Bearing That in Mind: Canadian Teachers' Experiences After Mental Health Literacy Training

Veronica Keefe

A Thesis in

the Department

of

Education

Presented in Partial Fulfillment of the

Requirements for the Degree of Master of Arts

(Education) at Concordia University

Montreal, Quebec, Canada

August 2023

CONCORDIA UNIVERSITY

School of Graduate Studies

This is to certify that the thesis

prepared by: Veronica Keefe

entitled: *Bearing That in Mind: Canadian Teachers' Experiences After Mental Health Literacy Training*

and submitted in partial fulfillment of the requirements for the degree of

Master of Arts (Education)

complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Signed by the final Examining Committee:

_____ Chair

Dr. Saul Carliner

_____Examiner

Dr. Patti Ranahan

_____Examiner

Dr. Muhammad Ayaz Naseem

_____Supervisor

Dr. Adeela Arshad-Ayaz

Approved by _____

Chair of Department or Graduate Program Director

_____2023 _____

Dean of Faculty

Abstract

Bearing That in Mind: Teachers' Experiences After Mental Health Literacy Training

Veronica Keefe

The rise in the number of mental health disorders in children and young people is a growing concern worldwide. As young people spend much of their time in a school environment, educational institutions and teachers are more frequently being asked to support students struggling with these afflictions. Programs intended to increase teachers' mental health literacy (MHL) have tried to equip them for this task. Previous research related to MHL has largely focused on quantitative means of assessing teachers' MHL in the short-term, with little qualitative focus on their long-term teaching experiences, or on the retention and application of these skills in teachers' day-to-day practice.

This thesis explores the lived experiences of seven Canadian teachers from a variety of teaching environments, and at various stages of their careers, who have taken MHL training. It investigates how their understanding of this MHL training has informed their teaching through semi-structured phone interviews that were recorded, transcribed, and analyzed using Interpretative Phenomenological Analysis (IPA). Four themes emerged from the research, including the need for 1) contextually relevant training, 2) role acceptance, 3) the feasibility of applying knowledge, and 4) self-efficacy.

The findings of this study are intended to improve future MHL programming, implementation, and ultimately early and improved mental health outcomes for students while also outlining directions for future research.

Acknowledgements

I would like to thank the seven participants who generously gave their time to share their experiences teaching in classrooms where students were experiencing mental health challenges. This research would not have been possible without their helpful insights and openness. I would also like to thank my Concordia professors and committee members, especially Dr. Patti Ranahan for sharing her wealth of knowledge, advice, and invaluable guidance. Finally, thank you to my family and especially my husband, Jordan, who has always provided unwavering encouragement and support in all my endeavours.

Table of Contents

List of Abbreviations **viii**

Chapter 1 Introduction **1**

Chapter Overview 1

Background and Context 2

Research Problem 4

Research Aim, Objectives, and Questions 5

Thesis Structure 6

Chapter 2 Literature Review **8**

Chapter Overview 8

Mental Health Measurement 8

Determinants of Mental Health 9

Mental and Physical Health Literacies 11

Mental Health in Schools 13

Andragogy: Teachers as Adult Learners 15

Experiential Learning Theory 15

PD and PLC 17

Five Critical Qualities of Effective PD 19

Teacher Wellbeing 21

Teacher Perspectives on their role in Mental Health 22

Efforts to Improve Mental Health 23

Pre-service MHL Teacher Training in Canada 24

In-Person MHL PD Workshops 25

Online Learning 26

Chapter 3 Methodology **28**

Chapter Overview 28

Researcher Reflexivity and Positionality 28

Qualitative Research Design 29

Interpretive Phenomenological Analysis (IPA) 30

Epistemological and Ontological Positions 32

Research Ethics and Recruitment 33

Participants 34

Data Collection and Analysis 35

Limitations of the Study 36

Chapter 4 Findings **38**

Chapter Overview 38

Theme 1: Contextually Relevant Training 38

Individually Relevant Training 39

Environmentally Relevant Training 40

Culturally Relevant Training 41

Theme 2: Role Acceptance 43

Teaching Philosophy 45

Personal Choice vs Mandated Attendance 46

Theme 3: Feasibility of Applying Knowledge 48

Strong Student-Teacher Relationships and Safe Spaces 48

Accessible Teaching Tools 51

A Manageable Workload 52

Theme 4: Self-Efficacy 55

Comfort Level, Support, and Closure 56

Traditional Training 57

Mentorship 59

Student Feedback 60

Chapter 5 Analysis, Recommendations, and Conclusions 63

Chapter Overview 63

Theme 1: Contextually Relevant Training 63

Theme 2: Role Acceptance 65

Theme 3: Feasibility of Applying Knowledge 68

Theme 4: Self-Efficacy 70

Recommendations for Future Research 72

Summary of Key Research Findings 73

References 77

Appendix A: Interview Questions for Study Participants 91

List of Abbreviations

CIHI	Canadian Institute for Health Information
COVID-19	Coronavirus Disease 2019
GP	General Practitioner
GTET	Go-To Educator Training
HL	Health Literacy
IB	International Baccalaureate
IPA	Interpretive Phenomenological Analysis
MHFA	Mental Health First Aid
MHL	Mental Health Literacy
MMIWG	Missing and Murdered Indigenous Women and Girls
PD	Professional Development
PLC	Professional Learning Community
TMHL	Teach Mental Health Literacy
WHMIS	Workplace Hazardous Materials Information System
WHO	World Health Organization
YMHC	Youth Mental Health Canada
YMHFA	Youth Mental Health First Aid

Chapter 1: Introduction

Chapter Overview

Health literacy (HL) is a concept Nutbeam (2000) defines as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to understand and use information in ways which promote and maintain good health" (p. 263). Strong HL increases the likelihood an individual will comply with a medical professional's advice and effectively adhere to medical instruction. The concept of HL continues to be a topic of interest in the field of public health and has since been adapted and expanded upon. It remains crucial for informed decision-making and the promotion of good health among the general population. By extension, mental health literacy (MHL), a term widely recognized as being coined by Jorm and colleagues (1997), focuses on an individual's ability to: recognize specific mental health disorders; seek information about them; understand the causes and risks associated with treatment; and to consult appropriate professional help where available.

Given the amount of time children spend in school, MHL training for teachers has been identified by academics as a promising approach to address the increase in children's mental health concerns, their associated stigmas, and the risk of these problems going unidentified and untreated (Koller & Bertel, 2006; Manion et al., 2011). As teachers are often the first point of contact for struggling youth in the school system, they are well positioned to significantly improve this situation by being among the first to recognize indicators of poor mental health and by more quickly directing them to appropriate mental health services. Research to date indicates that MHL training for teachers has proven effective in increasing teacher and student knowledge of MHL issues, decreasing stigma, and improving their ability to identify mental health disorders (Wei & Kutcher, 2014). However, much of the data collected in these studies has been

quantitative and short-term rather than qualitative and/or longer-term.

Current literature in the area also does not offer an in-depth understanding of teachers' experiences with school-based MHL training. This can best be appreciated by capturing teachers' lived experiences in their school communities more directly through interviews. This study aims to gather the unique perspectives of teachers who have taken MHL training to give this understudied group of professionals a clearer and louder voice in the debate. By hearing from those "in the trenches," this study hopes to highlight the value of teacher perspectives when developing MHL training and identify areas where it might be rendered more effective for a population with diverse needs.

This chapter will introduce the study's context, its central research problem, aim, objective, and questions, and will provide an overview of the structure of this document.

Background and Context

The World Health Organization (WHO) (2023b) estimates 20% of the world's children and adolescents will experience a mental health condition or illness during their lifetimes. These global trends are mirrored in the Canadian Institute for Health Information's (CIHI) estimate that "approximately 20% of Canadian youth are affected by a mental illness or disorder" (CIHI, 2023, para 1). The onset of most mental disorders occurs during childhood and adolescence (Kessler et al., 2007). As MHL in home and school environments is generally low, most of the growing number of children and youth struggling with mental health problems go untreated (Koller & Bertel, 2006; Manion et al., 2011). As a result, there is a growing mental health crisis in school settings that adversely affects both students and teachers.

The WHO says HL is a "stronger predictor of an individual's health status than income, employment status, education, and racial or ethnic group" (Kickbusch, 2013). HL is, therefore,

an essential competency for attaining and maintaining good health (Kutcher, Wei, Coniglio, 2016). MHL builds on the definition above to add that an individual with good MHL cultivates attitudes that help them seek and recognize appropriate assistance (Jorm et al., 1997). Improving MHL is part of a strategy to increase detection and early intervention to improve long-term mental health outcomes (Kelly et al., 2007; Leschied et al., 2018). Improving the MHL of teachers in Canadian schools has therefore become of interest to Canada's mental health researchers and an essential component in the campaign to address growing mental health concerns among children and adolescents in the country.

However, teachers have repeatedly said they feel overwhelmed, incompetent, and/or ill-prepared to support the mental health needs of their students, often because they feel they lack specific knowledge, skills, competence, and resources (Froese-Germain & Riel, 2012; Koller & Bertel, 2006; Whitely et al., 2013). To address this problem, MHL training has been implemented in several Canadian provinces as part of professional development (PD) for in-service teachers to increase educators' MHL and teach them how to deliver MHL curriculum in their classrooms. The training has included the following 3 most common programs:

- Mental Health First Aid (MHFA)
- Go-To Educator Training (GTET)
- Teach Mental Health Literacy (TMHL)

These programs have improved trained teachers' knowledge of, attitudes toward, and recognition of mental health disorders, and made them more confident in supporting students with mental health concerns (Kitchener & Jorm, 2002; Wei & Kutcher, 2014). However, this research has focused largely on quantitative data gathered in exit surveys completed in the first 48 hours after training. This has meant minimal focus on longer-term retention and application of

these skills on the job. There has also been little research into the teachers' practical application of MHL skills in the classroom during their day-to-day activities, curricula implementation, lesson plans, and interactions with students.

Research Problem

This study addresses the paucity of qualitative, long-term research about the lived experiences of teachers who have completed MHL training in order to improve the efficacy and application of that training within school contexts. Accurately portraying teachers' lived experiences to capture their complete, diverse, and undistorted personal perspectives will provide valuable insight in this area. This nuanced information is essential to researchers' ability to assess the efficacy of MHL training as a means of improving student mental health in the long term, particularly during their elementary or secondary school years.

Assessment of trained teachers' knowledge, or attitudinal shifts, in the short-term is insufficient in itself to understand how effective teachers have been in addressing students' mental health needs following their training. As a result, many scholars have highlighted the need for further research into teachers' experience of both the MHL training itself and its application in the classroom (Kutcher, Wei, & Coniglio, 2016; Nalipay et al., 2023; Ni Chorcora & Swords, 2022). Because this training has only recently been offered to teachers in Canadian provinces, and this research has yet to be conducted, it remains unclear what impact the training will have on teachers' day-to-day experiences and teaching practices.

By using interpretive phenomenological analysis (IPA) to understand the significance and efficacy of the MHL training for the teachers interviewed in this study, it was possible to capture their varied and unique perspectives with greater attention to detail and their intended meaning (Smith et al., 2009). IPA explores the *subjective* experiences and interpretations of participants

rather than imposing the researcher's own preconceived assumptions onto the data (Starks & Brown Trinidad, 2007). By authentically representing teachers' experiences in their own words, a more accurate and textured understanding of the issue emerges.

IPA is often used in research areas that have historically been marginalized or un-derrepresented in academic literature; mental health is one of those areas. By using IPA research in this context to illustrate the lived experiences of teachers in the classroom, it is possible to challenge the dominant discourses and power structures that currently inform the educational system. It is also a means of contributing to a more inclusive and diverse body of knowledge on MHL (Finlay, 2011).

Research Aim, Objectives, and Questions

The aim of this study was to capture the lived experiences of teachers who have completed MHL training to learn how this training directly affected their teaching practice. The IPA approach complemented current research in the field, which primarily relied upon quantitative data with short-term goals.

I conducted semi-structured phone interviews with seven participants, all of whom had taken MHL training and who were currently teaching (or within one year of retiring) Grades K-12 in a Canadian school. I did this to more precisely determine the effectiveness of this training in addressing the multifaceted and complex topic of youth mental health concerns in Canadian schools.

The two research questions this study asked were:

1. What are Canadian teachers' lived experiences of learning and applying MHL training in the classroom?
2. How has MHL training informed their day-to-day teaching practice?

This study contributes to the growing body of knowledge on MHL training with respect to:

- how MHL training affects teachers;
- whether or not MHL knowledge and skills are translated into teaching practice and if so in what ways; and
- identifying barriers that prevent MHL training from being broadly and effectively applied in the classroom.

Teachers in this study answered these questions after self-reflection and their responses inform the development and delivery of high-quality training to improve youth mental health through early intervention, diagnosis, and appropriate care.

Thesis Structure

Chapter 1 introduces the context of the study, its research objective and two central questions, and the value of this research to MHL training at large. Chapter 2 reviews the existing literature to identify key concepts in mental health research and strategies currently being deployed to increase MHL, and to provide current data related to MHL training for teachers. Chapter 3 justifies using IPA as the study's principle research method, outlining its design and limitations.

Chapter 4 identifies key findings from analyzing the seven participants' semi-structured, recorded phone interviews. This chapter lists four themes common to all interviews: 1) the need for contextually relevant MHL training, 2) role acceptance, 3) the feasibility of applying knowledge, and 4) self-efficacy. Participant quotes support interpretations and demonstrate the commonalities and differences in each participant's experience of MHL training.

Chapter 5 situates the findings within the current body of literature and identifies

opportunities for future research. Finally, Chapter 6 summarizes key findings related to the study's aims and questions, the value and contribution of these results to the field, recommendations for future research, and offers concluding remarks.

Chapter 2: Literature Review

Chapter Overview

This chapter provides an overview of academic literature relevant to teachers' experiences of MHL training, including how this is measured, its determinants, how it relates to health literacies more generally, and how MHL programs are delivered in Canadian schools. In this context, teachers are adult learners, and their own education constitutes experiential learning, PD, and relates to their associated learning communities. This training is therefore explored with an eye to five critical qualities of PD. This chapter also investigates teachers' own mental well-being and their personal efforts to improve their own MHL. Finally, the chapter will itemize the kinds of MHL training teachers have taken including traditional workshops, mentorships and modelling, and online learning opportunities.

Mental Health Measurement

Mental health has long been understood and defined as the absence of psychopathologies located along a continuum, a definition that is increasingly viewed as insufficient to understand the nuances of an individual's, or population's, mental health (Galderisi et al., 2015). The WHO's (2021) *Comprehensive Mental Health Action Plan 2013–2030* recognizes mental health as an essential component of overall health and, as such, defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (p. 2).

The WHO (2022) defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" (para. 1). The WHO (2022) also acknowledges that mental health "exists on a complex continuum, which is experienced differently from one person to the

next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes" (para. 2).

This definition challenges the idea that mental health is merely psychopathological and suggests instead that it is dynamic, situating it on two separate but related continua, one measuring the presence or absence of mental illness and the other measuring indicators of subjective well-being (flourishing or languishing) (Greenspoon & Saklofske, 2001; Suldo & Shaffer, 2008; Westerhof & Keyes, 2010). This dual-continuum model of mental health and illness was conceived by Keith Tudor in 1996 and appears in Figure 1 below. In the interim 27 years, it has been a useful tool for researchers assessing mental health and its broader contribution to individual and population health.

