seek peer advice, and separate their ideas from parental ideas or concepts, however they are less likely than older adolescents to pull away from their familial support systems (Steinberg, 1989; Susman, Koch et al., 1993). A study by Chandra and Minkovitz (2007) indicated that younger adolescents are able to articulate their perceptions about mental health and that their attitudes about mental health develop early. These findings paired with aforementioned statistics about mental disorders developing before age 14 would seem to
indicate that early adolescence is a necessary time to educate youth and introduce programming.

2.4 Snapshot of Mental Health Needs in Saskatchewan

Few published studies regarding mental health and youth exist in relation to Saskatchewan. A recent study in Saskatoon (Cushon, Waldner, Scott, & Neudorf, 2016) surveyed 3958 grades 5-8 students and had three significant findings worth noting. First, Aboriginal youth were significantly more likely to report depression than other students. Second, older girls were significantly more likely to report moderate/severe depression. Finally, neighbourhood income explained a substantial percentage of depressed mood differences between schools indicating a corroboration between mental health issues and socioeconomic status. While this study is specific to Saskatoon, it does represent a glimpse of an urban centre in Saskatchewan.

A study in Moose Jaw, Saskatchewan (de Lugt & Chan, 2017) was aimed at having youth in grades nine to eleven share their experiences with school-related anxiety and share suggestions about how their teachers could help. The students indicated their top five anxieties related to final exams, social situations, class presentations, homework and pressure from parents. 92% indicated feeling anxiety related to exams, 67% felt anxious during social situations and 63% had anxiety while giving a presentation to the class. Students identified many ways for teachers to offer support in order to reduce anxiety including building strong, genuine relationships with students, talking about mental health and teaching students the skills to manage mental health, paying attention to student needs and providing choice for presentations.
2.5 Impact of Mental Disorders in Adolescents

Mental health disorders affect many aspects of life for adolescents. Mental health issues can affect social development causing adolescents to feel isolated, stigmatized and unhappy and, in some cases, may lead to bullying (Froese-Germain & Riel, 2012). In an attempt to cope, young people may resort to inappropriate behaviours such as dropping out of school or using drugs as well as experience negative impacts to peer relationships (Meldrum, Venn & Kutcher, 2009). Students with mental disorders are at greater risk for committing suicide (Froese-Germain, Riel, & Canadian Teachers' Federation, 2012). In addition, mental health disorders can negatively impact students’ learning. These students may have difficulty with attendance, meeting grade requirements, recognizing their full academic potential, or even completing school (Wei et al. 2011).

2.6 Adolescent Mental Health and Schools

Mental health disorders represent the most common condition affecting young people which has major implications for schools (Meldrum et al., 2009). Schools provide a unique opportunity for discussing mental health for a number of reasons. In a school setting, mental health can be promoted and discussed without singling out students, mental health outcomes can be introduced within the curriculum, many professionals are available in this context, schools influence the skills children develop, and most children attend school (Cushon et al., 2016). In addition, schools can identify young people at risk for, or living with, mental disorders and educate their personnel to understand mental health issues and recognize mental disorders (Kutcher, Venn, & Szumilas, 2009).
2.7 School Connectedness as a Predictor for Mental Health

School connectedness is the “extent to which students feel personally accepted, respected, included, and supported by others in the school social environment” (Shochet, Dadds, Ham & Montague, 2006, p. 170). Studies suggest there is a correlation between school connectedness and mental health (Murnaghan, Morrison, Laurence, & Bell, 2014). The extent to which both boys and girls felt connected within their school predicted future depressive symptoms. It should be noted that the correlation did not work in reverse (Shochet et al., 2006). These findings suggest that a strong school community, environment and relationships play an integral part to students’ mental health.

A strong sense of community within a school has been associated with fewer academic, social, and behavioural problems. Developing a strong sense of community is done by creating a culture that embraces children, ensures safety and security and enables students to participate and learn. In addition, well-managed, organized classrooms without punitive measures from teachers foster effective school community (Trussell, 2008).

2.8 Mental Health Literacy in Schools

Schools present an opportunity to promote positive mental health. One way that the schools can positively affect mental health care is by addressing and incorporating mental health literacy into school curricula. Mental health literacy should incorporate four criteria: defining what positive mental health is and strategies to achieve it, including knowledge of mental disorders, promoting appropriate attitudes towards those with mental disorders and finally, outlining the knowledge of how to seek mental health care should it be needed (Kutcher, Wei, McLuckie, & Bullock, 2013; Kutcher, Wei, Costa,
Gusmao, Skokauskas, & Sourander, 2016). The best results for mental health promotion, mental illness prevention, and suicide prevention have been achieved by initiatives targeting specific groups (ex. age) and settings (ex. school) (MHCC, 2012).

As outlined in the Evergreen Framework (CYAC & MHCC, 2010), three foci regarding delivery of mental health literacy are promotion, prevention and intervention and ongoing care. Promotion involves using programs that promote positive markers of mental health for all students rather than just those with mental health issues. In this regard, a sense of belonging and community are established for all. Prevention programs focus on skill development and on identifying and challenging thoughts and beliefs that can lead to negative feelings and behaviours (Manion, Short & Ferguson, 2013; Mental Health Commission of Canada, Family Caregivers Advisory Committee, School-Based Mental Health and Substance Abuse Consortium, 2013). Intervention and ongoing care involve understanding and accessing mental health services.

Implementing programming that addresses mental health promotion and prevention in schools correlates with improved emotional and behaviour functioning, increased academic performance, and cost savings (Mental Health Commission of Canada, 2013). In order for programs to be successful, there must be a match between the program and the needs and resources within a setting. However, in this regard, there is a lack of research for special populations (cultural groups, clinical needs, targeted age groups). Further, successful implementation requires monitoring the outcomes of the program and needs of the students to make sure they are achieving the desired results (Manion et al. 2013; Mental Health Commission of Canada, 2012).
While many different mental health curricula exist for implementation, two specific programs are noteworthy in Canada for adolescents. The *FRIENDS for Life* program is an internationally recognized, school-based early intervention and prevention program. This program has been utilized since 2004 in British Columbia with grades 4-7. It is paired with a parent workshop and includes culturally relevant program materials for First Nations students. Findings from international research have found that 86 per cent of children showing signs of anxiety disorders no longer display symptoms after completing the program, compared to 31 per cent of the control group. These benefits have been sustained from one to six years (MHCC, 2012).

In addition, the Mental Health and High School Curriculum Guide (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017), a web-based mental health literacy curriculum, developed by mental health and education experts was created for use in junior high and secondary schools. It includes six modules for students taught by classroom teachers. As well, teachers took part in a one-day training session to become familiar with the curriculum and develop their own mental health literacy. Initial studies revealed that students’ knowledge scores increased significantly and substantially compared with baseline indicating that embedding a mental health curriculum within the classroom is a simple, effective approach to improving mental health literacy in young people (Kutcher, Wei & Morgan, 2015). Of particular note in this program is the implementation of a teacher training component. Kutcher et al. (2013) note that if a mental health curriculum is expected to help address mental health issues, it is imperative for educators to receive proper mental health literacy themselves as quality of content and role of the teacher as mentor are integral to success.
of the program. Embedding mental health literacy into regular curriculum may create a deeper understanding and longevity of application (Kutcher et al. 2013) as well as play a role in stigma reduction (Wei, Kutcher & Szumilas, 2011). The simple inclusion of mental health literacy as a regular part into curriculum legitimizes the educational value of the content (Kutcher et al. 2013).

2.9 Using Inquiry-based Learning to study Mental Health Literacy

Inquiry-based learning (IBL) is a student-centred approach to learning whereby students actively construct knowledge and deep understanding by investigating questions or inquiring into issues that are of genuine interest to them. In this sense, curriculum is co-constructed between teacher and student which can develop student ownership within learning as students are fully involved throughout the learning process from initial planning to assessment (Calder, 2015).

IBL is a cyclical process built into the Saskatchewan curriculum which allows students to pose their own questions, undertake research that is relevant and meaningful to them and revisit stages of the process as they make new discoveries (Saskatchewan Ministry of Education, 2008; 2009). Learning is strengthened as students are motivated to pursue their particular inquiry. Teachers scaffold students so that curriculum outcomes are able to emerge while students pursue driving questions (Calder, 2015). Therefore, teachers are able to merge curricula while students pursue topics of interest. In this regard, students will be able to focus on aspects of mental health literacy that are of interest to them and fit within multiple curricula.

Inquiry-based learning impacts more than engagement and multiple curricula. As a result of IBL, students’ retention of information, thinking, and learning of content
increases. Teachers revealed that student inquiry permitted students to enhance the complexity of their thinking (Clayton, Kilbane, & McCarthy, 2017). Additionally, Levy, Thomas, Drago and Rex (2013) indicate that “providing K-12 students with inquiry experiences in various subjects could enable them to transfer and use such analytical thinking in their everyday lives” (p.404). To this end, IBL would allow students to better retain information about mental health with the hope that it would impact their understanding of self and others as related to mental health issues.

2.10 Mental Health and Teachers

Studies suggest that teachers believe mental health issues are an ever-increasing concern in the classroom (Whitley et al., 2012). Many studies indicate that teachers perceive themselves as having a primary responsibility for supporting children’s mental health (Kutcher et al., 2013; Mazzer & Rickwood, 2015; Reinke et al., 2011). In fact, teachers are often viewed as the gatekeepers to mental health services, meaning that they are well positioned to first recognize when youth are experiencing mental health problems (Walter, Gouze & Lim, 2006; Wei, Kutcher & Szumilas, 2011). Trudgeon and Lawn (2011) indicate that teachers often know students better than any other adult aside from parents. Teachers can observe students against their peers, identify students at greatest risk of mental health issues and play a role in seeking help for students (Mazzer & Rickwood, 2015). Teachers and other school personnel are often the first to notice the development or decline of mental health problems (Whitley et al., 2012). The implied expectation of teachers to recognize and identify mental health concerns is a great responsibility.
Teachers indicated that one of their greatest barriers to addressing mental health problems in the classroom was lack of training (Kratt, 2018; Mazzer & Rickwood, 2015; Trudgen & Lawn, 2011; Whitley et al., 2012). Preservice programs often did not cover aspects of mental health indicating that teachers entered the profession with little mental health knowledge (Walter et al., 2006). In addition, years of experience with teaching did not equate to better understanding or increased knowledge of mental health problems in students (Trudgen & Lawn, 2011). Findings from the recent Canadian Teachers’ Federation national survey (2012) report that 68% of teachers had received no training in mental health literacy. Among less experienced teachers, 75% reported never having had any training. Despite the lack of training, teachers also expressed a desire to be educated in mental health literacy (Whitley et al., 2012).

Kutcher et al. (2013) indicate that educators are at the frontlines when it comes to academic and emotional development. Providing continuing education for teachers around mental health, disorders, and stigma may help teachers recognize signs and symptoms, provide support to those with a mental disorder, and refer students so they received the help they need. Trudgen and Lawn (2011) indicate that mental health training should be a core component of staff development. In addition, pre-service teaching programs should make a bigger commitment to training that helps teachers increase mental health literacy and recognize mental health concerns in their students (Trudgen & Lawn, 2011; Whitley et al., 2012).

2.11 Canadian Policy regarding Mental Health

In 2010, Kutcher, Hampton and Wilson conducted an analytical review of child and adolescent mental health policy in Canada. At that time, Saskatchewan was one of
only four provinces to have a mental health policy plan. Amongst the provinces, great variability existed regarding content of these plans. Kutcher, Hampton and Wilson (2010) concluded that a lack of policy within Canada helped explain why child and mental health services are poorly developed across the country and therefore recommended a national policy be developed.

In 2010, the *Evergreen Framework* was established (Kutcher, S. & McLuckie, A. for the Child and Youth Advisory Committee, Mental Health Commission of Canada). This resource is intended for use by governments, institutions and organizations to help develop child and youth mental health initiatives, but can also be used by young people, parents, professionals and others to inform their thoughts, choices, and priorities regarding child and youth mental health policies, plans, programs and services. The *Evergreen Framework* is developed around specific values as well as four strategic directions: promotion, prevention, intervention and ongoing care, and research and evaluation. These strategic directions are meant to guide and enhance mental health and mental health care across Canada specifically related to youth.

In Canada’s first national strategy on mental health, *Changing Directions, Changing Lives* (Mental Health Commission of Canada [MHCC], 2012), six strategic directions were put together to direct change with regard to improving mental health outcomes for all Canadians. One of the six strategic directions promotes mental health across the lifespan in homes, schools, and workplaces, as well as to prevent mental illness and suicide wherever possible. Promotion and prevention efforts in everyday settings where potential impact is greatest should be used to reduce the impact of mental health problems and illnesses and improve the mental health of the population (MHCC, 2012).
2.12 Comprehensive School Health

Comprehensive school health is an “internationally recognized approach to supporting improvements in students’ educational outcomes while addressing school health in a planned, integrated and holistic way” (Joint Consortium for School Health [JCSH], 2009, para 1). This whole-school approach focuses on achieving educational outcomes while keeping the whole child in mind, and includes well-being as part of its initiative for student achievement. Four distinct yet interrelated components make up comprehensive school health: teaching and learning, social and physical environment, partnerships and services, and policy.

The Evergreen Framework (Kutcher, McLuckie & [CYAC, MHCC], 2010), a framework regarding policy and direction related to mental health and youth, indicates the importance of school mental health and the necessity of linking school mental health initiatives with the most appropriate health providers. In addition, Changing Directions, Changing Lives (MHCC, 2012), the national strategy on mental health for Canadians, states that mental health needs to be addressed in everyday places such as school. Both of these policies will guide and inform educators and personnel related to mental health; however, few models exist with which to build a comprehensive school approach regarding mental health.

Wei, Kutcher, and Szumilas (2011) indicate that there is a need for a comprehensive school mental health model that can be applied across Canada. They proposed a comprehensive and coordinated model to address mental health problems and promote mental health in the school setting within Canadian educational contexts called
the School-Based Pathway to Care Model. The goals of the model included the following:

1) promote mental health and reduce stigma by increasing the mental health literacy of students, educators and parents
2) promote access to mental health care through early identification and site-based mental health interventions
3) improve relationships between schools and health care providers
4) provide a framework where students receiving mental health care can be supported in their educational needs within regular school settings
5) involve parents and community in addressing the mental health needs of youth (Wei et al., 2011, p. 218).

Within this model (Wei et al., 2011), a series of collaborative elements comprise an integrated pathway to care. Multiple people receive education and training about mental health such as students, educators, parents, student services personnel (guidance counselor, school psychologist, school social workers). In addition, certain teachers are trained more highly than others in order to be the “go-to” teacher or a gatekeeper to identify mental health problems and make referrals. At this point, health care providers (primary care and specialty mental health services) who have more expertise are able to better support students. Communication and training is ongoing within all facets and between all members involved in the process. The use of this suggested model encourages collaboration and sharing of information among organizations, agencies and institutions across all sectors serving young people. In addition, it requires partnerships among schools, parents, health providers and community organizations which removes
Kutcher and Wei (2013) indicate that the School-Based Pathway to Care Model is being applied in whole or part in various settings in Canada. A study of the implementation of the program yielded the following findings. For successful implementation, local educators and health providers must be willing to develop and mold the program to fit local realities, including developing, applying and evaluating the model as well as engaging key players from the different sectors to be involved in the process. The model has flexibility which allows locations to choose which components to apply in certain realities or circumstances. Another finding indicated that teachers found the supplementary mental health resources to be useful and bountiful. Kutcher and Wei cautioned that it is important to implement the mental health curricula in addition to educating go-to teachers: “Putting the Mental Health Curriculum into place without implementing the in-school capacity to recognize and respond to students with mental disorders is unfair to students, schools, and providers alike” (Kutcher & Wei, 2013, p. 100). Additionally, the integration of primary care within the school system is challenging, which is an issue related to policy and stakeholders.

While further research is required for interactions with primary care, conclusions support the implementation of the School-Based Pathway to Care model which is an approach that is consistent with national policies such as Evergreen (Kutcher & McLuckie, 2010) and Changing Directions, Changing Lives (MHCC, 2012). This model is focused on holistic education allowing the school to be one component within a system.
to meet mental health needs of young people. This takes some of the pressure off of teachers to be the only resources and identifiers of mental health issues.

2.13 Barriers related to Mental Health and School

2.13.1 Barriers recognized by teachers. As aforementioned, schools are an ideal place for approaching mental health issues. One of the difficulties in dealing with mental health issues solely within schools is lack of policy and coordinated services to support the needs of students with mental health needs beyond the scope of the school day or the school building. Teachers can only provide one means of dealing with mental health education and issues. Teachers surveyed within a Canadian national survey (Froese-Germain, Riel & CTF, 2012) indicated that one of the greatest restrictions to mental health provisions was a lack of school-based mental health professionals. In addition, 85% of teachers indicated that lack of funding for school-based mental health was a potential barrier. Over three-quarters of teachers believed another potential barrier was an insufficient number of community-based mental health professionals, and 75% of teachers surveyed indicated that a lack of coordinated services between the school and community was a possible barrier. Finally, 67% of teacher agreed that a lack of referral options in the community is a potential barrier. These statistics speak to the need for implementing a comprehensive school health model from the perspective of teachers.

2.13.2 Barriers recognized by adolescents. Bowers, Manion, Papadopoulos and Gauvreau (2013) indicate that with regard to seeking mental health services, three of the most common barriers reported by youth are stigma associated with seeking help, not recognizing one has a mental illness and not knowing where to go for help. Of these three, stigma was reported as the most significant.
Many studies report that stigma is the greatest barrier for youth regarding mental health (Bowers et al., 2013; Chandra & Minkovitz, 2007; Hartman, Michel, Winter, Young, Flett, & Goldberg, 2013; Zeifman, Atkey, Young, Flett, Hewitt, & Goldberg, 2015). Chandra and Minkovitz (2007), who conducted a study involving mental health and stigma with 8th grade students, define mental health stigma as the “perception that individuals with mental health disorders are weak, flawed, dangerous, and socially incompetent” (p. 764). Harman et al. (2013) further define self-stigma as a “sense of shame about expressing aloud mental health concerns and feel self-conscious about seeking help” (p. 39).

Studies indicate teens’ perception of whether or not they would face negative or positive social consequences as well as their mental health experience and knowledge were key factors in determining whether or not they would use mental health services (Chandra & Minkovitz, 2007). This information suggests that young people’s perceptions of stigma and self-stigma will affect their help-seeking behaviour. Additionally, seeking help is influenced by gender; males are less likely to seek help (Bowers et al., 2013).

Stigmas related to mental health disorders, along with not knowing whether or not one has a mental health problem or where to seek help, contribute to lack of mental health literacy (Bowers et al., 2013; Hartman et al., 2013). Hartman et al. (2013) recommend implementing global mental health promotion and anti-stigma initiatives for three reasons. First, young people generally have poor knowledge of mental health and stereotypes, however stigmatizing attitudes are developed early. Second, the most serious mental illnesses often peak during late adolescence. Early recognition and intervention can lead to better outcomes. Finally, most young people do not seek appropriate help.
Intervention and education will assist with the stigma of mental health as well as increase awareness of where to seek professional help.

