Evaluation of "Bell Let's Talk in the Classroom": A Guide for Improving Teachers' Confidence in Providing Mental Health Education

Brooke Linden, Heather Stuart
Queen's University

Alexandra Fortier
School Mental Health Ontario

ABSTRACT

The Let's Talk in the Classroom (LTIC) Guide was designed to provide teachers with the education and support required to feel confident delivering mental health-related material in the Grade 7/8 classroom. The overall goal of this preliminary evaluation was to explore the acceptability, feasibility, and utility of the Guide using a mixed methods approach. A matched, pre/post-test evaluation of the Guide was conducted during the 2017/2018 school year among a sample of educators in Ontario, Canada ($n = 42$). Quantitatively

Brooke Linden, Health Services and Policy Research Institute, Department of Public Health Sciences, Queen's University, Kingston, Ontario, ORCID ID: 0000-0002-8664-176X; Heather Stuart, Bell Canada Mental Health and Anti-Stigma Research Chair, Health Services and Policy Research Institute, Department of Public Health Sciences, Queen's University, Kingston, Ontario, ORCID ID: 0000-0002-8098-6652; Alexandra Fortier, Research Liaison Team Lead & Innovation and Scale Up Lab Lead, School Mental Health Ontario, ORCID ID: 0000-0002-8805-4251.

The development and evaluation of the Let's Talk in the Classroom Guide was initiated and financially supported by Bell Canada and the Bell Let's Talk initiative. LTIC Guide modules were created by researchers at Western University in partnership with Kids' Help Phone, Media Smarts, and Bell Let's Talk. Project team members from Western University also provided administrative support to the project. Team members from the Centre for Addictions and Mental Health (CAMH) in Toronto created and managed the online training platform, while team members from School Mental Health Ontario facilitated the recruitment of participants.

BL is a Research Scientist for the Health Services and Policy Research Institute and Adjunct Assistant Professor in the Department of Public Health Sciences at Queen's University in Kingston, Ontario, Canada. HS is a Professor in the Department of Public Health Sciences and a researcher in the Health Services and Policy Research Institute at Queen's University in Kingston, Ontario, Canada. She also holds the Bell Canada Mental Health and Anti-Stigma Research Chair. AF is the Research Liaison Team Lead at School Mental Health Ontario and Innovation and Scale Up Lab Lead in partnership with Western University's Centre for School Mental Health Ontario.

Correspondence concerning this article should be addressed to Brooke Linden, Health Services and Policy Research Institute, 21 Arch Street, Queen's University, Kingston ON K7L 3L3. Email: brooke.linden@queensu.ca

doi:10.7870/cjcmh-2022-024
Published by Canadian Periodical for Community Studies Inc.

and qualitatively, results demonstrated that teachers felt more confident and expressed fewer worries associated with teaching mental health-related lessons after engaging with the Guide and were suggestive of acceptability and utility, with continued challenges associated with feasibility identified.

Keywords: mental health, teacher confidence, school mental health, mental health literacy

RÉSUMÉ

Le guide « Bell : Cause pour la cause dans la salle de classe » (*The Let's Talk in the Classroom* [LTIC] *Guide*) a été conçue pour doter le personnel enseignant du premier cycle du secondaire (*7e et 8e année*) d'un support éducatif afin de les aider à enseigner au sujet de la santé mentale en toute confiance. L'objectif général de cette évaluation préliminaire était d'analyser l'acceptabilité, la faisabilité et l'utilité de ce guide dont l'approche repose sur différentes méthodes. Une évaluation mixe pré-posttest du guide a été entreprise durant l'année scolaire 2017/2018 à partir d'un échantillon d'enseignantes et enseignants en Ontario, Canada ($n = 42$). Quantitativement et qualitativement, les résultats ont montré que ces derniers se sentaient plus confiants et manifestaient moins d'inquiétudes quant aux interventions concernant la santé mentale après avoir adopté le guide, et mentionnaient l'acceptabilité et l'utilité, en lien avec des défis constants identifiés comme réalisables.

Mots clés : santé mentale, confiance enseignant, santé mentale à l'école, littérature en santé mentale.

BACKGROUND

Mental health is marked by holistic well-being and the ability to cope with the normal stresses of life, while individuals affected by mental illnesses experience a reduced ability to function and cope effectively (Government of Canada, 2017; World Health Organization, 2013). The dual-continuum model of mental health and mental illness provides a framework with which to understand the interrelationship between these concepts (Keyes, 2002; Westerhof & Keyes, 2010). In line with this model, an individual can experience poor mental health without experiencing a mental illness; conversely, an individual can be in good mental health while simultaneously living with a well-managed mental illness.

The onset of mental illness is most often observed during adolescence, with 70% of cases occurring before the age of 18 and 50% before the age of 14 (Kessler et al., 2007, 2005). Mental health challenges increase significantly with age, with 17% of youth aged 15–17 self-reporting "fair" or "poor" mental health, compared to only 7% of youth aged 12–14 (Statistics Canada, 2020). Overall, about 15–20% of school-aged youth report struggling with mental health, representing about one in five students in the average Canadian classroom (Kutcher et al., 2009). Importantly, mental health issues have been linked to poor academic performance, problematic relationship development, and attendance problems (Santor et al., 2009; School Based Mental Health and Substance Abuse Consortium, 2013; Statistics Canada, 2020).

Mental ill health is increasingly viewed as a result of accumulated structural disadvantages in social, economic, cultural, and environmental domains that can accumulate over the life course to produce significant health and mental health inequities (Allen et al., 2014). Structural risk factors for mental ill health and mental illness centre on issues of social justice, political will and power, policy action, resource maldistribution

and social norms that promote social exclusion, discrimination, and unequal distribution of opportunities (Compton & Shim, 2015). For school-aged children, these socio-structural determinants may include childhood trauma, poverty, lack of social support, bullying, living in a marginalized community (e.g., Indigenous, racial, or ethnic minorities), identifying as a sexual or gender minority (e.g., trans, lesbian, gay, or bisexual youth), racism, social stigma, and limited access to mental health resources that could help them recognize their own personal mental health challenges, overcome shame and embarrassment, and seek out appropriate supports and services (Macleod & Brownlie, 2014). In addition to these broad social determinants, school-aged youth experience a number of developmental challenges that can impact their mental health, such as navigating relationships, managing pressure from peers to engage in certain behaviours, coping with increasingly challenging class workloads, and exploring personal identities (i.e., gender, sexuality; Currie & Morgan, 2020). Significant, ongoing brain development during this period also makes youth vulnerable to mental health deterioration (Romeo, 2017) and the habitual adoption of negative coping mechanisms and risk-taking behaviours (Dayan et al., 2010). From this broad socio-structural or health equity lens, schools are important not only for traditional education, but also for creating environments that promote personal development, cognitive growth, equity, and inclusion (Allen et al., 2014).

While mental illnesses can be treated effectively using downstream approaches (i.e., counselling, pharmacotherapy), a public health perspective recognizes the broad social determinants of health and emphasizes upstream approaches (i.e., mental health promotion activities, and lower intensity interventions that improve resiliency and encourage healthy coping behaviours). These can prevent psychological distress from reaching a clinical threshold, thereby limiting the need for more intensive treatment (Bennet-Levy et al., 2010; Dopp & Lantz, 2020; O'Connell et al., 2009). This conceptualization of mental health support is reflected in the School Mental Health Ontario's Aligned and Integrated Model (School Mental Health Ontario, 2020), which identifies a multi-tiered system of support, where tiers one and two focus on more upstream mental health promotion and early identification, and tier three focuses on the downstream treatment and intervention level. Given the typical timing for onset of mental illnesses, it is particularly important that effective upstream approaches are implemented among school-aged youth, providing education designed to improve mental health literacy, bolster resiliency, encourage healthy coping, and promote help-seeking behaviours. In fact, schools have long been highlighted as an important venue for mental health promotion activities (Kirby & Keon, 2006; Santor et al., 2009; School Based Mental Health and Substance Abuse Consortium, 2013). At present, these skills are seldom formally addressed in the classroom, despite educators' endorsement of them (Froese-Germain & Riel, 2012).