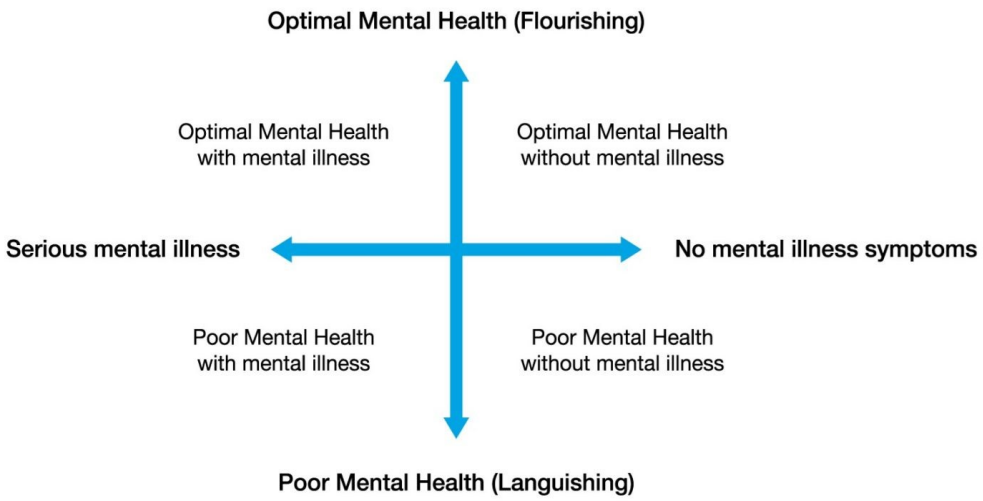


Figure 1 Dual-Continuum Model of Mental Health and Mental Illness (Opentext BC, Appendix B)

Determinants of Mental Health

An individual's mental health is affected by a range of social, economic, and physical factors (Allen et al., 2014). These factors are known as determinants of mental health. They can

include poverty, (un)employment, working and living conditions, access to affordable housing, the presence and nature of a crime, access to the natural environment, and education (Shah et al., 2021). Exposure to these negative determinants often results in poor physical and mental health and inequalities that exacerbate these issues (Allen et al., 2014; Whitehead & Dahlgren, 2006). These determinants underscore the need for ongoing MHL training as part of a national strategy to promote, prevent, and treat mental health issues.

Shah et al. (2021) undertook a literature review from 2000-2019 to understand "what national or population-level interventions or policies that address the social determinants of mental health have evidence of an effect on mental health and well-being" (p. 2). They concluded "only four reviews [were] of high or moderate quality. Common weaknesses included a lack of consideration of quality or bias, an unstructured discussion of these issues, and a range of different structured tools to appraise retrieved studies" (Shah et al., 2021, p. 3). However, these findings did conclude that access to welfare benefits, unemployment insurance, paid parental leave, gender equality, and less restrictive immigration policies improved mental health outcomes (Shah et al., 2021).

Shah et al. (2021) found that "despite using several search terms, we found very little evidence on social, cultural and community-based interventions, delivered at the population level and their impact on mental health apart from those linked to suicide prevention" (p. 7). Shah et al. (2021) went on to say that, "It is possible that these interventions, whilst widely used, are under-evaluated or not evaluated specifically for mental health outcomes at a population level" (p. 7). This statement underscores the need for the research conducted in my own study.

Mental and Physical Health Literacies

HL requires access to accurate and easily understandable health information to make informed decisions (Nutbeam, 2000). As noted in Chapter 1, Nutbeam (2000) defined HL as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to understand and use information in ways which promote and maintain good health" (p. 263). Nutbeam (2000) proposed a three-tier model that included functional health literacy, interactive health literacy and critical health literacy. Functional HL refers to "sufficient basic skills in reading and writing to be able to function effectively in everyday situations" (Nutbeam, 2000, p. 263). Interactive HL refers to "advanced cognitive and literacy skills which, together with social skills, can be used to actively participate in everyday activities, to extract information and derive meaning from different forms of communication, and to apply new information to changing circumstances" (Nutbeam, 2000, pp. 263-264). Critical HL refers to "cognitive skills which, together with social skills, can be applied to critically analyze information, and to use this information to exert greater control over life events and situations" (Nutbeam, 2000, p. 264).

Nutbeam's (2000) definition and model of HL described above has been expanded, reimagined, and further clarified by researchers in the fields of public health and mental health care in the two decades since. Many initiatives to improve individual HL have been proposed given that good HL often indicates better health outcomes for the patient generally and more efficient use of healthcare services overall.

We now understand that HL is setting- and context-dependent; that is, a well-educated individual may exhibit poor MHL despite good general literacy (Andrus & Roth, 2002). For example, it is possible for an individual to understand instructions and materials at home or work, but find it difficult to interpret unfamiliar medical vocabulary or to follow medical advice

in these locales. People with low health literacy are at greater risk of misusing medication, misunderstanding medical diagnoses, and poorly interpreting and following advice from medical professionals (Andrus & Roth, 2002).

Low HL is common, with certain populations being more vulnerable than others. Poor HL is not only linked to poorer overall health, but also to increased hospitalizations, poorer self-reported health, and increased healthcare costs (Andrus & Roth, 2002; Kickbusch et al., 2013). Knowing this, HL strategies are now putting more emphasis on personal empowerment and informed choice (Kutcher, Wei, Coniglio, 2016). HL has moved beyond singular focus on behaviour change to a more comprehensive understanding of environmental, political, and social determinants of health (WHO, 2023a). This acknowledgment and commitment has contributed to advancements in research, health policy, and education, and interventions aimed at improving individual and population health and equality. Consequently, new policy and educational methods and materials, and increased production of visual information, has increased patient understanding (Andrus & Roth, 2002; Kutcher, Wei, Hashish, 2016). Overall, improved HL has led to "personal and social benefit ... by enabling effective community action, and by contributing to the development of social capital" (WHO, 2023a).

MHL is a corollary to HL and was established to raise awareness, increase knowledge, and reduce the stigma surrounding mental health (Jorm et al., 2006). Since Jorm's definition received wide acceptance, MHL has expanded to include:

- the knowledge and competencies that promote positive mental health;
- identification of the signs and symptoms of mental health disorders;
- understanding the risks related to one's own poor mental health and how to reduce them;

- and knowledge of effective treatment and access to support and resources

(Jorm, 2000; Kutcher, Wei, Costa et al., 2016; Kutcher & Wei, 2020).

Framing MHL this way empowers individuals to engage in proactive and help-seeking self-care (Woloshyn & Savage, 2020; Leschied et al., 2018).

Mental Health in Schools

Youth Mental Health Canada (YMHC) reports that young people aged 15 to 24 are more likely to experience mental illness than any other age group, with 70% of mental health problems having their onset during childhood or adolescence (YMHC, 2023; Leschied et al., 2018; Kutcher & Wei, 2020). While mental health conditions such as depression, anxiety, and behavioral disorders account for the majority of illnesses and disabilities among the adolescent population, many mental health disorders remain underdiagnosed and undertreated. Improving MHL has consequently been identified as a strategy to increase detection and early intervention and improve long-term mental health outcomes for Canadian adolescents (Kelly et al., 2007; Leschied et al., 2018). Canadian teachers and effective MHL training are therefore essential to the success of this strategy.

Given that mental health disorders are on the rise, and that most mental disorders begin in adolescence, it is more critical than ever that MHL resources are promoted within the K-12 system, so teachers and specialists can intervene more quickly (Kessler et al., 2005; Wei et al., 2011; Waddell & Shepherd, 2002; Leschied et al., 2018). As adolescents spend up to 6 hours a day in school, their educators are well-positioned to provide mental health support during this time, and be a frontline offensive for early detection of mental health needs (Leschied et al., 2018; Kutcher & Wei, 2020).

Though three key MHL courses (listed on page 3) have been implemented in the education system, Kutcher, Wei, and Costa et al. (2016) point out that "very few, if any, interventions have addressed full components of MHL" (p. 569). Furthermore, these programs have demonstrated only "small to moderate effects improving student wellbeing" (Kutcher, Wei & Costa et al., 2016, p. 568).

Kutcher, Wei, and Hashish (2016) point out that the implementation of these MHL programs takes one of two approaches. The first approach focuses mainly on expensive external resources (i.e., health professional-led programs originating outside the school) in addition to academic curriculum designed for MHL training. This kind of training is usually not delivered by the school's teachers or expert staff, but rather looks outside the culture of the school for experts in the area. It is also not a regular part of daily activities as it parachutes in experts for a one-time event and therefore is seen as finite rather than an ongoing discussion. Interventions consequently rely heavily on teachers having taken and applied this kind of brief and external MHL training faithfully rather thsupporting teachers with an ongoing and evolving mental health strategy originating within the school itself (Kutcher, Wei, Hashish, 2016).

This approach also does not typically strengthen existing school resources and connections long term because of its quick delivery and external origins. External MHL resources also often focus primarily on one target group, i.e., teachers of a certain grade or in a certain role, or students of a particular age or presumed need, rather than offering comprehensive skills relevant to the broader school community. When budgets are tight, these PD initiatives can be cut to save money, so they aren't a reliable and sustained service regularly provided to the school body. If MHL is viewed as an add-on or bonus rather than a fully integrated and essential

part of the curricula for teacher preparedness, it is too easily sacrificed for higher priorities (Kutcher, Wei, Hashish, 2016).

The second approach to MHL programs focuses on long-term sustainability by utilizing embedded human and material resources in the form of specialized staff and MHL curricula, typical school structures and physical spaces, and accessible community resources to lower costs (Kutcher, Wei, Hashish, 2016). Many of these initiatives are teacher-led, integrated into the academic curriculum, and focus on eliminating stigma and increasing knowledge and help-seeking behaviour for students. This reduces long-term costs, increases equitable access to health services, and protects against the common shortcomings of externally led instruction.

The second approach is reflected in the "school-based pathway to care" model that uses "the existing social ecology" within schools (Kutcher, 2020, p.1). Canadian secondary schools have adopted this model to highlight the fundamental role of "mental health literacy, gatekeeper training, and education/health system integration in improving adolescent mental health and enhancing learning environments and academic outcomes" (Wei et al., 2011, p. 213). Research has shown that embedded programs must be evidence-based, easily accessible, and developmentally appropriate for students, as well as economical and applied by trained teachers (Kutcher &Wei, 2020).

Andragogy: Teachers as Adult Learners

School teachers, administrators, and parents look to expert teachers to facilitate their own learning. Hord and Hirsh (2008) assert that "teaching quality is improved through continuous professional learning" (p. 40). This means teachers are positioned as adult learners with respect to MHL training, making it important to take into account adult learning theories and practices in this study.

Andragogy, or adult learning theory, was developed by Malcolm Knowles who recognized that adult learning and interests differ from children's. Between 1980-1988, Knowles conducted research that concluded that as adults mature, they become more self-directed and increasingly draw on their own experiences to learn. Their readiness to learn is also closely associated with their social role, and they are inclined to immediately apply new knowledge in these roles. Adults also want to know *why* they are learning something (Merriam & Bierema, 2014) rather than taking its utility for granted.

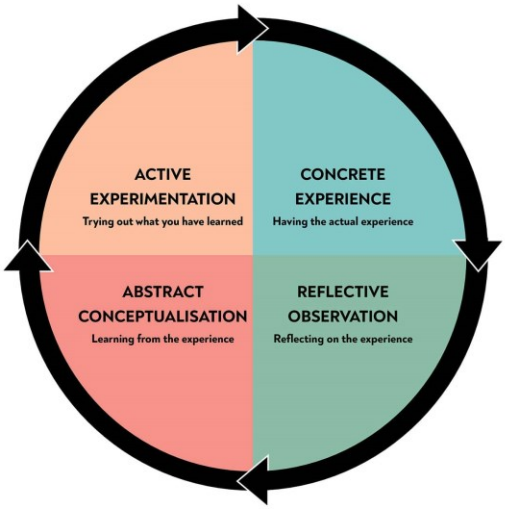
According to Knowles, acknowledging these principles of andragogy should result in the design of adult educational programs that differ significantly from those for youth that rely, by default, more on teaching and curriculum (1988). Beavers (2009) echoes Knowles in the call for better practices specific to mature students when she says, "By being aware of these attributes of the adult learner, it is easier to see how traditional methods of teaching children or adolescents might not be best suited for a group of teachers" (p. 26). This underscores the need to carefully tailor teacher MHL programs to teachers' questions, needs, and gifts, and their tendency to draw upon lived experience while learning.

Experiential Learning Theory

Experiential learning theory is a widely accepted adult learning theory. Since its conception, it has been adapted by theorists such as Dewey, Mezirow, Rogers, and Freire to include the element of critical reflection (Clarke et al., 2001). Kolb (2014) offers a newer experiential learning cycle model (Figure 2) to assert that learning is cyclical, continuously recurring in active and passive, concrete and abstract, processes in which "the learner is directly in touch with the realities being studied" (p. 5). Nearly 45 years earlier, Wight (1970) described

experiential learning in similar terms, asserting that learning "begins with the experience, followed by reflection, discussion, analysis, and evaluation of the experience" (p. 22).

Figure 2: Kolb's Experiential Learning Cycle Model (Main, 2023)



Wight (1970) argued, "We seldom learn from experience unless we assess the experience, assigning our meaning in terms of our own goals, aims, ambitions, and expectations" (p. 22). Learning through lived experiences requires careful and critical reflection on those experiences to arrive at a particular outcome.

PD and PLC

PD can be defined as "the process whereby an individual acquires or enhances the skills, knowledge, and/or attitudes for improved practice" beyond their initial training, qualification, and induction (Mitchell, 2013, p. 390). PD for educators often introduces teachers to the most recent research in their field, best-practices in pedagogy and classroom management, and advancements in educational technology to meet their students' diverse and ever-changing needs. The principles of adult learning theory are foundational to the delivery of effective PD (Zepeda et al., 2014).

According to Hord (2009), an individual's own professional learning community (PLC) is the most supportive of their career goals. Bolam et al. (2005) define an educator's PLC as "an inclusive group of people, motivated by a shared learning vision, who support and work with each other, finding ways, inside and outside their immediate community, to enquire on their practice and together learn new and better approaches" (p.1). A PLC is a group of educators (and/or invested affiliates) with a shared vision of educational excellence who seek expertise, critically reflect, collaborate, provide feedback, and support each other to enhance the student experience. PD that doesn't draw consistently on a teacher's PLC misses an educational opportunity. Lumpe (2007) suggests one-shot workshops for teachers' PD are rarely effective: "It is common knowledge that teachers seldom apply what they learn during workshops in their classrooms. In spite of this fact, school districts and grant agencies pour millions of dollars into …teacher professional development programs that are primarily workshop based" (p.125).

Marzano and colleagues (2006) want to improve upon this by translating academic research into practice and have identified several factors that increase the likelihood of teachers applying their PD knowledge and skills in the classroom over the long term. These factors include: "effective feedback, cooperation, collegiality, practice-oriented staff development, [and] a culture of shared beliefs and relationships" (Marzano, 2003; Lumpe, 2007). These qualities reflect the culture of PLC and should characterize PD workshops (Lumpe, 2007).

The seven participants in this study commented directly and indirectly in the following chapter on the six factors itemized in the quote above. In particular, they noted the benefit of receiving feedback from students and the need to feel supported by like-minded peers and more expert staff on school grounds who understood their teaching context (individual grade/students, racial and social environment, class culture). They also advocated for training from mentors and

visits to mental health facilities for experiential learning to offer a more practice-oriented learning opportunity.

In addition, participants noted that not all teachers believe that they will be effective in the classroom despite having taken MHL training. This is largely a function of teaching philosophies and where they are in their career, but also depended on when and how MHL training was introduced. They also noted that strong relationships with both students and mentors made applying MHL training more likely. In this respect, the four themes identified—contextually relevant training, role acceptance, the feasibility of applying knowledge, and self-efficacy—identified in the participants' responses parallel the six factors identified by Marzano and Lumpe above.

Five Critical Qualities of Effective PD

Fogarty and Pete (2004) suggest PD should be:

(1) interactive—training invites, involves, and engages participants;

(2) integrated—training format varies (online, print, workshop, mentorships, site visits);

(3) sustained—training is implemented over time;

(4) collegial—training builds and supports a community of learners; and

(5) job-embedded—training occurs and/or continues at the work site. (p. 63)

As per Knowles (1988) and Lawler and King (2000), interactive PD adopts a learner-centered approach that considers learners' experiences, prior knowledge, needs, and interests to maximize their engagement. A variety of learning materials and strategies should also be integrated into the PD workshop to be most effective. State et al. (2018) support multi-modal learning and refer to Fogarty and Pete's five core features listed above when they say: "effective

PD almost always necessitates more than a single activity or encompasses all of the … core features necessary for skill acquisition and translation of skills into practice" (p.109).