2.14 Implications and Recommendations

Adolescence, particularly earlier adolescence, is a critical time for development of mental health issues and therefore, is a crucial period for education about mental health, implementation of programming, collaborative partnerships, and seeking necessary health care resources. Mental health literacy must be implemented within the regular school curriculum. Issues of stigma, promotion of mental health, prevention of mental health problems and access to services need to be addressed. Increasing mental health knowledge can lead to improvements in attitudes toward mental illness as well as decrease stigma and increase help-seeking in adolescence (Bowers et al., 2013; Milin, Kutcher, Lewis, Walker, Wei, Ferrill, & Armstrong, 2016). Education should also be extended to parental and familial structures.

Prior to implementation of curricula, teachers need training around mental health literacy including understanding how to identify issues of mental health within students. Early detection paired with early and effective treatment of mental health problems can ease social and behavioural adjustments and improve school performance. The earlier mental health issues are addressed through appropriate interventions, the more likely that beneficial effects will be long lasting (Kutcher et al., 2009; Milin et al., 2016). This approach includes educating younger adolescents about mental health. Training of teachers and school-based personnel alongside a collaborative model of service will increase the likelihood of early detection. In addition, pre-service teaching programs need
to incorporate mental health literacy within their core programs (Trudgen & Lawn, 2011; Whitley et al., 2012).

Dealing with mental health and adolescents needs to extend beyond curricula and the role of the teacher and the school. Models based upon Comprehensive School Health (JCHS, 2009) such as the School-Based Pathway to Care Model (Wei et al., 2011) need to be implemented so that students are supported holistically. Policies already in place (Evergreen Framework & Changing Direction, Changing Lives) need to indicate specific ways to proceed with these holistic models including collaboration of personnel and services outside of schools.

Further studies regarding mental health and younger adolescents need to be conducted as 50% of mental health disorders develop before 14 years of age. In addition, younger adolescents develop stigma toward mental illness at a young age. Few studies have analyzed this age group (Chandra & Minkovitz, 2007; Manion et al., 2013; Milin et al., 2016).

2.14.1 Recommendations specific to Saskatchewan

From the study of young adolescents in Saskatoon (Cushon et al., 2016) findings indicate that mental health promotion programming should include culturally sensitive interventions with special attention paid to the impact of colonialism and multi-generational trauma upon Aboriginal people. Findings also suggest that programming for older adolescent girls should include causes of depressive symptoms such as body image, sexual harassment, peer pressure, and bullying. Finally, mental health promotion resources should be directed towards schools in lower socioeconomic neighbourhoods.
de Lught and Chan (2017) recommend that teachers build a caring classroom culture with genuine, caring relationships to ameliorate school-based anxiety. Additionally, teachers should talk about and provide resources pertaining to mental health. Providing alternatives to assessment and choice within types of presentation were also offered as ways for teachers to support students with anxiety.

2.15 Summary of Chapter Two

Chapter two highlights the fact that mental health issues are becoming staggeringly prolific in Canadian youth. Flett and Hewitt (2013) indicate that the “number of young people with identified and unidentified mental health problems vastly outnumber available supports in all regions of Canada” (p. 21). The reviewed literature suggests schools are a prevalent and primary place for interaction and development of mental health literacy. When teachers are properly educated, schools provide an opportunity for early intervention and education about mental issues to support youth and combat stigma. Additionally, policies on comprehensive school health models should be implemented to holistically and fully support the mental health of students. Together, these changes may create a stronger school culture with regard to supporting and promoting the mental health of Canadian students. As I considered the literature on the current state of mental health within youth in Canada, I believed that focusing on improving my implementation of mental health literacy could be a meaningful investment in the lives of my students.
CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

After reviewing literature and increasing my understanding of the landscape of mental health within schools, I decided that I wanted to frame my research around improving my own practice. Following analysis of different research methodologies, I decided that a qualitative approach would best suit the aim of my research as it allowed me to develop the components of my research and reflect on my own practice. More specifically, practical action research afforded me the opportunity to focus on a single problem and include my students as co-collaborators of data. Part of my research plan involved allowing students to drive the learning using an inquiry-based approach. This approach aligned with the tenets of action research. Finally, as a teacher, I continually assess and reflect upon my practice, so I recognized the need for teacher reflection in this study; the process of reflection is built into action research in a cyclical manner. The use of action research involving my students as co-collaborators outlined the basis for the development of my study.

3.2 Action Research

In order to investigate my own practice related to mental health literacy with the intention of improvement, I used the qualitative process of action research. Action research is a form of enquiry that allows professionals to study, investigate, and evaluate their own work (McNiff & Whitehead, 2012). The goal of action research is to give insight and improve practice immediately within a classroom setting. More specifically, I used practical action research within this study. Practical action research focuses on a small-scale research project with a specific problem taken on by an individual teacher or
a team of professionals (Creswell, 2002). As a researcher, the teacher is able to study an educational practice, commit to professional development, reflect on current practices and develop action plans (Mills, 2000).

While there are many different proposed models for action research, most models include a variation of the following four stages:

1. The planning stage (identify topic, gather info, lit review, develop research plan)
2. The acting stage (collect data, analyze data)
3. The developing stage (Based on what I have learned, what should I do now?)
4. The reflecting stage (sharing and communicating results/reflecting on process) (Mertler, 2017).

The stages are cyclical in nature. Depending on the study, stages may be repeated or completed out of order. Reflection is an integral part of action research as the methodology is based upon examining one’s own practice (Mertler, 2017).

I chose action research for this study as I wanted to find and improve ways to implement mental health outcomes in the curriculum I deliver. Action research allows me the opportunity to research, reflect upon and ultimately improve my own practice. Kemmis & McTaggert (1988) indicate that the three main components of action research are that the research is carried out by classroom teachers, it is collaborative, and finally, it aims for change. These three components enveloped the goals for my study. I wanted to construct a study to investigate my own practice. I desired to work collaboratively with my students as co-creators of data, and ultimately, I aimed to change and improve my practice based on analysis of the data from the study.
The action research cycle supports improvement in teaching for educators in several disciplines such as reading instruction (Hong & Lawrence, 2011), second language acquisition (Patterson, Baldwin, Araujo, Shearer, Ragina & Stewart, 2010), science (Tillotson, 2000) as well as health education (Acosta, Goltz & Goodson, 2015). In Patterson et al.’s study (2010), teachers worked through the cycles of action research and were able to modify and change their teaching practice based on the reactions and interactions with the students. During and as a result of action research, teachers moved away from a traditional teaching method to an inquiry-based approach when they recognized that students were more engaged as co-inquirers which led to sustained learning in and out of class.

A common error in thinking among seasoned teachers is that they will master curriculum and then be successful by doing what they have always been doing (Mertler, 2017). Education is an exceptional field in that we work with children who are unique in their interests, learning styles, and needs. Each class brings new and different challenges. Likewise, society brings changes that impact the learners in my classroom. Action research allowed me the flexibility to recognize and address the evolving field of education and needs of my students. Based upon theory and research, I was able to study my practice and then reflect upon ways to change and improve my practice to meet the needs of the individuals with whom I work.

3.3 Action Research Plan

I used practical action research to plan, implement, develop, and reflect on my implementation of mental health literacy with grades seven and eight students in my
I conducted four mini-action cycles within a holistic action cycle which comprised the entirety of the study.

Due to the lack of explicit mental health outcomes in the Saskatchewan Health Curricula, I had to research all of the grades seven and eight curricula to find places where I could incorporate mental health prior to conducting the study. Additionally, I used *The Mental Health & High School Curriculum Guide Version 3* (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017) which incorporates the four tenets of mental health literacy as indicated by Kutcher et al. (2013). Discussion and reflections of the lack of explicit outcomes and use of this particular guide follow in chapter four.

Throughout the action research study, inquiry-based learning was implemented. As described in the previous chapter, IBL is a student-centred approach where students actively construct knowledge and deep understanding by investigating issues that are interesting to them. Students and teacher co-construct the content which can develop student ownership (Calder, 2015). This model is also built into the Saskatchewan curriculum (Saskatchewan Ministry of Education, 2008; 2009).

I followed Mertler’s (2017) four step cyclical process of plan, act, develop, and reflect. Using this process, four mini-action cycles developed. Each of these cycles was derived by using a combination of student feedback, *The Mental Health & High School Curriculum Guide Version 3* (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017), and my professional judgment based upon reflection. The analyzed data from each mini-action cycle is presented and discussed in chapter four.
3.4 The Classroom Environment

The practical action research study took place in an urban elementary school encompassing a K-8 population. Participants were from my homeroom grade seven and eight class which included twenty-eight students including both male and female. I was the primary teacher for these students as I was responsible for eighty percent of their instruction. This afforded me flexibility in time and class design.

3.5 Participant Recruitment

After Research Ethics Approval, participants were recruited by myself with my school administrator present. I spoke about my intention to improve my own practice of implementing mental health literacy by conducting a study within the classroom. I indicated that participation in the study was optional and participation would have no bearing on marks or my relationship with them.

Students who wished to participate signed a Student Assent Form (Appendix A). In addition, students interested in participating took home and returned a signed Parent Consent Form (Appendix B). The teacher researcher collected and stored all signed Student Assent and Parent Consent forms. Both parents and students were provided with names and contact information for the teacher researcher as well as the thesis advisor and were encouraged to initiate conversations with either one or both should the need arise.

During the student recruitment, the teacher researcher made it clear that not only was participation optional, but those who decided to participate could withdraw for any reason by speaking to the teacher or the school administrator. In addition, there was no need to qualify the reason for withdrawal and no penalty would be applied. Students had
the option to withdraw at any point during the study up to two weeks after receiving their final grades.

All students participated in class lessons, discussions, activities, and assessments; however, data were only used from those with signed parental consent. Only the teacher researcher was directly aware of the identities of the participants; however, some participants gave consent to complete interviews in partners or small groups. In these cases, some students were aware of other participants’ identities.

3.6 Participants

The teacher researcher, accompanied by the school administrator, invited all twenty-eight students with the grade seven and eight homeroom classroom to participate in the study. A total of twenty students signed assent and received consent to participate in the action research study. This group encompassed fourteen female and six male participants between the ages of twelve and fourteen. While the students are identified as the participants, the study focused on improvement of my practice which I made clear to the participants. Together, my students and I collaborated to create the data for this practical action research study with the goal of understanding how to improve my implementation of mental health literacy in a middle-years classroom.

3.7 Data Collections Methods

3.7.1 Student data

3.7.1.1 Interviews. I completed initial as well as exit interviews with all participants. The interviews encouraged open-ended responses and detailed answers. Charmaz (2013) states that “interviewing is a flexible, emergent technique; ideas and
issues emerge during the interview and interviewers can immediately pursue these leads” (p. 29). As a researcher, I found this to be true and was able to use data from the interviews immediately in my study. Due to the large number of participants, I gave students the option of participating in an individual or small group interview. Interviews were transcribed following the study.

3.7.1.2 Pre and post assessments. All students in the class completed pre- and post-assessments. The pre-assessments included a questionnaire as well as a formative quiz. The post-assessments included open-ended questions as well as the initial formative quiz. While the main purpose of the pre- and post-assessments was to determine baseline knowledge and then growth over the unit, I did consult them in my data analysis.

3.7.1.3 Student exit slips and artifacts. All students completed exit slips following each mini-action cycle involving approximately four to six questions. In addition, I used an online chat room, student feedback, and assignments as a part of my data collection. Students were given time during class to complete the required elements. The main source of data was the student exit slips as they occurred regularly, and they also helped me navigate the research through the course of the unit.

3.7.2 Researcher Data: reflective memos. Throughout the course of the unit, I made small notes and reflections regarding observations, conversations, student artifacts, and my perceptions of a situation or a particular lesson. Observations were often noted as questions about student artifacts I received or ideas for lesson progressions in our learning. At various points within the unit, I would surmise why something may have occurred as I tried to make sense of the data. Additionally, I would write notes about
what went well or what I may need to change in the future. Ortlipp (2008) indicates that reflective journals allow the researcher to “make experiences, opinions, thoughts, and feelings visible and an acknowledged part of the research design, data generation, analysis, and interpretation process” (p. 703).

3.8 Data Analysis

Grounded theory analysis processes guided the analysis of the data. Grounded theory uses various materials within data analysis such as interviews, reflective journals, observations and student work which were implemented within this study. According to Charmaz (2013), grounded theory uses coding to make analytic sense of the meanings and actions of participants’ experiences. Codes help the researcher select, separate and sort data and build a framework for analysis. The researcher can name what is happening in the data and try to understand what it means. (Charmaz, 2013). Student artifacts, pre and post assessments, interviews and my reflective journal were coded to determine themes.

3.8.1 Coding

3.8.1.1 Interviews. Following transcription, I used initial coding. Initial coding needs to be grounded in the data. Using gerunds, I used line by line coding to name each line of data. Following this, I used focused coding to find the most significant and frequent codes to synthesize the data and explain larger segments. Focused coding is more directed, selective, and conceptual (Charmaz, 2013). For example, the following gerunds are taken from the exit interviews: learning from someone else’s perspective is interesting, learning through peoples’ experiences is important, preferring TED talks, hearing personal stories makes mental health real, learning from people’s stories is
meaningful. These gerunds were used to create the focused code of “learning through the stories of others” as the statements showed a frequency of thought related to a preference to learning by hearing the stories of others.

3.8.1.2 Written data: exit slips, student artifacts, reflective journal.

Differently than the interviews, I compiled the written data by reading through and highlighting for common words and ideas noting the frequency of repeated ideas and creating a summary document. I used Glaser’s (2008) constant comparative method whereby I would start by coding each piece of data into as many categories of analysis as possible. As categories emerged, I would add them to my summary document. Then I would add data that fit an existing category to determine if it was a theme. For example, in exit slip two, I highlighted “can be in multiple stages at a time” as something that students indicated that they had learned about mental health. This idea reoccurred in eight different students’ exit slips so I noted it as a category with each reference recorded in that category.

3.8.2 Memo-writing

Memo-writing is an important step between data collection, coding, and writing the drafts. It involves writing informal, analytic notes about the codes and data and then moving toward theoretical categorization (Charmaz, 2013). Memo-writing requires that the researcher analyzes data early in the process and stays intimate with the data. It forces the researcher to engage a category, write whatever comes to mind, and discover what has been seen, heard, sensed and coded (Charmaz, 2013). After I coded the data, I wrote memos about the congruencies as well as the misnomers in the data. This allowed me to determine reoccurring categories and ultimately interpret what the data revealed.
3.9 Summary of Chapter Three

This chapter provided an overview of action research with a focus on practical action research as the basis for the research methodology used in this study. It outlined the process for obtaining the twenty participants and that data collection would involve interviews as well as written artifacts from the students and myself. Finally, the chapter indicated that the grounded theory method of coding and memo-writing was used for analysis. Chapter four will present the analyzed data from the study in a detailed exposition.
CHAPTER FOUR: THE ANALYSIS OF MY MENTAL HEALTH DATA

4.1 Introduction

As a middle-years generalist teacher, I was excited to begin research around a topic that I felt was both relevant and interesting to my students. I’d experienced an increase in mental health issues within my classroom over the last few years and this year was no exception. I had students diagnosed with anxiety and ADHD as well as one who was newly diagnosed with an eating disorder. Beyond that, there were bound to be other mental health issues of which I was not even aware. Once I presented the information about the study, students began to make comments alluding to their interest. I heard, “When are we starting our unit? I’m so excited to study this topic. I’ve never learned about this before.” The anticipation of both my students and me was building as I prepared to begin.

I was astounded and a little overwhelmed when I discovered that I had twenty participants for the study. I wondered how I would be able to manage all of the data and analysis, but I was very excited that so many students wanted to be a part of the study. While not conclusive, this seemed to indicate that many students were interested in or believed mental health was an interesting and important topic.

The research project participants included fourteen girls and six boys who ranged in ages from twelve to fourteen. Only the participants took part in initial and exit interviews; however, all students in the class completed all other student artifacts and assessments within the unit including but not limited to, exit slips, surveys, discussions, and quizzes. The reasoning behind this choice was two-fold. First of all, it created inclusion for the participants. All students completed all activities so the class as a whole
was not aware of the participants. Secondly, due to the possible sensitivities of mental health topics as well as the desire for inquiry-based learning, I wanted to give all students a voice and space to share their thinking. Data used for this research are only derived from participants.

The research took place during the last two months of the year which was later than originally planned due to a few delays in paperwork, school holidays, and school activity interruptions. As I teach these students eighty percent of the time, I was able to be somewhat flexible in the scheduling of our lessons. We had approximately four one-hour classes per week within a five-week period. I believed that teaching this unit towards the end of the school year would ensure that our classroom community was established allowing us to safely discuss personal and vulnerable issues as a whole. In addition, I felt the students who participated in the study would know me well enough to be honest and forthright with their feedback. As I learned throughout the course of the research, the timing of the unit was not ideal which will be discussed further in chapter five.

4.2 Addressing the Research Question

The purpose of this research is to answer the overarching question:

1. How can I improve the way I teach mental health literacy as part of the grade 7/8 curriculum?

Two sub-questions are included to address this question:

a) Where can mental health be incorporated into the curriculum?

b) What do students know and want to know about mental health?
Finding places to incorporate mental health into the curriculum was a task that I had to do without students and was completed prior to the commencement of the study (sub-question 1). Understanding and inquiring into the knowledge and interests of the students was the question that would drive the bulk of the study (sub-question 2).

4.2.1 – Sub-question 1: Incorporating mental health into the curriculum. I decided to focus the mental health literacy unit on the first component of the Pathway to Care Model (Wei et al., 2011) as mentioned in chapter two which involves promoting mental health and reducing stigma by increasing the mental health literacy of students. According to Kutcher et al. (2013) and Kutcher, Wei and Coniglio (2016), effective mental health literacy should incorporate four tenets:

1. what positive mental health is and strategies to achieve it
2. knowledge of mental disorders
3. promotion of appropriate attitudes towards those with mental disorders
4. the knowledge of how to seek mental health care should it be needed

To develop a mental health literacy unit that addressed these tenets and focused on the sub-question of incorporating mental health into the curriculum, there were two obstacles related to curriculum that needed to be addressed.

4.2.1.1 – Saskatchewan Curriculum Considerations. In order to justify teaching mental health literacy within my classroom, it was imperative to find curricular outcomes that linked to the content and processes of learning related to the four mental health tenets. The Saskatchewan grade seven and eight curricula lack any explicit units or outcomes for teaching mental health. Therefore, one of my initial tasks was to find outcomes to support the content I planned to teach. The outcomes linked to this unit are taken from five different Saskatchewan curricula spanning three subject areas from grades seven and eight as follows:
Discussion of the lack of explicit mental health curricular outcomes in the Saskatchewan curriculum will follow in chapter five.

### 4.2.1.2 Presentation and Justification of Curriculum Resource.

I chose *The Mental Health & High School Curriculum Guide Version 3* (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017) as a mentor text to guide learning progression and activities. This Canadian guide provides a complete set of educational tools to increase understanding of mental health and mental disorders for both students and teachers. This guide is the only evidence-based mental health curriculum resource that has been demonstrated to improve both teachers’ and students’ mental health literacy through usual teacher education and application in the classroom in a variety of program evaluations and research studies in Canada and elsewhere.

(Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017, p.4)
There are six modules within the guide that address the four tenets of mental health literacy as stated in the introduction above. I planned to use the modules as a guideline within the unit as understanding how to successfully teach mental health was new to me and I wanted to be sure to have a resource that would be focused on the four tenets of mental health literacy (Kutcher et al., 2013; Kutcher et al., 2016). The modules are as follows:

Module 1: The Stigma of Mental Illness
Module 2: Understanding Mental Health and Mental Illness
Module 3: Information on Specific Mental Illnesses
Module 4: Experiences of Mental Illness & the Importance of Family Communication
Module 5: Seeking Help and Finding Support
Module 6: The Importance of Positive Mental Health

(Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017, p.8)

This guide framed the content necessary for students to learn; however, as an inquiry-based unit, I also wanted to allow students to express their own desires for methods and content in our learning, so we deviated from the modules at times based upon student input and my professional judgment.

4.2.2 Sub-question two: Inquiring into knowledge and interests of students.

Once I established the curricular components of where to link outcomes as well as what curriculum to use as a guide, I was ready to involve students in the process of the study and ultimately begin the student-based portion of the study. What follows is the progression of the unit using a combination of the outcomes, the chosen Mental Health guide as well as student input.
When I planned this study, I laid it out from start to finish to align with Mertler’s (2017) four stages of action research – planning, acting, developing, and reflecting which I will refer to as the Holistic Action Cycle. Chapter four discusses the planning, acting, and developing stages of the Holistic Action Cycle. The reflecting stage is discussed in chapter five.

I realized that as the students learned and shared their input we would navigate the pathway somewhat differently than I planned. As such, I knew that there were would be smaller action cycles within the holistic cycle, but I did not know how many cycles we would encounter. I initially envisioned the mini-action cycles developing around each of the six modules within the Mental Health and High School Curriculum Guide (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017). As we moved through the study, our journey evolved into four mini-action cycle within our holistic cycle. I will present the study within the following framework which indicates the flow of the study (Table 1).
### TABLE 1: Action Cycles used to implement Mental Health Literacy

| Planning Stage 4.3 | | | 1. Use questionnaire & quiz as formative assessment to determine baseline understanding, perceptions and interest 2. Initial interviews with participants |
| --- | --- | --- |
| **Acting Stage 4.4** | **Intro** | Today’s Meet – online anonymous group chat |
| **Mini action cycle 1** | **Module 1 – Defining stigma** |
| Planning | Based on student questionnaires, interviews and artifacts, where do we start? |
| Acting | • Use Module 1 as a guide |
| Developing/reflecting | Students complete an exit slip to determine understanding and interest going forward |
| **Mini action cycle 2** | **Module 2 – Understanding Mental Health & Mental Illness** |
| Planning | Based on exit slip what do students know about mental health? Where do we go next? |
| Acting | • Book Speaker  
• Use Module 2 as a guide |
| Developing/reflecting | Based on exit slip, where do we go from here? |
| **Mini action cycle 3** | **Module 3 – Information on Specific Mental Illnesses** |
| Planning | Based on exit slip, where do we go from here? |
| Acting | • Introduction for module 3  
• Independent student interest based research  
• Individual One-Slide Wonders |
| Developing/reflecting | Have each student complete an exit slip to determine understanding and interest going forward |
| **Mini action cycle 4** | **Module 5 & 6 – Seeking Help, Finding Support & Importance of Positive Mental Health** |
| Planning | Based on exit slip, where do we go from here? What do we need to cover to finish well? |
| Acting | • Skip module 4  
• Use module 5 and 6 as a guide  
• Student created simulation |
| Developing/reflecting | Final exit slip |
| **Developing stage: 4.5** | What do the data reveal?  
What did I observe in this data? | Post open-ended questions  
Post Assessment  
Exit interviews |
| **Reflecting stage: Chapter 5** | What are the implications of the data? How does my practice need to evolve?  
What will I do the same and differently when I teach mental health in the future?  
What are my recommendations (curricula and teaching)? |
4.3 Holistic Action Cycle – Planning Stage: Preparing to begin.

Prior to beginning the unit, I knew that I needed to do some baseline pre-assessment of my students regarding mental health. Because the curricula lacked explicit mental health outcomes, I was not sure how much the students would know about mental health or where their interests lay. In order to gather data, I used a questionnaire, a formative quiz, and participant interviews.

4.3.1 – Pre-assessments: Initial Individual Questionnaire and Formative Quiz. I decided to do the questionnaire and formative quiz to gauge student comprehension and interest related to mental health. Both pre-assessments were completed online within our google classroom which allowed me to collect data individually and as a whole. Students were informed that neither pre-assessment would be used for summative marks. I created the questionnaire (Figure 1) which focused on each student’s perception/interest about his/her personal experience with mental health. Nine statements were presented and students could respond with yes, no, or not sure. In addition, there was a section at the end that asked open-ended questions.

The formative quiz (Figure 2) was taken from the Mental Health & High School Curriculum Guide Version 3 (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017) and was laid out like a true/false quiz. It assessed students’ knowledge about facts related to mental health. It also included an option for each question for students to indicate that they did not know the answer to discourage guessing. The final question asked students to write a star next to any question that they wanted more information about. As an unmarked pre-assessment, I was aware
that students could merely guess and move through the content quickly without much thought, but I was hopeful that students would take the task seriously.

**Figure 1: Mental Health Initial Questionnaire**

** Each of questions 1-9 include the option to respond: yes – no – not sure

1. I know a lot about mental health (this question gave an option of “a few things”)
2. I can tell you what it means to have good mental health
3. I can tell you what a mental disorder is
4. I am interested in knowing more about mental health
5. I believe mental health is as important as physical health
6. I know how to get help for mental health issues
7. I know someone with mental health concerns
8. I know what stigma means
9. I’ve learned about mental health in school before
   Open ended questions …
10. I want to know more about …
11. Tell me what you know about mental health.
12. What questions do you have about mental health?
13. What types of things would you like to do or how would you like to learn about mental health?
14. Is there anything else you would like to tell me related to mental health?
**Each question included the option to respond:  true – false – do not know**

**Questions 1-6 of 28**

1. Mental health and mental illness both involve the brain and how it functions.
2. People who have mental illness can at the same time have mental health.
3. The brain can affect the way the body function, but the body cannot affect the way the brain functions.
4. The frontal lobes of a young person’s brain continue to grow and develop until the age of 25 years.
5. Three of the functions of the brain include thinking, signaling and behavior.
6. Most everyday stress is toxic (harmful) and should be avoided.

(Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017, p.47)

Both the questionnaire and the quiz yielded results that showed students were uncertain or knew little about mental health. The following figures *(Figures 3 & 4)* display a few highlights that were meaningful to me as I prepared to teach a unit on mental health literacy.
### Figure 3 – Mental Health Initial Individual Questionnaire Highlights

<table>
<thead>
<tr>
<th>Highlight</th>
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</thead>
<tbody>
<tr>
<td>100% of students were not sure or only knew a few things about mental</td>
</tr>
<tr>
<td>health</td>
</tr>
<tr>
<td>62% couldn’t say what it meant to have good mental health</td>
</tr>
<tr>
<td>62% weren’t sure what a mental disorder was</td>
</tr>
<tr>
<td>62% knew someone with mental health concerns</td>
</tr>
<tr>
<td>59% were interested in knowing more about mental health</td>
</tr>
<tr>
<td>93% couldn’t say what stigma means</td>
</tr>
<tr>
<td>69% had not learned or didn’t remember learning about mental health in</td>
</tr>
<tr>
<td>school</td>
</tr>
</tbody>
</table>

Top areas of interest: mental disorders, stigma, supporting others, what is mental health, how to get help

### Figure 4: Formative Quiz on Mental Health Facts Highlights

All of the following statements are false:

<table>
<thead>
<tr>
<th>Highlight</th>
</tr>
</thead>
<tbody>
<tr>
<td>55% of students believed stress was harmful</td>
</tr>
<tr>
<td>66% believed people with a mental illness could not get well and stay well</td>
</tr>
<tr>
<td>48% believed that people who were stressed out or unhappy had a mental</td>
</tr>
<tr>
<td>disorder</td>
</tr>
<tr>
<td>66% believed that mental disorders began because of the stresses of</td>
</tr>
<tr>
<td>everyday life</td>
</tr>
<tr>
<td>52% believed depression was caused by an event</td>
</tr>
</tbody>
</table>

Top areas of interest: schizophrenia, suicide, anorexia, anxiety, panic disorder
Mean score: 16/28

Prior to the pre-assessments, I expected that students’ school experience with mental health would be minimal as I knew it was not explicitly in the curriculum. However, from the questionnaire (Figure 3), I was surprised to learn that most students
had difficulty expressing their ideas related to mental health. They were uncertain about what mental health meant, how to define mental disorders or stigma, yet they could still identify that someone they knew was having mental health concerns. As I looked at the students’ knowledge about specific mental health facts from the quiz (Figure 4), it confirmed that students indeed had significant misconceptions about a number of mental health topics that needed to be addressed within the unit. Several questions arose for me at this point. What were their perceptions of mental health? How were they making these judgments about mental health and others? Did these data accurately reflect their knowledge? Where do we even begin?

Both the questionnaire and quiz had options for students to indicate further areas they wished to pursue or questions they wanted answered. Again, the topics they wanted to know more about ranged greatly as noted in the boxes above. In addition, many students indicated that they didn’t know what they wanted to learn more about or that they might have more questions along the way. A significant question for me came from Sasha who asked, “How do we get rid of it (mental health)?” (Sasha, Initial Survey).

At this point, I was beginning to realize that we needed to start from the very beginning. While some students were able to articulate accurate ideas about mental health, most students held misconceptions or lacked knowledge to the degree that they couldn’t identify what they wanted to learn or needed correcting on the knowledge they believed to be true. In fact, many students were unable to differentiate between the terms mental health and mental illness and used them synonymously. I was looking forward to the participant interviews to see if there would be any more clarity.
4.3.2 – Initial Interviews. I specifically chose to implement the questionnaire and quiz before the participant interviews so that there would be some interaction with mental health terminology and concepts for those students that may lack any understanding. Some students were interviewed on their own and some took place in groups. Based on my knowledge of the students and in dialogue with them, I grouped them in a way that I felt they would be most comfortable. I developed an outline of questions (*Figure 5*) to guide the interviews, but at times other questions developed within the flow of our conversations. In addition to questions about mental health, I also asked questions about how students liked to learn.

*Figure 5: Outline of Initial Interview Questions*

| 1. What do you know about mental health? |
| 2. What is your experience(s) with mental health? |
| 3. What are you curious about related to mental health issues? What questions do you have? Explain. |
| 4. How do you like to learn? |
| 5. What types of learning/activities are boring or not helpful in your learning? |
| 6. Is there anything you’d like to do to learn about mental health? |

During the interviews, I found that students struggled to identify or express what they knew about mental health even when I clarified or reworded questions. This reiterated the findings of the questionnaire and quiz. The following are a few examples verifying this, “Like mental health I’m pretty sure is related to suicide or some of the times when you’re like depressed. I don’t know much about it” (Korbin, Initial Interview).
It could affect the way you do things, obviously, but like it’s something in your head, I guess (Raven, Initial Interview).

I know about depression and anxiety, and how you can be bipolar, or other stuff. I know symptoms, but I don’t know, some of the things I don’t know what it actually means, like I’ve heard about it, but I don’t really know (Cara, Initial Interview).

I know it (mental health) can lead to horrible things, like suicide or like going mentally insane and I have to think here (Sasha, Initial Interview).

I don’t really know much (about mental health) (Josh, Initial Interview).

When asked about mental health, if students were able to elaborate, they discussed mental health in relationship to mental disorders or linked it to a negative connotation. Only two students made subtle comments alluding to positive mental health, “Like when I think of mental health, I don’t always think of healthy mental health. I think of depression or something like that” (Rayna, Initial Interview). In addition, Ariana stated, “Like I know there is like bad mental health and good mental health” (Initial Interview).
Even my students whom I knew had mental illness diagnoses were unable to articulate their experiences with mental health clearly or accurately as exemplified by Keir and Tyler:

It (mental health issues) runs in my family and there’s been things that we’ve been dealing with and stuff like that … My mom’s had it and I’ve kind of going with it … going through it. It’s nothing new. I’m dealing with it and stuff like that (Keir, Initial Interview).

Well, I know for a fact that I have a mental health…. I have ADHD (Tyler, Initial Interview).

Further on in the interview when Tyler was asked about what he was curious about related to mental health, his question was, “how can you get rid of it … how can you stop mental health?” (Tyler, Initial Interview). Clearly there was a gap of knowledge for these students related to mental health and a need for mental health literacy.

Another interesting discovery from the interviews related to student misconceptions and misinformation about mental health pertaining to themselves. Some students would make statements that labelled themselves with a mental disorder without any medical consultation. This excerpt of conversation between Bailey and myself shows an example:

“There’s bipolar. There’s people who have anger issues, addictions. But I don’t have a lot of them. For me, I guess I have bipolar.” (Bailey)

“You do? I didn’t know that.” (Interviewer)
“Yeah, so some days I’m really happy, and then a few minutes later, I can get really sad and angry and that. Yeah.” (Bailey)

“Okay. Did you talk to a doctor about it?” (Interviewer)

“No. My mom … I don’t know. She said she kind of figured it out that I have bipolar because she noticed how I can get really happy and then a few minutes later, I’m angry or … yeah.” (Bailey, Initial Interview)

Other students would make grand sweeping statements like Jamie, “I have anxiety myself and like my Dad’s side of the family, most of us have it so that’s it I guess. I’ve seen loads of people with it and I’ve heard things about it” (Jamie, Initial Interview).

I started to feel slightly anxious as I noticed that students (or families) diagnosed themselves or others so assuredly with mental disorders seemingly without professional diagnosis. I wondered if the student misconceptions were directly affecting their perceptions of themselves and others. I noted that these misconceptions needed to be addressed in our unit.

Feeling pressure to support friends was another common thread in the interviews with my female participants. Whether or not there was a true mental disorder diagnosis, it became clear that students had friends who were struggling with what they deemed as mental health concerns and that there was an expectation as a friend to know how to help or support them. A number of statements from students confirmed this idea:

I have a few friends that are pretty deep into it. It puts a lot of effect on me because I have to try to help them, so… I just want to learn how I can help other people with it and how it all works and more about it. I know some things, but not as much as I should (Claudia, Initial Interview).
Well, yeah with friends sometimes they want to kill themselves and stuff and I’d be like, No, you shouldn’t do that…. But they haven’t, but they would self-harm sometimes. But I can’t stop them … well, I’ve tried, but some people they’re just addicted to something that takes the pain away (Rayna, Initial Interview).

When it actually happens in front of you, you kind of get worried about the person who’s dealing with it, and it’s like you don’t know how to make them feel better and it’s really hard and confusing. So you can say the wrong things or do something that would actually hurt them. So, you have to be really delicate about it (Sasha, Initial Interview).

I know people online and just through social medias who are dealing with mental illness and it’s hard to comfort them through … they’re not there so again just knowing what words to use and how to just help them because it’s big and it hurts (Kayla, Initial Interview).

Well, one of my friends, she cuts a lot. I’ve been trying to help her stop that and think about the positive side (Bailey, Initial Interview).

I was beginning to see why most students indicated that they had friends with mental health issues, but didn’t really know how to define or talk about mental health. Students lacked knowledge and terminology, but they were insightful enough to know that people around them were struggling and that perhaps the issues related to mental
health. I also wondered if some of the “friends” were actually students talking about
themselves. Regardless, it was clear that mental health literacy was pertinent as students
were affected in a very real way by mental health concerns, but lacked accurate
knowledge or possessed misconceptions that restricted their ability to function effectively
with regard to their mental health and the mental health of others.

When students were asked about areas of curiosity related to mental health, I
found that their answers mimicked the questionnaire and quiz. There were a variety of
answers (including some misconceptions) such as mental disorders, how to help people,
what mental health is, how to “cure” mental health, suicide, amount of people diagnosed,
how to “stop” mental health, and how mental health affects different ages and genders.
Even students’ use of the term “mental health” was used incorrectly at times. At best,
students were able to give a phrase about something they would like to learn, but
generally, their feedback was vague. Many students indicated they didn’t know what they
were curious about. Keir’s response demonstrated a typical response when asked what
she was curious about learning,

    Definitely more… I know there’s some disorders and stuff like that, that I don’t
    know about, and those are things that I’d like to know about or maybe more stuff
    having to do with teens considering I’m a teenager, and just stuff like that. Just
    more about different things and stuff like that (Keir, Initial Interview).

It was apparent that students lacked the foundational understanding and terminology
about mental health needed to express what they would like to know. Once again, I
realized that we needed to start from a very rudimentary point.
After discussing questions related to mental health in the interviews, I shifted to questions pertaining to how students like to learn as I believed that part of improving implementation of mental health literacy included engaging students while learning. During nearly every interview, I had to reword or give examples for the question, “how do you like to learn?” I wasn’t sure if the question was worded poorly, if students lacked metacognition about their learning, or if they simply weren’t used to being asked about how they liked to learn. Connor stated, “I don’t really have a specific way (of learning). I’m more of a I’ll do what I have to do to learn” (Connor, Initial Interview).

Because students seemed uncertain about what I was asking, I verbally provided examples of ways students may prefer to learn. I wondered if these examples influenced the students as I was doing the thinking for them and they simply had to choose an option. Once I provided examples, students offered a variety of ideas related to preferred methodology of learning. Many students indicated that they preferred visuals of some variety including videos, slide shows or something for them to interact with (handout). As well, most students were in agreement that class discussions, outside experts/presenters, simulations and projects/researching (both independent and for social action) were helpful or fun ways to learn. Reading on their own, just listening to information being presented or writing essays was boring for the majority. However, a few students enjoyed working independently, interacting with text, lectures or writing essays. This indicates the ebb and flow of the various learning needs and preferences of a class of students; these answers were not surprising to me as an educator.

Hearing and understanding the stories of others related to mental health was a thread that reoccurred during the initial interviews. Students were very interested in
hearing from experts as well as understanding how others experienced and dealt with mental disorders. They wanted to learn first-hand how others experienced or struggled with mental health issues. Many students discussed this in their interviews, “I like watching documentaries, or even talking about people’s personal experiences and how they’ve dealt with it. I like to hear everybody else’s (perspectives)” (Cara, Initial Interview).

I like to understand, like the situation. I want to be able to understand, so I want to, in my mind, be thinking about it fully. Like talking to people that deal with it and how it affects them (Claudia, Initial Interview).

Videos work for me, or maybe sometimes stories. Any stories that deal with that (mental health issues) (Patrick, Initial Interview).

I would want someone actually with mental health problems, that have overcome it, come talk to us and will explain it more to us so we can actually get a feeling of what they go through (Jennifer, Initial Interview).

Maybe learning from others. Maybe experiences or something like that. Or people who have dealt with stuff like that. Just hearing what they went through … (Keir, Initial Interview).

