EDUCATOR EXPERIENCES INCORPORATING MENTAL HEALTH LITERACY INTO PRACTICE: HELPING AND HINDERING FACTORS

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Abstract

The purpose of this study was to gain an understanding of educators' experiences incorporating mental health literacy into practice, and the barriers and facilitators that influenced successful implementation. Utilization of the qualitative, Enhanced Critical Incident Technique (ECIT) methodology allowed for an exploratory, in-depth investigation of the topic. Through 14 individual, semi-structured interviews, high school educators described the factors that helped them and hindered them when supporting student mental health and incorporating mental health skills and knowledge into their work in the schools (i.e., critical incidents). Additionally, educators identified supports they wished were available to assist them in implementing mental health literacy into their practice (i.e., wish list items). From the interview transcripts, 256 Critical Incidents (CIs) were generated, including 137 helpful CIs, 86 hindering CIs, and 33 wish list (WL) items. Through an iterative data analysis process, critical incidents were organized into nine emergent categories: Building Relationships with Students, Normalizing Talking About Mental Health and Reducing Stigma, Accessible Mental Health Professionals, Mental Health Literacy Education, School Staff Communication and Collaboration, Time, Administrator Support, Family Communication and Collaboration, and School Culture and Values. These findings are reflective of frameworks for comprehensive school mental health supports, which emphasize teamwork and collaboration, school mental health literacy for all (i.e., school staff, students, families), and take into account systems and contextual factors. Findings are discussed through the lens of implementation science, with a focus on how determinant frameworks can facilitate understanding of the factors that influence the implementation of educator mental health literacy competencies. Finally, practical implications, study contributions, limitations, and directions for future research are discussed.

Lay Summary

Educators encounter students with mental health problems in their classrooms on a daily basis and many report that they lack the knowledge and skills needed to effectively support student mental health. The purpose of this study was to gain an understanding of educators' experiences supporting and promoting student mental health at school. This topic was explored by interviewing 14 high school educators about the factors that helped them and hindered them when supporting student mental health. Additionally, educators identified elements they wished were available to assist them in supporting students. Through analysis of the interview transcripts, nine commonly occurring themes were identified: Building Relationships with Students, Normalizing Talking About Mental Health and Reducing Stigma, Accessible Mental Health Professionals, Mental Health Literacy Education, School Staff Communication and Collaboration, Time, Administrator Support, Family Communication and Collaboration, and School Culture and Values.

Preface

This dissertation is the original work of Jaime Semchuk, under the supervision of Dr. William McKee. Drs. Wendy Carr and William Borgen served as members of the supervisory committee and provided input on the study and this manuscript. Jaime Semchuk was the primary individual responsible for the recruitment, data collection, analysis, and writing, and therefore, this thesis characterizes her work as a lead researcher and author. Three graduate research assistants contributed to interview transcription and credibility check procedures. Ethics Approval for this research project was obtained from UBC Behavioural Research Ethics Board (BREB) to conduct this research. The UBC BREB certificate number is H16-03322.

Table of Contents

List of Tables

List of Figures

Acknowledgements

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CHAPTER ONE: Introduction to the Problem

Teachers acknowledge that they encounter students with mental health problems in their classrooms on a daily basis (Koller & Bertel, 2006; Rothi, Leavey, & Best, 2008; Weist & Paternite, 2006) and many experience stress due to a mismatch between their mental health competencies and their perceived responsibility for supporting students (Ekornes, 2017). Although as many as 20% of adolescents experience significant mental health problems, many do not receive the formal mental health supports they need (Canadian Institute for Health Information, 2009; Waddell, Shepherd, Chen, & Boyle, 2013). Given educators' constant contact with students in their classrooms, it should not be surprising that educators feel a sense of responsibility to help identify and support students experiencing mental health problems. Student mental health problems also pose a significant barrier to learning (Lean & Colucci, 2010), as these difficulties negatively impact academic development, and are related to lower attendance rates and higher incidence of drop-out (Colman et. al., 2009; Fergusson & Woodward, 2002; Fleming, et. al., 1993). In light of these findings, mental health can be considered a prerequisite for learning, the central role of the school. To this end, it is critical that educators have both knowledge and confidence in their capacity to promote student mental health and support students who are at-risk for mental health problems.

A survey conducted by the Canadian Teachers Federation exploring teacher perspectives on student mental health suggests that educators indeed recognize the significant mental health problems many students face; they also acknowledge their important role in supporting students but feel ill-equipped to do so (Froese-Germain & Riel, 2012). Educators report that lack of knowledge about evidence-based classroom interventions, and risk factors for mental health problems can make it difficult to support the mental health needs of students (Froese-Germain &

Riel, 2012; Kidger, Gunnell, Biddle, Campbell, & Donovan, 2010; Stormont, Reinke, & Herman, 2011).

Mental health literacy professional development for educators provides a critical first step for better equipping them to support student mental health. The Canadian Alliance on Mental Illness and Mental Health (CAMIMH, 2007) defines mental health literacy as the knowledge, beliefs and skills that facilitate recognition, management, and prevention of mental illness. Research evaluations of educator mental health literacy professional development workshops have documented significant increases in teacher knowledge about mental health and mental illness, as well as improvement in attitudes towards mental illness (e.g. Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010; Kutcher, Wei, McLuckie, & Bullock, 2013; Kutcher, Wei, & Morgan, 2015; McLuckie, Kutcher, Wei, & Weaver, 2014). While mental health literacy professional development for educators has been shown to effectively increase educator knowledge, little is known about educators' experiences when incorporating these new skills into their practice, or the factors that facilitate or hinder successful incorporation.

Purpose and Significance of the Present Study

The purpose of the present study is to learn about the experiences of high school educators as they incorporate mental health literacy competencies into their work with students after completing a mental health literacy professional development workshop. Research is needed to help understand the factors that educators find helpful and unhelpful when implementing mental health literacy skills in their practice. As such, this study contributes to our understanding of educators' needs related to identifying and supporting students experiencing mental health problems at school and promoting mental health in the classroom. Ultimately, we hope that findings from this study provide practical information to help schools and educators become better

equipped to effectively support and promote student mental health.

Definition of Key Terms

Educator. For the purpose of this study, educator refers to school professionals and paraprofessionals whose job contributes to the education of students, including teachers, special education assistants, school administrators, and school counsellors.

Professional Development, Education or Professional Learning. For the purpose of this study the terms professional development, professional learning, and education are used interchangeably when referring to formal mental health literacy learning opportunities engaged in by educators. Learning and developing mental health literacy are understood to involve increasing knowledge, developing attitudes and learning new skills to be applied in practice.

Secondary School or High School. For the purpose of this study, secondary and high schools include schools that educate students in Grades Eight through 12.

CHAPTER TWO: Review of the Literature

Understanding Mental Health

Mental health is often defined and understood in terms of the presence or absence of mental illness. However, increasingly, definitions of mental health incorporate discussion of both the presence of positive indicators of wellbeing (e.g. life satisfaction, self-acceptance, positive emotions), as well as the absence of disorder (Greenspoon & Saklofske, 2001; Moore, Dowdy, Nylund-Gibson, & Furlong, 2019; Suldo & Shaffer, 2008). For instance, the World Health Organization's (WHO) definition of mental health includes the following statement:

> Mental health is more than the just the absence of mental disorders or disabilities. Mental health is a state of well-being in which an individual realizes his or her (or their) own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her (or their) community (WHO, 2016).

This definition of mental health aligns with a dual-factor model of mental health, which proposes that mental health be conceptualized as two separate but related continua (Greenspoon & Saklofske, 2001; Moore et al., 2019; Suldo & Shaffer, 2008). As depicted in Figure 1, the mental illness continuum includes the presence or absence of symptoms of mental illness or disorder on either end; the positive mental health or well-being continuum includes high or low levels of perceived well-being at either end.

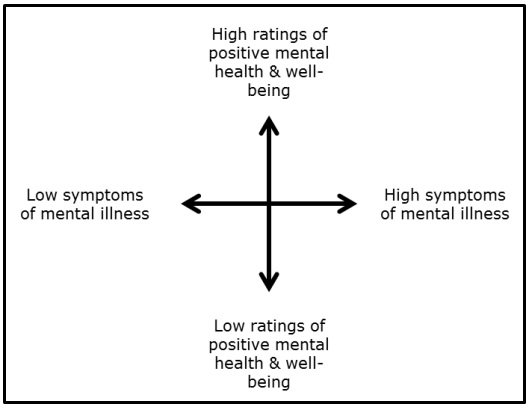

Figure 1. Dual-factor model of mental health (Adapted from Greenspoon & Saklofske, 2001; Suldo & Shaffer, 2008)

Research evidence supports the notion that positive mental health and mental illness operate on two separate continua for children and adolescents (Greenspoon & Saklofske, 2001; Moore et al., 2019; Suldo & Shaffer, 2008). For instance, an adolescent may experience symptoms of a diagnosable mental illness, but simultaneously have high ratings of positive mental health and well-being due to strong social supports and engagement in effective mental health treatment. The present study is grounded in a dual-factor understanding of mental health, which emphasizes the importance of both promotion of positive mental health and the identification and treatment of mental health problems.

Framework for Comprehensive School-based Mental Health Services

A population-based, public health or multi-tiered system of support (MTSS) approach to school mental health services offers a theoretical framework and rationale for providing educator-focused mental health literacy professional development as part of the foundation for supporting student mental health in schools. The population based, MTSS model is consistent with ecological and community mental health frameworks (Strein, Hoagwood, & Cohn, 2003). When compared to a traditional focus on the mental health of individual clients adhered to by clinical psychology, the public health model can be understood to address clients across the broader population (Strein et al., 2003; Weist, Lever, Bradshaw, & Owens, 2014). As such, targeting prevention and promotion of mental health and wellbeing at the universal level is balanced with providing targeted services to individuals at-risk for mental health problems, as well as serving those clients with significant mental health needs (Splett, Fowler, Weist, McDaniel, & Dvorsky, 2013; Weist et al., 2014). Furthermore, a population based, MTSS approach focuses on bolstering positive behaviours and strengthening connections across various community sectors to create integrated systems of care that serve the broad population (Strein et al., 2003; Weist, et al., 2014). The population-based,

MTSS approach's dual focus on promoting positive mental health and identifying and addressing mental health problems aligns with the dual-factor model of mental health described in the section above.

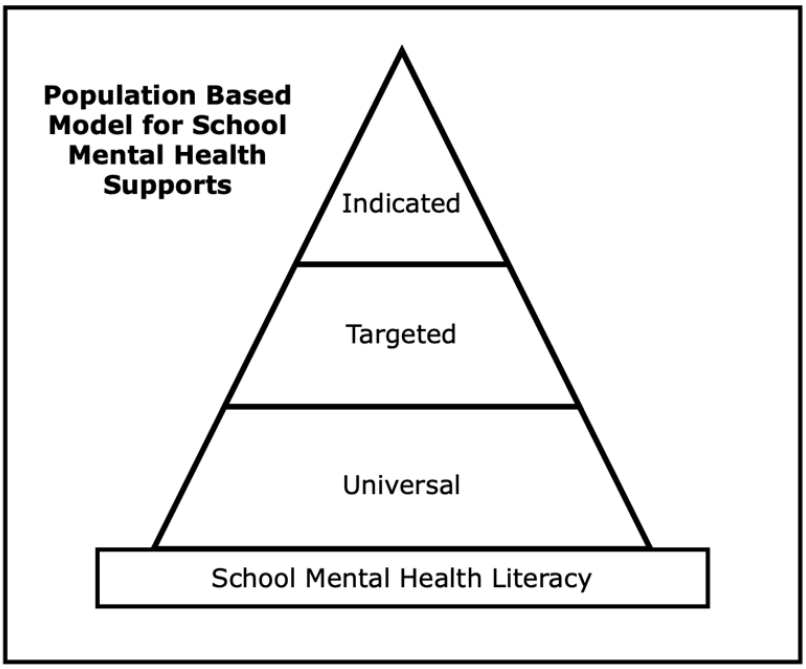

Figure 2. Population-based model for school mental health supports

As depicted in Figure 2, within a population based, MTSS mental health framework, at the universal level (i.e., tier one), mental health promotion strategies are focused on the general population. Within the school setting, universal strategies and interventions may include school-wide positive behaviour support initiatives, social emotional learning and other mental health promotion programs and curricula that can be delivered by educators and school teams that serve the entire student population (Franklin, Kim, Ryan, Kelly, & Montgomery, 2012). At the targeted level (i.e., tier two), individuals at risk for mental health problems are identified and supported through targeted prevention interventions and risk or harm reduction strategies. In the school context, educators help to identify students at-risk for mental health problems in need of further intervention and provide classroom adaptations to support students and promote mental wellbeing,

such as trauma-informed behavioural supports (Franklin et al., 2012). At the indicated level (i.e., tier three), individuals with mild to complex mental health problems are treated with therapeutic intervention at varying levels of intensity as indicated by the individual's specific mental health needs. Within schools, educators support indicated services by participating in referrals and support interventions, such as the implementation of crisis response protocols (Franklin et al., 2012). Additionally, within schools, educators collaborate with school and community mental health professionals to identify and facilitate access to treatment for students with significant mental health problems and support intensive interventions and needed accommodations.

Educators are well situated to play a role at all tiers within a MTSS with respect to the activities described above. Educators are not expected to take on formal mental health support roles, such as the role of school mental health professionals, and as such, do not provide mental health diagnostic or treatment services for students. Improving the mental health literacy of educators equips teachers and school staff with the knowledge and skills to take an active role in promoting positive student mental health, identifying students at-risk for mental illness, responding effectively, and collaborating with others when student mental health challenges arise.

Educator Perspectives on Supporting Student Mental Health

Educator Roles. Several studies conducted in Canada (e.g., Froese-Germain & Riel, 2012), the United States of America (e.g., Phillippo & Kelly, 2014), Australia (e.g., Mazzer & Rickwood, 2015), and Europe (e.g., Knightsmith, Treasure, & Schmidt, 2013) have investigated educators' perspectives on their role in supporting the mental health needs of students. Across studies, teachers generally agreed that promoting and supporting student mental health fits within their role as educators (Ekornes, 2015; Froese-Germain & Riel, 2012; Graham, Phelps, Maddison, & Fitzgerald, 2011; Koller, Osterlind, Paris, & Weston, 2004; Reinke, Stormont, Herman, Puri, &

Goel, 2011; Rothi et al., 2008; Shelemy, Harvey, & Waite, 2019a). However, a small number of studies reported variable findings when educators were asked about their role in providing school-based mental health services (SBMHS). For example, a qualitative study of teachers' perspectives and practices related to SBMHS in urban American secondary schools found that half of the 46 participants viewed supporting student mental health within their role and half viewed this as beyond their scope of practice (Phillippo & Kelly, 2014). Further, a key finding from a qualitative study conducted with 14 teachers in British secondary schools was that participants perceived a majority of teachers were reluctant to engage in emotional health and wellbeing practices with students, despite all participants acknowledging that supporting student mental health was part of their role as educators (Kidger et al., 2010).

Findings across studies indicate that educators viewed themselves assuming a variety of roles in supporting student mental health. Many educators identified their role as offering classroom-based supports for students who may be struggling with a mental health problem, or as providers of class-wide behavioural interventions (Andrews, McCabe, & Wideman-Johnston, 2014; Graham et al., 2011; Knightsmith et al., 2013; Koller et al., 2004; Phillippo & Kelly, 2014; Reinke et al., 2011; Rothi et al., 2008). Additionally, teachers viewed themselves as collaborators with school and community-based mental health professionals when supporting student mental health needs (Ekornes, 2015; Froese-Germain & Riel, 2012; Phillippo & Kelly, 2014). Findings also suggest that educators considered building relationships with students to be an integral factor in supporting the mental health needs of students (Kidger, et al., 2010; Shelemy et al., 2019a). In a study conducted by Ekornes (2015), educators primarily viewed themselves in the role of a gatekeeper who helped to identify students who may be struggling with their mental health and assist with linking them to appropriate mental health professionals and resources. Although

educators identified various roles in supporting student mental health, they also reported a lack of clarity regarding their precise responsibility (Ekornes, 2015; Mazzer & Rickwood, 2015; Phillippo & Kelly, 2014; Rodger et al., 2014; Shelemy et al., 2019a). This reported role uncertainty was identified as one of the significant challenges, among many, that educators experience when attempting to support student mental health.

Educator Challenges. While several studies found that educators recognized they have an important role in supporting the mental health needs of students, they also identified significant challenges and barriers to effectively serving in this role. Several structural and logistical barriers were identified related to collaborating with other mental health professionals, including time limitations, communication barriers related to confidentiality, and organizational barriers that create separation between educators and mental health professionals (Ekornes, 2017; Mælan, Tjomsland, Baklien, & Thurston, 2019; Phillippo & Kelly, 2014; Rothi et al., 2008; Shelemy et al., 2019a). Furthermore, educators recognized when their own emotional needs were neglected, this created a barrier to addressing students' emotional needs (Ball, 2011; Kidger et al., 2010; Rodger et al., 2014). However, the most commonly cited challenge amongst educators was a lack of knowledge about mental health and a lack of relevant learning opportunities during pre-service education and ongoing professional development (Andrews et al., 2014; Ekornes, 2015; Graham et al., 2010; Knightsmith at al., 2013; Mazzer & Rickwood, 2015; Reinke et al., 2011; Rodger et al., 2014; Rothi et al., 2008; Shelemy et al., 2019a).

Educator Needs. Given educators' widely recognized lack of knowledge related to supporting student mental health, it should not be surprising that further education was an essential need identified in several studies in order to increase educator confidence and competence in this area (Ekornes, 2015; Knightsmith et al., 2013; Koller et al., 2004; Mazzer & Rickwood, 2015;

Rodger et al., 2014; Rothi et al., 2008). In a study conducted by Rothi et al. (2008), educators specified that they required additional professional learning opportunities related to recognition of mental health problems, provision of classroom supports, relevant school resources and procedures, and appropriate community referral agencies. Another recent study investigated educators' perceived needs regarding the content and modality of mental health related professional development and resources (Shelemy, Harvey, & Waite, 2019b). Participants preferred applied education focused on providing concrete strategies that were adaptable based on the developmental level of the students being supported, such as how to approach and have conversations with students about mental health concerns. In terms of educational approach, participants indicated a preference for simple, quick, flexible professional development that incorporated multiple modalities to accommodate diverse learning styles. Furthermore, participants highlighted that interactive learning, incorporating case examples, opportunities for discussion, and built-in checks for understanding were desirable components.

Beyond educational and skill development needs, in several studies educators also acknowledged that they required additional support and collaboration from community and school-based mental health professionals in order to effectively support student mental health needs (Ekornes, 2015; Froese-Germain & Riel, 2012; Graham et al., 2010; Mælan et al., 2019; Reinke et al., 2011; Shelemy, et al., 2019b). Furthermore, educators identify that collaboration with mental health professionals allows for ongoing learning and increasing their own mental health knowledge and skills through the mental health professionals' expertise (Mælan et al., 2019). For instance, as part of a comprehensive mental health service network within a school, school psychologists, school counsellors, and/or school social workers may be well situated and have the

necessary background and expertise to support educators' mental health literacy practices through professional development, consultation, and ongoing collaboration.

Educator Mental Health Literacy

The construct of mental health literacy evolved from the domain of health literacy, which arose out of recognition that a significant proportion of the population possesses limited knowledge and skills related to maintaining physical health and identifying and seeking treatment for health problems (Kutcher, Wei, & Coniglio, 2016). Furthermore, limited health-related knowledge and skills are associated with numerous poor health outcomes (DeWalt, Berkman, Sheridan, Lohr, & Pignone, 2004). Similar gaps in knowledge and skills were found to exist in the mental health care field as well, which led to the development of mental health literacy as a distinct construct. As previously stated, mental health literacy has been defined as the knowledge, skills and attitudes that allow for effective prevention, identification, and treatment of mental health problems (CAMINH, 2007). More recently, definitions of mental health literacy have expanded to include the knowledge and skills that contribute to the promotion of positive mental health (Kutcher et al., 2016). Specifically, important areas of mental health knowledge and skill development include the ability to identify the signs and symptoms of mental health problems, including relevant risk and protective factors (Jorm, 2000). Additionally, mental health literacy includes knowledge about effective treatments and supports, and the skills that allow one to access or help others access mental health supports (Jorm, 2000; Kutcher et al., 2016). Furthermore, mental health literacy seeks to instil helpful and accurate beliefs and attitudes about mental health and mental illness to address the widespread misunderstandings held by many members of the general public that contribute to the problem of mental health stigma (Jorm, 2000; Kutcher et al., 2016). Finally,

mental health literacy includes the skills to maintain positive mental health and wellbeing (Kutcher et al., 2016).

When considering the application of mental health literacy within schools, mental health literacy can be considered a foundational component for comprehensive school mental health services (School Based Mental Health and Substance Use Consortium (SBMHSUC), 2012). A Canada wide group of researchers and practitioners with expertise in school-based mental health called the School Based Mental Health and Substance Use Consortium (SBMHSUC, 2012) developed a useful working definition, describing school mental health literacy as,

> the knowledge, skills and beliefs that help school personnel to: create conditions for effective school mental health service delivery; reduce stigma; promote positive mental health in the classroom; identify risk factors and signs of mental health and substance use problems; prevent mental health and substance use problems; help students along the pathway to care (p. 4).

As such, educators require skills and strategies for promoting mental health in the classroom, providing social emotional learning instruction, identifying signs of distress in students, and providing accommodations, support, accommodations, and links to professional services (Fortier, Lalonde, Venesoen, Legwegoh, & Short, 2017). This comprehensive understanding of school mental health literacy further assumes that developing mental health literacy is a shared responsibility for educators, students, families, school mental health professionals and communities (SBMHSUC, 2012).

Mental Health Literacy Professional Development for Educators

It is promising that researchers have identified and begun to take notice of the need for increased educator knowledge related to supporting student mental health. Fortunately, this increased recognition has led to the development, implementation, and evaluation of mental health literacy educational programs to address this gap in educator professional learning. Generally,

mental health literacy professional development programs are based on classical theories of behaviour change, which posit that increases in knowledge, attitudes and confidence will result in changes in actions (Anderson et al., 2019). Figure 3 provides a proposed logic model for educator mental health literacy professional development and potential associated outcomes. While multiple mental health literacy programs have been developed in various formats and for use with different populations, the objectives generally remain consistent: a) through psychoeducation, increase knowledge of how to achieve and maintain positive mental health, and knowledge of common mental health problems; b) decrease stigma and improve attitudes towards mental illness by illuminating misconceptions related to mental health; c) increase effective helping behaviours through skill development in identifying and responding to individuals experiencing mental health problems, and supporting access to appropriate services and resources (Kitchener & Jorm, 2008; Wei & Kutcher, 2014).