Emphasizing upstream mental health promotion among younger school-aged youth under the typical age of onset for mental illness is central to improving mental health outcomes among older adolescents. For example, a lack of mental health literacy can contribute to the development of stigmatizing attitudes, which have been shown to impede help-seeking behaviours (Clement et al., 2015; School Based Mental Health and Substance Abuse Consortium, 2013). In 2014, only 26–34% of youth with mental illnesses reported accessing mental health services, while a third of Ontario students (Grades 7–12) with a demonstrated need for mental health services reported not knowing where to go for support (Offord Centre for Child Studies, 2014). By designing mental health promotion activities that target younger students, we can provide them with the knowledge and tools required to recognize and respond to changes in their mental health early in

the process. This upstream approach can also support students in building their resiliency and developing healthy coping behaviours before mental health deterioration reaches a clinical threshold where downstream treatment is required.

RATIONALE

In 2012, responding to these gaps in mental health education among school-aged youth, Bell Canada commissioned the development of a three-lesson program designed to enable teachers to improve students' mental health literacy and encourage healthy coping and help-seeking behaviours. Feedback from a preliminary field test of these lesson plans showed that many teachers felt unprepared to bring mental health-related content into the classroom (Montgomery et al., 2014). More explicit step-by-step guidance on how to implement the lesson plans, less complex vocabulary, and more in-depth training on mental health literacy for teachers were among the recommendations made. These findings align with existing research, which suggests that teachers feel unprepared to broach the topics of mental health and mental illness with their students, despite reporting a high frequency of mental health issues in the classroom impacting student performance. Teachers have identified several barriers to bringing conversations about mental health into the classroom, including lack of organizational support and adequate teacher education in the area of child and youth mental health (Froese-Germain & Riel, 2012). Despite these barriers, the Mental Health Strategy for Canada explicitly highlights the role of schools in mental health promotion and stigma reduction, as well as the importance of early recognition of mental health problems in children and youth (Mental Health Commission of Canada, 2012).

While many school-based interventions have been designed with students as the ultimate target population (Dray et al., 2017; Reddy et al., 2009; Werner-Seidler et al., 2017), there is a scarcity of mental health-related educational interventions designed to educate and empower teachers to help students understand and respond to changes in their mental health. Few studies have addressed teachers' roles in implementing mental health-related interventions (Coombe et al., 2015; Erchul, 2015; Franklin et al., 2017; Franklin et al., 2012), though outcomes are usually focused at the student or intervention level. Despite the continued recognition of teachers as the first point of contact for students within school-based settings, to our knowledge, few studies have addressed outcomes at the level of the educator, including teachers' confidence in delivering mental health-related content. Together, these findings suggest a need for the implementation of effective mental health training programs for educators with outcomes measured at the teacher level.

Building on the recommendations resulting from the field test of the original Bell Let's Talk lesson plan material, a more comprehensive online teacher training resource called "Let's Talk in the Classroom" was designed to improve teachers' confidence in delivering mental health-related content in the Grade 7/8 classroom. Here, we report on the findings from a preliminary evaluation designed to assess the acceptability, feasibility, and utility of the Let's Talk in the Classroom teacher training guide ("the Guide").

METHODS

Intervention

Building from the original 2012 iteration designed by Bell Let's Talk, Kid's Help Phone, and Media Smarts, the Guide was developed and improved upon by mental health experts from School Mental Health Ontario and the Western University Centre for School Mental Health. An evaluation team from Queen's University conducted an independent evaluation. Evaluators were not involved in the development of the content or delivery of the Guide. Design experts at the Centre for Addictions and Mental Health (CAMH) Toronto provided technical support in preparing the online learning platform for use. Funding and sponsorship for the Guide was provided by Bell Canada.

Figure 1 depicts the logic model used to conceptualize and evaluate the Guide. The primary learning material in the Guide included four online modules: (1) an introduction to the goals and structure of the Guide (e.g., learning objectives, structure and format, time expectations); (2) an overview of the concepts of mental health and well-being as well as stigmatizing language and its impact (e.g., definitions of mental health literacy, mental health and well-being, stigma, the role of school culture and classroom dynamics, recognizing and strategies for addressing stigmatizing language, and related self-reflection activities); (3) an overview of the educator's role in promoting a mentally healthy classroom (e.g., defining the teacher's role, strategies for fostering a psychologically safe and welcoming environment, managing student disclosure, identifying and activating systems of support, and related self-reflection activities); and (4) guidelines for developing a strategy to teach three mental health lessons, the content of which is aligned with topics covered in the teacher training session (e.g., stigma, authenticating mental health information online, and help-seeking).

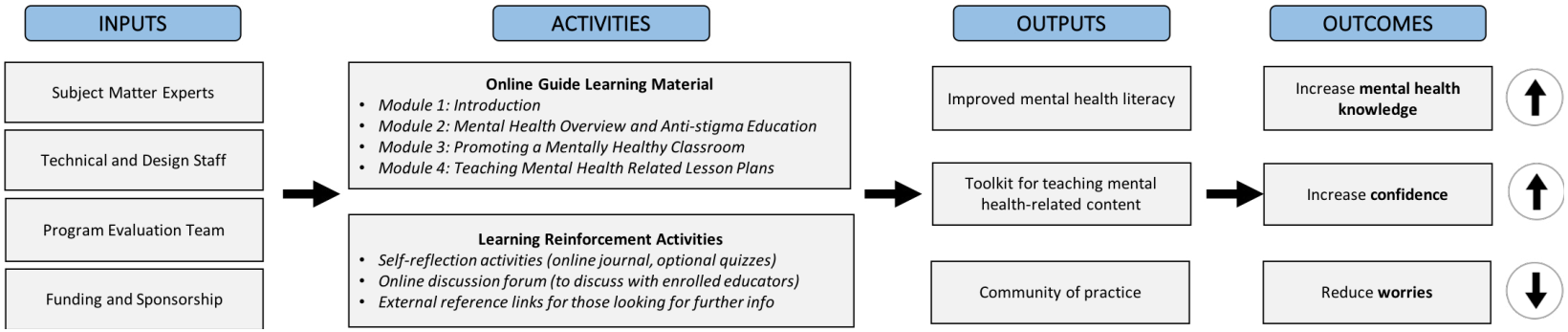
The Guide was delivered through an online learning platform, leveraging self-directed activities to reinforce education obtained from completing the modules. Learning reinforcement activities included self-reflection activities (e.g., journaling, quizzes), online discussion forums designed to foster communication between educators enrolled in the training, and external references for those seeking a "deeper dive" into mental health education and additional learning material beyond that which was provided in the modules. We hypothesized that the direct outputs of engaging with the Guide would include improving educators' mental health knowledge, allowing educators to develop a toolkit for teaching about mental health-related content, and fostering a community of practice among educators enrolled in the training. We sought to observe two hypothesized outcomes of interest: (i) improvement in teachers' confidence in delivering mental health-related content, and (ii) reduction in teachers' worries about discussing mental health in the classroom. Overall, the content of the Guide in its entirety was estimated to take educators 10 hours to complete.

Study Design

To evaluate the acceptability, feasibility, and utility of the Guide as well as the outcomes of interest, we conducted a preliminary pre/post-test evaluation using an online survey with both quantitative and qualitative components. Surveys were delivered via Qualtrics survey software (www.qualtrics.com). Quantitative measures were assessed at pre- and post-test, while qualitative data were collected at post-test only. User data from the online learning platform were also extracted and assessed. The evaluation was conducted over the course of the 2017/2018 academic year. This research was reviewed and approved for ethical

Figure 1

Logic Model for the "Let's Talk in the Classroom" Guide



compliance by Queen's University's Health Sciences and Affiliated Teaching Hospitals Research Ethics Board (EPID-596-17).

