

The development and delivery of
a mental health literacy and counselling skills workshop for educators:
A pilot study

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Abstract

School settings are increasingly being targeted as ideal entry points for youth mental health initiatives and naturally, educators have been identified as playing a critical role in supporting youth in distress. The current study set out to investigate how to strengthen the ability of educators to support youth experiencing bullying and mental health difficulties. The study was conducted in two phases: an initial phase in which a mental health literacy and communication skills workshop for educators was developed and refined, and a second phase in which the workshop was pilot-tested. The 2-hour workshop was delivered to two groups of students ($N = 35$) in a Teacher's Education (B.Ed.) program at a Canadian university. Participants completed a questionnaire following the workshop to assess their satisfaction with the workshop experience and their degree of change in knowledge and awareness of bullying and mental health difficulties, as well as self-efficacy and perceived confidence in communicating with young people in distress. Results showed that participant satisfaction with the workshop was high and that most participants would recommend the workshop for pre-service and in-service teachers. In addition, participant knowledge, awareness, self-efficacy, and self-confidence in communicating with youth in distress increased from pre- to post-workshop. Taken together, the results of the pilot study provide support for further development and delivery of this workshop to pre-service and in-service teachers to help prepare educators for the complex, demanding, and vital role of supporting young people in distress due to bullying and mental health difficulties.

Keywords: Bullying; communication skills; mental health; mental health literacy; pilot study; pre-service and in-service educators; relational caring; workshop evaluation; youth

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Statement of the Research Problem

Adolescence is a critical period in the developmental lifespan with respect to the onset of risk factors that can influence long-term mental health and well-being. Many of the social and psychological difficulties and disorders of adulthood first manifest in adolescence and young adulthood (Rickwood, Deane, Wilson, & Ciarrochi, 2005; Santor, Short, & Ferguson, 2009). In fact, current research findings indicate that 50% of mental health disorders emerge before the age of 14, and 75% prior to the age of 24 (Kessler et al., 2005; Rickwood et al., 2005). A significant portion of the disability burden associated with mental health disorders develops soon after the onset of illness (Purcell et al., 2011); as such, the impact of a mental health difficulty or illness in adolescence can be profound and far-reaching (Santor et al., 2009; Sheffield, Fiorenza, & Sofronoff, 2004). For this reason, early detection and intervention with effective mental health and wellness supports and services for young people is critically important in order to reduce the risk of a mental health difficulty undermining the critical growth process that unfolds in this developmental period. At present, however, only one in five young people who requires mental health services actually receives help (Health Canada, 2002; Wei, Kutcher, & Szumilas, 2011) and very few youth actually seek out help for problems related to bullying or mental illness (Eliot, Cornell, Gregory, & Fan, 2010; Craig, Pepler, & Atlas, 2000; Wilson & Deane, 2001).

In order to better meet the mental health needs of youth, researchers and policy-makers are calling for more attention and resources directed at the development of school-based initiatives that support children and youth with mental health difficulties. School settings have increasingly been targeted as ideal entry points for the delivery of mental health promotion, prevention, and intervention initiatives given that youth spend a substantial amount of time at school and that schools already play a key role in improving the health, life skills, self-esteem, and behaviour of young people (World Health Organization [WHO], 1997). School settings are also well-positioned to provide access to a considerable number of underserved and vulnerable youth who may face barriers to effective help-seeking or may be reluctant to seek help independently (Kutash, Duchnowski, & Lynn, 2006; Manion, Short, & Ferguson, 2012; Rickwood et al., 2005; Santor et al., 2009; Schwean & Rodger, 2013; WHO, 1997). Moreover, schools inherently provide opportunities for educators to build healthy, trusting relationships

with adolescents and youth prior to the onset of distressing experiences or mental health difficulties, which can make help-seeking pathways more accessible to youth (Rickwood et al., 2005; Santor, Poulin, LeBlanc, & Kusumakar, 2007). Accordingly, mental health prevention and intervention programs for students and initiatives to train educators on mental health literacy are increasingly being introduced in school settings (Kutcher, Wei, McLuckie, & Bullock, 2013).

A few preliminary evaluations of educator mental health literacy training programs have been reported in the Canadian literature (e.g., Kutcher et al., 2013; Wei & Kutcher, 2014); however, there remains a consensus among researchers that the body of literature on educator mental health literacy is small and that the ability of educators to support youth with mental health difficulties is relatively limited (Chenier & Bourget, 2007; Santor et al., 2009). Educators have also expressed concern about the expansion of school-based approaches to adolescent and youth mental health without corresponding professional development training for educators (Coalition for Children and Youth Mental Health, 2013; Manion et al., 2012; Mental Health Commission of Canada [MHCC], 2012).

A recent survey of board-level educators in Ontario found that 67% of administrative leaders believe teachers in their schools are not at all, or only a little, prepared to support the mental health needs of children and youth (Short, Ferguson, & Santor, 2009). In a national study, over two-thirds of teachers reported having never received knowledge or skills training on student mental illness (Froese-Germain & Riel, 2012); among teachers with less than five years of experience, less than 25% had received some type of professional development training related to student mental health needs. According to a national survey of educators and board-level staff supported by the Mental Health Commission of Canada, the shortage of professional development opportunities for educators, particularly regarding prevention strategies and recognizing mental health difficulties in youth, remains an obstacle to the successful implementation of mental health initiatives in schools (Manion et al., 2012; MHCC, 2012).

In order to begin to address these gaps in educator professional development and work towards better supporting the mental health needs of adolescents, the current study was designed with the intent to develop and pilot-test a workshop for educators on mental health literacy and communication skills for building healthy relationships with young people. The workshop content was organized along two themes. Firstly, consistent with existing educator mental health literacy training initiatives, the workshop provided training on the early identification of mental

health difficulties in youth by helping educators identify the observable signs of vulnerability and risk in adolescents and youth in the classroom. Secondly, and as an extension to existing research, it offered educators direct training on effective communication skills for developing positive student-teacher relationships.

Literature Review

Mental Health and Mental Illness

Mental health and mental illness emerge from the interaction of many social, psychological, and biological factors. Mental health is often the foundation of an individual's well-being and is intimately related to social functioning, behaviour, and physical health (WHO, 2005). Although mental health has historically been classified as the absence of mental illness, the most contemporary conceptualization recognizes mental health as a distinct state of balance, more aptly measured along a continuum from poor mental health to optimal mental health (Wells, Barlow, & Stewart-Brown, 2003; WHO, 2005). According to the U.S. Surgeon General's *Mental Health* report, mental health is defined as "a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity" (U.S. Department of Health and Human Services [U.S. DHHS], 1999, p. 4). More holistically, it is "the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face" (Public Health Agency of Canada [PHAC], 2014, np).

An individual with optimal mental health possesses psychological assets and skills for positive functioning, as well as a high level of subjective well-being (Centers for Disease Control and Prevention [CDC], 2016; Keyes, 2002, 2006; MHCC, 2009). In the broadest sense, subjective well-being is a holistic notion that refers to people's quality of life and their ability to enjoy life (MHCC, 2009). A state of subjective well-being generally includes the presence of positive affect (e.g., happiness), low negative affect (e.g., depression), and the cognitive judgment that one's life and life circumstances are satisfying (CDC, 2016; Diener, Suh, Lucas, & Smith, 1999). Individuals with low subjective well-being are categorized as languishing, which refers to "a state of emptiness in which individuals are devoid of emotional, psychological, and social well-being, but they are not mentally ill" (Keyes, 2006, p. 7).