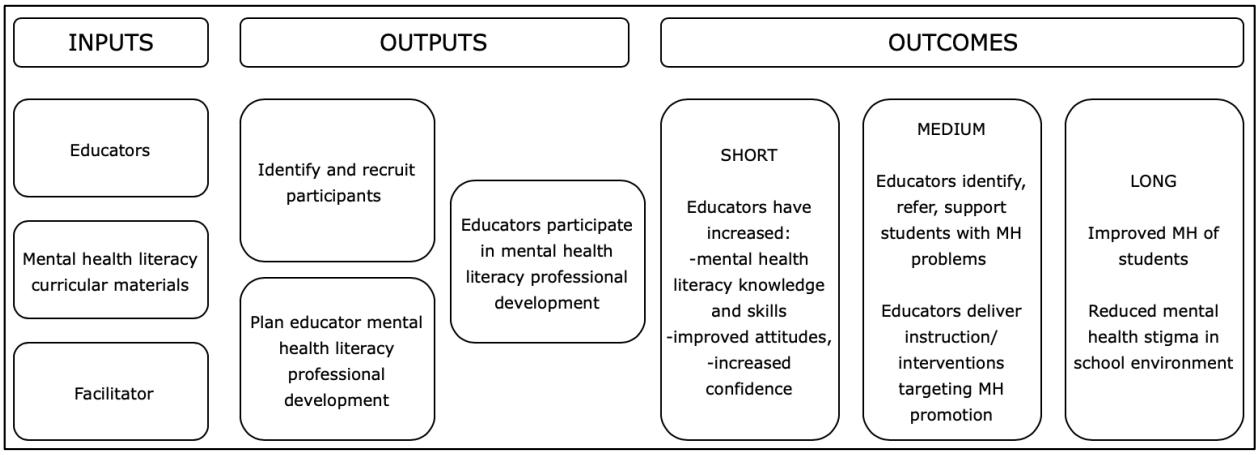

Figure 3. Educator mental health literacy professional development logic model

One example of an educator mental health literacy program is *"Go-to" Educator Training.* This one-day workshop was developed in Canada by a knowledge translation team of educators and mental health professionals and aims to equip educators to recognize mental health problems in school settings and respond by facilitating students' access to mental health care (Wei &

Kutcher, 2014). A notable strength of this program is an accompanying curricular resource called *The Mental Health and High School Curriculum Guide* that can be used by educators to deliver mental health literacy content to students, thus increasing student mental health literacy as well (Kutcher et al., 2013, 2015; McLuckie et al., 2014; Milin et al., 2016). Furthermore, a one-day professional development workshop called *The Guide Professional Development Program* was developed to train educators to effectively use the curricular resource. Recently, this program has been adapted for use with pre-service educators as well (Carr, Wei, Kutcher, & Heffernan, 2017). Research evaluations of the applications of these interrelated programs and resources consistently report significant increases in both teacher and student mental health knowledge and helping behaviours, as well as significant decreases in stigma, thereby indicating that these resources and professional development programs are effective for increasing educator mental health literacy (Kutcher et al., 2013, 2015; McLuckie et al., 2014; Milin et al., 2016).

Another widely adopted mental health literacy program is the *Mental Health First Aid* (MHFA) workshop (Kitchener & Jorm, 2002), which was originally developed in Australia and has subsequently been adapted internationally (Hadlaczky, Hokby, Mkrtchian, Carli, & Wasserman, 2014). This program is described in greater depth in the section below because it is the mental health literacy professional development opportunity in which participants engaged as a prerequisite for this study. The MHFA program was selected for use in this study because it has been widely researched and shown to be effective in increasing the core components of mental health literacy for participants, which will be reviewed in the section below (Hadlaczky et al., 2014). Additionally, MHFA is classified by the Public Health Agency of Canada (2016) as a "best practice" program due to the high quality of research and evaluation evidence, high adaptability of the program to various settings, and high potential for positive changes related to the program

goals. The American Substance Use and Mental Health Services Administration (SAMHSA) also recognizes MHFA in their National Registry of Evidence-based Programs and Practices (NREPP) (US Department of Health and Human Services, 2016). Finally, MHFA was selected for a logistical reason, that the primary researcher was certified to facilitate the workshop. The specific workshop that participants were trained in was the *Mental Health First Aid for Adults who Interact with Youth Workshop* (MHFA-Y, Mental Health First Aid Canada, 2010).

Description of Mental Health First Aid for Adults who Interact with Youth Workshop. *Mental Health First Aid for Adults who Interact with Youth* (MHFA-Y) is a 14-hour standardized educational workshop designed to increase participants' mental health literacy (Jorm et al., 2010). Specifically, the workshop is intended to improve participant attitudes and reduce stigma towards mental illness, and promote participant identification, support and helping behaviours for youth experiencing mental health crises or ongoing mental health problems (Kitchener & Jorm, 2002). The MHFA-Y course expands upon the original *Mental Health First Aid* (MHFA) course by adding topics most relevant to individuals who work with youth in the 12 to 25-year-old age range (Jorm et al, 2010). Workshop participants increase their knowledge about mental health and learn to recognize the signs and symptoms of common mental health problems and disorders, including substance abuse, mood disorders, anxiety and trauma-related disorders, eating disorders, psychosis, suicide, and deliberate self-injury. Additionally, participants develop skills to provide a person in distress with preliminary support and to respond to a mental health crisis. Specific skills addressed in the course include non-judgmental listening and communication, crisis assessment, providing reassurance and information, and linking individuals with relevant resources. The workshop structure includes a combination of lecture, case studies, videos, discussion, and interactive activities, and is accompanied by a comprehensive handbook, which

corresponds to the topics covered in the workshop. Course content was developed through rigorous literature reviews conducted by the course developers in Australia (Kitchener & Jorm, 2002). The content has been adapted in Canada to reflect statistics and trends in the Canadian population (Mental Health Commission of Canada, 2017). In Canada, workshops are delivered by facilitators who have relevant professional and/or personal experience in the field of mental health. Additionally, all facilitators are required to successfully complete a five-day train-the-trainer course provided through the Mental Health Commission of Canada (MHCC). The MHCC sets ongoing professional development and practice requirements for facilitators and collects evaluative feedback on the MHFA workshop and facilitators from all workshop participants.

Research Evaluations of MHFA-Y Workshop. The original MHFA course has been evaluated numerous times in Australia (e.g., Bond, Jorm, Kitchener, & Reavley, 2016; Hart, Mason, Kelly, Cvetkovski, & Jorm, 2016), North America (e.g., Aakre, Luckstead, & Browning-McNee, 2016; Massey, Brooks, & Burrow, 2014), Europe (e.g., Jensen, Morthorst, Vendsborg, Hjorthøj, & Nordentoft, 2016; Svensson & Hansson, 2014), and Asia (e.g., Wong, Lau, Kwok, Wong, & Tori, 2017). A recently reported meta-analysis of 15 MHFA evaluation studies concluded that the program effectively increases participants' mental health knowledge, decreases negative attitudes and stigma, and increases intention of helping behaviours directed towards individuals experiencing mental health problems (Hadlaczky, et al., 2014). The meta-analysis of MHFA evaluations included studies using disparate methodological approaches, including single group pre- and post-test studies, controlled trials, and randomized controlled trials. Notably, findings remained consistent across studies regardless of the methodology employed, with significant improvements found across the three constructs evaluated: knowledge, attitudes, and intended behavior change.

Fewer evaluations of the MHFA-Y course have been conducted than evaluations of the original MHFA course, with seven published MHFA-Y studies to date (Aakre et al., 2016; Anderson, Treger, & Lucksted, 2020; Gryglewicz, Childs, & Soderstrom, 2018; Jorm et al., 2010; Kelly et al., 2011; Noltemeyer et al., 2020; Rose, Leitch, Collins, Frey, & Osteen, 2017). Generally, evaluation results appear to be consistent with the original MHFA course, with evidence of increases in mental health literacy knowledge, reduction in stigma, and increased confidence of participants with regards to supporting youth mental health reported.

Notably, two of the seven published studies evaluated the applications of the MHFA-Y workshop in school settings with high school educators (Grylewicz et al., 2018; Jorm et al., 2010). A cluster randomized control trial was conducted in Australia in 14 high schools with 327 teachers to measure both direct (i.e., teacher effects) and indirect effects (i.e., student effects) of the MHFA-Y workshop (Jorm, et al., 2010). Results indicated that the workshop significantly increased teachers' knowledge, reduced teachers' mental illness-related stigma, and increased teachers' confidence in providing support to students when compared to the wait-list control group (Jorm, et al., 2010). Additionally, teachers who completed the workshop were more likely to support school policies and procedures related to student mental health. Further, a significant indirect effect of the program was that students in participating high schools reported receiving more mental health related information from school staff than control group schools. These changes were generally sustained six months after workshop completion.

More recently, an evaluation of the effectiveness of MHFA-Y was conducted in a school district in the USA with 356 elementary, middle school, and high school educators using a pre- and post-test design (Gryglewicz et al., 2018). Workshop participants included teachers, school administrators, and other school staff, with the majority of participants being teachers (83%).

Results of the study indicated that workshop participants significantly increased in mental health literacy, with improvements observed in both knowledge and attitudes. Educators' confidence in identifying and responding to students experiencing mental health problems significantly increased as well, along with educators' intentions to promote student help-seeking behaviour. Moreover, the majority of participants (76%) reported that they liked the workshop and believed the skills gained would be easy to integrate into their work.

These study findings provide support for the utility of MHFA-Y in school settings as a means of improving the mental health literacy of school personnel. Findings offer some preliminary support that participating in the MHFA-Y workshop can lead to behaviour change amongst educators, as illustrated in the findings that trained staff were more likely to support school mental health policies and provide significantly more mental health information to students than untrained staff.

Researchers have recently published multiple systematic reviews examining the evidence base for various mental health literacy professional development programs for educators, including the MHFA-Y workshop and "*Go-to" Educator Training* (Anderson, et al., 2019; Ohrt, et al., 2020; Yamaguchi, Foo, Togo, & Sasaki, 202020). Across reviews, findings indicate that mental health literacy professional development programs for educators contribute to significant increases in mental health knowledge, and improvement in attitudes, but the current research studies lack evidence supporting changes in educator behaviour. As such, researchers have called for future investigations that are sensitive to and track educator behaviour change. Altogether, there is still very little known about the experiences of educators who participate in professional development and incorporate mental health literacy into their practice, including their behaviours and the actions they take, as well as the factors that promote successful implementation, and what challenges or

barriers they face.

Implementation Science Lens

Identifying the factors that educators find helpful and unhelpful when incorporating mental health literacy into their practice can be usefully conceptualized through the lens of implementation science. The field of implementation science was developed to address the identified gap between research and evidence-based practice in healthcare and other areas of professional practice (Nilsen, 2015). As depicted in Figure 4, implementation science is concerned with three main theoretical components: a) the process involved in translating research to practice (i.e., Process Models), b) understanding the factors that influence the implementation of a practice (i.e., Determinant Frameworks), and c) evaluating the implementation of a practice (i.e., Evaluation Frameworks) (Nilsen, 2015). Outcomes of interest in implementation science include acceptability, appropriateness, adoption, cost, feasibility, fidelity, and sustainability, which can be addressed by targeting barriers and facilitators to implementation (Lyon et al., 2019). Within implementation science, different models and frameworks are most applicable to each component of practice. This study explored educators' experiences of implementing a practice (i.e., incorporating mental health literacy into their practice) and identifying the factors that help or hinder this practice. As such, determinant frameworks are the most relevant conceptual model because they are concerned with understanding the factors that influence implementation outcomes (Nilsen, 2015). Considerable evidence supports that implementation determinants have significant impacts on program outcomes, which is why it is important to explicitly investigate this component of implementation science in research (Durlak & DuPre, 2008; Powell et al. 2015; Proctor, Powell, & McMillen, 2013).

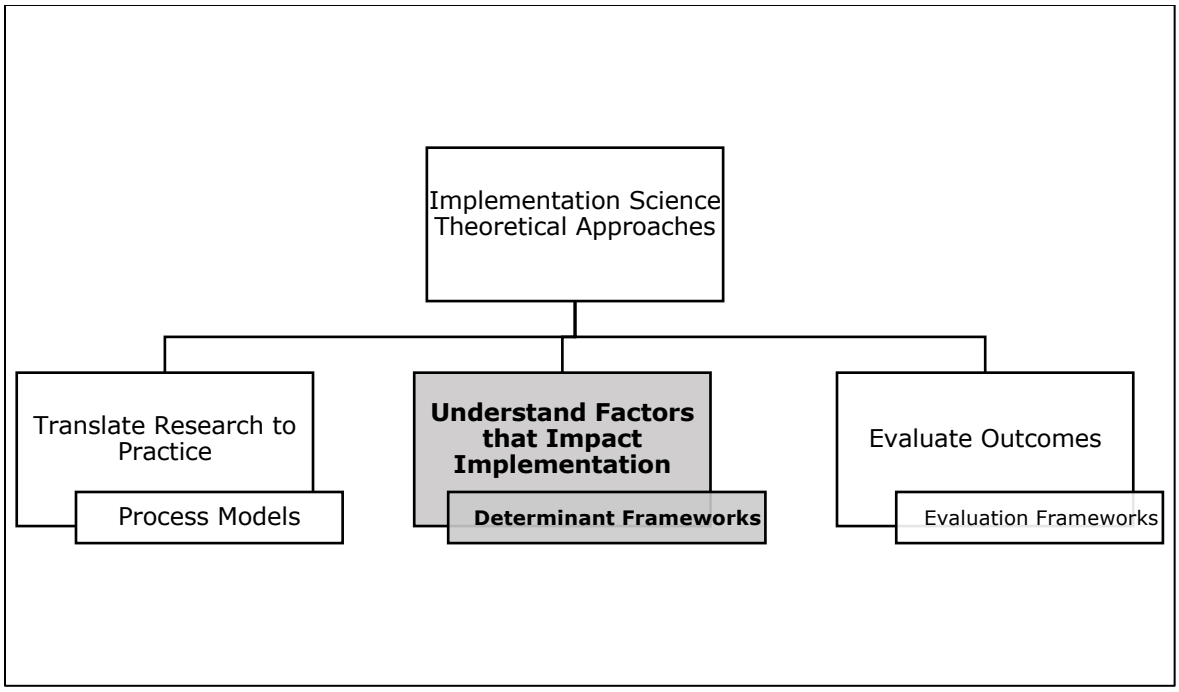

Figure 4. Three theoretical components of implementation science (Adapted from Nilsen, 2015)

Determinant frameworks describe the general domains that can influence implementation outcomes, with specific barriers and enablers (i.e., helping and hindering factors) identified within each domain (Nilsen, 2015). Determinant frameworks are considered models rather than theories because they do not offer causal mechanisms for how change takes place. A systems-level approach to implementation is implied within determinant frameworks because multiple levels of determinants are often identified (e.g., individual and organizational factors), with possible relationships among determinants both within and across levels (Nilsen, 2015).

A determinant framework with potential relevance to the proposed study was developed by Durlak and DuPre (2008) based on an analysis of 81 quantitative and qualitative studies that examined the implementation of youth health promotion and prevention programs. Durlak and DuPre's analysis supported a multi-level, ecological determinant framework with five proposed domains: community and contextual factors, provider characteristics, innovation characteristics, organizational capacity and processes, and training and technical assistance. Analysis revealed that

relevant community level factors included contextual variables, funding, politics and policy. Important provider characteristics were buy-in and self-efficacy. Significant innovation characteristics included program adaptability and compatibility with intervention context. Relevant organizational factors included general features of the organization, practices and procedures within the organization, and staffing. Finally, relevant training and technical assistance factors identified were ongoing support, educating new staff, emotional support, and problem-solving mechanisms.

To our knowledge, high school educators' implementation of mental health literacy skills within a school context has not been previously investigated through an implementation lens. As such, relevant determinant frameworks have not yet been established. Thus, the proposed study adopted an exploratory approach to investigate this specific topic in an open-ended manner. Nilsen (2015) points out that many studies with an implementation focus examine determinants using survey questionnaires, which means the determinants are pre-selected by the researcher. While this approach allows relevant determinants to be quantified, the researcher may be unaware of contributing barriers or enablers, which in turn could be overlooked in a study. Furthermore, examining the presence of barriers and enablers through surveys does not provide information regarding how the determinant factors impact implementation or substantiate relationships among factors. For the proposed study, rather than applying a pre-existing determinant framework and collecting quantitative data about relevant determinants, a qualitative approach was utilized to explore implementation broadly by learning about the experience of individuals implementing a practice. This approach allowed participants to generate the determinants based on their experiences without imposing pre-existing categories. The findings can later be compared and

contrasted with pre-existing determinant frameworks to assess the utility, such as Durlak and DuPre's (2008) multi-level ecological determinant framework.

The Current Study

A review of the literature substantiates educators' role in supporting the mental health needs of students, yet educators acknowledge that a lack of knowledge and skills serves as a major barrier to supporting students in this role. Mental health literacy professional development programs for educators have been developed to address this gap in knowledge. Evaluations of mental health literacy professional development programs have shown increases in knowledge, reduction in stigma, and increases in educators' confidence in supporting students and helping them to access appropriate resources. However, little is known about educators' experiences of incorporating and implementing mental health literacy skills into their practice. For instance, multiple systematic reviews of educator mental health literacy professional development programs have raised concerns that documented educator behaviour change is lacking in the evidence base. Through the lens of implementation science, this study explored high school educators' experiences of implementing mental health literacy skills and practices, and the determinants that they perceived to help or hinder them. Educators' experiences of implementing mental health literacy skills in their practice were explored by asking the following research questions:

Research Questions

1. What factors (e.g., events, behaviours, or processes) help educators when incorporating mental health literacy into their practice?
2. What factors (e.g., events, behaviours, or processes) hinder educators when incorporating mental health literacy into their practice?

3. What factors or supports did educators perceive as missing, or did they wish they had when incorporating mental health literacy into practice?

Situating the Study within a Qualitative Research Paradigm

Qualitative inquiry allows research questions to be explored in the natural world and lets researchers learn about the meaning individuals attach to their experiences (Morrow, 2007). Qualitative approaches can be particularly useful when there is a lack of research on a particular topic, and the focus of the study is to explore and describe a phenomenon and provide a rich representation of participants' experiences. This study utilized a particular qualitative methodology called the Enhanced Critical Incident Technique (ECIT), which is particularly well-suited to applied research investigating implementation of a skill or practice (Butterfield, Borgen, Amundson, & Maglio, 2005; Butterfield, Borgen, Maglio, & Amundson, 2009; Woolsey, 1986). Based on Creswell's (1998) formulation of the five dimensions of qualitative traditions, Butterfield at al. (2005; 2009) identified five key features that make ECIT distinct from other qualitative methodologies. First, ECIT emphasizes critical incidents, events, or factors that help or hinder the successful performance of an event, activity, or experience. Second, ECIT is grounded in the discipline of organizational and industrial psychology, which is known for an applied research focus. Third, data are most commonly collected through interviews, which allows research questions to be open-ended, exploratory, and grounded in everyday experiences. Fourth, ECIT has specific procedures for data analysis involving establishing a frame of reference, forming emergent categories, and identifying the consistency of categories across participants. Finally, findings are represented narratively through thematic categories with self-descriptive titles and operational definitions. In summary, the ECIT fits well with the aims of the study, given the methodology's

applied research focus, in combination with an in-depth, exploratory approach grounded in participants' experiences.

When considering the overarching research paradigm and assumptions about knowledge (i.e., epistemology) inherent to ECIT, this methodology can be understood to adhere to assumptions of both post-positivist and constructionist underpinnings (Bedi, Davis, & Williams, 2005). Morrow (2007) acknowledges that often research projects do not fit tidily into a single paradigm and suggests it is possible to work across paradigms, as long as one does so carefully in response to the research questions. The pragmatic nature of the ECIT methodology draws from both paradigms in a manner that allows data to be generated that allows for practical applications. For instance, the post-positivist underpinnings of ECIT are evident in the credibility checks aimed at generating reliable data, such as quantifying participation rates; these procedures aim to produce trustworthy data that can contribute to practical recommendations. ECIT's focus on the stories of individuals and the meaning people attach to their experiences aligns with a constructionist paradigm, and ensures the data remains grounded in educator experiences. Furthermore, constructionist underpinnings acknowledge the active role the researcher plays in constructing meaning through interaction with participants during data collection and additionally during interpretation of study results (Crotty, 1998; Morrow, 2005). As such, engaging in researcher reflexivity was an important ongoing process throughout the study, which allowed for consideration of how the researcher's assumptions, background, and personal experiences both contributed to and impacted exploration of the research questions.

The researcher's personal reflection included below briefly summarizes some relevant aspects of my background, perspectives and assumptions that I reflected upon throughout the

study. The particular research procedures, as well as the history of ECIT, are discussed in greater depth in the following methodology chapter.

Researcher Personal Reflection

While conducting this study, it was important to regularly reflect upon how my own experiences and perspectives influenced the research process, including the questions I asked, the interviews I engaged in with participants, as well as my interpretation of the data and conclusions that were drawn.

Educational and employment background. As a psychology major since my undergraduate studies, I acknowledge that my education has shaped my understanding of mental health and mental illness. My master's and doctoral education in School and Applied Child Psychology in the Faculty of Education has been situated in the field of both education and child psychology and shaped my understanding of the role of the education system in supporting and promoting the mental health of students. Over the past seven years, I have completed several practica and internship experiences working within schools in the capacity of a school psychologist and mental health clinician. I have collaborated and consulted extensively with educators to support student learning and mental health. However, I do not have background or experience as an educator. While I am familiar with the education system in the role as a mental health professional, I am unfamiliar and unexperienced in supporting student mental health in the role of an educator. Thus, study participants have lived experience and expertise that I do not possess. As such, it was important to remain mindful of my outsider status while conducting the study.

My research interests have focused on school-based mental health services since my master's studies. For my master's thesis, I explored youth experiences of school-based mental

health supports through a qualitative interview study. Of all the services and supports participants discussed, they spoke in the most depth about the significant impact of teachers. Participants reported that when educators are knowledgeable about mental health, willing to accommodate a student's individual needs, and show they care, this went a long way in supporting students experiencing mental health problems. This finding led to my interest in further exploring educators' perspectives on their role in supporting student mental health, and the ways through which educators can be equipped to take on this role. Both my research and clinical experiences have led me to believe that offering comprehensive and collaborative mental health services in schools is a worthwhile pursuit for supporting the positive development of students. Maintaining awareness of potential assumptions and biases related to my perspective and these experiences was crucial as I conducted interviews and analyzed data.

