"It's overwhelming":

Physical and Health Educators Reflect on the Practice and Provision of Mental Health Education in Québec High Schools

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Abstract

Despite the growing body of literature that highlights the imperatives of mental health training for school–aged youths, there remains a critical lack of programming within Canadian schools. The Québec Education Program designates only one unit per year (roughly two hours total) to mental health education despite elevated rates of mental distress among youths (Mental Health Commission of Canada, 2013). This thesis explores the practice and provision of mental health education from the perspective of Physical & Health Education (PHE) instructors formally tasked with its delivery in the province of Québec. Specifically, I explore the following questions: How do PHE instructors teach the subject of mental health to their students? How comfortable and prepared do PHE instructors feel when discussing the subject of mental health with their students? Finally, how do PHE instructors view the practice and provision of mental health education relative to the scope of mental health–related issues in Québec high schools? My analysis is drawn from semi–structured interviews with eight high school PHE instructors working in the Greater Montreal Area. The research revealed that all eight participants inadvertently embedded some form of mental health related content in their classrooms, while prioritizing an "open door" policy for youths in–distress. The participants also identified a slew of personal and structural barriers that impeded their ability to integrate meaningful mental health pedagogy in their classes, including the lack of formal training, large class sizes, stereotypes of PHE as a non–cognitive subject, and restricted time allotments that forced PHE teachers to balance teaching vs. fostering mental health through physical activity. Finally, early–career PHE teachers also noted how the normalization of limited–term teaching contracts in Québec has impeded their ability to forge strong relationships with their students, which further compromised their ability to address delicate subjects, such as mental health.

Résumé

Malgré le nombre croissant de documents qui soulignent les impératifs de la formation en santé mentale pour les jeunes d'âge scolaire, il y a toujours un manque critique de programmes dans les écoles canadiennes. Le Programme de formation de l'école québécoise ne consacre qu'une unité par an (environ deux heures au total) à l'éducation en santé mentale, malgré les taux élevés de détresse mentale chez les jeunes (Commission de la santé mentale du Canada, 2013). Cette thèse explore la pratique et la prestation de l'éducation à la santé mentale du point de vue des instructeurs d'éducation physique et santé (EPS) officiellement chargés de sa prestation dans la province de Québec. Plus précisément, j'explore les questions suivantes : Comment les instructeurs d'EPS enseignent-ils le sujet de la santé mentale à leurs étudiants ? Dans quelle mesure les enseignants d'EPS se sentent-ils à l'aise et préparés lorsqu'ils abordent le sujet de la santé mentale avec leurs étudiants? Enfin, comment les enseignants d'EPS perçoivent-ils la pratique et la prestation de l'éducation à la santé mentale par rapport à l'ampleur des problèmes liés à la santé mentale dans les écoles secondaires du Québec? Mon analyse est tirée d'entretiens semi-structurés avec huit instructeurs d'EPS travaillant dans la région du Grand Montréal. La recherche a révélé que les huit participants ont intégré par inadvertance une certaine forme de contenu lié à la santé mentale dans leurs classes, tout en privilégiant une politique de " porte ouverte " pour les jeunes en détresse. Les participants ont également identifié une série d'obstacles personnels et structurels qui ont entravé leur capacité à intégrer une pédagogie significative de la santé mentale dans leurs classes, y compris le manque de formation formelle, les classes nombreuses, les stéréotypes de l'EPS en tant que matière non cognitive, et le temps limité qui oblige les enseignants d'EPS à trouver un équilibre entre l'enseignement et la promotion de la santé mentale par l'activité physique. Enfin, les enseignants d'EPS en début de

carrière ont également noté comment la normalisation des contrats d'enseignement à durée limitée au Québec a entravé leur capacité à établir des relations solides avec leurs élèves, ce qui a compromis davantage leur capacité à aborder des sujets délicats, tels que la santé mentale.

Contribution of Authors

Angelini, B. was the primary investigator who collected the data and prepared the thesis. Dr. Jordan Koch played an integral role in the development and editorial review of the thesis while also providing an exemplary amount of feedback and support.

Both Chapter 1 and Chapter 2 were written by Bobby Angelini with editorial review provided by Dr. Jordan Koch. The study procedures and methodology were formulated by Bobby Angelini and Dr. Jordan Koch while the committee members Dr. Lee Schaefer and Dr. Harvey provided key insight and review during the formal colloquium. Both minor and major editorial changes were completed according to their recommendations. Chapter 3 and Chapter 4 were written by Bobby Angelini with editorial review provided by Dr. Jordan Koch. Furthermore, Dr. Jordan Koch aided in the analysis and interpretation of the data as well as in the formulation of the results. Finally, Chapter 5 was written by Bobby Angelini with editorial review provided by Dr. Jordan Koch. An external review of the thesis was performed by Dr. Celena Scheede who provided minor edits that were considered and applied for the final thesis submission.

Chapter 1

Introduction

In recent years, schools have become important venues for teaching students about mental health, as well as for administering preliminary interventions as rates of mental distress rise among Canadian youth (School–Based Mental Health in Canada: A Final Report, 2013). In Canada, 10–20% of youth aged 12–19 years are affected by mental illness ("Child and Youth Mental Health in Canada", 2020). Suicide also remains the second leading cause of death for young people aged 10–24 years—an outcome that is further compounded by the fact that only 1/5 children in–need of mental health services will receive them, with waitlists for help taking upwards of 1–year in most provinces (“Youth Mental Health Stats in Canada”, 2020). In Québec, the number of young people under 20 years old diagnosed with a mental health disorder doubled over a 10–year period from 2000–2010, which represented the highest spike in all of Canada ("Surveillance of Mental Disorders in Québec", 2013). Researchers have contributed these elevated rates of mental distress to various societal barriers, including stigma, lack of mental health services, and widespread physical inactivity brought on by a more sedentary lifestyle (Corrigan, Morris, Michaels, Rafacz & Rüsch, 2012; Ahn & Fedewa, 2011). Even more striking is that these elevated rates of mental distress precede the COVID–19 pandemic in which 64% of youth aged 15–24 have reported worsening mental health ("Canadians' mental health during the COVID–19 pandemic", 2020).

Despite the growing body of literature that highlights the imperatives of mental health training for school–aged youth—and the urgent need for resources—there remains a critical lack of programming within Canadian schools. For example, the Québec Education Program (QEP) only designates one unit per year (roughly two hours total) to mental health education. The QEP

also designates only 150 minutes per week to Physical and Health Education (PHE) despite the abundance of mental health benefits associated with regular engagement in physical activity, including its antidepressant affect, ability to reduce stress, increase stress tolerance, and improve mental health outcomes for children (Ahn & Fedewa, 2011; Stephens, 1988). Indeed, only 15% of Canadian youths aged 5–17 years met their respective physical activity recommendations in 2019 ("Family Influence", 2020)—a trend that was reportedly even worse during the COVID–19 pandemic where physical activity rates plummeted by over 50% among Québec youths aged 14–17 years ("COVID-19 – Coalition Poids", 2020).

The goal of this qualitative study was to explore the practice and provision of mental health education at high schools in the Greater Montréal Area (GMA). My focus was on the formal delivery of mental health education within a school–based setting. In Québec, this task falls to the PHE instructor—a teacher who is also responsible for educating students about a host of complex issues linked to health and wellness.[1] The study was guided by the following questions:

- How do PHE instructors teach the subject of mental health to their students?
- How comfortable and prepared do PHE instructors feel when discussing the subject of mental health with their students?
- Finally, how do PHE instructors view the practice and provision of mental health education relative to the scope of mental health–related issues in GMA high schools?

My study began with the assumption that both formal and informal education about mental health is not restricted to the official curriculum, but inevitably also occurs in an

[1] Other subject matters also folded under the umbrella of PHE include motor development, individual skills related to sports, physical fitness, teamwork, hygiene, relaxation, behavior, and mental health ("Québec Education Program, Secondary School Education", 2004).

extracurricular fashion, i.e., in school hallways and cafeterias, on buses and on sport fields, and through dialogue with peers and family members, guidance counsellors and other teachers. The study's purpose was nevertheless to assess how PHE instructors formally tasked with educating the student body about mental health conceive and negotiate this subject against a backdrop of growing adolescent mental distress and anxiety. Preliminary research has also shown that PHE instructors harbour conflicting perceptions about their roles and responsibilities as both teachers and health care providers (Mazzer & Rickwoord, 2015; Kratt, 2019; Shelemy et al., 2019; Graham et al., 2011). My study has contributed to this literature by helping to identify the pedagogical faultiness that arise when PHE instructors try to discuss a key social issue affecting the health & wellbeing of many GMA students in today's classrooms.

The primary methodology for this study was a series of semi–structured interviews with high school PHE instructors from different public high schools in the GMA.[2] Participant recruitment was conducted in the Winter of 2022 through snowball sampling—a form of convenience sampling that utilizes the initial research participants to recruit other similar participants who may be otherwise difficult to find because of their characteristics (Naderifar et al., 2017). As a certified PHE instructor in Québec, I had the good fortune of enjoying numerous professional relationships with various schoolboards located in the GMA. My aim was to build upon these connections by contacting other PHE instructors currently employed in the field to gather a diverse population sample across the GMA. I have also worked in different PHE settings through my field experiences in both elementary and secondary schools, which gave me a unique perspective on current teaching practices about mental health.

[2] All public and private schools in Québec must legally conform to the same basic school regulations outlined in the Education Act. School curricula must also follow the QEP and adhere to the minimum time allotments designated for each of the different subjects. *Act Respecting Private Education*, CQLR, c. E 9.1, s. 25(1).

My thesis has been organized into an introductory chapter, three middle chapters, and a conclusion. In Chapter Two, I situate my thesis in relation to the broader academic literature on student mental health and mental health education. This chapter introduces the concept of mental health literacy (MHL) and further outlines the different pedagogical frameworks commonly used for promoting MHL in school–based contexts, with a particular focus on Canada. In Chapter Three, I next describe the study's methodological framework, which includes a discussion about the study's theoretical orientation, the research setting, limitations, and ethical considerations that informed this research. In Chapter Four, I then introduce the empirical results and analysis from this study which have been organized into three distinct themes derived from my three primary research questions: 1) how do PHE instructors teach the subject of mental health to their students, 2) how comfortable and prepared do PHE instructors feel when discussing the subject of mental health with their students, and 3) how do PHE instructors view the practice and provision of mental health education relative to the scope of mental health–related issues in GMA high schools? Finally, Chapter Five concludes the thesis with a summary and reflection on the implementation of mental health education within GMA high school PHE classes and the current structural challenges affecting PHE instructors' willingness to broach the topic. I also suggest future directions for researchers and pedagogues interested in addressing various critical topics such as mental health education within high school PHE classes.

Chapter 2

Literature Review

This thesis is situated within three main bodies of literature connected to adolescent mental health. First, I draw from scholarship about mental health literacy (MHL) to explain the benefits and limitations of current MHL research. Second, I explore the different Canadian initiatives and interventions that have been used to reform mental health education within schools while also identifying the intrinsic link between physical and mental health education. Finally, the chapter concludes with a discussion about the role of PHE instructors in today's schools. My goal here is to explain the reasons why PHE instructors are regularly tasked with delivering mental health education within Canadian high schools—even though they have often received limited training on mental health–related issues and interventions.

2.1. Mental Health Literacy

Health Studies scholars commonly use the term health literacy (HL) as convenient shorthand to describe an individual's ability to effectively understand and make–use of medical information and resources in their daily lives. For example, a person with strong HL will be able to understand the information on their medication bottles or consent forms. Conversely, a person with poor HL will likely have worse health outcomes and higher health care related costs due to their inability to understand potential treatments for their health–related issues ("Health Literacy," 1999). In theory, a person's HL can be improved through education aimed at enhancing his/her ability to decipher health–related messaging and to subsequently make informed decisions about their health and wellness, thus making it a key potential factor in improving a person's health outcomes (Kutcher, Wei, & Coniglio, 2016) and for helping to

mitigate various other social determinants of health linked to a person's income or education level (Kickbusch et al., 2013).

Health Studies scholars have developed the sub–term Mental Health Literacy (MHL) to more accurately describe a person's ability to understand and make–use of information pertaining to mental health and wellness (Kutcher, Wei, Coniglio, 2016). The sub–term was first described by Jorm et al. (1997) in reference to a person's knowledge about mental disorders and was later redefined by Jorm (2012) to explain the dynamic between both knowledge of, and action to improve, mental health (either one's own or someone else's). This distinction from mere passive knowledge about mental health to a literacy that is generative of a person's decision–making has opened the door to broader applications of MHL and education–linked initiatives. For example, knowledge about the different factors that shape mental health has enabled the creation of a host of different resources and preventative strategies aimed at improving both an individual's knowledge about mental health, as well as the social conditions in which good mental health and positive decision–making are experienced (Jorm, 2012).

Most recently, scholars have defined MHL as a combination of four interrelated components: "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 (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, p. 155). These four components frame MHL as a more holistic concept that encompasses various aspects of mental health, including stigma which has often been discussed separately from mental health. Wei (2017) also explained that this more holistic

definition is consistent with the World Health Organization's (WHO) characterization of MHL as a resource that can help to empower people to participate in their own health care.

Numerous scholars have shown that improving young people's MHL will yield positive health benefits and help to reduce barriers related to stigma by improving knowledge and increasing help–seeking behaviors (Ratnayake & Hyde, 2019; Gulliver et al., 2010). Scholars have also argued that programs aimed at improving MHL should not embrace a one–size fits all model and must instead be adapted to reflect the sorts of issues that are prevalent within local settings. Modifying information and/or disseminating content linked to mental health with sensitivity to locally specific settings will help to ensure that programs are appropriate and supportive of targeted populations. Furthermore, it is also important to ensure that the programs are appropriately integrated into previously established structures/organizations to optimize efficiency and not waste valuable resources (Kutcher, Wei, Coniglio, 2016). For example, successfully integrating a MHL program into a school environment would not only facilitate knowledge translation to a desired audience (i.e., children and adolescents), but would also help build on existing school infrastructure linked to mental health and wellness (Weare & Nind, 2011). Moreover, both European and Canadian education boards have advocated for increased use of MHL programming to help address the mental health pedagogy gap within their respective education systems (Kutcher, Wei, Costa, Gusmão, Skokauskas, Sourander, 2016).

Research on MHL and associated programming is limited and still evolving alongside our understanding of mental health generally. Spiker and Hammer (2019) explained the lack of consensus about which concepts (mental illness knowledge, stigma, help–seeking efficacy, etc.) should be included or left out of the definition of MHL. The authors further noted that discrepant views of MHL may be linked to the growing amount of research dedicated to each individual

concept and/or the belief that MHL should focus exclusively on mental health knowledge. The debate over the parameters of MHL or its definition has generated considerable uncertainty within the literature, with Chen et al. (2017) deferring to Jorm et al.'s (1997) original definition in which only one's knowledge of mental health and mental disorders were discussed.

Programs aimed at improving MHL have also varied considerably along with definitional changes (Spiker & Hammer, 2019). In a scoping review of MHL intervention studies, Wei et al. (2015) analyzed three MHL outcomes (knowledge, stigma, and help–seeking behaviors) and found that most programs targeted stigma while other components of MHL were only marginally addressed, including those linked to help–seeking behaviors. In addition, the effectiveness of these programs was rarely evaluated, with little to no research evaluating their individual psychometric properties; e.g., properties such as reliability, validity, and sensitivity to change (Wei et al., 2015). Scholars who have performed similar reviews have echoed this sentiment and further argued that because the components of MHL are so closely related, interventions must take the time to evaluate the effectiveness of each component—an argument that has generated uncertainty about how to carry out such an analysis (Kutcher, Wei, Coniglio, 2016).