Participants

Teachers across Ontario were recruited by mental health leads (MHLs), a systems-level position held by a senior clinician who supports the development and implementation of their school board's Mental Health and Addictions strategy. MHLs are in every school board in Ontario. Teachers were eligible to participate if they were actively teaching at the Grade 7 or 8 level during the 2017/2018 academic year. Teachers provided their informed consent to participate and were provided with a certificate of completion upon finishing the Guide.

Measures

To evaluate the nature of the sample, several demographic questions were posed to participants in the pre-test survey, including gender, age, years of teaching experience, whether the participant had previously completed a course on teaching about mental health, and whether they had previously taught about mental health in their own classroom. In addition to these demographics, we included two questions designed to measure participants' previous social contact with mental illness by asking whether they or a close acquaintance had lived experience with a mental illness, or whether they had previously taught a student with a mental illness.

To evaluate the utility of the Guide, two scales were used to assess changes in confidence and worries: the Teacher Confidence Scale for Mental Health (TCS-MH) and the What Worries Me Scale (WWMS). The TCS-MH is a 12-item scale evaluating teachers' confidence in delivering mental health-related content in the classroom. Respondents are asked to indicate their level of confidence for each item on an adjectival scale ranging from 1 (not at all confident) to 10 (extremely confident). The WWMS is a 11-item scale evaluating teachers' worries about delivering mental health-related content. As with the TCS-MH, items are rated on a scale ranging from 1 (not at all worried) to 10 (extremely worried). For each scale, item responses are summed to derive a total score, with higher scores indicating greater confidence and worries, respectively. Preliminary validation evidence for both scales, including content and internal structure evidence, has been published in detail elsewhere (Linden & Stuart, 2019). In brief, a single-factor solution for both the TCS-MH and WWMS was supported by exploratory factor analysis, with all factor loadings >0.65 and adjusted eigenvalues of 7.4 and 5.2, respectively. Cronbach's alpha values of 0.96 for the TCS-MH and 0.93 for the WWMS suggested strong internal consistency (reliability). Evidence of content validity for both scales was collected via consultations with educational experts in the form of online consensus surveys as well as focus groups.

In addition to using the TCS-MH and WWMS to quantitatively assess pre/post changes in teachers' confidence and worries, we also included opportunities for educators to provide open-ended, qualitative comments in order to assess the acceptability of the Guide and provide us with contextual information regarding its feasibility. Participants were asked to share open-ended comments regarding their perspectives about the Guide and perceived impact of its content on their confidence and worries associated with delivering mental health-related content in the classroom. Finally, user data detailing the module activities completed by

participants was extracted from the online learning platform and reviewed by evaluators to provide further context about acceptability and feasibility.

Procedure

Recruitment took place between August and September 2017, with registration closing in October 2017. Teachers completed the Guide between October 2017 and June 2018, with participation rates fluctuating over the course of the study period (Figure 2). Participants were asked to complete two brief, online surveys: a pre-test survey, which was completed upon registration before accessing the Guide content, and a post-test survey, to be completed in June 2018 after having engaged with the Guide. Individual responses on pre- and post-test surveys were linked using an alphanumeric unique identifier to preserve anonymity. To maximize participation, we employed an implementation-sensitive approach, setting no requirement for teachers to complete the Guide in its entirety in order to participate in this study. As a result, teachers were able to pick and choose the components of the Guide that most interested them. Over the course of the academic year, we observed a gradual drop-off in participation, with the fewest teachers participating in the final module of the Guide, which guided teachers through developing a strategy to deliver the three "Let's Talk" lesson plans.

Analysis

Descriptive statistics were first calculated for demographic and social contact variables to determine the nature of the sample and highlight selection biases. To assess whether observed changes occurred in our outcomes of interest, we calculated aggregate absolute change in average scores on the TCS-MH and WWMS at pre- and post-test (i.e., the degree to which scores received at pre-test changed at post-test, by the number of overall scale points). Evaluating absolute change in scores indicates whether there has been any movement in scores between pre- and post-test but does not provide us with any statistically meaningful information. To assess statistical change, we calculated paired samples t-tests and Cohen's *d* standardized effect sizes to determine whether the differences in scores were statistically and/or practically significant. Qualitative responses from participants and user data extracted from the online learning platform were used to evaluate the acceptability and feasibility of the Guide. In line with a qualitative description framework (Sandelowski, 2000), we reviewed qualitative responses, using content analysis to identify common themes and extract exemplary quotations for additional emphasis. Finally, descriptive statistics (frequencies and proportion of module activities completed) were calculated from the user data extracted from the online learning platform.

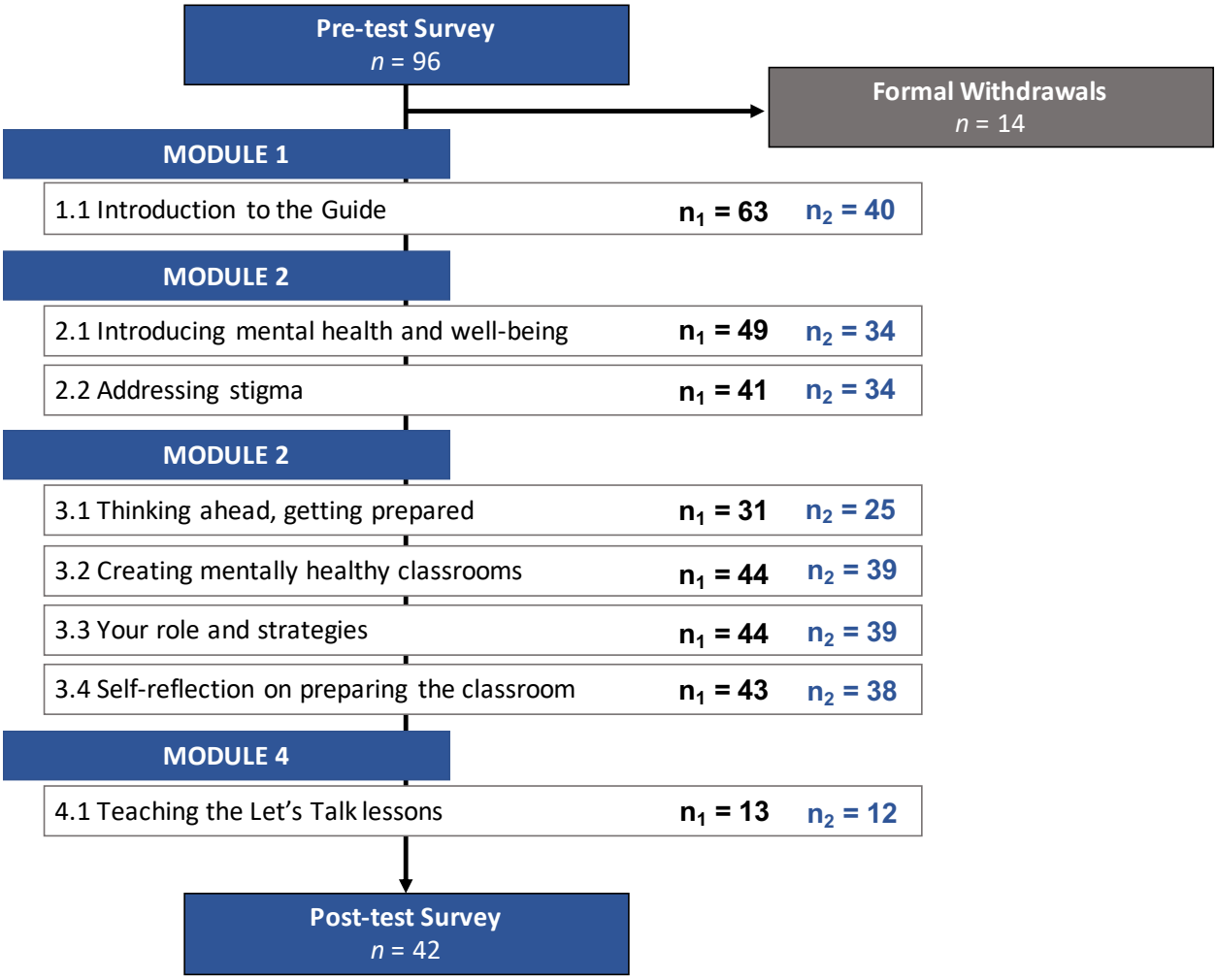
RESULTS

Sample

While 96 educators initially signed up to participate in the Guide training (submitting a pre-test survey), only 42 submitted a post-test survey, representing a 44% participation rate. Most participants were female, with an average age of 39 years (SD = 8.6), and an average of 11 years of teaching experience (SD = 8.9; Table 1). Most participants reported between 6 and 15 years of teaching experience. Many participants reported previous social contact with individuals living with a mental illness, either among themselves