Mental health literacy workshop facilitator. My experience as a Mental Health First Aid for Adults who Interact with Youth (MHFA-Y) instructor was also important to consider as I conducted the study. I completed training in order to be certified to facilitate this workshop and I believe in the workshop's utility as an intervention to equip individuals to increase their mental health literacy and support student mental health. I also acted as the facilitator for the MHFA-Y workshops in which study participants took part. Given these factors, it was particularly important to manage my assumptions and remain aware of my dual role as facilitator and researcher when conducting interviews with participants. For instance, while I believed the MHFA-Y workshop would be useful for educators, this did not mean participants felt the same way. Additionally, I was mindful that participants may feel pressured to speak positively about the workshop during interviews. I addressed this potential issue by reminding participants that the purpose of the study was not to evaluate the workshop or myself as facilitator, but to

understand their experiences incorporating mental health literacy knowledge and skills into practice and the factors that helped or hindered them.

CHAPTER THREE: Methodology

This chapter describes the ECIT methodology in greater depth, including the history and evolution of this approach. Next, a summary of the research procedures is provided, including descriptions of study setting, participant recruitment and demographics, data collection, data analysis, and strategies employed for establishing credibility and scientific rigour when interpreting the findings.

Description of the Critical Incident Technique

The Critical Incident Technique (CIT) is a qualitative research methodology originally developed by Flanagan (1954) to allow for human behaviour to be investigated systematically for the purpose of collecting relevant information in a manner useful for understanding and solving practical problems. More specifically, a CIT study, as it developed historically, may focus on exploring effective and ineffective ways of performing a task, identifying helping or hindering factors in a process, examining successes and failures, or determining critical characteristics of an activity or event (Flanagan, 1954). This methodology provides an approach for identifying and collecting observations (or critical incidents (CIs)) that have particular significance to the problem of interest. For example, CIT was first used to evaluate aviation crew qualifications in World War II and identify the specific factors (CIs) that contributed to many pilot candidates being terminated from flight training school in 1941 (Flanagan, 1954). Originally, CIs were gathered through direct observation, retrospective interviews, or by reviewing written records.

While the CIT methodology originated in organizational and industrial psychology, it has been demonstrated to be a flexible methodology that allows researchers to learn about diverse phenomena from the perspectives of insiders in applied settings (Butterfield et al., 2005; Wertz et al., 2011). The CIT has been applied within various disciplines including counselling psychology,

nursing, psychology, education, job analysis, marketing, and social work (Butterfield et al., 2005, 2009; Woolsey, 1986).

More recently, researchers have expanded CIT procedures to develop the Enhanced Critical Incidence Technique (ECIT) (Butterfield et al., 2009). While ECIT remains consistent overall with Flanagan's (1954) original approach, additional procedures include: a) gathering contextual information at the beginning of an interview to provide background for data analysis, b) adding nine credibility checks to enhance the trustworthiness of the findings, and c) asking participants to generate wish list (WL) items in addition to helping and hindering CIs (Butterfield et al., 2009). WL items allow participants to reflect on supports, people, or information that they believe would have been useful in the situation being studied but were not available during the participants' experiences. The ECIT remains a diversely applied and flexible methodology, as evidenced in several recent studies that have used the ECIT approach to investigate practical problems in the field of education (e.g., Andreou, McIntosh, Ross, & Kahn, 2015; Chou et al., 2015; Curle et al., 2017; McIntosh, Kelm, & Canizal Delabra, 2016), counselling psychology (e.g., Arsenault & Domene, 2018; Collins, Arthur, Brown, & Kennedy, 2015; Kivari, Oliffe, Borgen, & Westwood, 2016), social work (e.g., Chen & Fortune, 2017), and vocational and career psychology (e.g., Smith et al., 2014)

Wertz et al., (2011) observed that a major contribution of the CIT was it being the first qualitative research methodology to offer psychological researchers clear and specific protocols, for establishing the research purpose, designing the study, collecting and analysing data, and reporting findings. According to Flanagan (1954), CIT has five major components: (1) identifying the aims of the activity being investigated; (2) setting specifications (3) data collection; (4) data analysis; and (5) data interpretation and reporting. Consistent with the Flanagan (1954) approach,

these components are described in relation to the procedures applied in present study in the sections below.

Step One: Determining Study Aims

The aim of this study was to investigate high school educators' experiences of incorporating mental health literacy skills and knowledge into practice, with particular attention to the factors perceived to help and hinder their success. A review of the literature on educators' perceived mental health literacy needs, and the goals of mental health literacy educational programs helped to further specify the study aims. All participants completed the MHFA-Y workshop, which helped to ensure that participants shared a similar frame of reference regarding their experience in mental health literacy professional development (Flanagan, 1954).

Setting and Recruitment Process. This study was conducted with educators working in three independent, religiously affiliated secondary schools located in Lower Mainland British Columbia. The process of study recruitment began with the establishment of a partnership between the primary researcher and the Director of Student Support (DSS) for an independent schools' organization (ISO). Through this partnership, the researcher was invited to attend monthly meetings for a professional learning community (PLC) of high school Learning Support Coordinators (LSC) facilitated by the DSS and an educational consultant. During these meetings, the primary researcher provided professional development and facilitated discussion on the topic of capacity building for educator mental health literacy in high schools. Topics discussed during capacity building sessions included: understanding mental health literacy; resources for educators when supporting student mental health in schools; educator self-care and understanding compassion fatigue; resources for talking about mental health with school staff. Additionally, during a PLC meeting, the researcher shared information about the MHFA-Y workshop and

associated research study. LSCs were provided with information about how to contact the researcher if interested in hosting a MHFA-Y workshop for educators at their school. The goal was to conduct three MHFA-Y workshops with 8-15 participants per workshop, through which study participants would be recruited. Through the partnership with the PLC, two high schools hosted MHFA-Y workshops, and an additional workshop was hosted at the ISO head office with educators from four high schools participating. Prior to each workshop, the researcher provided workshop participants with a consent form and verbally informed them about the research project associated with the workshop. Participants were asked to consent to be contacted for a follow-up interview and were reassured they were not required to do so in order to participate in the workshop. A copy of the consent form can be found in Appendix A. Through facilitation of three MHFA-Y workshops, 27 high school educators participated and consented to be contacted for follow-up interviews (i.e., 100% consent rate). Six-18 months after completing the workshop, the primary researcher contacted participants to request a follow-up interview. Of those contacted, 14 educators from three high schools were available to participate in follow-up interviews (i.e., 52% participation rate). Nine participants worked at School A, four participants worked at School B, and one participant worked at School C. A visual summary of the participant recruitment process is provided in Figure 5.

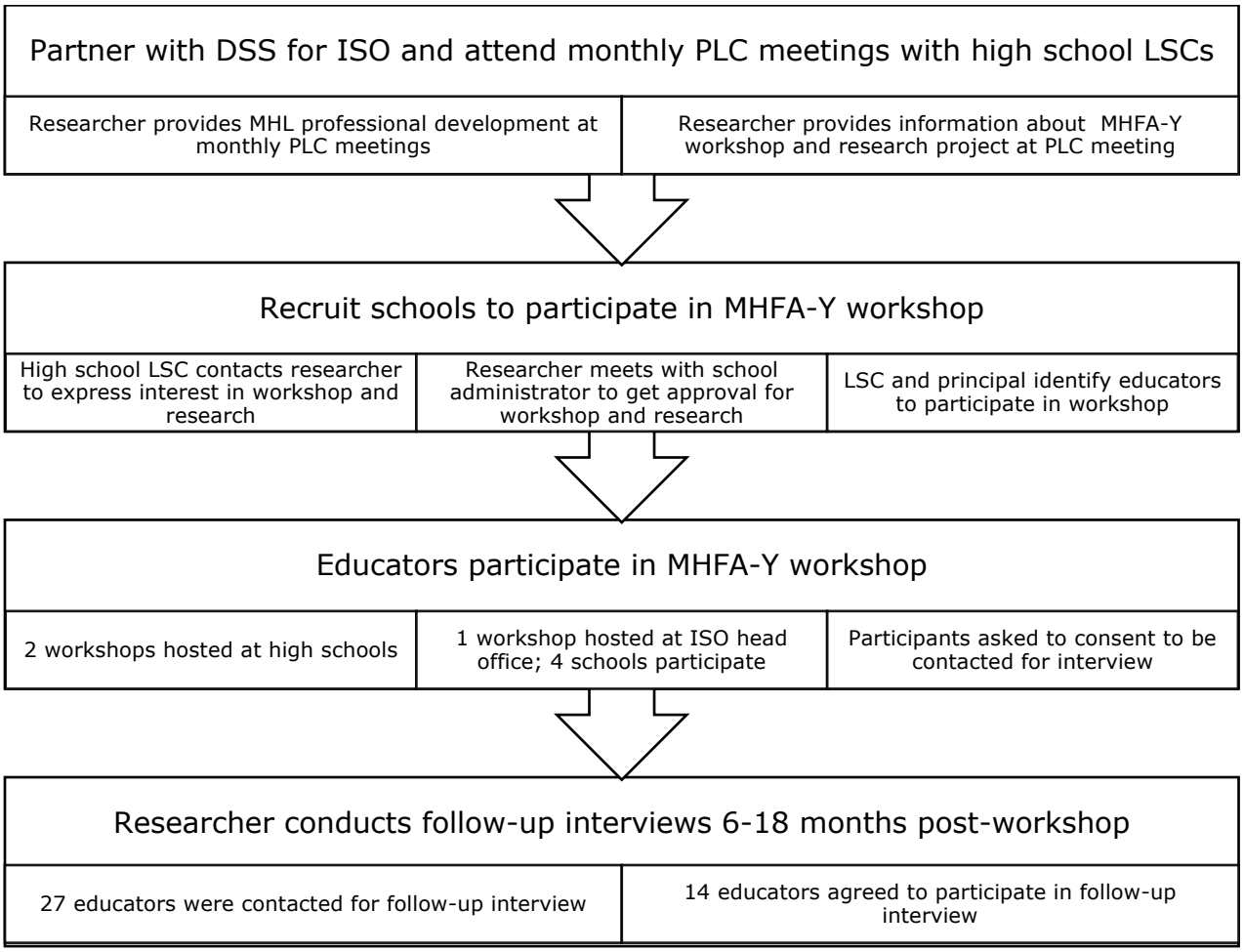

Figure 5. Participant recruitment process

Participant Demographics. Study participants included a purposive sample of 14 high school educators, including seven teachers (e.g., subject teachers, resource teachers), three special education assistants (SEAs), three school administrators (e.g., principal, director of student support), and a school counsellor. With respect to the length of time participants had worked in the field of education, this ranged from 1.5 to 27 years, with a mean of 11 years work experience in education. In terms of gender identities, 10 participants identified as female and four participants identified as male. With respect to participants' racial and ethnic identities, 10 participants identified as white or Caucasian, two identified as Latin American, European, one identified as Asian, and one identified as Western European.

Sample Adequacy. In ECIT studies, sample adequacy is not determined by the number of participants, but rather by the generation of a sufficient number of critical incidents to ensure data exhaustiveness and redundancy (Butterfield et al., 2009). Redundancy is achieved in a data set when new categories or themes are no longer identified in the data (Butterfield, et al., 2009). The researcher used a log to track critical incidents and thematic groupings of preliminary categories after analyzing each interview transcript. Generally, collecting 100 CIs is considered adequate for a data set, but researchers may opt to collect more to obtain increased detail and depth of data (Flanagan, 1954; Radford, 1996; Voss, 2009). Interviews with 14 participants yielded a total of 256 helping and hindering CIs and WL items. No new categories were identified after analyzing the transcripts of five participants. However, nine subsequent interviews were analyzed to provide additional richness and depth to these categories and ensure that each emergent category was explored in sufficient detail.

Step Two: Planning and Setting Specifications

Interview. Semi-structured individual interviews were conducted with participants using an interview protocol developed by the primary researcher and adapted from guidelines outlined by Butterfield et al. (2009). A detailed interview protocol can be found in Appendix B. Preparing an interview protocol in advance helped to ensure that the relevant situations, events, and processes (i.e., CIs) were clearly identified for the participant to recall and kept the interview grounded within the ECIT procedures (Butterfield et al., 2009). To facilitate a shared frame of reference, all participants were provided with a description of the aims and competencies of educator mental health literacy practices at the beginning of the interview. Specifically, participants were provided with a definition of educator mental health literacy skills and competencies, including the aims of increasing knowledge of mental health and mental illness, improving attitudes and reducing stigma

related to mental health, and promoting recognition and support for youth experiencing mental health problems. Participants were then asked to identify CIs (i.e., events, processes, situations) when they incorporated or planned to incorporate mental health literacy into practice and the factors that were helpful to or hindered their perceived success. In keeping with the ECIT approach, participants were asked follow-up questions to identify the significance of a CI and why the incident was perceived to be helpful or unhelpful (Butterfield et al., 2009). Additionally, participants were asked to identify a WL of supports they believe would have been helpful in facilitating successful incorporation of mental health literacy into their practice but were missing from their experiences.

Step Three: Data Collection

Thirteen interviews were conducted in-person at the participant's school in a private room that allowed them to participate in the interview confidentially. One interview was conducted by phone due to inclement weather, which prevented both the researcher and participant from travelling to the school site. Prior to the interview, informed consent was re-obtained by reviewing the consent form the participants previously signed and providing participants the opportunity to ask questions prior to beginning the interview. Interviews ranged from 29 minutes to 75 minutes in length, with 49 minutes representing the mean interview length. Interviews were audio-recorded and transcribed verbatim (e.g., including pauses and utterances such as "uhmm") by a trained transcriptionist who signed a confidentiality agreement (Appendix C).

Two follow-up interviews were conducted with participants via email. The first follow-up interview involved a preliminary member check seeking feedback on whether a summary of the critical incidents that arose in the interview was a fair representation of a participant's experience. The subsequent interview took place after initial data analysis was complete and participants were

provided with a summary of the emergent thematic categories that arose across participants; participants were asked to provide feedback regarding whether the overall summary resonated with their experiences. These interviews are described in further detail in the section focused on establishing trustworthiness below.

To ensure confidentiality, all identifying information was removed from the transcripts and documentation of other communication with participants (i.e., phone calls, emails), and participants were assigned identification codes. To further protect participant data, all audio recordings and transcripts were stored in encrypted digital files and hard copies of data were stored in a locked filing cabinet in the Principal Investigator's office at UBC.

Step Four: Data Analysis

Organizing Raw Data and Identifying CIs and WL Items. CIs were extracted from the data and organized based on the approach recommended by Butterfield et al. (2009). When organizing the raw data, the primary researcher began by reviewing individual interview transcripts in order to identify CIs and WL items. Using word processing software, the primary researcher highlighted helping CIs, hindering CIs, and WL items in three different colours. The researcher also made note of any items that appeared to be CIs or WL items, but the (helping or hindering, or wish list) significance was not discussed by the participant; these flagged items were clarified during the follow-up email interview with the participant.

Category Creation and Coding. When analyzing the data, the researcher's frame of reference was determined in advance to ensure that the results linked to the purpose of the study (Butterfield et al., 2009; Flanagan, 1954). For example, the categories developed during analysis may differ depending on whether the data was to be used for developing a job description, or for generating training procedures (Woolsey, 1986). In the present study, the frame of reference was

to collect data for the purpose of developing recommendations for supporting educators when incorporating mental health literacy into their practice and to inform future research on implementation of educator mental health literacy practices.

Butterfield at al., (2009) recommend that the researcher begins to create categories with a set of three randomly selected interview transcripts. The researcher began by examining the helping CIs in the first selected interview transcript with a view to identifying patterns, themes, similarities and differences (Butterfield et al., 2009). Using an inductive approach, the researcher then identified tentative categories and sorted the CI excerpts into tabs on a spread sheet software titled by category. The process of categorizing the data is similar to open coding, in which data is sorted in order to best represent "persistent ideas" by forming emergent categories (Creswell, 1998). The language used by participants during interviews facilitated this process of open coding because CIs with similar sentences, words, and phrases were grouped together. This process was then repeated for hindering CIs and WL items, and for the remaining two interviews within the initial set. The researcher then built upon this process with another set of three interviews, until all the interviews were coded and categorized. Throughout the coding process, categories were renamed or merged as new critical incidents were added, which reflects the iterative nature of the categorization process.

Step Five: Establishing Trustworthiness, Interpreting the Data, and Reporting the Results

A key component of interpreting the study data is engaging in credibility checks to establish the trustworthiness of the findings and ensure appropriate scientific rigour (Butterfield et al., 2005; Butterfield, et al., 2009). Within the ECIT methodology, nine credibility checks are recommended to ensure the categories are reliably generated, and that the findings are grounded in the voices of the participants and applicable to the field of study (Butterfield et al., 2005;

Butterfield, et al., 2009). The nine credibility checks employed in this study are briefly described in the section below, with the results reported in-depth in the following chapters focused on reporting and discussing the study findings.

Interview fidelity check. A researcher with expertise in the ECIT methodology was asked to review the transcript of the first interview conducted by the primary researcher to confirm that the interviewer probed for sufficient detail when having the participant describe CIs and to ensure that no leading questions were asked. The methodology expert provided feedback and confirmed that the initial interview aligned with the ECIT methodology. The methodology expert also provided constructive feedback, noting a few instances when the primary researcher provided directive reflections or asked directive questions. This feedback was incorporated into subsequent interviews, so directive reflections and questions in future interviews were avoided.

CI exhaustiveness. A running log was kept recording the preliminary CIs and WL item categories identified during each interview. Preliminary CI categories were added to the log after analysis of each transcript. The log was considered a working document because categorization shifted as further transcripts were analyzed and was updated to reflect the change in categorization. However, the purpose of the log was to provide a rough estimate of when new categories were no longer identified during the interviews. As previously mentioned, no new categories were documented in the data after five interviews. However, analysis of additional interviews allowed the emergent categories to be explored in greater detail. While new critical incidents were described by participants following the fifth interview, all were represented by the categories identified in earlier interviews.

Preliminary member checks. Following each interview, the researcher summarized the CIs that were identified. A follow-up interview to clarify CIs identified by each participant was

conducted by email, with each participant given the option of participating in a follow-up phone call upon request. For the email interview, participants were sent a summary of the CIs derived from their interview and asked to provide feedback regarding whether the summary was a fair representation of the experience they shared during the interview (See Appendix D for a template of the follow-up interview). One participant elected to participate in an additional follow-up conversation by phone with the primary researcher. The phone conversation was not audio recorded. Instead the primary researcher typed a summary of the conversation immediately following the interview and provided the summary to the participant to allow for feedback regarding whether the summary was an accurate description of the topics discussed.

Independent extraction of CIs and WL items. A graduate student with a background in qualitative research methodologies was provided with a random sample of 25% of the interview transcripts and asked to independently identify CIs and WL items. The researcher then compared both sets of CIs and found a 90% agreement rate. Mismatches between the CIs extracted by the primary researcher and independent rater were primarily due to critical incidents that appeared to address multiple helping or hindering factors, and discrepancies pertained to whether excerpts represented one or two CIs. The primary researcher and independent rater discussed these discrepancies and were able to resolve the discrepancies to reach 100% agreement.

Sorting of CIs and WL items by independent rater. A graduate student with a background in qualitative research and the ECIT methodology served as an independent rater to sort CIs and WL items into the emergent categories established by the researcher. The independent rater was provided with a brief description of each category developed by the primary researcher during data analysis and asked to sort a random selection of 25% CI excerpts into the categories. A match-rate guideline of 80% is recommended by researchers with expertise in ECIT methodology (Andersson

& Nilsson, 1964; Butterfield et al., 2009). Upon the independent rater's initial sort of CIs into categories, 88% agreement was obtained. The researcher and independent rater discussed the discrepancies and achieved 100% agreement regarding categorization. This procedure helped to clarify and confirm the distinctness of the categories identified by the primary researcher.

Emergent category member checks. In order to assess the consistency of the researcher's interpretation with the participants' intended meaning, all participants were provided with a summary of the emergent categories, including the category name and a brief description of each category (See Appendix E for the emergent category summary document provided to participants). Participants were asked to complete a brief follow-up email interview and answer whether each of the categories made sense, whether the categories resonated with their experiences, and whether they were surprised by any of the categories (See Appendix D for a template of the follow-up email interview). Of the 71% of participants who responded to the follow-up email, all reported that the categories were representative of their experiences. One participant shared that the summary of emergent categories was utilized during a team meeting to plan school mental health supports and educator mental health literacy professional development within their school.

Minimum participation rate. Flanagan (1954) suggests that categories should be assessed for validity based on the frequency of CIs extracted, which represent a given category. Butterfield et al. (2009) suggest that a minimum participation rate must be established to support a category's trustworthiness. Specifically, categories can be considered valid if a minimum of 25% of participants report a CI that falls within either the helping or hindering category. Participation rates for each category are summarized in the findings chapter in Table 1.

Expert feedback. A researcher in the field of mental health literacy professional development for educators reviewed the emergent categories and provided feedback on their

applicability to the field, including whether the categories made sense, and whether they were surprising. Overall, feedback supported that the categories could be easily understood and were applicable based on the state of knowledge in the field of educator mental health literacy. The expert researcher identified there was significant overlap between two categories, which led to the categories being combined in the final presentation of the study findings.

Comparison of categories to extant literature. Findings from the present study, presented in the next chapter (i.e., Chapter Four: Findings) were compared to previous findings in the research literature that focused on school mental health supports and educator perceptions about their needs and challenges when supporting student mental health and incorporating mental health literacy into practice. These comparisons form part of discussion chapter. The discussion chapter also examines the findings from this study in relation to theories and models within implementation science, with a focus on determinant frameworks (Nilsen, 2015), such as Durlak and DuPre's (2008) multi-level ecological model.

CHAPTER FOUR: Findings

The results of the study are presented in this chapter. In this research study, high school educators responded to semi-structured individual interview questions about the factors that helped them and hindered them when incorporating mental health literacy into practice. Interviews were recorded and transcripts of interviews were analyzed iteratively to identify commonly occurring categories/themes amongst participants. Interviews with 14 participants yielded a total of 256 helping and hindering critical incidents and WL items. Of these, 137 were helping incidents, 86 were hindering incidents, and 33 were WL items. The critical incidents were organized into a total of nine categories, representing reoccurring themes or common experiences among educators when incorporating mental health literacy in their practice. As depicted in Table 1, the majority of categories encompassed critical incidents pertaining to both helping and hindering categories, with six of the categories also including WL items. In Table 1, the categories are arranged in order from the helping category of critical incidents endorsed by the largest percentage of participants, to the helping category endorsed by the lowest percentage of participants. A description of each category, along with exemplar participant quotes is provided in the narrative below. To increase readability of the text, the study author lightly edited the participant quotes that are presented in the narrative. Specifically, brief utterances, such as “like,” “mmmm,” or “kind of” were removed. Portions of the excerpts that did not significantly contribute to illustrating a critical incident, such as repetitions or unintelligible speech were also omitted. These omissions are indicated with ellipsis points (…). Finally, remarks added by the researcher to help clarify a quote are indicated within parenthesis.