Even the students’ interest in simulations related to learning and understanding how others felt. Jennifer and Gabby made the following comments justifying their
preference for simulations, “So kind of like pretend … it helps me understand what other people are thinking when I can do a simulation because then I get to be in the situation” (Jennifer, Initial Interview). Gabby stated, “You can put yourself in their situation and then it’s easier to see how they feel and stuff” (Initial Interview).

The thread of hearing the stories of others was repeated throughout nearly all of the interviews in one way or another. I was surprised by the clarity with which the students spoke about this preference. I wondered how I was going to make this happen within our time frame, with my limited resources, and on such a sensitive topic.

4.3.3 – Reflections on Planning Stage:

1) Knowledge of mental health in general - Students knew very little about mental health as a whole. I needed to start from a very rudimentary point to be sure that we were all at the same place of learning as well as deal with misconceptions that students held. I was grateful for the Mental Health and High School Curriculum Guide (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017) as I was uncertain myself about where to begin. Because the guide provided logical progressions and modules and had been effectively implemented in other classrooms (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017, p.4), I believed it was a good place to begin.

2) Learning methodologies – Students were not used to having input about how they learned. Not surprisingly, they preferred visuals and interactions with their peers and generally wanted to stay away from a lot of pencil and paper
tasks. A little more surprising to me was their clarity around having presenters or hearing the stories of others. I needed to contact people and search for resources that would allow this preference to be fulfilled. In addition, I needed to work on involving students in their learning and giving them more opportunities to indicate preferences.

3) Time frame of the planning stage - Students began to ask “when are we really going to start?” Obviously this planning section was too long. I am thankful that it didn’t curb their enthusiasm, but I will take that into consideration when planning future units. I need to be aware of upcoming holidays and school events as well as determine which parts of the pre-assessment are necessary and useful. As we headed into the Action Stage of the unit, I was cautiously optimistic as I thought of Keir’s words as we ended her initial interview. “I’m pretty excited for learning about it (mental health)” (Keir, Initial Interview).

4.4 Holistic Action Cycle – Acting Stage: Implementing the Mental Health Unit.

The action cycle involved implementing and teaching the mental health unit to the students. Within the cycle, four mini-action cycles evolved based upon time, my professional judgement, and the interests of the students.

4.4.1 – Introduction to the Unit: engaging the learners. By the time we actually began the learning within the unit, it had been nearly a month since students completed the initial questionnaire and quiz which was far longer than I originally planned. To spark conversation and regenerate interest about the unit, I decided to use TodaysMeet.com, an online backchannel which allows students to join a group chat room anonymously.
Students were excited to answer questions anonymously and indicated that the use of a group chat room was exciting. I led the chat room discussion by asking pre-planned questions based on upcoming content within the teaching modules as well as questions I was curious about related to prior responses in the surveys and interviews (Figure 6).

Figure 6: Sample Questions asked during TodaysMeet chat

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>What are signs of good mental health?</td>
</tr>
<tr>
<td>What do you think causes mental health problems?</td>
</tr>
<tr>
<td>Do you think all people have mental health problems?</td>
</tr>
<tr>
<td>Do you think people are honest about their mental health? Why or why not?</td>
</tr>
<tr>
<td>How do you know if you have a mental illness (MI)?</td>
</tr>
<tr>
<td>Do you feel like you have mental health issues?</td>
</tr>
<tr>
<td>How do teens know if what they are feeling is normal or if they have a MI?</td>
</tr>
<tr>
<td>What is stigma? How is stigma related to mental health?</td>
</tr>
<tr>
<td>Do you feel pressure from friends to deal with mental health issues?</td>
</tr>
<tr>
<td>Do you like using TodaysMeet? Why or why not?</td>
</tr>
</tbody>
</table>

This online chat reaffirmed students’ lack of understanding of concepts related to mental health, mental illness, and stigma; however, students responded much more personally when they were able to be anonymous. Overwhelmingly, students felt like they personally experienced mental health issues and they also felt pressure to deal with friends who had shared their own mental health concerns. I was caught off guard as many students wrote about personal experiences or experiences with friends related to suicidal thoughts and plans, self-harm, anxiety, bullying, and feelings of worthlessness. Normally this type of disclosure would involve personal discussions with the individual student and potentially involve counselors. As the chat was anonymous, I was unable to tell who was providing the information which was disconcerting for me. Following the online chat, I
iterated to students that if they needed to talk about their personal circumstances now or at any point throughout the unit that people were available for them. As I reflected on this after the unit, I realized that directly involving and introducing our school counselor prior to the unit would have given the students the face of a contact should they need it. Additionally, providing students with phone numbers of help lines or further literature that they could consult would have been wise and something that I will do in the future.

4.4.1.1 Reflections on introduction to the unit:

1) Time frames within unit - As an educator, I need to be very aware of time frames, interruptions to schedules as well the flow of a unit. Taking a month to collect data and complete introductions could potentially disengage the learners. Luckily, the extended beginning of the pre-assessments and introduction did not ebb the engagement of my students concerning the mental health unit. However, next time, I would be much more conscious about the time frame when beginning our unit.

2) Providing outside resources in advance – Mental health is a deeply personal and volatile topic. I did not predict the topics or issues that arose from our class online chat or our assessments. These issues are potentially life-threatening. As an educator, I do not want to be responsible nor am I equipped to know how to support all the concerns that arose. Next time, I would introduce our school counselor and have him/her provide any pertinent information for support as well as put a face to a person who could support the students should they need it. Also, giving the students
contact numbers for anonymous support or literature that they could consult would be helpful.

4.4.2 Mini-action cycle 1: defining and understanding stigma. This mini-action cycle focused on understanding the term stigma and how it related to mental illness. The initial questionnaire and quiz indicated that students lacked schema and any understanding related to stigma. While the Mental Health and High School Curriculum Guide (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017) indicated that the lessons on stigma should begin our unit, I was skeptical as I knew students lacked a handle on the very concept of mental health. I wondered if students needed more teaching on the basics of mental health before we delved into stigma. However, I decided to begin with stigma as suggested as I had little experience teaching about mental health.

To begin our first lesson, I introduced box breathing as an exercise to use when taking on challenges or feeling stressed out. We discussed how the Navy Seals use this practice during training. We used this strategy many times throughout our unit. While students participated actively, I was unsure about how effective or meaningful it was to them. However, during our exit interviews, one student discussed its usefulness, “Now I know that stress isn’t bad. The box breathing really helps me… I do it a lot” (Bailey, Exit Interview).

As I reflect on that simple exercise, it is clear that students want and need strategies to help them cope with mental distress.

During the initial interviews, students indicated that that they liked visuals, videos, and wanted to hear the stories of others. To understand stigma, I used a TED Talk
by Kevin Breel (2013) who has depression, but appeared to the outside world to be mentally healthy. He addressed the reality of trying to face mental illness in silence as he didn’t know how to speak about it or how it would be received by others. Students watched the video silently and intently.

This was the first of many TED Talks throughout the unit. Using TED talks was a way that I could incorporate the stories of others without actually having a live presenter. Feedback at the end of the unit indicated that TED Talks were a popular part of students’ learning. Nearly every exit interview revealed that TED talks were helpful, “I did like doing the TED talks … those were the best because you could actually hear people and their stories instead of just an article” (Patrick, Exit Interview).

My favourite thing was the TED talks because I’d hear people’s experiences and what they had to say and every single time it was something new. So, I feel like that was really important to me (Keir, Exit Interview).

I actually liked the TED talks the most. I don’t really know why. Probably because of how they were presented and the topics that they were on. I feel like I learned best when they were being presented (Connor, Exit Interview).

Following each of the TED talks, students expressed an appreciation for hearing the stories of others either within class discussions or on exit slips. This affinity for TED talks reiterated students’ earlier preference for learning through the stories of others. This is something I will continue to use in various avenues of my teaching in the future.

Following our initial TED talk, we had a class discussion around stigma, perceptions about mental illness and stigma, media and stigma as well as the effect of
stigma on the lives of people with mental illness. Again, students were active participants. Some students couldn’t wait to share and others listened carefully. Reactions were varied, but from my perspective almost all students were engaged with the information. We moved into a slide presentation on myths and realities of mental illness related to stigma which presented students with factual information as well as false information surrounding mental illness.

Our next lesson students focused on famous people with mental illnesses. Students were presented with a list of famous people and they researched multiple individuals and their mental illnesses. When the list of names went up, there was instant uproar about the people’s names that were on the list. Students couldn’t believe that Jim Carey, Lady Gaga and Robin Williams had mental illnesses. I heard many comments about how these successful celebrities seemed so “normal” and students were shocked to hear that they suffered from a mental illness. One student commented that they couldn’t believe that Jim Carey had depression as he was so funny and was a comedian alluding to the belief that comedy/happiness could not associate with depression. Another student commented on the fact that we don’t actually see the real lives of celebrities – only the great parts----which was telling as she unknowingly made reference to negative perspectives associated with mental illness.

Students clearly possessed their own issues related to mental illness and stigma. Whether or not they were aware, they held perceptions about what someone with mental illness looked like and was able to achieve and how mental illness presented itself in people. At this point, I realized that understanding stigma prior to learning about mental health and illness afforded students the opportunity to face the stigma/stereotypes they
held. As we chatted about the harmful effects of these stereotypes, students were eager to learn about the realities surrounding mental health.

To complete this mini-action cycle, all students completed an exit slip (Figure 7). The purpose of each exit slip was to evaluate students’ learning about the concept as well as get feedback about students’ thinking and ideas about where they wanted to go with their learning.

**Figure 7: Exit Slip 1 Questions**

1. What did you learn about stigma?

2. Did you find the information about stigma as well as the myths and facts interesting? Why or why not?

3. Besides what you answered in question 1, what is one new thing that you learned?

4. What would you like to do to learn about the mental illnesses?

In the exit slips, many students indicated that they enjoyed learning about the myths as they realized that previous to this, they believed certain myths themselves:

For most of my life I’ve been told that people with a mental illness don’t act like us or have the same rights but I learned that they have the exact same rights as a person who doesn’t have a MI (Jamie, Exit Slip 1).

I learned that people with mental illness are not usually violent. I used to think that people with MI are violent (Nathan, Exit Slip).
I found it interesting because I used to believe those myths and when my sister was depressed I just wanted her to ‘snap out of it’. But I now know that’s not how it works. I wish I would have known back then and if we learnt about it more as a society I would have (Gabby, Exit Slip 1).

As students spoke so maturely about their learning, I became more aware of the fact that students at this age held preconceived ideas about mental health and mental illness. These ideas were generated somewhere. Perhaps families? Friends? Media? Regardless of the influence, it was evident that students needed education and literacy about mental health at a younger age as they entered their grade seven and eight classroom already believing a number of common myths related to mental health.

One particular student made a comment within her exit slip that would be echoed throughout the unit. Jennifer stated:

A new thing I learned was how everyday stress is actually normal and doesn’t cause mental illness. I thought this was interesting because I personally have a lots of stress and I thought it was good to know that some stress is normal…. I would really just like to know what they (MI) all are and then I would like to learn how to see if you actually have one of them (Exit Slip 1).

This was the first specific evidence I received that indicated that students were concerned about whether or not what they were experiencing in life was “normal”. However, I would see this question asked in a variety of ways throughout the unit. Students wanted to know the parameters of mental health and mental illness in order to compare their own understanding of self and normality.
As I endeavoured to find out about how students wanted to learn as we proceeded in the unit, I was surprised that nearly half of all students misunderstood the question. Instead of telling me *how* they wanted to learn, they told me *what* they wanted to learn. I wasn’t sure if the question was worded poorly or if students were not used to being asked for input on how they would like to learn. Those who did answer the question correctly indicated that they would like to have visuals, videos, speakers, jot down notes, have class discussions, and do research.

4.4.2.1 - Reflections on mini-action cycle 1

1) Methodologies – My students were not used to being an active part of the planning process. How could I be a better facilitator vs direct instructor? Based on comments from the students, I needed to find ways to incorporate the stories of others using speakers and videos as students connected with this type of learning. I wondered how to weave research into the process as this wasn’t a part of the *Mental Health and High School Curriculum Guide* (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017). As I entered into mini-action cycle 2, I knew I needed to do a better job of listening to how/what the students wanted to learn.

2) Personal Relevance & Truth – Students saw themselves in the learning. Whenever they were presented with new information, they connected with the information and automatically applied it to their own personal context and understanding. They were willing to admit error when it came to pre-conceived misconceptions about mental
health and wanted to know the truth especially as it related to themselves. In addition, they wanted accurate information that they could apply to their current understanding of their own mental health and where they were situated on a spectrum of mental health. As we learned more information about mental health, their questions and desire to understand increased. For learning to be deep and meaningful to them, I needed to keep the information relevant and continue to ask their opinions.

4.4.3 – Mini-action cycle 2: Understanding mental health and mental illness.

As we approached mini-action cycle 2, I was excited for our lessons as I knew we were about to open up a whole new understanding of the fluid nature of mental health. From the class discussions, exit slips, and initial interviews, I knew that many students held an over simplified view of mental health and mental illness. They believed that people fit into one category or the other – mentally ill or not. Other students were not familiar with the concept of mental health and held negative perceptions about mental illness. Many students alluded to their uncertainty as to how they personally fit into this puzzle of mental health.

The entirety of mini-action cycle 2 took place in one day. To begin our learning within this cycle I stepped away from the direct instruction format identified in the Mental Health and High School Curriculum Guide (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017) as I really wanted students to sit in their messy understanding of mental health and wade through information to make sense of it. Students worked in small groups to try and define the
following terms on chart paper: mental health, mental distress, mental health problem and mental disorder/illness. These terms make up the four different mental health stages, but students were unaware of that when I gave them the task. I wanted students to begin to understand that the components of mental health were much more fluid than mentally ill or healthy. Trying to place definitions or words for these terms would allow students to try and create meaning in order to widen their context of mental health and illness.

Students struggled with the task as they lacked schema, but they tried to pull words/phrases apart and identify how they might differ from each other. When we looked at our data as a class, there was some overlap of ideas, but there was little consistency in the understanding of the mental health stages. Students were curious about the real definitions. They also had an inherent desire to know who had been “right”.

To find answers to our wonderings about the four stages, I showed students a slideshow from the *Mental Health and High School Curriculum Guide* (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017) which identified and explained the four stages. We stopped and discussed the terms and stages at length. The following diagram (*Figure 8*) became a common reference point as students started to understand that the stages of mental health were fluid and that you could be in multiple stages at one time as exemplified in our investigation of celebrities as well as the TED talk presenters.
Following our class, I noted that there were several elements of new learning voiced during our class discussion. Students said they learned that you could be in every mental health stage at the same time. They also said they learned that a person may require a counselor for a mental health problem, but that an actual doctor must diagnose a mental illness. In addition, there was a lot of student discussion about mental distress being a normal, everyday experience. Finally, we had robust discussion about people falsely labelling others with a mental illness diagnosis when in fact they were not qualified.

My teacher excitement was palpable at this point in the study as I began to see previous misconceptions deplete within our learning. As a teacher, it was gratifying to witness learning that impacted and affected the daily lives of students. Students were
replacing misconceptions with truth that changed their perception and understanding of self as illustrated in the examples above. I was beginning to see that learning about mental health and its various facets mattered.

Later the same day, we were fortunate to have a guest speaker from the Canadian Mental Health Association (CMHA). In the initial interviews and in the exit slips, students mentioned that they wanted to listen to presenters and hear the stories of others. I contacted several people and organizations about presenting, but many people were unable to make it which created a barrier in terms of trying to meet the desire of students to hear the stories of others.

During the CMHA presentation, I was able to be act as an observer and note the behaviours of my students as well as collect formative information about their knowledge around mental health. The CMHA presenter ended up reiterating information about the different stages of mental health which we discussed earlier that day. As the presenter asked questions, I could see that many of the students understood the information presented earlier that day as they were engaged and shared accurate answers. When the presenter shared a power point and factual information, I noticed that some students seemed to be sitting on the edge of their seats seemingly interested while others were laying on their desks seemingly disengaged. Students looked more interested and engaged as a whole when the presenter shared personal stories of people she had worked with who had mental illnesses. In addition, when she shared a fact/fiction quiz, students all participated. Following the formal presentation, students had a lot of questions related to mental illnesses. They indicated to the presenter that they felt like they did not have a lot of information about specific mental illnesses.
As we finished the day, I noted a shift in the students. Students seemed more certain of the knowledge that they possessed about mental health as compared to the beginning of the unit when it came to understanding themselves. They were beginning to situate themselves personally within the stages of mental health. As they gained more information, they were beginning to ask more and more questions. For example, following the presentation, they expressed a better understanding about the stages of mental health, however, they felt they did not know enough about mental illnesses. I knew I needed more specific feedback about what they had learned and how they wanted to proceed with their learning. We ended mini-action cycle 2 the next day by completing an exit slip (Figure 9).

*Figure 9: Exit Slip 2 Questions*

1. What did you learn about the different stages of mental health?
2. Discuss one thing you learned from our mental health presenter?
3. Did you enjoy having a presenter? Why or why not?
4. What could I do to make the learning more interesting?

Within the exit slips, most students indicated that they learned that you can be in multiple stages of mental health at once and that it is normal to experience different stages of mental health. Often, they related their learning to beliefs about themselves. Jayla shared the following:

I learned you are able to have all the stages at once. You can be feeling stressed
about a test which is mental distress so it is normal to feel stressed now I know that it is an everyday thing I won’t have to worry that I might have a mental health problem. (Jayla, Exit Slip 2)

I learnt that just because you’re experiencing everyday normal stresses you don’t have a mental disorder and it’s ok to be stressed about a test. And to be honest there were times I thought to myself I was mentally ill but now I know that it’s normal to feel that way sometimes. (Gabby, Exit Slip 2)

During the exit interviews, students continued to discuss their learning related to the four different stages of mental health. When questioned about what they learned about mental health during the entire unit, students made the following statements:

I didn’t know they [mental health stages] could be all together at the same time. Like you could have a mental illness, mental problem, mental distress and just mental health at the same time … It’s helpful for me because if I’m going through a mental problem or mental distress I know that it’s, that mental distress is normal to have it and I’m not fearing that I have a mental illness or something. (Cara, Exit Interview)

[I learned] that you can be in all stages of mental health. You can go out with friends and be happy and have a good time, but you can also have a mental illness or disorder and have mental distress, and you can be everything at once. The
stress, mental distress, and stuff like that is completely normal. (Keir, Exit Interview)

One thing I like that I learned about is that you could be in all of the states at a time. Like the problem, and the stress and the mental health and the illness, because that put a different perspective on things. You’re not just in one spot always. (Ariana, Exit Interview)

Understanding “self” relative to mental health was a theme that permeated the unit. Students desired to know if they were normal with respect to mental health topics which is consistent with their developmental stage and wondering about all aspects of their lives relative to normality (McNeely & Blanchard, 2009). Learning about the stages of mental health allowed students to gain perspective about their own experiences and identities concerning topics of mental health and mental illness.

When questioned on exit slip 2 about having a presenter, many students appreciated having an expert or a different person presenting information and indicated that it was a good change of pace. However, some students indicated that they were bored by repetitive information and did not enjoy just listening. For me as a teacher, having a presenter afforded me the opportunity to observe the learning and understanding of my students from a different perspective as I was able to stand back and view their interactions and body language without leading the discussion.