PD is sustained if learning continues over time so "the continuous nature of effective PD" is essential to this goal (Zepeda et al., 2014, p. 298). State et al. (2018) also suggest PD is most effective if it is "intensive and ongoing" (p. 109). In contrast, short-term workshops "do not provide the consistent, ongoing support teachers need to be able to translate theory into practice" (State et al., 2018, p.109) and are seen by many teachers and researchers as insufficient to implement learned knowledge or skills.

Teachers require collegial engagement following PD that is "paired with follow-up and other methods of support" in a peer environment to sustain learning (State et al., 2018, p. 109). If teachers and their colleagues establish a PLC after PD, this is even more likely: "Participation in PLCs have been shown to increase collaboration among educators, change teacher practice, improve teacher knowledge and efficacy, and improve student achievement" (State et al., 2018, p. 110).

Workplace learning ideally should be ongoing and occur before, during, and after the official PD workshop. Adult education's experiential learning approach, and the collegial support that a PLC can provide, both make it more likely that job-embedded learning occurs cyclically, as in Kolb's (2014) experiential learning cycle. An individual may have an experience in the workplace, acquire the knowledge and skills during PD to negotiate this experience, and apply that knowledge and skills when the experience reoccurs. This regular application and revisiting of what has been learned in the PD session is an invaluable part of the iterative experiential learning process.

Teacher Wellbeing

Teacher wellbeing is of vital importance to a healthy educational system and to that system supporting students with mental health concerns. However, teacher attrition due to burnout and stress is a frequent reality. Kyriacou (2001) suggests teachers are stressed when "unpleasant, negative emotions, such as anger, anxiety, tension, frustration, or depression, [arise] resulting from some aspect of their work as a teacher" (p. 28). Studies show that teachers experience a disproportionate level of professional stress and anxiety, making them more susceptible to absenteeism, burnout, and attrition (Brasfield et al., 2019; Froese-Germain, 2014; Kotowski et al., 2022). This causes 40-50% of teachers to leave the profession in their first five years (Kotowski et al., 2022; Leschied et al., 2018). A 2014 study surveyed more than 8,000 Canadian teachers to understand work-related stress and work/life balance and concluded 79% felt their stress levels had increased over the last five years, with 85% reporting that stress was affecting their ability to teach (Froese-Germain, 2014).

Recent research on the impact of COVID-19 on teacher wellbeing indicates higher levels of stress, anxiety, and depression relative to pre-pandemic rates (Alves et al., 2021). Gadermann et al. (2021) also conducted a study investigating the impact of the COVID-19 pandemic on teacher wellbeing in British Columbia in which teachers reported their workload increased and that their mental health deteriorated. As a result, teacher turnover and attrition rates more than doubled during the pandemic (Kotowski et al., 2022; Pressley, 2021).

Teachers who are stressed and exhibit poor mental health themselves are not well-positioned to implement mental health programs or support their students with mental health concerns (Leschied et al., 2018). Rodger et al. (2014) proposed that the focus on MHL in schools

be expanded beyond the students to include teacher wellbeing as well, given these realities (Leschied et al., 2018; Rodger et al., 2014).

Teachers' Perspectives on their Role in Mental Health

According to several studies, teachers perceive concern for student mental health to be an aspect of their professional role (Beames et al., 2020; Froese-Germain & Riel, 2012; Graham et al., 2011; Phillippo & Kelly, 2014; Shelemy et al., 2019). However, not all teachers agree on what this role entails (Dimitropoulos et al., 2021; Weston et al., 2018). A qualitative study by Dimitropoulos et al. (2021) concluded school staff perceived their primary role in promoting adolescent mental health to be establishing and maintaining strong relationships with students, their caregivers, and their peers. This included providing helpful communication, safe spaces, and access to mental health support. Greater clarity regarding teachers' roles is essential, given that role ambiguity and role conflict lead to negative MHL outcomes, increased anxiety, burnout, and job dissatisfaction for teachers (Weston et al., 2018).

Though teachers are actively navigating student mental health challenges, they report feeling they lack the knowledge, skills, and confidence to be truly competent in this role (Andrews et al., 2014; Dimitropoulos et al., 2021; Reinke et al., 2011). Andrews et al. (2014) found that while over 97% of teachers agreed they *should* be knowledgeable about navigating student mental health concerns, only 26.6 % felt they currently possessed the necessary knowledge and skills to do so. The gap between the demands of teachers' roles, and the knowledge and skills needed to fulfill those roles, indicates the need for additional MHL training.

Efforts to Improve Mental Health

The WHO recognizes good mental health and wellbeing as critical for individuals to lead fulfilling, productive lives in their communities and demonstrate resilience in times of adversity (WHO, 2021). The WHO's (2021) *Comprehensive Mental Health Action Plan 2013-2030* is therefore designed to create "a world in which mental health is valued, promoted, and protected, mental disorders are prevented, and persons affected by these disorders are able to exercise the full range of human rights and to access high-quality, culturally-appropriate health and social care in a timely way" (p. 4). The action plan proposes a multi-sectoral approach to mental health promotion that involves partnerships and coordinated action between health care, education, employment, judicial, and other sectors (WHO, 2021).

In Canada, the education system is also part of a multisectoral partnership to address increasing child and adolescent mental health needs. This has been achieved through:

- an increased presence of mental health professionals in schools;
- development of online mental health hubs with self-guided modules and resources;
- mental health awareness campaigns; and
- mental health student and teacher programming.

These combined efforts in a four-pronged approach makes clear the pivotal role teachers play in each area through their leadership, referrals, curricula, resource delivery, publicity, and activities related to improving the MHL of students and peers. This will, in turn, improve the number of students identified with needs and given the appropriate mental health supports.

Pre-service MHL Teacher Training in Canada

Wei and Kutcher (2014) identify schools as "important locations in which identification of youth with mental health disorders, referral to mental health care, and support for those receiving mental health care can be provided *if* educators are appropriately trained" (p. 219). Kutcher et al. (2013) emphasize "it is essential that attention be paid to the mental health literacy of educators who will be applying the curriculum in their classes" (p. 84). Unfortunately, teachers have repeatedly said, as noted above, that they feel overwhelmed, incompetent, and/or ill-prepared to address the mental health needs of their students (Froese-Germain & Riel, 2012; Koller & Bertel, 2006; Whitely et al., 2013).

To address this problem, MHL programming for pre-service and in-service teachers has been implemented in different settings, using a variety of learning styles and formats. Some of these programs are being developed *specifically for teachers*. The three most common programs, noted in Chapter 1, are:

- Mental Health First Aid (MHFA)
- Go-To Educator Training (GTET)
- Teach Mental Health Literacy (TMHL)

These are designed to both increase teachers' MHL and teach them how to deliver a MHL curriculum in their own classrooms. However, these are recent elements of teacher PD, so it is unclear what impact they will have on teachers' day-to-day experiences and teaching practices.

As teaching and navigating mental health in schools become increasingly intertwined, pre-service teacher training plays a larger role in preparing teachers for this task (Leschied et al., 2018). However, despite agreement that MHL training for pre-service teachers is beneficial,

"there are seemingly few systematic Canadian programs that do so" (Woloshyn & Savage, 2020). Rodger et al. (2014) conducted a survey of Canadian post-secondary teacher education programs and found very few offered MHL courses (Gilham et al., 2021; Rodger et al., 2014; Woloshyn & Savage, 2020).

Woloshyn and Savage (2020) responded to the call for additional research into the efficacy of MHL training for teachers with a qualitative study of their own. This explored teacher candidates' mental health narratives and their evolving understanding of wellness after having taken an elective, for-credit MHL course. The study found that "participants reported gaining more complete and nuanced understanding of mental health and wellbeing as a function of completing the course" (Woloshyn & Savage, 2020, p. 925). Participants also reported increased awareness of mental health and illness generally, learned effective coping strategies, and were more aware of self-monitoring and self-regulation (Woloshyn & Savage, 2020).

In-person MHL PD Workshops

As these studies offer evidence to suggest the positive impact of MHL PD, three of these in-person opportunities have been rolled out in Canada as noted above. MHFA is a 12-hour course launched in 2001 designed to teach the public how to support someone who might be developing a mental health problem or experiencing a mental health-related crisis and help them access appropriate healthcare support (Kelly et al., 2011). The YMHFA course was launched in 2007 and had the same goals, but was designed to educate adults about how to support adolescents. This content is adolescent focused, but it is not specific to the school setting.

GTET is designed to increase a teacher's capacity to help students with mental health needs. This program specifically targets teachers to whom students naturally gravitate for support and with whom they have a close and trusting relationship (Wei et al., 2021). These in-

person PD opportunities are delivered by accredited personnel over a series of sessions and/or days and have delivered the positive learning outcomes outlined below.

Online Learning

While in-person PD is an option for some, some teachers have limited access to these courses due to geographical, financial, and/or other obstacles, so various online sites have emerged to extend this reach (Wei et al., 2020). Both https://teachmentalhealth.org and https://mentalhealthliteracy.org/ are hubs offering information, resources, and online learning modules for youth, parents, health professionals, and teachers. They provide free courses such as Learn Mental Health Literacy, a self-guided series of modules completed at the individual's convenience. The Teach Mental Health Literacy (https://www.teachmentalhealth.org/) course is directed at in-service teachers who want to increase their MHL and provides a classroom-ready curriculum appropriate for students ages 12 to 19. These courses are appropriate for both undergraduate and postgraduate teachers (Kutcher & Wei, 2020). The MH LIT Mental Health in Action course is a 6-hour, 6-module, self-paced online course aimed at building educators' "basic knowledge and information related to mental health, strategies to enhance student mental health, and everyday practices for use in the classroom" (School Mental Health Ontario, 2023b, para. 2).

The MHL training programs noted above, both in-person and online, have been rolled out across many Canadian provinces. Some preliminary data about the short-term impact of these programs is either available or research evaluating these efforts is underway. In a study examining the impact of GTET across 6 Canadian provinces, Wei et al. (2021) found it significantly improved teacher MHL knowledge, but they suggested further research be conducted to see if positive results were maintained over the long-term.

In a study comparing the impact of online MHL PD for teachers versus courses taken in-person Wei et al. (2020) found that both indicated significant and sustained improvements in teacher knowledge and attitudes and led to more student help-seeking behaviour. This suggested that both forms of PD had a positive impact on teacher MHL compared to the control group who had no exposure to PD. Several studies evaluating the effectiveness of MHL programs have seen an increase in teachers' confidence and ability to recognize mental health disorders, as has been noted (Jorm et al., 2006; Wei & Kutcher, 2014). However, a focus on declared knowledge or attitudinal shifts in the short term is insufficient for a more nuanced understanding of the efficacy of the training and confirms the need for the present study.

The literature explored above demonstrates the evolving conceptualization of mental health as it takes into account determinants of health and health literacies and the role they play in the promotion, prevention, and treatment of mental disorders. The literature confirms the prevalence of youth mental disorders, discusses the role of schools and teachers in addressing these, and identifies MHL teacher training as a promising means of doing so. This qualitative study now builds on this knowledge to analyze 7 teachers' experiences with MHL training, as articulated in answers to interview questions. It also examines how this training affected their day-to-day teaching practice.

Chapter 3: Methodology

Chapter Overview

This chapter offers a rationale for the methodological approach chosen to address the following research questions:

1. What are Canadian teachers' lived experiences of learning and applying MHL training in the classroom?
2. How has MHL training informed their day-to-day teaching practice?

It also discusses researcher reflexivity and positionality, qualitative research design, IPA, and the epistemological and ontological position of the researcher. The chapter concludes by outlining the study's research procedures and the limitations of the study.

Researcher Reflexivity and Positionality

According to Olmos-Vega et al. (2023), the researcher's involvement in qualitative research needs to be both examined and interpreted. Furthermore, "personal reflexivity requires researchers to reflect on and clarify their expectations, assumptions, and conscious and unconscious reactions to contexts, participants, and data" (Olmos-Vega et al., 2023, p. 244).

I underwent the reflexive process described by Olmos-Vega et al. (2023), and acknowledge my position as both the primary investigator of this study and a novice researcher. This study was conducted in partial fulfillment of my Masters in Educational Studies at Concordia University. In addition to being a student researcher, I am also a practicing middle school teacher. I have taken several MHL courses and have taught students with mental health concerns in public, private, and clinical educational settings. Like those who I have interviewed for this study, I am "in the trenches" with students suffering mental health disorders.

Many of my research ideas stem from my personal experiences and observations as a

teacher and as a colleague to teachers who have also taken MHL training. I frequently conduct self-guided searches for solutions to student mental health concerns and try to connect MHL training taken as PD to these situations. Consistently applying this newfound knowledge on top of my pre-existing teaching responsibilities is challenging. For these reasons, I was keen to understand how other teachers assessed their MHL training and how they implemented it in their day-to-day practice.

I believe teachers occupy an important role in society, one that comes with a responsibility to support young people in many aspects of their lives. This role is often misunderstood and undervalued. I also value data, best-practices, and science-based evidence when investigating phenomena that intrigues me. The volume of literature about MHL in the school system was unfortunately disappointing and offered very little information from the teacher perspective. This realization contributed to the motivation for and focus of this study.

Olmos-Vega et al. (2023) suggest "personal reflexivity ought to occur continuously across the duration of the investigation and should be interwoven with all aspects of the project—i.e., from the project's conception to research outputs" (p. 248). As a continuation of the reflexive process, I focused on the data and honoured participant voices by engaging in the hermeneutic circle, revisiting my epistemological and ontological position, and member checking the findings. These practices are discussed in detail below.

Qualitative Research Design

According to Creswell (2018), qualitative research design investigates complex phenomena to provide an in-depth understanding of a research problem, its context, quantitative data, and participants' perspectives (Creswell, 2018; Denzin & Lincoln, 2018). Qualitative research uses various kinds of data collection, from interviews and observations to document

analysis, to collect data from study participants.

Denzin and Lincoln (2018) state that qualitative research is inductive in nature, generating new theories from the researcher's observations and interpretations of the data. In qualitative research, “The gendered, multiculturally situated researcher approaches the world with a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology), which are then examined (methodology, analysis) in specific ways” (Denzin & Lincoln, 2018, p. 52). Each researcher interprets, analyzes, and writes from a distinct perspective, so it is critical they actively engage in an ongoing dialogue with the data in an iterative and dynamic cyclical process known as the hermeneutic circle (Peat et al., 2019).

The hermeneutic circle is a central concept in qualitative research in which the researcher and data continuously inform and shape each other (Braun & Clarke, 2019). It highlights the need to frequently return to earlier interpretations given new insights and perspectives that arise from ongoing analysis (Creswell & Poth, 2018). In this way, qualitative researchers ensure their understanding of the data is based on challenging and thoughtful analysis, and that their results are finely detailed and situated relative to overarching theoretical and empirical frameworks.

Interpretive Phenomenological Analysis (IPA)

As Reid et al. (2005) note, IPA uses inductive research to investigate the life experiences of a small number of participants in a study. The research is designed to assess the importance and implications of a specific occurrence from the point of view of those who have lived through it (Smith et al., 2009). Participants share their narratives and speak candidly while commenting on what these experiences have meant to them in hindsight. This allows them to develop their thoughts, and verbalize their critique, without time pressures to be overly concise (Smith et al., 2009).

These experiences are, by definition, subjective. Their own interpretations are an important contrast to the researcher's notions of what the data means (Starks & Brown Trinidad, 2007). To reflect the participants' experiences more sincerely and literally, the researcher records the commentary word for word and with careful attention to accurate word choice, punctuation, gesture, and idiom. This offers a very nuanced view of the topic being interrogated.

As noted earlier, IPA is frequently used for subject areas that have systematically been overlooked or sidelined by history or academia. Mental health and its adjacent social justice concerns such a subject. In IPA, the voices and experiences of participants are elevated in the research process to challenge both the literature and institutional influence and to offer a more fulsome picture of the issue at hand (Finlay, 2011).

This study uses IPA to explore teachers' personal accounts of taking MHL training and its efficacy with respect to addressing student mental health concerns. Their unique perspectives crucially supplement school-based MHL research to date. Findings here are intended to inform MHL curriculum designers and school administrators so MHL teacher training translates to better student mental healthcare. The study attempts to understand, support, and value teachers on the frontlines who daily deal with student mental health concerns.