The term mental illness broadly refers to all diagnosable disorders resulting in "alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and/or

impaired functioning” (U.S. DHHS, 1999, p. 5). The diagnosis of mental illness is done by a qualified professional according to one of the current systems of diagnostics; namely, the DSM-5 (American Psychiatric Association, 2013) or the ICD-10 (WHO, 2016b). Mental illness can affect an individual at any age; however, most mental illnesses have an onset in adolescence or young adulthood (Kessler et al., 2005; PHAC, 2014). In the literature, mental illnesses or disorders are distinguished from mental health problems based on the intensity and duration of the individual’s symptoms, with the term “mental health problem” referring to psychological conditions with signs and symptoms of insufficient intensity or duration to meet the criteria for a particular mental disorder (U.S. DHHS, 1999). Although the prevalence rates for mental health problems are not reported, such difficulties may still result in significant distress or disability, especially for vulnerable individuals or populations (Santor et al., 2009). In fact, there is a significant population of youth that have not being diagnosed with a mental health disorder, but frequently experience mental health problems (Sheffield et al., 2004).

For the purpose of this research, the term *mental health difficulties* is used to collectively refer to both mental illnesses and less severe mental health problems, given that mental health literacy and programming initiatives can universally impact young people experiencing distress of any duration or severity (Santor et al., 2009).

Mental health difficulties in adolescence. Adolescence, the period of human development between 10-19 years, is a stage of life characterized by rapid growth in cognitive, emotional, social, and physical domains (American Psychological Association, 2002; WHO, 2016a). For some young people, the period of adolescence is also marked by the first emergence of a mental health problem or the onset of mental illness (Kessler et al., 2005; Patel, Flisher, Hetrick, & McGorry, 2007; Rickwood et al., 2005). An estimated one in five children and youth are currently diagnosed with a mental illness in a given year (Government of Ontario, 2016; Kessler et al., 2005; Santor et al., 2007).

The vast majority of mental health disorders are diagnosed prior to the age of 25, with approximately 50% of mental health difficulties emerging prior to age 14 (Kessler et al., 2005; MHCC, 2013). Among young people, mental health disorders are the leading cause of disability and disease (Patel et al., 2007) and the greater part of the disability associated with a mental health difficulty develops soon after the onset of illness (Purcell et al., 2011). In adolescents, anxiety and mood disorders are the most common mental health difficulties, with approximately

7% of Canadian youth aged 12-19 years being diagnosed with an anxiety or mood condition in 2011/2012 (MHCC, 2015). Adolescents and youth are also more likely than any other age group to report suicide risk factors, such as suicidal thoughts and self-harm behaviours (MHCC, 2015).

Without appropriate and timely intervention, adolescent mental health difficulties can lead to poor immediate and long-term outcomes, including difficulty with social functioning, impaired learning and achievement, absenteeism and school drop-out, poorer relationships, and increased mortality (Patel et al., 2007; Santor et al., 2009; Wei et al., 2011).

Bullying and peer victimization in adolescence. Bullying and peer victimization are major contributors to the onset of mental health difficulties in youth. In fact, one of the major consequences of bullying involvement in adolescence is an increase in social and emotional problems, which are risk factors for poor mental health across the lifespan (Craig & McCuaig Edge, 2010). As such, the prevalence of bullying and peer victimization is of significant concern for researchers, policymakers, and school administrators working with youth.

According to the international findings of the WHO Health Behaviour in School-aged Children (HBSC), approximately 11% of adolescents 11 to 15 years of age experience peer victimization or bullying involvement at least twice a month (Currie et al., 2012). An adolescent is the victim of bullying when repeatedly exposed to intentional, negative acts by another student or a group of students who have real or perceived power over the victim (Olweus, 1994, 2013). According to the Promoting Relationships and Eliminating Violence Network (PREVNet, 2007), bullying is fundamentally a relational problem that can involve acts of physical, verbal, social, or cyber aggression that are perceived as harmful or distressing to the victim.

In Canada, the rates of adolescent bullying and peer victimization are consistently higher than the rates reported by more than half of other developed nations (Currie et al., 2012). In 2009/2010, the HBSC study found that approximately 20% of Canadian students were victimized, 14% perpetrated bullying, and over 40% were both victims and perpetrators of bullying (Craig & McCuaig Edge, 2010). Among the students who reported being victimized by peers, the majority experienced occasional victimization, while 3-8% of victims reported being bullied weekly. Consistent with extant research, the HBSC study found that the overall prevalence of victimization decreases from middle school to high school and the incidence of bullying others increases across middle and high school (Craig & McCuaig Edge, 2010; Hymel & Swearer, 2015; Vaillancourt et al., 2010b). Of the substantial number of students who reported

being both victims and perpetrators of bullying, the prevalence of reported bullying involvement was relatively consistent across the grades (Craig & McCuaig Edge, 2010).

Decades of research on the bullying phenomenon have established a causal link between bullying and poor mental health both concurrently and longitudinally (Craig & McCuaig Edge, 2010; Vaillancourt et al., 2010a; Vaillancourt, Hymel, & McDougall, 2013). In particular, peer victimization in childhood or adolescence has been associated with increased incidence of anxiety, social withdrawal, depression, low self-esteem, behavioural problems and somatic symptoms, such as headaches and stomach aches (Craig & McCuaig Edge, 2010; Currie et al., 2012; PREVNet, 2007; Vaillancourt et al., 2010a; WHO, 2005). Adolescents and youth who perpetrate bullying are also at risk of increased anti-social behaviour and substance use, and may also suffer from unhealthy relationship dynamics across their lifespan (Craig & McCuaig Edge, 2010; Pepler, Jiang, Craig, & Connolly, 2008). As such, prevention and intervention initiatives that address peer victimization and bullying are clearly needed in order to address both the pervasiveness of the phenomenon and the long-term negative consequences of bullying involvement on important mental health outcomes.

Trends in Adolescent Help-seeking

The impact of bullying experiences in adolescence can be profound and disruptive, and the consequences may extend into adulthood (Craig & McCuaig Edge, 2010; Patel et al., 2007; Purcell et al., 2011; Rickwood et al., 2005; Santor et al., 2009). As such, there is an obvious need to provide timely and effective interventions for adolescents experiencing victimization, bullying, and resulting mental health difficulties. Regrettably, there is overwhelming evidence that very few adolescents independently seek out help for problems related to bullying or mental illness (Craig et al., 2000; Eliot et al., 2010; Leach & Rickwood, 2009).