One possible strategy for evaluating the effectiveness of educational programming aimed at improving MHL within a school setting is to examine the perspectives of school teachers; i.e., those individuals tasked with delivering mental health education and evaluating students' comprehension of this material. Though the definition of MHL and its parameters remains the subject of debate, scholars agree that the integration of MHL programming within education has the potential to benefit students, staff members, and broader society. As the responsibility for disseminating content linked to mental health commonly falls to PHE instructors, researchers

would be wise to consider these perspectives on the practice and provision of mental health education within distinct school and community settings, such as the GMA.

2.2. Frameworks for MHL

In Canada, organizations such as the Canadian Teacher's Federation and National Mental Health Commission have advocated for increased resources dedicated to mental health systems (Rodger et al., 2014). There have also been multiple initiatives and projects that have called for improved mental health education and resources for youths. For example, *Project Evergreen: A Child and Youth Mental Health Framework for Canada* was conceived of as a resource that educators, policy makers, parents, and youths could utilize to inform youth mental health interventions/programs in Canada. The project introduces numerous strategies to help address different facets of mental health, including the promotion of mental health education, the prevention of mental distress, and the development of intervention strategies (Kutcher & McLuckie, 2010). While the strategies discussed by *Project Evergreen* are not prescriptive in nature, they at least offer a framework for how schools might approach the delivery of mental health education and other promotion campaigns within a school–based setting.

Another prominent initiative was the *School Based Pathway to Care* developed by some of the leading researchers in the field such as Wei, Kutcher and Szumilas (2011). This initiative was based on the WHO's 1995 global health initiative called *Health Promoting Schools* (HPS) which was created to combat rising health concerns, improve the health outcomes of all respective educational community members, and advocate for multiple health initiatives and strategies (*WHO | What Is a Health Promoting School?*). The scholars that developed the *School Based Pathway to Care* described high school as the perfect venue to address mental health

issues for adolescents and created the model with 5 main goals including: 1) reduce stigma and promote mental health through the improvement of MHL for all stakeholders within the education system, 2) promote access to mental health care with earlier identification of distress, 3) improve the link between schools and health–care providers, 4) create a framework to enhance the resources for students still in school and receiving mental health support, and 5) involve parents and the entire community in attempting to address the lingering issues of mental distress (Wei, Kutcher, & Szumilas, 2011). This flexible model provides an overview of at least a few ways schools can address the rising rates of mental distress among youths.

The most widely studied and tested mental health education initiative in Canada is known as *The Guide*. *The Guide* is a high school mental health curriculum created in 2007 by Dr. Kutcher in cooperation with the Canadian Mental Health Association. *The Guide* was also created in collaboration with multiple educators and mental health experts to produce an evidence–based approach for improving mental health literacy for educators and youths (Kutcher et al., 2013). This resource is extremely comprehensive and includes six different modules along with a teacher's self–study guide, teacher's knowledge self–assessment, and student evaluation. These modules include: 1) the stigma surrounding mental illness, 2) understanding mental health and wellness, 3) understanding different mental illnesses, 4) the youth population's experiences with mental illness, 5) resources for seeking help and support, and 6) the significance of positive mental health (Hayes et al., 2019). *The Guide* also includes additional resources for each module such as videos, PowerPoints slides, handouts, and other web–based resources. *The Guide* is delivered as a one–day training program for teachers that lasts between 8–12 hours and is provided by either the developers of the program or select individuals who have been trained by the developers (Kutcher, Bagnell, Wei, 2015).

In one of the first studies to produce significant results, *The Guide* was implemented as a regular part of grade 9 health classes in the regions of Durham and Peterborough/Kawartha. *The Guide* was used by the regular classroom teachers (not specialists) during prescribed class time with a total of 265 students. Pre– and post–test evaluations demonstrated profound improvements in students' knowledge about mental health while also decreasing stigmatizing attitudes (Mcluckie et al., 2014). One year later *The Guide* was implemented at 3 additional schools within the Toronto District School Board to examine if the previous findings could be replicated. Grade 9 students were once again evaluated with 175 participants. The researchers discovered similar test results and argued that regular use of *The Guide* among teachers produced substantial improvements in student knowledge and overall MHL (Kutcher, Wei, Morgan, 2015). These results were further corroborated by the first randomized control trial on the effects of a mental health curriculum intervention on secondary school students' MHL. Milin et al. (2016) performed the study in 30 different high schools in Ottawa, Ontario, in grade 11 and 12 classes with 534 total students. The intervention group consisted of teachers using *The Guide* while the control group were taught using the "Teaching As Usual" (TAU) curriculum. Teachers were trained by the research assistants in half–day sessions and proceeded to implement *The Guide* over 6 hours of classroom time. Students' knowledge was measured with pre– and post–test questionnaires with results demonstrating improved MHL among students who received the curriculum intervention in comparison to the control group. The researchers further noted that *The Guide* can be adapted by classroom teachers to promote regular use as a standardized curriculum resource in Canadian secondary schools (Milin et al., 2016).

While *The Guide* has been shown to consistently improve MHL among secondary school students, the resource has also been shown to improve MHL among educators, thus making them

more comfortable and confident broaching the subject with youths. In 2014, the ability of *The Guide* to improve MHL scores among 228 in–Service teachers was evaluated across 7 school boards in Nova Scotia. These teachers participated in a one–day training session on mental health and mental health pedagogy and were assessed using pre– and post–test evaluations and survey data. The results showed significant improvements among teachers in terms of their mental health knowledge, as well as their feelings of comfort and preparedness to address mental health in the classroom. The study further discovered that the training had also improved teachers' attitudes about the stigma that surrounds mental illness (Wei et al., 2014).

In a final analysis, scholars such as Kutcher, Wei, and Hashish (2016) have praised *The Guide*'s ease of use and its adaptability across different school and educational settings around the world. For example, *The Guide* was studied among school teachers in both Malawi and Tanzanian and found to help improve mental health knowledge and decrease negative and stigmatizing attitudes towards mental illness (Kutcher et al., 2015; Wei et al., 2014).

However, despite the success of *The Guide* and other MHL frameworks, there remains a critical lack of information regarding MHL programming in the GMA and other Québec high schools. Furthermore, qualitative research on teachers' views of mental health education is needed to get a better handle on the potential resources that must be committed to improve adolescent mental distress in the GMA. Indeed, a key limitation of *all* programming aimed at improving MHL is that it inevitably falls short of addressing the root causes and broader social determinants that have contributed to elevated rates of mental distress among students in the first place—a matter to which I will turn my attention in the following chapter.

2.3. Teacher Views of Mental Health Education Training

To date, there exists limited scholarship that explores teachers' views of mental health education within a school–based setting. One of the most cited studies was performed by Mazzer and Rickwood (2015) who utilized semi–structured interviews with 21 Australian teachers to identify teachers' perceived role in mental health education. Findings from these interviews showed that teachers believed that they played an important role in supporting student mental health. However, the findings also showed that teachers were hesitant to teach and/or address mental health–related issues in the classroom due to a lack of knowledge. The teachers further worried that they would potentially do harm by giving vulnerable students wrong or misleading information. The researchers concluded that additional teacher training in mental health education was needed for developing more prepared and knowledgeable teachers.

Researchers working with teacher populations in different national contexts also discovered a similar need for more robust teacher training about mental health. For example, Kratt (2019) and Shelemy et al. (2019) advocated for more flexible, practical, and expert–led mental health education training for both pre– and in–service teachers based upon their qualitative studies with secondary school teachers in the United Kingdom, as well as their work with elementary school teachers located in the United States. The researchers further argued that additional teacher training or teacher preparation programs would ultimately result in greater student support, as well as improved teacher mental health.

Research about how to deliver mental health education programs to both pre– and in–service teachers has grown considerably in recent years owing to the increased prevalence of mental health concerns among students, staff, and in the general population. Scholars at the university of Western Michigan worked with 41 pre–service teachers to explore the impact of a

health education course on pre–service teachers' perceptions of teaching health education to students grade K–8. The results showed that, while this type of course was a step in the right direction, it still did not properly prepare them to teach the curriculum in an actual school environment (Vamos et al., 2020). A similar study was led by Canadian researchers Woloshyn and Savage (2020) who explored an upper–year elective undergraduate course on mental health and wellness for teacher candidates. Participants reported that the class enhanced their overall mental health literacy and enabled them to better discuss and clarify their roles as future educators with respect to the promotion of student mental health and wellness. The findings from these studies further suggested that even a single course on mental health and wellness for pre– and in–service teachers could potentially improve their knowledge about mental health, as well as their confidence in delivering lessons on the subject.

However, despite the obvious benefits of mental health education for both teachers and students, the actual delivery and pedagogy of mental health education within Canadian schools remains shrouded in mystery. For example, within the province of Québec, the Québec Education Program (QEP) outlines the curriculum and policy standards for all primary and secondary schools within the public system. By law, public schools must adhere to the curriculum and policy standards outlined in the QEP to receive funding and accreditation for their various programs. Teachers nevertheless retain a certain measure of autonomy with respect to how they teach particular subjects so long as the exit competencies are achieved (more on this below). More precisely, teachers must utilize both the Progression of Learning (POLs) and the 'Framework for the Evaluation of Learning' documents outlined in the QEP to help guide both their teaching and their evaluation of the different competencies specific to each school subject.[3]

[3] In PHE there are 3 competencies that include: 1) To perform movement skills in different physical activity settings, 2) to interact with others in different physical activity settings, and 3) to adopt a healthy and active lifestyle.

These documents can be adapted and changed within reason depending on the grade and skill level of the teacher's particular classes ("Québec Education Program, Secondary School Education", 2004), but the overall integrity of the documents must remain intact.

As noted in Chapter one, while the QEP contains numerous references to student mental health, the formal delivery of mental health education in Québec schools is restricted to PHE classes. The QEP nevertheless fails to explain or offer–up any strategies for how PHE teachers should help students to develop positive mental health, reduce stigmatizing attitudes at school, or to promote any other competencies related to MHL among students—an omission that is in stark contrast to the heavy emphasis placed on developing the physical health of students. Indeed, mental health is only mentioned within competency 3 of the QEP (adopting a healthy and active lifestyle) where it states that performing physical activity is positively associated with beneficial health outcomes such as improved sleep, relaxation, better stress management, and other psychological improvements ("Physical Education and Health, Secondary", 2020). The implication here is that the simple act of performing physical activity within PHE class is enough for students to develop positive mental health attitudes and behaviours ("Québec Education Program, Secondary School Education", 2004). In addition, the 'Framework for the Evaluation of Learning' for PHE fails to include information related to mental health. In fact, only one activity is listed in the POLs called "relaxation techniques" that has any explicit link to mental health ("Progressions of Learning in Secondary Schools, Physical Education and Health", 2020).

The lack of explicit POLs about mental health is surprising considering the central function they are meant to play in helping teachers to prepare and implement their lesson plans, which may account for at least part of the reason why teachers feel inadequately prepared to approach the topic. However, additional research is needed to determine if and how PHE

teachers approach the subject of mental health within their classrooms, as well as to see how they address various other critical topics about health and wellness. Of significance is that past educational reforms in Québec have made it possible for PHE teachers to introduce new critical topics within their classes; the prime example of a reform being the transition from a performance–based curriculum to a child–centered one. In this new model, students are no longer evaluated exclusively on how they perform a sport–specific task or competency, but on their ability to prepare and execute individual routines and team strategies. PHE instructors can also now introduce a variety of different topics related to health and wellness into their classrooms beyond the traditional team–based sports or fitness routines. As Fitzpatrick (2013) explained in her study of urban schooling in South Auckland, PHE instructors are well positioned relative to other subjects to deliver lessons that supersede the traditional methods of teaching.[4] In Québec, this opportunity is even more pronounced given the prominent roles that PHE instructors play within the delivery of mental health education. Historically, though, PHE teachers have struggled to determine their role in the provision of mental health education (Mazzer and Rickwood, 2015), and this lack of confidence has affected the implementation of MHL programs across Canada—a matter to which I will return in Chapter four.

2.4. Chapter Summary & Concluding Remarks

This chapter reviewed literature on MHL including its origin and influence on the different Canadian mental health education initiatives and interventions that have been

[4] Fitzpatrick (2013) mainly focused on a teacher named Dan, who was the PHE instructor for Kikorangi High School. Dan used PHE as a space to teach his students about various components related to health and wellness and ensured that his lessons had a strong pedagogical purpose behind each of them. An example of this can be seen when Dan organized a camping trip to not only connect to the student's culture but to help them develop relationships and interpersonal skills through adversity training and decision–making scenarios. Dan also used decision–making scenarios within PHE as a method of sharing leadership and authority with his students to alert them to the different power–dynamics at play within schools and in the outside world.

implemented over the last few years. Although only a few of these interventions have been adequately tested, one important initiative known as *The Guide* stands above the rest because of its continued field testing and promising results that have demonstrated improvements in both educator and student MHL (though it still has yet to become standardized as part of the curriculum). Within Québec, the delivery of mental health education falls to the purview of PHE instructors as it is still considered part of their official curriculum, albeit an extremely small portion of it. While PHE instructors have shown they are capable of addressing a host of critical topics linked to health and wellness (Fitzpatrick, 2013), we must still consider their suitability and preparedness for teaching a topic of this nature at a time when students are reporting such high levels of mental distress and anxiety. The following chapter outlines the methodology I used to explore this topic from the perspective of PHE teachers in the GMA.

Chapter 3

Methodology

This chapter discusses the methodological framework that has guided this study. The chapter is divided into three sections. In section one, I introduce the seminal work of Émile Durkheim whose theories about mental health and social integration have shaped research across several academic disciplines by drawing important attention to the sociological (vs. individual) underpinnings of mental health (Durkheim, 1897; Pescosolido & Georgianna, 1989; Tartaro & Lester, 2005). Most recently, Johann Hari (2018) has applied Durkheim's theories to the contemporary North America context, drawing attention to the broader socio–cultural and economic–political factors that contribute to enhanced stress and anxiety.

In section two, I provide a brief overview of my research setting in the GMA and further outline the history of the Québec public and private school sectors. My intention here is to introduce some of the key contextual factors that shaped my methodological decisions related to data collection. The section also includes an overview of my primary methods for data collection, which included semi–structured interviews with eight PHE teachers from the GMA. The methodological strategy and approach I used for data analysis is also discussed.

Finally, in section three, I discuss the various ethical considerations and limitations that were negotiated over the course of my study. Given the restrictions imposed by the Covid–19 pandemic, I took extensive measures to ensure the health and safety of my participants by conducting all my interviews over Zoom rather than in–person. I have also conducted several follow–up interviews with many of my participants to ensure their views were fully articulated and that my arguments accurately reflected their experiences in the field.

3.1. Theoretical Framework

The theoretical framework that guided this study was rooted in critical theory. Bloomberg and Volpe (2012) explained that critical theory is synonymous with terms such as advocacy or social justice because of its focus on the emancipation of marginalized or disenfranchised groups. Scholars have thus described critical theory as inherently political and further argued that it consists of, "a core idea that knowledge is structured by existing sets of social relations" (Sparkes & Smith, 2013, p. 50). In terms of social change, critical theory is intended to be used to improve the lives of whoever the research may focus upon while also bringing to light the social, political, and historical context surrounding the specific issues in question (Bloomberg & Volpe, 2012)—all of which remain aspirational yet core goals of my proposed thesis. Indeed, my study's central objective is to explore the practice and provision of mental health education in the GMA with the long–term aim of helping to improve mental health among teachers and youths.