Much of the research on MHL training has focused on program development, implementation, and successes and failures and has used quantitative analysis. Few have asked teachers who respond to students' mental health needs about their experience. Research to date has also focused on increasing teacher knowledge, decreasing stigmas related to mental health, and improving teacher attitudes toward mental health. The hope is that improving teacher MHL will improve student MHL. Though research shows MHL training yields short-term gains in teachers' MHL knowledge, skills, and attitudes, very little research explores teachers' lived

experiences in any depth or over the long term (Wei & Kutcher, 2014).

Epistemological and Ontological Positions

The participants and I are influenced by our individual experiences, including our living spaces, age, bodies, and human relations (Tuohy et al., 2013). Consequently, I took care when recruiting and interacting with participants in interviews to offer "a transparent evidence trail that maintains a clear connection between the data and interpretation" (Peat et al., 2019, p. 9). Peat et al. (2019) recommend "active engagement with the hermeneutic circle, ensuring both a substantial voice is given to the experiences of the participants" and to interpretations of their narratives by the researcher (p. 9).

To ensure interpretations don't oversimplify, misconstrue, or introduce intent where none was present, I rigorously reviewed participants' original comments in verbatim transcriptions and clarified meaning by requesting backstories and examples. By returning to recordings and logically coding transcriptions of spoken text to key ideas and themes, evidence drove conclusions. Balancing evidence and interpretations required returning to both frequently to ensure they were mutually supportive. I took care not to overlook or dismiss anything that contradicted a point for the sake of making a more seamless argument.

It is best practice for the researcher to verify interpretations of participant experiences by checking with all members. According to Birt et al. (2016), "The trustworthiness of results is the bedrock of high-quality qualitative research" (p. 1802). I checked synthesized and analyzed data with members by distributing a summary and inviting participants to provide feedback. When participants were recruited, they were asked on their consent form if they were willing to receive and/or comment on the data analysis. They received the data summary (translated for the layperson) by email. I encouraged participants to keep a hard copy for their records and to

respond directly to me to affirm the analysis matched their experience. I also asked them to add comments that might enrich my analysis. I then cross-referenced the new data with existing codes/themes and integrated any new findings. I triangulated all analyzed data from participant interviews and member-checked data with literature in the field. This is included in Chapter 5.

Teachers provide mental health support to students by operationalizing information learned in school-based MHL training programs. By giving them space to share their experiences, we can capture unique perspectives about this programming and identify alternative pathways for future inquiry.

Research Ethics and Recruitment

This research was conducted following ethical approval by Concordia University. The University Human Research Ethics Committee members examined the application for this study and certified interaction with human subjects was ethically acceptable. Participation in the study was open to Canadian academic/classroom, physical health education, and/or specialist teachers of all genders, ages, and levels of teaching experience. All schools/academic institutions where participants worked were located in Canada. As is typical in IPA, I focused on a small and homogenous group of teachers who identified that they:

a) had completed MHL training;

b) were currently teaching in a K-12 school setting or retired from teaching within one year of the interview; and

c) had the resources to participate in an audio-recorded interview (i.e., phone, computer, internet).

One participant was excluded from the study after realizing they had not taught in a K-12 Canadian school in the last year. Two participants who showed initial interest did not return the

consent form after recruitment. I knew, through professional teaching relationships, 1-2 teachers who had taken MHL training and sent them an invitation to participate in the study. I sent them a recruitment email that briefly described the project and invited them to recruit other qualifying teachers. Those interested were encouraged to contact me directly and confidentially by email if they wished to volunteer or learn more about the study.

Once this initial contact was made, I then obtained consent and demographic information from each participant via forms that were signed and emailed back to me. Using Dr. Ranahan's research relationship with the creators of http://teenmentalhealth.org, who offer the GTET program, I met with these key researchers in the MHL field who provided the names of additional recruiters for the study.

Participants

Seven participants took part in the study. This number is consistent with the 5 to 25 participants typical of IPA studies (Creswell, 2013). A brief description of each participant appears below, including their assigned participant number used to protect their identity.

Participant 1 self-identified as a current elementary school teacher working in a private school. They took the MHFA course in addition to several in-school mental health PD courses.

Participant 2 self-identified as a specialist teacher working in a low-needs private school and had substantial collegial support through immediate access to school counselors. Their MHL training was a single-session in-school mental health PD course that was offered annually.

Participant 3 self-identified as an elementary school teacher working with students with mental health and behavioural disorders in a specialized facility. Their MHL training took place weekly via in-school mental health PD courses.

Participant 4 was a high school teacher who had retired less than one year before the interview.

They had taken a single session of an in-school mental health PD course offered annually.

Participant 5 was an elementary school teacher who had retired less than a year before the interview. Their MHL training was a single session of an in-school mental health PD course offered annually.

Participant 6 was a teacher from a marginalized population and an elementary school teacher working with students with mental health and behavioural disorders in a specialized facility. They took weekly in-school mental health PD courses.

Participant 7 was a high school teacher who had been mentored in-person by a mental health professional and former teacher.

Data Collection and Analysis

Participants completed one semi-structured phone interview lasting 35-75 minutes using prepared questions (Appendix A) as prompts to help them provide a rich account of their experience. Interviews focused on their perspectives, and lived experiences, of MHL training and its impact on their teaching practice.

All participant interviews were conducted remotely via telephone due to travel and personal contact restrictions issued by public health authorities during the COVID-19 pandemic. Interviews were audio recorded and transcribed by the researcher. Data was stored on a personal, password-protected computer and all names and identifying characteristics were redacted after transcription.

Participants who identified on their consent forms that they wished to receive a summary of initial findings were provided with a lay summary. As part of the member-checking process, participants were invited to identify any omissions, offer additional or different interpretations, or correct errors to improve the trustworthiness and accuracy of the data.

The data analysis procedure was consistent with recommendations from Peat et al. (2019). In the first phase, I listened to the audio-recorded interviews multiple times, transcribing each interview verbatim to ensure the accuracy and authenticity of the data. I also read and re-read the transcripts. I then noted my initial thoughts and assigned codes to various sections in the margins of transcripts using Track Changes in Microsoft Word. Codes were grouped and sub-grouped into categories that suggested emerging themes. I read relevant literature to contextualize and identify themes.

Phase two began by re-examining transcripts to revisit themes and interpret participants' experience. To preserve participants' unique lived experiences, I used quotes to highlight pertinent commentary (Peat et al., 2019).

Limitations of the Study

IPA is frequently used in contemporary qualitative research, particularly in regard to social work and mental health research (Tuffour, 2017). It explores the meaning individuals assign to their experiences so the researcher can interpret them with as few preconceptions and assumptions as possible (Smith et al., 2009; Tuffour, 2017; Willig, 2013). Researcher bias is always a limitation of a study in that it can lead to conclusions not fully grounded in the data.

Another possible limitation of this study is its reliance on a small sample size, which limits the generalizability of findings and can raise questions about the representativeness of the sample. Small sample sizes can also make it difficult to detect patterns or themes across a larger population, leading to potentially incomplete or inaccurate conclusions (Guest et al., 2020). For example, several study participants were recruited via Dr. Ranahan's research relationships. This process of recruitment may have led to some bias as participants who volunteered had a pre-

existing interest in mental health and preconceptions about a teacher's role in student mental health.

Finally, IPA can be time-consuming and resource intensive, particularly because the circular hermeneutic process involves multiple stages of data analysis, transcription, coding, interpretation, and re-interpretation. To fully explore the individuals' experiences in detail, more extensive interviews or other forms of data collection may be necessary. This can be costly or difficult and thus limits the feasibility of using IPA in certain research contexts, particularly larger studies or those with limited resources (Smith et al., 2009).

This chapter made the case for a qualitative approach to this study over other kinds of research design. It argued IPA was the most appropriate method of analyzing the teachers' interview responses. It also clarified how ethics approval was sought and granted, how the seven participants were recruited by email and referrals, consent was given, and how they were unique regarding teaching experience, type, training, and career status. Data was collected in approximately hour-long recorded phone interviews, transcribed, coded, and grouped into the four themes listed above. Participants verified the synthesized and analyzed data by reviewing a summary and offering comments. These responses were cross-referenced with existing codes/themes. Data from participant interviews, member-checked comments, and academic literature were triangulated to provide an analysis.

As noted above, research bias is always a risk in studies of this nature, the sample size could have been larger and more diverse, and the length of interviews extended or supplemented with other forms of data collection. Despite the limitations of this research, I hope readers will appreciate a rich narrative about teachers' experiences of MHL training. I also hope it will inform future MHL research and educational opportunities.

Chapter 4: Findings

Chapter Overview

This chapter outlines findings from the analysis of semi-structured, audio-recorded interviews with seven Canadian teachers who related their experiences of MHL training in several school contexts and resource formats. Four themes were identified: 1) contextually relevant training, 2) role acceptance, 3) feasibility of applying knowledge, and 4) self-efficacy. The context and definition of relevant terms are supplied and sub-themes are identified. Direct quotations from participants are presented to support interpretations throughout and demonstrate similarities and differences in each participant's experience.

Theme 1: Contextually Relevant Training

Participants did not share a singular understanding of what constituted *"valuable"* MHL training. That said, they did all prioritize the need for contextually relevant training, that is, training connected to, or appropriate for, a teacher's distinct classroom circumstances. To maximize value, participants preferred training that was directly relevant to *"who I am teaching and where I am teaching"* (Participant 4).

MHL training and resources have expanded in recent years to span a variety of formats, learning platforms, certifications, curricula types, and programs. This has led to greater specialization to enhance the relevancy of training. For example, Participant 6 attended weekly MHL training sessions specifically chosen for their relevance to her teaching practice. Participant 6 felt her experience was valuable and expressed gratitude for having attended, calling the training *"very, very helpful."* They said the MHL training:

> *...is directly related to the children who attend our program. So, it's just targeted to our child psychiatry department…. We wouldn't get training on [adult psychiatry], for*

example. Everything is directly for our population ... so it will help me a lot to understand my students when I'm trying to help them with their academics.

However, not all participants characterized their training as specialized. Many participants reported that training was very broad and thus limited in value as it did not directly apply to their teaching practice. For example, Participant 4 said the MHL workshops they took, *"were pretty generic, I think. I guess we were just expected to apply it to the kids we had, but I think [targeted training] would have been helpful."*

Participant 1's MHL training was exclusively focused on and delivered to teachers. In their view, this mental health training was overly generalized because *"they just kind of lump[ed] it all into one category."* Participant 1 said the *"very broad"* nature of their training was *"a downfall of the program"* and inadequate in meeting the needs of their teaching practice. Participant 1 challenged the utility of universal approaches to mental health and MHL training by providing an example of targeted training in physical health: *"When you look at regular first aid, the physical first aid, they show you…how to do [cardiopulmonary resuscitation] on a baby, on a child, on an adult… they do all the different levels. So, why not with mental health too?"*

Participants attributed value to MHL training if it was targeted in nature and directly relevant to their own circumstances. This relevancy was either specific to them as an individual or to their environment.

Individually Relevant Training

Participants said the training was individually relevant if it acknowledged, accommodated, and addressed their students' specific cognitive, emotional, behavioural, and age-specific needs. For example, Participant 4, a teacher of highly motivated and high-achieving International Baccalaureate (IB) high school students, needed training relevant to teenagers and

"the kinds of things that IB kids might be struggling [with], like putting too much pressure on themselves."

Likewise, Participant 1 illustrates the need for training materials specifically targeting elementary school-aged children: "*The majority of the videos and examples that they showed us were between adults. I think [child-centred videos] would be more beneficial for me as an elementary school educator because how it would look in an adult would maybe look different in a child, right?"*

Environmentally Relevant Training

Participants also expressed a desire for training relevant to their teaching and school environments. Participant 2 said there was a heavy focus on crisis intervention during their MHL training. They had never been involved in a mental health crisis at school, so they "*would have liked more ways and strategies to address [classroom-specific] situations."*

Participant 1 acknowledges the importance of relevant examples from different environments because *"there could be different triggers at school,"* and the training would also be applied in the classroom or private office hours according to a teacher-student dynamic. Participant 1 added MHL instructors should know, "*This is how it looks here and show us examples in a school setting."*

Participant 2 felt they would benefit from training that was *"a little bit more in-depth and geared toward…showing me how I can use [the MHL training] in my classroom a little better.*" For participants, clear and relevant connections between training and practice are essential. Participants continued to situate their training in the school, but extended this beyond the physical structure of the classroom to include social and cultural environments distinct to their communities as well.

Culturally Relevant Training

Participants expressed interest in learning more about the mental health needs of their students, particularly those from marginalized groups. All participants indicated that they teach in culturally, racially, and linguistically diverse settings. Participant 3 aptly identified the important role culture plays in the classroom: *"Culture is a huge part of learning. Ethnicity is a huge part of learning."*

Participants also asked for MHL training materials that could be situated within local, geographical, socioeconomic, racial, and cultural contexts. They noted these aspects were inadequately addressed in their MHL training, especially as it related to students' home lives. Participant 4 described their experience working in numerous schools with diverse student populations, yet their MHL training did not specifically address the diverse emotional, cultural, and economic contexts of mental health or that speak to *"students who have a difficult home life"* or live *"in a low-income area"* (Participant 4).

The absence of culturally relevant MHL training disregards the current realities of Canadian society and its education system. To compensate, Participant 6 draws on their lived experiences as a member of a marginalized community:

> *That's one piece that is very lacking everywhere. I feel like this year is probably the first time we had one seminar on thinking about how culture can have a big impact in the mental health field. And that's a big, big, big part that's missing in all of the training…. Because I'm from a marginalized community, I always think about it. Whether in education, whether in mental health, in every single setting that you're in, I find that very, very lacking.*

Participant 6 noted that unequal and unethical treatment of marginalized groups can be amplified in the absence of culturally responsive MHL resources.

> *Black parents have a really tough time dealing with mental health because, in our community, it's really just not talked about…. You think, as a parent, especially as a Black parent raising a Black boy, that, oh my goodness, I failed my child. God knows if he's gonna come home to me alive, because if [a mental health crisis] happens in public and the police are called, that's it…. It's a very, very, very scary thing to be raising Black children in Canada.*

When culturally relevant MHL training is absent, and drawing on lived experience is impossible, teachers are uncomfortable navigating mental health with marginalized or racialized students in their class. Participant 7 discloses their tendency to *"tiptoe a little bit"* in their culturally diverse class and recalls an uncomfortable moment in a lesson related to Indigenous mental health and the Missing and Murdered Indigenous Women and Girls (MMIWG) crisis. *"I don't wanna trigger anything [and] I worry that I could maybe do the opposite of what I'm trying to do and upset somebody …. I might, depending on the group that is in front of me, I might not talk so much."*

The need to take into account cultural considerations in MHL training suggests an opportunity for future research in this area. Resources could, and should, be customized to local, geographical, socioeconomic, racial, gendered, and cultural concerns of students and teachers in specific school settings and grades. Participants preferred training that was contextually relevant to the individuals and environments in which they taught. When this was not the case, they questioned its value. Finally, when culturally relevant MHL training is unavailable, participants

pivoted by drawing on their own lived experiences and/or adapting as best they could even if it meant navigating with less certainty, comfort, and confidence.

Theme 2: Role Acceptance

Participants shared stories and examples that reflected how they saw MHL fitting into their role as a teacher and whether or not this had evolved after the training. Participants suggested their engagement with MHL was a recent extension of the teacher role and noted that their comfort with this was a function of *where* they were in their teaching career and *when* they received the MHL training.

Participants with child-centered teaching philosophies, or "whole child" approaches, tended to more thoroughly embrace MHL as part of their teaching role compared to participants with subject-centered teaching philosophies. Finally, participants who sought out MHL training voluntarily, or as part of their regular teaching commitments, appeared more accepting of this aspect of their job.