Figure 2

Participation Flow Chart



Notes. (1) n_1 refers to the number of participants who completed the modules, including those who dropped out of the study

(2) n_2 refers to the number of participants who completed the study (i.e., submitted both a pre- and post-test survey) who completed the modules

or a close acquaintance (83.3%), or a student (94.8%). The majority reported that they had never taken a course in teaching about mental health-related topics (70.8%), though 76% reported that they had taught about mental illness in their classroom. Notably, we examined whether there were differences in those who completed the pre-test survey only compared to those who completed both the pre- and post-test surveys and no meaningful differences were observed.

Pre/Post-test Changes in Teachers' Confidence and Worries

We first examined whether changes had been observed in aggregate scores on the two outcome measures of interest to assess the utility of the Guide. At baseline, the average score on the TCS-MH was 67.5 (*SD* = 14.8). By follow-up, the average score had increased to 87.2 (*SD* = 8.6), representing an absolute improvement of nearly 20 points on the confidence scale, where one point represents one cumulative score point. The average baseline score on the WWMS was 53.7 (*SD* = 17.1).

By follow-up, the average score had decreased to 43.1 (*SD* = 18.3), demonstrating an improvement (by way of reduction) in teachers' worries, representing an absolute change of about 10 points on the WWMS. The mean change in scores for the total sample is shown in Figure 2. We also ran regression models to assess (1) whether the amount of Guide activities participants completed predicted the degree of change in confidence ($\beta = 2.11$, $t = 1.85$, $p = 0.10$) and/or worries scores ($\beta = 1.35$, $t = 1.0$, $p = 0.35$), and (2) whether having previously taken a course for teaching about mental health in the classroom predicted the degree of change in confidence ($\beta = 1.91$, $t = 1.27$, $p = 0.10$) and/or worries ($\beta = 1.59$, $t = 1.10$, $p = 0.28$). In both cases, no significant findings emerged (data not shown).

Finally, we observed whether changes had occurred in individual participants' scores between pre- and post-test. Results were statistically significant for both the TCS-MH ($t = -8.59$, $p < 0.001$) and WWMS ($t = 3.76$, $p < 0.001$). Standardized effect sizes were large ($d = 1.33$) and medium ($d = -0.58$) for the TCS-MH and WWMS, respectively (Cohen, 1988; Sawilowsky, 2009).

Acceptability and Feasibility of the Guide

Through open-text responses, participants provided additional contextual detail about their experience with the Guide and areas where they remained uncertain. Table A in Appendix A shows the results of the content analysis conducted. Responses were first coded by category (i.e., acceptability and feasibility), and then by theme. All quotations are included in the table, mapped to the appropriate theme to demonstrate the range of responses received.

Three themes emerged within the category of feasibility: worries about students' level of maturity with regard to broaching more sensitive topics (n = 7), worries about unpredictability associated with bringing conversations about mental health into the classroom (n = 8), and lack of time to thoroughly engage with and implement Guide material (n = 8). Educators expressed concerns about how students at a Grade 7/8 level might respond to sensitive topics like suicide. Concerns were also expressed about students not respecting the confidentiality and "safe space" of the classroom to share thoughts and feelings related to mental health. Similarly, educators expressed concerns about unpredictabilities, such as being asked a question they did not know the answer to, unintentionally triggering a student, or as one participant noted, "the 'what if' questions."

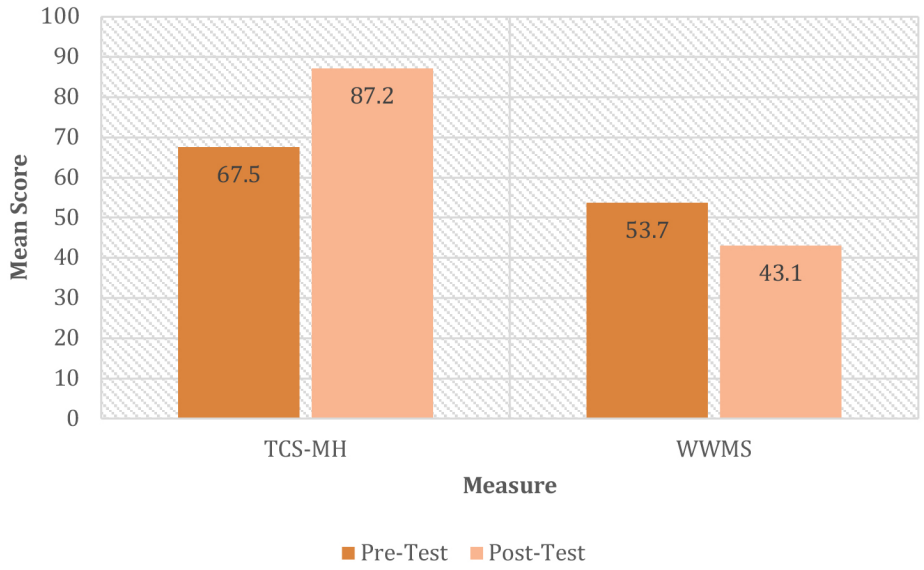
Table 1

Participant Demographics

Variable	Baseline (n = 96)			Follow-up (n = 42)		
	N	%	Mean (SD)	5	11.9	Mean (SD)
Sex						
Male	21	21.9				
Female	73	76.0		36	85.7	
Non-binary	2	2.1		1	2.4	
Age			39 (8.6)			39 (8.9)
24–29 years	14	14.6		7	16.7	
30–39 years	39	40.6		14	33.3	
40–49 years	27	28.1		13	31.0	
50 years or older	16	16.7		8	19.0	
Teaching experience			11 (6.8)			11 (7.0)
0–5 years	19	19.8		9	21.4	
6–10 years	33	34.4		14	33.3	
11–15 years	20	20.8		10	23.8	
16–20 years	15	15.6		5	11.9	
More than 20 years	9	9.4		4	9.5	
Personal or close acquaintance with a mental illness						
Yes	80	83.3		34	81.0	
No	6	6.3		2	4.8	
Unsure	10	10.4		6	14.3	
Student with a mental illness						
Yes	91	94.8		40	95.2	
No	2	2.1		1	2.4	
Unsure	3	3.1		1	2.4	
Previous course on teaching about mental health						
Several times before	12	12.5		4	9.5	
Once before	16	16.7		9	21.4	
Never	68	70.8		29	69.0	
Previously taught about mental health						
Yes	73	76.0		30	71.4	
No	18	18.8		9	21.4	
Unsure	5	5.2		3	7.1	

Figure 3

Mean Pre- and Post-Test Scores for TCS-MH and WWMS



Notes. (1) Change in TCS-MH (t = -8.59, p <0.001) and WWMS (t = 3.76, p <0.001) scores were statistically significant. Standardized effect sizes were large (d = 1.33) and medium (d = -0.58) for the TCS-MH and WWMS, respectively.

Finally, several educators expressed a lack of time to thoroughly engage with the Guide material, participate in all learning reinforcement activities, and find time in the curriculum to fit in their mental health lessons.