Table 1. Critical incident categories with corresponding number and percentage of participants contributing to each category

Category	Helping CIs	Hindering CIs	WL Items	Total CIs
Building Relationships with Students	30 (93%)	4 (21%)	-	34
Normalizing Talking About Mental Health and Reducing Stigma	33 (86%)	17 (50%)	6 (29%)	56
Accessible Mental Health Professionals	23 (79%)	9 (43%)	6 (36%)	38
Mental Health Literacy Education	16 (64%)	16 (64%)	14 (57%)	46
School Staff Communication and Collaboration	16 (43%)	11 (43%)	5 (36%)	32
Time	4 (29%)	13 (57%)	-	17
Administrator Support	6 (29%)	-	-	6
Family Communication and Collaboration	7 (21%)	8 (29%)	2 (14%)	17
School Culture & Values	2 (21%)	8 (29%)	-	10
Total CIs	137	86	33	256

Building Relationships with Students

The category referred to as Building Relationships with Students included incidents where participants described how their relationships with students impacted them when attempting to incorporate mental health literacy into their practice. The helping category included incidents in which participants described how developing respectful, compassionate, non-judgemental relationships, grounded in trust, facilitated them in supporting the mental health of students. Examples of supporting student mental health through relationships included being a safe adult a student can open up to when struggling, acting as a bridge to formal mental health supports, and

knowing the student well enough to observe changes in their behaviour that could be indicative of mental health concerns.

In the following excerpt, a participant shared the experience of connecting and developing a rapport with a student who they had identified as disengaged in a physical education class. This relationship laid the groundwork for the student to later open up with the teacher regarding mental health problems he was experiencing and allowed the educator to act as a support for the student at school:

> So, there was one student in Grade Nine in PE (Physical Education); he hated PE and I knew it right away. You could tell, right. So, I feel like those are the kids that I gravitate towards. So, I find myself talking to them often. Okay, God, I've got to get a connection with this kid somehow. I'm like the uber sports guy, I love athletics. I was the complete opposite of this kid in high school, so I knew that wasn't gonna be a connection. Yes, I want to find something to connect with him. So, it was either he spoke six or seven languages and he did dance outside of school. So, we used those to have rapport, which allowed us to get through his Grade Nine year. And then it was literally the first week of school the following year, I just ran into him in the hallways, *Hey, how are you?* Just asked him and he stopped me dead in my tracks and he said, *Do you really want to know?* And I said, *yes*. And he pulled me aside and opened up about everything that had been happening, eating disorder, depression, struggles with his sexuality, possibly gender, just you name it…So I find that was the rapport and the relationship coming to fruition, and it allowed me to be someone who could support this student (Participant 8, Teacher and Coach).

Similarly, the following participant shared that developing connections with students with mental health problems has helped them to become a safe person in the school for those students and allowed them to support these students in getting through the school day when they are struggling:

> A lot of my day is involved working with kids who are having mental health challenges, whether they're diagnosed or not. I do think, I mean the main thing that I feel my role involves is really connecting with the students and trying to give them a place where they feel safe and able to open up. I'm more in the department head role, so I'm not necessarily case managing, and I do see kids less than I would like to. There are some that I've just developed a really close connection with who- now I'm their safe person in the school. I think that has helped give them a place to go if they are feeling like they're getting really too anxious or they're having a really rough day, they can come and re-regulate and go

> back. I think that just on a personal level, connecting with the kids. (Participant 4, Learning Support Coordinator).

Several participants discussed the importance of relationships with students as a foundation for helping students to access more formal mental health services. A trusting relationship allowed students to open up to educators and further, meant the student was willing to trust the suggestions of the educator, as illustrated in the following excerpt:

> Often, I find I am a bridge between the student and further support that they need, whether that be academic counselling, tutoring, whether that be guidance counselling, or whether it be counselling on campus or off campus. I find, they'll come to me. I have a rapport with them and then it's like, *Okay, we need to address this; you need to see a psychologist, or a nutritionist, or a tutor or whatever it might be*. So, I find myself being a bridge at times (Participant 8, Teacher and Coach).

Participants also identified that certain roles at school were conducive to developing relationships with students. For instance, Participant 12 shared that coaching a team allowed for connections to develop through a common interest and opportunities for informal and extended interactions with students:

> The personal connection that we have. He (the student) is a lacrosse player; I am a lacrosse player. I still play lacrosse; he loves lacrosse. So, we already have that rapport. So, he would feel like, it's ok if I'm over there like, *Hey, are you ok?* If it was somebody else, he might just lie, or you know change the story and not even be wanting support. So, I think that's something, if you don't have a connection in some sort of way with the student then they are going to dismiss you as kind of, *why are you here?* (Participant 12, Special Education Assistant and Coach).

Another participant identified that as a grade level coordinator, following the same cohort of student across grades, allowed relationships with students to be built through repeated contact over time. In turn, this facilitated noticing student mental health concerns and allowed for opportunities to check-in with students regarding mental health:

> I think it's just interactions and just the number of contacts with different kids because some kids deal with it very differently. Like with anxiety, some kids have totally shut down, other kids go the opposite, where they talk and they like just act up and they go nonstop, and some are in between, some just burst out in tears. So, it's weird because there isn't one

> specific way. And some of them when you first meet them, there isn't even a baseline because they're not in a good place mentally. So, it's knowing what their normal is. And then checking daily, are they different than how they normally are? Yeah, that's the biggest help with the coordinator role because I'm in charge of one grade and I picked them up in Grade Eight and then I stayed with them through Grade 12. The year I find that I'm most effective is the year that I teach them because then I have multiple contacts, so then I can see friend groups and how they interact, and what their normal is. And then I get to know them as a student, and then as individuals as well (Participant 1, Teacher and Grade Level Coordinator).

Overall, 30 helping critical incidents contributed to the Building Relationships category, with 93% of participants identifying this a helpful factor.

The hindering category included incidents where participants acknowledged that a lack of relationship with students impeded them from incorporating mental health literacy into their practice. Participants reported that being new to a school or lack of contact with students could be a barrier to developing relationships needed to support the mental health of their students. Participants acknowledged that in the absence of a relationship, students would be unlikely to open up to or seek support from an educator. In the following excerpt a participant described the challenges inherent to being new to a school:

> I think personally, for me, being new this year has been a challenge. They (the students) don't know me, and I mean, I don't blame them. I mean, why would you open up? I wouldn't expect you to. So, I would say being new has been a challenge…But I know that is going to take time and that's fine (Participant 9, Teacher).

Furthermore, some participants identified that they would be unlikely to check-in with a student they were concerned about if they did not have a pre-established relationship. Participants acknowledged that they would address this barrier by identifying an adult at the school who does have a relationship with the student to check-in, as illustrated in the following excerpt:

> As you're walking around, you can see kids with hoods pulled up, or their eyes down, they'll stand out. I'll make an effort sometimes to ask how they're doing. Especially if it's someone that I've met before. I try not to do any of that with people that I don't know, right, because then it's just really awkward. But if it's something that I'm really concerned about, I can

> find out which grade the kid is in. And then I can let their (grade level) coordinator know; they can do it, check in (Participant 1, Teacher and Grade Level Coordinator).

Overall, four critical incidents were extracted from the Building Relationships hindering category, with 21% of participants identifying lack of relationship as a hindering factor when incorporating mental health literacy into practice. No WL items were identified that fit within this category.

Normalizing Talking About Mental Health and Reducing Stigma

The following category summarizes critical incidents in which participants discussed how taking opportunities to discuss mental health with students allowed them to normalize the topic of mental health and contribute to reducing mental health stigma. Normalizing mental health can be understood as engaging in discussion and activities to support mental health in becoming a topic regularly integrated within schools, thus helping to raise awareness of the importance of mental health knowledge, increasing understanding of how mental health impacts everyone, and creating situations where students feel safe to share their feelings and experiences. Conversely, participants also identified how ongoing stigma hinders actions that might facilitate normalization of mental health in schools.

The helping category includes incidents in which participants identified certain subjects, curricular areas, programs, events, or roles within the school that facilitated engaging students in conversations about mental health and stigma. To illustrate, in the following excerpt, a participant described how covering Shakespeare in an English class provided for fruitful discussion with students about the relationship between suicide and mental illness, as well as suicide prevention:

> It's easy with English because you can really approach any kind of subject matter as something to read, to explore, to discuss. So, in classes we will touch on certain mental health concerns. So, for example, suicide, it goes with Hamlet. We have been reading Hamlet. So, Ophelia drowns herself, and so we talk about what might have led to that. You know, what could have prevented it, if anything (Participant 2, Teacher and Grade Level Coordinator).

Other participants identified that other subject areas such as Physical Education, Psychology, and Religion also provided avenues for incorporating discussion about mental health into the curriculum. Participants' role or position within the school was also identified as a factor that supported opportunities to normalize mental health by integrating mental health into everyday conversations with students. Specifically, roles that offered more flexibility or unstructured time, such as working as a school librarian or in the learning resource department, helped educators create opportunities to talk about mental health with students. For instance, in the following excerpt Participant 14 shared that the flexibility in their resource teacher role allowed for regular mental health related check-ins and conversations with students:

> I think in the last few years, for me it's been really a huge part of my role with the students to be checking in with them with their mental health. I really embrace the fact that students' mental health is as important, if not more important than their academic success at school. And for me personally, as a resource teacher, I think I have more flexibility as a teacher to do those check-ins regularly, to see where the kids are at and see how they are doing in their day. This year I implemented this thing called Weekend Updates. And my Weekend Updates are very specific to like, *What is something that you did this weekend that made you happy? Or what's something that you did that made you appreciate the people in your life?* So, I check in on what they are doing and also how they are feeling (Participant 14, Resource Teacher).

Participants also shared that certain times of the school year, such as exam time could provide a natural opening to discuss various mental health-related topics with students, such as self-care, and strategies for coping with stress. Other participants shared that a retreat program at their school created a safe environment that facilitated students in sharing personal stories and provided opportunities for staff to normalize and discuss mental health with students:

> I would say one thing our school does a really good job is - towards the end, especially Grade 12 - the retreats they go on. They are very open. There is a lot of sharing. Kids will bring up a lot of things you had no idea about. The first one I went on, and the only one I've been on was this past fall…It was very powerful. I feel like that it is helping kids see that, *Hey, I can talk about this.* And, *Hey, my classmates are going through stuff too.* And you often hear a lot of kids, everybody has issues, but sometimes when they see other

> people's issues, it's not so bad. They share in small groups, kids open up, they open up. It's impressive and it's great to see, good to see courage (Participant 8, Teacher and Coach).

Furthermore, participants identified how a societal shift related to reduced mental health stigma within society facilitated the normalization of mental health in their schools. To illustrate, in the following excerpt a participant described the observation of an overall shift in terms of openness to talking about mental health, which she attributes to dialogue about mental health in the media and popular culture:

> I think before the students' private lives were more private and we didn't really know what was going on. Whereas now I think the students are more open. I don't know what has made it like that. The students are just a lot more open in sharing what is happening with their lives with the teacher and counsellors…I think a lot of it is with the media, that it's an okay thing now to talk about. So, I think the students are also feeling more comfortable with that. It's an okay thing, and to ask for help is okay too (Participant 10, Teacher).

Participants identified that bringing mental health into a wide variety of interactions with students served to normalize mental health discourse, reducing taboo and stigma surrounding the topic. Overall, 86% of participants identified normalizing talking about mental health as a helping factor when incorporating mental health literacy into their practice, with 33 helpful critical incidents reported.

In the hindering category, participants described challenges they had faced in meaningfully integrating mental health into instruction and conversations with students due to mental health stigma. Participants reported encountering both staff members and students who held stigmatizing attitudes and beliefs about mental health. These attitudes created perceived barriers to having productive discussions about mental health at school and successfully supporting student mental health. Furthermore, stigmatizing beliefs held by students were found to undermine group discussions about mental health in the classroom, due to a subset of students making disparaging comments. The following excerpt illustrates a participant's experience incorporating mental health

into classroom discussions and dealing with stigmatizing comments made by students, acknowledging the need to consider and protect students who may be harmed by such comments:

> There's always that kid - especially in an all boy's school - there's no filter. Kids, they say whatever they want. Right. So, let's say we're talking about schizophrenia and I may have a kid in my class who is schizophrenic or who might be schizophrenic one day or has a relative. So that kid in the class goes, *Yeah, I always see those crazy schizos*. I know that those things will come up and I just don't want to upset anyone. I'm not going to encourage that; you will address it. But I'm afraid of that happening, of it triggering anything in the kid. And we always talk about the stigma. And we always talk about like how it's important to understand - what's the word I'm looking for - how we further the stigma by using words like, *schizo* and *she's crazy,* you know, *he's crazy.* I tried to get the students to be mindful of how we do that and how we can help end the stigma (Participant 8, Teacher and Coach).

In the next excerpt a participant described how stigma can prevent staff from being open to supporting students with mental health problems in the classroom, such as following recommendation to provide students with adaptations or accommodations:

> In my role, I am a huge advocate to the rest of the staff for kids who are experiencing mental health challenges. So, I think the stigma is definitely something I deal with a lot. I guess one of maybe the most interesting things is trying to take assessments or take information from counsellors or whatever it is, I'm taking the facts and translating them into actions or things that teachers can do to support the kid, or maybe just to understand it more clearly, I guess. So, for example if we have a student who had a physical illness -if you do, they're much quicker to act on that. And so, I find it tougher to really fully explain and reason why we're doing things for students, certain kids when they have something that's invisible (Participant 4, Learning Support Coordinator).

Additional hindering incidents included participants' observations that students can be disengaged from mental health conversations or instruction. For instance, stigma may contribute to the mental health content being perceived as irrelevant or boring by students, which in turn can serve as a barrier to normalize talking about mental health. For instance, in the following excerpt a participant described how mental health conversations were often incorporated into annual events that students complained about, ostensibly, because the content was redundant and not clearly pertinent to their lives:

> They get that (mental health related topic), then it kind of never comes up again in meaningful ways. We have a couple of events for mental health, but sometimes, it's the same event. So that's where the kids make fun of it. You know, *We already did this. I've done this for four years now. What's the point of it?* (Participant 1, Teacher and Grade Level Coordinator).

Another participant echoed similar concerns:

> How do we reach the kids with, A) not making it boring, B) that it's not forced? So, finding a way that actually reaches them or allows them to feel as though they are being heard. But I know that schools are working on this. I know this something that is being worked on, but I still think that it probably could be worked on, you know it's just going to take time (Participant 9, Teacher).

In summary, 50% of participants identified hindering incidents related to challenges normalizing mental health related to stigma, with 17 hindering incidents reported.

In the WL category, participants primarily identified desiring a greater focus on positive mental health and wellbeing when incorporating mental health related topics into instruction to facilitate mental health normalization. In the following two excerpts, participants suggested that mental health is often equated to mental illness and wished for more opportunities to normalize mental health by incorporating positive mental health topics into conversations with students, such as self-care, and factors and skills that can promote wellbeing:

> I don't think it's helpful for them (students) to just see, this is what anxiety is, or what the diagnostic criteria is for a mental illness. But just general self-care and mental health, supporting positive mental health and how someone with mental illness can still have good mental health. I guess maybe it's not something that has happened yet, but something I've been hoping for as a next step. A wish would be to have that just more ingrained in the school culture. Okay, we're going to do - we do really value positive mental health - and have more opportunities for kids to explore and learn more about it and the staff as well (Participant 4, Learning Support Coordinator).

Another participant echoed this sentiment:

> There's a speaker, and he was invited to a wellness week at a school. That's great, I love that. It's a great idea. Again, (in our school) Monday is about anxiety, Tuesday is about eating disorders, Wednesday is about psychological disorders, Thursday is about suicide or something. That is not a wellness week, that is a sickness week. Yes, I get that. I think framing it in also a positive way, I wish we did more of that. I find we often scare kids. We

> talk about the horrible things, rather than just getting them active, and teaching them meditation and teaching them other ways, the positive things you can do...We don't get equipped, you know, we just understand about what's wrong but we don't get equipped (Participant 8, Teacher and Coach).

In summary, 29% of participants contributed to this category, with six WL items related to Normalizing Talking About Mental Health and Stigma reported.

Accessible Mental Health Professionals

Several critical incidents highlighted how the accessibility of mental health professionals significantly helped or hindered high school educators' perceived success when incorporating mental health literacy into practice. Participants reported that access to mental health professionals both at school and in the community was an important support for helping them effectively incorporate mental health literacy into their practice. The helping category included incidents where participants described successfully referring students to a school or community-based mental health professional when concerned about the student's mental health, and directly consulting with the mental health professional regarding recommendations for supporting the student in the classroom. Furthermore, participants valued the expertise of mental health professionals and felt they were able to increase their own mental health literacy by learning from the perspectives provided by these other professionals, as described by the following participant:

> What has helped me, and my mental health literacy is having very informed people around me who are able to - who are experts in different areas of mental health… I always like to collaborate with our school counsellor when possible, just so that it's coming from, not just my lens, but also from a mental health professional's perspective (Participant 4, Learning Support Coordinator).

Accessible mental health professionals allowed for ongoing reciprocal communication, which facilitated participants in implementing classroom-based supports for students accessing mental health services. Accessible mental health professionals also allowed educators to consult regarding behaviours they observed in students and adjust supports over time based on the

changing needs of students. In the following excerpt, a participant shared how support and regular communication with the school counsellor helped them to incorporate mental health literacy into practice:

> Well one of the biggest things are the counsellors at our school, they are really good at taking the time to meet with students. If the teachers hear any of the students talking and think, *Oh, maybe this student is having a hard time*, we let the counsellors know. Then they meet with the students right away and then they relay information back to the subject teachers, so we are made aware of that. And they also sometimes write up little reports for us to read of some steps we can take to help students that are having some mental health crises at the moment, or if we want to make sure that they don't have a crisis and try to prevent it. So that is my biggest resource right there. They really try hard to go out of their way to make it specific to that student and their situation in that time (Participant 10, Teacher).

Participants identified that accessible mental health professionals also allow for the provision of collaborative supports to students. In the following excerpt, a participant shared how collaboration can be helpful when a student may be resistant to seeing the mental health professional, but is willing to get support from a teacher with whom the student has already built a relationship:

> I have spent a lot of time working with the counsellor one-on-one, which has been really good because whether you bring them a student and they are like, *Yup, we have got it from here*, or they are like, *you know what, we don't have that relationship with that student, but you do. Let me talk you through this, and we are going to have you deal with that student, but we are going to be the liaison between the two of you,* which has been really good as well. So, having that support system where you really can bounce ideas off of them (Participant 9, Teacher).

The following excerpt summarizes how accessible mental health professionals support educators' incorporation of mental health literacy into their practice in many ways, including learning from them during school-based team meetings, helping educators feel better equipped to provide supports to students, and consulting with them for advice:

> Working with the psychologist here and listening to her in meetings when she's talking about things when we're developing a plan for some kids, because for some of them, they're not coming to school. So how to get them back to school? Or how to get them to a point

> where they're passing their classes? And then listening to how she speaks to them (the students) and the words that she chooses, and I guess the lens, that she kind of points out things. That adds into it, where I feel I can do a lot more on my own with helping a student. And then I'm really clear as to where the student needs help, and then I can better direct if the student needs further help. So sometimes I go to the psychologist - sometimes it's just going for advice, like, *how would you approach this*? Or because some of them (the counsellors) are very busy because we have two staff that help counsel, they would give me some ways to help or coach the student through whatever it is. And then sometimes they'll meet with them (the student) directly (Participant 1, Teacher and Grade Level Coordinator).

Overall, 23 critical incidents contributed to the Accessible Mental Health Professionals helping category, with 79% of participants identifying this as a helpful factor.

The hindering category included incidents when participants described challenges associated with mental health professionals being inaccessible. Factors that created barriers to accessibility included a lack of available mental health professionals in schools and the community, and compartmentalization of mental health services. Participants identified that inaccessible mental health professionals hindered them in helping students obtain appropriate mental health services, and from effectively supporting students in the classroom, due to limited opportunities for needed consultation. The following excerpt illustrates participants' challenges related to supporting students, when there is a lack of follow-up or reciprocal communication from mental health professionals to whom they refer their students:

> I don't know what the connection is between us and our school psychologist… So, we were reporting on something and then they say this has to be dealt with over there (psychology department). But then you would never get back what's going to happen with that...I feel like there is different compartments where I don't necessarily know the outcome of something that started within our department. For example, you see something, and then you report it, and then in our department they say, *well, this has to be dealt with here*. Even though you're going to still keep on working with the student, you won't be able to know what came out of that...So in this case, it was a case of bullying. And the parents were here talking to us, and I worked directly with him (the student), so at that point I was an advocate…But then again, we at the department, we passed this on to our psychology department and it was to be dealt with there. But we don't get anything back from them. So, if the mom is to come again to us, we wouldn't know, I wouldn't know (Participant 13, Special Education Assistant).

According to multiple participants, insufficient numbers of mental health professionals contributed to increased burden on school staff to support students while on waitlists for mental health services, or due to a lack of appropriate service options for students. The following two excerpts encompass participants' perceptions of a lack of available mental health professionals to refer students. First, Participant 14 described challenges associated with a limited number of mental health professionals employed in the school setting:

> The challenge in our school is that we only have one school personal counsellor, so there is not a diversity of who you can actually talk to. Which I'm sure is the challenge in many schools, where there is only one professional available for a number of students and that student might not necessarily click with that professional, right? So, you are trying to say, *okay, well, who else can we get? Like who else can we refer them to?* And then outside referrals are always tricky because you don't necessarily know if they follow-up (Participant 14, Resource Teacher).