Participant 5 noticed a new emphasis on mental health in education: *"There's been such a focus in the last five years on mental health."* For them, this shift came more than two decades into their teaching career:

> *"In my first 25 years of teaching, you didn't hear a lot about [mental health]. And the last five years [there has been] a lot more of a focus on the more emotional well-being of the students in the class .... They were always so focused on delivering curriculum and meeting those expectations, so I did see a big switch."*

Participant 4 also describes this change in the teacher's role as *"a much more recent approach"* and adds that veteran teachers may find it challenging to adjust to new expectations

nearing the end of their careers: *"I think maybe teachers that are a little bit older, or that have been teaching for a longer time, they're not accustomed to that [mental health] role as much."*

Participant 7, a veteran teacher who was recently thrust into delivering a newly implemented high school mental health curriculum, notes the stress associated with rapid changes, something inherent in the teaching profession: *"When I found out that these were the courses that I was assigned, it was quite a shock. We're not given any choice in that, and I've been teaching now for over 20 years, so that was a big change."* Participant 7 noted that lack of training for a new role is a negligent and unacceptable practice in other professions:

> *I received no training ever in my life. No training was mentioned to me. No training was offered. I do find it kind of ridiculous that teachers are just… 'Here, teach this.' In the real world, I don't think that would happen to somebody in a different profession…. You receive training. When something new is added to your plate, usually you receive training and with us, it's just kinda like, 'Here you go,' and you figure it out for yourself.*

Participant 5 said lack of early career training opportunities contributed to how 'unequipped' they felt teaching MHL:

> *I probably wish I would have had [training] earlier, I'll be honest." Participant 4 echoed this when they said, "I think, like as a person who's retiring, it's maybe not as big an issue for me, but…I think if I was a younger teacher, I would definitely want more specific training so that I could feel a little more confident in that role.*

The timing of training proved to be significant for participants, signaling the need to re-evaluate the nature of pre-service MHL training. Participant 6 notes this is an oversight in pre-service teacher education:

Especially when you just arrive out of university, you are so not equipped. You don't get training. You don't know how to deal with it. You barely even know what mental health issues are…. So, it's very, very, very lacking in our teacher training.

Participants noticed a recent paradigm shift in education that put more emphasis on mental health and a consequent change in their role that was challenging, especially in the later stages of their careers. This challenge increased when adequate training was unavailable. Participants point to pre-service teacher education as an ideal moment for MHL training to set teachers up for success.

Teaching Philosophy

Participants who adopted a subject-centered teaching philosophy tended to be less likely to view mental health as part of their teacher role. Participant 4 said:

When I'm teaching, I'm thinking about the curriculum and what I'm teaching, and so I don't think of that as my role every day, that I'm sort of…monitoring everybody's mental health.…I'm thinking about the lesson that I have to teach, and especially teaching IB. It's a pretty intense program, and so there's a lot of, 'OK, let's get through this.'

By contrast, participants who had student-centred teaching philosophies, or "whole child" approaches tended to accept that responding to mental health needs was part of their role. When asked if mental health was a component of their teaching practice already, Participant 1 responded, *"Yes, it is, because I try to see the child as a whole person, not just an academic."*

For Participant 2, the MHL training only affirmed their child-centred teaching philosophy. They reflected on a 3-day MHL training session they had just attended and said it was *"absolutely fantastic in the sense that it wasn't anything new, but it was something that puts into words my philosophy and my beliefs."*

MHL training can also realign participants' teaching philosophies. Participant 5 describes beginning their teaching career focusing on subjects and assessment as they were teaching a grade that completed mandatory standardized testing for math at various points in the school year. They described attending MHL training as *"a step back"* that allowed them to slow down and distance themselves from a fast-paced assessment-driven path. The MHL training was a catalyst that shifted their teaching philosophy toward a holistic, child-centred approach, which helped bring new excitement and much-needed balance to their curriculum-focused classroom. The training helped them realize:

> *There's a lot more going on, and actually more important things to address, in the classroom. So, for me, it was good to know that ... we can take time out to meditate. We can go on a nature walk and journal our feelings. There's time…to do those things.*

The degree to which participants accepted and integrated MHL into their teaching role was a function of their teaching philosophy and where they were situated on the subject-centred to student-centred spectrum. Participants with student-centred, "whole child" philosophical approaches tended to embrace MHL more fully in their teaching practice, while subject-centred teachers tended to remain highly focused on curriculum and performance in the classroom. For one participant, training shifted their philosophy and teaching practice, suggesting MHL training could inspire more student-centred, mental health-oriented classrooms.

Personal Choice vs. Mandated Attendance

The body of literature on MHL suggests teachers' interest and involvement in MHL initiatives is often sparked by their own personal struggles with mental health or with friends or family members who have had mental health issues. However, the participants in this study fell into three categories that described the circumstances under which they took MHL training, i.e.,

whether it was mandated, volunteer, or part of their regular work commitments. When training was sought out voluntarily, it was received more positively. Conversely, when attendance was mandated, training was seen less positively.

Prior to having taken MHL training, Participant 7 struggled to *"figure things out"* as they lacked the knowledge, skills, and confidence to teach mental health subject matter. They described feeling excitement and hope after receiving an unexpected email from the mental health lead of their school district, who reached out to offer assistance and resources. Participant 7 recalls *"*I *just grabbed my cell phone and called him right away (laughing)…. Yes, please help me!"* Participant 7's rapid acceptance of training and resources indicates teachers' need and desire for MHL training and the power of accessible support for teachers.

Participant 1 also volunteered for MHL training to become more equipped to teach this material in their classroom. *"Students that I've seen have been anxious, even at a young age, about little things in the classroom. So, I thought it would be helpful to equip me with how to handle certain situations."* For these participants, voluntarily attending MHL training helped them adjust to ever-changing circumstances in their classrooms and improved the knowledge, skills, and confidence they needed to succeed.

Participants 3 and 6 are teachers in high-needs classrooms in clinical settings who regularly attend MHL training. For them, training is embedded into the school culture and considered part of their weekly workload and schedules. Participant 6 said, *"So, every Wednesday, we have what is PD for our team, and it's a wide range of topics and themes and seminars and workshops, really just to help us understand our students and our patients better."* In this setting, ongoing MHL training is neither voluntary nor mandated, but rather seen as a regular part of their commitment to best practices.

Participants 4 and 2 were mandated by their employers to take MHL training as in-school PD. Participant 2 explains,

> *"I think it was just like the next thing on the agenda, to be honest." Participant 4 describes their MHL training as one course among "a million [PD courses] that we have to do now. Like, we have WHMIS. We have concussion protocol. We have…Epi-pen. We have violence in the workplace, sexual harassment in the workplace. We have a couple of other ones."*

For them, MHL training was obligatory, inconvenient, and an item to cross off their to-do list.

For participants, MHL training was either voluntary, part of their weekly teaching workload, or mandated. When training was sought out voluntarily or as part of a weekly commitment, training was perceived more positively. When attendance was mandated, training was perceived unfavourably.

Theme 3: The Feasibility of Applying Knowledge

Participants shared whether they were likely or unlikely to apply new-found MHL skills and whether or not this was a "feasible" task, i.e., something possible and likely to be achieved. Based on participants' responses, using MHL knowledge was more feasible if there was an existing and strong student-teacher relationship, the material was accessible to their students, and MHL was a manageable addition to their workload.

Strong Student-Teacher Relationships and Safe Spaces

Regardless of the degree to which participants embraced MHL in their teaching role, all agreed on the importance of providing safe spaces for students, as well as developing and nurturing quality student-teacher relationships. Participants felt teachers must be seen as trustworthy, reliable, and stable figures for optimal classroom functioning and student

development. Participant 1 identified the need for students to feel *"comfortable and welcome in the classroom."*

Conversely, when student-teacher relationships were weak, applying MHL training was seen as less feasible. Participant 1 explained that regular and casual interaction helped build relationships with students because *"if you only talk to them about knowing their facts of math or English or anything like that, they're just going to see you as strictly their teacher."* However, when safe spaces and quality relationships are cultivated, students are more likely to confide in teachers regarding their mental state. When student-teacher relationships are strong, Participant 5 reported feeling *"pretty in tune with the kids if they're having trouble."* Participant 4 said, *"If you have a good relationship with your students, you can recognize someone struggling."* Noticing changes in student behavior helped participants identify concerns with a student's mental health and helped facilitate referral to more specialized care.

Participant 1 said that taking the time to *"know your students"* opened up conversations and provided an opportunity to learn more about students who were struggling. Participant 1 describes a student they are currently teaching:

> *There is a student who…will literally clean every little thing, the back of the chair… everything on his desk, like everything that he is going to touch before he sits down. And he told me that, when he goes home, he has a specific room that he calls 'the dirty room,' where he will do his homework, where he will bring his books and papers from school, because he doesn't want [germs] to go into the rest of the house. I just feel he has grown more anxious and he was not like that last year…. I feel like he has definitely changed his mood…. He looked blank.*

Participant 2 describes a typically polite and respectful student who suddenly began displaying unusual behavior.

> *There was one week where his behavior just completely changed. I took him aside, and asked him, 'What is going on? Can you explain to me where this behaviour is coming from? Because it's very unlike you.' Then he just broke down and told me a very personal thing.*

These participant stories demonstrate how having a pre-existing and strong relationship with a student helped them notice emotional and behavioural changes, creating an opportunity for conversation that revealed how and why the student was struggling. Participants explained that students regularly viewed them as trustworthy confidants and their classrooms as safe spaces for delicate conversations. Participant 3 notes, *"They tell me stuff all the time that they don't tell other people. I've had children confide in me. Every student I have does at some level."*

Participant 5 shares, *"I had a lot of kids come to me and tell me things"* and goes on to say the *"little things"* teachers do to be present with students create an *"open door"* policy. This, in their experience, has led to an increase in help-seeking behavior in students: *"I did feel I had great relationships with the kids in my class, and the few that were struggling did come to me. They would come to see me, so that was good."* Participant 7 confirms that having an *"open door"* was *"the only reason I kind of knew the full story."* Opening up their classroom as a place for students to *"stay and talk"* after school was helpful in providing a space for students to engage in help-seeking behavior, because otherwise, *"I wouldn't really know what was happening."*

These tactics were important for developing and maintaining quality student-teacher relationships and held space for teachers to apply their MHL skills. Participant 1 confirms the value of a good student-teacher relationship and safe spaces:

> *Each kid is different, but I think the most valuable resource is having a teacher there who knows the child. I find that even if you have all the texts in the world, you need to have a relationship with the person to understand how to best handle it.*

Applying MHL knowledge and skills is not feasible without both a close student-teacher relationship and a safe space for students to share their thoughts and concerns.

Accessible Teaching Tools

Participants shared their experiences using MHL training tools in the classroom and emphasized the need for activities that were adaptable to their students' abilities and that were easy to integrate into existing teaching practices. Participant 2 used guided deep breathing exercises with their students to promote the regulation of emotions. They encouraged students to *"picture blowing the dandelions"* while pointing to a dandelion poster at the front of the class. A visual reference and relatable experience made the deep breathing exercises more accessible for elementary students.

Participant 6, a teacher of a high-needs classroom in a clinical setting, echoed the need for accessible resources. Their student population *"struggle[s] with a lot of the expectations that are required ... in a regular school setting,"* specifically academic achievement, social interaction, emotional regulation, dealing with peer conflicts, and transitioning from one space to another. In addition to the differentiation and accommodations required to make learning more accessible for their students, Participant 6 used relatable imagery and catch phrases *("Ask out, don't act out"* or *"Think it, don't say it"*), to make MHL concepts clearer for their students.

Participant 6 described regularly using the image of a toolbox as a metaphor for accessing the skills/tools a child needs in a variety of social situations:

> *Every strategy that they learn, they add it to that toolbox so that when they are feeling as if, 'Oh my goodness, my emotions are getting out of control,' [they] can think about, 'What tool can I use in this moment?' So, for a lot of our students, it would be, take deep breaths, or clench my body and then release, or in this moment, I am really, really, really upset, and I might wanna swear, but I can't. So, the tool in that moment is, 'Think it, don't say it' or, a tool will be asking for space, asking to leave, asking out. So, we say, 'Ask out, don't act out.'*

Participants said that having access to activities and resources that are developmentally appropriate makes implementation of MHL in the classroom more feasible. Participant 3 set *"expectations that the child can actually reach [and] feel the gratification of reaching that goal."*

Participant 5 used meditation and mindfulness practices they learned in MHL training and *"found the kids loved 'em, so I just kept doing them."* Observing their students respond positively was gratifying for teachers and increased the likelihood of other MHL skills being attempted.

A Manageable Workload

Participants found that a manageable workload and feasible activities led to a greater likelihood of implementation of MHL curricula. If tasks had an "easy ask," that is, they required little additional time to prepare and execute and did not significantly add to an existing workload, they were more likely to be attempted. Conversely, tasks that required considerable time, effort, or expertise were seen as less feasible and, therefore, less likely to be employed.

Participants describe time constraints and heavy workload as an ever-present challenge. Participant 7 feels *"so overworked"*, and Participant 4 says their workload is *"always a challenge"* because, *"you're just so busy all the time."* Participant 3 echoes this sentiment: *"There's always something that comes up, so you know, the spare that you have on paper… I mean if you get to go to the bathroom, you've had a good day."* Heavy workloads make MHL integration in the classroom unattractive and onerous on top of other duties they are expected to execute.

Participant 5 was hesitant to attempt a mindfulness exercise with students despite the skills, knowledge, and confidence gained from the MHL training. This exercise required little expertise, preparation, or execution time and could be gradually introduced so that it became an enjoyable and sought-after activity consistently used and sustained over time:

> *I had never done [meditation and mindfulness] before with the kids in my class, and I had no idea how that was gonna go…. I mean, at first, I started with just a minute that they do it, and then we sort of increased the time…. We were doing it for 10 minutes at the end of the day. It was a hit. Like… they just loved it. They would ask me—sometimes you know, you forget—'Miss, are we gonna meditate today?'*

By contrast, Participant 7 said that the lack of bilingual resources required them to generate translated MHL content themselves, which was difficult when juggling a heavy workload. *"I have to teach [a high school MHL course] in French with no resources in French…. They're just not available in French…. I would have to translate it myself and create it myself, which is always a huge barrier."*

Participant 3 added that the ever-increasing expectations placed on teachers means they are always scrambling to manage expanding workloads. *"Unfortunately…in the teaching sector*

…the workload keeps getting more difficult. We keep having more kids with challenging behaviours… and complicated portraits of their mental health, abilities and learning disabilities, but we are given more to do instead of less." Teachers struggling to fulfill current responsibilities may also perceive implementing new things as competing with other priorities. When MHL concepts are implemented in this context, it becomes a lower priority and threatens the sustainability of MHL programs in schools as well as teachers' wellness.

Participants also pointed out the futility of implementing MHL concepts as a singular event or on an irregular basis. For them, consistency delivers lasting benefits for students and teachers. Participant 3 explains:

> *It's like piano. You can learn a piece, but if you don't practice it, you're never gonna get good…. That's what we need to do with mental health practices…. We have to put them in place, and they have to be maintained.*

Consistent practice builds teacher confidence, competence, and sustainable school-based MHL programs.

Participants noted a concern for their own mental health given their work in a system noted for its attrition, unmanageable working conditions, and burnout. Participant 3 said, *"In Quebec, we have a very high attrition rate. So, we lose about 40% of our teachers in the first five years of teaching because the workloads are too high."* (Participant 3). Participant 3's own health issues are evidence of unmanageable working conditions: *"I had to take two years off because it was too demanding, physically, emotionally, and the workload was too much."* In their view, this ever-present pressure to catch up, implement more, and do better is a principal contributor to teacher illness.

Participant 3 calls for a realistic assessment of teaching workloads that realigns expectations with the realities of the job. This would determine what constitutes optimal teaching and learning conditions before appropriate systemic and structural changes to the education system can be made.

> *We should support mental health. The problem is, how do you implement it in our system? You need to have teachers who are well, teachers who are stable, teachers who aren't on the verge of burnout .... You have to make it teacher-friendly and actually effective, efficient, and very simple to apply in your daily routine. It can't be more work for the teachers; it has to be less work. You have to take some load off .... I don't know how many people have to burn out or how many children have to fail before we do the right thing.*

Agreeing upon more manageable workloads for teachers would make it more feasible to apply MHL best practices as one of a shorter list of priorities in the classroom. When quality student-teacher relationships and safe spaces are present, and MHL concepts and learning activities are relatable, adaptable, achievable, and accessible, teachers can use them more regularly and organically in their daily practice. Tasks with an initial "easy ask" that required little additional time to prepare and execute, and did not add significantly to the workload, were also attractive in this regard. Conversely, MHL tasks that added to an already demanding workload were seen as competing with pre-existing responsibilities, negatively affected teachers' health and job satisfaction, and were unlikely to be implemented.