In terms of acceptability, many educators shared comments reflecting a positive experience with the Guide, finding it to be informative, thorough, and engaging (n = 13), and many indicated they felt more confident after completing the program (n = 5). One educator shared that they would have preferred to customize their own lesson plan (n = 1), rather than using a pre-designed Bell Let's Talk lesson, and two educators expressed a desire for a French language version of the Guide (n = 2). Finally, some educators shared that they felt the need to do some additional research on their own time to augment the content provided in the Guide, while others shared that they felt the content was thorough (n = 7). One educator indicated their desire for additional lesson plans beyond the three provided. Two educators shared comments about a lack of clarity concerning one of the lesson plans where classes were connected with a Kid's Help Phone speaker, though one indicated that despite their hesitancy, this element of the module ended up being a great experience for their class. Overall, comments were encouraging and suggestive of the acceptability of the Guide, but some concerns about feasibility were raised. Most notably, teachers expressed concerns regarding a lack of available time to dedicate to completing all components of the Guide, as well as challenges associated with finding space in the curriculum to deliver mental health-related lessons.

To gain even further insight about the feasibility and acceptability of the Guide, we extracted the user data from the online learning platform, which provided a breakdown of all module activities and the completion percentage for each participant (Appendix B, Table B). The average completion percentage was 78%, with the majority (33 out of 42, or nearly 80% of participants) completing 75% or more of the module activities. Importantly, Module 4 (*Teaching the Let's Talk Lessons*) was completed by the fewest educators. Notably, only 10 participants completed 100% of the module activities, though the majority "skipped" only 1 or 2 activities.

DISCUSSION

The results of this evaluation were encouraging and suggestive of the acceptability and utility of the Let's Talk in the Classroom Guide. A pre/post-test analysis showed that teachers' confidence in delivering mental health-related content to their Grade 7/8 students significantly increased after engaging with the Guide. Similarly, teachers' worries associated with bringing conversations about mental health into the classroom significantly decreased. Notably, a larger change (and standardized effect) was observed in TCS-MH scores than in WWMS scores. We propose that this may be due to the unique differences in the underlying concepts each scale captures as they relate to an educational context. The TCS-MH captures confidence in teaching about mental health-related topics. Items on this scale assessed teachers' belief in their ability to learn new content (i.e., mental health) and develop a strategy to educate their students on the topic. Observing a substantial increase in confidence in delivering material following engagement with a training Guide on how to do so is not necessarily a surprising finding; after all, this is exactly what teachers are trained to do. Indeed, the construct of teacher confidence (sometimes referred to as "teacher efficacy") has long been evaluated (Nolan & Molla, 2017; Tschannen-Moran et al., 1998; Tschannen-Moran & Woolfolk, 2001), and in the years since our study was conducted, several published works have shown a similar improvements in teacher confidence following brief training interventions (Greif Green et al., 2020; Yamaguchi et al.,

2020)supporting, and referring students with mental health needs to school-based mental health providers. However, most teachers receive little or no preparation in this area. The present study examines the impact of one brief, single-session, online role-play simulation designed to prepare teachers to identify students in psychological distress, talk with them about their concerns, and, if necessary, refer them to school mental health services. Forty-six preservice teachers (i.e., undergraduate and graduate students training to be teachers.

In contrast, the WWMS assesses worries associated with teaching about mental health-related topics, with items on this scale capturing concerns surrounding the less controllable aspects of teaching students about mental health. This included potentialities such as experiencing an emotional reaction in a student, inadvertently triggering or singling a student out, or being unable to help a student who discloses a mental health-related issue. These concerns were echoed in several of the qualitative comments shared by teachers even after engaging with the Guide content, emphasizing the potential unpredictabilities that may come along with bringing conversations about mental health into a classroom of curious youth. Even though a smaller change was observed in worry scores as compared to confidence scores, the fact that significant change was observed in this more complex construct after engaging with the Guide is notable and supports the utility of the resource.

Overall, the qualitative results of this study supported the acceptability of the Guide as a teacher resource for those looking to improve their confidence and reduce their worries associated with delivering mental health-related content. Research suggests that teachers remain willing to support students in navigating their mental health, but continue to express a need for further training and guidance about how to do so in a way that is meaningful for students, but does not place the educator in the role of "therapist" (Graham et al., 2011; Kratt, 2020; Shelemy et al., 2019) teachers' roles have expanded to include identifying students with mental health needs and delivering mental health interventions. However, teachers rarely receive mental health training. This study's purpose was to explore teachers' perspectives on an educator mental health competency framework proposed by a group of researchers using the following questions: (a. Many of the teachers who participated in our study expressed positive reactions to the Guide content and several shared that their students enjoyed the classroom material as well.

Although findings supported the acceptability of the Guide, some concerns regarding feasibility were raised. The most frequently identified challenge was time, with many teachers expressing concerns about having a lack of time to not only to engage with the Guide in its entirety, but also with fitting the lesson plans into the busy curriculum. Since this research was conducted, the Guide has been made available in its entirety to educators in both official languages as a downloadable resource that continues to leverage a multimedia approach (i.e., providing links to brief video recordings), without requiring teachers to complete the content within a particular time frame or take part in an online discussion component. The Guide continues to encourage teachers to develop a community of practice within their school, supported by Mental Health Leads, but without a time-bound component. This more flexible implementation approach may remove some of the time-related challenges that were identified by participants. However, issues at the broader level (i.e., lack of capacity in the curriculum) remains an important structural barrier to increasing mental health content in the classroom and the feasibility of the Guide.

Limitations

Several limitations to this study should be noted. First, it is likely that volunteer bias was present in our small sample. Teachers who participated in our study were invested and in favour of bringing the topic of mental health into the classroom. As a result, teachers in our sample may also have demonstrated higher confidence scores and fewer worries at baseline compared to what might be observed among a broader sample of educators. However, it is noteworthy that we still observed significant and meaningful change in confidence and worries scores, despite the likelihood of beginning with skewed scores. While it is noteworthy that we were able to detect medium and large standardized effects in this small study, it is important to note that effect size calculations do not take into account other variables, such as the diversity within the study population (Sullivan & Feinn, 2012). As a result, it is possible that the effect sizes we observed may have appeared larger within our fairly homogenous sample, with effects expected to be lower in a broader sample of educators where there is more variability in interest in teaching about mental health, years of teaching experience, etc.

Secondly, we did not collect data to directly measure the outputs outlined in our logic model. However, it is important to note that mental health knowledge and the fostering of a community of practice were indirectly evaluated through items on the TCS-MH and anecdotal feedback from teachers who participated in the study. The course content is now available at no cost to all Ontario educators in both official languages as a toolkit for teaching mental health-related content, accessible through the CAMH store as a free, downloadable resource (https://store-camh.myshopify.com).

Despite this sample of teachers being invested in the project, we also experienced some challenges with participation, receiving a total of 14 formal withdrawals, all citing lack of time to participate and lack of capacity in the curriculum to add new mental health-related content. An additional 40 participants "informally" withdrew their participation (i.e., ceased participation without notifying the project team) over the course of the study period, resulting in a relatively small final sample of 42 participants. To maximize participation, we provided teachers with the majority of the school year to complete the Guide, despite its relatively low time commitment. We also set no requirement for teachers to complete the Guide in its entirety in order to participate in the study (albeit completion of all activities was required in order to receive a certificate of completion). While some teachers indicated that they enjoyed this flexibility in content delivery, the lack of structure may have been partially responsible for the attrition we observed during the course of the study period. Participation rates gradually decreased, with the most drastic drop in participation observed in the final course activity which provided teachers with "Let's Talk" lesson plans to teach to their students. We propose that this may have been a result of two potential factors: (1) the comparable lack of participation in this final module may have stemmed from teachers preferring to develop their own lesson plans based on the knowledge gained from the Guide, rather than using pre-designed ones (supported by one comment shared in the open-text responses on the post-test survey); and (2) teachers may have been unable to find time in the curriculum to fit in this additional content, a prevalent barrier in the literature that was also identified by several teachers in the open-text responses on the post-test survey.