Further, Participant 4 discussed how lengthy waitlists for access to community-based mental health professionals creates additional strain for educators and mental health professionals within the school system:

> We have kids who have been on waitlists for ministry counselling for sometimes up to eight months. Usually, not less than four months. So, there's no quick fix. And I think that's something that is important for everyone to understand as well… Again, our counsellor is wonderful, but she should be acting as a supplementary to an outside support who's going to be the primary, but a lot of our kids can't get that primary support, just with waitlists. I mean, financially it's quite expensive to go private, outside of schools, so a lot are waiting for the publicly funded support. So, she (the school counsellor) is acting like the primary and that's really tough to do when there's so many, so many in crisis too. We have a lot of students who just need a lot more than they're getting right now…By the time students are reaching out, it's pretty significant, I think for the most part. And then when they're met with very little immediate intervention or response, I think that is really discouraging...I just, I can't tell you how disheartening it is when a student really needs help and is told that they're put on a wait list. I think that just a lot of the kids are not feeling good at that time. And I can't imagine being told that you're not important enough to get help right away would make you feel any better. So, I think that's a huge thing, and I mean we are given a huge responsibility because the system to me seems so unreliable right now, because we are now counted on as being the people who are going to care for the kids until they can receive support. Of course, the families too (Participant 4, Learning Support Coordinator).

In summary, seven hindering critical incidents were categorized within the Accessible Mental Health Professionals category, with 36% of participants identifying challenges associated with accessing mental health professionals as a hindering factor.

In the WL category, participants primarily identified wishing that more mental health professionals and services were embedded within the school setting. Participants suggested that integration of additional school-based mental health professionals could provide additional opportunities for consultation and collaboration:

> Someone with a skill set to collaborate well with the existing school counsellor, to make that a reality because they need to work in tandem, I think, and not feel threatened. Yeah, they wouldn't feel threatened by the person let's say...but also being able to collaborate, the mental health professionals collaborating with all the school staff as well (Participant 6, Director Student Support Services).

Furthermore, increasing the number of school-based mental health professionals would allow educators to have access to professional development provided by these professionals and function as a better integrated member of the staff team:

> Our counsellors see so many students and there are a lot who are in crisis. And so, I think - she's here three days a week, which is not enough - having someone in the school every day of the week would be ideal. And then that would maybe also allow for her to be more- and I think right now her role is very much in her office seeing students reactively - If there was more opportunity for her to be more involved in the staff, because I think it kind of reinforces that "us versus them" mentality where if she was more a member of staff and more, I guess, available for discussion and maybe even professional development, things like that, that would be very helpful (Participant 4, Learning Support Coordinator).

Another participant suggested that having increased numbers of mental health professionals integrated into the school setting would allow more students to build relationships with mental health professionals:

> I think just having more people in the mental health profession in the school. I think, you know, moving forward, when I think about schools, and all schools, not just our school, that we lack mental health professionals that are embedded in the school system. And I think that's a misstep because kids are at school every day for six hours or whatever, and that's an opportunity for people to have those connections and bridge those opportunities

> to have relationships. Or for kids to feel safe enough to have those dialogues, right? (Participant 14, Resource Teacher).

Overall, six WL items contributed to the Accessible Mental Health Professional category, with 36% of participants contributing.

Mental Health Literacy Education

This category summarizes critical incidents in which participants discussed professional development and education that impacted the incorporation of mental health literacy into practice. As previously described, as a prerequisite for participation in the study, all participants completed the two-day mental health literacy educational workshop, *Mental Health First Aid for Adults who Interact with Youth* (Mental Health First Aid Canada, 2010). For many participants, this workshop was the first formalized mental health literacy professional development opportunity they had participated in during their careers. Other participants reported they had sought out other educational opportunities that contributed to the development of mental health literacy, such as workshops or graduate level education. For instance, one participant was a school counsellor, and another participant was in the process of completing a graduate degree in counselling and both had completed post-secondary level coursework focused on mental health.

In the helping category, participants described how taking part in mental health literacy professional development helped them to better understand students with mental health problems, increased their awareness of the signs to watch for when a student may be struggling with their mental health, and helped participants feel better equipped to talk with students about mental health. In the following excerpt, a participant shared how mental health literacy education helped them to initiate a conversation with a student they were concerned about, without pushing him to open up before he was ready:

> There was one incident when I was working with a student one on one; we were just in a little room and he started crying all of a sudden. Then I just asked him what was wrong, and he was like, *nothing*. And I was like, *do you want to talk about it?* And he's like, *no*. Then I was like, *I am here if you need to talk, and is there anyone you feel like you can talk to?* And he's like, *no.* And I just gently kind of supported him and I have kept - sometimes when he seems frustrated, when I am with him, I am like, *You can talk to me about anything and even if you don't like what we are doing, if you are frustrated with this and you don't like working on math, you can tell me that.* And I think the mental health training has helped with that as being a support for him, and not pushing him too much if he doesn't want to share. Because right now he doesn't want to share anything. Yeah, I think it was the Mental Health First Aid training that helped me just to be more sensitive to it, to not push too hard about getting the information out of a student. Because I really would have liked him to open up to me and say what was wrong, but then I just kind of accepted that he is not ready. I'll just keep supporting him and keep asking him every so often how he is doing, see if eventually he wants to talk (Participant 3, Special Education Assistant).

The next participant shared that mental health literacy education helped them to better understand students who were experiencing mental health problems, which increased their patience when working with this population of students. Education also helped them to feel better equipped to communicate and work with students who were experiencing mental health problems:

> Well, I noticed a lot more kids are having difficulties with things. So for me to be able to teach them, I felt I needed to understand that more because I found there was a large group of them that I wasn't able to, I guess, reach, or access because there was almost a misunderstanding between me, and I couldn't figure out how to reach them. So, I saw the (Mental Health First Aid) workshop as a way to overcome some of those barriers and be able to communicate more effectively with them because I wasn't understanding even sometimes what they were saying...And then after doing the course I got even more knowledge…So, it was a database I guess, of options. Okay, I'll try this and if it doesn't work, then I'll try this…Where I started off before, where it was a lot of frustration, it's lessened now. I'm not as frustrated when working with these kids because I remind myself that, okay, this isn't something that they're fully in control of and these are just knee-jerk responses for protecting themselves, and not to get caught up in exactly the words that they're using. But more on why they're saying things…So, I guess it's given me a little bit more patience and understanding with it. So, I'm not so quick to get frustrated or reactive (Participant 1, Teacher and Grade Level Coordinator).

In the next excerpt, a participant described how mental health literacy education helped to increase their awareness of their role in identifying students who may be experiencing mental

health problems, the signs to watch out for, and the importance of not ignoring potential warning signs:

> Well, I'll be quite honest, when we had that (Mental Health First Aid) session, that was very good because that told me, you have to pay attention to this…Cause you get so bogged down, like I am two weeks behind on my curriculum and shit…You know, I don't pretend to remember all the details of it (Mental Health First Aid), you know the terminology. But I think more than anything, just the idea of, I'll be on the lookout for this more. And looking around, if a behaviour stands out, I won't chalk it up necessarily to, *Oh, he's just being a teenager, he's just acting like a teenager. He's acting out his teenage-ness* (Participant 7, Teacher and Librarian).

Another participant shared that mental health literacy education helped them to learn that talking about mental health concerns with students was not harmful for the student:

> I think that a big game changer for me was the idea that you guys presented in the (Mental Health First Aid) workshop about being able to talk - that idea that you are not able to instill the idea of suicidal thoughts or anything like that in a student or in a child, just by bringing it up. I think that this is something that I found was a barrier for me… So, I think that was really helpful, learning that you can bring these kinds of things up (Participant 13, Special Education Assistant).

Overall, 64% of participants identified mental health literacy education as helpful for incorporating mental health literacy into their practice, with 16 helpful critical incidents reported.

In the hindering category, participants described how a lack of education or ineffective education could hinder them when incorporating of mental health literacy into practice. Hindering incidents also included participants' observations that many educator colleagues had not participated in mental health literacy education. This variability in knowledge and skills amongst educators within a school contributed to challenges to effectively discussing mental health with school staff and students due to not all educators having the same background knowledge, as illustrated in the following excerpt:

> I've had (mental health literacy) training and I'm more aware of it just because of my role (as grade level coordinator). But I think if other classroom teachers had training then they would, I'm assuming they would be like me and you look for opportunities to work different things in, like life skills, then they might use it as well. And then it would be more of a

> holistic theme, and not just segregated to one class that they took in Grade 8, or just with that one teacher, that it's a little bit all over, or more consistent. Because I think consistency might be an issue with how we have it set up now (Participant 1, Teacher and Grade Level Coordinator).

To provide context for the next excerpt, Participant 12 previously discussed an experience supporting a student experiencing a mental health crisis where they were able to collaborate with another educator who had also participated in mental health literacy education. The participant then reflected on how the experience would have been significantly more challenging, had the other educator not had any mental health literacy background:

> So, on the flip side, the struggle with that is if it wasn't a teacher (with mental health literacy education) and someone who isn't adept at knowing how to deal with that (mental health) potentially, then it's tougher. And that's a little bit of that struggle part, not everyone knows or agrees or is willing to see it that way (Participant 12, Special Education Assistant and Coach).

Another participant identified mental health literacy professional development without follow-up as a hindering factor because it does not effectively facilitate behaviour change or support the incorporation of new skills into practice:

> In education across the board you have many one-day workshops, or one day refreshers, or a one-day Pro-D opportunity. Could be mental health, could be pedagogy, assessment, it doesn't matter what it is. The problem with that is, a one-day seminar, within that day people value this experience. Either from the receiving, they'll absorb it. And if it's not put into practice in the subsequent days, or there is no follow-up, or there is not a continuation of it, or there is no incident where its applied, that knowledge that's retained on that day is gone. The practice is gone. It is an ineffective way of improving a person's ability to have whatever, whatever the topic might be. So, although everyone who took, in this case, the mental health workshop on the day, saw value in it, appreciated it, and there is a plethora of information that was needed, absorbed, useful. If it wasn't put into practice in the next week, two weeks, it's lost for the most part. Unless it's revisited. Well, it's not revisited until you have an incident, or until you have an emergency, or mental health crisis...One and done are never effective (Participant 11, Principal).

Overall, 64% of participants identified variability in educator mental health literacy education or ineffective educational approaches as a hindering factor related to incorporating mental health literacy into practice, with 16 hindering incidents reported.

Consistent with Participant 11's perspective on the challenges associated with "one and done" professional development, several participants identified in the WL category that they would benefit from access to ongoing mental health literacy professional development. In the following two excerpts, participants describe how access to ongoing professional development opportunities could promote the successful incorporation of mental health literacy into practice:

> I learned so much from the (Mental Health First Aid) workshop and I feel like if all schools could - if there was someone - and a refresher would be great because you forget information as time goes on, but even just having more Pro-D where, not even just for the counselling department, but in all the different departments where we have our Pro-D days, to have the option to just learn about just different anxiety levels and different mental health issues students may have in the class and an appropriate way to react. That would be great to have that opportunity because when you have a day just for Pro-D, usually teachers just go to whatever their academic courses are, but to have opportunities to go to what you put on (mental health literacy workshop) would be fantastic. Or even just going to different schools, like schools having their own little sessions, like during a staff meeting or something like that just to let us know a little bit more of what we can do to support the students. That would be good (Participant 10, Teacher).

> More regular insertions, like conferences, and sessions of awareness, right. I gotta remember that. Yeah, I equate it somewhat to CPR or First Aid. I haven't had that in five years. I don't know if I'd know it. Especially if I was nervous because it was real life. Yeah. What the hell do I push first? Or do I? I can't remember. And so that's when I am actually helpless. That should be every year…So to just to have that more, perhaps more regular sessions. I think more professional development (Participant 7, Teacher and School Librarian).

Furthermore, the majority of participants reported that mental health literacy was not discussed or incorporated into their pre-service teacher education and identified this as an important gap to be addressed. Mental health literacy education during pre-service teacher education programs would allow for all teachers to begin with a similar foundation for supporting student mental health, as highlighted in the following quote:

> But I think that (supporting student mental health) is a huge responsibility for us and we don't, we're not given the skills on our own. Like I said, I do readings by myself, in my own time. This is something I care about, so I look into it. But for people who it's not a big passion for, they won't go to the Pro-D's, or won't necessarily even think about it at all, or whether they're off base with it. So, I think that's, I guess, bigger scale, having more mental

> health literacy in teacher training programs would be a great start. I went to school in Ontario and there was nothing. I didn't learn anything about mental health at the teacher's college, which was really disappointing. So, I would say that there are more opportunities for this to be - we can be better. I think teacher training is a good place to start, but then ongoing (Participant 4, Learning Support Coordinator).

In summary, 57% of participants identified increased opportunities for mental health literacy education for all educators with 14 WL items reported, which included integration of mental health literacy education into pre-service teacher education programs and ongoing professional development opportunities.

School Staff Communication and Collaboration

The School Staff Communication and Collaboration category included incidents where participants discussed how their interactions with other staff members impacted them when attempting to incorporate mental health literacy into their practice. The helping category included incidents in which participants described how open, consistent communication with other staff members helped them to identify and support students whose mental health they were concerned about, as illustrated in the following excerpt:

> Thankfully there's a number of teachers who will say, *Hey, heads up, "Johnny" doesn't look so good. There might be something going on there, could you follow up?* Sometimes it's nothing, sometimes it is something, *No I haven't been feeling very well because of this or that or things are happening at home*. And we're able to support it. Yeah, but is it perfect? No, I'm, guaranteeing there's still kids that we have no idea are struggling, no idea. We might not find out before they graduate, but sharing that with the staff I think, it sits with them as well. They also know that it's possible to just slide through the cracks, so that's been helpful. And then I find that's one way to that I've kind of connected the staff too (Participant 8, Teacher and Coach).

In the next excerpt, Participant 12 described how valuable it was to engage in regular communication amongst staff members. This communication allowed various staff members who had a relationship with the student to share observations and work together to support a student experiencing mental health problems:

> He (the student) would have conversations with other teachers that were his favourites, and I have relationships with them as well. So, they know that I have a relationship with him, so we would start collaborating. There were more than just one set of eyes looking out for (the student), which was the big thing I think...So he would be coming in late to school, so coming in half way through the block and maybe in tears or upset or whatever the situation, he might tell that teacher or that teacher might send him to another teacher that they know he has good relationship with. At that time, most of the staff knew him well and were aware of his situation. So we were - not like on a lookout - but we were keeping an eye on him and if something were to happen…And since I was coaching him every day, I was also involved with that so it was a team effort of keeping an eye on him (Participant 12, Special Education Assistant and Coach).

Overall, 16 incidents were reported that fit within the Staff Communication and Collaboration helping category, with 43% of participants contributing to this category.

In the hindering category, participants identified how siloes and inconsistent communication between various school departments and variability in school staff perceptions surrounding confidentiality created barriers to communication and collaboration amongst school staff. In the following excerpt, a special education assistant (SEA) described how one's role within the school can impact the information one is privy to. Additionally, this excerpt illustrates the participant's experience of how inconsistent communication made it difficult to provide appropriate supports to students:

> I think that comes up a lot here that kids who are struggling with mental health issues; it's not always shared with teachers or SEAs, so there is not great communication. I know that a lot of it is confidential, between them and the counsellor. But even if we could even know that they are struggling with mental health, like some teachers and SEA's we don't even know that these kids are struggling, so we are frustrated with assignments that are late, and then they are getting more anxious or whatever because of it. But if we knew that they had mental health, then we would act differently. So, I think that's a big thing, communication between just different departments. I think that sometimes the SEAs don't always get all the information too, like maybe information that teachers get, SEAs might not get. I might hear it like just from people talking, and then I am like, *Oh, I didn't even know this*… But then also the communication between the classroom teacher and whoever is the teacher in the resource room, there's teachers in there and our office is in there. There is not always communication between, *Oh, we have a student coming in he's really anxious*. They can just come there without anyone knowing that they are going there, so we don't know to give them support (Participant 3, Special Education Assistant).

The next quote demonstrates how educators may experience tension between the desire to share student mental health information with other staff members to ensure students receive appropriate supports, but also respect a family's or student's desire for privacy. This quote also further illustrates how educators' roles may determine the type of information to which they have access. Specifically, as a grade level coordinator, Participant Two was entrusted with mental health information about students that other teachers were not:

> One of our big hurdles is the type of communication that we can have regarding student mental health. So, say student A is depressed and anxious, and the parents are aware of it, and student A is getting some counselling, but does not want teachers to know. However, the student is getting overwhelmed with all the assignments and what not. So, say if I am the person that knows - how do I say to teachers, *Well there are things going on, which means I need you to be more lax about deadlines. Or I need you to cut down some assignments* - Because if I just go ahead and just tell people, *okay, I need you to do this for this student, that for that student, that for that student,* there is going to be a little bit of push back. Where if there is more open communication, say, *Okay, you don't need to know the details, but the student is really struggling with depression. As you know depression causes the student to not get much sleep, or sleeping pattern is completely changed, or they can't concentrate. So, it's really, really hard for this student to do this and that.* You can reduce it to this, but hands can be tied a little bit sometimes. I understand just like any kind of medical concern, these are private matters. But when it comes to supporting the student, how private are we going to be? (Participant 2, Teacher and Grade Level Coordinator).

Similarly, in the following excerpt Participant One echoed that there was an overall lack of clarity about information that is confidential and information that educators need to know to support students. In this excerpt, the participant emphasized that educators do not need to know overly personal or sensitive details about a student's background and mental health but having no information could contribute to educators making a situation worse for a student:

> So that one's a hindrance, just that flow of communication and what's actually confidential and what would be helpful for the teacher. I mean for most teachers, nobody wants to know specifics. Nobody wants to know why someone's self-harming. Nobody wants to know that they were molested or abused, neglected, any of that stuff. But you want to not make them feel bad, and not make it any worse for the student. (Participant 1, Teacher and Grade Level Coordinator).

In summary, 43% of participants identified barriers related to Communication and Collaboration with School Staff, with 11 hindering incidents reported.

Finally, several participants identified various WL items that could contribute to improvements in staff communication and collaboration. Several participants suggested that meetings or email communications that include all staff working with a student could allow for consistency across staff members in understanding a particular student's needs and providing appropriate supports, as illustrated in the following two excerpts:

> Maybe a meeting or even just an email between the teachers, SEAs and who ever needs to know about the student, just saying what this student is struggling with generally. Like if they are struggling with anxiety, they don't have to go into detail, but just say that they are struggling with anxiety, and maybe suggest things that the counsellor or the student thinks would be helpful. That would be good to have (Participant 3, Special Education Assistant).

> I think having time to talk to people and collaborate. A lot of the time, what I see in a 60-minute class, I might think that there's something, but I don't know. So, it's helpful to go to - we do that sometimes with learning difficulties, we'll email the other teachers for the student and be like, *Hey, have you noticed that the writing's not quite where it should be for whatever grade level?* -Having the time to do that with mental health. And as a coordinator, I get that from individual teachers. They'll send it (an email) to me and say, *Hey, so and so looks sad, they look kind of down.* But they won't necessarily do that with other teachers, like we do with the learning difficulty. So, I'm wondering if having just more meeting time where you can talk about students in that way...We do have those, but it's more focused on like academic performance, there isn't really a mental health aspect to it. So that could be an easy fix. Maybe incorporating mental health into that (Participant 1, Teacher and Grade Level Coordinator).

In summary, 36% of participants contributed WL items to this category, with six items related to Communication and Collaboration Amongst School Staff reported.

Time

The following category describes incidents where participants identified Time as an important helping or hindering factor when incorporating mental health literacy into their practice. The helping category includes incidents in which participants discussed the value of having time that is specifically allocated or at least available for interactions with other staff and students

regarding mental health. According to participants, it was helpful to have designated times for interdisciplinary meetings to discuss student mental health concerns or work on mental health related projects, allowing administrators, teachers, grade level coordinators, and counsellors to collaborate. The following excerpt highlights how time for meetings allowed various staff members to work closely together to support students experiencing mental health problems:

> Having the time to go in myself having really you know close interactions with admin, with teachers, with our grade level coordinators. We have a coordinator per grade also keeping an eye on kids and helping them. Helping them (staff) to be aware of the concerns that they (students) are facing. We have regular meetings (Participant 5, School Counsellor).

Participants also discussed how unstructured time can be helpful for allowing informal and one-on-one interactions with students to build relationships and check-in regarding their mental health. Roles such as SEAs, librarians, coaches and resource teachers were identified by participants as allowing for additional opportunities for unstructured time and individual check-ins with students. In the following excerpt, a school librarian shared the benefit of having unstructured time:

> I may have time that others don't…So even if there is a class in here (the library), I have the time. If a boy came in from another class and he just says, *Oh, I'm not feeling well today, can I just have a quiet place to be?* Absolutely. Sure. Come on over. And I'm like, *Question, hey, is everything okay?* And he goes, *See, I just, you know, just, I just need a quiet place right now.* And I'll just go first and say, *Who is your teacher in this block? Do they know where you are?* Yeah, they just let him go. And I said, okay, we'll look at you if there's any problems. And so, there's that. And I'm not in the throes of teaching a literature class. I actually had the time to deal with that...Yeah. And I think most teachers, certainly during their class time, they have a bit, but for the most part, I know they can step into the hall, but they can't leave because they legally have to be in that class, so those types of conversations may not happen in front of 30 other students. So, it's a unique position in that regard (Participant 7, Teacher and School Librarian).

Although time was identified as a helping factor by 29% of participants, with four helpful incidents reported, a significantly larger number of CIs were contributed detailing lack of time as a hindering factor when incorporating mental health literacy into practice. Generally, participants identified that educators have busy schedules with many competing demands, which can contribute

to time constraints. Specifically, a hectic schedule can make it difficult for educators to find time to check-in with students they may be concerned about, as illustrated in the following excerpt:

> Sometimes I feel like - oh that person (student) didn't really look that great and I never said anything to them, so I am hoping that they are doing okay. Or I am sure that there are tons that I have missed, so that is a big one. Teachers are so busy; there are so many things happening that I find sometimes that my mind may be somewhere else. Like, I have this event that we are organizing today, and I might have that in the back of my mind. And then, okay, I will need to get the tests back and I might not take the time to pay attention to my students; I may just be focused on what needs to be done...Well a lot of times where I don't have any breaks in the day and I might have a test the next day, so I have students who want to see me before school and maybe at recess. I often have meetings at lunch, so I will be running for a meeting at lunch and I may not have any spares that day so I will have the whole day of no break and then I rush after school to pick up my kids from their school, so I get really tired and I usually don't get to eat very much that day because I pretty much grab something while I am on my way to the meeting - things like that. So I get tired and hungry, and then students are seeing me, and just mentally I am like, *ugh,* at the end of the day... Yah, it's hard for me to just stop and just pay more attention to the students, as opposed to just getting done all the stuff that is piling on, that I need to get done by the end of the day, and you don't have time to just stop on your own and just breathe (Participant 10, Teacher).