Theme 4: Self-Efficacy

Self-efficacy refers to a "belief in one's capabilities to organize and execute the courses of action required to manage prospective situations. Efficacy beliefs influence how

people think, feel, motivate themselves, and act" (Bandura, 1995, p. 2). Participants cited examples that demonstrated their belief in their ability to learn and apply MHL concepts in their teaching practice. Participants perceived their role at the intersection of education and mental health as stressful and challenging, but said support from specialized in-house staff, and communication of student support improved their self-efficacy. The type of MHL training they had taken also influenced self-efficacy, especially if it was hands-on, mentorship-based training. Finally, student feedback validated teachers' efforts and was appreciated, both of which contributed to self-efficacy.im

Comfort Level, Support, and Closure

Participant 5 felt uncertain and uncomfortable navigating MHL concepts within the teaching role: *"I used to often think, you know, I'm not a doctor or a social worker."* Participant 7 reflected on the moment they learned they would be teaching MHL concepts: *"I was like 'Holy shit. I don't know enough.' I was very, very, very uncomfortable. I'm not gonna lie."* For these participants, this was a high-stakes proposition and required specialized expertise compared to other academic subjects. Participant 7 explains: *"It's so different to deliver a mental health curriculum compared to math or science. This is a more human thing and really could mean the difference between life and death for somebody."* Participant 5 felt they lacked the specialized skill set needed to take on MHL-related concepts in the classroom, despite pressure to *"do the right thing"* and as a result had low self-efficacy.

If teachers felt they could defer to more specialized staff with expertise in-house, they were relieved and more likely to feel a situation was manageable. Participant 7 describes feeling grateful for timely access to in-school support in a situation where *"I wasn't 100% sure how to help him, [but] thankfully, now I know that the social workers are available."* However, if

channels of communication between expert staff and teachers were weak or non-existent, this relief was fleeting. Participant 2 describes a disappointing hand-off to a counsellor without follow-up: *"It was the first time that I realized 'OK, so we have to identify [mental health issues in students], but then we just hand it off to somebody else?' And not that I felt qualified to help him, but I would like to [know what happened next]."*

Identifying students' mental health disorders, supporting them in the classroom, and referring them to the appropriate resources and supports, requires teachers to commit time, energy, and emotional investment. When teachers feel involuntarily removed/sidelined from the process or shut out of the communication loop, this is a negative experience. Participant 4 explains:

> *I think most teachers would, you know, just appreciate a follow-up conversation, even if it's through email…. I think we should probably be aware of the follow-up and what's being done, and how the person is doing…just as someone who cares about the person that you're teaching. I think it's important for just closure…. Did I do the right thing, you know?*

Teachers are making an additional emotional investment in their students when engaging in MHL, but this is not something that can be turned off easily once offered. Remaining included in the process validates teachers' efforts and affirms they've made the appropriate choice for the student.

Traditional Training

MHL training offered participants an opportunity to learn and grow more confident when applying MHL concepts in their teaching practice. However, the nature of their training

experiences in terms of content, duration, instructional modality, and context informed their level of confidence.

Some participants took MHL training delivered primarily through lectures and found this format helpful. Participant 5 stated, *"In general, I felt more comfortable. I think some of the strategies that I learned helped with one particular student."* Others felt this traditional type of instruction had limited impact. Participant 4 said their PowerPoint-based MHL course was *"not as valuable," "not as engaging,"* and *"not as enduring"* as other types of instruction. *"I don't really feel that this bit of [PD] training that I've had over the years has really made me that confident that I'm some awesome first line of defense…."*

Participant 7 suggests that a traditional course will still require the teacher to interpret and implement it in the classroom in their own way:

> *I guess in that traditional setting, you're there with a large group of people, they're giving you handouts; they're usually doing a PowerPoint or something and it's good … but it's not alive…. It's a group of educators with an educator in front of them, and I mean there's nothing wrong with that. You receive the information and whatnot, but you're gonna have to muddle your way through and figure it out for yourself.*

Though this type of learning is very familiar, even predictable, and can deliver a lot of content to be referred to after the fact, it is not always as participatory, hands-on, and engaging as a more interactive and creative approach. Regardless of the instructor and mode of delivery, participants will always need to make the information their own by adapting it to their own approaches and personal voice. This is a process of trial and error that customizes MHL to individual students, classroom cultures, and teachers' own talents and comfort levels.

Mentorship

Two participants who had taken less traditional MHL training through internships and mentoring opportunities were new to MHL and took it as part of their pre-service and in-service teacher training. Participant 1 found the vicarious experience of watching their mentor appropriately respond to mental health concerns in the classroom was effective and built confidence in their own ability to replicate these skills. They described this experience in an elementary school classroom when a student had a severe outburst during a learning activity:

> *Luckily…the teacher I was with knew what to do, and I just modeled her behavior afterwards. It was really simple. I think being in the field and having that experience firsthand is different [than traditional training alone]. You might not always remember what it says in the book, right?*

After being thrust into a new role teaching a mental health course, Participant 7 described a similar experience with mentorship. Their MHL training consisted of several one-on-one co-teaching opportunities with their school district's mental health lead. This mentor was a trained psychologist and former schoolteacher. Participant 7 acted quickly to secure the position saying: *"I called right away [and said] 'I saw that you offered co-teaching.... That's what I want. I want to watch you, because I feel like in teaching, there's nothing like watching somebody teach.'"*

Participant 7 said this experiential MHL training was *"learn[ing] on the spot ... as opposed to just going to a session and sitting there and listening and, you know, maybe asking a couple of questions. But this, I have totally immersed in it as a student myself."* The mentorship took place over several weeks, during which they had numerous opportunities to observe their mentor modelling MHL concepts, designated times to replicate them supervised by the mentor,

and meetings to receive feedback. *"Once we had gone through that whole experience…I now felt comfortable…almost like a brand-new teacher…. I feel like I got the best possible training."*

Participants reiterated the value of an internship or mentorship as effective MHL training. Participant 7 said, *"There's nothing that is going to teach you how to be a teacher in a book. It really doesn't work that way."* They also suggested mentorship be implemented into future MHL training for teachers. Participant 7 proposed *"there should be a mentorship possibility of some sort [because] there's nothing like hands-on learning."*

Participant 1 endorses this idea, stating that teachers would benefit from going to:

> *…an inclusive school that has ... students with mental health disabilities. That would actually be more beneficial [than traditional training]. Even in the regular [Bachelor of Education] program, we read about implementing lesson plans, we read about classroom management, all that stuff, but you learn the most when you're actually in the field.*

Modelling from more knowledgeable, experienced, and advanced MHL practitioners outlined a developmental path for teachers and improved their self-efficacy. The vicarious experiences of watching their mentors and then applying MHL concepts with their support were encouraging and helped them master these concepts in their own teaching.

Student Feedback

Participants also shared moments in their teaching careers when they received positive feedback from students. Participant 7 recalls an encouraging moment when a student thanked them after a MHL course, saying, *"Because of this course, I was encouraged to seek help."* Similarly, Participant 5 reflected on their experience teaching students who had struggled with mental health issues. They and their teaching partner put a lot of extra work into learning and applying MHL concepts with this student who they ran

into 15 years later: *"He remembered and he came up and once he said his name, I remembered him and it was so nice to see him ... and he was so appreciative of everything."* Participant 5 received feedback validating their efforts and then felt the MHL course *"wasn't all for nothing"* and that they were successful and appreciated, which in turn increased their self-efficacy.

Participants became more comfortable and confident engaging with MHL concepts after taking MHL training, especially if this involved a mentorship, a format favored over traditional training. Receiving encouraging feedback from students or peers validated their efforts and had a positive impact on their self-efficacy as well. Though balancing the demands of regular teaching and MHL was stressful and challenging, those who were open to it were much more likely to employ their training than those who reacted negatively to the prospect.

This chapter reviewed the four themes—the need for contextually relevant MHL training, accepting MHL as part of a teacher's role, the feasibility of applying MHL knowledge, and self-efficacy—to highlight key findings using participants' voices to nuance these key points. The study results revealed a number of important ways in which MHL training could be more reflective of the unique students, environments, and cultures in Canadian K-12 classrooms. The data also indicated that an educator's teaching philosophy can indicate their willingness to take MHL courses and apply that learning effectively. Incentivizing teachers to take the training and giving them this choice was preferable to mandating attendance.

Teachers also noted that where they had existing relationships with students that were strong and built on trust, their classrooms and offices became safe spaces for private and

respectful conversations about mental health. Teachers also asked for MHL teaching resources that were very accessible and easily integrated into the workload, so they did not require significant time and energy to adapt or translate to the classroom. While not all teachers were equally at ease with the MHL content, and their ability to deliver and apply it well, they all noted that support was welcome and ideal. They also requested good communication from mental health experts to whom students were referred, as this would confirm that their actions were appropriate and that students were receiving good care. Feedback from the students themselves was also welcome and validating.

Finally, though teachers took their MHL training in a variety of formats, from live workshops with expert leaders to online courses, to one-on-one mentorships, there was a preference for mentorships and experiential learning. This insightful commentary introduces exciting new ways MHL programmers might adjust both the mode and content of delivery to better engage a larger contingent of teachers and extend the reach and effect of MHL training in Canadian schools.

Chapter 5: Analysis, Recommendations, and Conclusions

Chapter Overview

This study explored the lived experiences of seven teachers who had recently taken MHL training. Participants' accounts of their experiences were analyzed and grouped into four major themes: 1) contextually relevant training, 2) role acceptance, 3) feasibility of applying knowledge, and 4) self-efficacy. This chapter situates the findings of this study within the current body of literature available on this topic to respond to the study's two research questions:

1. What are Canadian teachers' lived experiences of learning and applying MHL training in the classroom?
2. How has MHL training informed their day-to-day teaching practice?

In this chapter, study participants' responses are analyzed in the context of literature in the field on this topic before concluding with recommendations for future research and application, concluding with key research findings in relation to the research aims and questions.

Theme 1: Contextually Relevant Training

Participants did not share a single understanding of what constituted valuable MHL training. For example, Participant 6 derived value from MHL training that was *"directly related to the children who attend our program,"* calling her staff training *"very, very helpful."* Others said their training lacked specificity and relevancy, calling it *"broad"* or *"pretty generic."*

These varied results support adult learning theory that recognizes teaching adults is an elusive, non-linear process largely rooted in the learner's experiences. It is "influenced by diverse factors in every social context and unique to each adult learner" (Rocco et al., 2020, p. 73). MHL training was deemed most valuable when contextually relevant to the individuals and environments where teachers taught.

The value of contextually relevant MHL programming is highlighted in a study by Hodgins et al. (2007) examining the impact of locally developed and delivered training. In Australia, general practitioners (GPs) are considered vital frontline supporters of MHL. They diagnose many patients because systemic barriers inhibit patient access to more specialized mental health care and support (Hodgins et al., 2007). The results of this study suggest that when MHL training was developed locally, aimed at linking GPs and mental health patients with local resources, and was delivered by local clinicians, this led to positive outcomes (Hodgins et al., 2007). The benefits of contextually relevant, locally driven mental health training strategies such as this have recently been included in Australia's primary care mental health guidelines (Hodgins et al., 2007).

Participants' desire to engage in MHL training that is contextually relevant also aligns with andragogy, a foundational adult learning theory discussed in Chapter 2. Malcolm Knowles (1988) defined andragogy as "the art and science of helping adults learn" (p. 43). This method is different from the pedagogy used to help children learn, as it emphasizes that the adult student experience is central to the learning process (Rocco et al., 2020). Knowles suggests that:

a) as a learner matures, they move from being a dependent learner toward being a self-directed learner,

b) the experience that an adult accumulates acts as a rich resource for learning,

c) the readiness of an adult to engage in learning is directly connected to their social role,

d) as learners mature, their focus shifts from the future application of learning to immediate application,

e) internal motivations to learn are more powerful tools than external motivations to learn, and

f) adult learners like to know *why* they are learning something (Knowles, 1984, 1988).

Several of Knowles' observations about adult learning reflect the experiences of study participants. When teachers viewed training as broad and universal, it lost value. However, when training was viewed as contextually relevant, it gained value. Training relevant to the teaching and school environment was better received than MHL training disconnected from those realities. Participant 4 said of their general training that *"We were just expected to apply it to the kids we had."* Participant 1 said their MHL training delivered to a group composed exclusively of teachers *"just kind of lump[ed] it all into one category"* so it was inadequate in meeting their needs.

When training is not contextually relevant to the participants' social role, they are less ready to learn, and teacher readiness is "one of the five critical features that buttress the successful implementation of a sustainable mental health literacy initiative" (Weston et al., 2018, p. 113). Knowles also suggests adult learners want to immediately apply newfound knowledge to their practice (Rocco et al., 2020). This was true of Participant 2, who felt the heavy focus on crisis intervention in their MHL training was not part of their school experience, so they *"would have liked more ways and strategies to address [classroom specific] situations… showing me how I can use [MHL training] in my classroom."* Participants' desire for clear, immediate, and relevant connections between MHL training and their teaching practice suggests they want to use this knowledge as soon as they return to the classroom.

Theme 2: Role Acceptance

Not all participants agreed MHL was part of their role as a teacher. Some prioritized subject-centered curriculum, while others adopted student-centered and "whole child" approaches to teaching that was more easily integrated with MHL. When asked if MHL was part

of their role as a teacher, Participant 4 said, *"I would say no, I guess if I'm being honest.… When I'm teaching, I'm thinking about the curriculum and what I'm teaching, and so I don't think of that as my role every day."* This view contrasts that of Participant 1, who said, *"Yes, it is because I try to see the child as a whole person, not just an academic."*

This ambiguity challenges findings from recent studies that suggest teachers perceive their professional role as one that includes involvement in student mental health (Beames et al., 2020; Froese-Germain & Riel, 2012; Graham et al., 2011; Phillippo & Kelly, 2014; Shelemy et al., 2019). However, the data from participants in this study supports the findings of Dimitropoulos et al. (2021), and Weston et al. (2018), who found teachers' opinions varied considerably regarding their role in student mental health. This ambiguity has implications for research, development, and implementation of MHL programming and may be a reaction to increased emphasis on MHL in schools in the last 5-10 years. Participant 4 described this push as a *"much more recent approach"* and Participant 5 said, *"There's been such a focus in the last five years"* compared to the focus on curriculum in the early years of their career.

Participants suggested *where* one is situated in their teaching career and *when* one received MHL training affected how open they were to integrating MHL into their teaching. Participant 4 suggested veteran teachers may find it challenging to adjust to new expectations nearing the end of their careers: *"I think maybe teachers that are a little bit older or that have been teaching for a longer time, they're not accustomed to that [MHL] role as much…."*

Meeting expectations and adjusting to a new role can be especially difficult for teachers who feel that they are not adequately trained. Participant 5 cited the lack of early career training opportunities in MHL as a barrier: *"I probably wish I would have had [training] earlier, I'll be honest."* Participant 6 noted, *"When you just arrive out of university, you are so not equipped.*

You don't get training. You don't know how to deal with it. You barely even know what mental health issues are…. It's very, very, very lacking in our teacher training." These findings are consistent with Weston et al. (2018) who suggest a gap between the formal education teachers receive in MHL, and what teachers are expected to know and carry out.

This perception that teachers lacked adequate MHL training is consistent with findings from a Canadian Teachers' Federation National Survey conducted by Froese-Germain and Riel (2012) that reports "87% of teachers surveyed agreed that a lack of adequate staff training in dealing with children's mental illness is a potential barrier to providing mental health services for students in their school" (p. 12). More research is underway to close this gap, including Masters (2019), who evaluated online MHL instruction in pre-service teacher education at Western University. MHL training was delivered to 275 students in their teacher education program over 10 weeks and 20 hours of online instruction. Results showed significant improvement in MHL, decreased stigma, and increased belief in one's ability to teach students with diverse mental health challenges (Masters, 2019).