Research findings from a study of Australian youth found that although 23% of males and 31% of females reported having a mental health disorder, only 13% of males and 30% females with diagnosed mental illness sought professional help within a year (Rickwood, Thomas, & Bradford, 2012). Correspondingly, the National Survey of Mental Health and Wellbeing in Australia found that only 29% of children and youth with mental health problems contacted a professional for health, mental health or education services within a 12-month period (Rickwood et al., 2005). Similarly, epidemiological and mental health surveys in Canada and the United States reported that while 12-20% of children and youth aged 4-17 years old had a

diagnosed mental illness, only 16-25% of those diagnosed received specialized mental health services from a mental health practitioner or community mental health service (Waddell, Offord, Shepherd, Hua, & McEwan, 2002). Findings from the National Health Interview Survey suggest that approximately 75% of children and youth in the U.S. have unmet mental health needs (Kataoka, Zhang, & Wells, 2002). Clearly, there is a marked mismatch between the prevalence of mental health difficulties and service utilization, which researchers have suggested may be related to both help negation and inappropriate or insufficient help-seeking behaviours (Rickwood et al., 2005). Help negation occurs when youth in need of help do not use available support and services due to factors such as fear or perceptions of negative judgment. Inappropriate and insufficient help-seeking behaviours are often the consequence of youth only seeking help from untrained sources of support, such as family and friends, even though these individuals may be poorly prepared to address emerging mental health difficulties.

Research has also shown that adolescent victims of bullying rarely seek help from others, despite the robust finding that adult involvement can end or significantly reduce incidences of adolescent bullying (Eliot et al., 2010; Leach & Rickwood, 2009; Smith & Shu, 2000; Sulkowski, Bauman, Dinner, Nixon, & Davis, 2014). Consistent with other research, Sulkowski et al. (2014) found that less than one third of students aged 11 to 19 years old told an adult at school about being victimized by peers. Moreover, youth have been found to be increasingly less likely to seek help from an adult at school for peer victimization as they get older (Bauman, Meter, Nixon, & Davis, 2016; Sulkowski et al., 2014; Williams & Cornell, 2006), which suggests that facilitative conditions for help-seeking are especially important to encourage adolescents to receive the support and services they need.

Of further concern is that the adolescents most at risk of negative outcomes are the least likely to engage in help-seeking for mental health difficulties (Ciarrochi, Deane, Wilson, & Rickwood, 2002; Garland & Zigler, 1994). For instance, Dowling and Carey (2013) found that over three-quarters of bullying victims did not share their negative experience with anyone. Adolescents and youth with bullying involvement also have more negative attitudes towards help-seeking and lower help-seeking intentions than their peers (Leach & Rickwood, 2009) and have been found to have insufficient social support, which is a risk factor for the development of mental health problems if the adolescent is unable to engage in appropriate help-seeking (Sheffield et al., 2004). Moreover, the consequences of peer victimization, namely increased

feelings of depression and hopelessness, as well as social withdrawal and isolation, contribute to making help-seeking more difficult for victimized adolescents (Leach & Rickwood, 2009). The presence of mental health difficulties, including symptoms of depression and suicidal ideation, also decrease the likelihood that an adolescent will seek help (Deane, Wilson, & Ciarrochi, 2001; Garland & Zigler, 1994; Wilson, Deane, & Ciarrochi, 2005). In fact, in studies involving youth with elevated risk of suicide, professional help-seeking has been reported by less than 30% of adolescents (Cotter et al., 2015; Hom, Stanley, & Joiner, 2015).

In order to address the disparity between mental health needs and service utilization, researchers have long studied the factors that contribute to translating help-seeking intentions into actual help-seeking behaviours. In general, help-seeking involves actively seeking out another person in order to “obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience” (Rickwood et al., 2005, p. 4). Research has consistently demonstrated that help-seeking for mental health difficulties and psychological problems is an adaptive coping behaviour that can serve as a protective factor for many adolescent outcomes, including personal distress and suicidal ideation (Rickwood et al., 2005; Wilson & Deane, 2001). The research findings also suggest that help-seeking behaviours rely on effective interpersonal communication skills and that pathways to mental health care can be strengthened by fostering better relationships between adolescents and adult help-providers (Rickwood et al., 2005; Santor et al., 2007).

There are several key factors that influence the likelihood of adolescents seeking help for mental health difficulties, including: the strength of the relationship with the help-giver; perceived trustworthiness and familiarity of the help-giver; and confidentiality factors (Rickwood et al., 2005; Walcott & Music, 2012; Wilson & Deane, 2001). Most saliently, a strong positive relationship with a potential help-giver who is supportive and encouraging and who makes the youth feel valued and heard is critical for appropriate help-seeking (Wilson & Deane, 2001). For this reason, many youth currently prefer seeking help from family and friends for personal and emotional problems (Rickwood et al., 2005; Sheffield et al., 2004), despite their lack of the professional skills required to provide the youth in need with competent services. Nevertheless, professional adults in regular contact with young people also have a key role in promoting mental health and early intervention with youth in distress. In fact, maintaining a healthy relationship with one caring adult is a crucial protective factor for at-risk youth (Sabol &

Pianta, 2012). For many adolescents, a positive student-teacher relationship can address this need while also enhancing their academic and social-emotional functioning (Sabol & Pianta, 2012).

Universal Mental Health Promotion and Prevention in Schools

Schools have a central and fundamental role in the lives of most children and youth and are key contributors to the social and emotional development of young people (Morrison & Kirby, 2010; Saarento, Garandea, & Salmivalli, 2015; Wells et al., 2003). Schools also provide daily access to children and youth, including many vulnerable and underserved youth who may otherwise not receive adequate or timely mental health services (Rickwood et al., 2005; Santor et al., 2009; Wei et al., 2011). For these reasons, the Mental Health Commission of Canada asserts that “schools are an excellent place to promote positive mental health, [and] more needs to be done to take advantage of the growing number of school/community partnerships, coalitions and networks focused on moving the field forward” (MHCC, 2013, p. 15). As such, school settings are increasingly being targeted for the implementation of prevention and intervention initiatives to support youth with personal and emotional problems.

In Ontario, the provincial government, which funds and administers education according to the *Education Act* and its regulations, has explicitly recognized the importance of mental health promotion and prevention in school settings (Ministry of Education, 2009; Ministry of Health and Long-Term Care, 2011). In fact, in order to enhance the school-based capacity in this area, the Ontario government has outlined a comprehensive mental health strategy to better support individuals with mental illness, starting with school-aged children and youth (Ministry of Education, 2013; Ministry of Health and Long-Term Care, 2011). One of the specific goals of the strategy is to enhance the capacity of schools and teachers to “identify problems and intervene early and appropriately” through the implementation of mental health literacy programs for educators, universal school-based identification and intervention initiatives, and mental health resources in schools (Ministry of Health and Long-Term Care, 2011, p. 14).

Emerging research demonstrates that school-based bullying prevention and mental health initiatives are effective at improving emotional and behavioural functioning and supporting youth in distress when the intervention is universal (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Santor et al., 2009; Weare & Nind, 2011). Universal prevention strategies refer to initiatives that are implemented school-wide in order to prevent the onset of mental health difficulties in the general population and optimize positive mental health in all children

and youth (Education Development Center [EDC], 2011; Santor et al., 2009). Effective school-wide approaches encourage collaboration in order to establish positive psycho-social environments that promote academic learning, school connectedness, and healthy relationships (Durlak et al., 2011; Education Development Center [EDC], 2011; Rowe & Stewart, 2009).