For example, after examining the Québec Education Program (QEP) document, I observed a striking lack of content linked to mental health education at the high school level. Moreover, as my earlier chapters explained, all the research to date displays elevated levels of mental distress among high school aged youths in Canada, which points to mental health being a complex social and public health phenomenon as opposed to a merely individual one. My theoretical framework and analysis thus draw from the sociologist Émile Durkheim who wrote famously about the link between complex social structures and individual mental health. Durkheim's (1897) seminal text *Suicide: A Study in Sociology* used broad based statistical data[5]

[5] To be sure, Durkheim's (1897) statistical analysis has been questioned by numerous scholars owing to its over–reliance on the 'official data' published by various countries about their yearly suicide rate. For example, Atkinson (1978) and Douglas (1966; 1967) both argued that Durkheim's analysis of yearly suicide rates neglected to consider the potential discrepancies between countries' use of the term suicide. Furthermore, they also argued that Durkheim's theory failed to account for the effect of concealment or attempted concealment on the rates of suicide, meaning that the suicide rates were likely a lot higher than those published in the official statistics.

to examine the unusually high rates of suicide that occurred during the Industrial Revolution—a period marked by intense technological advancements leading to the automation and mechanization of industry. For Durkheim, the transition from a labour force driven by a rural agrarian economy where folks worked alongside their family members to one driven by dispassionate urban factory work contributed to what Karl Marx (1867) called the alienation of labour, meaning that working–class citizens felt increasingly disconnected from their work, their co–workers, the product they produced, and most importantly, from themselves.

Durkheim also identified several other aspects of industrial life that enhanced mental distress leading to suicide among urban citizens. For example, according to Durkheim, suicidal iterations occurred most frequently among individuals who lacked social integration, which Richard (2015) defined as "common ties or bonds that hold people together and give them a common outlook and a feeling of solidarity" (p. 23). Durkheim believed that individuals who were generally detached or dislocated from others and from various social institutions (e.g., religion, marriage, and family) were at an increased risk of mental distress leading to suicide as they relied solely on themselves for support. In this sense, Durkheim believed that suicide was inversely proportional to an individual's participation in society. He further argued that factory workers, unmarried people (men, in particular), migrants who left large families in the countryside to pursue work in the city, and even the wealthy, experienced especially high levels of mental distress owing to their lack of social support and compromised integration in the community (Durkheim & Simpson, 1999). Therefore, for Durkheim, the lack of social integration, and its corresponding risk of suicide, was emblematic of a wider societal problem associated with industrialisation, as opposed to a problem rooted in individuals.

Durkheim explained further that, over the course of people's lives, their value and belief systems tend to reflect the larger societal structures in which they reside. Hence, when these structures are unexpectedly disrupted or changed in some way, people experience a corresponding period of uncertainty and identity conflict as they learn to cope with their new situation. It is within this adaptation period, Durkheim argued, that people's depressive symptoms elevate and their risk of committing suicide also increases. Durkheim described this form of suicide as 'anomic' and he further argued that it "results from man's activities lacking regulation and his consequent sufferings" (Durkheim & Simpson, 1999, p. 258). While Durkheim's main concern involved the abrupt societal changes associated with industrialization, he illustrated anomic suicide through another scenario about an individual who suddenly became rich. Although discovering newfound wealth is normally viewed as fortunate, Durkheim stated that the abrupt change in a person's socio–economic status and the multitude of new options available to them could prove detrimental to their mental health (Durkheim & Simpson, 1999). This person – ill–equipped to handle their newfound wealth – could become increasingly anxious and isolated from their former peer groups due to their sudden lifestyle changes.

Johann Hari's book *Lost Connections* (2018) applied many of Durkheim's core arguments to contemporary Western society and argued that much of the psychological distress and anxiety witnessed today can be linked to a growing form of "disconnection" among civilians, which he defined as, "ways in which we have been cut off from something we innately need but seem to have lost along the way" (p. 129). Hari (2018) described nine forms of disconnection that have been propagated by modern social environments and that contribute to mental distress (much like Durkheim's seven factors that contribute to social anomie). Examples of disconnection include the disconnection from meaningful work, from people (through remote

work, for example), and from meaningful relationships, which is associated with increased feelings of loneliness. Hari also examined how mental illness has been mistakenly characterized as a weakness of character that could be resolved if only a person just "tried harder."

Scholars have long challenged popular stigmas surrounding mental illness, such as the notion that people with mental illness are inherently dangerous (Hales & Lauzon, 2015). However, in studying mental illness as a purely biological phenomenon – i.e., the result of an individual's biochemistry –, some scholars have inadvertently downgraded the social dimensions of mental health and wellness in society. For example, one longstanding theory that persists in popular understandings about mental illness is that anxiety and depression stem almost entirely from the impaired functioning of serotonin within the body. As such, the primary treatment for anxiety and depression has historically been through prescribing selective serotonin reuptake inhibitors (Cowen & Browning, 2015) – a treatment that fails to address broader personal and social causes of mental illness (Hari, 2018). While not dismissing biological explanations, Hari suggested that anxiety and depression are universal reactions to how we live in society, and he further noted that we are all vulnerable to experiencing them depending on the circumstances.

For example, the enhanced mental distress reported during the Covid–19 pandemic provides an important illustration of the social dimensions of mental health and wellness, as well as a prescient illustration of Durkheim's anomie. During the pandemic, governments across the world restricted citizens' right to travel and forced them to stay at home under lockdown to curb the spread of the virus. In Canada, families and friends were separated from each other for long periods of time, people were prevented from entering their workplaces, schools were shut down, and only businesses deemed essential were allowed to stay open. People were also forced to use digital technology more than ever to communicate with each other. Collectively, these

restrictions constituted an extreme rupture in the social fabric that corresponded with a significant uptick in reports of mental distress during the pandemic. According to one national survey, from Fall 2020 to Spring 2021, an increased number of Canadian adults screened positive for major depressive (15% to 19%) and generalized anxiety (13% to 15%) disorders ("The Daily — Survey on COVID-19 and Mental Health", 2021). Moreover, a higher number of young Canadian adults aged 18 to 24 years reported experiencing negative mental health effects due to the Covid–19 pandemic during this period. Youths were particularly deprived of all the venues and activities they typically pursue to experience a sense of connection and belonging with their peers (e.g., school, sports, and extracurricular activities were all cancelled indefinitely). Youths were also told a haunting message that, if they disobeyed pandemic regulations, they would be putting at risk the health of their parents, grandparents, and others.

While the global pandemic enhanced peoples' feelings of depression and anxiety, researchers like Johann Hari and others had long drawn attention to the feelings of anxiety and isolation that appeared to be growing among the general population in Western societies, especially among young people and the elderly. Scholars have attributed elevated rates of mental distress to various social attitudes and behaviours, including stigma related to mental illness, widespread physical inactivity brought on by a more sedentary lifestyle, and the emerging asocial society (Corrigan, Morris, Michaels, Rafacz & Rüsch, 2012; Ahn & Fedewa, 2011; *The Next Generation of Emerging Global Challenges,* 2018). In particular, the stigma associated with mental illness has been shown to enhance feelings of isolation among youths with anxiety, depression, and other forms of mental illness (Pescosolido et al., 2007). Collectively, these feelings coupled with the stigmatizing attitudes surrounding mental illness demonstrate the need

to examine the practice and provision of mental health education wholistically; that is, as pedagogy that occurs within (as opposed to severed from) broader social environments.

3.2. Methods

Research Setting

The general research setting for this study was GMA high schools which operated as part of the broader Québec education system. Importantly, Québec's education system is distinct in comparison to other Canadian provinces because of the relationship between its public and private school sectors. Magnuson (1993) defined private schools as: "a school owned and operated by a non–public authority rather than by the government, usually charging fees and offering full–time tuition at the elementary and/or secondary school level" (p. 5). Québec private schools run independently of any governmental institution and, in the past, were often founded by either religious groups or untenured teachers who sought to carve out their own institutional niche separate from the public school system. Most private school students must pay tuition rates that depend on whether the school receives subsidies from the government. In addition, most private schools in Québec also receive government subsidies but will not qualify for any extra funds issued through school tax rebates or for accepting students with learning difficulties ("Frequently asked questions | Quebec independent and private schools", 2021).

There are a total of 2740 public and 254 private educational institutions in the province of Québec, with most of them being French language based ("Daily Numbers for the Province – Public and Private School Systems List of Schools", 2021). Although private schools make up only a small fraction of the total number of educational institutions in Québec, they accommodate over 10% of the entire student population, making Québec the province with the

highest concentration of students in private schools in Canada (“Independent Schools at A Glance”, 2012). This rather large inclination toward private education has roots in 17th century New France where religious institutions were tasked with educating the populace. Private education became deeply entrenched as part of French Canada’s history and garnered a reputation for successfully catering to society’s elite (Magnuson, 1993). These sentiments are still prominent today and can be witnessed through the growing number of Québec families opting to register their children for private institutions despite their high cost and low admissions rates (Gutnick, 2017). However, the relationship of a robust private system to the suppression of public unions and teacher wages is another a key contributor to the relatively high percentage of private schools in Québec. Indeed, Statistics Canada reported Québec as having the lowest primary and secondary school teacher salaries in all of Canada ("Annual statutory teachers' salaries in public institutions,” 2020). Salaries are especially low for early–career teachers in Québec who, in 2019, earned almost 11% less than teachers in the next lowest paid province, and 16% lower than Ontario. The relationship of this pay gap to teacher precarity and the social bonds generated and sustained among both teachers and students is a theme I will revisit in Chapter four, especially as it relates to mental health education.

However, despite important distinctions, both the public and private educational systems in Québec share several commonalities, including the overarching mission to provide students with instruction, qualifications, and opportunities for socialization with the goal of preparing them to be capable members of society (“Policy on Educational Success”, 2017). According to s. 25 of the *Act Respecting Private Education,* all Québec public and private schools must legally conform to the same basic school regulations outlined in the Education Act. They must also adhere to the objectives outlined in the QEP, including: the frameworks for the evaluation of

learning, the progressions of learning (POLs), and the minimum time allotments designated for each subject. Private schools nevertheless retain the ability to modify the time allotments suggested within the QEP for various subjects, including religion, and can alter how the curriculum is administered (so long as they satisfy the minimum requirement).[6]

For the purposes of my study, I focused solely on PHE instructors currently teaching in public high schools within the GMA. Public high schools within the GMA have a strict curriculum and time allotment mandate for all subjects, including mental health education. Conversely, private/religious schools may each approach mental health education differently depending upon their religious affiliations. The lack of a standardized curriculum makes each private/religious school unique in terms of their delivery of course content and, if included in the study, could have potentially skewed the findings. To avoid confusion and improve generalizability across provinces and social classes, private/religious schools have been omitted from this study in favor of the public sector. However, the findings are still relevant for private schools owing to the commonalities between the two systems, as well as to the fact that all teachers in the GMA are similarly qualified and compensated for their pedagogical duties.

Data Collection Procedures

The primary methodology for this study was a series of semi–structured interviews with high school PHE instructors from different public high schools in the GMA. Longhurst (2003) defined semi–structured interviews as "interviews that unfold in a conversational manner

[6] For example, Loyola High School (a private Catholic high school in Montréal) has on several occasions tried to change the Ethics and Religious Culture (ERC) program on account of the conflict between their Christian views and other religious worldviews. This dispute has gone as high as the Supreme Court of Canada for a decision about religious and pedagogical autonomy in Québec (see Loyola High School v. Québec (Attorney General), 2015 SCC 12, [2015] 1 S.C.R. 613).

offering participants the chance to explore issues they feel are important" (p. 143). Semi–structured interviewers utilize a pre–planned interview script to guide the direction of the conversation (Sparkes & Smith, 2013). However, the questions are predominately open–ended to allow the participant adequate time to expand their ideas, increase the range of their responses, and share meaningful verbal interactions with the researcher.

Participant recruitment was conducted in Winter of 2022 through snowball sampling—a form of convenience sampling that utilizes the initial research participants to recruit other similar participants who may be otherwise difficult to find because of their characteristics (Naderifar et al., 2017). As a certified PHE instructor in Québec, when this research began, I already enjoyed numerous professional relationships with various schoolboards located in the GMA. My aim was to build on these connections by contacting other PHE instructors currently employed in the field to gather a diverse population sample across the GMA. I had also worked in different PHE settings through my field experiences in both elementary and secondary schools giving me a unique perspective on current teaching practices about mental health.

The criteria for the research participants were as follows:

- They must have been currently working as a PHE instructor at the high school level;
- They must have been working within the public sector;
- They must have been working in the GMA;
- The must have been working for an English school board;
- They must have been employed on a contract or tenured basis to ensure that they had adequate teaching experience in the field of PHE and could provide relevant information about the current state of mental health education.

In total, I interviewed eight participants who varied in terms of their age and experience. Four of the participants including Marty, Kyle, Ben, and Patrice were tenured PHE instructors who had each worked in the field for over 15 years and had primarily taught at one school throughout their careers. Another participant named Randy had similarly been teaching in the field for over 10 years but had failed to find any permanent PHE teaching positions and instead worked on a contractual basis replacing tenured teachers who were forced to take a leave of absence. The youngest participants—Sammy, Lan, and Nick—had only been teaching in the field for less than two years each and similarly worked replacement contracts for extended periods.[7] The interviews were conducted for approximately 50–90 minutes each with the participants responding to a series of questions that invited them to explore their views on the current state of mental health education in high schools and, more specifically, their own PHE classes. Sparkes and Smith (2013) explained that, unlike more structured interview methods, semi–structured interviews are much less restrictive and do not rely on identical interview plans for each participant. This flexibility promotes greater confidence among participants and allows them to exert a greater degree of control on the overall interview process. Longhurst (2003) also argued that this more informal strategy helps participants to feel more comfortable responding to different questions and opening–up about their experiences. Collectively, the strengths to this methodological approach promoted a comprehensive interview process that helped to reveal findings that may have proven less accessible during a more structured interview style.

Formal interviews took place over a 4–month period between February 2022 and May 2022. The participants were given the option to perform the interviews in–person at a location that was convenient for them (excluding school property) or over Zoom due to the health

[7] A detailed table of the participant's teaching profiles can be found in Appendix C.

regulations linked to Covid–19. Notably, all the participants opted to perform the interviews over Zoom for various personal reasons. Some obvious benefits to performing interviews through online platforms are that they are less expensive and time consuming (Lo Iacono et al., 2016). Furthermore, as there is no need to meet in–person, interviews can be performed safely at a distance to limit the potential transmission of the Covid–19 virus. Braun et al. (2017) also highlighted some other benefits to utilizing Skype or Zoom platforms such as their close resemblance to actual in–person interviews which allows the interviewer and participants to build a visual connection with one another and to still identify non–verbal cues such as body language or other environmental factors. Moreover, because there is a degree of disassociation caused by the online format, these types of interviews have the potential to be more inclusive for people who suffer from chronic diseases, social anxiety, or for people with limited mobility or transport options (Nicholas et al., 2010; Thomas et al., 2013). All interviews for this study were audio recorded and transcribed verbatim before they were categorized into themes.

Crucially, preliminary interviews and informal discussions with participants took place prior to conducting any formal interviews. These types of casual conversations were intended to help build rapport with participants, to explain the purpose of the study, outline the ethical protocols governing the study, and to address any questions or concerns they had prior to conducting the formal interview. None of these interviews were audio–recorded.

Textual Materials and Analysis

Various formal and informal documents and other textual materials were reviewed for this thesis that pertained to MHL, mental health and distress, Canadian mental health education initiatives, and social theory. For example, books written by prominent social theorists such as

Émile Durkheim were reviewed to help frame the study with sensitivity to broader social and historical work on this subject. Durkheim's work – and others who have built upon it, such as Johan Hari – were particularly useful for framing mental health as a sociological and public health phenomenon, as opposed to casting it merely as an individual struggle linked to a person's biochemistry. I also reviewed various informal documents related to the Québec education system and the rates of mental distress amongst the Canadian youth population. Examples of informal documents that were reviewed include: web pages on the private and public education systems in Québec, statistics on the rates of mental illness and distress among both Québec and Canadian youths, and public health documents related to the MHL programs or interventions that have been planned/implemented within Canadian schools.