A study by Gilham et al. (2021) introduced online, interactive MHL modules for educators to a cohort of students in a teacher education program at St. Francis Xavier University to identify changes in the MHL of participants. Results showed a "significant and substantial effect on MHL knowledge was achieved, and a significant and small effect was achieved with help-seeking behaviors" (Gilham et al., 2021, p. 560). These studies and continued data in this area are of significant interest to MHL researchers and programmers who want to improve the efficacy of existing and future programs.

Theme 3: Feasibility of Applying Knowledge

Participants emphasized the need for MHL knowledge to be applied in the classroom, something they identified was more likely in the presence of strong student-teacher relationships because, as Participant 4 said, *"If you have a good relationship with your students, you can recognize someone struggling."* Changes in student behavior signaled concern for teachers who, often after investigation, might refer the student to more specialized care. Quality student-teacher relationships have proven to lead to positive socio-emotional outcomes in adolescents (Wong et al., 2021). Halladay et al. (2020) found a correlation between student perception of teacher responsiveness to their emotional and mental health needs and their likelihood of seeking help.

Quality student-teacher relationships are a key concept in the GTET program that was developed and rolled out as a pilot program in Canadian schools (Wei & Kutcher, 2014). GTET suggests there are educators in each school with whom students form high-quality relationships and who they naturally approach to talk about mental health concerns (Wei & Kutcher, 2014). Offering MHL training to these "go-to" teachers is a strategy supported by participant comments in this study. Participant 5 stated: *"I did feel I had great relationships with the kids in my class, and the few that were struggling did come to me."* Participant 7 opened up their classroom to be a place for students to *"stay and talk"* after school and found this space allowed students to engage in help-seeking behaviour.

The objective of GTET is to empower these teachers to recognize mental disorders and refer students to more specialized care, promoting early identification and interventions (Wei & Kutcher, 2014). Wei et al. (2021) conducted an evaluation of GTET that showed "participants' mental health knowledge significantly improved, and stigma decreased significantly as a result of GTET within and across six Canadian provinces" (p. 926). However, more research is needed

to understand how teachers' MHL training serves them long-term and if skills continue to be effectively and sustainably integrated into their teaching practice. This study goes some way to advancing research in this area.

Participants also described the teaching profession as one with a high workload. Participant 7 says teachers are *"so overworked,"* while Participant 4 says heavy workloads are *"always a challenge [because] you're just so busy all the time."* Consequently, implementing MHL activities that were an "easy ask" because they require little additional time to prepare and execute are more feasible. For Participant 7, lack of bilingual resources meant translating MHL content to French themselves otherwise, they'd *"have to teach [a high school MHL course] in French with no resources in French… which is always a huge barrier."*

Tasks that add to an already heavy workload compete with pre-existing responsibilities. Participant 3 noted that expectations of teachers continue to grow, but the realities of the job mean there is no time to fit more into the day. Teachers are constantly scrambling to manage these expectations. Participant 3 explains: *"Unfortunately, what happens in the teaching sector is that the workload keeps getting more difficult…. We are given more to do instead of less."*

Participant 3's experience of ever-expanding workloads is reflected in recent data on attrition within the teaching profession by Karsenti and Collin (2013). Attrition rates in teaching are a global problem, with estimates of 1 in 3 teachers leaving the profession within the first five years (Karsenti & Collin, 2013). Participant 3 took *"two years off because it was too demanding, physically, emotionally, and the workload was too much."* In their view, this ever-present pressure to catch up and implement more significantly contributes to teacher illness.
Ball (2011) found that high levels of stress were a predictor of teachers' unreadiness to adopt MHL practices. Moreover, Heffernan et al. (2022) point to increasing teacher stress, burnout, and

illness that "attributed to external pressures, ongoing reform, and the increasing complexity of the role of both the teacher and the school" (p. 197). Weston and Rodger (2018) suggest teachers' working conditions are one of the five previously listed critical considerations for the success of MHL initiatives. Furthermore, Fullan's (1993) study of organizational change in the school system suggested "a system is a whole made up of interrelated parts, and when change happens in one area [e.g., educating teachers to identify students with mental health problems], this change puts pressure on other areas of the system" (Weston & Rodger, 2018, p.113).

This study supports these findings. Participant 3 calls for a realistic assessment of teaching expectations given the realities of the job: *"You need to have teachers who are well, teachers who are stable, teachers who aren't on the verge of burnout .... You have to make it teacher-friendly and actually effective, efficient, and very simple to apply in your daily routine."* Addressing teachers' workload will make applying MHL best practices, and caring for children with poor mental health, significantly more feasible.

Theme 4: Self-Efficacy

Self-efficacy in this context refers to participants' belief in their ability to learn and apply MHL concepts in their teaching practice. Participant 7 recalls feeling unprepared when they learned they would be teaching a MHL course. Her first thought was: *"'I don't know enough.' I was very, very, very uncomfortable."* However, other participants felt their MHL training did make them more confident to apply these concepts in their teaching practice. Participant 1 said, *"I feel comfortable .... I wouldn't shy away from it."* Participant 5 said, *"I think some of the strategies that I learned helped with one particular student."*

Other participants did not derive the same benefits from training. Participant 4 was less optimistic: *"I don't really feel that this bit of [PD] training that I've had over the years has*

made me that confident." This varied assessment of the impact of MHL training may be due to the uneven nature of their training experiences in terms of content, duration, instructional modality, and context. Participant 4, whose MHL training was a lecture and PowerPoint, said this experience was not valuable, engaging, or enduring. In contrast, Participant 7, whose training involved modelling the behavior of a local mental health professional and former teacher in their classroom, described it as much more beneficial: *"I feel like I got the best possible training."* The mentorship took several weeks, during which Participant 7 had numerous opportunities to observe their mentor modelling MHL concepts, designated times to apply MHL concepts under supervision, and meetings to debrief. They describe their experience as *"learn[ing] on the spot … as opposed to just going to a session and sitting there and listening."* Participant 7 added that *"once we had gone through that whole experience … I now felt comfortable … almost like a brand-new teacher."*

Participants' preference for MHL mentoring that is contextually relevant and experiential is mirrored in the literature. According to Bova and Phillips (1984), "mentoring is a basic form of education for human development because it provides a wholistic, yet individualized, approach to learning (p. 16) Those who work with mentors also become more intellectually competent, purposeful, autonomous, and possess a greater sense of integrity (Bova & Phillips, 1984). Knowles' key assumption that adult learners' accumulated experiences are a rich resource for learning is also borne out in the study (Knowles, 1984, 1988). Participant 7's comment that *"There's nothing that is going to teach you how to be a teacher in a book. It really doesn't work that way,"* speaks to this preference.

Participant 1 also supports Bova and Phillips' (1984) view that mentoring is a quality and enduring form of experiential learning when advocating for pre-service MHL training: *"Go[ing]*

to a school, an inclusive school that has ... students with mental health disabilities, that would actually be more beneficial …. You learn the most when you're actually in the field."

In a study by Hodgins et al. (2007) examining the impact of locally developed and delivered MHL training for a cohort of GPs, researchers state that "to achieve greater change in GP practice and patient outcomes, more focus needs to be placed on allowing GPs the opportunity to rehearse and fine-tune new skills, providing more flexible learning" (p. 56-57). Providing MHL mentorships and experiential learning is of increasing interest as MHL researchers and practitioners look for ways to translate short-term gains into long-term improvements in mental health early intervention.

Recommendations for Future Research

The following recommendations derived from the results of this study highlight several future research areas related to MHL teacher training and its impact on early intervention and classroom programming in the long-term.

Future research could:

- focus on a larger scale, qualitative, in-depth study to understand the experiences of a broader range of teachers (i.e., not just teachers with a pre-existing interest in MHL);
- focus on developing MHL programming that is contextually relevant, locally developed, and delivered to meet the unique needs of particular cultures, geographical areas, and populations;
- focus on identifying the needs of teachers teaching different groups of students (i.e., elementary-specific programming, high school-specific programming, etc.);
- focus on analyzing the systemic barriers that inhibit MHL training in the education system;

- take adult education principles into consideration when delivering MHL training;
- clearly communicate to teachers the expectations of their reimagined role at the intersection of education and mental health; and
- integrate MHL training and mentorship into pre-service teacher education programs at Canadian universities (i.e., including one with students with mental health disorders).

Research in the areas above will offer a more robust and nuanced understanding of the classroom realities of teachers who are ideally placed to recognize and intervene early with students experiencing mental health crises. Notably, during the interview process study participants did not specifically question the reasons for rising mental health concerns among children and youth. Future research may also explore teachers' perspectives on external factors that contribute to children and youth's mental health, such as the neoliberal economy, the COVID-19 pandemic, or wide-spread social media use, and how MHL training can be extended to address these larger systemic considerations. Designing more relevant, more accessible, and more hands-on MHL training will ideally inform future best practices for teachers and make them more likely to be applied on a daily basis not only in individual student-teacher relationships, but also position teachers as agents in societal change.

Summary of Key Research Findings

This study explored the lived experiences of seven Canadian teachers who completed MHL training and investigated how this training impacted their teaching practice by focusing on the following two research questions:

1. What are Canadian teachers' lived experiences of learning and applying MHL training in the classroom?

2. How has MHL training informed their day-to-day teaching practice?

Seven teachers were interviewed for this study. Participants' accounts of their experiences were gathered in recorded phone interviews and analyzed using IPA. Their responses were grouped into four major themes: 1) contextually relevant training, 2) role acceptance, 3) feasibility of applying knowledge, and 4) self-efficacy. These were paired with verbatim quotes inserted to highlight and clarify meaning. Organizing participant accounts thematically and including direct quotes helped capture their fulsome, diverse, and undistorted personal perspectives. Details of how their experiences taking MHL training, and applying it in their teaching practice over a longer-term, supplements existing research that has tended to focus on quantitative exit interviews from MHL workshops.

Theme 1: Contextually Relevant Training

Participants assessed the relevancy and value of their MHL training relative to their own needs and expectations. Participants did not share a singular understanding of what constituted valuable MHL training, but rather ranked its effectiveness relative to how it related to, and was appropriate for, their distinct classroom circumstances. To maximize value, participants sought training directly applicable to the students, grades, and cultural environments in which they teach. Future MHL training should adhere more closely to the general principles of adult education, understand teachers' own perceptions of their role, and be developed and delivered locally to maximize contextual relevance. This will increase the likelihood that teachers apply the MHL training they receive to the needs of their constituencies.

Theme 2: Role Acceptance

Participants related how MHL fit into their own perceptions of their role as a teacher and how they have or have not evolved in that role after receiving the training. Participants felt MHL

was a relatively recent extension of their role (the last 5 years) and suggested that *where* they are situated in their teaching career, and *when* they received MHL training, informed how they viewed these new MHL responsibilities. Several respondents proposed incorporating MHL education into pre-service teacher training to increase familiarity and comfort navigating MHL concepts upon entering the profession. This would position MHL as a foundational element of a teacher's role, rather than an optional accessory to that role.

Theme 3: Feasibility of Applying Knowledge

Several factors ease or obstruct the application of MHL concepts for teachers. Participants underscored the need for activities and curricula to be feasible (requiring little prep and adaptation and already appropriate for the audience) for both the teacher and students. This was more likely if strong student-teacher relationships were present, training takeaways were accessible for students, and both constituted a manageable workload. Granting additional release time or prep periods for selected "go-to" educators that have undergone MHL training would address teachers' concerns about making time for this in their current workloads and make MHL less likely to be viewed as competing with pre-existing responsibilities. This could also improve teacher wellness and workplace satisfaction by giving them more time to connect with students in high-quality relationships. These initiatives would also increase the likelihood that students seek help for mental health concerns and accept referrals to more specialized care.

Theme 4: Self-Efficacy

Participants had varying levels of confidence in their ability to apply MHL concepts in their teaching practice after taking the training. Participants found it stressful and challenging to take on this responsibility without more guidance and support within the school environment. If teachers saw MHL responsibilities as a burden and not part of their role, they had low self-

efficacy. When participants' MHL training took the form of mentoring and experiential learning, teachers were more engaged and felt more confident in their ability to apply MHL in their classrooms. If MHL training was delivered through mentorships and experiential learning, this could translate positive short-term benefits (increased ability to identify mental illnesses and decreased stigma) into long-term change, integrating MHL as part of the teaching profession at every level.

This study related the experiences of seven Canadian teachers taking and applying MHL training to their day-to-day teaching practice over a longer term. The research also highlights future opportunities to support teachers by adopting adult learning principles, adapting delivery methods for MHL training, and developing more contextually relevant and accessible resources for teachers. The findings also support reimagining MHL education to implement experiential learning and mentorships as part of in-service PD and pre-service teacher education programs in Canadian universities. Teachers should also be granted additional release time to build confidence and competence in gradual and sustainable MHL practices. The abovementioned findings and recommendations indicate several means by which teachers' MHL training, and their application of these concepts in the classroom, could be significantly improved for greater reach and impact. These findings also add to the body of research investigating teachers' ability to support mental health campaigns in the educational environment, with new emphasis on qualitative analysis of teachers' own perspectives and the effects of MHL training over the longer term. *Bearing that in mind*, additional research, grounded more immediately in teachers' perspectives, is needed to support them more specifically and effectively where they work at the intersection of education and mental health.

References

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, *26*(4), 392–407. https://doi.org/10.3109/09540261.2014.928270

Alves, R., Lopes, T., & Precioso, J. (2021). Teachers' well-being in times of Covid-19 pandemic: Factors that explain professional well-being. *International Journal of Educational Research and Innovation, 15*, 203-217.

Andrews, A., McCabe, M., & Wideman-Johnston, T. (2014). Mental health issues in the schools: Are educators prepared? *The Journal of Mental Health Training, Education, and Practice*, *9*(4), 261-272.

Andrus, M.R., & Roth, M.T. (2002), Health literacy: A review. *Pharmacotherapy, 22*, 282-302. https://doi.org/10.1592/phco.22.5.282.33191

Bandura, A. (Ed.). (1995). *Self-efficacy in changing societies.* Cambridge University Press. https://doi.org/10.1017/CBO9780511527692

Beavers, A. (2009). Teachers as learners: Implications of adult education for professional development. *Journal of College Teaching & Learning, 6* (7), 26-27. doi:10.19030/tlc.v6i7.1122

Beames, J. R., Johnston, L., O'Dea, B., Torok, M., Boydell, K., Christensen, H., & Werner-Seidler, A. (2020). Addressing the mental health of school students: Perspectives of secondary school teachers and counselors. *International Journal of School and Educational Psychology,* 10(1), 128-143. https://doi.org/10.1080/21683603.2020.1838367

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802-1811. doi:10.1177/1049732316654870

Bolam, R., Stoll, L., McMahon, A., Thomas, S., Greenwood, A., Atkinson, A., & Smith, M. (2005). *Creating and sustaining effective professional learning communities*. University of Bristol.

Bova, B. M., & Phillips, R. R. (1984). Mentoring as a learning experience for adults. *Journal of Teacher Education*, *35*(3), 16-20.

Brasfield, M. W., Xu, Y. J., & Lancaster, C. (2019). Wellness as a mitigating factor for teacher burnout. *Journal of Education, 199*(3), 166–178. https://doi.org/10.1177/0022057419864525

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Canadian Institute for Health Information. (2023, May 8). *Children and youth mental health in Canada*. https://www.cihi.ca/en/children-and-youth-mental-health-in-canada

Candy, P.C. (1980). *A personal construct approach to adult learning*. Adelaide College of the Arts and Education.

Clarke, J., Hanson, A., Harrison, R., & Reeve, F. (2001). *Supporting lifelong learning: Volume 1 Perspectives on learning*. Routledge.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage.

Creswell, J.W., & Poth, C.N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2018). *The Sage handbook of qualitative research* (5th ed.). Sage.

Dimitropoulos, G., Cullen, E., Cullen, O., Pawluk, C., McLuckie, A., Patten, S., Bulloch, A., Wilcox, G., & Arnold, P. D. (2021). Teachers often see the red flags first: Perceptions of school staff regarding their roles in supporting students with mental health concerns. *School Mental Health, 14*(2), 402–415. https://doi.org/10.1007/s12310-021-09475-1

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. John Wiley & Sons.

Fogarty, R., & Pete, B. M. (2004). *The adult learner: Some things we know*. Corwin Press.