Extant research has demonstrated that schools with positive psycho-social climates that promote high levels of connectedness better support the mental health and well-being of adolescents (Aldridge et al., 2016; Currie et al., 2012). Moreover, positive school climate and connectedness provide protection that reduces adolescent health-compromising behaviours (Klein, Cornell, & Konold, 2012; Rowe & Stewart, 2009) and increases help-seeking for adolescents in distress (Aldridge et al., 2016; Eliot et al., 2010; Suldo, McMahan, Chappel, & Loker, 2012). Positive school climates are founded on positive student-teacher relationships in which adolescents experiencing bullying or mental health difficulties are provided with support from caring adults who promote healthy youth psycho-social development (Myers & Pianta, 2008; Pepler & Craig, 2014; Reddy, Rhodes, & Mulhall, 2003). In fact, positive student-teacher relationships have been identified as promising entry points to help to address the mental health needs of adolescents (Myers & Pianta, 2008; Pepler & Craig, 2014) and provide adolescents with a trusted help-seeking pathway (Jorm et al., 2006; Rickwood et al., 2005). In order to effectively implement universal, school-wide mental health initiatives and attain these positive outcomes for adolescents and youth, it is necessary to involve educators in school-based bullying and mental health initiatives and to provide educators with appropriate, high quality professional development opportunities.

Educator involvement. Considering the high incidence of adolescent victimization, bullying, and mental health difficulties, it is inevitable that educators will be in close contact with students in distress. In fact, the vast majority of elementary and secondary teachers who participated in a national survey conducted by the Canadian Teachers' Federation in collaboration with the MHCC reported being concerned by the prevalence of stress, anxiety, and depressive problems among students in their schools (Froese-Germain & Riel, 2012). Given that educators spend a considerable amount of time interacting and engaging with youth, teachers are inherently well positioned to facilitate universal, school-wide initiatives that support the mental health needs of adolescents (Kutash et al., 2006; Myers & Pianta, 2008; Wei & Kutcher, 2014; Whitley, Smith, & Vaillancourt, 2013), a fact that is highlighted in Ontario's Ministry of

Education draft report entitled *Supporting Minds: An Educator's Guide to Promoting Students' Mental Health and Well-being*. In this report, educators are acknowledged as having to play a key role in “promoting positive mental health at school, identifying students who may have mental health problems, and connecting those students with appropriate services” (Ministry of Education, 2013, p. 6).

In order for educators to effectively participate in school-wide mental health initiatives, however, identified gaps in mental health literacy and the professional development training of teachers and teacher candidates need to be addressed (Froese-Germain & Riel, 2012; MHCC, 2013; Short et al., 2009). Providing educators with resources to increase their knowledge and awareness of adolescent mental health needs and their ability to develop healthy relationships with youth are two critical ways to better position educators to contribute to universal mental health initiatives in school settings (Dods, 2016; Sabol & Pianta, 2012).

Educator mental health literacy. Mental health literacy is a multi-faceted concept that refers to the knowledge and beliefs that facilitate an individual's ability to recognize, manage or prevent mental illness (Jorm et al., 1997). Recently, the concept has been expanded to also include “skills that enable people to access, understand and apply information for mental health” (Canadian Alliance on Mental Illness and Mental Health, 2008, p. 11). The vast majority of the mental health literacy training programs reported in the literature have aimed to teach one or more of the following aspects: the recognition of mental health problems; knowledge of mental illness, risk factors, and sources of support; and the promotion of positive and non-stigmatizing attitudes towards mental illness (Jorm et al., 1997; O'Connor, Casey, & Clough, 2014). Mental health literacy training programs for educators, although relatively new, have focused on providing educators with knowledge, understanding, comfort, and skill development. In particular, one Ontario-based mental health literacy initiative that was developed as part of the province's Comprehensive Mental Health and Addictions Strategy (Ministry of Health and Long-Term Care, 2011) proposes offering educators training in both “general knowledge and skills for student mental health and well-being at school” and more specific knowledge on delivering mental health and well-being content to students (Fortier, Lalonde, Venesoen, Legwegoh, & Short, 2017, p. 69). Similarly, Atkins and Rodger (2016) recently reported the findings from the development and delivery of an elective course on mental health literacy for pre-service educators. This course had five learning outcomes: (1) to learn about the mental

health and well-being of children; (2) to learn about the impact of mental illness on school-related outcomes; (3) to understand more about inclusivity and the role of caring adults in the lives of children; (4) to develop mental health literacy and understand positive mental health; and (5) to develop self-awareness knowledge and skills related to personal resiliency.

Research on the effectiveness of mental health literacy training has shown that the trainings can increase an individual's knowledge and ability to recognize various mental health difficulties (Anderson & Pierce, 2012; Kelly, Jorm, & Wright, 2007) and can reduce prejudice and stigma towards mental illness (Anderson & Pierce, 2012; Jorm et al., 2006). Additionally, mental health literacy training has been shown to increase an individual's confidence in his or her ability to help someone with a mental health issue (Anderson & Pierce, 2012; Jorm, 2012).

Correspondingly, the provision of mental health literacy training specific to educators can enhance educators' knowledge and ability to identify at-risk adolescents (Kutcher et al., 2013; Wei & Kutcher, 2014). Educator mental health literacy training can also improve an educator's perceived comfort and confidence in addressing adolescent mental health needs (Kutcher et al., 2013; Wei & Kutcher, 2014) and perceived capacity to prevent and address bullying issues (Benítez, García-Berbén, & Fernández-Cabezas, 2009). In fact, Dods (2016) reported that increases in educator mental health knowledge significantly increased educator self-efficacy and feelings of preparedness. There is also evidence that educator mental health literacy training can provide educators with the competencies needed to link adolescents in distress with appropriate mental health supports (Wei & Kutcher, 2014).

Educators and healthy student-teacher relationships. From Bowlby's (1969) seminal theory of attachment to Bronfenbrenner's (1979) ecological model of development, the importance of healthy relationships for child and youth development is well established. Research has shown that quality adult-youth relationships are critically important determinants of positive youth development in several environments, including schools (Chhuon & LeBaron Wallace, 2014). In fact, youth with quality relationships or connections in multiple contexts (e.g., family, peers, and non-related adults) have higher well-being across almost all dimensions than youth without connections (Schonert-Reichl & Rowcliffe, 2011). According to Myers and Pianta (2008), student-teacher relationships offer "a unique entry point for educators and others working to improve the social and learning environments of schools and classrooms" (p. 601).

Research findings also suggest that enriching the quality of student-teacher relationships may considerably improve mental health and well-being outcomes for youth. Healthy student-teacher relationships have been shown to be a developmental asset and protective factor for youth at risk of bullying involvement and mental health problems (Connors-Burrow, Johnson, Whiteside-Mansell, McKelvey, & Gargus, 2009; Pepler & Craig, 2014; Sabol & Pianta, 2012). Positive student-teacher relationships have also been shown to influence adolescent learning and development (Chhuon & LeBaron Wallace, 2014; Myers & Pianta, 2008) and mental health outcomes (Currie et al., 2012; Pepler, Craig, & Haner, 2012). In fact, recent findings aggregated by the WHO using data from the HBSC study found a significant association between the overall mental health well-being of adolescents aged 11-15 years and the quality of their relationship with their teacher, with healthy student-teacher relationships correlating with better overall mental health well-being (Currie et al., 2012).