Furthermore, participants reported that time limitations associated with the many competing demands in one's role as an educator can negatively impact one's own self-care and wellbeing, which can make it difficult to incorporate mental health literacy into practice.

> September is usually a rotten time where I don't eat properly, I don't get enough sleep because everything, it's all the paperwork and, it's all the meetings and everything is kind of going. So, my own care I think goes on a decline. And then I'm able to recover sort of October, November or so...I feel a little bit like a hypocrite sometimes (Participant 1, Teacher and Grade Level Coordinator).

As discussed previously, ongoing mental health literacy professional development was identified as an important helping factor for participants when incorporating mental health literacy into practice. However, participants acknowledged that there were many logistical challenges when attempting to find the time to incorporate professional development into educators' schedules, which is described in the following quote:

> I guess the challenge we ran into is that the school year is already so packed and the teachers are always - people have lesson plans and this is not something that necessarily easily fits

> into the schedule- but finding more ways to have it more ingrained in our school...I think the time is a big factor, finding the time in the day, and I kind of cut off opportunities at school but they don't naturally exist. So, I think that, to reiterate, that it's a big factor... I mean even with Mental Health First Aid training, that took a long time to figure out, ok, when can people receive this training? It's not just kids who have trouble with balance, I think a lot of the staff feel - we have a great school, everyone gets very involved with extracurriculars, I mean it's like a part of your life, it's not just a job, it's your life - But I think it also makes people stretched very thin, so adding something at the end of the day wasn't very feasible, saying you need to stay and do this training, so cutting that, starting at lunch. I mean there's lots of logistical challenges (Participant 4, Learning Support Coordinator).

Participants also encountered similar logistical challenges when attempting to find time for interdisciplinary meetings to address student mental health due to conflicting schedules, as illustrated in the following excerpt, "Yeah, logistics of like that many teachers coming together at a time that works for everybody. You know, in between their schedule and coaching and other extra curriculars that teachers were involved in" (Participant 14, Resource Teacher).

In summary, 57% of participants identified barriers related to time, with 13 hindering incidents reported. While no WL items were identified as being within the time category, many WL items in other categories stated or implied the need for additional time to be able to more effectively incorporate mental health literacy into practice. Specifically, participants wished for more time for ongoing mental health literacy professional development, and more time to connect and collaborate with school staff and mental health professionals when supporting student mental health.

Administrator Support

The category referred to as Administrator Support included incidents where participants described how the extent to which administrators bought into the value of educator mental health literacy and supporting student mental health at school impacted them when attempting to incorporate mental health literacy into their practice. The helping category included incidents in

which participants described how administrators supported educator mental health literacy by allowing time for staff professional development, approved and supported school events and activities focused on mental health, and collaborated with school staff to support students. In the following excerpt, a participant described how it was particularly helpful to have the administrator participate in mental health literacy professional development along with other school staff, which demonstrated support and facilitated future collaboration:

> Well, having the vice principal who went through the (Mental Health First Aid) course with us. Knowing that he supports mental health. You know, he's walking the talk. That helps as well because we can talk about, *Okay, I think that this student is struggling with some mental health issues. He's got this, and that, and that going on. Can we give him some concessions?* So, he's very open to that (Participant 2, Teacher and Grade Level Coordinator).

In the next excerpt, a participant described how administrator support was key for facilitating collaboration amongst teachers and school counsellors. Furthermore, the participant highlighted that administrators are key collaborators with counsellors when supporting students with mental health problems at school:

> So, the factors that come to mind are definitely supportive admin(istrators) and acknowledging that mental health is an important thing. And that's created the full-time (personal counsellor) role…So that's even evolving there. So supportive administration, definitely, and you know a genuine commitment to it. I would say, supporting (counsellor) time in the classroom, supporting kids coming out of class to come see the counsellor instead of just fitting it in at lunch, which is impossible to do. Collaborating when there are mental health issues. I work very closely with the assistant principals when there are situations that would require that, and it would be appropriate, right, like risk situations etc. (Participant 5, School Counsellor).

In summary, 29% of participants identified helping incidents with respect to administrator support, with six critical incidents reported. No hindering incidents or WL items were reported in this category.

Family Communication and Collaboration

The category referred to as Family Communication and Collaboration included incidents where participants described how the extent to which they were able to communicate and collaborate with families impacted them when incorporating mental health literacy into practice. In the helping category, participants described how beneficial it was when families kept in regular contact with school staff regarding a student's mental health, sharing information and observations, as well as communicating about any supports the student was receiving outside of school. In the following excerpt, a participant describes how parent collaboration was a key factor for effectively supporting students experiencing mental health problems at school:

> I think the big piece is the parents collaborating. Because for some students, so we don't have the parent pieces in there, it makes everything a lot harder. You only have them (the student) for so long at school. So, whatever goes on at home can even undo everything, or we don't know that information, so having that (parent collaboration) helps everybody help the student. So, I think that's a big piece is having the collaboration between everyone that has eyes on him (the student) for the day (Participant 12, Special Education Assistant and Coach).

Another participant shared their experience collaborating with families and observed that some families may initially be more receptive to collaborating with educators than mental health professionals:

> And connecting with the family too, in a different way. It's not the counselling role, so there's less of a barrier. It's not like, *oh mental health*. It's the teacher coming to me and the teacher hands out grades, and the teacher knows my son because they are coaching them as well. *So yah, I really trust what they are saying.* So, there's that piece that transcends the role as a mental health specialist. They see you as someone who is trustworthy. They have rapport with you already and they are going to listen to what you have to say. So, that's really important (Participant 6, Director of Student Support).

Overall, seven incidents were identified in the helping category, with 21% of participants reporting family communication and collaboration as a helping category.

In the hindering category, participants described experiences when families were resistant to collaborating with school staff and acted as barriers to students receiving mental health supports.

The following excerpt illustrates how a family's lack of mental health awareness and knowledge contributed to the family be unreceptive or unwilling to accept educators' mental health concerns regarding a student:

> A student that I know, I taught him in grade 8, would not really interact with others very much, other than with his small group of friends that he came from elementary school with. But then you really branch out - with most kids, by the end of Grade Eight, they've made a few new friends from other places, or other schools. And he always missed anything that was a project or anything that you have to speak in front of people. Like anything that was social, would not attend at all. We brought it up with the parents, and they're just like, *Oh no, he's lazy*. *Yeah. He's smart, but he's lazy*. And every year, it came up, and then they were refusing to even explore that there might be some other reasons for him not performing well in school, or not wanting to be at school, other than lazy. So, it came to a head this year in Grade 11, because basically he stopped coming to school. Because in Grade 11, a lot of the courses are discussion, essays and those kinds of things. And that stuff, that upsets him, and it makes him anxious, and he was just avoiding it. And at that point, then the parents accepted that there could be another reason for it other than laziness. Um, so now he's in a program like working on, I guess it's the sort of social anxiety…. So, I'd say that's one where the parents have kind of gotten in the way of getting him help (Participant 1, Teacher and Grade Level Coordinator).

In the next quote, a participant articulated how challenging it can be when parents and educators convey different information to students regarding mental health or respond to student concerns in conflicting ways, which has the potential to confuse or cause distress for the student:

> The primary educators are the parents. So, if you want to talk about mental health issues, were the parents involved? Cause they are still the primary educators. So, you know the message could be this at school, but completely different at home. So, although I may not tell a student how to feel or I may be a good listener, or I'm not going to pass judgment. When they are in the home, if it's a complete 180, they get mixed messages, and who do they even believe? Right, so this adds on to the trouble (Participant 11, Principal).

In summary, 29% of participants identified challenges with respect to family communication and collaboration, with seven critical incidents reported.

In terms of WL items, some participants suggested that making mental health literacy educational opportunities available to families could help to ensure that caregivers get appropriate mental health related knowledge. Participants proposed that increased family mental health literacy could promote consistent supports across home and school and facilitate families'

receptivity to school concerns. For instance, one participant suggested several methods for increasing family mental health literacy, "I think if there was some mandatory parent nights or information at least that went home or something online. Like, *Please watch this and you can help your child, support them because things are changing in the high schools"* (Participant 1). In summary, 14% of participants contributed two WL items to the Family Communication and Collaboration category.

School Culture and Values

The next category summarizes incidents where participants identified Values and Culture as an important helping or hindering factor when incorporating mental health literacy into their practice. The helping category includes incidents in which participants discussed how a school's value system and overall culture can promote supportive relationships amongst students and staff. In the following excerpt, a participant described how a school culture that emphasized community was helpful for promoting students' willingness to both seek and accept mental health related supports from educators:

> I think working in a school, particularly ours that feels like and is recognized as a real community and sort of a family. That's a word that the kids use often. So, I think teachers find it easier to approach students that they are concerned about. Students hopefully feel that it's easier to approach some teachers when they're not doing well and then that can hopefully, not always, but sometimes facilitate the referral process...For example, one thing I can think of when I spoke to a student who transferred from a public school and said, *well you know what's different about it here?* And he said, *it really feels like family, like the teachers really seem to care, they don't all seem to disappear at three* (Participant 5, School Counsellor).

Furthermore, a participant highlighted how working in a school that values compassionate and caring educators facilitates the relational aspect of schools:

> I would say, at least for the last 19 years, a fantastic culture of which has only improved, but it's, I know it's goofy to say this, but there's a real sense of community and I think you have teachers who are, for the most part, very compassionate. It's built into our discussions in our retreats and that, that if these words aren't spoken exactly, the meaning is that, you know, we're here to teach students, not subjects...But I just find that most of the staff here, there's a general,

> there's a general culture of compassion and listening (Participant 7, Teacher and School Librarian).

In the helping category, 21% of participants contributed two helpful critical incidents.

With respect to hindering incidents associated with culture and values, participants identified challenges when overarching cultural and value systems within their schools were at odds with supporting student mental health. The following excerpt illustrates challenges associated with supporting 2SLGBTQ+ students within the formal value system of this participant's religiously affiliated school:

> So being at a (religious) school that typically is very conservative. We have noticed students that are homosexual, who struggle, and it affects their mental health. And as a (religious) school we're not doing everything we can to support them. There's a number of us who are trying to support, but like as a school we can't really. So, here's the example, if we know that 40% of the LGBTQ+ community has struggled with or have had suicidal thoughts. Let's just say we have four kids in our building who are having suicidal thoughts and they're of this population, right? That is a major issue that needs to be addressed. If we have four students walking down the hall who are thinking about committing suicide, we need to address that. We won't address that because we'll just address it from a mental health standpoint, but not a being gay standpoint... But if we had four kids who are at risk of getting hit by a car at the street corner, you're damn sure that's going to be addressed because it's not a marginalized group who is just simply not in line with our (religious) values... There's a ton of people in this building where we want to support these people. But the [central office] says we can't you know. I went to a Safer Schools workshop and they talked about this and they said, *We've seen tremendous benefit to having safe space stickers.* Done. I went and bought them and put one on my door. And within 24 hours I was told that they had to come down...You know the one that says that this is a positive space with the LGBTQ triangle (Participant 8, Teacher and Coach).

Participants also identified how unspoken culture or value systems related to the demographics of the student population can pose challenges when incorporating mental health literacy into practice. For instance, the following excerpt illustrates how a gender segregated and athletically oriented school presented unique challenges and considerations:

> So, the potential downside or some of that innate challenges that we have here, at this school is that 'boy culture' is a very unique culture. It's not mediated by the typical more mature, emotionally literate girl or the positive peer pressure of girls. And because we are a very athletic school, there is sort of you know a high testosterone, sort of exaggerated socialized male environment you could say. Well, I am saying there are times and places where it's not

> comfortable to share. And that might be more exaggerated than where it would be in a co-ed school. So, that's what makes you know talking about it and the curriculum like "The Mask You Live In" even more important (Participant 5, School Counsellor).

Overall, eight hindering incidents were reported, with 29% of participants expressing barriers to incorporating mental health literacy into practice with respect to school culture and values. No WL items were reported within this category.

CHAPTER FIVE: Discussion

This study investigated high school educator experiences of incorporating mental health literacy into practice. Utilization of the qualitative, Enhanced Critical Incident Technique (ECIT) methodology allowed for an exploratory, in-depth investigation of the topic. Through 14 individual, semi-structured interviews, educators described the factors that helped them and hindered them when supporting student mental health and incorporating mental health skills and knowledge into their work in the schools. Additionally, educators identified supports they wished were available to assist them in implementing mental health literacy into their practice. All participants spoke at length, relating their personal experiences of integrating their mental health literacy knowledge and skills into their practice and their extensive interview transcripts yielded rich descriptions of personal experiences that were then analysed for critical incidents.

From the interview transcripts, 256 Critical Incidents (CIs) were generated, including 137 helpful CIs, 86 hindering CIs, and 33 WL items. Despite the uniqueness of each participant's perspective and experiences, the ECIT methodology facilitated thematic groupings of categories allowing for representation of common and shared experiences. Through an iterative data analysis process, critical incidents were organized into nine emergent categories: Building Relationships with Students, Normalizing Talking About Mental Health and Reducing Stigma, Accessible Mental Health Professionals, Mental Health Literacy Education, School Staff Communication and Collaboration, Time, Administrator Support, Family Communication and Collaboration, and School Culture and Values. These emergent categories are reflective of frameworks for comprehensive school mental health supports, which emphasize teamwork and collaboration, school mental health literacy for all (i.e., school staff, students, families), and take into account systems and contextual factors.

In this chapter, the emergent categories are discussed in the context of existing school mental health literature and research focused on the role of educators in supporting student mental health and educator mental health literacy. Findings are also discussed through the lens of implementation science, with a focus on how determinant frameworks can facilitate understanding of the factors that influence the implementation of educator mental health literacy competencies. Practical implications of the study findings are presented throughout this chapter. Finally, study contributions, limitations, and directions for future research are discussed.

Discussion of Categories and Extant Literature

Building relationships with students. This study supports the notion that teacher-student relationships play pivotal role in incorporating mental health literacy into practice, particularly for supporting the mental health of individual students. This is consistent with findings from previous qualitative studies in which educators identified that building relationships with students was an integral factor when supporting the mental health needs of students. (Kidger, et al., 2010; Shelemy, et al., 2019a). Moreover, findings from the present study offer helpful nuances regarding the possible mechanisms through which student-teacher relationships allow educators to support student mental health. For instance, participants perceived supportive student-teacher relationships as allowing educators to be a safe adult to whom a student can open up about mental health concerns and allowing educators to bridge students to formal mental health services. Furthermore, participants also emphasized how relationship can provide a foundation that facilitates educators in observing changes in student behaviour that may be indicative of mental health problems. Participants in this study also identified that certain roles in the school system are more conducive to relationship building. For instance, grade level coordinators regularly check-in with the same cohort of students as they advance grades, and coaches interact with students on an ongoing basis

in less formal contexts. This finding is consistent with Wei and Kutcher's (2014) suggestion that educator mental health literacy professional development should target *"Go-To Educators;"* this term describes school staff with whom students naturally form relationships and go to for support.

Previous large-scale quantitative studies have examined how the quality of student-teacher relationships correlates with student mental health. For instance, a longitudinal study of adolescent depressive symptoms found that teacher support predicted reduction in depressive symptoms over time (Wang, Brinkworth, & Eccles, 2013). Unfortunately, student mental health problems are generally associated with poorer student-teacher relationships (Hamre & Pianta, 2001; Holen, Waaktaar, & Sagatun, 2018; Rudasill, Reio, Stipanovic, & Taylor, 2010). The link between student-teacher relationships and success in identifying students experiencing signs of mental health problems has not been identified in previous literature and should be explored further in future studies. Altogether, evidence from both previous and current studies suggest that supportive student-educator relationships are foundational for incorporating mental health literacy into practice and supporting student mental health.

Normalizing talking about mental health and reducing stigma. Reducing mental health stigma and normalizing discussions about mental health are key and commonly identified aims of mental health literacy professional development programs (e.g. Kitchener & Jorm, 2008; Wei & Kutcher, 2014). Overwhelmingly, participants identified and validated that when discussion of mental health is normalized broadly across the school population of students and school staff, this is incredibly important for facilitating participants' success when incorporating mental health literacy into practice.

Participants highlighted several methods through which they normalized talking about mental health at school, including integrating mental health related topics into classroom

instruction and school events, and facilitating mental health discussions in a safe environment where students can share their feelings and personal experiences. Participants identified that particular subjects and curriculum topics were more conducive to engaging in discussions to normalize mental health, such as English, Physical Education, Psychology, and Religion. Furthermore, participants observed that an apparent reduction in mental health stigma at a societal level (e.g., through increased discussion about lived experiences related to mental health and mental illness in popular culture) appeared to increase students' comfort with sharing and discussing mental health related topics at school. These practices and observations suggest that participants are aware of the potential benefit when mental health is accepted as an important, normal facet of human experience, and furthermore, that it is normal and acceptable to discuss and access support for mental health problems within their school environments. Findings from previous studies also support the importance of normalizing discussion of mental health in schools, with results suggesting that when educators engage in normalization of mental health, this can promote student help-seeking (Anderson et al., 2019; McLuckie et al., 2014).

Findings from the present study align with and expand upon current research focused on interventions targeting the normalization of talking about mental health and stigma reduction amongst students in school settings. Contact-based educational interventions in schools currently have the strongest evidence base in the research literature for improving knowledge, and attitudes related to reducing mental health stigma (Chen, Koller, Krupa, & Stuart, 2016; Koller, & Stuart, 2016). Contact-based interventions involve facilitating students' engagement in learning and dialogue with individuals who have lived experience of mental illness through in-person or video-based presentations, and often involve sharing recovery oriented personal stories (Chen et al., 2016). Additional promising practices in youth stigma reduction expand upon contact-based

interventions through the youth summit model, which includes additional educational components, and explicitly targets action through youth leadership and engagement strategies (Koller, Chen, Heeney, Potts, & Stuart, 2014). Beyond the discrete stigma reduction presentations currently supported in the literature, participants in the present study articulated that mental health is best normalized when topics and discussions are integrated broadly and frequently across various educators, courses, and contexts within the school setting.

Conversely, participants also identified mental health stigma as an ongoing hindering factor experienced by educators when incorporating mental health literacy into practice. Stigma can be understood as a complex social phenomenon that operates on both structural and individual levels (Chen, Sargent, & Stuart, 2018). At the structural level, organizational policies and practices contribute to inequities for individuals with mental health problems (Chen et al., 2018). At the individual level, individuals possess stigmatizing thoughts (e.g., stereotypes), emotions (e.g., prejudice) and engage in stigmatizing behaviours (e.g., discrimination) (Chen et al., 2018). In the present study, participants identified that mental health stigma operates at both individual and systemic levels within schools. For example, stigma at the structural level contributed to observed staff member reluctance to provide accommodations for students experiencing mental health problems. At the individual level, educators experienced challenges when students made prejudiced comments or disengaged during mental health discussions, which hindered educators when attempting to create a safe place for sharing and dialogue. In the school mental health literature, stigma is widely cited as a barrier to students seeking and participating in school mental health supports (Gronholm, Nye, & Michelson, 2018; Huggins, et al., 2016). For instance, a systematic review of qualitative studies focused on how stigma impacts student participation in school mental health interventions identified a range of stigma-related barriers experienced by

students, including self-stigma, fear of discrimination by school staff, fear of bullying and hostility from peers, fear of negative consequences related to opening up during counselling sessions, and fear of personal information being shared (Gronholm et al., 2018).

Finally, participants in the current study wished for a greater focus on positive mental health promotion in schools and noted that many events, presentations, and resources available to schools were overly focused on mental illness. This finding is consistent with previous studies that found students were more receptive to engaging in mental health instruction and intervention when such instruction was framed in terms of everyday positive coping skills, or relational-based support (Prior, 2012). Furthermore, this finding is consistent with a dual-factor model of mental health that identifies both positive dimensions of mental health and mental health problems as distinct, yet interrelated components of mental health (Greenspoon & Saklofske, 2001; Moore et al., 2019; Suldo & Shaffer, 2008). Taken together, these findings support the importance of a holistic conceptualization of school mental health literacy where action is taken to reduce stigma, and normalize mental health for all school staff and students through an array of practices from formal events to informal discussions embedded across the school day and within the fabric of school culture. While stigma continues to pose a significant barrier to educators' successful engagement in mental health literacy practices, promoting the normalization of talking about mental health is clearly a fundamental helping factor for educators' successful incorporation of mental health literacy into practice.

Accessible mental health professionals. The findings from this study suggest that accessible mental health professionals are an important factor for helping educators successfully incorporate mental health literacy into their practice. Participants acknowledged the significance of mental health concerns experienced by students and as such, the importance of being able to

network effectively with mental health professionals. Accessible mental health professionals allowed participants to know who, where, and how to connect students to supports, and allowed educators to access the consultation and information they needed to provide timely classroom supports. Accessible mental health professionals in schools and in the community allowed participants to feel successful when referring students for mental health services, supporting students with MH problems in the classroom, and increasing their own MHL by learning from the expertise of the mental health professionals with whom they interact. Reciprocal communication and collaboration with mental health professionals characterized helping incidents, while hindering incidents were characterized by a perceived lack of access to and availability of MH service providers and siloed services that created logistical barriers to collaboration, such as lack of clarity related to information sharing and confidentiality. Participants observed that a lack of accessible mental health professionals posed a significant threat to the wellbeing of students whom they were supporting. Furthermore, participants expressed the desire for additional mental health services to be embedded in school settings.

These findings are consistent with previous studies that identify collaboration with mental health professionals as critical for educators when supporting student mental health (Ekornes, 2015; Froese-Germain & Riel, 2012; Graham et al., 2010; Mælan et al., 2019; Reinke et al., 2011; Shelemy et al., 2019b). Similar barriers to collaboration amongst educators and mental health professionals were cited in previous studies as well (Ekornes, 2015; Mælan et al., 2019; Phillippo & Kelly, 2014; Rothi et al., 2008; Shelemy et al., 2019a). Barriers to collaboration identified in previous research included uncertainty and lack of clarity about educator roles when supporting students, lack of communication, and time constraints. Furthermore, concerns related to confidentiality have been found to impede collaboration and information sharing between

educators and mental health professionals (Phillippo & Kelly, 2014; Spratt, Shucksmith, Philip, & Watson, 2006; Weist et al., 2012).