Data Analysis and Synthesis

The primary challenge of analyzing qualitative data gathered through semi–structured interviews is the management and organization of information. Researchers must have proficient knowledge of the data set and be prepared to invest a good chunk of time immersing themselves in the data to properly identify appropriate themes or generalities (Field, 2019). To help address these challenges, I pursued hierarchical content analysis to help explore and prioritize the *least* and *most* important themes pertaining to my research questions. The aim of hierarchical content analysis is to "identify patterns in the data collected and explore the ways these patterns interplay hierarchically" (Sparkes & Smith, 2013, p. 116). Notably, this strategy allows the researcher to identify larger or smaller categories within the data set and to compare both their similarities and differences. Researchers can then organize the content into a hierarchical format which allows for a clear demonstration of the importance associated with each of the emerging concepts

(Sparkes & Smith, 2013). The step–by–step format promoted by hierarchical content analysis also makes it a suitable analytic strategy for novice researchers to create a concise and coherent presentation of the analyzed data.

Sparkes and Smith (2013) outlined a series of progressive steps for researchers to follow when analysing qualitative data, including immersion, identifying/labeling themes, connecting and ordering themes, cross checking, confirming, and produce a table to help organize data (pp. 117–118). The first step, immersion, is when researchers familiarize themselves with the data by reading the interview transcripts or listening to the audio recordings of the interviews. After the researcher has completed step one, they can navigate through the data to identify and label preliminary themes across the participants responses. The researcher can then begin to group similar themes together into relevant larger categories and refine them over time. These themes and categories are then cross checked by re–examining the original transcripts to determine whether the themes and categories were appropriately represented. The researcher's analysis is subsequently inspected and confirmed by an investigator who is familiar with qualitative research but who was not a part of the data collection process (i.e., my MA supervisor). Finally, the results of the analysis are integrated into a table or figure that is designed to demonstrate how the categories and themes are ordered hierarchically.

3.3. Ethical Considerations and Trustworthiness

Ethical issues must be considered when performing any type of research that involves direct contact with human participants. For this study, all protocols, and procedures were pre–approved by McGill University's Research Ethics Board (REB)–II prior to any data collection. I

submitted my ethics application to REB–II following my colloquium in Fall 2021 to ensure that I integrated any feedback gained from my committee into the final submission.

Several protocols were practiced ensuring that no ethical issues arose during the interviews with adult PHE instructors. Following recruitment, research participants were contacted through email or phone and were given the opportunity to voluntarily participate in the interview sessions. Consent forms were also distributed to the participants in which they were informed about the research design, the context, and the information gathering process that was used for the study. Participants were given the option to either perform the interviews in–person at a location of their choice or online through Zoom. Zoom interviews were also utilized in case there were additional Covid–19 safety measures that restricted in–person meetings. Additionally, no interviews were allowed to be performed on any type of school property to ensure that there would be no need to seek approval from each participant's individual school or school board. Interviews were all performed online through Zoom and were recorded on the secure platform issued by McGill University and were stored on a password–protected computer. Confidentiality and anonymity were handled with the utmost care with all participants and their host schools being given pseudonyms to maintain anonymity (Clark, 2006). Only myself and my supervisor, Dr. Jordan Koch, had access to the raw data captured through interview recordings.

Limitations

There are several limitations that must be discussed in the interest of transparency. Trustworthiness relates to how well the researcher represents the phenomenon or question they are attempting to explore through the data they have collected (Bloomberg & Volpe, 2012). To address various issues related to trustworthiness, I will first explain my own biases and

assumptions as a researcher. As a certified PHE instructor, I have an active interest in improving pedagogy and curriculum development as it pertains to the subject of mental health. I am also personally invested in improving school and community resources related to mental health owing to my own struggles with anxiety and depression, as well as the struggles I have witnessed among friends, family members, and various students I have taught over the years.

Another limitation is that all participants for this study were from English–speaking high schools located in the GMA. As most high schools in Québec are French–speaking, this may have led to a sample population that was not entirely representative of the teacher population within the GMA. Furthermore, only a small sample size of eight PHE instructors were interviewed for this study. This small sample size allowed for long–form interviews that undoubtedly added greater depth to the participants' responses and increased the amount of data I could gather from everyone. However, one limitation from this small sample size is the potential for participant bias due to the limited number of subjects who are interviewed. Furthermore, another limitation of a small sample size is that it may be difficult to reach the point of data saturation. More specifically, a small sample size makes it more difficult to compile and analyze enough data to ensure that that all relevant viewpoints, themes, and constructs have been appropriately represented in the data set (Saunders et al., 2018).

Finally, another potential limitation of this study concerns the sincerity of participants' responses because I interviewed PHE instructors about their jobs, which means they may have been fearful of employment consequences should they produce a negative view of their workplace. As a PHE instructor myself, I was well positioned to identify and relate to potential friction points and hesitations among participants in an interview setting. My top priority was to cultivate a safe environment where participants felt free to speak their mind knowing that I

would guarantee their confidentiality and anonymity. My hope is that this study will help us all to better understand the practice and provision of mental health education in Québec so that we might improve our delivery in future years. More research will be needed to properly implement the changes and suggestions I discovered through my interviews, such as the need for increased time allotments in PHE, decreased class sizes, and more thorough mental health related trainings – all of which I will discuss in the following chapter.

3.4. Chapter Summary & Concluding Remarks

This chapter outlined the various methods that were employed to conduct my research related to the practice and provision of mental health education in GMA high schools. Critical and social integration theories were used to help guide the method of inquiry. More precisely, the works of Emile Durkheim and Johann Hari were used to theoretically frame the issues and themes that would emerge during my interviews with sensitivity to the broader social context of student mental health in Canada. The primary form of data collection for this study was semi–structured interviews with eight English high school PHE instructors located within the GMA. These interviews were performed on Zoom (due to the Covid–19 restrictions) and were recorded with an audio recording device or through Zoom's online platform. I used hierarchical content analysis to properly identify emergent themes from my interviews, and then ordered them hierarchically based on their importance. Finally, I addressed various ethical concerns and limitations encountered throughout my study by prioritizing trustworthiness and transparency, and by also vetting my research protocols through McGill University's Research Ethics Board (REB)–II prior to data collection.

Chapter 4

Analysis

This chapter discusses the analysis of data gathered from interviews with eight high school PHE instructors working in the GMA. The chapter is organized into three sections that have been labelled according to the primary questions that guided this research project. In Section One, I discuss the delivery of mental health education in GMA high schools in both formal and informal settings. In Section Two, I discuss the negative culture and stigma associated with PHE that has been perpetuated through stereotypical understandings of PHE as a non–cognitive subject, and of PHE instructors as dispassionate "jocks". This discussion prompted PHE instructors to contemplate whether PHE was the environment most suitable for discussions about mental health given their lack of formal training and access to relevant resources. Finally, Section Three explores several broader social factors that PHE instructors identified as impeding their ability to effectively teach mental health in their classrooms. Specially, I examine the limited amount of time afforded to them during the school year and the challenges associated with building strong relationships with their students as a precariously employed PHE instructor—an observation that was described as dissuading students from approaching their PHE teachers about personal struggles, such as mental illness.

4.1. How do PHE instructors teach the subject of mental health to their students?

Officially, all members of a school's staff are partly responsible for the development and maintenance of the mental health and psychological well–being of their students. As noted previously, however, the formal delivery of mental health pedagogy under the Québec Education Program (QEP) falls to the purview of PHE instructors—a fact about which all eight participants were only partially aware. Indeed, when participants were first asked about the formal delivery

of mental health pedagogy within their PHE classes, several confessed to being wholly unaware that the QEP delegated it as one of their responsibilities. Moreover, all participants noted that they had never deliberately taught a lesson centered on mental health during one of their PHE classes. This omission was highlighted by Marty who stated, “Right now I don't … I've never dedicated time for it in PHE, like a mental wellness period where I only focus on that.” Both Sammy and Nick similarly explained that most formal conversations about mental health and wellness occurred during schoolwide events such as *Bell Let’s Talk Day* or *Pink T–Shirt Day*, and almost never during PHE classes. Exceptionally, Patrice addressed mental health only when there had been a traumatic event in the community. For example, Patrice made sure to discuss both depression and suicide in her class after a few students at the school had attempted to commit suicide at relatively similar times. Patrice further stated that she always stressed the importance of positive mental health in her class and alerted her students to the resources that were available both at school and within their communities if ever they felt anxious or depressed.

Crucially, the absence of formal lessons or pedagogy centred on mental health within their PHE classes did not mean that the instructors devalued or dismissed the subject, or that formal presentations about mental health did not occur elsewhere. Patrice, Kyle, Ben, and Nick all stated that they had witnessed several presentations about mental health by external partners and specialists brought in by their school administrators to address the students. Patrice also stated that topics such as stress management strategies were regularly addressed by stress relief experts during the school’s Ethics & Religious Culture classes, and perhaps during other courses, too. He further explained that experts were occasionally brought into the school to speak to students about various critical topics linked to mental health and well–being. However, Nick

described the sheer inadequacy of one–off presentations for dealing with the complexity of student mental health:

> It was my class … so my secondary 5 students, and it was a lady from the board. She was a certified nutritionist and was an incredibly nice person, but the presentation was designed for fourth or fifth graders. Like, "this is what your plate of food should look like," and "this is what protein is. It comes from animals and plants." I'm just like, "Oh my god!" She did mention body image but never really elaborated on it. It was kind of like, "Oh, Instagram is really bad for body image" and "you should be careful what you see on Instagram because it's going to affect your body image," and "body image is important." It wasn't like … there wasn't a tool kit or any formal ideas like, "Okay, this is how you can monitor this or think about this." It was as superficial as it gets when it comes to actually talking about body image and mental health.

Nick further expressed that this seminar communicated very little information that was relevant for his 17–year–old students and criticized the speaker for offering few tangible resources for both staff and students—a theme that I pick–up on later in this section.

While most participants confessed to having rarely (if ever) centred their lesson on mental health, they noted that the subject was at least tangentially addressed during some of their lessons. For example, Ben described an occasion where he had invited two guest speakers into his PHE class to discuss various eating disorders with senior students. Kyle, likewise, worked with the school's spiritual animator to help deliver stress management strategies during his leadership classes. He explained, "So, just today, we went into a couple of classes, and I did some yoga breathing and some of my leadership kids did the tree pose or the rag doll just to get

them ready for exams." In a similar vein, Marty described a fitness assignment that he introduced to encourage his students to reflect on the cognitive benefits associated with physical activity:

> Once that mile run is done and recorded, they must look at their data and see what they've noticed about their data: their eating habits, their sleeping habits, those four factors and, again, I think their… So, once that's done, I ask them to reflect on the changes that they've made. That's when they'll start focusing on how you were in school: were you more attentive at school? Did you feel more engaged? Were you more relaxed? And I ask them to focus on certain aspects of their… Again, not all physical, but to focus on how they're feeling in school after having made those changes. So, at that point, yeah, I guess I do ask them to focus on their mental health and their mental well–being.

Much like Marty, Ben regularly preached to his students about the cognitive benefits associated with physical activity, such as enhanced self–image and improved performance at school. Ben also described how he often tried to correct a student's negative or inappropriate behaviour by appealing to mental health:

> So, if a kid makes an inappropriate comment to a teammate, "Oh, you suck," I'll stop the class and I'll say, "Why would you say that to your teammate? What did they do to spark that reaction? How can we fix this? How did your teammate feel? Is there a better way to communicate? And do you realize that you pull your whole team down by utilizing language that destroys, instead of builds, your teammates?"

Of significance was that all eight participants noted that by far the bulk of their conversations about mental health occurred informally with students, in incidences such as those outlined above or through impromptu one–on–one conversations after class. Only one participant (Kyle) had experience teaching a formal "health class" to cycle 1 high school students (grades 7

and 8) that explicitly addressed mental health, as well as other topics such as sexuality—a class that Kyle noted was a "rarity" in Québec and that he further lamented had only one offering at his school as a supplementary (as opposed to mandatory) PHE course. Thus, with little in the way of formal instruction, teachers like Sammy noted that students tended to approach their teachers individually for help and guidance with respect to mental health: "I get approached at least once per week by a student in–distress," explained Sammy. "It's overwhelming!" Similarly, both Patrice and Nick stated that they were approached almost every day by students needing to discuss their interpersonal problems. While the teachers were encouraged by the willingness of some students to talk about mental health, they were also concerned about the sheer volume of students approaching them to discuss more severe mental health issues, such as suicidal thoughts and other traumas. According to Patrice, Kyle, and Ben, there had been a substantial increase in the number of students experiencing depression, anxiety, and other mental health issues over the past several years. For example, Ben explained, "I've been dealing with a lot of students over the last three years who are going through serious issues related to transphobia, transitioning, or are asking a whole bunch of complicated questions about their identity."[8]

In response to these trends, all participants described having adopted an "open door policy" for their students if they needed to talk after class. However, the PHE teachers also acknowledged feeling both overwhelmed and unprepared to manage the sorts of discussions that were emerging among youths. Marty described his feelings in the following excerpt:

> It's a lot, Bobby. I mean, if they want to talk to me about it … if it's not a major level, you know, if it's something minor, often I can absolutely talk to them about that. And I've

[8] Unsurprisingly, Patrice, Kyle, and Ben's anecdotes coincide with the figures published by Statistics Canada which demonstrate increased rates of mental distress affecting Canadian youths aged 12–19 years ("Child and Youth Mental Health in Canada", 2020).

> done it. We've done it before and we kind of sort out the problems or we hash out some solutions. We figure it out between … maybe it's classmates or maybe it's someone in another class. If it's nothing major, you know, maybe a little bit of high school drama or something like that, then I am always available. I mean, that's just par for the course. But for some of the other stuff that they're dealing with… I just don't know where to start.

In more serious scenarios, Marty and the other PHE instructors were unequivocal in their approach: "I always refer students to the school's health professionals," such as a resident counselor, psychologist, behaviour technician, or nurse. Sammy explained:

> I had one of my kids in grade 8 who just got dumped by his girlfriend and was super depressed. He was telling me about these mental struggles that he was having, but very often I have informal conversations to gauge how serious an issue is for that student. When in doubt, and with the student's consent, I will be like, "Look, I really think you should talk to someone or talk to our school psychologist." Again, with their consent, I will then go ahead and try to set them up with whoever they need to talk to.

Like Sammy, the PHE teachers had a range of both formal and informal strategies that they employed to help students in distress depending on the student and the issues with which they were struggling. For example, both Marty and Nick encouraged their students to leave class if they were feeling overwhelmed and to find a quiet space where they could relax and collect their thoughts, such as an empty classroom. Lan also gave his students the opportunity to leave class and go visit the school's 'Zen Zone', which was a space dedicated for students who needed time to relax and to work quietly or to talk with another teacher or guidance counselor.

Conversely, Nick, Kyle, and Ben encouraged their students to stay in–class and to exercise to help manage their emotions. Ben also tried to promote the gymnasium as a safe zone for students to relax and to forget about their grievances for a while:

> If you're feeling overwhelmed or that you need time, you let me know. I'll bring you aside, we can do what we got to do. But I try my best to encourage students that, when you enter the gym, you can focus on what's happening here, and you can let go of whatever issues or difficulties you might be having by being active.

Ben here identified an important dynamic and tension that emerged over the course of my interviews: one where physical activity was itself deployed as a potential remedy for mental distress. Of course, Ben and the other PHE instructors understood that students' mental distress or other personal problems would not be resolved through physical activity alone, but they nevertheless wanted their students to experience how leading a physically active lifestyle could improve their mental health and wellness. Ben explained, "I'd love to teach formal lessons on mental health, but wouldn't that take away from physical activity? They need that activity *for* their mental health! These are the kinds of decisions we're forced to make. It's a catch–22 when you think about it." I will revisit this theme later in the chapter, particularly as it relates to the relatively low–status and small time–allotments dedicated to PHE in Québec.

An additional concern that emerged among all eight participants interviewed for this study was that, despite the abundance of students opening–up about their mental health, they believed there were likely far more students who remained reluctant to discuss their personal struggles with anyone, let alone a PHE teacher. Randy speculated that most of his students avoided talking about mental health even if though they were clearly in–distress. Marty similarly feared that students remained silent about their struggles due to stigma:

> I feel for the students who sit there quietly and are afraid to open–up. Unfortunately, we don't always see them, right? Like I said, I could see a broken leg, but you don't always see the anguished brain or broken heart type thing. You don 't see that all the time.