According to Lindsey and Kalafat (1998), healthy student-teacher relationships are based in part on individual educator characteristics, such as authenticity and genuineness, warmth and acceptance, availability and willingness to help, and empathetic demeanor. The strength of student-teacher relationships is also influenced by teacher involvement and support. Skinner and Belmont (1993) conceptualized involvement as the extent to which teachers “take time for, express affection toward, enjoy interactions with, are attuned to, and dedicate resources to their students” (p. 573). Noddings (2015) has long argued that teacher involvement can be conceptualized as a form of relational caring in which teachers act as ‘carer’ by attuning to student needs, listening attentively, and being ready to respond or intervene.

From a relationship-building perspective, relational caring requires that a teacher engage with a student on the student’s own terms (Bouchard & Smith, 2017) or put another way, “*be with them instead of doing to them*” (Lyon, 2014a). Relational caring also necessitates that the carer be “attentive, receptive, empathetic, and responsive” and in direct communication with the cared-for (Noddings, 2015, p. 123). Although many individuals in helping professions receive extensive training in these competencies, teacher education programs in Canada do not currently address these relational competencies in a systematic and comprehensive way.

Educators and effective communication skills. The relational aspect of both help-seeking and relational caring necessitates that educators be able to effectively communicate with youth about their difficult personal experiences. According to Bouchard and Smith (2017), the

most salient communication skills for educators to employ within student-teacher relationships include “*attentive listening, observation, and responding* (including questioning, paraphrasing, and summarizing skills).” This position is reinforced by research findings from adolescent focus groups in which a substantial number of adolescents identified that effective adult helpers listen attentively, use paraphrasing statements to provide feedback, and demonstrate empathy and warmth (Lindsey & Kalafat, 1998; Wilson & Deane, 2001). As succinctly summarized by Lindsey and Kalafat (1998), these skills “read like a primer on effective helping skills” and correspond closely to the core counselling conditions first proposed by Carl Rogers (1957/1992) and extensively described in the counselling process literature (p. 183).

In fact, the Rogerian counselling approach, referred to as client- or person-centered therapy, has been adapted for educators and empirically tested in educational settings (e.g., Aspy & Roebuck, 1982; Aspy, Roebuck, & Aspy, 2014; Cornelius-White, 2007; Render, 1985; Richards & Combs, 1992). The principal findings from these studies and meta-analyses suggest that skills in empathetic understanding, genuineness, prizing (caring and demonstrating positive regard for students), active listening, and responding, can create trust in interpersonal relationships between students and teachers. Moreover, this research has shown that many successful care-giving professionals, such as teachers, naturally possess traits in empathy, genuineness, and positive regard and that counselling skills can be taught and enhanced in professionals willing to learn (Lyon, 2014b). Presently there is a dearth of training opportunities for pre-service or in-service educators interested in developing these skills (Lyon, 2014c). Nevertheless, there is mounting evidence to suggest that participating in training programs that focus on cultivating proficiency in communication and relationship-building skills is effective and appropriate for educators (Aspy et al., 2014). As such, the development of a workshop for educators that focuses on fostering mental health literacy and healthy relationship-building skills, as well as training and practical experience with counselling skills such as active listening and paraphrasing skills, could have remarkable value for both educators and their students.

Theoretical Framework

The theoretical framework that guides this study is Urie Bronfenbrenner’s bioecological systems theory (Bronfenbrenner & Morris, 2006), which proposes that human development and growth cannot be studied in isolation: they must be studied within the context of an individual’s entire bioecological system. According to this paradigm, human development is the result of

various reciprocal interactions between individuals and their environmental or social contexts. Specifically, the theory suggests that developing persons are embedded in five different environmental systems, ranging from the most immediate contexts (e.g., family, school) to the broader contexts of cultural values and societal norms. Each environmental system interacts simultaneously with the others and with the individual to influence development and growth.

The specific interactions that occur within an individual's immediate environment — the micro-system — are the strongest predictor of developmental outcome (Bronfenbrenner, 1979, 1994). These intimate interactions, termed proximal processes, typically occur at home in parent-child and child-child relationships, as well as at school when children engage in reciprocal transactions with teachers, peers, objects, and educational content. The processes that occur in the broader and more remote contexts — the exo- and macro-systems — are distal processes; these processes are hypothesized to impact development more indirectly (Bronfenbrenner, 1979).

Recent studies have demonstrated that quality student-teacher interactions and effective student-teacher relationships can provide a developmental context that promotes positive student outcomes (Allen, Gregory, Mikami, Lun, Hamre, & Pianta, 2013; Baker, Grant, & Morlock, 2008; Hamre & Pianta, 2001; Sabol & Pianta, 2012). For instance, in a study of children with significant behavioural problems, Baker et al. (2008) found that quality student-teacher relationships characterized by warmth, trust, and low conflict resulted in more positive school outcomes and better school adjustment for students. The authors concluded that the unique context of the student-teacher relationship (i.e., the micro-system) is an important factor to consider in school- and classroom-based interventions.

The bioecological systems theory also helps to ground the current study as it explains the relevance and value of working with teachers to improve their relationships with students in order to better support young people who are experiencing bullying and mental health difficulties. The paradigm also helps to justify the importance of strengthening relevant proximal processes (student-teacher interactions) through the promotion of relational caring principles and effective communication skills for educators.

Study Rationale

The proliferation of universal mental health initiatives in school settings necessitates that educators have proficiency in strategies to promote youth mental health and are able to identify signs of distress in students (Fortier et al., 2017). It also requires educators to be comfortable and

confident to effectively support students struggling with bullying and mental health difficulties. The successful implementation of these programs also requires that educators are able to effectively communicate with youth about their experiences with bullying and mental illness and act as referral agents for students who require more intensive resources. Extant research has found that pre-service teachers struggle with feeling prepared and competent to support youth with mental health difficulties (Dods, 2016) and currently, this type of training is not provided within traditional teacher education programs (Fortier et al., 2017). In fact, a recent scan of teacher education programs in Canada revealed that only two accredited programs offer courses on mental health literacy for educators (Rodger et al., 2014). There is also scarcity of training and professional development opportunities for in-service educators on youth mental health difficulties and bullying experiences (Froese-Germain & Riel, 2012).

Accordingly, the objectives of the current study are to develop and pilot-test a workshop for pre-service teachers on mental health literacy and communication skills for building healthy relationships with youth. The study also sets out to assess whether a professional development workshop can contribute to increasing participant knowledge and awareness, and self-efficacy and perceived confidence in communicating with children and youth in distress due to mental health and bullying experiences. For the purpose of this study, self-confidence refers to a feeling of self-assurance or the trust in one's abilities, while self-efficacy refers to a sense of mastery or the belief that one has the capability to exercise control over one's functioning or attainment (Bandura, 1997; WHO, 2005).

Research Questions

The research questions that guide this study are as follows:

1. Do participants report that a workshop on educator mental health literacy and communication skills is useful, informative, and relevant to their work?
2. Do workshop participants report changes in knowledge and awareness of youth bullying and mental health difficulties following the workshop?
3. Do workshop participants report changes in self-efficacy and self-confidence to interact and intervene with students in distress following the workshop?

Based on prior findings from research on mental health workshop interventions for educators, I hypothesize that the participants will find the workshop content useful, informative,

and relevant. I also hypothesize that participant-perceived knowledge and awareness, self-efficacy and self-confidence will increase as a result of the workshop intervention.