Previous study findings suggest that opportunities to build relationships between educators and mental health professionals through working together on systems level mental health initiatives provided an important foundation for successful interprofessional collaboration (Mælan et al., 2019; Mellin, Ball, Iachini, Togno, & Rodriguez, 2016; Moran & Bodenhorn, 2015). Taken together, the findings from this study and previous studies suggest that educators require support and collaboration with mental health professionals in order to successfully incorporate mental health literacy into practice. Findings from this study also suggest that strategies, processes, and structures for collaboration must be thoughtfully incorporated into educator mental health literacy initiatives. For instance, when schools and districts plan mental health literacy professional learning opportunities for educators, inclusion of school and community mental health professionals can provide an opportunity for relationship building and dialogue and provide a foundation for ongoing collaboration. Previous research has found that situating mental health professionals in schools does not automatically lead to collaboration (Spratt et al., 2006). As such, schools must consider how to strategically build in time for consultation between educators and mental health professionals when supporting students experiencing mental health problems and promoting school and educator mental health literacy.

Mental health literacy education. Study participants highlighted that mental health literacy education was imperative for increasing their knowledge about signs of mental health problems and improving their confidence and the skills needed for both talking with students about mental health and supporting students in the classroom experiencing mental health problems. Increases in knowledge and improvements in mental health-related attitudes are widely

documented outcomes in previous studies examining the effects of educator participation in mental health literacy professional development (Aakre et al., 2016; Gryglewicz et al., 2018; Jorm et al., 2010; Kelly et al., 2010; Kutcher et al., 2013, 2015; McLuckie et al., 2014; Milin et al., 2016). However, systematic reviews of educator participation in mental health literacy professional development interventions have reported limited evidence of changes in behaviours of individuals as an outcome (Anderson et al., 2019; Ohrt et al., 2020; Yamaguchi et al., 2020). In this study, participants provided numerous examples describing how their mental health literacy education led them to take action in identifying and supporting student mental health. While qualitative studies do not allow for determination of causation or generalizable findings, they offer a means of documenting rich descriptions of behaviour change from the insider perspective. Future research should consider mixed methods approaches as a means for ongoing documentation and exploration of behaviour change associated with mental health literacy education interventions.

Findings from the present study also highlighted teacher perceptions that a lack of mental health literacy education during pre-service teacher education programs, and the provision of one-time professional development without follow-up hindered educators from successfully incorporating mental health literacy into practice. Many participants expressed a desire for ongoing opportunities for learning and skill development in the area of mental health literacy. These findings are consistent with extant literature examining overall teacher professional development preference for continuous learning with opportunities for discussion, skills practice, regular review, and coaching/mentorship (Cordingley, Bell, Evans, & Firth, 2005; Fortier et. al., 2017; Sharma, Forlin, Loreman, & Earle, 2006; Timperley, Wilson, Barrar, & Fung, 2007). A recent qualitative study focused on educators' mental health professional learning and resource needs reported similar findings, citing the desire for an expert-led, evidence-based, applied and skills-

based approach, content that was adapted based on the developmental level of students, and an interactive approach to instruction involving opportunities for discussion and checking for understanding (Shelemy et. al., 2019b).

In terms of the gap in pre-service mental health literacy education identified by participants, this finding is consistent with a recent study that examined pre-service teacher certification standards in Canada (Brown, Phillippo, Weston, & Rodger, 2019). Only six out of the 11 Canadian provinces and territories explicitly incorporated learning objectives or competencies related to student mental health into pre-service teacher education standards. Furthermore, the existing standards rarely provided recommendations about how to practically facilitate teacher candidates' learning and skill development related to supporting student mental health. Taken together, findings from both the current and previous studies highlight support the potential benefits of educator mental health literacy professional learning being incorporated into pre-service teacher education programs, followed by access to ongoing professional development, as well as coaching and mentorship for practicing educators.

School staff communication and collaboration. Participants in the present study emphasized that effective collaboration and communication amongst school staff members are important for educators when incorporating mental health literacy into practice. Participants highlighted that open, consistent communication amongst staff members regarding student mental health concerns helped educators to identify and monitor students in need of support through sharing observations of student behaviour. Furthermore, open communication facilitated educators in providing consistent supports to students. Collaboration was also helpful for educators when developing lesson plans and activities focused on incorporating mental health into classroom discussions. In a similar vein to the barriers identified by participants with respect to collaboration

with mental health professionals, barriers to communication and collaboration amongst school staff included unclear guidelines for information sharing and confidentiality and siloes between different departments within a school. To improve school staff communication and collaboration, participants wished for additional time to collaborate, such as regular meetings with other educators or email communication focused on supporting student mental health. Although the importance of interprofessional collaboration between educators and mental health professionals is well documented in the school mental health literature (Ekornes, 2015; Froese-Germain & Riel, 2012; Graham, et al., 2010; Mælan, et al., 2019; Reinke, et al., 2011; Shelemy, et al., 2019b), the significance of communication and collaboration amongst school staff broadly with respect to supporting student mental health (e.g., teachers, administrators, and special education assistants) is a unique contribution of this study.

Teacher collaboration has been widely studied in the education literature. A systematic review of 82 studies on teacher collaboration investigated associated outcomes, as well as facilitators and barriers to successful collaboration and wide-ranging benefits of teacher collaboration were found (Vangrieken, Dochy, Raes, & Kyndt, 2015). Teacher collaboration was linked to improvements in school culture, such as increased innovation and a more egalitarian power structure. Furthermore, several teacher-specific improvements were identified, including improved job performance, reduction in sense of isolation and improved teacher morale. With respect to barriers to collaboration, an overarching culture within education of individualism and autonomy was a primary barrier, which was also reflected in individual teacher mindsets. Identified collaboration facilitators included structural supports (e.g., providing time for meetings), group related factors (e.g., composition), and factors related to the collaborative process (e.g., clearly defined the roles of collaborators). Findings from the present study similarly indicated that

participants wished for additional collaboration time for supporting student mental health, a feature which is supported by Vangrieken et al.'s (2015) finding that structural supports such as regularly scheduled meetings indeed facilitate teacher collaboration. Additionally, the knowledge that educational values of individualism and autonomy act as a barrier to collaboration (Vangrieken, et al., 2015) may help to explain the collaboration barriers reportedly faced by participants in the present study, including perceived siloed departments within schools and unclear processes for sharing information amongst educators.

Time. Given that educators experience demanding jobs and hectic schedules, it is not surprising that a lack of time to incorporate mental health literacy into practice was widely cited as a hindering factor for participants in this study. Conversely, when time was allocated for mental health literacy activities or unstructured time was available, this helped educators feel successful incorporating mental health literacy into practice. Time is needed for various mental health literacy practices: time for ongoing professional development and planning; time for collaboration with other educators, mental health professionals, and families; as well as time to build relationships with students and check-in with students individually. Participants reported that they experienced many competing demands in their role as educators and experienced difficulty finding time for various mental health literacy practices. Additionally, some participants reported that lack of time contributed to increased stress and also negatively impacted their own self-care. These findings are consistent with previous studies that have investigated the challenges educators experience when supporting student mental health and found time constraints to be significant structural barrier and source of stress for educators (Ekornes, 2015; Mælan et al., 2019; Phillippo & Kelly, 2014; Rothi et al., 2008; Shelemy et al., 2019a). Additionally, in both the current study and previous studies, time limitations were seen as created barriers at the organizational level, making

it logistically difficult for educators to participate in mental health literacy professional development due to limited staff release time (Fortier et al., 2017). Furthermore, the theme of experiencing a lack of time and the need for additional time to engage in mental health literacy practices is strongly interwoven with the other emergent categories identified during this study. When schools and organizations plan for the development of educator mental health literacy competencies, an investment of time is not only needed up-front for professional development, but additional time also must be allocated for ongoing planning, collaboration, mentorship, and engagement in mental health literacy practices.

Administrator support. Participants in the present study identified administrator support as a key helping factor for educators when incorporating mental health literacy into practice. Effective leadership and administrator support were considered essential factors for the success and sustainability of any school-based interventions or practices. Participants reported that school administrators, including principals and vice principals supported educator mental health literacy practices by allowing time for staff professional development and school wide mental health events and activities, and by collaborating with educators and mental health professionals to support students experiencing mental health problems. Although the specific role school administrators play in the implementation of educator mental health literacy practices has not been previously investigated, school principal support is widely regarded as critical to the success of a range of school improvement efforts (Iachini, Pitner, Morgan, & Rhodes, 2016). For instance, the support of school principals has been found to be critical for successful implementation of evidence-based, mental health prevention and intervention programs in school settings from the perspective of intervention developers (Forman et al., 2009) and clinicians implementing the interventions (Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). Important aspects of administrator support

identified in previous research include strong management skills, and demonstration of buy-in through positive attitude toward the intervention, participation in professional development, and discussing implementation during staff meetings (Forman et al., 2009).

Previous studies have also found school administrator leadership and support to be important for facilitating other helpful factors identified by participants in the present study, including promoting positive school climate (Nettles & Herrington, 2007; Sebastian & Allensworth, 2012), improved collaboration amongst school staff (Whitley, 2010), and development of effective partnerships with families and school and community based mental health professionals (Mellin et al., 2016, Nettles & Herrington, 2007; Sanders & Harvey, 2002; Whitley, 2010).

Family communication and collaboration. Communication and collaboration between home and school is considered fundamental for supporting student mental health (Brandt et al., 2014; Christenson, 2002). Participants in the present study highlighted the benefits of collaborating with families who were willing to coordinate student services and supports with the school and engage in reciprocal information sharing, such as providing observations, and information about school and community-based services a student was receiving. Conversely, participants identified challenges collaborating with families when they were resistant or unreceptive to student mental health concerns expressed by the school. Participants proposed that families' receptivity to collaborating with schools to support student mental health could be improved if families had access to mental health literacy learning opportunities as well, to facilitate increased mental health knowledge and reduce mental health stigma for families.

A study investigating family perspectives on barriers and facilitators to family engagement in school mental health reported remarkably similar findings to the perspectives shared by

educators in the present study (Fette et al., 2009). Families identified barriers to collaboration included mistrust and negative past experiences with schools, lack of knowledge about mental health problems and effective supports, and stigma. Furthermore, families identified helpful strategies to promote effective partnerships, including strength-based approaches to collaboration, respectful communication, and school staff skill development in family engagement skills. Taken together, findings from the current study and those already represented in the literature support the importance of collaborating with families when supporting student mental health. Engaging in practices to facilitate effective family-school partnerships and providing mental health literacy learning opportunities to families can support educators' successful incorporation of mental health literacy into practice.

School culture and values. In this study, participants identified that their school's overall culture and value system helped them incorporate mental health literacy into practice, with respect to fostering an environment that promoted the development of caring, trusting, and supportive relationships between students and staff. In conjunction with the previously described actions taken by educators to build relationships with students, school culture appeared to be an important precondition that empowered educators in the present study to instil and value these relationships, as it was understood to be fundamental to their role. This is consistent with findings reported in the school climate literature that identify caring and supportive relationships between teachers and students as an important facet of positive school climate (Zullig & Matthews, 2014). Furthermore, the relationship between school climate and adolescent mental health outcomes is widely recognized in the research literature (Aldridge & McChesney, 2018). A recent systematic review documented that positive relationships with teachers was associated with both increases in positive student mental health and decreases in mental health problems and risk behaviours (Aldridge &

McChesney, 2018). Moreover, findings from a previous study examining the relationship between school climate, depression literacy, and mental health stigma found school climate to be an important factor when implementing mental health literacy programming for staff and students (Townsend et al., 2017). Specifically, positive school climate was found to be associated with increased depression literacy and reduced stigma amongst students, when compared to students who attended schools with less positive school climates.

Findings from the present study also highlighted how particular aspects of a school's culture and value systems were viewed to hinder participants from successfully incorporating mental health literacy into their practice. Specifically, participants identified challenges supporting the mental health of 2SLGBTQ+ students in their religiously affiliated school when the religious leadership did not allow their school to be overtly affirming or inclusive to 2SLGBTQ+ identities. This is consistent with findings from previous studies that identified religiously affiliated schools as potentially discriminatory environments for 2SLGBTQ+ students, contributing to decreased wellbeing (McCann, Donahue, & Timmins, 2020; Wilkinson & Pearson, 2009). These challenges supporting 2SLGBTQ+ students experienced by educators in this study should also be considered from a human rights perspective. All Canadian provinces and territories have laws in place that prohibit discrimination based on sexual orientation and gender identity (Canadian Civil Liberties Association, 2014). As such, considering this barrier through a human rights lens could help to identify solutions and propel systemic change. Addressing school policy is one important avenue for systems change. Research shows that schools with explicit anti-homophobia, biphobia, and trans-phobia policies are more likely to be experienced as respectful environments by 2SLGBTQ+ students (Taylor & Peter, 2011). Furthermore, students attending schools with such policies are

significantly less likely to experience verbal or physical harassment as a result of their sexual orientation.

Taken together, these findings support the notion that school culture and values must be considered at individual, family, organizational, and community level when supporting the mental health needs of children and youth (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010). When a school's overarching culture and value system undermines the mental health and wellbeing of certain populations of students, this creates significant barriers for educators when supporting the mental health of students. Conversely, aspects of school culture and values have the potential to be important facilitators for educators, including valuing caring relationships between students and teachers.

Discussion of Findings from Implementation Science Lens

Implementation science is concerned with the uptake of evidence-based practices into real world settings, such as schools (Owens et al., 2014). As described throughout the findings and discussion chapter, participants demonstrated intervention uptake as they integrated their mental health literacy knowledge and skills into various practices throughout their work in schools. As such, uptake of participants' mental health literacy practices was explored through an implementation science lens. In applying mental health literacy competencies, educators identified several important facilitators, as well as barriers to implementation. Examining the barriers and facilitators of implementation is essential for informing strategic planning to allow educator mental health literacy implementation outcomes to be targeted, including intervention appropriateness and acceptability (Cook, Lyon, Locke, Waltz, & Powell, 2019; Weiner et al., 2017).

In the field of implementation science, determinant frameworks assist with understanding the domains that influence implementation outcomes, with specific barriers and enablers (i.e.,

helping and hindering factors) identified within each domain (Nilsen, 2015). While an intervention such as MHFA-Y may be standardized, implementation strategies and supports can be applied flexibly to best meet the needs of a particular context. The findings from the present study are useful for informing relevant implementation supports to promote uptake of educator mental health literacy practices in a school setting. The emergent categories that arose in the present study parallel a multi-level ecological determinant framework conceptualization, which suggests individual, organizational and community level factors can be understood to influence implementation (Durlak & DuPre, 2008; Nilsen, 2015). Furthermore, the overlapping nature of the emergent categories that arose in this study aligns with the interactive nature of determinant frameworks (Nilsen, 2015).

Durlak and DuPre (2008) proposed a five-component model for understanding factors that influence successful implementation, including: community and contextual factors, provider characteristics, innovation characteristics, organizational capacity, and training and technical assistance. It is informative to consider each component as a way of framing the findings of the current study. Given the exploratory approach of this study, not all aspects of determinant framework domains were explicitly discussed by participants. However, the multi-level ecological framework provides a useful model for considering the emergent categories that arose in this study as important factors to be considered when planning implementation supports for educator mental health literacy professional development and embedding educator mental health literacy practices in schools.

Innovation characteristics. Innovation characteristics reliably linked to implementation include adaptability and the compatibility of the innovation with an organization (Durlak & DuPre, 2008). With respect to adaptability of the MHFA workshop, some participants spoke to challenges

scheduling or participating in a two-day, in-person professional development workshop, with limited professional development and release time afforded to educators. Participants also discussed adapting the application of mental health literacy skills expanded beyond the scope of MHFA-Y workshop, which primarily focuses on skills for identifying and responding to mental health problems. Specifically, participants identified normalizing conversations about mental health and reducing stigma as an important helping factor for incorporating mental health literacy skills into practice. As such, participants found ways to incorporate mental health related topics into classroom instruction and facilitate discussions where students feel safe and comfortable talking about their emotions. Participants also expressed a desire for content focused on strategies and skills for promoting positive mental health. In terms of the compatibility of the MHFA-Y and mental health literacy skills with the organization's culture, values and mission, school culture and values were perceived as both helping and hindering incorporation of mental health literacy skills into practice. These findings suggest that innovation fit, and necessary adaptations should be carefully assessed when selecting a mental health literacy professional development program with respect to both program content and delivery modality.

Provider characteristics. Provider characteristics related to implementation success include perceived benefit and need for the innovation, as well as skill proficiency and self-efficacy (Durlak & DuPre, 2008). Participants in this study shared that mental health literacy professional development increased their confidence and willingness to take action to support student mental health and discuss mental health with students, indicating MHFA-Y helped to increase their perceived sense of self-efficacy and skill proficiency. Additionally, participants identified key actions they took that facilitated successful incorporation of mental health literacy, including building relationships with students and taking action to normalize mental health. Because the

MHFA-Y professional development workshop was voluntary, participants were likely to perceive benefits of the intervention from the outset. Greater attention to assessing participant readiness and initial perceptions about mental health literacy would likely be necessary in settings where mental health professional development is applied on a universal or mandatory basis. Furthermore, study findings suggest some unique provider characteristics of potential importance to the implementation of educator mental health literacy practices.

Community level factors. Overarching community factors important for implementation success include the state of the theory and research in the field, and the overall political landscape that dictates policy and funding decisions (Durlak & DuPre, 2008). In this study, barriers and facilitators to successful implementation were explored from the perspective of educators, who can be considered equivalent to providers within the determinant framework. As such, educators were more attuned to particular domains relevant to mental health literacy practices on the ground within their schools and less so to overarching macro community factors, such as policy and politics. However, participants largely identified that they had not had access to previous professional development or pre-service instruction in the area of mental health literacy, implying that overarching policy and funding decisions are not currently aligned with the need for this educator mental health literacy education articulated in the research literature. Macro level community factors relevant to educator mental health literacy implementation should be investigated further by learning about the perceptions of barriers and facilitators from individuals in systems level positions, such as school district administrators and educational policy makers.

Training and technical assistance. Training and technical assistance are consistently related to implementation success (Durlak & DuPre, 2008; Lyon et al, 2019). In fact, ongoing

training, and coaching or mentorship have been identified as two of the top five most important implementation strategies impacting the success of school-based interventions (Lyon et al., 2019).

The purpose of training is typically initial skills development and preparation for new tasks. In the present study, participants completed the MHFA-Y professional development workshop designed to prepare educators to develop knowledge and skills to identify and provide preliminary supports for students experiencing mental health problems, and participants reported that indeed this training was helpful in equipping them with these skills. However, participants identified a need for education in a broader scope of mental health literacy skills relevant to educators, including engaging in actions to normalize discussion of mental health in the school environment. Furthermore, participants viewed preservice education as the opportune time for mental health literacy skills development, both for their own learning and to help ensure consistent skills and knowledge across the education field. As such, educator mental health literacy learning needs must be carefully considered when selecting and adapting professional development opportunities.

Technical assistance refers to ongoing support with knowledge acquisition and skill development, and the provision of resources to support ongoing implementation. Technical assistance is not built into the MHFA-Y intervention, and participants suggested that a lack of ongoing professional development and support was a hindering factor for incorporating mental health literacy into practice. Taken together, findings from this study and previous studies suggest that building technical assistance into a school mental health literacy strategy is important for supporting implementation success (Durlak & DuPre, 2008; Lyon, et al., 2019).

Organizational capacity. Overall organizational capacity factors related to implementation success include workplace climate and norms, organizational processes, and staffing considerations (Durlak & DuPre, 2008). Several emergent categories from the present study were

related to organizational capacity, including accessible mental health professionals, staff communication and collaboration, school culture and values, and administrator support.

With respect to relevant aspects of workplace climate and norms, shared vision and staff buy-in were identified as important in the present study. When mental health literacy vision was not shared across school staff, this was seen as hindering necessary staff communication and collaboration to effectively support student mental health. Furthermore, participants experienced challenges supporting 2SLGBTQ+ students related to their school culture; the lack of inclusive practices and policies within their religiously affiliated school acted as a limiting factor for developing organizational capacity for educator mental health literacy practices.

In terms of specific practices, participants identified a need for effective mechanisms and organizational processes to facilitate ongoing and open communication amongst school staff, such as regular interdisciplinary meetings and guidelines around information sharing amongst staff members while taking into account confidentiality considerations. Additionally, participants highlighted the importance of working groups to have time to discuss student mental health supports and plan mental health related instructional content. Coordination with community mental health professionals was also viewed as an important helping factor for supporting student mental health. Finally, leadership is an important staffing consideration related to implementation success, which aligns with the administration support category that arose in the present study, and previous literature documenting the importance of school principal support for intervention success (Forman et al., 2009; Langley et al., 2010).

Altogether, study findings support the utility of a multi-level ecological approach to developing an implementation plan to support and promote successful uptake of educator mental health literacy practices. Findings also provide preliminary considerations for unique facets related

to school organizational context. Future research eliciting the perspectives of personnel operating in systems level roles is needed to enhance our understanding of community level barriers and facilitators to implementation.

Implications for School Mental Health Professionals' Practice and Education

In this study, educators identified school mental health professionals as key consultants and collaborators when incorporating mental health literacy into practice. Findings suggest several critical roles school mental health professionals (e.g., school psychologists, school counsellors, school social workers) may play in supporting the development and implementation of educator mental health literacy practices. Furthermore, beyond educators' professional development needs, findings from the study have implications for the educational needs of school-based mental health professionals. The following section is situated within the school psychology literature given that the researcher's doctoral program is in School and Applied Child Psychology.

As part of a comprehensive school mental health service network, school psychologists may be well situated and have the necessary background and expertise to contribute to the development of a school mental health literacy implementation plan. Contributing to systems-level initiatives, such as improving school mental health literacy fits within the field of school psychology's shift from services that are individually focused to an emphasis on improving outcomes for all students (Ysseldyke et al., 2006). Specifically, school psychologists' education in research and evidence-based practices equips them with the skills to support selection and adaptation of mental health literacy professional development interventions to meet the school needs. Additionally, school psychologists can play a role in assessing and promoting educator readiness, and improving organizational capacity, by coordinating interdisciplinary meetings, and developing guidelines for information sharing. As such, school psychology graduate programs must equip trainees with

general systems-level and capacity building competencies, such as program planning and evaluation, and skills to support intervention implementation and sustainment (Splett & Maras, 2011).

As school-based mental health professionals, school psychologists and educators are key collaborators when supporting the mental health needs of individual students. Additionally, school psychologists can provide consultation to promote the development of educator mental health literacy. Given the importance of collaboration, school psychologists require pre-service learning opportunities, including course work and practicum-based experiences focused on school mental health interprofessional collaboration (Splett & Maras, 2011).

Findings from this study suggest that implementation of educator mental health literacy practices are a multi-faceted endeavour that requires planning and supports on individual, organizational, and community levels, multidisciplinary collaboration, and likely systems change. With appropriate educational background, school psychologists and other school mental health professionals have the potential to act as drivers of change to support the implementation of school mental health literacy in the context of comprehensive, population-based school mental health services.