This time when I asked the students in the exit slip about how to proceed in the unit, I changed the language of my question. Instead of just asking what they want to do
to learn, I asked how I could make the learning more interesting. Students seemed to understand and respond to this question. However, the responses from the students were quite varied. They wanted to have games, research, presentations, chat rooms, interactive learning, reading and highlighting notes, making posters to teach others, simulations, and choice of topic. Each time I asked for feedback, I realized that the learning preferences of students were varied. I wasn’t going to meet the needs of every student with every format, so I needed to be aware of varying the format.

4.4.3.1 Reflections on mini-action cycle 2:

1) Learning is personal - Students liked learning in different ways. Rarely would all students be satisfied with a certain mode of learning. I needed to be sure that I presented a variety of learning opportunities as well as provided an opportunity for choice within learning where appropriate.

In addition, students indicated that they craved the personal stories and experiences of others. They wanted to learn about mental health on a personal level, not just a conceptual level.

2) Students want to know if they are normal - Students desired truth related to their reality. They had a deep desire to determine whether their own mental state was “normal”. Learning the stages of mental health was enlightening for the students. The relief they felt in understanding that their own truths fell within fluid stages was almost tangible. Students seemed aware of how they were feeling, but they seemed afraid that the pressure, anxiety, or feelings were not normal. As they began to realize that mental health was fluid and others felt the same way, there was a
great sense of relief as expressed in our discussions. Why was this the first time they were learning this? Wouldn’t this be helpful for them earlier on in life? As evidenced earlier in the initial interviews, students were already grappling with friends and issues related to mental health. This should be introduced in early adolescence. Is there a way to modify curriculum to ensure this?

3) Learning is more meaningful when students possess schema – As the unit evolved, I realized students lacked schemata around mental health. The term “schema”, which I refer to throughout this paper, is derived from schema theory (Anderson, Spiro & Anderson, 1978) which describes how knowledge is acquired, processed, and organized. Schema refers to a person’s prior knowledge about a topic or way of organizing information. Schemata allow people to make sense of the complex information in the world around them (Dixon, 2017).

I realized students need guidance even in inquiry learning. Without schemata or prior knowledge, students are often unsure about what they need to know or what they lack in understanding which indicates that scaffolding is necessary. Once students were able to label their thoughts and feelings within the stages of mental health, they were able to create more specific questions and wonderings that they wanted answered. When students understood the tenets of mental health and situated themselves within them, they were able to have a clearer view of where they wanted to go as well as how and what they wanted to learn.
4.4.4 – Mini-action cycle 3: Information on specific mental illnesses. At this point in the unit, I knew that most students were interested in learning more about mental illnesses; however, students also had very specific questions of interest so I needed to be able to provide opportunities for students to guide their own learning. I decided that I wanted to have students delve into their own topics of interest related to mental illnesses. However, based on my understandings from mini-action cycle 2, I knew that students would be better equipped to ask questions if they had some background information, so I decided I would provide them with a little bit of information prior to doing research.

To begin mini-action cycle 3, I decided to use slide shows and provide some animations on various mental illnesses as provided in the *Mental Health and High School Curriculum Guide* (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017). These sources provided information on what happens when the brain gets sick as well as what it was like to live with certain mental illnesses. I noted that students were very engaged in the videos and particularly expressed interest in how mental illness affected the brain.

Prior to teaching this section, I let the students know that following the slides/animation, they would be creating a question to study further related to mental illness. I encouraged them to have a paper handy to keep track of any questions that arose during the presentation. Students seemed excited about the prospect of choosing what they wanted to learn.

Due to the time constraints as we approached the end of the year, I knew that we didn’t have time for research and full class presentations, yet I knew that it was important for students to share what they had learned so that they could learn from each other. I
decided that we would do what I called “The One Slide Wonder”. I created a google slide presentation and students got one slide each within that presentation to share their thinking about whatever it was that was learned. Students had two classes total to create a question, research it, and then create their one slide.

Students had no problem getting to work and choosing multiple options to research. They worked feverishly to narrow their topics and create questions to research. Some initial inquiries developed into more specific inquiries. For example, Shauna initially decided to research treatments for anorexia nervosa; however as she continued to learn, she decided to narrow her search to bone health in anorexia nervosa. I knew that this was a topic that I would never have covered in class. It occurred to me that given opportunity, students’ learning could be much richer if they received choice along with guidance.

As mini-action cycle 3 played out, I started to notice the thread of mental health begin to weave itself into other facets of our classroom. Without any prompting, some students began to incorporate it into their English Language Arts. One student wrote a narrative from the perspective of someone with a mental illness. Another person wrote poetry about someone contemplating suicide. I had conversations with both of these students due to the sensitive nature of their work and learned they were inspired by the learning in our unit. As well, two students decided to create a genius hour project on how music might affect the brain regarding mental health.

Additionally, I started to notice increased ownership within our mental health unit. I would regularly find sticky notes on my desk about sites I should visit or videos recommended for our class to view. Students would talk to me about what they were
learning and that they thought the rest of the class should know about it as well. I was so excited about their enthusiasm, but I was legitimately perplexed. Why had they taken a sudden interest? I have been teaching for quite a while, yet I have never had a group become so genuinely interested in a topic in the sense that they began to tell me what/how they and others should learn. I genuinely felt as though students were taking ownership for the learning of our class. The learning extended beyond personal gain and students seemed to take responsibility for the knowledge of their peers. I became part of the periphery as students drove the learning; it was beautiful. I have not flushed out the exact explanation for the increased ownership. Perhaps it was the simple fact that I asked the students, gave them a chance to pursue their own avenues of interest and followed through on their requests.

Mini-action cycle 3 ended with our individual “One Slide Wonder” presentations. Each student shared his/her learning with the rest of the class. Students asked questions of each other and genuinely paid attention to one another. While there was some overlap of topic, each presenter shared a new perspective. A plethora of information was shared related to mental illness and I was thrilled. I would wager a guess that the depth of learning was far superior to anything I could have delivered on my own. Mini-action cycle 3 concluded with an exit slip (Figure 10).
### Exit Slip 3 Questions

1. What did you learn about mental illnesses?
2. What are you still curious about? What made you curious about this?
3. Did you enjoy researching about a topic of your own interest? Why or why not?
4. Are you enjoying the mental health unit? Why or why not?
5. What do you think is the most important thing you’ve learned?

Exit slip 3 was rich with feedback and details. Answers to the questions were very in depth and specific. More than any other exit slip, the answers were multi-faceted and specific to the individual. Students were processing and making sense of the information in different ways that related to their specific interests and learning about mental health.

The students’ curiosities lay in a variety of domains related to mental health. The students were clear about what they were still wondering; however, very few students were curious about the same thing. Queries ranged from wondering what happens to your brain with different mental illnesses to questions about self-harm and suicide to how dogs can help PTSD to how doctors prescribe medications and diagnose mental illness just to name a few.

Many students’ wonderings were tweaked by their own research. For example, Rayna stated,

After doing my own research, I still want to know more about the history of mental illness … I very much enjoyed doing my research! I don’t really like history because sometimes I find it boring, but this just kept me wondering more!
I’m so glad I got to do this research because if you didn’t make this a mini-project, I wouldn’t have thought to ask this question. (Rayna, Exit Slip 3)

Every single student indicated that researching a topic of personal interest was enjoyable. Students expressed the following when asked if they enjoyed researching a topic of interest, “We get to learn about what we’re interested in. It is also really cool seeing what everyone is interested in learning about or even why they are (interested).” (Claudia, Exit Slip 3)

I was able to research something that I was interested in and not research something that I already know about. It gave me more information of a topic I wanted to learn more about. (Jayla, Exit Slip 3)

Yes, because I learned so much about panic disorder that I thought I would never know and I can’t wait to learn more. (Ariana, Exit Slip 3)

I was able to do what I wanted to do so that made it different or more special to me. (Connor, Exit Slip 3)

As a teacher it made sense to me that students liked to research topics of personal interest; however, I was surprised at the depth of learning and the amount of new questions the students experienced as a result of their research. The richness of their learning and the precision of their extended wonderings caused me to recognize the
necessity of incorporating more student-driven and individualized inquiry-based learning. If we had not been limited by time, we would have explored more avenues of personalized research and learning.

When asked about whether or not they were enjoying the mental health unit, students unanimously agreed that it was enjoyable, beneficial and necessary. Reasons for enjoying the unit varied. Students made the following comments, “It’s very important and more people need to learn about it to help decrease stigma. I also find it very interesting” (Gabby, Exit Slip 3).

I really like the mental health unit because I think mental health is something kids our age should learn about so they can see if someone if not themselves has a mental illness. (Kayla, Exit Slip 3)

This unit interests me greatly because there have been mental illnesses in my family so finally learning about what went through their minds helps me understand why they did what they did. (Nathan, Exit Slip 3)

It’s interesting and I know it’ll be beneficial to us even in the future. I feel like it’s important to learn about mental illnesses especially at this age. (Rayna, Exit Slip 3)

While I was very glad to hear that students were enjoying the unit, I was more curious about what they felt was the most important concept they had learned to date. I
also wondered about how their thinking had changed since the beginning of the unit. Many students related their most important learning about mental health to their own understanding of self. Students expressed a desire to know that what they were experiencing in their own lives was normal or how to determine if it was normal. A number of comments confirmed this:

One of the most important things I learned is that it is okay to have mental stresses and problems. I always worry about stuff, so to know that it is very normal to feel like that makes me feel relieved. (Jamie, Exit Slip 3)

I think that the most important thing I’ve learned is that there are different levels of mental health. Because it’s important to know that stress doesn’t mean you have a mental illness but it means that you’re normal. (Connor, Exit Slip 3)

That being depressed and being sad are not the same thing. Being sad is a mental distress which is an everyday thing we could experience. Being depressed is a mental illness. (Cara, Exit Slip 3)

Other students indicated that their most important learning related to understanding others. Students made the following comments:

I think that the most important thing I’ve learned is just because someone has a mental illness doesn’t mean that they are bad friends or you should act weird around them. If you be yourself around them, it makes them feel safe” (Sasha, Exit Slip 3).
Understanding it (mental health) is a huge key. So in the future we don’t think “stigma” and we treat somebody with a mental illness with respect and like a normal human being. (Keir, Exit Slip 3)

I think that the most important thing that I have learned so far is how to treat the mental illnesses and how to get help and where you can go get help if you need it. Because if you ever need help or if you know someone that needs help you know where to go. (Raven, Exit Slip 3)

I feel like everything was pretty important. I feel like how we should treat others with mental illnesses is really important because we should make sure that everyone feels safe and comfortable and everyone should get the help they need. (Rayna, Exit Slip 3)

**4.4.4.1 – Reflections on mini-action cycle 3:**

1) Richer learning occurs with choice – Despite the fact that I thought that not all students could be engaged with one type of learning or assignment, all students indicated that they enjoyed the self-directed research. I learned that with schema, students are able to guide and direct their own learning given the option of choice. As well, they are able to educate their peers. Due to the increased freedom, students are able to refine their own questions and narrow their learning so that the learning is richer and more meaningful. In addition, the breadth and depth of topic and learning far
surpasses what I can deliver as a teacher. When students are able to pursue their own interest, curiosity increases. In fact, students began to express their knowledge of mental health in other subject areas without prompting. How can I incorporate choice into more facets of my teaching? When is it the most beneficial for students? What is the balance between teacher decision and student choice given the requirements of curriculum?  

2) Students need to know about mental health to make sense of their world – Students discussed a desire to understand and situate both self and others in relationship to mental health and mental illness. I found many students questioning their normalcy related to mental illness and their daily feelings and experiences as well as the need to know how to help and interact with others. If we incorporated mental health earlier in the curriculum as suggested by students, there would not be such anxiety around the issue of mental health and mental illness.

4.4.5 – Mini-action cycle 4: Seeking help & the importance of positive mental health. As we began mini-action cycle 4, we were dangerously close to the end of the year. I made the decision to skip over module four from the Mental Health and High School Curriculum Guide (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017) which covered the experiences of mental illness and importance of family communication. I felt that we had discussed elements of these topics within our individual research and class discussions. As it was, we were going to have to try and touch upon the concepts of two modules within a week in order to work within the confines of the school year.
Mini-action cycle 4 started with a TED talk recommended by a student. This talk (Wax, 2012) featured Ruby Wax, a comedian with a mental illness, who discussed mental illness and stigma with humour but candor. While this wasn’t part of the topic related to what we were studying, I wanted to honour the request of the student. The students loved the TED talk and once again reiterated their enjoyment of hearing the stories of others who experience mental illness.

We worked through the concepts in module five in one day which focused on seeking help and treatment as well as recovery for mental illnesses. Students watched slide shows about treatment and recovery and then participated in groups analyzing “what if” scenarios. They had to discuss what they would do given a particular situation. The point of the activity was for the students to determine if there was something abnormal that required further attention regarding mental health. Following the group work, we looked at checklists which gave guidelines of healthy and unhealthy behaviours. During discussion following the activities, many students expressed that this checklist was personally helpful as a way to determine if what they were feeling or experiencing was within the parameters of normal feelings or behaviours.

Module six focused on the importance of positive mental health and was probably the most enlightening module for me as an educator as well as for the students. I began the module by having students write on sticky notes what they thought of when they heard the word stress and then I collected them. Following this we looked at a flow chart that showed negative and positive reactions and perspectives related to stress. This diagram mimicked our learning earlier in the year around growth mindset. Essentially, students got to choose their reaction to stress in a situation as positive and something to
grow from or negative and something to avoid. After we debriefed this chart, we watched another TED talk by Kelly McGonigal (2013) who used scientific facts to prove that the body is built to deal with stress and that stress should be viewed as positive. While the students watched the video, I sorted their sticky notes about stress into categories of positive and negative viewpoints about stress. All responses with the exception of one associated stress with a negative connotation.

Students were blown away by the TED talk. Many students indicated that they had never considered stress to be a good thing and that this information changed their entire mindset. When I showed them the visual of almost all of their sticky notes under the column of negative, most students talked about how they had always thought of stress as negative and didn’t understand how the body worked to prepare for stress. At this point, I had students turn and talk about their new understanding of stress.

Students shared that understanding that the body was built to deal with stress was very freeing. They indicated that they needed to change how they expressed themselves. Instead of saying that they felt anxiety or stressed out or depressed, they could talk about having a stress response and understood that their body was getting ready to take on a task.

We ended the module by completing an activity where students had to take phrases about ways to cope with stress and place them under headings of positive ways or negative ways to deal with stress. Students seemed very clear about which methods were positive and negative.

As an educator, I thought it was strange that teaching about positive mental health came at the end of the unit; however, after we worked through the unit, it made sense that
students needed the background of mental illness, the stages of mental health, and criteria for what was normal and abnormal in order to appreciate how important it was to have positive mental health. Understanding the language and content of mental health and illness helped students to better understand stress versus mental illness.

In the exit interviews, many students stated that learning about stress was the most important facet of their learning. Connor stated the following:

I’d say probably the most important thing that we learned was probably about the stress, how it’s not bad to have stress is actually good to be able to adapt to it and then apply it to different circumstances. I think that’s the most important thing, because it’s an everyday life thing that we have to deal with. It’s better to know that it’s good to deal with it and not shy away from it. (Connor, Exit Interview)

Patrick concurred with Connor and indicated that “probably the most important thing is when we were talking about the stress and stresses of normal life. That it’s normal to experience mental distress, it’s just stress. And it should not be viewed as a bad thing.” (Patrick, Exit Interview)

As students became more educated about the stages of mental health, the positive nature of stress, and the normal stresses of everyday life, it was like a visible weight lifted off of them. I saw the enlightenment that occurred and the understanding of self that began to permeate the classroom. During class discussion, students began to comment about how they had never viewed stress as something beneficial and how that positively
changed their perspectives. Others acknowledged that learning about the stages of mental health helped them understand themselves. Shauna stated that:

it is so good to know that stress can be positive and I think the most important thing is knowing about the stages (of mental health) so I know what is healthy or what is not. Then I can know if I need to get help and estimate where I’m at.

(Shauna, Exit Slip 4)

At this point, it was clear to me that with knowledge, students have freedom to understand their own state and situation. Students need to be educated about mental health in order to understand themselves.

Following our lesson on stress, three girls came to me and wanted to run a mental health simulation in our classroom. For one day they wanted a few students to take on the role of someone with a specific mental illness. They did not want any of the other students to know about it. Instead they wanted to see the reactions of the other students and see how the actors would be supported and then discuss it at the end of the day.

Throughout the unit, these three girls kept talking to me about their desire to participate in a simulation. I searched for various simulations online but couldn’t find anything that I felt was relevant, and I let them know that on a few occasions. I was not surprised these girls wanted to participate in a simulation. I was surprised, however, by their ambition to create their own simulation. I was encouraged by their enthusiasm to drive their own learning, but very hesitant about whether or not they could pull off a simulation that would be authentic and respectful given the sensitive topic of mental illness. In addition, I didn’t know how to help monitor or control the situation and be sure that the actors were not stigmatizing mental illness with their actions. However,
throughout the entirety of the unit, I was encouraging students to take control of their learning and I was trying to follow their lead. Do I take over the learning due to my uncertainty or do I release some of my control and trust my students? This became my dilemma.

After careful consideration throughout the course of the day, I agreed to the simulation. I knew these students well. I knew the content that we had covered and I knew that the intention of the students was to create a meaningful learning experience. Finally, I had been urging them throughout the whole unit to take control of their own learning. While this type of simulation was not an avenue I would normally pursue in my teaching, I felt that in this situation I needed to move forward with it. Prior to the simulation, I spoke with the girls and the actors. We chatted about how they planned to act and what behaviours would be appropriate and inappropriate. In addition, we agreed that at any point in the day, one of us could put an end to the simulation for any reason.

The following day, we had three students who represented people with anxiety, depression, and OCD. For the morning, I carried out our day as usual and I noted that these three individuals had markedly different yet appropriate behaviours for their roles. Students gave them strange looks as they watched their behaviours. As well, when other students tried to interact with them, they stayed in role and students were unsure how to react. I met with the actors briefly during lunch to see how they felt and we agreed that we should let the class know that we were running a simulation so that they were mindful that something was occurring, but we left out all other details. After lunch, I let the class know that we were running a simulation and that we would discuss it at the end of the day.
At the end of the day, students were eager to identify the actors and which mental illnesses they represented. All actors and mental illnesses were identified correctly which indicated how well the students had acted. Students who were observers noted that the student with depression had a hood up all day which was not normal and when she was asked if she was okay, she moved away or did not respond. Students indicated that they were worried about her and did not know how to react to her. Students identified the student with OCD as she was overly concerned about how her environment was organized and was acting differently. Identifying the student with anxiety was the most difficult for students. Students said that this student acted differently, but her behaviours were harder to name and distinguish.

In all cases, students discussed that they noted that there was something different about their peers and that they tried to interact with them, but they didn’t know how to properly support them. This led to a great conversation about when to get support from an adult or talk to someone else when you are concerned. We also chatted about how anxiety might be harder to recognize and support.