Finally, the interventions tested in this study are individually focused. Individual teachers must be interested in providing mental health content and either adopting the lesson plans provided or feel confident enough to develop their own. By definition, individual-level programs do not challenge the socio-structural

factors that promote mental illnesses in youth, nor do they attempt to alter school curricula that leave little room for mental health training. Therefore, these resources represent one small piece of a multi-level and multi-sectoral solution to the problem.

CONCLUSION

Implications for Evidence-Based, Implementation-Sensitive Approaches

During the course of this project, lessons learned were apparent in the areas of implementation and research. First, the need for multi-level buy-in was essential for successful implementation. The primary obstacle to completing this training program was time. With already limited curriculum and prep time, teachers needed to have the support of their school administration and board to participate. Given the time restrictions faced by teachers, the program was implemented over the course of an academic year, despite the content consisting of approximately 10 hours of material. Acknowledging the likely time barriers for many teachers, we opted for an implementation-sensitive approach, allowing teachers to pick and choose which components of the Guide they would like to complete. This flexibility appeared to be appreciated by teachers. Even still, multiple withdrawals from the study and open-text responses submitted by teachers who did complete the study indicated that many still found time to be a barrier, with several reporting that participating in the learning reinforcement activities (i.e., online discussion forum, personal journal) was not possible.

To further improve the flexibility of the resource and facilitate its implementation at the national level, the Guide was updated to overcome some of these barriers and enhance uptake. For example, while the interactive version of the Guide remains accessible, an interactive PDF option was also developed (akin to an e-book). The option of an interactive e-book format was also developed to facilitate access to users who may be in remote areas of the country where internet service is unstable (i.e., Northern Canada) as well as to provide an alternative option for those with different learning preferences.

In terms of practical challenges associated with the evaluation of the Guide, it is important to note that multiple layers of ethics approval were required, at the levels of individual schools, school boards, and the institutional research ethics board overseeing the evaluators' work. As a result, prospective evaluators unaccustomed to conducting research within school settings should budget additional time for the implementation of evaluation or monitoring studies related to use of the Guide. If a start date in September is desired, it is important for researchers to take note of the meeting times of school boards' ethics review boards. As with any survey-based research, data collection tools used in evaluations should be concise to prevent survey fatigue and the accumulation of missing data. The use of mixed methods data collection, such as collecting qualitative feedback in addition to quantitative assessments of the Guide, are recommended to gain a more holistic and contextual understanding of the resource and teachers' experiences.

Overall, the results of our evaluation were encouraging and suggestive of acceptability and utility of the Let's Talk in the Classroom Guide as a resource to improve teachers' confidence and reduce their worries associated with bringing conversations about mental health into the Grade 7/8 classroom, with some continued challenges around feasibility identified. While there was a low rate of open-text responses submitted, those that were submitted reflect high levels of perceived acceptability. It is possible that individuals who did not

find the program acceptable were less likely to have completed the post-test and may also have been less likely to have provide responses to open-text entries, further limiting the generalizability of these findings as they relate to acceptability.

Results demonstrated the potential of brief online interventions to improve teacher confidence and comfort with mental health content. Future research should explore the utility of the Guide among larger samples of teachers and explore whether outcomes are maintained in the long-term. Though challenges associated with time and resources (i.e., curriculum time) are likely to continue to be obstacles moving forward, adoption of the Guide may be an important step forward in empowering teachers to help students recognize and respond to changes in their mental health in line with an upstream, mental health promotion approach to improving the mental health outcomes of school-aged youth.

APPENDIX A

Table A

Qualitative Comments Thematically Coded within Categories of Feasibility and Accessibility

Category	Identified Themes	Extracted Quotations
FEASIBILITY	Worries about student maturity	I really enjoyed the PSA aspect of this activity. I decided to have my students complete PSA posters. Here was my problem…students didn't have sufficient background knowledge to make an informed PSA. They were just searching up random facts and some of my posters were a bit too serious for their age group. Partially my fault for not setting restricted sites to search on.
		I was nervous about [my students'] ability to access material.
		I think the lessons were carefully crafted and although some of my students are a bit immature, it served them well.
		I am worried about the maturity level of my students and how they will respond to these types of serious conversations. I also hope my students will open up and engage in thoughtful conversations with both myself and their peers about mental health and well-being. It is challenging promoting talk in a classroom where many students are ESL learners.
		I'm always a little hesitant to bring up serious topics like suicidal thoughts with a group of teens/preteens. It can be a very sensitive topic and can bring up fears in students, however; the I felt prepared to deal with questions that were being asked and it was helpful to have clearly laid out for me the steps to take if a student discloses anything to me. This guide was very helpful in providing that support to me and making me feel safe to discuss serious topics, and my students were very interested in what we spoke about and more than willing to share their experiences which I think was very helpful for others in my class to hear.
		Some of the conversations that may happen as we start really getting into Lesson 3 may end up very personal and I do worry about some of the students not respecting the safety and confidentiality of the space that we are creating together.
		The lesson in which students had to try to find information online was challenging because my students struggle with literacy. I teach Grades 6–8 but most of them didn't understand what they were coming across. It would be great if there was one resource they know they could go to that is accessible for young students.
	Worries about unpredictability	Anytime you discuss tough issues with people, there is always a risk of too much personal experience interfering with the student time. Also worried I might not know what to say, just need to keep it real and admit when you don't know.
		I am always nervous teaching a new lesson, however, I feel that there are enough materials to cover any areas of concern. I think the only area of concern that I have is being asked a question that I can't answer.

Table A, continued

Qualitative Comments Thematically Coded within Categories of Feasibility and Accessibility

Category	Identified Themes	Extracted Quotations
		I definitely feel more comfortable than I did at the beginning, but I am always nervous about a student divulging personal information. But I feel better prepared to handle it.
		The only thing I am always nervous about are the "What if" questions and if a student brings up or has a question about suicide. That is still one component I do not feel completely comfortable discussing as it is a very sensitive topic.
		I'm nervous about feeling frustrated if there doesn't appear to be enough supports to help a student. Or what to do if you've offered supports to families, but they are not ready to use them. It's difficult if the student is with you every day, but you can not help beyond what has been offered.
		No, I think the more I try and refer to the materials the more confident I will become. I think I am nervous simply because these are sensitive issues and may be personal, but I compassion drives my work with the students and I reference terms and definitions then I will feel better with the delivery.
		I am only nervous about being unable to answer questions that may arise involving specifics related to students. However I do feel more equipped to know where to go for support now.
		I suppose still worried that it might trigger some of my students that presently struggle with mental health issues. These students may choose not to participate but then they are the students I want to help the most.
		Training modules – length of time for working through was difficult to fit in.
		I hope that I have enough time to dedicate to this topic, given the scope of the curriculum we need to cover.
		More time to complete all the course material to obtain the certificate would have been helpful. The timelines in place did not align nicely with classroom teacher deadlines. Overall, the experience was positive.
		I found it hard to get myself on the forums on a regular basis. I liked the video as a quick explanation of things but discussing with other teachers was not convenient for me due to time constraints.
		I did find the last few refection questions to be similar. I felt like I was repeating myself. I also didn't have the time to use the discussion forum. I was going through the material on my own so I didn't post to the discussion forum unless I had to. I would have liked to have done the course with a colleague for live discussions.
		Honestly, just more time.
		It was hard to find the time to complete all the activities, I wish we had more in school time! But the activities were very informative!
		Only to give us more time to complete everything.