Methodology

Research Design

The present study used a mixed-methods survey research design. Survey research is a measurement procedure that asks direct questions of participants in order to elicit demographic, personal or attitudinal information or request feedback to use in planning or program improvement (O'Leary, 2014; Thayer-Hart, Dykema, Elver, Schaeffer, & Stevenson, 2010). The survey method involves designing the survey process, developing the survey instrument, piloting the instrument, as well as survey administration and analysis (Graziano & Raulin, 2007; O'Leary, 2014).

The principal survey instrument utilized in this study was a retrospective pre-post questionnaire designed by the researcher. The retrospective pre-post research design is similar to conventional pre- and post-intervention self-assessment questionnaires, with the primary difference being that the questionnaire is only administered once, following the intervention (Davis, 2002). The retrospective pre-post method is appropriate for the assessment of interventions or trainings in which one objective of the intervention is to change the participants' awareness or understanding of particular dimensions (Howard, 1980; Skeff, Stratos, & Bergen, 1992). The primary advantage of the retrospective pre-post method for educational interventions is that it allows respondents to acquire a baseline level of literacy about the subject matter and gain insight into their own knowledge or understanding of the topic prior to data collection (Davis, 2002). Given that research has shown that respondents can overestimate their baseline level of knowledge pre-intervention because they are unaware of their lack of knowledge or skill until participating in the educational intervention (Howard, 1980), a retrospective pre-post design approach allows participants to reflect more accurately on the degree of change in their knowledge or skill that is due to the intervention (Davis, 2002; Howard, 1980; Skeff et al., 1992). Research on educational interventions has shown that the validity and efficiency of retrospective pre-post evaluations are equal, if not superior, to conventional pre-post self-assessment approaches (Howard, 1980; Levinson, Gordon, & Skeff, 1990).

The retrospective pre-post questionnaire was administered to teacher candidates in the Bachelor of Education program at the University of Ottawa as a data collection instrument

following the workshop intervention. All students who attended the workshop were invited to participate in the research component of study, which involved completing the retrospective pre-post questionnaire and two additional questionnaires immediately following the workshop. The retrospective questionnaire assessed participant knowledge and awareness of youth mental health difficulties, as well as the participants' perception of self-efficacy and confidence in using communication skills to build healthy student-teacher relationships pre- and post-workshop. A second questionnaire collected mixed-methods feedback on the workshop content for the purpose of refining the presentation content and delivery. A final questionnaire collected participant demographic (e.g., gender, age) and background (e.g., teaching experience) information.

Participants

Participant recruitment. Following approval from the University of Ottawa Research Ethics Board (see Appendix A), the participants for this study were recruited from the Teacher Education program at the University of Ottawa through their course instructors. The Teacher Education program is a two-year Baccalaureate program for teacher candidates. The program leads to certification as a professional educator qualified to teach in elementary or secondary school settings. Candidates train in one of three streams: primary / junior (kindergarten to grade six), junior / intermediate (grades four to ten), and intermediate / senior (grades seven to ten). Teacher candidates at the University of Ottawa are registered in courses for 20 months and are required to undertake community service learning and two teaching practica in school settings. At minimum, teacher candidates will hold a prior three-year undergraduate degree and relevant experience in the field of education prior to entry into the program.

The "Teaching Across the Intermediate / Senior Curriculum" course is a compulsory course for students in either the junior / intermediate or intermediate / senior stream of the Teacher Education program. As the curriculum for this course includes a discussion of mental health, the professors for both sections of this course were approached by the primary researcher and offered the opportunity to have the workshop presented to all students as a classroom lecture during the Winter 2017 semester (see Appendix B for professor invitation text), which they accepted. The professors also accepted that their students would be invited to participate on a completely voluntary basis in the research component of the study. The professors notified students in advance of the workshop and research components of the study (see Appendix C for

student invitation text). All students enrolled in the courses (40 in total) were invited to participate in the research component.

Participant sample. The final sample of research participants ($N = 35$; response rate 87.5%) was virtually balanced for gender ($n=18$ male, $n=17$ female) and teacher training stream ($n=16$ junior / intermediate, $n=19$ intermediate / senior). The majority of the participants were 20-24 years of age (65.7%), 25.7% of participants were aged 25-29, 5.7% were aged 30-34, and one participant was over 50 years old. All participants had completed a bachelor's degree prior to beginning their teacher training; four participants (11.4%) had also completed a master's degree. Although the participants had yet to complete their first practicum placement, the majority (85.7%) had previous experience in education (e.g., tutoring, mentoring, volunteering in a classroom). Of the participants with experience, 23.3% had 1-5 months of previous experience, 20.0% had 6-11 months, 10.0% had 1-2 years, 16.7% had 2-3 years, 6.7% had 3-5 years, and 23.3% had 5-10 years.

Participation in the research component of the study was voluntary and non-remunerated. Upon completion of the questionnaire, however, participants had the option to enter their name into a draw for one of two \$50 gift certificates to local restaurants (one gift certificate per participating classroom). Participants who were interested in receiving a summary of the research results were asked to provide their mailing address. The draw entry and research summary request form were separated from the questionnaire forms during data collection to protect participant anonymity.

Procedures

The current research study involved two distinct phases: a workshop and questionnaire development phase and an intervention phase. Each phase had a distinct set of procedures.

Phase 1: Workshop and questionnaire development. The first phase of this research study involved developing and refining the workshop intervention and creating the questionnaire measures. The principal researcher designed both the workshop content and the questionnaires. The principal investigator is a graduate student and professional in counselling psychology. She has a background in working with at-risk youth and researching youth mental health, bullying and school climate. She also has over five years of experience creating workshop content and delivering training workshops to post-secondary students, teacher candidates and professionals.

The principal researcher designed the workshop content using literature resources on mental health literacy, youth mental health and bullying difficulties, student-teacher relationship development, and effective communication skills for building healthy relationships. The questionnaire development was informed by the research questions, an outline of the workshop content, and scale development principles. The workshop and the questionnaire measure were shared with professionals in education and counselling psychology for review and further refinement, as described in detail below.

Workshop development. The workshop presentation was designed to align and expand on the youth mental health section of the curriculum taught within the Teacher Education program. The workshop presentation was conceptualized and proposed to course professors as a three-hour presentation for teacher candidates; however, during initial discussions with the professors, the primary researcher was informed that only two hours of class time were available for the workshop. As the workshop development was still in progress, the workshop content and delivery was designed with this timeframe in mind.

The two-hour presentation included didactic information on mental health and bullying issues, mental health issues in the classroom, and effective communication skills for building healthy relationships with youth. The presentation also included an experiential mindfulness and reflexive self-awareness component (see Appendix D) and practical exercises for developing and enhancing communication skills for healthy and effective student-teacher relationships. The experiential mindfulness and reflexive self-awareness activity was introduced immediately after the workshop introduction and a brief discussion of youth mental health and mental illness. The purpose of introducing the experiential mindfulness and reflexive self-awareness activity early in the workshop was to promote critical awareness among the workshop participants and to encourage participants to set an intention or learning goal for the remainder of the workshop.