I was encouraged but not surprised by the reactions of the students to the simulation. What did surprise me was the reaction of the actors in the simulation. They expressed exhaustion and relief at being finished with the simulation. They talked about feeling “dark” and unfocused and physically drained at the end of the day. One participant stated the following:
I enjoyed the experiment with the illnesses… Everything felt so different and the way people treated me was different. It gave me a lot of different feelings and I felt as if I was in the person’s shoes. I will definitely learn from this experience.

(Keir, Exit Slip 4)

While we couldn’t presuppose the feelings of those with mental illness, we did discuss that it is probably difficult to live daily with a mental illness and carry on in the world around you.

What a way to end our unit on mental health! Despite my hesitations, I was so proud of the students for suggesting and participating in the simulation. I realized that if students are really invested in a topic and are given the opportunity for input, they will far surpass my expectations or ideas. Additionally, like a walking a tightrope, listening to students and using my professional judgment are both necessary components of balanced inquiry learning.

Our learning for the unit concluded six weeks later with exit slip 4 (Figure 11). This exit slip was more extensive than the others as it asked questions about the learning in mini-action cycle 4, but it also asked questions related to the overall learning and thinking within the unit.
When asked about the most valuable thing learned, the responses within the exit slip were so individualized. While this range of responses seemed overwhelming at first when I coded the data, I was soon encouraged as I realized that the most valuable thing students learned related to their own personal life. I interpreted this to mean that their ability to apply and synthesize the knowledge in relationship to their own experiences meant that the learning was meaningful. Some responses were holistic such as Kayla and Connor’s:

There are a lot of things we learned that are very valuable and I don’t think I could choose just one. I am very grateful you decided to teach us about mental health because it wasn’t something that I was taught in previous years. So I value everything we learned in this unit. (Kayla, Exit Slip 4)
Learning all things was valuable like knowing that you can and should deal with stress. You can’t put a price on knowledge. (Connor, Exit Slip 4)

Other students were very specific about the most valuable information they learned. Students identified the following areas as valuable:

That stress is not bad for you. I learned so much about stress in the last past few days, it’s amazing. I have a completely different point of view… now I will face stress with resilience. (Nathan, Exit Slip 4)

Learning how the brain works with mental illness because now I can really pick up and talk to someone if I do see signs and maybe get them help. (Claudia, Exit Slip 4)

It is good to know about the stages to know what is healthy or what is not. Then I can know if I need to get help and estimate what stage I am at. (Shauna, Exit Slip 4)

How to find help and how to deal with a stressor. Both of these things everyone should know. They are important to teens and adults and even little kids so the sooner the little ones learn the better for their mental and physical health. These things I wish I learned earlier so I could know. (Ariana, Exit Slip 4)
That feeling a stress response or being sad doesn’t mean you are mentally ill it just means you have mental distress or a mental health problem and it’s okay to feel those things. And it’s normal. Also what to do if we have a friend we think has a mental illness. Life before friendship. (Gabby, Exit Slip 4)

Looking at the feedback regarding preferences for ways of learning, the data varied. Once again, many students expressed enjoyment for the TED talks indicating that they liked to hear real stories and the perspectives of others. They also enjoyed completing their own research. Students generally expressed enjoyment when there was a visual such as a video or a slideshow; however, there were some students who found that the slideshows were too boring or had too much information to process. While a few students liked taking notes, highlighting, and interacting with information independently, many others found this boring. In the same way, some students preferred interactive group work while others wanted to work on their own. A number of students commented that they enjoyed the variety of types of activities. Keir made the following statements:

Personally, everything worked for me actually. I took various types of info from everything presented to me. I took pieces from everything, and it helped me to build a puzzle to paint the big pictures. Even if it was the smallest detail. (Keir, Exit Slip 4)

All of the comments and reactions showed the diversity of the students and the need to provide different learning opportunities within the classroom.

When I asked students about their final thoughts or recommendations, the feedback was very positive and insightful. A few comments stood out to me, “I feel like
you should start earlier in the year to touch more on the topics within mental health” (Kayla, Exit Slip 4).

I honestly think the unit was great. The TED talks were helpful and a great learning tool. It is also a really important unit to learn about. And the more it’s taught the sooner the stigma will be lesser and lesser (Gabby, Exit Slip 4).

I overall really enjoyed this unit. I wish we started it earlier in the year, so we could learn more about it (Connor, Exit Slip 4).

All I have to say is that I had a lot of interest for this unit and you taught it very well. More people need to learn this (Claudia, Exit Slip 4).

I don’t really have much to say and I wish this unit could go on but I guess we have to move on. This unit was actually awesome and I’ve always wished people would learn this and I think everyone should be taught this because if you think about it, it could’ve saved so many lives and we’ll never know but no one deserves to kill themselves (Rayna, Exit Slip 4).

While I was glad that the students enjoyed the unit, I was most grateful for their insight into the importance of learning the content as well as the desire to know both earlier within a year as well as earlier in life.

4.4.5.1 – Reflections on mini-action cycle 4:

1) Students value mental health knowledge - All students were able to
discuss some specific way that they benefitted from learning about mental health. In addition, several students indicated that more people need to learn about mental health and illness. The learning was personal and relevant as students were able to apply it to their own understanding of self.

2) Mental health needs to be taught at an earlier age - Many students referenced learning about specific topics that were very helpful to understand themselves (stress, stages of mental health, accessing help, etc.). Learning about these mental health topics helps students to understand who they are and what is happening to them. More than any unit I have taught previously, I felt students were relieved to learn about mental health so that they could place themselves within a context to determine if what they were experiencing was normal (healthy) or abnormal (unhealthy). If mental health was explicitly incorporated into the curriculum at an earlier age, perhaps students would experience less anxiety around what they are thinking or feeling and perhaps mental health/illness would be less stigmatized. We spend a lot of time discussing the physical development of the body. In fact, in the Saskatchewan Health Curricula, every grade between grades one to five has at least one outcome that directly focuses on the physical body (Saskatchewan Ministry of Education, 2010). Why is there a lack of explicit curricula that requires students to learn about mental health and the mental development of the body? Unless the curriculum is explicit, we cannot expect teachers to
teach it. Students also indicated that they would like to learn about the content earlier in the year. Perhaps this was due to the fact that we were rushing at the end year. I need to do a better job of planning timeframes, but perhaps it would also be a good unit at the beginning of the year for understanding self.

3) When asked for input, students will take ownership of their learning – Sharing TED talk suggestions, writing outside of the scope of Health, presenting the simulation as a tool to learn are all examples of how students independently took ownership of their learning. This was different than any other teaching experience I remember. Perhaps this was because I regularly asked for their input or possibly it was because the topic was interesting to them? Either way, when students take ownership of their learning, I believe it deepens and enriches the learning as they are making their own meaning. In addition, when students make reasonable suggestions that align with my professional judgment, I need to listen and be willing to step away from my plan as it validates their learning.

4) The topic of mental health is more delicate than other topics – There are more facets to consider when teaching mental health than other topics. Students may be facing personal issues of which I am not aware or may require help that I do not know they need. As I consider teaching strategies such as the simulation, I must be more cognizant of the effects on students.
4.5 Holistic Action Cycle – Developing Stage: presentation and reflections of post-data

4.5.1 – Post-data. Post-data was comprised of both written and oral data. At the end of the unit, all students completed a summative quiz which was the same true and false formative quiz used at the beginning of the unit. I wanted to be able to compare their knowledge and thinking at the beginning of unit with the end of the unit. In addition, I looked at the initial questionnaire and created open-ended short answer questions for students to answer related to their learning. Both assessments were completed online through google classroom. Following these assessments, participants in the study completed exit interviews with me. Once again, I gave them the option of having an interview on their own or with peers with whom they felt comfortable.

4.5.1.1 – Written post-data: summative quiz and short-answer questions. Students accessed the summative quiz (Figure 12) and short answer questions (Figure 14) in google classroom and individually completed the assessments.

Figure 12 – Sample Questions: Summative Quiz on Mental Health Facts

**Each question included the option to respond: true or false
Questions 1-6 of 28

1. Mental health and mental illness both involve the brain and how it functions.
2. People who have mental illness can at the same time have mental health.
3. The brain can affect the way the body function, but the body cannot affect the way the brain functions.
4. The frontal lobes of a young person’s brain continue to grow and develop until the age of 25 years.
5. Three of the functions of the brain include thinking, signaling and behavior.
6. Most everyday stress is toxic (harmful) and should be avoided.

(Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017, p.47)
Figure 13: Formative and Summative Quiz Highlights

<table>
<thead>
<tr>
<th>Formative Quiz</th>
<th>Summative Quiz</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the following statements are false.</td>
<td>All of the following statements are true.</td>
</tr>
<tr>
<td>55% of students believed stress was harmful</td>
<td>96% believed stress was not toxic</td>
</tr>
<tr>
<td>66% believed most people with a mental illness could not get well and stay well</td>
<td>86% believed most people with a mental illness can get well</td>
</tr>
<tr>
<td>48% believed that people who were stressed out or unhappy had a mental disorder</td>
<td>89% did not believe that people who are stressed out or unhappy have a mental illness</td>
</tr>
<tr>
<td>66% believed that mental disorders began because of the stresses of everyday life</td>
<td>75% believed that mental disorders were not caused by the stresses of everyday life</td>
</tr>
<tr>
<td>52% believed depression was caused by an event</td>
<td>71% did not believe depression was caused by an event</td>
</tr>
<tr>
<td>Mean score: 16/28</td>
<td>Mean score: 23/28</td>
</tr>
</tbody>
</table>

As identified in Figure 13, the results of the summative quiz showed a marked improvement in the misconceptions the students held at the beginning of the unit. At the beginning of the unit, students held various erroneous beliefs about mental health, stress and the causes of mental illness. As we ended the unit, many students correctly identified the causes of mental illness, the nature of stress, and the definition of mental health.

In addition to the summative quiz, I wanted students to answer written questions so that they could elaborate on their thinking and I could assess the depth of their understanding beyond a true/false statement (Figure 14). I based some of the questions upon our Initial Individual Questionnaire (Figure 1) as well as the concepts that I felt were most important to our learning and discussions. Students accessed the questions through our google classroom and answered the questions digitally.
Figure 14: Open-ended Short Answer Questions

1. Stigma is …
2. A way I can change stigma is …
3. Mental illness is …
4. The stages of mental health are …
5. Ways I can get help or help others with mental health issues are …
6. What I now believe about stress …
7. I would now define mental health as …
8. My greatest “take-away” or most important learning about mental health is …

The first seven of eight questions in the open-ended short answer questions (Figure 14) asked for concrete information which required students to include specific, factual answers that we had studied. Overwhelmingly, students provided accurate information and were able to clearly express their thinking. Question eight asked students to share their opinion on their most important learning within the unit. There were many different takeaways in the unit. Answers included learning about myths/facts, stigma, stress, getting help for self and others, the stages of mental health and the prevalence of mental illness in society.

Initially, I was somewhat surprised at the range of answers to the students’ greatest learning. As I pondered the reasons for the variety of answers and considered the students that provided them, I began to understand that students valued the information that most directly related to them personally. For example, one of the students who indicated that her greatest learning was about finding ways to help others indicated in her initial interview that she felt pressure to help friends dealing with mental health concerns, “I just want to learn how I can help other people with it and how it all works and more about mental health. It puts a lot of pressure on me … like my friends” (Claudia, Initial Interview).
(My most important “takeaway” was) learning about all the different ways to help. Personally I have lots of friends with mental issues and I’m glad that I can actually know what to do in that situation (Claudia, Open-ended Short Answer).

It makes sense that learning is personal and is most relevant when it relates to a student’s personal experience and schema. What each student takes away relates to what is key in his/her own life. As an educator, I need to be sure that learning is relevant as I believe the depth of learning increases when students relate. This requires intentional dialogue with students and interaction about their thoughts, opinions, and experiences.

4.5.1.2 – Oral post-data: exit interviews with participants. Prior to the exit interviews, I spoke to the students and let them know that I wanted them to share their honest feelings and that I would give them a choice of a group or individual interview. One student chose to be interviewed on her own while the others indicated that they felt comfortable for me to put them into small groups. Based on my knowledge of the students and in consultation with them, I grouped them in a way that I felt they would be most comfortable. Similar to the initial interview, I developed an outline of questions (Figure 15) to guide the interviews, but at times other questions developed within the flow of our conversations.

Figure 15: Exit Interview Sample Questions

1. What did you know about mental health before this unit?
2. What did you learn?
3. What was the most interesting part of the unit?
4. Why did it interest you?
5. What would you change?
6. What do you still want to learn concerning mental health?
7. How can I improve the way I teach mental health literacy as part of the grade 7/8 curriculum?
During the initial interviews, students lacked the knowledge and vocabulary to discuss mental health. Contrary to the initial interview, students possessed more schema and more language related to mental health during the exit interviews. The vocabulary, definitions and depth of understanding that had been added to their existing schema increased their ability to have dialogue about mental health. Their answers contained more specificity and clarity which allowed for a richer discussion about their learning and mental health.

Many of the concepts students discussed previously in exit slips or the written post-assessment re-emerged in the exit interviews. Nearly every interview mentioned that learning about the stages of mental health was very helpful. Several students indicated that learning about the stages of mental health was the most important thing that they learned and they referred to having a better understanding of themselves through this information.

(Learning) that you can be in all stages of mental health. You can go out with friends and be happy and have a good time, but you can also have a mental illness or disorder and have mental distress, and you can be everything at once. The stress, mental distress, and stuff like that is completely normal. (Keir, Exit Interview)

One thing I liked that I learned about is that you could be in all of the states at the same time. Like the problem, and the stress and the mental health and the illness, because that put a different perspective on things. You’re not just in one spot always. (Ariana, Exit Interview)
It’s (stages of mental health) helpful for me because if I’m going through a mental
problem or mental distress I know that it’s, that mental distress is normal to have
it, and I’m not fearing that I have a mental illness or something. (Cara, Exit
Interview)

Many students also commented about how important it was to learn about stress
and its effect on day to day life. Once again, students made personal reference to how the
information about stress affected their understanding of self.

I’d say probably the most important thing that we learned was probably about the
stress, how it’s not bad to have stress. It’s actually good to be able to adapt to it
and then apply it to different circumstances. I think that’s the most important
thing because it’s an everyday thing that we have to deal with. It’s better to know
that it’s good to deal with it and not to shy away from it. (Connor, Exit Interview)

The most important thing is probably when we were talking about the stress and
stresses of normal life. That it’s normal to experience mental distress, it’s just
stress. And it should not be viewed as a bad thing. (Patrick, Exit Interview)

I deal with a lot of stress and I don’t really know how to handle it as well and just
knowing that it’s a positive thing and it happens to everyone, it just kind of helped
to reassure me and then just know maybe what are some stress relievers … and
deal with it in a healthy way. (Kayla, Exit Interview)
Now every time I’m stressed out, I know that it’s just my body preparing me for challenges. It’s cooperating or adapting to the things so in the future if I ever come across that stressor again, I’ll know how to deal with it. (Keir, Exit Interview)

Regarding preferred methods of learning, hearing the stories of others through TED talks was the most popular way voiced by students to learn about mental health. Students wanted to be able to understand the experiences of others through their stories and identified best when they believed that the stories were authentic. “I like the TED talks. I felt they were the most effective because they … it was real life people with a real life experience” (Gabby, Exit Interview).

My favourite thing was the TED talks because I’d hear people’s experiences and what they had to say and every single time it was something new. So I feel like that was really important to me. (Keir, Exit Interview)

TED talks were the best because you could actually hear people and their stories instead of just an article. (Patrick, Exit Interview)

Additionally, students enjoyed the individual research and expressed a desire to do more self-driven research concerning mental health and mental illness.
I found it (research) helped me because you got to learn what you wanted to learn about, something that you didn’t know. Whereas if we did it as a class, some people would know and some people wouldn’t know. (Gabby, Exit Interview)

A few students also expressed enjoyment of the simulation. Jamie stated, “I liked when we did the activity where … certain people had mental illnesses. I liked it” (Exit Interview). As I reflected on the students’ preferences for learning, I realized that all of the methods they preferred were suggested to me by them through conversation, exit slips or sticky notes. It appears to me there is a direct relationship between their investment in the unit, the depth of their learning, and their ability to drive their learning.

Students referred to the timing of the unit within the school year. Kayla expressed that she wished we did the unit at the beginning of the year.

I think starting back at the beginning, starting with stress because in a new environment that can be pretty stressful so start with kind of like the stress kind of bit, and then you can just kind of move into all the illnesses and everything.

(Kayla, Exit Interview)

Keir concurred and stated, “I think it would be good at the start of the year, so you don’t have to rush and you can kind of take your time with it and learn things over the year.” (Exit Interview)

Also related to timelines of teaching mental health, students indicated in two different interviews that they felt that students should be educated about mental health at an earlier age.
I think it’s important to learn about mental health in grade six or so because it’s something that starts to affect you, and I really felt it in grade seven that it was something that I just need to learn about and just kind of know because I felt really lost and just kind of the issue that I was facing. So it was definitely something that I needed to know last year. (Kayla, Exit Interview)

Like 11 or 12 (age) or grade six or seven we definitely should have learned about it cause now that we’re getting into grade eight or grade nine, like high school and stuff like that, it’s most definitely coming into our traffic. We don’t know how to react to it. (Rayna, Exit Interview)

I was impressed by the students’ ability to self-reflect and indicate that earlier learning about mental health would have been beneficial to their understanding of self.

4.5.1.3 – Reflections on post-data:

1) With schema, students are more articulate – As our unit progressed, I noticed a steady progression of the students’ ability to use appropriate vocabulary, express their personal needs for learning as well as their general knowledge of mental health. While this seems like an obvious statement, I need to remember that if students are struggling to express themselves or share understanding that perhaps I need to provide more of a framework or background in order to provide the scaffolding for them to succeed.

2) Learning mental health is personal and delicate – Students based their most important learning of mental health upon what was personally
relevant to them. This depended upon their past and current experiences, their knowledge of mental health or lack thereof, or the issues that were most relevant in their own lives. Many students were looking for a way to identify what they were feeling and to situate themselves in a framework where they could understand what they were thinking and feeling as compared to others. As a teacher of adolescents, I am always aware of this vulnerable age, but the topic of mental health seems especially fragile for them. Part of my responsibility as I see it is to help them navigate their understanding of self by providing mental health literacy in a safe environment where they can navigate personal learning.

3) Learning is richer with student input – Earlier in my reflections, I wondered what had changed with the students causing them to be more invested in our unit. As I look at the data, it is clear that using their preferred methods of learning allowed them not only to take ownership, but increase the depth of their learning. Releasing some of my teacher control and allowing students to drive some of their own learning allowed for a richer, more invested group of learners. While this is a small change, it is not always easy to relinquish control. I have definitely seen that the benefits far outweigh my fears.

4) Students are aware of the need to learn about mental health earlier - Once students became aware of mental health definitions, issues and general understanding, they were able to express a need and desire for it to occur both earlier within a school year as well as earlier in their lives. If
students are able to articulate this, certainly as the adults that support and teach them, we need to listen and find ways to incorporate it into the curriculum. As I listened and watched students throughout, there were moments of palpable relief as students came to a personal understanding of self as related to mental health. Students should not have to experience the anxiety and uncertainty of mental health concerns simply because they are not educated early enough.