Table A, continued

Qualitative Comments Thematically Coded within Categories of Feasibility and Accessibility

Category	Identified Themes	Extracted Quotations
		No. I am so excited to deliver the lessons. With guidance from my administrator, the only thing that I am going to do is provide a letter for parents, letting them know that we will be speaking with someone from Kids Help Phone. I always feel that it is important to ensure that they are aware so that they may ask questions or obtain clarification, where needed.
		I've developed a strong enough rapport with students to feel confident about the content.
		I feel more confident about delivering the program and speaking to students.
		The only thing I'm still a little nervous about is saying the wrong thing. But I feel better now than I did before I started this course.
		The only thing I am a bit nervous about is my delivery. Entering this course I did not have much education on mental health and much of this course was new information to me. At this point I am going to read over the material and resources multiple times before I do the lessons with my class. As of right now, I am a bit nervous because I do not feel that all the material is stuck in my head. But I am hoping with more reviewing and researching I will strengthen my knowledge and confidence even more.
	Desire to customize lesson plans	I thought we would be writing our own lessons but much of the work was done for us. I am nervous about implementing plans I did not really create and hadn't had a chance to discuss (in person) with other teachers. This is just what I like to do to better think through a lesson. (This may be because I'm still a fairly green teacher). Anyway, I'm not nervous about discussing these topics, just the logistics of teaching them (especially in the context of only have 35-minute health lessons.
	Desire for French version	I'm hesitant in finding ways to conduct some of this "authentic" learning in French since we are a French Immersion school within a prominently anglophone community.
	Positive experience	As a French Immersion teacher, I would have preferred to have access to French lessons I could use in my classroom.
		I really enjoyed the Guide and would be interested in any additional courses, in this area of expertise.
		Please make this available to all teachers.
		[The Guide was] well laid out and helpful
		I thought [the Guide] was very helpful and thorough.
		I really liked the way the course was laid out. I like that I could go at my own pace.
		The lessons were a bit wordy. But I liked the activities included. The course material was informative and helpful. Provided some good resources.
		I think the course was very informative, and the lessons look engaging and interesting.

Table A, continued

Qualitative Comments Thematically Coded within Categories of Feasibility and Accessibility

Category	Identified Themes	Extracted Quotations
		Thank you for providing such as valuable learning experience.
		No. I think the clear definitions and background knowledge to support our understanding as well as the signs to look for and how we can be supportive was very helpful.
		I would like to know if the materials in the course are still going to be available as I share this with my intermediate team members.
		I used the personal journal for my reflections and was very proud of the effort and level and depth of thinking I put in. I found it useful and ensured I had a copy for my own reference. I would have liked to have someone read it. I know the required postings in the discussion area receive feedback, but it would be nice to have someone access the personal journal as well.
		I have thoroughly enjoyed this course and feel I have learned a lot. My only comment is that this program is very well done and I am very glad that I signed up to be a part of it.
		I enjoyed the self-reflections. It allowed me an opportunity to explore my own practice as a teacher and the influence/role I play with my students.
	Level of content provided	At times the lessons could have been a bit clearer. I had to do a bit of research beforehand.
		I think the course has done a great job to walk you through what needs to be done for the teaching. However, I found that I needed to create my own slide show that included some of the material from the lesson plans as well as the course to feel confident presenting it to my class. It included the links for videos, visual of task assignments, definitions, statistics etc.
		I found the 3 lessons to be well-developed and clearly outlined. The reading materials are relevant and user-friendly. I've printed most of them to include in a reference binder. I've saved the mental health/mental illness video and shared it with staff. Very useful for opening up discussion. The only thing I would be looking to add would be more resources in terms of other lessons. More specifically, what and how to teach this topic or how to incorporate it with other subjects. It is already difficult to fit all the curriculum in throughout the day so I would be interested in learning about how to incorporate mental health form day 1 and how.
		I felt the course material was thorough. It provided a solid foundation for addressing mental health with my students. It provided many useful strategies and the lessons plans were very helpful.
	Clarity of content	I am unsure how the phone conversation that I've booked with the Kids Help Line will work. I would have liked better information on format with my class of 30.

Table A, continued

Qualitative Comments Thematically Coded within Categories of Feasibility and Accessibility

Category	Identified Themes	Extracted Quotations
		I was a bit hesitant about the call to kids help phone line but mostly about the logistics of it. However the person we spoke to put us all at ease and I found it very valuable for the students. They indicated that they learned new and interesting information, and many misconceptions were addressed appropriately.

Notes. Participants were posed two, open-ended questions: (1) "After completing the Guide, is there anything that still worries you?" And (2) "Do you have any further comments on your experience, or recommendations for improvement of the Guide?". The quotes shown here reflect all qualitative responses received. Note that the total number of quotations in the table does not equal the number of participants in the study as not all participants provided a response to both questions.

APPENDIX B

Table B

Proportion of Completed Module Activities for Matched Sample (*n* = 42)

Participant	Module 1	Module 2		Module 3				Module 4	Completed *n*	Completed %
	1.1	2.1	2.2	3.1	3.2	3.3	3.4	4.1		
1	✔								1	12.5
2									0	0.0
3	✔	✔	✔		✔	✔	✔		6	75.0
4									0	0.0
5	✔	✔	✔		✔	✔	✔		6	75.0
6	✔	✔	✔	✔	✔	✔	✔	✔	8	100.0
7	✔		✔		✔	✔	✔	✔	6	75.0
8	✔	✔	✔		✔	✔	✔		6	75.0
9	✔	✔	✔	✔	✔	✔	✔		7	87.5
10	✔	✔	✔		✔	✔	✔		6	75.0
11	✔	✔	✔	✔	✔	✔	✔		7	87.5
12	✔	✔	✔		✔	✔	✔		6	75.0
13	✔				✔	✔	✔		4	50.0
14	✔	✔	✔	✔	✔	✔	✔	✔	8	100.0
15	✔	✔	✔		✔	✔	✔	✔	7	87.5
16	✔	✔	✔	✔	✔	✔	✔	✔	8	100.0
17	✔	✔	✔	✔	✔	✔	✔		7	87.5
18	✔	✔	✔	✔	✔	✔	✔		7	87.5
19	✔	✔	✔	✔	✔	✔	✔		7	87.5
20	✔	✔	✔	✔	✔	✔	✔	✔	8	100.0
21	✔	✔	✔	✔	✔	✔	✔		7	87.5
22	✔	✔	✔	✔	✔	✔	✔	✔	8	100.0
23	✔	✔	✔	✔	✔	✔	✔		7	87.5

Table B, continued

Proportion of Completed Module Activities for Matched Sample (n = 42)

Participant	Module 1	Module 2		Module 3				Module 4		
	1.1	2.1	2.2	3.1	3.2	3.3	3.4	4.1	Completed *n*	Completed %
24	✔		✔		✔	✔	✔		5	62.5
25	✔	✔	✔	✔	✔	✔	✔		7	87.5
26	✔			✔	✔	✔	✔		5	62.5
27	✔	✔	✔		✔	✔			5	62.5
28	✔	✔	✔	✔	✔	✔	✔		7	87.5
29	✔	✔	✔	✔	✔	✔	✔		7	87.5
30	✔				✔	✔	✔		4	50.0
31	✔	✔		✔	✔	✔	✔		6	75.0
32	✔	✔	✔		✔	✔	✔		6	75.0
33	✔	✔	✔	✔	✔	✔	✔	✔	8	100.0
34	✔	✔	✔	✔	✔	✔	✔	✔	8	100.0
35	✔	✔	✔		✔	✔	✔		6	75.0
36	✔	✔	✔	✔	✔	✔	✔	✔	8	100.0
37	✔	✔			✔	✔	✔		5	62.5
38	✔	✔	✔	✔	✔	✔	✔		7	87.5
39	✔	✔	✔	✔	✔	✔	✔	✔	8	100.0
40	✔	✔	✔	✔	✔	✔	✔		7	87.5
41	✔	✔	✔	✔	✔	✔	✔		7	87.5
42	✔	✔	✔	✔	✔	✔	✔	✔	8	100.0
Completed *n*	40	34	34	25	39	39	38	12	—	—

Notes. (1) Participant numbers displayed here are randomly assigned (not the unique IDs used in analysis).
(2) Numbers displayed here are only for participants who submitted both pre and post-test surveys (i.e., withdrawals and dropouts not included).

REFERENCES

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

Bennet-Levy, J., Richards, D., Farrand, P., Christensen, H., & Griffiths, K. (Eds.). (2010). *Oxford Guide to Low Intensity CBT Interventions*. OUP Oxford.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., … Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11–27. doi: 10.1017/S0033291714000129

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Erlbaum.