Froese-Germain, B. (2014). *Work-life balance and the Canadian teaching profession*. Canadian Teachers' Federation. https://files.eric.ed.gov/fulltext/ED546884.pdf

Froese-Germain, B., & Riel, R. (2012). *Understanding teachers' perspectives on student mental health: Findings from a national survey.* Canadian Teachers' Federation. https://files.eric.ed.gov/fulltext/ED544259.pdf

Fullan, M. (1993). *Change forces: Probing the depths of educational reform*. Falmer Press.

Gadermann, A.M., Warren, M.T., Gagné, M., Thomson, K.C., Schonert-Reichl, K.A., Guhn, M., Molyneux, T.M., & Oberle, E. (2021). *The impact of the COVID-19 pandemic on teacher well-being in British Columbia.* Human Early Learning Partnership. http://earlylearning.ubc.ca/

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry, 14*(2), 231-233. https://doi.org/10.1002/wps.20231

Gilham, C., Neville-MacLean, S., & Atkinson, E. (2021). Effect of online modules on pre-service teacher mental health literacy and efficacy toward inclusive practices. *Canadian Journal of Education, 44*(2), 559–599. https://doi.org/10.53967/cje-rce.v44i2.4601

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

Greenspoon, P. J., & Saklofske, D. H. (2001). Toward an integration of subjective well-being and psychopathology. *Social Indicators Research, 54*(1), 81-108.

Guest, G., Bunce, A., & Johnson, L. (2020). How many interviews are enough? *Field Methods, 32*(1), 3-24.

Halladay, J., Bennett, K., Weist, M., Boyle, M., Manion, I., Campo, M., & Georgiades, K. (2020). Teacher-student relationships and mental health help-seeking behaviors among elementary and secondary students in Ontario Canada. *Journal of School Psychology, 81*, 1-10.

Heffernan, A., Bright, D., Kim, M., Longmuir, F., & Magyar, B. (2022). I cannot sustain the workload and the emotional toll: Reasons behind Australian teachers' intentions to leave the profession. *Australian Journal of Education, 66*(2), 196–209. https://doi.org/10.1177/00049441221086654

Hodgins, G., Judd, F., Davis, J., & Fahey, A. (2007). An integrated approach to general practice mental health training: The importance of context. *Australasian Psychiatry, 15*(1), 52–57.

Hord, S.M., & Hirsh, S.A. (2008). Making the promise a reality. In A.M. Blankstein, P.D. Houston, & R.W. Cole (Eds.), *Sustaining professional learning communities* (pp. 23-40). Corwin Press.

Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry*, *177*(5), 396-401.

Jorm, A. F., Barney, L. J., Christensen, H., Highet, N. J., Kelly, C. M., & Kitchener, B. A. (2006). Research on mental health literacy: What we know and what we still need to know. *Australian & New Zealand Journal of Psychiatry*, *40*(1), 3-5.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). Mental health literacy: A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, *166*(4), 182-186.

Karsenti, T., & Collin, S. (2013). Why are new teachers leaving the profession? Results of a Canada-wide survey. *Education, 3*(3), 141-149.

Kelly, C. M., Jorm, A. F., & Wright, A. (2007). Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Medical Journal of Australia*, *187*(S7), S26-S30.

Kelly, C. M., Mithen, J. M., Fischer, J. A., Kitchener, B. A., Jorm, A. F., Lowe, A., & Scanlan, C. (2011). Youth Mental Health First Aid: A description of the program and an initial evaluation. *International Journal of Mental Health Systems, 5*(1), 1-9.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593-602.

Kickbusch, I., Pelikan, J. M., Apfel, F., & Tsouros, A. (2013). *Health literacy*. WHO Regional Office for Europe. https://apps.who.int/iris/bitstream/handle/10665/128703/e96854.pdf

Kitchener, B. A., & Jorm, A. F. (2002). Mental Health First Aid training for the public: Evaluation of effects on knowledge, attitudes and helping behavior. *BMC Psychiatry 2* (10), 4-6. https://doi.org/10.1186/1471-244X-2-10

Knowles, M. S. (1984). *Andragogy in action: Applying principles of adult learning*. Jossey-Bass.

Knowles, M. S. (1988). *The modern practice of adult education: From pedagogy to andragogy* (2nd ed.). Cambridge Adult Education.

Kolb, D. (2014). *Experiential learning: Experience as the source of learning and development* (2nd ed.). Pearson.

Koller, J. R., & Bertel, J. M. (2006). Responding to today's mental health needs of children, families and schools: Revisiting the pre-service training and preparation of school-based personnel. *Education & Treatment of Children, 29*(2), 197–217.

Kotowski, S., Davis, K. G., & Barratt, C. (2022). Teachers feeling the burden of Covid-19: Impact on well-being, stress, and burnout. *Work, 71*(8), 1-9. https://doi.org/10.3233/WOR-210994

Kutcher, S., & Wei, Y. (2020). School mental health: A necessary component of youth mental health policy and plans. *World Psychiatry, 19*(2), 174–175. https://doi.org/10.1002/wps.20732

Kutcher, S., Wei, Y., & Coniglio, C. (2016). Mental health literacy: Past, present, and future. *The Canadian Journal of Psychiatry*, *61*(3), 154-158.

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

Kutcher, S., Wei, Y., & Hashish, M. (2016). Positive mental health, fighting stigma and promoting resiliency for children and adolescents. In M. Hodes & S. Gau (Eds.), *Positive mental health, fighting stigma and promoting resiliency for children and adolescents* (pp. 161-172). Academic Press. https://doi.org/10.1016/B978-0-12-804394-3.00008-5

Kutcher, S., Wei, Y., McLuckie, A., & Bullock, L. (2013). Educator mental health literacy: A program evaluation of the teacher training education on the mental health and high school curriculum guide. *Advances in School Mental Health Promotion, 6*(2), 83-93.

Kyriacou, C. (2001). Teacher stress: Directions for future research. *Educational Review, 53*, 27–36.

Lawler, P., & King, K. (2000). *Planning for effective faculty development: Using adult learning strategies*. Krieger.

Leschied, A. W., Saklofske, D. H., & Flett, G. L. (2018). *Handbook of school-based mental health promotion*. Springer.

Lumpe, A. T. (2007). Research-based professional development: Teachers engaged in professional learning communities. *Journal of Science Teacher Education 18*(1), 125-128.

Manion, I., Short, K., & Ferguson, B. (2011). A snapshot of school-based mental health and substance abuse in Canada: Where we are and where it leads us. *Canadian Journal of School Psychology, 28*(1), 119-135. https://doi.org/10.1177/0829573512468847

Main, P., (2023, June 20). *Kolb's Learning Cycle*. Structural Learning.com. https://www.structural-learning.com/post/kolbs-learning-cycle

Marzano, R. J., Waters, T., & McNulty, B. A. (2006). *School leadership that works: From research to results.* Hawker Brownlow Education.

Masters, E. R. (2019). *Promoting mentally healthy classrooms: Evaluation of online mental health literacy instruction in pre-service teacher education* [unpublished doctoral thesis]. University of Western Ontario.

Mental Health Commission of Canada. (2023, July 29). *Mental Health First Aid*. https://mentalhealthcommission.ca/training/mhfa/

Mental Health Literacy. (2023, July 29). *Get literate*. https://mentalhealthliteracy.org

Merriam, S. B., & Bierema, L. L. (2014). *Adult learning: Linking theory and practice* (1st ed.). Jossey-Bass.

Mitchell, R. (2013). What is professional development, how does it occur in individuals, and how may it be used by educational leaders and managers for the purpose of school improvement? *Professional Development in Education, 39*(3), 387-400.

Nalipay, M. J. N., Chai, C. S., Jong, M. S. Y., King, R. B., & Mordeno, I. G. (2023). Positive mental health literacy for teachers: Adaptation and construct validation. *Current Psychology*, 1-11.

Ní Chorcora, E., & Swords, L. (2022). Mental health literacy and help-giving responses of Irish primary school teachers. *Irish Educational Studies*, *41*(4), 735-751.

Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International, 15*(3), 259-267.

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher*, *45*(3), 241-251.

OpentextBC. (2023). *Appendix B – Dual-Continuum Model*. https://opentextbc.ca/mhwframework/back-matter/appendix-b/

Peat, G., Rodriguez, A., & Smith, J. (2019). Interpretive phenomenological analysis applied to healthcare research. *Evidence Based Nursing, 22*(1), 7-9. doi: 10.1136/ebnurs-2018-103017

Phillippo, K. L., & Kelly, M. S. (2014). On the fault line: A qualitative exploration of high school teachers' involvement with student mental health issues. *School Mental Health, 6*(3), 184–200. https://doi.org/10.1007/s12310-013-9113-5

Pressley, T. (2021). Factors contributing to teacher burnout during COVID-19. *Educational Researcher, 50*(5), 325-327.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18*(1), 20-23.

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly, 26*(1), 1-13.

Rocco, T. S., Smith, M. C., Mizzi, R. C., Merriweather, L. R., & Hawley, J. D. (Eds.). (2020). *The handbook of adult and continuing education*. Stylus Publishing.

Rodger, S., Hibbert, K., Leschied, A., Pickel, L., Stepien, M., Atkins, M., Koenig, A., Woods, J. & Vandermeer, M. (2014). Shaping a mental health curriculum for Canada's teacher education programs: Rationale and brief overview. *Physical & Health Education Journal, 80*(3), 28–29. https://www.csmh.uwo.ca/docs/publications/Rodger,%20Hibbert%20et%20al%202014.pdf

School Mental Health Ontario. (2023a). *MH LIT: Student mental health in action*. https://smho-smso.ca/online-resources/mh-lit-student-mental-health-in-action/

School Mental Health Ontario. (2023b). *Mental health literacy course for educators*. https://smho-smso.ca/educators-and-student-support-staff/mh-lit-online-course/

Shah, N., Walker, I. F., Naik, Y., Rajan, S., O'Hagan, K., Black, M. & Stansfield, J. (2021). National or population level interventions addressing the social determinants of mental health: An umbrella review. *BMC Public Health, 21*(1), 1-14.

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

Simonds, S. K. (1974). Health education as social policy. *Health Education Monographs, 2*, 1-25.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage.

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380.

State, T.M., Simonsen, B., Hirn, R., & Wills, H. (2018). Bridging the research-to-practice gap through effective professional development for teachers working with students with emotional and behavioral disorders. *Behavioral Disorders, 44*(2), 107-116. doi:10.1177/0198742918816447

Suldo, S. M., & Shaffer, E. J. (2008). Looking beyond psychopathology: The dual-factor model of mental health in youth. *School Psychology Review, 37*(1), 52–68.

Tudor, K. (1996). *Mental health promotion: Paradigms and practice*. Psychology Press.

Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: A contemporary qualitative research approach. *Journal of Healthcare Communications, 2(*52) 1-4.

Tuohy, D., Cooney, A., Dowling, M., Murphy, K., & Sixsmith, J. (2013). An overview of inter-pretive phenomenology as a research methodology. *Nurse Researcher, 20* (3),17-20.

Waddell, C., & Shepherd, C. (2002). *Prevalence of mental disorders in children and youth: A research update prepared for the Ministry of Children and Family Development*. Ministry of Children and Family Development. http://www.mcf.gov.bc.ca/mental_health/pdf/02a_cymh.pdf

Wallace, S. (2015). *A dictionary of education*. Oxford University Press.

Wei, Y., Carr, W., Alaffe, R., & Kutcher, S. (2020). Mental health literacy development: Application of online and in-person professional development for pre-service teachers to address knowledge, stigma, and help-seeking intentions. *Canadian Journal of Behavioural Science, 52(2),* 107-114.

Wei, Y., & Kutcher, S. (2014). Innovations in practice: Go-to Educator Training on the mental health competencies of educators in the secondary school setting. *Child and Adolescent Mental Health, 19*(3), 219-222.

Wei, Y., Kutcher, S., Baxter, A., & Heffernan, A. (2021). The program evaluation of Go-to Educator Training on educators' knowledge about and stigma toward mental illness in six Canadian provinces. *Early Intervention in Psychiatry, 15*(4), 922–931. https://doi.org/10.1111/eip.13037

Wei, Y., Kutcher, S., & Szumilas, M. (2011). Comprehensive school mental health: An integrated "school-based pathway to care" model for Canadian secondary schools. *McGill Journal of Education, 46*(2), 213-229. doi:10.7202/1006436ar

Westerhof, G. J., & Keyes, C. L. (2010). Mental illness and mental health: The two continua model across the lifespan. *Journal of Adult Development, 17*(2), 110–119. https://doi.org/10.1007/s10804-009-9082-y

Weston, K., Ott, M., & Rodger, S. (2018). Yet one more expectation for teachers. In A.W. Leschied, D. Saklofske, & G.L. Flett (Eds.), *Handbook of school-based mental health promotion: An evidence-informed framework for implementation* (pp. 105-126). Springer.

Whitehead, M., & Dahlgren, G. (2006). Concepts and principles for tackling social inequities in health: Levelling up part 1. *World Health Organization: Studies on social and economic determinants of population health, 2,* 460-474.

Whitley, J., Smith, J. D., & Vaillancourt, T. (2013). Promoting mental health literacy among educators critical in school-based prevention and intervention. *Canadian Journal of School Psychology, 28*(1), 56-70.

Wight, A. R. (1970). *Participative education and the inevitable revolution*. Centre for Research and Education.

Willig, C. (2013). *Introducing qualitative research in psychology: Adventures in theory and method*. Open University Press.

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

Wong, M. D., Dosanjh, K. K., Jackson, N. J., Rünger, D., & Dudovitz, R. N. (2021). The longitudinal relationship of school climate with adolescent social and emotional health. *BMC Public Health, 21*(1) 1-7. https://doi.org/10.1186/s12889-021-10245-6

World Health Organization. (2021). *Comprehensive mental health action plan 2013–2030*.

World Health Organization. (2023, May 8). *Health promotion*. https://www.who.int/teams/health-promotion/enhanced-wellbeing/seventh-global-conference/health-literacy

World Health Organization. (2022, June 17). *Mental health*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

World Health Organization. (2023, May 8). *Mental health overview*. https://www.who.int/health-topics/mental-health#tab=tab_2

Youth Mental Health Canada. (2023, May 8). *Youth mental health stats in Canada*. https://ymhc.ngo/resources/ymh-stats/

Zepeda, S.J., Parylo, O., & Bengtson, E. (2014). Analyzing principal professional development practices through the lens of adult learning theory. *Professional Development in Education, 40*(2), 295-315.

Appendix A

Interview Questions for Study Participants

1. Research Question 1: What is your experience of learning and applying MHL training in the classroom?

Guiding Questions:

a. What does a school day look like for you?

b. What are some everyday activities that you engage in as a teacher?

c. Is teaching students about mental health one of your responsibilities?

   i. If so, is it an add-on to other commitments?

   ii. How does it impact your other duties and responsibilities and how do you navigate this?

d. Do you think teachers should be expected to deliver mental health curriculum?

   i. Do you feel comfortable including MHL in your teaching practice? Why or why not?

Research Question. 2: How has MHL training informed your day-to-day teaching practice?

Guiding Questions:

a: Tell me about how you came to take the MHL training.

i: Did you have an interest in mental health/student mental health prior to taking the MHL training?

b: What was your biggest take away from the training?

c: Have you found your training has translated to the classroom and/or altered your teaching practice or behaviour in any way?

i: What specific area of the training do you feel is most applicable to your day-to-day work in school?

ii. Did you feel that the training was culturally and/or locally relevant and applicable to you/your classroom/your teaching practice?

d: What adjustments would you make to the MHL training you received if you were able to take it again?

e. What services, interventions, educational opportunities and/or support would you find helpful in your teaching practice?

f. Would you say that the training has helped you in your position as a teacher?

   i. If so, can you provide an example or story about a time this training helped you deliver the mental health curriculum, refer a student to mental health services, given you confidence or skills when talking with students, or otherwise helped you?

g. Can you provide an example or story about a barrier you've encountered or challenge you've experienced despite having taken the training?

   i. What do you think could have been added/adjusted in the training to prepare you for that?

Thank you very much for your time and input. It has helped me better understand your teaching experience.