4.6 Summary of Chapter Four

Chapter four discussed implementing mental health literacy in a grade 7/8 classroom through four mini-action cycles within a holistic action cycle which took place over six weeks. Within this framework, I explored the incorporation of mental health into the middle-years curriculum as well as how to improve the implementation of mental health literacy by listening to the needs and guidance of the students as well as reflecting on the needs of my practice. Throughout chapter four, I included reflections based upon the reoccurring ideas of students and my own personal reflections. Through this process, I was able to understand elements that affect the implementation of mental health literacy in my classroom. I will address these findings in chapter five which serves as the reflecting stage of the holistic action cycle that framed the research project.
CHAPTER FIVE – INTERPRETING DATA:  
Holistic Action Cycle - Reflecting Stage

5.1 Introduction

In chapter four, I presented data from four mini-action cycles within the planning, acting and developing stages of the Holistic Action Research cycle. The data was collected from twenty participants from my grade seven and eight homeroom. In addition, I used my own thoughts and reflections as part of the analyzed data. All data was analyzed through the lens of responding to my research question: how I can improve my implementation of mental health literacy to middle-years students?

Chapter five serves as the interpretation of data presented in chapter four. It represents the reflecting stage within the Holistic Action Cycle detailed throughout the study. The reflecting stage answers questions such as: what are the implications of the data? How does my practice need to evolve? What will I do the same and differently when I teach mental health in the future? What are my recommendations (curricula and teaching)? (Mertler, 2017). Chapter five serves to address these questions.

In order to understand how to improve my implementation of mental health literacy to middle-years students, I found it necessary to deconstruct my research question and look at it in sections: How can I improve my implementation of mental health to middle-years students?

I found that each piece of my question could be broken down to focus on specific findings. For example, improving my implementation related to my teaching practices. Improving my implementation of mental health literacy focused on teaching the subject area of mental health. Improving my implementation of mental health literacy
to middle-years students concentrated on teaching to the specific needs of middle-years students.

Four themes arose within the data that will affect improving my implementation of mental health literacy:

a) Exploring my teaching: analyzing instructional practice and professional decisions
b) Exploring my teaching of mental health: a unique subject
c) Exploring my teaching of mental health to middle years students: unpacking the needs of adolescents
d) Exploring the need for mental health literacy in the curriculum

5.2 Exploring my teaching: analyzing instructional practice and professional decisions

As I began this study, I was aware of my lack of past success and knowledge pertaining to the implementation of mental health literacy (MHL). I wondered if my lack of success in my initial implementation of MHL was related to its teacher driven nature. As such, I endeavoured to use an inquiry-based method including student involvement and choice to move through the unit. The following components are insights I made throughout my analysis of the data related to improvement of my instructional practice.

5.2.1 Instructional choices. I chose the Mental Health and High School Curriculum Guide (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental Health Association, 2017) as a guideline for teaching. My lack of knowledge about mental health literacy was a roadblock to teaching a mental health unit, so I was
grateful for age appropriate content and suggested progression in order to cover the four tenets of effective mental health literacy as outlined by Kutcher et al (2014). In the end, the guide became a framework for progression versus a prescriptive teaching tool.

The decision to use this curriculum guide yielded positive and negative effects. On the positive side, the guide was a rich source of information and framework for educating youth about mental health. When we began the unit, students were unable to verbalize what they wanted to learn or know about mental health so having a pre-planned framework provided a starting point. Furthermore, it provided suggestions for dealing with my students’ misconceptions. Initially, I questioned the progression of the framework. For example, I wondered why it suggested to begin with stigma surrounding mental health and ended with understanding positive mental health. This seemed contradictory to me. After working through the proposed framework, it made sense that understanding stigma prior to learning about mental health and illness afforded students the opportunity to face the stigma/stereotypes they held. Additionally, introducing positive mental health at the end of the unit provided students with schema surrounding mental illness, the stages of mental health, and criteria for what was normal and abnormal in order to appreciate how important it was to have positive mental health. Without the guide, the progression of learning may have been too linear, rudimentary or less meaningful. Furthermore, as a teacher, it is beneficial to be able to utilize and rely upon resources that have been field-tested and deemed as effective based upon research.

The guide was very well laid out; however, this curricular tool nearly derailed my teaching. The guide was so clear and organized that I struggled to stray from it. My intended goal was to incorporate student choice to drive the learning. When I realized
that their desired learning veered away from the guide, I struggled with the need to stay in control and drive the learning and lessons myself. After all, this guide was field-tested and effective (Kutcher, Wei & Morgan, 2015), so who was I to stray from it? If I controlled the content as the teacher, I would be sure that we would cover the necessary components. As an educated professional, it seemed counterintuitive to let students drive the learning. However, as I reflected, I realized that the truth was that it was easier for me to control the instruction than to work with the students’ suggestions. The balance of control was hard for me to relinquish.

Kaput (2018) indicates that when students are taught from a predetermined curriculum and provided with specific procedures for completing tasks, there is minimal ownership and agency in their learning. This lack of ownership was evidenced in my previous attempt at teaching mental health literacy. In order for my students to invest in their learning, I had to teach differently; I had to be willing to step away from my plan, my need to control, and allow students to express choice in navigating our pathway. One of the successes of the implementation of this unit, as compared to my previous attempt, was the ownership and investment of the learners concerning mental health. I believe that as I released control to the students and accepted that we would leave the parameters of the guide, the students became more invested in their learning. The relationship between the students and myself became reciprocal as we mutually shared ownership and this complemented the learning within the unit. We began to co-construct the learning by collaborating on decisions, content and pathways. As I shifted control to the students, the guide became a framework to consult and not the dictator of our learning.
5.2.2 – **Data Collection Tools.** When I planned this unit, my data collection tools included formative quizzes and open-ended surveys to determine baseline knowledge, exit slips to assess current knowledge and how the students wanted to move forward, summative quizzes to compare knowledge to the beginning of the unit as well as individual or small group interviews. I found all of the tools to be beneficial. Using a pre-assessment provided me with the information that students had very little knowledge about mental health yet many pre-conceived misconceptions. In addition, using similar quizzes and surveys at the beginning and end of the unit allowed me to clearly compare initial and final knowledge and determine growth of the students. Interviews allowed me the opportunity to clarify and ask more directed questions.

While all data collection tools were advantageous, the use of exit slips was the most informative for this unit and for my practice. The exit slips were typically four questions at the end of each mini-action cycle that included a place for students to comment on their understanding of the concept being studied as well as give suggestions for future direction or methods of learning.

The exit slips were quick for the students to complete and gave me a formative snapshot of their knowledge, misconceptions, wonderings, and preferences for learning. Initially, the exit slips were my first indicator that students were not accustomed to being asked how or what they wanted to learn. Their responses were minimal, lacked clarity and often did not address the question asked. I had to restructure my questions; we also had class discussions to clarify how I wanted them to participate in the learning. After my redirection, I noticed the exit slip responses became richer in content with greater specificity about learning methodologies. Additionally, I began to find sticky notes and
random notes taped to my computer that gave suggestions for materials and projects. Barell (2012) indicates that formative assessment can lead directly to students assuming more control of their learning which seemed to be happening within the space of our classroom. When I asked the students to share their recommendations within the exit slips and they saw that I was listening to their recommendations, their investment and action in our learning increased. This finding supports the research on formative assessment, but the experiential nature of researching my own practice was the most convincing way for me to understand it.

5.2.3 Using inquiry-based learning: incorporating student choice. In order to improve the implementation of mental health literacy in my classroom, I knew that I needed to shift my teaching methodology from using a prescriptive curriculum to provide leeway for student choice. Inquiry-based learning (IBL) is a cyclical process allowing students to pose their own questions and undertake research that is relevant to them. IBL is already built into the Saskatchewan curriculum (Saskatchewan Ministry of Education, 2008; 2009), so I decided to plan with this approach in mind.

5.2.3.1 Inquiry requires schema. Inquiry-based learning is based upon the premise of students asking questions to drive their inquiry or research process and ultimately make choices about what they want to learn. During the initial interviews and survey, I asked students how and what they would like to learn regarding mental health and students either misunderstood the question or were unable to answer it clearly. I was perplexed about the students’ lack of direction and clarity as I assumed that with opportunity, students would be eager to indicate how and what they would like to learn. However, they seemed to lack any background knowledge around mental health.
According to van Riesen, Siswa, Gijlers, Anjewierden, & de Jong (2018), in order for learning through inquiry to occur,

it is crucial for the student to have a basic understanding of the topic of investigation. If the student does not have at least basic knowledge about the topic, it is very difficult or even impossible to formulate meaningful research questions. (p. 1328)

As I reflected on my formative assessments, I realized that many students were unable to accurately express their knowledge about mental health. Much of the information expressed was also based upon misconceptions. Inquiry-based learning at its root requires students to drive the learning based upon interest. If students lack schema or background knowledge, there is little basis for them to create or develop their inquiries.

In order to truly develop a classroom driven by students, I realized that I had to scaffold the learning until students possessed enough schema to drive the learning on their own. Hattie and Donoghue (2016) indicated that active forms of learning can have a profound effect on students as they promote deep knowledge but only when learners have first established the necessary prerequisite knowledge. My research confirms this as my students were unable to navigate their pathway of learning initially as they lacked vocabulary and depth of understanding related to mental health. Rich, authentic learning happened after students gained prerequisite knowledge and developed schema around mental health.

**5.2.3.2 Inquiry requires intention and persistence.** As aforementioned, when I began trying to implement student choice and inquiry into my teaching, students were reluctant. At that point, I had not made the connection between inquiry and the relationship between student schema and scaffolding on my part. When the students were vague in their preferences for topic or methodology, it was tempting to revert back to
teaching prescriptively. After all, I asked and the students seemed disinterested. However, I had already intended to keep retrieving the students’ feedback on exit slips and so while I was reluctant, I kept asking for their input both through class discussion and exit slips.

In seemingly small steps, students started to offer more specific feedback indicating their preferences for specific methodology or content. As students became more familiar with having choice within our learning, I noticed increased engagement and ownership within the unit. Suddenly I was finding random notes making suggestions about how we should proceed with our learning. Students became more connected and engaged with the content and the process.

In order for students to invest in our unit, I had to remain persistent. I had to wait for students’ understanding of mental health to increase to the point that they were able to know what to wonder. In addition, because students were not used to being asked how or what to learn, I had to follow through on their requests and let them know that I was serious about allowing them to guide the learning. Barell (2012) indicates that if students do not feel like they have any power, they will not own their learning. This was certainly evident in my previous attempt at a mental health unit. Students did not have power or choice and as a result, there was no investment of ownership. Conversely, when students know what is expected of them and feel as though they are contributing to the learning, ownership increases (Barell, 2012). With persistence and intention on my part, students began to understand how to take ownership of their learning. As the data indicates, the learning that resonated the most with students was based upon their suggestions. In fact,
as voiced in the post-assessments, students’ favourite activities for learning were all activities suggested by them.

5.2.3.3 Inquiry promotes richer, more engaged learning. Kaput (2018) found that meaningfully involving students in their learning can increase their achievement, motivation, effort, participation and engagement. This was evident to me as students became increasingly involved in the learning. Stating preferences for instructional strategies, leaving suggestions for resources as well as asking for the opportunity to research and conduct simulations are all examples of ways students began to own and engage in their learning.

When students were able to individually guide their learning in a research project, I found that they chose topics that were more refined, specific and interesting to them. In addition, they were helping each other choose areas of interest. When they presented their findings to the class, students were very curious about the various discoveries and asked many questions of each other that were beyond my scope of knowledge. The depth and breadth of their learning far surpassed what I could have planned. Anderson (2016) indicates that given choice in their learning, students engage in deeper, richer learning, display more on-task behavior, and the learning environment becomes more collaborative. I concur with this finding as I found that our classroom had heightened energy, more interaction between the students, and I became the observer on the outside who was consulted as needed.

Barell (2012) states:

Teachers who afford students an opportunity to pose their own questions related to the designated content report that students become more highly motivated, more engaged intellectually and emotionally and more in control of their own learning, and thereby, more responsible for achievement. (p.54)
As we moved through the unit and students increased their involvement and focused on areas of interest, I noticed increased motivation as well as greater depth of learning. Students asked when our next class would take place; others asked if they could continue researching on their own and I noticed that all students were producing richer content in their exit slips. As our exit slips continued, students took longer to write them and wrote with great depth about what they were learning as well as what they wanted to learn in future lessons.

As I reflect on the journey of our inquiry-based learning, it is evident to me that my students experienced a richer more engaging unit of study due to their ownership and ability to drive their learning. As an educator, it makes sense that increased engagement and deeper learning will result if students are afforded the opportunity to explore areas of interest. Furthermore, I believe that when students understand that their teacher is trusting them to be in charge of their learning, they feel more ownership and responsibility to do their best work. I found that as a teacher I had difficulty relinquishing control as I did not know what to predict or how to plan for student driven learning. However, I discovered that the depth of learning and investment of the students far outweighed my moments of insecurity and vulnerability. Ultimately, my job is always about what is best for my students and giving students choice through inquiry-based learning as I scaffold them appears to be a very successful learning strategy that I will continue to employ in my teaching.

5.3 Exploring my teaching of mental health: a unique subject.

Teaching mental health, as opposed to other curricular components, requires different considerations and has different implications. The topic of mental health is
personal and one that affects understanding and awareness of self. In addition, understanding mental health can seem messy as there are so many elements that weave together to make up the fibres of one’s own mental state and awareness. As an educator, there are many factors to consider when approaching and teaching mental health.

5.3.1 Dealing with misconception and preconceived ideas. As I began teaching this unit, I realized that students’ schema related to mental health was slim to non-existent. However, students did possess beliefs and attitudes about mental health. Many of these preconceived notions were rooted in misconception. Chandra and Minkovitz (2007) indicate that younger adolescents are able to articulate their perceptions about mental health and that attitudes about mental health develop early. At the ages of 12-14, nearly all of my students were receiving their first educational experience with mental health that they could remember; yet, they already held and could identify beliefs and perceptions about mental health either from past experiences, media, discussions with others or simply their own organic opinion. As an educator, I had to be aware of not only teaching the content of mental health, but also addressing the misconceptions that existed. As I move forward in teaching about mental health, I realize that having students share understanding prior to a unit will help me to be aware of the scope of the learning that needs to be addressed.

5.3.2 Role of the teacher. Teaching mental health literacy is also unique from other content in the role that it demands of teachers. Mental health is a topic that directly impacts students’ understanding of identity, yet in my experience, students may have incomplete perspectives of self and/or they may be dealing with mental issues of which they may or may not be aware. As an educator, when teaching about content that is so
personal, it is difficult to predict the reactions and needs of the students. In fact, teachers may never be aware of the needs of a student or the impact information has upon a student. This fact weighs heavily on me because I now recognize that there are needs that I am not aware of and I could make an impact both negatively or positively without knowing it.

More than any other topic I have taught, I found that teaching mental health required more of me as a teacher. I had to be aware of students’ comments, actions and reactions, as well as any changes that I perceived while still being sure to provide a safe environment allowing for vulnerability. Additionally, depending on what I observed or suspected in students’ behaviour or written work, I had to react or research differently. For example, Jack.org (2014) provides an extensive list of what schools should and should not be doing based upon different mental illness diagnoses within the classroom. I felt a responsibility to be more aware of what students may be feeling or thinking with regard to the stages of mental health and what they may require of me to properly support them.

Mazzer and Rickwood (2015) indicate that teachers can observe students against their peers, identify students at greatest risk of mental health issues and play a role in seeking help for students. Teachers and other school personnel are often the first to notice the development or decline of mental health problems (Whitley et al., 2012). Even identifying changes in students can be complicated. For example, symptoms of a mental illness such as depression may actually be situational (ex. parents’ divorce) and therefore indicate that a student is having a mental health problem and does not in fact have a mental illness (Sun Life Financial Chair in Adolescent Mental Health & Canadian Mental
Health Association [SLFCAMH & CMH, 2017). There are so many layers of complexity to mental health.

At times, I was nervous about the impact of my words or the content we pursued and could not always predict the reactions or needs of students. I felt as though the scope of the needs was beyond what I, as an educator, could or should need to provide. My job is essentially about implementing curricula in a safe place, not identifying the mental health needs within a child; however, I cannot compartmentalize a child. Mental health education requires teaching the child as a whole and the impact of this information affects the intellectual, mental, and emotional aspects of a person. I came to recognize in a new way that I needed other professionals to be involved.

5.3.3 – The need for a team. Comprehensive school health, as discussed in chapter two, focuses on achieving educational outcomes related to school health while keeping the whole child in mind and is founded on four pillars: teaching and learning, social and physical environment, partnerships and services and policy (Joint Consortium for School Health, 2009). Wei, Kutcher, and Szumilas (2011) indicate that there is a need for a comprehensive school mental health model that can be applied across Canada. They proposed a model to address mental health problems and promote mental health in the school setting within Canadian educational contexts called the School-Based Pathway to Care Model. Providing mental health literacy was only one of five components within this model. Other components included promoting access to mental health care; improving relationships between schools and health care providers, finding ways for students to receive mental health care within their regular school settings, as well as involving parents and the community. The use of this suggested model encourages
collaboration and sharing of information among organizations, agencies and institutions across all sectors serving young people.

Although I was implementing this mental health unit on my own, I recognized the need for a team of people. I began the unit with an anonymous online chat during which I had students reveal information about self-harm and suicidal thoughts. At that point, I remember feeling out of my depth as I was not sure how to navigate the situation and meet the needs of the students in my room. I realized that in the future when I teach mental health, I need to build a team rather than rely on just me.

Incorporating supports is a necessary component of teaching mental health literacy. Prior to teaching mental health literacy, I will make contact with our school support team and invite them into my classroom in order to be visible to the students and talk about their availability. I will communicate with parents about what we are learning in our classroom in order to provide awareness and another system of support for students. In addition, I would like to incorporate community supports who would come in and speak with students about resources available to them. “Teachers should be part of the circle of care that surrounds a student in need” (SLFCAMH & CMH, 2017, p.44); however, we cannot be the entire circle.

5.4 Exploring my teaching of mental health to middle years students: unpacking the needs of adolescents.

Adolescence is a unique and critical period in life where students are developing an understanding of self and beginning to develop a sense of personal identity and agency (Pajares & Urdan, 2005). As a result, it is important to view the learning of mental health through the lenses of adolescents. In my experience and in this study, adolescents want to
better understand themselves and directly seek information that answers questions about their identity and concept of self. In order to improve my practice related to middle-years students, I believe it is important to understand the components that students identify as critical to their learning. Throughout this unit, I determined three reoccurring ideas that pertained to teaching mental health based on the needs of middle years students: personal relevance, authenticity, and timing.

5.4.1 Personal Relevance. At the beginning of the unit, I found that students felt a strong desire to situate themselves in the learning. Understanding mental health content in relationship to themselves began early on in the unit. Students wondered, “Am I normal? Are the thoughts and feelings that I am experiencing common to everyone?” The desire to find and learn information that validated their feelings or satisfied their curiosities about being normal was strong and persisted until they had enough schema with which to compare themselves.