The mental health awareness content of the workshop was driven by key understandings and definitions in the field of youth mental health and bullying (Currie et al., 2012; Government of Ontario, 2016; Kessler et al., 2005; MHCC, 2013; Olweus, 1994; U.S. DHHS, 1999), as well as reflexive self-awareness principles (Kondrat, 1999; Osterman & Kottkamp, 1993). The mental health literacy content included information drawn from resources on understanding mental health and bullying issues in youth (Craig & McCuaig Edge, 2010; Currie et al., 2012; Kessler et al., 2005; Ministry of Education, 2013) and recognizing these difficulties in classroom settings

(FORCE Society for Kids' Mental Health, 2008; Ministry of Education, 2013; Pepler & Craig, 2014; PREVNet, 2015). Finally, the communication skills content was assembled from resources on empathy (RSA, 2013), teacher involvement and attunement (Bouchard & Smith, 2017; Lindsey & Kalafat, 1998; Noddings, 2015; Skinner & Belmont, 1993), and communication skills (Bouchard & Smith, 2017; Hackney & Cormier, 2013; Noddings, 2015).

Questionnaire development. A questionnaire was developed as a part of this pilot study, as there were no existing measures that assessed the specific constructs of this study. The questionnaire development process was informed by scale development principles (Furr, 2011), literature on retrospective pre-post questionnaire design (Davis, 2002; Howard, 1980; Skeff et al., 1992), and questionnaire items from extant research on educator mental health literacy training (Kutcher et al., 2013; Wei & Kutcher, 2014). The questionnaire was developed by the principal researcher and included three sections: a retrospective pre-post questionnaire, a workshop feedback questionnaire, and a respondent demographics questionnaire.

According to Furr (2011), questionnaire construction is an iterative process that begins with articulating the construct to be measured and the context in which the questionnaire will be used. For this study, the retrospective pre-post questionnaire was developed to measure the impact of the workshop intervention, by assessing whether participant mental health literacy and communication skills improved following the workshop intervention. The content for the questionnaire items was informed by research on the components of the mental health literacy construct, which include basic knowledge of mental health difficulties, awareness of personal attitudes towards individuals dealing with mental health difficulties, and the ability to recognize the signs and symptoms of mental health difficulties (Jorm et al. 1997; O'Connor et al., 2004). Mental health literacy training also involves learning skills for effectively applying newly acquired knowledge and awareness in interactions with others (Canadian Alliance on Mental Illness and Mental Health, 2008). According to Bouchard and Smith (2017), training on interpersonal and communication competencies for building healthy relationships is an effective way to improve an individual's interactions with others and provide an individual with the opportunity to demonstrate their acquired knowledge and skills. As such, the questionnaire also included items assessing the interpersonal and communication competencies of participants. More specifically, for the purpose of assessing whether workshop participants are able to apply

their newly acquired knowledge and skills in future interactions, self-efficacy and self-confidence in listening and responding to youth in distress were included as constructs.

For the purpose of assessing the mental health literacy and communication skills constructs and addressing two of the study's research questions (i.e., do workshop participants report changes in knowledge and awareness of youth bullying and mental health difficulties following the workshop? and do workshop participants report changes in self-efficacy and self-confidence to interact and intervene with students in distress following the workshop?), the retrospective pre-post questionnaire included three items related to respondent knowledge and attitudes towards mental illness (items 1-3), two items related to perceived self-efficacy to support youth in distress (items 4-5), and three items related to perceived self-confidence to effectively interact and intervene with youth in distress (items 6-8). The first three items were conceptually grouped into a subscale entitled 'knowledge and attitudes,' the next two into a subscale named 'self-efficacy' and the last three items into a subscale named 'self-confidence.'

The workshop feedback questionnaire was designed to capture information from participants about their workshop experience for the purpose of improving the workshop intervention and addressing the first research question (i.e., do participants report that a workshop on educator mental health literacy and communication skills is useful, informative, and relevant to their work?). The content for the five Likert-type scale items was derived from previous studies of mental health literacy workshop interventions (e.g., Wei & Kutcher, 2014), while the content for the open-ended responses was compiled according to feedback from the study's thesis committee members.

Finally, the demographics questionnaire was developed in order to collect information about the respondent population (e.g., gender, age, and education) and factors related to their teacher education program (e.g., teaching stream, teaching experience). The content was derived from previous research and knowledge of the teacher education program format.

In addition to aligning the questionnaire items with the study's research questions and relevant research constructs, the questionnaire content was also informed by scale development principles (e.g., DeVellis, 2016; Furr, 2011) for using questionnaires in time-sensitive research contexts with a university-educated adult population. Accordingly, the instructions for each section of the questionnaire, the response format and questionnaire length, and the item pool were designed in keeping with recommendations from the literature. In addition, the thesis

supervisor (DS) and several reviewers amended the questionnaire for clarity and conceptual relevance. A description of the workshop and questionnaire review process follows.

Workshop and questionnaire review process. Following the initial development of the workshop presentation and the questionnaire, the materials were presented to several reviewers for feedback. The reviewers each had experience in one or more of the following domains: teaching and education, teacher education, special education, school administration, curriculum development, educational research, and counselling psychology.

The first round of revisions was conducted with the thesis supervisor (DS), who is a licensed psychologist with scholarly expertise in bullying prevention and school climate. Following this revision, the experiential mindfulness and reflexivity exercise was considerably expanded, and several workshop presentation slides were eliminated. In addition, a few questionnaire items assessing participant self-efficacy and self-confidence were added to the retrospective pre-post questionnaire section and several open-ended questions were added to the feedback questionnaire section. There were no items discarded during the questionnaire revision process; however, certain items were edited for clarity and length.

The second round of revisions was conducted with three teaching professionals. The first reviewer was a retired teacher, elementary school principal, and curriculum services professional with over thirty years of experience; the second was a certified special education teacher and instructional coach with over twenty-five years of experience; and the third was a certified teacher who graduated from a Canadian Teacher Education program within the last two years.

During these revisions, the reviewers were provided with the workshop presentation, presenter notes, and the questionnaire. Feedback from the reviewers was provided verbally and through the completion of an online feedback questionnaire hosted on the survey platform SurveyMonkey. The educators were also asked to share their experiences working with youth with mental health and bullying difficulties in school and classroom settings; these experiences were used as vignettes for the practical communication skills exercises in the workshop. Participation in the workshop content and questionnaire consultation process was acknowledged with a \$20 coffee shop gift certificate.

In the initial round of revisions, minor edits recommended by the reviewers were integrated into the workshop and questionnaire materials. Additionally, one reviewer provided a suggestion on how to improve the formation of the triad groups for the practical exercises; this

suggestion was integrated into the presenter notes for the workshop. Following the initial round of feedback, two of the educators met with the researcher for an in-person focus group session to further review and refine the workshop content, the questionnaire, and the vignette texts. The feedback received during this session was very positive, with reviewers reporting that the workshop content was relevant, useful and practical for pre-service and in-service teachers. The reviewers specifically noted that the definitions and recent research information provided throughout the workshop were helpful for establishing a common understanding. In addition, the reviewers positively rated the visual layout of the presentation and the depth of the information provided in the workshop presentation and vignette texts. In terms of recommendations, the educators felt strongly that although the knowledge and awareness aspects of the workshop were important, the researcher should ensure that adequate time was dedicated towards debriefing the practical exercises presented during the workshop. In order to address this concern, triad exercises on reflective responses and paraphrasing responses were combined into one exercise, which focused on the skill of paraphrasing alone. One reviewer also noted the importance of reminding pre-service teachers of in-school resources for supporting teachers working with students in distress, including the availability of school administrators and special education staff. This recommendation was included in the presenter notes in two separate instances. Following the focus group session, minor edits were made to the questionnaire items and vignette texts. No questionnaire items were added or eliminated.