The fact that PHE instructors and their colleagues were already feeling overwhelmed by students approaching them in–distress was described by Marty as "seriously concerning", especially considering his belief that most students were still struggling in silence. All participants believed that more resources were urgently needed to support student mental health at public schools in the GMA, and to support teachers in their efforts to learn how to support students. For example, Nick described an occasion when he identified a student who was exhibiting depressive symptoms who became increasingly detached and withdrawn at school. Out of concern, Nick contacted the school's administrators and encouraged the vice principal to check–in on the student so that he could provide extra support as needed. Nick further explained that the administrators failed to contact the student for over one month due to staffing shortages and noted that the student's mental health deteriorated rapidly over that time. Nick—and other PHE teachers—have thus grown increasingly frustrated by a trend he described as "alarming", one where students in–distress seldom received support when they needed it most.

Crucially, all eight PHE teachers interviewed for this study expressed a willingness to "help out" and "do more" for their students if only they were given adequate resources, training, and time (both in–class time and through more permanent contracts that would allow them to build rapport with students). However, the teachers also questioned the appropriateness of PHE for addressing mental health in the current climate—a concern I explore in the following pages.

4.2. How comfortable and prepared do PHE instructors feel when discussing the subject of mental health with their students?

PHE (colloquially known as "gym") class has long been stereotyped as a space in which students can suspend critical thinking and take a break from the labour of learning. Marty encapsulated this view by citing the old aphorism, "Those who can't do, teach. And those who can't teach, teach gym"—a stereotype that resonates in today's GMA high schools.[9]

Indeed, all eight PHE teachers agreed that the stereotype surrounding PHE has made it difficult to integrate critical topics such as mental health education within their courses. Randy explained how this stereotype has been perpetuated by the "roll out the ball" culture that persists in many GMA high schools, one that he has witnessed over his teaching career:

> The person that I'm replacing has been there for 40 years and from what I'm told from others, he rolls out the balls and just lets them play. So, I think it's a cultural thing throughout every single school I've been to, especially high school. In the kids' minds, when they come to PHE class, it's open gym and they can do whatever they want.

According to Randy, the PHE instructor he replaced rarely dedicated any in–class time to skill development, healthy lifestyle habits, or other critical topics during his tenure as a PHE instructor, and unintentionally fostered a culture that skewed his students' expectations of PHE. Hence, when Randy entered the school mid semester, he had to manage several behavioural issues among students who refused to participate in more structured lessons and activities.

[9]Durkheim's (1999) observation that the education system tends to reflect broader ideologies and social structures may help us to understand the stereotype of PHE as a non–cognitive/non–serious subject. For example, popular portrayals of PHE teachers in shows and movies such as Kenny Powers from *Eastbound and Down*, Mr. Walters from *21 Jump Street*, and Jasper Woodock *from Mr. Woodcock*, all reinforce the public persona of PHE teachers as lazy, unqualified, and unintelligent instructors, who are often verbally abusive to their students.

Patrice, Sammy, Ben, and Nick all reported similar experiences and frustrations with their colleagues in PHE who apparently invested little energy preparing for their classes.

Marty, Lan, Randy, Nick, and Ben all reported that school administrators and teaching staff often perpetuated the one–dimensional stereotype of PHE by assuming that teachers simply "played" with their students and offered little formal instruction. Ben explained that he had been subjected to various prejudices and stereotypes from his school staff:

> The number of times over my career I've heard, "Ah, it's only gym!" from my colleagues and administrators … even from people at the board level. I've heard it for 25 years. It's at a point now where if I hear it, I kind of react viscerally, and I don't mean positively!

While Ben noted that negative perceptions of PHE had become far less frequent in recent years, Lan explained that PHE was essentially cut off from other subjects in his school:

> We're in the basement and everyone else is upstairs and we kind of don't mingle or interact with other teachers. I think very few of them even know my name. I assume they think of PHE as a free for all, with games and almost no mental work.

In a similar vein, Nick believed that PHE was given less attention compared to other core subjects because of its low status. He was further concerned that none of his classes had ever been audited or evaluated by any of his school's administrators: "It's not a priority subject. If students aren't rioting, administration is not going to get involved. And that kind of mindset is decently present among my students from grades 7 to 11."

Accordingly, all eight PHE teachers interviewed for this study believed that most students harboured similarly one–dimensional views and stereotypes of PHE as a non–serious subject. Lan explained that one of his biggest challenges in teaching anything health or non–sport related was how students viewed PHE: "they want to play, they want to learn about sports

and games, not health and nutrition." Both Kyle and Nick echoed these sentiments and explained that students referred to PHE class "as a joke." Nick recited an anecdote about a student asking if he could skip his PHE class to study for a test in another subject that he deemed more important. After Nick denied the request, the student yelled profanities at him before being sent to the office and later suspended. Nick acknowledged that, while this was an extreme example, the student's mindset was surprisingly common among other high school students in the GMA.

Indeed, all participants reportedly encountered similar antagonistic sentiments among students if ever they introduced any in–class work or take–home assignments in PHE. For example, both Randy and Nick recalled how their students "always try to get out of first aid trainings", and similar classroom–based lessons, during PHE because they only wanted to play different activities and sports. Nick eventually had to discipline some of his students because they refused to participate in anything other than sports and games. Randy experienced similar grievances among students and was regularly asked if he was "serious" about making them write a test or assignment on the CPR unit. Ben also received heavy criticism from his students whenever he administered a test at the end of his sport units: "it's gym! Why do I have to do tests? We should be kicking balls," were common retorts from his students. Patrice also shared a story about her students' total disregard for a health assignment in her PHE class:

> When I first started teaching, we had these health booklets and we graded students on whether they were keeping track of their sleep, their food intake, or different things like that. The kids would always copy off each other or just wouldn't hand it in. They could not have cared less about this assignment, and it was essentially treated as a joke.

The fact that many staff and students in the GMA appeared to dismiss PHE as a less serious subject prompted deliberation among participants about its viability for broaching critical topics such as mental health with students. Randy explained:

> They [students] have a have a firm mindset about PHE and believe that it's just play time. All the kids want to do is play games, and if you were to suggest a unit or some other form of pedagogy related to mental health, I just think that they would not be open to it. At the end of the day, it's better left to the mental health professionals.

Both Ben and Patrice agreed that most students did not see value in PHE beyond a site for physical activity and as a reprieve from their other school subjects, nor did they value the grades they received for the class. Conversely, though, Lan wondered whether it was strictly the idea of "busy work" that the students were opposed to or if it was the topics themselves that disinterested students. For example, he described a recent assignment he introduced in PHE called *Exploring Black Athletes*, where he witnessed an unprecedented amount of student engagement. For Lan, we could "absolutely" get buy–in from students if we integrated more relevant topics in PHE, such as mental health, as opposed to taking the same dispassionate "roll out the balls" attitude that persists with other aspects of PHE. He explained:

> I always circle back to mental health as a way to motivate my students. When I ask them how they're doing and we have those conversations related to mental health, they're all for it. They share information about their life, and I share information with them as well. It's just … if mental health is attached to an unrelated assignment or busy work, then I think that's where they're opposed to it. They want to learn about it [mental health]. Seriously, they do! And PHE is as good a place as any to talk about it with them.

While participants such as Lan expressed keen interest in educating students about mental health, they also described how a lack of formal training would make it difficult to teach such a delicate subject. Even the more senior PHE teachers—like Marty, Kyle, and Ben, who had all taught for over 20 years—shared similar concerns about the lack of formal training. As Marty explained:

> I don't have [any training]. I could not even draw upon any past experiences. It has never been taught to me, really. That's basically the short end of it, Bobby: I've never been trained to teach mental health to youths. I'm trying to think back, jeez, my McGill days are a long way away, but there were never any courses back then on mental health or anything like that, so I have not done any trainings for that. I don't want to make the problem worse by raising issues in class that could potentially retraumatize any students, especially if I'm not capable or qualified to then deal with the fallout from that trauma.

This theme of caution and concern about the potential negative effects of addressing mental health in the classroom was prominently expressed among my participants. In addition to their lack of formal schooling, many participants also noted that they had never received education about mental health during their pedagogical (PED) days and other mandatory workshops. More precisely, Randy and Nick noted that they had never participated in a formal mental health training course during a PED day or workshop. Marty also recalled having only attended a 10–minute presentation on mindfulness throughout his entire teaching career. The other five participants further stated that, while they had at least received some training on mental health education during their PED days, the quality of training was woefully inadequate given the size and scope of mental distress among youths in GMA high schools. Indeed, both Kyle and Lan stated that they had only ever been provided with limited training and resources on mental

health, including a few videos, books, manuals, and small information sessions. Lan explained, "As a PHE teacher, I feel like we're kind of left out of this information."

In the absence of formal training, some participants have relied on their own experiences and research to learn how to teach and talk to their students about mental health. For example, Kyle watched various documentaries and read academic papers to better understand the positive and negative effects of video games on adolescent development and presented this material to his students to generate meaningful discussion and reflection on the subject. Moreover, after several students at her school had attempted suicide, Patrice felt compelled to "do a better job" of addressing topics such depression, anxiety, and suicide during her PHE class:

> When stuff like that happens, Bobby, I don't know how to address it with the kids, but I can't just ignore it or pretend it never happened. I kind of just go back on experiences that I've had with other students in the past. I obviously don't name them, and I make sure that there's a big gap between the kids that I've seen now and when it [a suicide attempt] happened. For suicide, for example, I try and explain to the students that people don't know why they necessarily want to commit suicide, they just know that they have a lot of pain and feel that this is their only way out. They feel like they've exhausted all other venues to feel better. It's hard to convey that kind of stuff to students, especially young teens who are in this intense moment of development in their lives, and when they are very self–centred and will say, "Well, that's just them, they're wimps!" So, we're not always prepared for that kind of pushback. That can be damaging for those kids who feel anxious, depressed, and maybe even suicidal, if they hear that from their peers. As teachers, we have to be prepared to reframe the narrative about mental health.

Patrice struggled with how to adequately inform her students about complex issues such as depression and suicide, and the lack of formal training added further concern and self–doubt about the potential to inflict trauma. This exposes a series of questions and ethical dilemmas for PHE teachers: should they bother talking to their students about mental health and risk traumatizing them? Should they avoid the subject altogether? If not them, then who?

Patrice suggested that more mental health related resources must be made available for both teachers and students to prepare for discussions about mental health. One suggestion that Patrice offered included changes to the students' schedules to accommodate more dedicated study periods which could potentially help relieve some of their stress. Ben revealed that a major problem associated with PED workshops was that they were not delivered in a timely and consistent manner. He lamented the fact that he had never received enough workshops on a specific topic throughout the school year to feel confident implementing it with students:

> It's like when I go to the movies, I'll remember some cool stuff that I like, but am I going to remember what aunt May said to Peter Parker in scene four? No, I will probably only remember when she said, "with great power comes great responsibility." So, I might get the high point and it'll stick, but 98% of everything else goes into the jumble of my brain and it's the same for most of us. We sit there, we'll take notes, we're all happy in the moment, we're going to respond because we're professionals, but then what?

Ben further suggested that a potential strategy to help teachers learn about mental health education would be to require attendance at multiple workshops on the same topic during a given schoolyear, along with offering them activities to complete before each training session. Ben felt that 4–5 workshops on mental health education over the course of the year could substantially increase teachers' comfort level when discussing the matter with students. Sammy said:

> If I had a class, if I had lesson plans, if I had a full unit, PowerPoint slides that I made back in university, or resources that were given to me, I would do it [teach mental health] in a heartbeat, like I did for CPR. I learnt the course, I had all the slides, and I was able to deliver it in a strong way because the resources were there, and I had help. Whereas if I was tasked with making a unit like that now, I'd have no idea where to begin. I am not an expert in this, and the potential to do harm is far greater in discussions about mental health than with CPR. But if we had classes on it, then 100%, I would teach it!

Coupled with their lack of formal training, all eight participants interviewed for this study expressed serious concern about the general lack of physical activity among high school students in the GMA. Consequently, these teachers were reluctant to dedicate any class time to anything that may compromise their main goal: to ensure that students were "as physically active as possible" during their PHE classes. Sammy explained:

> Really, my main goal, and I'm sure it's this way for a lot of PHE teachers, is to get them moving as much as possible within a short time window. I find I'm fighting a battle against the clock because I do want them to have exposure to these other topics, but I also want to get them moving as much as possible. They need that physical activity and, unfortunately, so many of them just aren't getting it elsewhere.

Nick also agreed that PHE teachers must prioritize physical activity during class time: "Students are already not moving enough, Bobby. I struggle with the idea of taking time away for anything unrelated to physical exercise and movement." Marty agreed:

> Sometimes for students … for them to have to go sit into another theoretical class, it might not be easy for them. They've already been sitting for six periods in school, or five periods in a classroom, and now here they are in another class listening to a lecture.

Kyle was similarly reluctant to dedicate class time for anything other than physical activity:

> Again, my philosophy has changed. I want them moving. I want them enjoying movement. I want them to maybe learn a new skill. I want them to leave saying, "Hey, that was fun! I'm ready to do math now!" Or "that was a great time, let's go do science!"

Kyle described his teaching priority as "maximizing student movement", and he further believed that PHE enhanced the ability of students to focus on their other courses.

Collectively, these reflections show that, in some respects, the participants reproduced the stereotype of PHE as a non–cognitive subject by assuming that critical topics such as mental health could only be addressed in a disembodied fashion (i.e., in a regular classroom setting with students sitting at their desks, listening to a lecture, or doing a writing assignment). The negative stereotypes surrounding the PHE space combined with the participant's lack of formal training on matters related to mental health brought into question the appropriateness of PHE for addressing such sensitive topics. Additionally, these concerns are only exacerbated by the limited amount of time allotted for PHE and the challenges associated with teachers who are forced to work through replacement contracts—two issues I discuss in the following section.

4.3. How do PHE Instructors View the Practice and Provision of Mental Health Education Relative to the Scope of Mental Health–Related Issues in GMA High Schools?

> We're not psychologists. We can help guide them [students] in the right direction and show them where they can get the resources and the help they need but dealing with mental health is so time consuming and we're not given the opportunity to properly address it, especially with the increased levels of anxiety that I'm seeing this year. I feel like, as a society, we need to do better. We need to help these kids and their families.

Without exception, all PHE teachers interviewed for this study believed two things: 1) that mental health education was important, and 2) that more resources were urgently needed to promote mental health education and mental health generally among high school students in the GMA. In addition to the barriers outlined in the previous section, all the PHE teachers also noted that one of the primary barriers affecting their ability to integrate mental health education in their classes was the small window of time dedicated to PHE each week. All participants described teaching only two PHE classes on either a six or nine–day cycle depending on their respective school boards, meaning that they taught each group of students for a maximum of two periods per cycle. The time allotted for PHE varied wildly among participants but those who taught on a six–day cycle had shorter class periods with which to work because they saw their students more frequently during the cycle compared to those who taught on a nine–day one. For example, Randy, Sammy, and Nick taught PHE two periods out of every six–day cycle for 50 minutes each period. Conversely, Patrice and Kyle both taught PHE two periods out of every nine–day cycle for approximately 75 minutes per period. In theory, those teachers who taught on a six–day cycle were supposed to see their students 1–2 times per week; however, the large number of school activities that required the use of the gymnasium each semester (such as exams, assemblies, and PED days) meant these PHE instructors rarely taught their classes more than once per week. Moreover, the PHE teachers who taught on a nine–day cycle were even more severely affected by school activities that conflicted with their class schedules and, at times, would not see their students for up to three weeks at a time. Patrice explained:

> I'm just going to teach two classes on field hockey and then move on to something else because, for me to go back, sometimes I don't see them for three weeks if there's a PED day or an assembly. So, it's hard to refer to their acquired knowledge, or get into a rhythm

> with even something like field hockey, let alone mental health, and say, “Remember what you learned two weeks ago? Now we're going to take that and build on this.”