Harvey, Brown, Crawford, Macfarlane and McPherson (2007) found that adolescents express a great deal of worry when they believe that they diverge from normativity. Understanding the root issues of the worry can be useful for communication and providing health education (Kang, Cannon, Remond & Quine, 2009). As I asked more questions and read more exit slips, I realized that students knew so little about mental health that they were concerned that the feelings or thoughts they were experiencing were indications that something was wrong for them. When we worked through our lesson about the different stages of mental health, I noted students’ worry dissipated as they began to see themselves within a stage or multiple stages; more
importantly, they were able to understand a framework to determine that what they were experiencing was either normal or a cause for concern.

Brighton (2007) indicated that adolescents are eager to learn about topics that they find personally relevant. Additionally, Martin and Dowson (2009) noted that students’ engagement and motivation is directly related to whether or not they find relevance in what they are learning. As we moved through the unit, I felt as though students were exceedingly engaged with the content as compared to other health units or subjects we studied. Many of their written responses indicated that they identified with content, found it personally or socially useful, and continued to identify areas of further interest based on their own curiosities. Many of these inquiries revolved around better understanding self, peers, or family members. The data from this unit suggested that students based their most important learning of mental health upon what was personal and relevant to them; therefore, being sure that the content I teach is personal and relevant is integral to the learning and engagement of middle-years students.

5.4.2 Authenticity. During the course of the unit, students repeated the idea that they wanted to understand mental health from the perspective of people who have firsthand experience. They felt that these people would be able to provide authentic information and truth as opposed to learning statistics or facts that would be less meaningful. Kellough and Kellough (2008) indicate that youth are more interested in real life experiences and authentic learning opportunities which I found to be true relating to the topic of mental health.

One of the strongest threads that pervaded the data was the desire for students to learn by hearing the stories of others. Marshall (2009) indicates that:
the human brain has a natural affinity for narrative construction. People tend to remember facts more accurately if they encounter them in a story rather than a list… these findings suggest a kind of give and take between life stories and individual memories, between the larger screenplay and the individual scenes. The way people replay and recast memories, day by day, deepens and reshapes their larger life story. (p. 53)

Based on students’ desire for relevance and situating themselves in their learning, it made sense to me that they would want to learn through stories as they could reflect on how their personal story integrated within the stories of others.

Throughout the unit, we had a presenter as well as many videos and TED talks to incorporate the stories of others. No matter how many stories we heard, students were not satiated. Exit slips continued to ask for more viewpoints, perspectives, and stories from other people related to mental health. Students indicated that they found the stories meaningful and relatable. In the post data, students expressed gratitude for the use of stories as they were based on people’s real-life experiences. Real life experiences seemed to validate the information. Stories of others were viewed as authentic and an accurate reflection of each person’s individual truth.

Based on students’ affinity for hearing the stories of others, I have started regularly incorporating the use of story into my practice. I have found it to be a powerful, yet simple strategy to weave into my instruction. Students continue to express an affinity for learning authentically through the stories of others.

5.4.3 Timing. Several times within the unit, students made comments about the timing of learning about mental health. Students spoke about how they wished we would have started earlier within the school year. Some students indicated that learning about it earlier in the year would have been advantageous to understanding each other in the class. Other students expressed a desire to start earlier in order to have enough time to go
further with the content. This spoke to my role in planning. Students felt rushed by the timing of the unit and I need to do a better job of anticipating time frames both in planning as well as progressing through the unit.

Also, many students spoke about a desire for mental health literacy earlier in life. They questioned why this information was just being presented to them during grades seven and eight. Additionally, they indicated learning about the information in younger grades would have been helpful to understand themselves and others as well as reduce stigma. Voicing an opinion about the need for mental health earlier in life also signifies the importance of the information to students.

Flett and Hewitt (2013) indicate that the mental health needs of children and adolescents in Canada are not being met. As I reflect on the unit and the data from it, I would concur with this. My students had so many misconceptions, questions, as well as anxiety related to mental health; I believe all of these uncertainties could be alleviated simply by introducing mental health literacy at a younger age. Incorporating mental health literacy into a spiral curriculum would be advantageous as students would be introduced to concepts at an early age and age-appropriate content could be added with each grade level.

5.5 Exploring the need for mental health literacy in the curriculum.

5.5.1 Need for explicit outcomes in the curriculum. One of the drawbacks to implementing mental health literacy (MHL) was finding connections to the curriculum. As I searched the Saskatchewan curricula, I found outcomes from multiple curricula in which MHL could connect as I explained in chapter four. While there is value in being able to combine outcomes from multiple curricula to teach a topic, all of the outcomes I
found required me to intuit the connection myself. None of the outcomes in the Saskatchewan curriculum are explicit to MHL. As an educator, unless you perceive the need to teach MHL and find a connection yourself, it will easily be missed.

If we are aiming to teach holistically, I believe it is essential to include mental health alongside physical health. The Saskatchewan Health Curricula place great emphasis on physical health education. Every grade between grades one to five has at least one outcome that explicitly focuses on the physical body (Saskatchewan Ministry of Education, 2010). The effects of the lack of outcomes for MHL are apparent as students reach grades seven and eight. My students experienced anxiety about normality, concerns about peers, as well as misconceptions about mental health; yet they possessed an overwhelming desire to know more about it and even expressed this mental health unit as their favourite unit, indicating that all students should be taught MHL. Although the need for MHL is great, unless the curriculum is explicit, it is unlikely that teachers will teach it as intentionally and meaningfully as they would another topic where the learning outcomes are explicitly named.

5.5.2 Need for mental health literacy at a younger age. Tully, Hawes, Doyle, Sawyer and Dadds (2019) indicate that half of all mental health disorders emerge in childhood, so intervening during the childhood years is critical. In addition, they point to low levels of child mental health literacy as a key reason for the high prevalence and low treatment of child mental health disorders in spite of an increase in evidence-based interventions.

As we began the unit, my students lacked basic understanding about mental health, and they held many preconceived misconceptions. When young people are put in
situations to make sense of their reality or the reality of their peers, I believe they create answers and make assumptions if facts have not been made available to them. A study by Chandra and Minkovitz (2007) indicated that younger adolescents are able to articulate their perceptions about mental health and that attitudes about mental health develop early. These findings paired with aforementioned statistics about mental disorders developing in childhood would seem to indicate that early adolescence is a crucial time to educate youth and introduce programming.

A great deal of literature indicates that school is the primary context for dealing with mental health and mental health literacy (Cushon, Waldner, Scott, & Neudorf, 2016; Flett & Hewitt, 2013; Kutcher, Wei, McLuckie, & Bullock, 2013; Manion, Short, & Ferguson, 2013; Meldrum, et al., 2009; Reinke, Stormont, Herman, Puri, & Goel, 2011; Whitley, Smith & Vaillancourt, 2012; Wei et al. 2011) as mental health can be promoted and discussed without singling out students, mental health outcomes can be introduced within the curriculum, many professionals are available in this context, schools have influence on the skills children develop and most children attend school (Cushon et al. 2016). However, I believe that to be most effective, MHL must be introduced earlier in the curriculum. By waiting longer, students must contend with correcting misconceptions, cope with anxiety or unknowns related to understanding of self and peers as well as navigate their world without a holistic education inclusive of all facets of a person. While I believe MHL must be introduced earlier, I am uncertain as to how early it should be incorporated into the curriculum. Further research is warranted in this area.
5.6 Implications and Recommendations for Mental Health Literacy

Based upon the analysis of my research as well as my personal reflections, I determined three recommendations for implementing mental health literacy in a middle-years classroom. First, I recommend that students be involved in their learning and given choice in order to experience rich, authentic learning of MHL. IBL provides opportunity for both involvement and choice. Using IBL, teachers are able to facilitate learning by using pre-assessments to determine initial understandings, misconceptions, and desires for learning in order to build schema necessary for IBL. As well, formative assessments such as exit slips are useful throughout learning to determine student understanding and further directions of learning. With the teacher’s guidance, students drive the content. IBL is particularly useful in MHL as students are able to determine their areas of interest based on personal relevance and authenticity resulting in more engagement producing greater breadth and depth of knowledge for each individual.

IBL provides the opportunity for student choice and rich learning, however, it does require careful facilitation, intention, and balance from the teacher. Choosing to implement IBL may be difficult for someone who prefers to follow a prescriptive curriculum but, in my experience, there is no question that a student driven curriculum with regard to MHL far surpasses the depth of learning in a prescriptive curriculum.

My second recommendation is that teachers create a team of people prior to implementing mental health literacy. It is impossible to know all of the experiences that students bring to their learning. Mental health can be a very sensitive topic as students begin to understand their own mental health and situate themselves within the stages of mental health. There were moments that I was unsure about the impact of our lessons or
the current situation that some students were facing. Introducing and involving a school counselor prior to the beginning the unit would provide another contact for students to seek counsel. Additionally, involving community supports through presentations, access to pamphlets, and contact information would be helpful as an additional source.

Teachers perceive themselves as having a primary responsibility for supporting children’s mental health (Kutcher, Wei, McLuckie, & Bullock, 2013; Mazzer & Rickwood, 2015; Reinke et al., 2011), however, as indicated by the School-Based Pathway to Care Model (Wei, Kutcher & Szumilas, 2011), teaching mental health literacy should not happen in isolation. Integrating MHL with other site-based mental health interventions as well as involving parents and community members and supporting students within regular school settings provides a greater avenue of support.

My final recommendation is that mental health literacy should be explicitly incorporated into student outcomes at a younger age and throughout the health curricula. As I taught this unit, I noted the urgency with which students wanted to understand their current mental health realities as well as the misconceptions that we had to address in our learning. Earlier education would alleviate both of these issues.

Similar to physical health literacy, I believe MHL should be spiraled into our curricula so that students touch upon components related to mental health each year beginning in early childhood and moving through middle years curricula. If more than half of mental health disorders materialize during childhood and students are not getting the help that is needed based on low levels of mental health literacy (Tully, Hawes, Doyle, Sawyer & Dadds, 2019), it is imperative that we start incorporating it into our curricula. Furthermore, incorporation of mental health outcomes must be explicit. We
cannot expect teachers to surmise the need for MHL and search for connections to the curricula. I recommend explicit additions to the curriculum that place as much weight on mental health as physical health.

5.7 Conclusion

When I began this action research study, I endeavoured to answer the following research question: How can I improve my implementation of mental health literacy to middle years students? To answer my research question, I asked two sub-questions: Where can mental health be incorporated into the curriculum? What do students know and want to know about mental health issues? As my research concluded, I realized that improving my implementation of mental health literacy is multi-faceted. Improvement of my practice is not isolated and must weave together several components in order to be effective. Considerations must be made to instructional practice, the unique topic of mental health as well as the distinct needs of middle years students. There is also a need to consider how curricula needs to change to incorporate the explicit teaching of mental health literacy.

As a reflective practitioner, I am learning the value of listening to the needs and voices of my students. I am noticing a shift in my approach to teaching. As I began this study, I planned for students to be co-creators and collaborators producing data for my research. What I didn’t realize is that they would become co-creators and collaborators within the domain of our learning. Within the framework of this study, our classroom became a living, breathing and evolving work of art whereby ownership shifted back and forth between teacher and student. It was a beautiful interplay of dynamics. Moving forward, I will continue to reflect and focus on improving my pedagogy of mental health
as well as other curricula, knowing the shift between teacher and student control will ebb
and flow; however, I will try to be mindful of remaining focused on allowing my students
to be co-constructors of knowledge in our classroom. While this research gave me
direction to improve my implementation of teaching mental health literacy, it also
reminded me that the field of education is living, breathing, and full of bright, beautiful
minds.
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Dear Student,

As you may know, I am currently working on my Masters in Education. To complete my program, I am completing a thesis which involves doing research and then writing my findings.

I am excited to let you know that I am going to be conducting a study about my own teaching in our classroom over the next few months. I want to improve how I teach mental health literacy in our classroom. Mental health literacy is understanding how to have positive mental health, understanding mental disorders and knowing how to get help.

I will be teaching a unit to our whole class and all students will be completing the same activities as we try to understand mental health. Some of the ways you will participate are surveys, exit slips, and interviews. Because all students will be doing the activities, no one will be aware of who is actually participating.

Choosing to participate in this study is voluntary (your choice). If you choose to participate, it will not affect your grades or any other part of our class. If at any time you decide you don’t want to participate, you can simply tell me or Mr. Keyes that you don’t want to participate and that is just fine.
This study will help me understand how to be a better teacher of mental health which I think is a very important topic for people your age.

If you would like to participate in the study, you will need to:
a) take the consent form home for your parent to read and sign
b) sign the bottom of this form giving your permission

______________________________
Assent
Your signature below indicates that you have read and understand the information about the study; I have had a chance to ask questions and my questions have been answered.

Name of Participant (printed)   Signature of Participant   Date

Researcher’s Signature   Date

ASSENT TO GROUP INTERVIEW:
As a part of the study, you may be asked to participate in a group interview. In this case, you would be a part of a discussion with myself and a few classmates. One of your responsibilities in a group interview is to respect comments of other group members and to keep other peoples’ ideas and comments confidential. Confidential means that you do not talk about what is said in this group interview with people who were not in the interview. If you feel comfortable participating in a group interview and can meet these expectation, please sign below.

Group Interview Assent:
Your signature below indicates that you are willing to participate in a group interview and keep all discussion confidential.

Name of Participant (printed)   Signature of Participant   Date

Researcher’s Signature   Date

This project has been approved on ethical grounds by the U of R Research Ethics Board. Any questions regarding your rights as a participant may be addressed to the committee at 585-4775 or research.ethics@uregina.ca.
Project Title: Improving the Implementation of Mental Health Literacy in a Middle Years Classroom

Researcher(s):
Natalie Schapansky
Graduate Student, Faculty of Education, University of Regina
Email: mclean2n@uregina.ca
Telephone: 306-791-8510

Supervisor:
Twyla Salm
Faculty of Education, University of Regina
E-mail: Twyla.Salm@uregina.ca
Telephone: 306-585-4604

Purpose(s) and Objective(s) of the Research:

The purpose of this research is to improve my teaching of mental health literacy in my classroom. The study intends to inform my practice about engagement of grades seven and eight students related to mental health outcomes. I am working on developing better mental health instruction and evaluation to integrate a relevant topic within my current classroom. Mental health literacy is defined as understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy which includes knowing when and where to seek help and developing competencies designed to improve one’s mental health care and self-management capabilities (Kutcher, Wei, & Coniglio, 2016).

Research indicates that attitudes about mental health disorders represent the most common condition affecting young people (Meldrum, Venn, & Kutcher, 2009). Additionally, young adolescents are able to articulate their perceptions (which may not be based upon fact) about mental health from an early age. Attitudes about mental health develop early (Chandra and Minkovitz, 2007). These facts indicate that early adolescence is a necessary time to introduce programming and concepts surrounding mental health literacy. I believe that mental health is a pertinent need within our schools and that schools are an excellent location to pursue the topic. The purpose of this
research is to advance my understanding and teaching specifically related to mental health literacy in my own classroom.

The data collected will be used to complete a Master’s thesis. Should the opportunity arise, the data may also be used for journal publication.

**Procedures:**

All students in the classroom will participate in a mental health literacy unit using inquiry based learning. Data will be collected from those participants who have written parental consent.

For the purpose of data collection, students may be asked to complete:

- an initial survey to determine baseline understanding of mental health
- up to 8 exit slips (two brief, written questions at the end of class)
- two individual interviews (interviews will be 20 minutes and will be audio-taped and transcribed)
- possible group interview

Interviews will occur at the beginning and end of the study. They will be one on one and take place at George Lee School. The interview questions will focus on student interest and curiosity in mental health as well as the effectiveness of my teaching strategies and activities related to mental health.

Students and parents are encouraged to ask any questions regarding the procedures and goals of the study or their roles. Students will only need to answer questions that they are comfortable answering.

**Potential Risks:** There are no known or anticipated risks to you by participating in this research.

**Potential Benefits:**

By participating in this study, students are able to assist me in improving my implementation of mental health literacy. If I am able to improve my teaching of mental health literacy, it will be beneficial to students both now and in years to come. Additionally, an improvement in my mental health literacy delivery may result in students becoming better learners, healthier individuals and citizens. Finally, improving my implementation of mental health delivery will increase my effectiveness as a teacher of adolescents

**Confidentiality:**

To ensure as much confidentiality as possible, student names will NOT be used and a pseudonym will be assigned when the interviews are transcribed and reported. Also, care will be taken that no identifying information will be included in direct quotes.
Additionally, all students in the class will be participating in the activities in the unit so participants will not feel as though they are identified.

**Storage of Data:**
The data will be stored in a locked filing cabinet and computer files are protected by a password. After the required five years, the audio-tapes will be erased and destroyed, and the transcripts, including computer files, will be deleted or shredded and discarded.

**Right to Withdraw:**
Student participation is voluntary and students may answer only those questions with which they are comfortable. If they do not want to answer a question or would like to withdraw from the study, he/she would say “I would like to withdraw from the study” to myself or Mr. Keyes. Students’ rights to withdraw will be acknowledged without penalty. Students may withdraw from the research project for any reason, without explanation or penalty of any sort up, until two weeks after the study or when marks for the course are distributed, whichever of the two is later. Data will be deleted. However, after two weeks the data may be integrated into the analysis or part of the final report. If you withdraw from the study, you will not be penalized by the researcher. Following the two week period after the study or two weeks after marks are distributed, students will no longer be able to withdraw their data.

**Follow up:**
A summary of the final report will be available by request from the researcher.

**Questions or Concerns:**
Contact the researcher using the information at the top of page one (1). This project has been approved on ethical grounds by the U of R Research Ethics Board. Any questions regarding your rights as a participant may be addressed to the committee at [585-4775 or research.ethics@uregina.ca].

**Consent**
Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to have my child participate in the research project. A copy of this Consent Form has been given to me for my records.

<table>
<thead>
<tr>
<th>Name of Participant</th>
<th>Parent/Guardian Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

| Researcher’s Signature | Date |

*A copy of this consent will be left with you, and a copy will be taken by the researcher.*
### APPENDIX C – ETHICS APPROVAL

**Research Ethics Board Certificate of Approval**

<table>
<thead>
<tr>
<th>PRINCIPAL INVESTIGATOR</th>
<th>DEPARTMENT</th>
<th>REB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natalie Schapansky</td>
<td>Faculty of Education</td>
<td>2018-039</td>
</tr>
</tbody>
</table>

SUPervisor: Dr. Twyla Salm

**Title:** Improving the Implementation of Mental Health Literacy in a Middle Years Classroom

**Approved on:** March 8, 2018

**Renewal Date:** March 8, 2019

**Approval of:** Application for Behavioural Research Ethics Review, Participant consent Form, Participant Assent Form, Introduction Letter to Parents, Sample Interview and Exit Questions.

Full Board Meeting: ☐

Delegated Review: ☒

The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment...
procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.uregina.ca/research/faculty-staff/ethics-compliance/human/forms1/ethics-forms.html.

Raven Sinclair, BA,
CISW, BISW,
MSW, PhD REB
Chair

Please send all correspondence to: Research Office
University of Regina
Research and Innovation Centre 109
Regina, SK  S4S 0A2
Telephone: (306) 585-4775   Fax: (306) 585-4893
research.ethics@uregina.ca