Compton, M., & Shim, R. (2015). The social determinants of mental health. *Focus: Psychiatry Online*, *13*(4), 419–425. doi: 10.1176/appi.focus.20150017

Coombe, J., Mackenzie, L., Munro, R., Hazell, T., Perkins, D., & Reddy, P. (2015). Teacher-mediated interventions to support child mental health following a disaster: A systematic review. *PLoS Currents*, *7*. doi: 10.1371/currents.dis.466c8c96d879e2663a1e5e274978965d

Currie, C., & Morgan, A. (2020). A bio-ecological framing of evidence on the determinants of adolescent mental health – A scoping review of the international Health Behaviour in School-Aged Children (HBSC) study 1983–2020. *SSM - Population Health*, *12*(100697), 1–22. doi: 10.1016/j.ssmph.2020.100697

Dayan, J., Bernard, A., Olliac, B., Mailhes, A. S., & Kermarrec, S. (2010). Adolescent brain development, risk-taking and vulnerability to addiction. *Journal of Physiology Paris*, *104*(5–6), 279–286. doi: 10.1016/j.jphysparis.2010.08.007

Dopp, A. R., & Lantz, P. M. (2020). Moving upstream to improve children's mental health through community and policy change. *Administration and Policy in Mental Health and Mental Health Services Research*, *47*(5), 779–787. doi: 10.1007/s10488-019-01001-5

Dray, J., Bowman, J., Campbell, E., Freund, M., Wolfenden, L., Hodder, R. K., … Wiggers, J. (2017). Systematic review of universal resilience-focused interventions targeting child and adolescent mental health in the school setting. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(10), 813–824. doi: 10.1016/j.jaac.2017.07.780

Erchul, W. P. (2015). Put me in, coach: Observations on selected studies implementing supportive interventions to teachers. *School Mental Health*, *7*, 74–79. doi: 10.1007/s12310-015-9144-1

Franklin, C., Kim, J. S., Beretvas, T. S., Zhang, A., Guz, S., Park, S., … Maynard, B. R. (2017). The effectiveness of psychosocial interventions delivered by teachers in schools: A systematic review and meta-analysis. *Clinical Child and Family Psychology Review*, *20*(3), 333–350. doi: 10.1007/s10567-017-0235-4

Franklin, C., Kim, J. S., Ryan, T. N., Kelly, M. S., & Montgomery, K. L. (2012). Teacher involvement in school mental health interventions: A systematic review. *Children and Youth Services Review*, *34*, 973–982. doi: 10.1016/j.childyouth.2012.01.027

Froese-Germain, B., & Riel, R. (2012). *Understanding teachers' perspectives on student mental health: Findings from a national survey*. https://www.ctf-fce.ca

Government of Canada. (2017). About mental illness. https://www.canada.ca/en/public-health/services/about-mental-illness.html#a1

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. doi: 10.1080/13540602.2011.580525

Greif Green, J., Levine, R. S., Oblath, R., Corriveau, K. H., Holt, M. K., & Albright, G. (2020). Pilot evaluation of preservice teacher training to improve preparedness and confidence to address student mental health. *Evidence-Based Practice in Child and Adolescent Mental Health*, *5*(1), 42–52. doi: 10.1080/23794925.2020.1727793

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustün, T. B. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry*, *20*(4), 359–364.

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. doi: 10.1001/archpsyc.62.6.593

Keyes, C. L. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Behavior*, *43*(2), 207–222. doi: 10.2307/3090197

Kirby, M., & Keon, W. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Ottawa. https://mentalhealthcommission.ca/wp-content/uploads/2021/09/out_of_the_shadows_at_last_-_full_0_0.pdf

Kratt, D. (2020). Teachers' perspectives on educator mental health competencies: A qualitative case study. *American Journal of Qualitative Research*, *2*(1), 22–40. doi: 10.29333/ajqr/5792

Kutcher, S., Venn, D., & Szumilas, M. (2009). Mental health: The next frontier of health education. *Education Canada*, *49*(2), 44–45.

Linden, B., & Stuart, H. (2019). Preliminary analysis of validation evidence for two new scales assessing teachers' confidence and worries related to delivering mental health content in the classroom. *BMC Psychology*, *7*(32), 1–11. doi: 10.1186/s40359-019-0307-y

Macleod, K. B., & Brownlie, E. B. (2014). Mental health and transitions from adolescence to emerging adulthood: Developmental and diversity considerations. *Canadian Journal of Community Mental Health*, *33*(1), 77–86. doi: 10.7870/cjcmh-2014-007

Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. https://www.mentalhealthcommission.ca

Montgomery, C., Chouinard, J., Lennox Terrion, J., Montgomery, N., Rioux, M., & Daubney, A. (2014). *Efficacy evaluation of the "Let's talk: Finding reliable mental health information and resources" program for Grades 7 and 8 students in three Ontarian school boards and one independent school in Quebec*. Ottawa.

Nolan, A., & Molla, T. (2017). Teacher confidence and professional capital. *Teaching and Teacher Education*, *62*, 10–18. doi: 10.1016/j.tate.2016.11.004

O'Connell, M., Boat, T., & Warner, K. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. https://www.ncbi.nlm.nih.gov/books/NBK32775/pdf/Bookshelf_NBK32775.pdf

Offord Centre for Child Studies. (2014). *2014 Ontario child health study: Ontario provincial report*. http://ontariochildhealthstudy.ca

Reddy, L. A., Newman, E., De Thomas, C. A., & Chun, V. (2009). Effectiveness of school-based prevention and intervention programs for children and adolescents with emotional disturbance: A meta-analysis. *Journal of School Psychology*, *47*(2), 77–99. doi: 10.1016/j.jsp.2008.11.001

Romeo, R. D. (2017). The impact of stress on the structure of the adolescent brain: Implications for adolescent mental health. *Brain Research*, *1654*, 185–191. doi: 10.1016/j.brainres.2016.03.021

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*, 334–340.

Santor, D., Short, K., & Ferguson, B. (2009). *Taking mental health to school: A policy-oriented paper on school-based mental health for Ontario*. http://www.excellenceforchildandyouth.ca/sites/default/files/position_sbmh.pdf

Sawilowsky, S. S. (2009). New effect size rules of thumb. *Journal of Modern Applied Statistical Methods*, *8*(2), 597–599. doi: 10.22237/jmasm/1257035100

School Based Mental Health and Substance Abuse Consortium. (2013). *School-based mental health in Canada: A final report*. https://www.mentalhealthcommission.ca/

School Mental Health Ontario. (2020). About student mental health. https://smho-smso.ca/about-student-mental-health/

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

Statistics Canada. (2020). *Canadian health survey on children and youth, 2019*. Ottawa.

Sullivan, G. M., & Feinn, R. (2012). Using effect size – or why the p value is not enough. *Journal of Graduate Medical Education*, *4*(3), 279–282. doi: 10.4300/JGME-D-12-00156.1

Tschannen-Moran, M., Hoy, A. W., & Hoy, W. K. (1998). Teacher efficacy: Its meaning and measure. *Review of Educational Research*, *68*(2), 202–248.

Tschannen-Moran, M., & Woolfolk, A. (2001). Teacher efficacy: Capturing an elusive construct. *Teaching and Teacher Education*, *17*(7), 783–805.

Werner-Seidler, A., Perry, Y., Calear, A. L., Newby, J. M., & Christensen, H. (2017). School-based depression and anxiety prevention programs for young people: A systematic review and meta-analysis. *Clinical Psychology Review*, *51*, 30–47. doi: 10.1016/j.cpr.2016.10.005

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

World Health Organization. (2013). *Mental health action plan 2013-2020*. https://www.who.int/mental_health/action_plan_2013/en/

Yamaguchi, S., Foo, J. C., Nishida, A., Ogawa, S., Togo, F., & Sasaki, T. (2020). Mental health literacy programs for school teachers: A systematic review and narrative synthesis. *Early Intervention in Psychiatry*, *14*(1), 14–25. doi: 10.1111/eip.12793