Ben further explained how the small window of class time allotted for PHE each week was constantly reduced due to preparatory tasks unique to PHE, including the time needed for students to change into and out of their proper sports attire:

> I have 80–minute periods; they [students] get five minutes of change time before and after class, so that drops it down to 70 minutes. Taking attendance takes about 5–6 minutes because I always try to make eye contact when I'm saying a student’s name to make sure they know who I am, and that I know who they are. That there is 15 minutes gone! Now I only have 65 minutes left to work with, assuming everything goes smoothly.

Of significance is that the small window of class time dedicated to PHE each week was not only inhibitive of pedagogy, but it was also inhibitive of rapport and relationship building. For example, Patrice explained how hard it was to “really get to know my students” when “I only have one period per week with them.” All eight participants also stated that the sheer volume of students in each class has further compromised their ability to bond with their students, with numbers trending even higher over the past five years. Kyle stated that an ideal class size for PHE was around 21–24 students; however, he claimed that his class size typically ranged from 27–28 students. Sammy similarly described teaching PHE classes with over 30 students and further explained that it was “an absolute zoo” this past year due to behavioural issues. Patrice and Kyle both stated that they’ve taught PHE classes with 34–36 students, which made it almost impossible to address student mental health beyond superficial breathing and yoga exercises. Most egregiously, Ben recalled having taught classes with upwards of 44 students without any additional support from an educational assistant. In one instance, he also co–taught a class of 66

students in one gymnasium because it was wintertime, and their other gym space was being shared with kids from another school.

All the PHE teachers noted that their ability to provide individual support to a student experiencing anxiety or depression was severely compromised by the "impossible combo" of short class times coupled with large class sizes. For example, Nick calculated that he could only dedicate approximately 90 seconds to each student during a 40–minute period for his smallest class of 25 students. Similarly, Ben explained the limited time he could invest in each student:

> In those 65 minutes [of PHE class] I've got to get anywhere from 18–38 kids moving, developing, understanding, working, cooperating, growing, and not arguing. So, if you've got a group of 38 kids, I have to give each and every kid everything they need in two minutes! If I've got 18 kids, we're talking less than four minutes each.

Patrice summarized the abundance of difficulties caused by overcrowded class sizes in PHE:

> Within the 75 minutes I have my students, I'm like, "Okay, well this kid, I have to make sure he stops hitting his head against the wall, and this one is not running away from school, and this one can't be with that one." We have so much more to manage because in PHE kids are not sitting at a desk, right? So, you've got safety, you've got equipment, you've got to plan out the stations, the flow, the delivery, each child's individual needs, and just that alone is a massive headache. I mean, the management itself is mind–blowing. I don't know how we do it every day, is what I'm trying to say to you.

Collectively, the "impossible combo" of short periods, large class sizes, scheduling interruptions, and behavioural issues in PHE, impeded the ability of PHE instructors to achieve their primary fitness goals for students, let alone deliver effective pedagogy on mental health. However, in addition to shaping pedagogy, this combination of factors also shaped the quality of

the relationship that PHE teachers were able to establish with their students. Teachers felt increasingly disconnected from their students owing to the “mind–blowing” time and energy they poured into class management. This problem was even more pronounced for early career teachers who worked replacement contracts within the Québec public education system—a status that was unique to only half the participants interviewed for this study, i.e., Randy, Sammy, Lan, and Nick were all replacing PHE instructors on either sick or maternity leave. Teachers who work on a contract basis have little–to–no job security because the teacher whom they are replacing can return at any moment and with almost no warning. Randy explained:

> I wish I could tell you right now that I'll be here until the end of the school year, but I don't know. This guy could call me tonight and say, " You know what? My knee is fine! I went to the doctor and I'm coming back tomorrow. Tough luck, kid!"

Randy further described replacement teaching as a “revolving door” of personnel where teachers are expected to change both schools and subject matters “at the drop of a hat”, almost always being forced to teach subjects for which they have received little to no formal training. Both Randy and Sammy revealed that the months leading up to September were always stressful as they awaited news from school boards about potential teaching contracts. Sammy was also acutely aware that these sorts of stresses would only become amplified as he aged:

> At least I'm at a stage in life now where, if I don't find something for a year, it's not the end of the world. However, in a few years, when I'm looking at getting married and having kids, I feel that my stress levels will be through the roof without a secure gig.

All my participants acknowledged that finding a permanent teaching position is exceptionally rare and difficult in the GMA, especially for PHE instructors. For example, Randy has been looking for a permanent high school PHE position for over ten years without success:

> It sucks, Bobby. I don't know what to tell you. I've taught every subject under the sun, and I am nowhere close to a permanent gig. It's stressful as all hell!

Crucially, the lack of secure employment for PHE instructors had a three–pronged effect on both mental health education and mental health generally in GMA high schools: First, all four precariously employed PHE teachers noted that their lack of job security was associated with enhanced mental distress and anxiety among teaching staff. Randy explained:

> This rotating door of teachers is especially frustrating! It's a vicious cycle and, in my opinion, it's one of the primary reasons why teachers are leaving the profession. We're going crazy, and we're burning out! We can't sustain ourselves for years at a time when we don't know when or where we'll be teaching.

Johann Hari (2018) identified this type of work–related stress as one of the nine forms of social disconnection responsible for enhanced mental distress and anxiety in contemporary society: *Disconnection from a hopeful or secure future*. More precisely, Hari (2018) argued that employment and other forms of insecurity generates feelings of isolation and depression among people because they are unable to effectively plan and work toward their future life goals.

Secondly, all four precariously employed PHE teachers noted that their lack of job security was associated with diminished motivation to create new content and implement meaningful pedagogy in their classes. For example, Nick's teaching contract was shortened by two months when the teacher he was replacing notified the schoolboard they were returning:

> I'm not going to start preparing manuals, rubrics, or gameplay packets if I can get fired the next day. That was also a struggle for my other courses, Bobby. I mean, do they really expect me to give them real assignments and real content when I could be canned at any moment? How far in the future can I realistically plan to teach in that environment?

Thirdly, and perhaps most importantly, the lack of job security for these teachers compromised their ability to forge strong and meaningful bonds with their students. Both teachers and students require time and resources to properly acclimate to new school environments, to build trust and rapport amongst each other, and to confidently speak with one another about delicate subject matters, such as mental health. However, the ability to forge strong relationships with colleagues, students, parents, and in the community was constantly hamstrung by high staff turnover. Lan explained how he only witnessed improvement in students' engagement and behavior during his second year of teaching at the same high school:

> At first, behavior was a bit of an issue for me because I'm a young teacher and students thought that they could take advantage of me. However, now that we have a common understanding, and they know me from last year, and I know them, we can actually get somewhere in class. We've built that bond between us, right? So far, it's working well, and it has been much better than last year in every respect.

Sammy was in a similar position when teaching PHE for the second consecutive year at a local high school. He credited this second year with improving his relationships with his students, and further described them as "integral" to his teaching successes:

> The benefits of teaching in the same school was one of the biggest reasons why I wanted to return here. By the end of last year, I felt I had a pretty good relationship with everyone. I had taught almost 350 students spread out across the different grades. So, when I came back this year, I knew that I had already taught a third of the entire school, which made it so much easier to get in front of the class and connect with my students. Last year, I was just trying to survive. This year, I feel like I can actually teach!

The rapport Sammy had built with his students allowed him to take chances in his classes, and to introduce subject matters that would have otherwise been difficult to address. Predictably, the participants noted that their students also benefitted from more stable relationships, as they became more comfortable and willing to open–up and share their concerns about mental health with their teachers. Moreover, when a teacher leaves a school after forging strong bonds with their students, the participants described a "withering" effect it can have on a students' sense of purpose and investment in the school community. Randy explained:

> It's stressful for the students when they see a substitute teacher and they don't know whether they'll be there for a few days, a week, or even a year! They're always seeing new faces and they're not used to constantly having to learn the new teacher's personality and program. A lot of the time, when these new people come in after the school year has already started, it's mayhem for those first few weeks. It makes sense, right? Why would students buy in to their teacher if their teacher doesn't buy into them? It's obviously not the teachers' fault, but that's what perpetual insecurity does to an environment. It takes a toll on everyone, right? In the end, we all suffer because of it.

Randy's reflection draws important attention to another social dimension of public education that often passes unnoticed in discussions about the size and scope of mental distress in the GMA: the normalization of precarious teaching labour. In theoretical terms, Randy has here identified the cementing of what Emile Durkheim (1999) called "anomie" in educational institutions, a form of disconnection that extends beyond individuals into social institutions that shape both the nature and quality of their relationships. In the context of precarious teaching labour, it is not only students who suffer from disconnection, but the teachers as well, and broader school staff, who experience greater distress and anxiety owing to the lack of job security and temporary nature of

their professional relationships. Consequently, as Randy and other participants have explained, many teachers remain dispassionately invested in their pedagogy, and ambivalent about their student–teacher relationships. This final observation is tremendously unfortunate considering the size and scope of mental distress in the GMA, and especially considering the impact it will have on future PHE teachers and their students, whom will both suffer from lost innovation, poorer quality education, and weaker relationships in both their schools and in their communities.

4.4 Chapter Summary & Concluding Remarks

This chapter explored PHE teachers' response to three broad questions related to the practice and provision of mental health education in GMA high schools: 1) how do PHE instructors teach the subject of mental health to their students, 2) how comfortable and prepared do PHE instructors feel when discussing the subject of mental health with their students, and 3) how do PHE instructors view the practice and provision of mental health education relative to the scope of mental health–related issues in GMA high schools? While, at times, participants' responses wandered from these questions, there answers ultimately shed light on numerous professional trends, barriers, and opportunities for improved mental health and mental health education at GMA high schools.

For example, the PHE teachers explained that most conversations about mental health occurred informally during one–on–one conversation with students. The PHE teachers also identified several personal and systemic barriers that impeded their ability to introduce critical topics during their PHE classes, such as: stereotypes of PHE as a non–serious subject, their lack of formal education and training on mental health, the "impossible combo" of short time

allotments coupled with large class sizes in PHE, and the challenges of building and remaining invested in strong school–based relationships as contractually employed replacement teachers.

Finally, while the participants all agreed that mental health education was an important component of health and wellness that should be addressed in GMA high schools, they constantly struggled with their obligation to attend to students' physical and psychological needs amidst the broader context of sedentary living in both school and society. This challenge in particular forced them question the appropriateness of PHE for tackling sensitive topics such as mental health since it would almost always come at the expense of physical activity. The participants concluded that more resources are urgently needed to promote mental health education and mental health generally among both staff and students in the GMA.

Chapter 5

Conclusion and Recommendations

This study provides important insight into how mental health education is delivered in Greater Montréal Area (GMA) public high schools within the eastern Canadian province of Québec. The narratives captured from semi–structured interviews with eight Physical & Health Education (PHE) teachers in the GMA revealed several personal and systemic barriers that impeded their ability to introduce mental health pedagogy within their PHE classes.

In Chapter Two, I situated this thesis in relation to the broader academic literature on student mental health and mental health education in Canada. I argued that, although much of the literature has highlighted how certain interventions/programs can be used to improve mental health literacy (MHL) among both teachers and students, there remains limited scholarship that explores teachers' views on the practice and provision of mental health education with sensitivity to broader social determinants, such as time allotment, class sizes, etc.

Chapter Three discussed the theoretical and methodological framework for this study. Specifically, I introduced the seminal work of Émile Durkheim and outlined his theory of "anomie" (1999) used to illustrate the important link between complex social structures and individual mental health. I further explored Johann Hari's (2018) research on "disconnection" within contemporary Western societies, which argued that heightened rates of mental distress among individuals is linked more to 'how we leave', than it is to our individual biochemistry.

Chapter Three also reviewed the qualitative methods used to conduct this study, which included: a snowball sampling recruitment strategy, semi–structured interviews with eight high school PHE teachers over Zoom, and textual analysis of various formal and informal documents. The ethical considerations and the limitations for this study were also discussed.

Finally, Chapter Four discussed the primary observations and findings that emerged from my interviews with eight high school PHE teachers in the GMA. My first observation was that mental health is not being formally taught to students in PHE classes despite their being issued with this task in the Québec Education Program (QEP). While PHE teachers expressed a willingness to go above and beyond in assisting students in–distress through informal conversations, they only tangentially addressed mental health during some of their formal lessons, e.g., through yoga, meditation, or breathing exercises. This was in part caused by my second finding, which showed that PHE teachers felt unprepared to handle or address the abundance of mental health issues they are witnessing in today's high schools. The reasons for this feeling of unpreparedness are multifold (as discussed below); however, the fact that PHE teachers lacked any kind of formal education and training with respect to mental health rendered them highly uncomfortable and weary of potentially inflicting harm through broaching this subject with youths. In response, the teachers were highly supportive and encouraging of the idea of receiving formal training on mental health in their PED days. Perhaps Kutchers' *The Guide* (2007) or other similar mental health related training modules would be useful for teachers and other school staff to establish baseline competencies and improved literacy on mental health.

The third observation discovered through this research was that, by and large, students were craving more physical activity and movement opportunities in the GMA. The fact that most high school students are forced to remain seated at a desk for the bulk of their day was viewed as reinforcing the stress and anxiety associated with student life. While PHE is a logical fit for mental health education, the PHE teachers universally believed that it's inclusion must not come at the expense of physical activity. In practical terms, this can mean two things: 1) More physical activity is urgently needed at school (beyond PHE classes), and 2) Kinesthetic pedagogy should

be explored as an option to teach critical issues in both PHE and other school subjects. Indeed, research on kinesthetic pedagogy has shown promising results for students across all socio–cultural demographics and may further help rid PHE (and embodied learning, generally) of its stereotype as a non–cognitive/non–serious subject (Othman & Amiruddin, 2010; Sivilotti & Pike, 2007; Wolfman & Bates, 2005).

Another important and related observation that emerged in my interviews was that the highly restricted class time dedicated to PHE coupled with large class sizes have made attending to students' physical and psychological needs exceedingly difficult for teachers. Hence, administrators and policy makers would be wise to reassess how PHE classes are structured in GMA high schools and to explore the addition of a dedicated "health class" as a part of the core curriculum in Québec. This class could include pedagogy that explicitly addresses critical topics such as mental health, sexual health, and nutrition, while also helping to alleviate the pressure on PHE instructors to collapse all these important topics in a single course that must compete against students' expectations and desires to move, play, and to be physically active.

Finally, the fourth observation from this study was that kids are presently experiencing high levels of stress, anxiety, and disconnection in GMA high schools owing to a range of complex social factors that extend beyond the purview of PHE class. For example, the increased pressure for students to excel both socially and academically coupled with feelings of disconnection at home and at school has contributed to feelings of isolation and loneliness among many high school students in Québec—feelings that were exacerbated during the global pandemic when both schools and other venues where young people go to experience connection with others were temporarily closed. In many respects, these same stresses have also penetrated the psychology of early career PHE teachers who have been forced to navigate teaching careers

with little to no job security. In this context, researchers, politicians, and school administrators must expand our thinking beyond questions such as 'how ought we teach mental health education in high schools' to 'how must we redesign and reconfigure our learning environments to promote social cohesion and connection among students, teachers, and in broader society'? To that end, future researchers would be wise to think both pedagogically *and* structurally about mental health in GMA high schools. In practical terms, the practice and provision of mental health education must not only be accompanied by improved training and resources, but also by a reconfiguration of priorities aimed at optimizing strong relationships in our schools.

To conclude, I hope that this study has provided some useful insights into how PHE instructors have contemplated the delivery of mental health education in GMA high schools. The participants were incredibly kind and eager to share their thoughts and experiences related to this subject, and they shared important insights about the struggles they have encountered while trying to improve the mental health and wellbeing of students in their classes. In a final analysis, the insights offered in this study provide important directives for future research about mental health education, and for improved understandings about mental health in schools, generally. The vignettes provided in this thesis further highlight how PHE instructors are a crucial resource for nurturing the health and wellbeing of our students and communities.