Implications for Provincial Mental Health Policy and Programming

British Columbia recently initiated efforts to transform the system of mental health and substance use care in the province, targeting child and youth mental health care as the cornerstone of these efforts (MMHA, 2019). In *A Pathway to Hope*, British Columbia's Ministry of Mental Health and Addictions (MMHA) outlines actions to be taken during the next three years to transform the systems of mental health and substance-use care for children, youth and families (MMHA, 2019). A key component of *A Pathway to Hope* action plan is increased collaboration

across relevant systems, including health, community mental health, and education to develop a more cohesive, integrated, and child and family-centred approach to services.

A number of the findings that arose from the present study are consistent with and support the directions proposed in the *A Pathway to Hope* document. Specific elements of the plan support actions identified within the education system, including increasing school personnel's capacity to identify children and youth exhibiting early signs of mental health problems and increasing mental health prevention and intervention activities in schools. The MMHA documents acknowledge that to execute these actions effectively, school staff will require mental health literacy professional development. As such, the emergent themes can serve to inform planning of mental health literacy professional development and implementation supports, as well as inform plans for embedding additional mental health services and supports in schools.

Within the MMHA (2019) action plan, students with greater mental health needs will access integrated services through integrated child and youth (ICY) teams that bring together families, community and school-based mental health professionals, as well as relevant community partners (e.g. indigenous elders, non-profit organizations) to engage in collaborative service planning and goal setting. While school staff members, such as school counsellors have been identified as potential ICY team members, results from this study suggest that classroom teachers, special education assistants and school administrators should also be considered integral team members for integrated supports. The implementation of ICY teams has the potential to delineate clear structures and models for collaboration, communication, and sharing information across individuals from multiple disciplines and organizations. As such, it is essential that educators are systematically and thoughtfully included within this model.

Research Contributions, Limitations, and Future Directions

Through application of the ECIT methodology, this study took an exploratory, qualitative approach to eliciting educators' perceptions of the barriers and facilitators encountered when incorporating mental health literacy into practice. This qualitative approach leverages participants' direct expression of their experiences through their own words, which allows detail, meaning making and contextual information afforded by an insider's perspective to be captured in the study results. An important advantage of the ECIT is that the methodology supports authentic representation of participants' experiences while clearly delineated research procedures and credibility checks provide scientific rigor to the qualitative inquiry.

This study makes several contributions to the current literature. First, the descriptive nature of the emergent categories is useful for both researchers and practitioners working in the field of educator mental health literacy and school-based mental health. For instance, findings from this study offer a preliminary framework for planning implementation supports when organizing mental health literacy professional development for educators and validate the utility of multi-level ecological determinant frameworks when implementing a school mental health literacy professional development program. Furthermore, although several emergent categories are consistent with the extant literature, the present findings offer a holistic view of helping and hindering determinants influencing implementation, generated through an exploratory approach to inquiry.

A distinct aspect of this study's design is the participant sample focused on high school educators who had engaged in mental health literacy professional development and how they incorporate these skills into their practice. Previous studies have explored educators' perceived needs and challenges when supporting student mental health, and mental health literacy education

is one of the most commonly reported needs identified by educators. Gaining an understanding of the factors that help or hinder educators who have already participated in professional learning helps to identify needed supports and procedures that allow educators to successfully and sustainably incorporate mental health literacy knowledge and skills into practice. For instance, findings from the present study support arguments that educators require opportunities for initial mental health literacy knowledge and skill development during pre-service education, ongoing professional development, and access to coaching and mentorship. Furthermore, participants identified several additional implementation supports needed beyond the mental health literacy workshop itself, such as time and mechanisms to facilitate collaboration, building partnerships, and coaching. Future research using larger samples and quantitative methodologies can further validate the relevant determinants for educator mental health literacy implementation identified in the present study and the utility of a multi-level ecological determinant framework.

Furthermore, this study offers unique contributions to the research literature worthy of further exploration in future research. For instance, while interprofessional collaboration amongst educators and mental health professionals, and collaboration with families is widely considered foundational in the school mental health literature, the importance of collaboration amongst teachers when supporting student mental health is a unique finding of this study. Specifically, teacher collaboration allowed participants to identify, monitor, and provide consistent supports for students experiencing mental health problems. Another novel contribution is participants' suggestion that student-teacher relationships can facilitate identification of students experiencing mental health problems. While numerous positive impacts of student-teacher relationships are documented in the literature, future research is required to validate and further explore the role of student-teacher relationships in identification of student mental health problems. Finally, an

exploratory approach allowed for findings to broadly explore educators' understanding of incorporating mental health literacy into practice. For instance, participants mental health literacy practices in this study moved beyond the aims of the MHFA-Y workshop, which focuses on identifying and providing initial support to individuals experiencing mental health problems or crises. Participants identified the need for additional education to develop knowledge and skills focused on promoting positive mental health and addressing mental health stigma in schools.

With respect to limitations, qualitative studies employ purposive sampling procedures and recruit small numbers of participants with the intent of exploring a topic in-depth and eliciting the experiences of individuals. The aim of this study was not to generalize findings to the population at large, but document meaningful experiences and perceptions with applications for policy, practice, and future research. As such, the findings from this study are reflections of the experiences of a specific group of educators who participated in a particular mental health literacy professional development workshop with a specific facilitator and incorporated their knowledge and implemented the skills within their own educational settings. It is worth noting some important characteristics of the participant sample that likely impacted the categories that arose in the study results. Notably, all participants were employed at religiously affiliated independent high schools. Additionally, all participants volunteered to participate in the mental health literacy workshops; this is likely an important feature of the sample, as volunteering to participate in the MHFA workshop suggests a belief in the utility or importance of educator mental health literacy and motivation to develop skills in this area. Future studies conducted with educators in secular school settings, with educators at the elementary school level, and in schools where mental health literacy professional development was required versus voluntary could extend the findings from

this study and determine whether similar or different barriers and facilitators were experienced across these settings and scenarios.

A further limiting feature of this study worthy of acknowledgement is the fact that critical incidents were gathered through interviews, which inherently require participants to subjectively and retroactively recall their experiences. While this approach to data collection introduces the possibility of bias and imperfect recall, it likely that incidents recalled were those that were most impactful and meaningful to participants. To address this potential issue, future studies should consider multiple modalities for gathering critical incidents. For example, a critical incident log could be utilized by participants to document instances of incorporating mental health literacy into practice as they arise.

Conclusion

Participants in this study offered thoughtful and in-depth descriptions of their experiences incorporating mental health literacy into their practice, further supporting arguments for the important role educators play in supporting student mental health that is well documented in the research literature. Implementation science is a useful lens for considering educators' implementation of mental health literacy practices, and various individual, organizational, and contextual factors that help and hinder their success. These findings offer practical recommendations for school systems and educators when planning mental health literacy professional development programming. With respect to mental health literacy professional development, educators require initial learning opportunities during pre-service education, as well as iterative professional development with access to ongoing coaching and mentorship. However, findings suggest that mental health literacy education and professional development is necessary, but not sufficient for educators' successful incorporation of mental health literacy into practice. In

addition to professional development, participants in this study identified a need for accessible mental health professionals with whom they can consult and collaborate, support from school administrators, and viable mechanisms for collaborating with school staff and families; all of which require significant investments of time. Additionally, educators identified that their actions to normalize mental health and build relationships with student had significant implications for their successful incorporation of mental health literacy. Finally, school culture and values were salient contextual factors. Given the interpersonal, organizational, community and contextual factors that influence educators' implementation of mental health literacy practices, educator mental health literacy should not be considered separately from school mental health literacy or comprehensive school mental health supports.

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Appendices

Appendix A

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Staff Workshop Participant Informed Consent
CISVA High School Mental Health Literacy Project:
Mental Health First Aid for Adults Who Interact with Youth (MHFA-Y) Workshop

Dear Participant,

This is a request for your participation in a research study that is part of a Doctoral Dissertation at the University of British Columbia, which is a public document. Please read this form carefully because it provides details about the study.

Purpose of the Study: You are being invited to take part in this study because you are a participant in the in the 14-hour MHFA-Y workshop (professional development activity). The purpose of this study is to evaluate and learn about staff experiences participating in a professional development activity focused on increasing mental health literacy for individuals who work with youth. Additionally, this study will explore how the knowledge gained through the workshop can be used to develop resources and plan new programs for the broader school community to increase the overall mental health literacy of staff and students. Overall results of the study will be made available to your school, other schools within the CISVA and will be shared at research conferences, but no identifying information will be included in the overall results. Participants may also contact the researcher to receive their own summary of the study results.

Study Procedures: We are inviting you to participate in three study activities related to your participation in the MHFA-Y workshop

a) **Survey:** You will be asked to complete a 20-minute survey at the beginning of the workshop and upon workshop completion.
b) **Interview:** In the months following the workshop you will be asked to participate in an hour long one-on-one interview with Jaime Semchuk (researcher) to discuss your experience of participating in the workshop and of incorporating what you learned into your practice as an educator. Interviews will take place in a private room at your school and will be audio-recorded and transcribed so we don't miss anything that you say.
c) **Participant Researcher Team:** After completing the workshop, you will be invited to join your school's Participant Researcher Team (PRT). This team will participate in meetings to apply the knowledge gained during the workshop to plan and implement mental health literacy programs for the broader school community. The time spent planning and implementing school programs will be determined collaboratively by the PRT. UBC

researcher Jaime Semchuk will collaborate with you as a member of the PRT; she will document the proceedings of PRT planning meetings with research field notes.

Potential Risks: You will be asked about your mental health literacy knowledge, and role in supporting student mental health. It is possible that you may feel uncomfortable with some of the questions. That is the only risk associated with participating in the study. It is unlikely that stress associated with participation will be greater than the stresses of daily life, but as a precaution you will be provided with a resource sheet of mental health resources in the community. You may use these resources if you would like to talk to a mental health professional following participation in the research activities.
Potential Benefits: Potential benefits of participating in the study include having the opportunity to increase your school's knowledge of staff perspectives regarding student and staff mental health and wellbeing. You will also have the opportunity to help to plan and implement programs to meet the mental health literacy needs of students and staff in your school. This information will also help other schools to plan similar programs. Study results will be made available to staff, students, and families in your school using methods determined in consultation with the school community.

Confidentiality Participation in this study will be considered strictly confidential when communicating the results of the study. Participation in surveys and interviews is strictly confidential, but as a member of the participant researcher team, your identity will be known to other group members. Staff names will not be collected on surveys, interviews, or as members of the Participant Researcher Team. All computer-based data records will be stored in encrypted password protected files, and physical data records will be stored in a locked filing cabinet in the office of the Principal Investigator.

a) **Surveys:** On pre-post research surveys, we will protect staff identities by using a numerical identification code. Only the UBC researchers will have access to identification codes. The online survey tool that will be used to collect responses complies with the strict British Columbia privacy legislation.
b) **Interviews:** Recorded interviews will be transcribed. You can read your transcript if you like. The transcriber will not have access to any of your identifying information. The transcriber will also be bound by a signed confidentiality agreement, which means they will not discuss the interviews with anyone. When communicating interview results, we will protect your identity by using a pseudonym that you select. Your identity will also be protected on your interview transcript by using a code number.
c) **Participant Researcher Team Field Notes:** The team will meet as a group, so your identity will be known to other participant researcher team members and therefore will not be confidential. Participants will be asked not to repeat what they hear in this group. However, you should think about what you decide to share with the group if there is something you want to be private. Please note, no identifying or personal information will be documented as part of the UBC researcher field notes, and your identity will remain confidential in any communications of the study results.

Contact for information about the study: If you have any questions about the study, you may contact the researchers (Dr. McKee and Ms. Semchuk) at any time using the contact information above.
Contact for concerns about the rights of research subjects: If you have any concerns or complaints about your treatment or rights as a research participant, you may contact the Research Participant Complaint Line in the UBC Office of Research Services at 604-822-8598. For long distance inquiries: e-mail to RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Consent: Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without repercussions. If you decide to withdraw your participation part way through the study, you may choose to withdraw any data you have contributed up to that point. Please confirm your interest in participation by adding your consent form to the research consent drop box in the front office at your school.

Staff Participant Informed Consent-Signature Page

CISVA High School Mental Health Literacy Project: Staff Workshop

Your signature below indicates that you have received a copy of this consent form for your own records. Please confirm your interest in participation by adding your consent form to the research consent drop box in the front office at your school.

Please circle your desired response for each of the following three statements. You may decline to participate in any component of the study without repercussions:

1. **Survey:** I consent (**circle if applicable)** to my participation in the survey portion of this study.

2. **Follow-up Interview:** I consent **(circle if applicable)** to be contacted by the researcher Jaime Semchuk to schedule a follow-up interview four to twelve months after completing the MHFA-Y workshop.

Phone number: _____

Email address: _____

3. **Participant Researcher Team:** I consent **(circle if applicable**) to my participation in the participant researcher team, and to the documentation of the proceedings with researcher field notes. I am willing to be contacted by the UBC researcher, Jaime Semchuk to schedule participant researcher team meetings.

Phone number: _____

Email address: _____

_____
Participant's Name (Please Print)

_____
Participant' Signature (Please Sign)

_____
Date

Appendix B

Interview Guide

1. **Welcome and thank participant**
2. **Review and obtain informed consent**
3. **Setting the Scene and Rapport Building (Sample Questions)**
    a. Tell me about your role at your school and the nature of your work with students
    b. Tell me about any mental health literacy training you received prior to participating in the MHFA workshop
4. **Establishing Aims and Summary of Mental Health Literacy**

Mental health literacy refers our knowledge, beliefs, and skills that enable us to recognize, manage, and prevent mental health problems. You participated in a mental health literacy workshop called Mental Health First Aid for Adults who Interact with Youth. The goals of this workshop are to increase knowledge about mental health and mental illness, improve attitudes and reduce stigma related to mental illness, promote recognition and providing support for youth experiencing mental health crises or ongoing mental problems.

Now I would like you to talk about your experiences of incorporating mental health literacy skills into your practice as an educator. I want you to try to remember specific examples and events. I want you to think of examples of factors that were helpful and not so helpful when incorporating mental health literacy into your work as an educator.

5. **Helping Incidents-General Focus**

Let's begin with factors or supports that were helpful to you when incorporating mental health literacy into your practice. Factors can include behaviours, attitudes, processes, events, activities, or experiences. Examples can include anything you thought that helped you. There are no right or wrong answers. Take some time to think of some specific examples, and I would like you to tell me about it in as much detail as possible.

Follow-up Prompts:

- Can you tell me more about…
- Why was this helpful/important/useful to you?
- Can you give me a specific example of…

Helpful factors & what it means to participant	Importance (How did it help? What about it did you find helpful?)	Example

6. **Unhelpful Incidents- General Focus**

Now let's shift and spend some time talking about the factors that were not helpful to you or made incorporating mental health literacy into your practice at school challenging. Examples can include anything you thought that helped you. There are no right or wrong answers. Take some time to think of some specific examples, and I would like you to tell me about it in as much detail as possible.

Follow-up Prompts:

- Can you tell me more about…
- Why was this helpful/important/useful to you?
- Can you give me a specific example of…

Unhelpful factors & what it means to participant	Importance (How did it help? What about it did you find helpful?)	Example

7. **Wish List**

We have talked about various factors that helped or hindered you when attempting to incorporate mental health literacy into your practice as an educator. Was there something missing from the support you received that you think would have been helpful to you?

Follow-up Prompts:

- Can you tell me more about…
- Why do you believe this would be helpful/important/useful to you?
- Can you give me a specific example of…

Wish List & what it means to participant	Importance (How would it help?)	Example

8. **Debriefing**

Before we wrap up, is there anything else you would like to discuss, or any questions you have?

Following this interview, I am going to listen to the recording of our conversation and write down the things you told me. Then, I will send you a letter with a summary of our conversation. I would like to check-in with you to make sure I understood the things you told me. Would it be alright if I call you to ask you if I misunderstood anything and need to make any changes to what you said

Appendix C

Follow-up Telephone Interview Guide

Follow-up Interview One

Dear _____,

This is Jaime, the UBC researcher. We spoke about your experiences of incorporating mental health literacy into your practice _____ weeks ago. I am emailing to follow-up on the summary I provided of our interview.

I would like your feedback on your interview summary. Do you feel that the summary represents your experiences accurately? Is there anything you would like to add or change?

Follow-Up Interview Two

Dear _____,

This is Jaime, the UBC researcher. We spoke about your experiences of incorporating mental health literacy into your practice _____ months ago. I am emailing because I would like to discuss the overall results of the study with you.

I am interested in hearing your feedback on the overall categories that were identified based on the interviews with all participants. Have you had the chance to review the summary of the categories?

If so,

- I am hoping to get feedback on the category titles and descriptions. Did they make sense to you?
- Do the categories seem to represent your experiences?
- Did any of the categories surprise you?

Appendix D

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Confidentiality Agreement

Transcriptionist

I, _____ transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentations received from Jaime Semchuk related to her research study on the researcher study titled High School Mental Health Literacy Project.

Furthermore, I agree:
1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents.
2. To not make copies of any audiotapes or computerized titles of the transcribed interviews texts, unless specifically requested to do so by the researcher, (name of researcher).
3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession.
4. To return all audiotapes and study-related materials to Jaime Semchuk in a complete and timely manner.
5. To delete all electronic files containing study-related documents from my computer hard drive and any back-up devices.

I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed) _____

Transcriber's signature _____

Date _____

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Appendix E

Summary of the Factors that Help and Hinder Educators When Successfully Incorporating Mental Health Literacy into Practice

WHAT HELPS	WHAT HINDERS
1. Building Relationships with Students	
Establishing a trusting and caring relationship with students	Lack of relationship with students
• Getting to know a student makes it possible to observe changes in a students' behaviour or signs a student may be at-risk for or struggling with a mental health problem • Relationships with students allow educators to act as a bridge between student accessing formalized mental health supports • Certain roles facilitate relationship building, such as coach or grade level coordinator	• Relationships are built over time, so it can be challenging to establish relationships when educators are new to the school • Students unlikely to open up about their mental health or accept support when there is no relationship • Challenging to act as bridge between student and mental health professional when student does not have relationship with mental health professional
2. Normalizing Talking About Mental Health & Reducing Stigma	
Ability to integrate discussions about mental health into classroom discussions, small groups, and school events	When students and educators hold stigmatizing attitudes, it creates barriers to productive discussions about mental health, as well as providing student supports
• Integrating mental health into curriculum (e.g. in English, Psychology, Physical Education lessons) • Planning school-wide mental health events (e.g. Beyond the Blues Anti-Stigma Event) • Identifying authentic moments to initiate mental health discussions with students • Creating a safe space where students feel comfortable sharing their feelings, personal experiences and connecting with educators or other students (e.g. small-group check-ins, school retreat programs, school library, or learning support centre • Increased dialogue and reduced stigma related to mental illness in society and popular culture contribute to students being more willing to talk about mental health and seek supports	• Students express stigmatizing beliefs and attitudes during school wide or classroom mental health discussions • Students unwilling to accept support or services due to self-stigma • Educator stigma around mental health presents barriers to collaboration with colleagues and results in inconsistent support for students

WHAT HELPS	WHAT HINDERS
3. Accessible Mental Health Professionals	
Mental health professionals readily available to consult with educators and provide services to students	Limited access to, and lack of communication with mental health professionals
• Mental health professionals work collaboratively with educators and are willing to consult • Helpful when mental health professionals provide short summaries with recommendations educators can implement to support a student • Ability to refer students to community and school-based mental health services	• Lack of follow-up communication from mental health professionals when students are referred by educators • Not enough mental health professionals and services integrated into school setting • Large waitlists for community mental health services
4. Mental Health Literacy Education	
Skill-building, practical education that can be utilized in a school setting	Skill-building, practical education that can be utilized in a school setting
• Helps educators know how to respond when a mental health crisis or problem arises at school • Helps educators feel more confident talking to students about mental health • Helps educators to better understand students with mental health problems • Helps to provide framework and vocabulary educators can apply	• Helps educators know how to respond when a mental health crisis or problem arises at school • Helps educators feel more confident talking to students about mental health • Helps educators to better understand students with mental health problems • Helps to provide framework and vocabulary educators can apply

WHAT HELPS	WHAT HINDERS
5. School Staff Communication and Collaboration	
Staff work as a team to support student mental health by communicating regarding supports for individual students and classroom resources	Siloed school departments and variability in perceptions of confidentiality contribute to communication barriers
• Communicating with school staff regarding the mental health of particular students and monitoring students across different environments • Collaborating with school staff to develop activities and resources for incorporating mental health into classroom discussions • When other staff share strategies they have found helpful when supporting student mental health • Collaborating to develop care plans for students	• Inconsistent communication amongst different departments in a school can lead to have staff not receiving relevant information regarding a student's mental health needs • Variability of perceptions regarding information about a student that needs to confidential
6. Time	
Time allocated for interactions with other staff and students regarding mental health	Educators have a busy schedule and many competing demands that create time constraints
• Creating time to have interactions with school staff, including administrators and other teacher regarding student mental health concerns through regular meetings • Time to have informal and one-on-one interactions with students to check-in regarding wellbeing and build relationships	• Lack of time to check in with students individually • Conflicting schedules makes it difficult for educators to find time to collaborate • Difficult to find time to incorporate mental health literacy professional development into educators' schedules
7. Administrator Support	
When school administrators buy-in to mental health literacy activities, provide formal approval, and time	No hindering incidents were identified
• Administrators support and allot time for mental health literacy professional development for school staff • Administrators provide approval for school wide events and classroom discussions focused on mental health	-

WHAT HELPS	WHAT HINDERS
8. Family Communication and Collaboration	
Families work collaboratively with school staff to support the mental health needs of individual students	Families resist collaborating with school staff and act as barriers to students receiving mental health supports
• Families share information and observations regarding a student's mental health with school staff • Families communicate about how they are supporting a student outside of school	• Families lack mental health knowledge and awareness, which creates barriers to understanding educators' mental health concerns regarding the student • Families resistant to accepting or addressing a mental health concerns and recommendations suggested by the school
9. School Values and Culture	
School culture and values can promote supportive relationships amongst students and staff	Overarching school culture and values at odds with applying mental health literacy skills
• School cultures that emphasize community • Values of compassion, caring	• Particular value systems adhered to by school make it difficult for educators to provide needed supports to students (e.g. religiously affiliated school disallows formally communicating inclusive messages to 2SLGBTQ+ students) • Unspoken culture or values can be at odds with successfully incorporating mental health literacy into practice (e.g. "masculinity culture" or "warrior culture")