References

Act Respecting Private Education, CQLR, c. E 9.1, s. 25(1).

Ahn, S., & Fedewa, A. (2011). A Meta-analysis of the Relationship Between Children's Physical Activity and Mental Health. *Journal Of Pediatric Psychology*, *36*(4), 385-397. doi: 10.1093/jpepsy/jsq107

Annual statutory teachers' salaries in public institutions, by level of education taught and teaching experience, Canadian dollars, Canada, provinces and territories, 2018/2019. Www150.statcan.gc.ca. (2020). Retrieved 5 July 2022, from https://www150.statcan.gc.ca/n1/pub/81-604-x/2020001/tbl/tblc3.1-eng.htm.

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom Videoconferencing for Qualitative Data Collection: Perceptions and Experiences of Researchers and Participants. *International Journal of Qualitative Methods, 18*, 1609406919874596. https://doi.org/10.1177/1609406919874596

Atkinson, J.M. (1978). The Suicide Problem in Sociology. In: Discovering Suicide. Palgrave Macmillan, London. https://doi-org.proxy3.library.mcgill.ca/10.1007/978-1-349-06606-3_2

Biddle, S., & Asare, M. (2011). Physical activity and mental health in children and adolescents: a review of reviews. *British Journal Of Sports Medicine*, *45*(11), 886-895. doi: 10.1136/bjsports-2011-090185

Bloomberg, L., & Volpe, M. (2012). *Completing your qualitative dissertation* (2nd ed.). LosAngeles, Calif: Sage.

Braun, V., Clarke, V., & Gray, D. (2017). Innovations in Qualitative Methods. In B. Gough (Ed.), *The Palgrave Handbook of Critical Social Psychology* (pp. 243–266). Palgrave Macmillan UK. https://doi.org/10.1057/978-1-137-51018-1_13

Canadians' mental health during the COVID-19 pandemic. (2020). Retrieved 25 November 2020, from https://www150.statcan.gc.ca/n1/daily-quotidien/200527/dq200527b-eng.htm

Chen, S., Wu, Q., Qi, C., Deng, H., Wang, X., He, H., Long, J., Xiong, Y., & Liu, T. (2017). Mental health literacy about schizophrenia and depression: A survey among Chinese caregivers of patients with mental disorder. *BMC Psychiatry*, *17*(1), 89. https://doi.org/10.1186/s12888-017-1245-y

Child and Youth Mental Health in Canada. (2020). Retrieved 12 August 2020, from https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/201835E

Cho, J., & Trent, A. (2006). Validity in qualitative research revisited. *Qualitative Research*, *6*(3), 319-340. doi: 10.1177/1468794106065006

Clark A. (2006) *Anonymising Research Data*. ESRC National Centre for Research Methods, Real Life Methods; Working Paper Series. Manchester: Real Life Methods. Available at: http://eprints.ncrm.ac.uk/480/1/0706_anonymising_research_data.pdf (accessed 31 August 2014). [Google Scholar]

Corrigan, P., Morris, S., Michaels, P., Rafacz, J., & Rüsch, N. (2012). Challenging the Public Stigma of Mental Illness: A Meta-Analysis of Outcome Studies. *Psychiatric Services*, *63*(10), 963-973. doi: 10.1176/appi.ps.201100529

COVID-19 - Coalition Poids. Coalition Poids. (2020). Retrieved 25 August 2020, from https://www.cqpp.qc.ca/fr/nos-priorites/covid-19/.

Cowen, P. J., & Browning, M. (2015). What has serotonin to do with depression? *World Psychiatry, 14*(2), 158–160. https://doi.org/10.1002/wps.20229

Daily Numbers for the Province – Public and Private School Systems List of Schools. (2021). Retrieved 17 May 2021, from https://cdn-contenu.quebec.ca/cdn-contenu/adm/min/education/publications-adm/covid-19/reseauScolaire_listeEcoles_ANG.pdf?1600972861

Douglas, J. D. (1966). The Sociological Analysis of the Social Meanings of Suicide European Journal of Sociology, 7: 249-298.

Douglas, J. D. (1967) The Social Meanings of Suicide. Princeton, New Jersey: Princeton University Press

Durkheim, E. and Simpson, G., (1999). *Suicide*. New York: Free Press.

Durkheim, E., 1897. *Suicide: A Study of Sociology*. 1st ed. Paris.

Family Influence. (2020). Retrieved 25 November 2020, from https://www.participaction.com/en-ca/resources/children-and-youth-report-card

Ferguson, J. M. (2001). SSRI Antidepressant Medications: Adverse Effects and Tolerability. *Primary Care Companion to The Journal of Clinical Psychiatry*, *3*(1), 22–27.

Field, M. (2019). Building risk matrices from interview transcripts utilising HCA and IPA. *Contemporary Ergonomics and Human Factors*, 8.

Fitzpatrick, K. (2013). *Critical pedagogy, physical education and urban schooling*. New York: Peter Lang Publishing.

Frequently asked questions | Quebec independent and private schools. (2021). Retrieved 19 May 2021, from https://ecolespriveesquebec.ca/en/private-school/faq/

Giulianotti, Richard, "Routledge Handbook of the Sociology of Sport" (Abingdon: Routledge, 04 Aug 2015), accessed 12 Jul 2021, Routledge Handbooks Online.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The qualitative report*, *8*(4), 597-607.

Graham, A., Phelps, R., Maddison, C., & Fitzgerald, R. (2011). Supporting children's mental health in schools: Teacher views. *Teachers and Teaching*, *17*(4), 479–496. https://doi.org/10.1080/13540602.2011.580525

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, *10*(1), 113. https://doi.org/10.1186/1471-244X-10-113

Gutnick, D. (2017). Are Quebec's private high schools creating a segregated society? | CBC Radio. Retrieved 7 October 2021, from https://www.cbc.ca/radio/sunday/the-sunday-edition-october-29-2017-1.4374949/are-quebec-s-private-high-schools-creating-a-segregated-society-1.4374965

Hales, D., & Lauzon, L. (2015). *An invitation to health* (4th ed.) (pp. 28-47). Toronto: Nelson Education Ltd.

Hari, J. (2018). *Lost Connections: uncovering the real causes of depression-- and the unexpected solutions*. Bloomsbury.

Hayes, D., Moore, A., Stapley, E., Humphrey, N., Mansfield, R., Santos, J., Ashworth, E., Patalay, P., Bonin, E., Boehnke, J. R., & Deighton, J. (2019). School-based intervention study examining approaches for well-being and mental health literacy of pupils in Year 9 in England: Study protocol for a multischool, parallel group cluster randomised

controlled trial (AWARE). *BMJ Open, 9*(8), e029044. https://doi.org/10.1136/bmjopen-2019-029044

Health literacy: report of the Council on Scientific Affairs. Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association. (1999). *JAMA, 281*(6), 552–557.

Heflinger, C. and Hinshaw, S., 2010. Stigma in Child and Adolescent Mental Health Services Research: Understanding Professional and Institutional Stigmatization of Youth with Mental Health Problems and their Families. *Administration and Policy in Mental Health and Mental Health Services Research*, 37(1-2), pp.61-70.

Independent Schools at A Glance. (2012). Retrieved 18 May 2021, from https://www.ofis.ca/wp-content/uploads/2012/08/Private-Schools-By-The-Numbers-Independent-School-Statistics-2012.pdf

Ingham A.G. (2004) The Sportification Process: A Biographical Analysis Framed by the Work of Marx, Weber, Durkheim and Freud. In: Giulianotti R. (eds) Sport and Modern Social Theorists. Palgrave Macmillan, London. https://doi-org.proxy3.library.mcgill.ca/10.1057/9780230523180_2

Jansen, H. (2010). The logic of qualitative survey research and its position in the field of social research methods. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* (Vol. 11, No. 2).

Jorm, A. (2012) Mental health literacy: empowering the community to take action for better mental health. Am Psychol;67(3):231–43.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognise mental disorders

and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, *166*(4), 182–186. https://doi.org/10.5694/j.1326-5377.1997.tb140071.x

Kickbusch, I., Pelikan, J. M., Apfel, F., Tsouros, A. D., & World Health Organization (Eds.). (2013). *Health literacy: The solid facts*. World Health Organization Regional Office for Europe.

Kratt, D. (2019). Teachers' perspectives on educator mental health competencies: A qualitative case study. *American Journal of Qualitative Research*, *2*(1), 22–40.

Krouwel, M., Jolly, K., & Greenfield, S. (2019). Comparing Skype (video calling) and in-person qualitative interview modes in a study of people with irritable bowel syndrome – an exploratory comparative analysis. *BMC Medical Research Methodology*, *19*(1). doi: 10.1186/s12874-019-0867-9

Kutcher, S. and McLuckie, A. for the Child and Youth Advisory Committee, Mental Health Commission of Canada. (2010). Evergreen: A child and youth mental health framework for Canada. Calgary, AB: Mental Health Commission of Canada.

Kutcher, S., Bagnell, A., & Wei, Y. (2015). Mental Health Literacy in Secondary Schools. *Child and Adolescent Psychiatric Clinics of North America*, *24*(2), 233–244. https://doi.org/10.1016/j.chc.2014.11.007

Kutcher, S., Gilberds, H., Morgan, C., Greene, R., Hamwaka, K., & Perkins, K. (2015). Improving Malawian teachers' mental health knowledge and attitudes: An integrated school mental health literacy approach. *Global Mental Health*, *2*, e1. https://doi.org/10.1017/gmh.2014.8

Kutcher, S., Wei, Y., & Coniglio, C. (2016). Mental Health Literacy: Past, Present, and Future. *The Canadian Journal of Psychiatry*, *61*(3), 154–158. https://doi.org/10.1177/0706743715616609

Kutcher, S., Wei, Y., & Hashish, M. (2016). Mental Health Literacy for Students and Teachers. In *Positive Mental Health, Fighting Stigma and Promoting Resiliency for Children and Adolescents* (pp. 161–172). Elsevier. https://doi.org/10.1016/B978-0-12-804394-3.00008-5

Kutcher, S., Wei, Y., & Morgan, C. (2015). Successful Application of a Canadian Mental Health Curriculum Resource by Usual Classroom Teachers in Significantly and Sustainably Improving Student Mental Health Literacy. *The Canadian Journal of Psychiatry*, *60*(12), 580–586. https://doi.org/10.1177/070674371506001209

Kutcher, S., Wei, Y., Costa, S., Gusmão, R., Skokauskas, N., & Sourander, A. (2016). Enhancing mental health literacy in young people. *European Child & Adolescent Psychiatry*, *25*(6), 567–569. https://doi.org/10.1007/s00787-016-0867-9

Kutcher, S., Wei, Y., McLuckie, A., & Bullock, L. (2013). Educator mental health literacy: A programme evaluation of the teacher training education on the mental health & high school curriculum guide. *Advances in School Mental Health Promotion*, *6*(2), 83–93. https://doi.org/10.1080/1754730X.2013.784615

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, Calif: Sage Publications.

Lo Iacono, V., Symonds, P., & Brown, D. (2016). Skype as a Tool for Qualitative Research Interviews (http://journals.sagepub.com/doi/full/10.5153/sro.3952). *Sociological Research Online*, *12*. https://doi.org/10.5153/sro.3952

Lobe, B., Morgan, D., & Hoffman, K. A. (2020). Qualitative Data Collection in an Era of Social Distancing. *International Journal of Qualitative Methods*, *19*, 160940692093787. https://doi.org/10.1177/1609406920937875

Longhurst, R. (2003). Semi-structured interviews and focus groups. *Key methods in geography*, *3*(2), 143-156.

Loy, J. W., & Booth, D. (2000). Functionalism, Sport and Society. In *Handbook of Sports Studies* (pp. 8–28). SAGE Publications Ltd. https://doi.org/10.4135/9781848608382.n1

Loyola High School *v.* Quebec (Attorney General), 2015 SCC 12, [2015] 1 S.C.R. 613

Magnuson, R. (1993). A Profile of Private Schools in Quebec. *Mcgiu Journal Of Education*, *28*(1), 3-12.

Marx, K. (1867). Capital: A critique of political economy. Volume 1, Part 1: The process of capitalist production. New York, NY: Cosimo.

Mazzer, K. R., & Rickwood, D. J. (2015). Teachers' role breadth and perceived efficacy in supporting student mental health. *Advances in School Mental Health Promotion*, *8*(1), 29–41. https://doi.org/10.1080/1754730X.2014.978119

Mcluckie, A., Kutcher, S., Wei, Y., & Weaver, C. (2014). Sustained improvements in students' mental health literacy with use of a mental health curriculum in Canadian schools. *BMC Psychiatry*, *14*(1), 379. https://doi.org/10.1186/s12888-014-0379-4

Mental Health Commission of Canada. 2013. *School-Based Mental Health in Canada: A Final Report*. [online] Available at: <https://www.mentalhealthcommission.ca/sites/default/files/ChildYouth_School_Based_Mental_Health_Canada_Final_Report_ENG_0.pdf> [Accessed 12 April 2021].

Milin, R., Kutcher, S., Lewis, S., Walker, S., Wei, Y., Ferrill, N., & Armstrong, M. (2016). Impact of a Mental Health Curriculum on Knowledge and Stigma Among High School Students: A Randomized Controlled Trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *55*, 383–391. https://doi.org/10.1016/j.jaac.2016.02.018

Naderifar, M., Goli, H., & Ghaljaei, F. (2017). Snowball Sampling: A Purposeful Method of Sampling in Qualitative Research. *Strides in Development of Medical Education, In Press*. https://doi.org/10.5812/sdme.67670

Nicholas, D. B., Lach, L., King, G., Scott, M., Boydell, K., Sawatzky, B. J., Reisman, J., Schippel, E., & Young, N. L. (2010). Contrasting Internet and Face-to-Face Focus Groups for Children with Chronic Health Conditions: Outcomes and Participant Experiences. *International Journal of Qualitative Methods*, *9*(1), 105–121. https://doi.org/10.1177/160940691000900102

Nowell, L., Norris, J., White, D., & Moules, N. (2017). Thematic Analysis. *International Journal Of Qualitative Methods*, *16*(1), 160940691773384. doi: 10.1177/1609406917733847

O'Connor, M., Casey, L., & Clough, B. (2014). Measuring mental health literacy – a review of scale-based measures. *Journal of Mental Health*, *23*(4), 197–204. https://doi.org/10.3109/09638237.2014.910646

Othman, N., & Amiruddin, M. (2010). Different Perspectives of Learning Styles from VARK Model. Procedia - Social And Behavioral Sciences, 7, 652-660. doi: 10.1016/j.sbspro.2010.10.088

Pescosolido, B. A., & Georgianna, S. (1989). Durkheim, suicide, and religion: Toward a network theory of suicide. *American Sociological Review*, *54*(1), 33–48. https://doi-org.proxy3.library.mcgill.ca/10.2307/2095660

Pescosolido, B. A., Fettes, D. L., Martin, J. K., Monahan, J., & McLeod, J. D. (2007). Perceived Dangerousness of Children With Mental Health Problems and Support for Coerced Treatment. *Psychiatric Services, 58*(5), 619–625. https://doi.org/10.1176/ps.2007.58.5.619

Physical Education and Health Secondary. (2020). Retrieved 6 July 2020, from http://www.education.gouv.qc.ca/fileadmin/site_web/documents/education/jeunes/pfeq/PFEQ_education-physique-secondaire-premier-cycle_EN.pdf

Policy on Educational Success. (2017). Retrieved 18 May 2021, from http://www.education.gouv.qc.ca/fileadmin/site_web/documents/PSG/politiques_orientations/politique_reussite_educative_10juillet_A_1.pdf

Progressions of Learning in Secondary Schools, Physical Education and Health. (2020). Retrieved 6 July 2020, from http://www.education.gouv.qc.ca/fileadmin/site_web/documents/education/jeunes/pfeq/PDA_PFEQ_education-physique-secondaire_2010_EN.pdf

Québec (Province) & Ministère de l'éducation. (2004). *Québec education program: Secondary school education, cycle one.* Éducation Québec.

Ratnayake, P., & Hyde, C. (2019). Mental Health Literacy, Help-Seeking Behaviour and Wellbeing in Young People: Implications for Practice. *The Educational and Developmental Psychologist, 36*(1), 16–21. https://doi.org/10.1017/edp.2019.1

Rodger, S., Hibbert, K., Leischied, A., Pickel, L., Stepien, M. and Atkins, M., (2014). Shaping A Mental Health Curriculum for Canada's Teacher Education Programs: Rationale and Brief Overview. *Physical & Health Education Journal*, 80(3), pp.28-29.

RWJF - Informal Interviewing. (2020). Retrieved 11 December 2020, from http://www.qualres.org/HomeInfo-3631.html

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., & Bartlam, B. et al. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality &Amp; Quantity*, *52*(4), 1893-1907. https://doi.org/10.1007/s11135-017-0574-8

Shelemy, L., Harvey, K., & Waite, P. (2019). Supporting students' mental health in schools: What do teachers want and need? *Emotional and Behavioural Difficulties*, *24*(1), 100–116. https://doi.org/10.1080/13632752.2019.1582742

Sivilotti, P., & Pike, S. (2007). The suitability of kinesthetic learning activities for teaching distributed algorithms. *ACM SIGCSE Bulletin*, *39*(1), 362. doi: 10.1145/1227504.1227438

Sparkes, A. C., & Smith, B. (2013). *Qualitative research methods in sport, exercise and health: From process to product.* Routledge/Taylor & Francis Group.

Spiker, D. A., & Hammer, J. H. (2019). Mental health literacy as theory: Current challenges and future directions. *Journal of Mental Health*, *28*(3), 238–242. https://doi.org/10.1080/09638237.2018.1437613

Stephens, T. (1988). Physical activity and mental health in the United States and Canada: Evidence from four population surveys. *Preventive Medicine*, *17*(1), 35-47. doi: 10.1016/0091-7435(88)90070-9

Stevenson, C. L., & Nixon, J. E. (1972). *A Conceptual Scheme of the Social Functions of Sport*. 14.

Surveillance of Mental Disorders in Québec: Prevalence, Mortality and Service Utilization Profile. (2013). Retrieved 21 July 2020, from https://www.inspq.qc.ca/pdf/publications/1662_SurvMentalDisorQc_PrevMortServUtiliProfile.pdf

Swain, J. M., & Spire, Z. D. (2020). The Role of Informal Conversations in Generating Data, and the Ethical and Methodological Issues. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *21*(1). https://doi.org/10.17169/fqs-21.1.3344

Tartaro, C., & Lester, D. (2005). An Application of Durkheim's Theory of Suicide to Prison Suicide Rates in the United States. *Death Studies*, *29*(5), 413-422. https://doi.org/10.1080/07481180590932526

The Daily — Survey on COVID-19 and Mental Health, September to December 2020. Www150.statcan.gc.ca. (2021). Retrieved 5 July 2022, from https://www150.statcan.gc.ca/n1/daily-quotidien/210318/dq210318a-eng.htm.

The Next Generation of Emerging Global Challenges – Policy Horizons Canada. (2018). Retrieved October 6, 2021, from https://horizons.gc.ca/en/2018/10/19/the-next-generation-of-emerging-global-challenges/

Thomas, C., Wootten, A., & Robinson, P. (2013). The experiences of gay and bisexual men diagnosed with prostate cancer: Results from an online focus group. *European Journal of Cancer Care*, *22*(4), 522–529. https://doi.org/10.1111/ecc.12058

Vamos, S. D., Xie, X., & Yeung, P. (2020). Effects of a Health Education Course on Pre-Service Teachers' Perceived Knowledge, Skills, Preparedness, and Beliefs in Teaching Health Education. *Journal of School Health*, *90*(3), 224–233. https://doi.org/10.1111/josh.12868

Wahl, O., Susin, J., Lax, A., Kaplan, L., & Zatina, D. (2012). Knowledge and Attitudes About Mental Illness: A Survey of Middle School Students. *Psychiatric Services, 63*(7), 649-654. https://doi.org/10.1176/appi.ps.201100358

Weare, K., & Nind, M. (2011). Mental health promotion and problem prevention in schools: What does the evidence say? *Health Promotion International*, *26*(suppl 1), i29–i69. https://doi.org/10.1093/heapro/dar075

Wei Y. (2017). The assessment of the quality of mental health literacy measurement tools: A scoping review and three systematic reviews (unpublished doctoral dissertation). Halifax, Nova Scotia: Dalhousie University.

Wei, Y., Kutcher, S., & Szumilas, M. (2011). Comprehensive School Mental Health: An integrated "School-Based Pathway to Care" model for Canadian secondary schools. *McGill Journal of Education*, *46*, 213–229. https://doi.org/10.7202/1006436ar

Wei, Y., Kutcher, S., Hines, H., & Mackay, A. (2014). Successfully Embedding Mental Health Literacy into Canadian Classroom Curriculum by Building on Existing Educator Competencies and School Structures: The Mental Health and High School Curriculum Guide for Secondary Schools in Nova Scotia. *Literacy Information and Computer Education Journal (LICEJ)*, *5*, 1158–1163. https://doi.org/10.20533/licej.2040.2589.2014.0220

Wei, Y., McGrath, P. J., Hayden, J., & Kutcher, S. (2015). Mental health literacy measures evaluating knowledge, attitudes and help-seeking: A scoping review. *BMC Psychiatry*, *15*(1), 291. https://doi.org/10.1186/s12888-015-0681-9

WHO | What is a Health Promoting School? (n.d.). WHO; World Health Organization. Retrieved February 2, 2021, from http://www.who.int/health-promoting-schools/overview/en/

Wolfman, S. A., & Bates, R. A. (2005). Kinesthetic learning in the classroom. CCSC. 203-206.

Woloshyn, V., & Savage, M. (2020). Increasing teacher candidates' mental health literacy and stress coping skills through an elective mental health and wellness course. *International Journal of Inclusive Education*, *24*(9), 921–935. https://doi.org/10.1080/13603116.2018.1497097

Youth Mental Health Stats in Canada – Youth Mental Health Canada. (2020). Retrieved 6 July 2020, from https://ymhc.ngo/resources/ymh-stats/

Appendix A

Semi-Structured Interview Guide

Preamble

Thank you for taking the time to participate in this interview. The goal of this study is to explore the practice and provision of mental health education at high schools in the Greater Montréal Area. All questions are designed to be open-ended so please elaborate as much or as little as you want. I would like to remind you that participation in this study is strictly voluntary and that you are free to ask questions or to withdraw your consent to participate in this study at any time with no penalty. You are also free to refuse to answer any line of questioning during the interview process and are free to take as many breaks as you require. The interview should take anywhere from 60-90 minutes to complete and will be recorded through the use of an audio recording device that will be visible to you at all times if done in-person. If the interview is performed through Zoom, then the session will be recorded using Zoom's online platform. All your responses will be kept strictly confidential and only my supervisor and I will have access to your interview data. In the case that this study is published, your identity will remain confidential.

Do you have any questions?

May I please start the recording?

---

1. Background Questions

Can you please tell me a little about your teaching career so far?
Prompt: For how long have you been teaching Physical and Health education?

Prompt: How long have you been teaching at (BLANK) high school?

Prompt: Please tell me about any other subject areas you have taught in schools?

Can you please give me a brief description of what a typical physical and health education class consists of content wise during the school year?

Prompt: How does your course content change from year to year?

2. Broader Contextual Questions

Over time, have you noticed any specific changes in student's ability to perform physical activity or engage in class?
Prompt: If so, to what do you attribute these changes?

Prompt: Have you noticed any specific changes in the ways in which student's discuss topics related to the components of health and wellness? If so, to what do you attribute these changes?

3. General Information About Mental Health Programming in the School

To the best of your knowledge, where do conversations about mental health typically occur at your school?

Prompt: Can you please provide an example of where you have seen the topic of mental health come up?

Prompt: In your opinion, do these types of conversations typically occur more often in formal or informal settings?

What mental health related resources currently exist in your school?

Prompt: Is there additional funding, workshops, trainings, time allotments, or other resources allocated to mental health education?

4. Experience Teaching Mental Health

Have you ever taught about mental health during your class, or taught any activities related to it? Has it ever been the main component of a specific lesson or activity?

Prompt: If yes, then how did you teach it and what resources did you use to adequately prepare?

Prompt: If not, then why do you think you have never delivered a lesson based on mental health (or some mental health component)? Have you ever been discouraged from teaching or talking about mental health with your students?

5. Preparedness to Teach Mental Health Related Content

Please tell me about your comfort level when discussing the topic of mental health with your students?

Prompt: Are you more comfortable discussing the topic of mental health in either formal or informal settings? Why?

Prompt: Do you believe you have received adequate training to discuss this subject matter with your students? Either through your pre-service training as a student or through your training as a teacher in the field?

Could you please discuss your opinion about including critical topics such as of mental health into classes?

Prompt: What do you believe are the factors that impede you from teaching mental health within your classes (i.e., restricted time allotments)?

Prompt: Within schools in general?

Prompt: In your opinion as a Physical and Health Education instructor, is teaching about mental health a part of your job? Should it be?

6. Feasibility of Integrating Mental Health Related Content

Based on your experiences, please tell me about any strengths or weaknesses with the way mental health education (or mental health in general) is approached in today's schools?

Prompt: Please tell me about some of the good things that you see happening in today's schools with respect to mental health and mental health education.

Prompt: Please tell me what you think could be done differently in today's schools with respect to mental health and mental health education.

Can you think of any other mental health resources that should be made available to support the mental health of students and staff in today's schools?

Conclusion

Are there any last comments you would like to make regarding the topics we discussed today?

Appendix B

Participant Consent Form

Study Title: "It's overwhelming": Physical and Health Educators Reflect on the Practice and Provision of Mental Health Education in Québec High Schools

Principal Investigator: Bobby Angelini, B.Ed.

Supervisor: Jordan Koch, Ph.D.

Study Sponsor: SSHRC - Joseph Armand Bombardier Canada Graduate Scholarship-Master's (CGS M)

Purpose of the Study:

I am kindly inviting you to take part in my study exploring how Health and Physical Education instructors address the subject of mental health in Greater Montreal Area high schools.

Study Procedure:

All potential research participants have been contacted through email, text, or phone to inquire about taking part in the study. If you are eligible and are willing to participate in the study, you will be asked to take part in one semi-structured interview with the principal investigator. This interview will take between 60 - 90 minutes to complete at a location of your choice including Zoom (and excluding school property). Participants may also be asked to answer some follow-up questions after the formal interview is completed. The interviews will be recorded using an audio recording device which will remain clearly visible for the duration of the discussion. After the interview is completed, the recording will be transcribed onto a password protected computer and will be kept confidential. Once interviews with all of the participants have been completed, your interview data (along with the others) will be analyzed in order to identify emergent themes, generalisabilities, and ideas related to the research questions and objectives.

COVID-19

In light of the current COVID-19 pandemic, some extra precautions will be taken to ensure that the interviews can be performed safely. If it is not possible to safely hold in-person interviews, interviews will be performed online through ZOOM. All study procedures will remain identical but, in this case, the interview will be recorded through ZOOM's online recording feature and will then be saved onto a password protected computer.

Voluntary Participation:

Participation in this study is strictly voluntary and you are free to ask questions or to withdraw your consent to participate in this study at any time with no penalty. You are also free to refuse to answer any line of questioning during the interview process and are free to take as many

breaks as you require. If you choose to withdraw, your data will not be utilized in the study but will be securely stored for 7 years after the paper has been published.

Potential Risks:

A potential harm for this research may be the resurfacing of some type of psychological distress to which you may have previously been subjected to as a schoolteacher. As the research pertains to mental health, a discussion surrounding the topic may prompt you to remember a specific mental health related issue you have faced in the past or one that you are currently facing. Additionally, this interview may remind you of a traumatic mental health related issue you may have previously witnessed with a student in your classroom.

To reduce these risks, all participants will first be asked to sign this consent form before any interview is performed. I will also not be asking you any questions about your personal life or your own mental health related issues. All lines of questioning that pertain to mental health will be within the educational context.

Potential Benefits:

Participating in this study will have no direct benefit for you but the study will shed important light on mental health education within Québec high schools. These insights will contribute to the growing body of literature on student mental health (and the pedagogy that surrounds and promotes it). The results may also afford new insights into the types of resources and training required to improve the delivery of mental health education in Québec high schools.

Confidentiality:

All of the information gathered throughout the study will remain confidential as the law mandates. In-person interviews will be recorded with an audio-recording device (that will be clearly visible) and will be transcribed onto my personal password protected computer. If interviews must be performed over ZOOM due to the COVID-19 safety measures, they will be recorded on the platform and then safely stored onto a personal password protected computer or the cloud. Additionally, to maintain your anonymity, pseudonyms will be used for all participant's names and places of work.

Only my thesis supervisor and I will have access to the raw data that is collected. This data will only be used to reach the study goals that have been outlined within this information and consent form. Additionally, your study information will be securely stored on an external drive for 7 years from the date of publication and will then be destroyed.

Dissemination of Results:

The results of this study will be presented to my thesis committee at the end of my master's degree. Publication opportunities will be sought out after the formal approval of my thesis, but it will not be possible to identify you.

Questions and Concerns:

If you have any questions related to the research study or your participation in it, please feel free the researchers responsible for the project:

- Bobby Angelini, B.Ed.
  Bobby.angelini@mail.mcgill.ca
  (438) 998-9687

- Jordan Koch, Ph.D.
  jordan.koch@mcgill.ca
  (514) 398-4184 ext. 09987

If you have any ethical concerns or complaints about your participation in this study, and want to speak with someone not on the research team, please contact the Associate Director, Research Ethics at 514-398-6831 or lynda.mcneil@mcgill.ca citing REB file number # 21-11-010

Department of Kinesiology & Physical Education
475 Pine Avenue West
Montreal, Quebec H2W 1S4

SIGNATURE PAGE

Study Title: *"It's overwhelming": Physical and Health Educators' Reflect on the Practice and Provision of Mental Health Education in Québec High Schools*

Principal Investigator: Bobby Angelini, B.Ed.
Bobby.angelini@mail.mcgill.ca
(438) 998-9687

Institution: Department of Kinesiology and Physical Education
Faculty of Education
McGill University

SIGNATURE

Please sign below if you have read the above information and consent to participate in this study. Agreeing to participate in this study does not waive any of your rights or release the researchers from their responsibilities. To ensure the study is being conducted properly, authorized individuals, such as a member of the Research Ethics Board, may have access to your (your child's) information. A copy of this consent form will be given to you and the researcher will keep a copy.

_____	_____
Name of Participant (Please print)	Person who Obtained Consent (Please print)
_____	_____
Signature of Participant	Signature of Person who Obtained Consent
_____	_____
Date	Date

Appendix C

Participant Profiles

Participant	University	Mental Health Education Training in University	Mental health Education Training in the Field	Years of Teaching Experience	Teaching Status (Tenured/Untenured)
Randy	McGill University	None	None	10+ years	Untenured
Marty	McGill University	None	Some training	26 years	Tenured
Kyle	McGill University	None	Very limited training	20+ years	Tenured
Ben	McGill University	None	Some training	25+ years	Tenured
Patrice	McGill University	None	Very limited training	12+ years	Tenured
Sammy	McGill University	None	Very limited training	1.5 years	Untenured
Lan	McGill University	None	Very limited training	1.5 years	Untenured
Nick	McGill University	Very limited training	Very limited training	1.5 years	Untenured