Phase 2: Intervention. The second phase of the study was designed as a pilot study of the workshop with teacher candidates from the Teacher Education program at the University of Ottawa. For this pilot study, the workshop presentation was delivered to two classes of teacher candidates by the principal investigator during a lecture in one of their mandatory program courses (see Appendix E for the workshop slides). Prior to delivering the workshop, the principal investigator explained the research project, including its objectives and data requirements, to students in the class. The students were informed that while the workshop was being included as part of the course curriculum, the research component of the study was entirely voluntary. The workshop delivery occupied an hour and forty-five minutes of class time, with the final fifteen minutes dedicated to data collection.

Data Collection

Questionnaire measure. The data collection instrument for this study was a three-part questionnaire. The first two parts of the questionnaire collected the primary research data, while the third part collected demographic information (see Appendix H).

Specifically, the first part of the questionnaire was a retrospective pre-post assessment of participant knowledge and awareness of youth mental health and bullying difficulties, as well as perceived self-efficacy and confidence in their ability to effectively communicate and support youth in distress. In completing this questionnaire, respondents were asked to respond to 8-items that compared their knowledge, awareness, self-efficacy and self-confidence before and after the workshop intervention. The item responses were arranged according to a 5-point Likert scale ranging from 'strongly disagree' to 'strongly agree' for participant ratings before and after the workshop intervention. A 5-point Likert scale was chosen because it allowed respondents to express degrees of agreement and disagreement without creating too many gradations in the response format (Furr, 2011). The Likert scale response options were balanced and fully labelled for clarity and a neutral mid-point was added so respondents were not forced to agree or disagree with a statement.

The second part of the questionnaire collected participant feedback on the workshop in order to improve the workshop content for future presentations. On this measure, respondents were asked to rate their degree of agreement with five statements about the workshop, according to a 5-point Likert scale ranging from 'strongly disagree' to 'strongly agree.' The scale response options were identical to those used in the retrospective pre-post questionnaire for simplicity and clarity. Respondents were also asked to elaborate in writing on what they liked and disliked about the workshop, and what might have been missing from the workshop content. Respondents were also asked to provide a general comment about their overall workshop experience.

The third part of the questionnaire collected participant demographic information including gender, age, previous education and experience, and teacher candidate information (e.g., teaching candidate stream, practicum experience). There were seven questions in total and respondents were asked to select the most appropriate answer from a list of possible responses.

Each part of the questionnaire measure was limited to a page in order to prevent respondent fatigue, which is a phenomenon that affects the quality of the data provided by respondents as a result of a decrease in attention or motivation during questionnaire completion

(Ben-Nun, 2008). The questionnaires were also oriented with the retrospective pre-post questionnaire first, followed by the workshop feedback questionnaire, and the demographic information questionnaire. The questionnaires were organized in this manner to ensure that respondents completed the most cognitively demanding parts of the questionnaire first in case of respondent fatigue issues. The questionnaire items and response options were also designed in keeping with scale development principles to minimize bias (e.g., use of balanced scales, use of simple item wording, having neutral items, and promising anonymity) (Furr, 2011).

Data collection procedures. Data collection occurred immediately following the workshop presentation in the classes. After the workshop intervention, the principal researcher invited the teacher candidates to participate in the research component of the study. An envelope that included a study information letter (see Appendix F), informed consent form (see Appendix G), the questionnaires (see Appendix H), and a draw entry form (see Appendix I) was distributed to each participant. Participants were instructed to return all the research materials, whether completed or blank, in the envelope provided to the front of the classroom or to a designated drop-off location. Participants were given fifteen minutes to complete the questionnaires in class or a seven-day deadline to submit their research materials to a drop-off location.

Data Analysis

The quantitative data collected from the retrospective pre-post questionnaire and the feedback questionnaire, as well as the respondent demographic data, were analyzed using IBM SPSS Statistics for Windows, version 24 (IBM Corp., Armonk, N.Y., USA). In order to evaluate the impact of the workshop intervention and to address the study's research questions, nonparametric tests of significance were performed comparing respondent ratings on the pre-intervention and post-intervention scales of the retrospective pre-post questionnaire. The responses to the individual questionnaire items were grouped into subscales according to the conceptual factors identified through literature review: knowledge and awareness; self-efficacy; and self-confidence. The quantitative data from items related to workshop feedback and demographics were analyzed using frequency counts. The psychometric properties of the retrospective pre-post questionnaire were also tested: the dimensionality of the scale was extracted using exploratory and confirmatory (principal components) analysis and the internal consistency of the scale was calculated using Cronbach's alpha and Spearman rank-order correlations.

The qualitative data collected from the participant feedback questionnaire were first explored using summative content analysis. Using this approach, participant responses to the open-ended questions were reviewed and counted (Hsieh & Shannon, 2005). Subsequently, participant responses were examined using a latent content process that involved interpreting the response content to discover the underlying meaning or context of the words and phrases (Hsieh & Shannon, 2005).

Results

Psychometric Properties of the Retrospective Pre-post Questionnaire

Reliability. The reliability of the questionnaire was assessed using Cronbach's alpha. The Cronbach's alpha for the total scale was .90, suggesting that the questionnaire items have high internal consistency. An alpha value of .70 - .80 is generally considered sufficient for research (Furr, 2011). No increases in the alpha value could be achieved by eliminating items; therefore, all eight pre-post items were retained. The alpha values for the pre- and post-intervention total scales were .76 and .87, respectively. The individual alpha values for the pre-intervention and post-intervention subscales ranged from .64 to .86 (see Table 1). The pre- and post-intervention self-confidence subscale had the lowest reliability ($\alpha = .64$ and $\alpha = .67$, respectively) and the only alpha values under the acceptability standard of .70.

Table 1.

Descriptive Statistics and Alpha Values for the Subscales and Total Scales of the Retrospective Pre-post Questionnaire

		Items	Mean	SD	α
Pre-intervention	Knowledge & awareness subscale	3	4.20	.59	.74
	Self-efficacy subscale	2	4.04	.57	.76
	Self-confidence subscale	3	4.03	.57	.64
	Total scale	8	4.10	.44	.76
Post-intervention	Knowledge & awareness subscale	3	4.50	.55	.86
	Self-efficacy subscale	2	4.33	.64	.81
	Self-confidence subscale	3	4.41	.46	.67
	Total scale	8	4.42	.46	.87

Note: SD = standard deviation; α = Cronbach's alpha

The reliability of a subscale can be improved by adding items to the scale that are psychometrically equivalent to existing ones (Furr, 2011). According to calculations using the Spearman-Brown Prophecy test, a formula that predicts the reliability of a scale with revised length, lengthening the self-confidence subscale by a factor of 1.33, from three to four items, would result in an estimated reliability of .70 and .73 for the pre- and post-intervention self-confidence subscales, respectively.¹ As such, revising the self-confidence scale to include one or more additional items should be considered.

Dimensionality and Subscale Correlations of the Retrospective Pre-post Questionnaire

The 8-item retrospective pre-post questionnaire was hypothesized to have three underlying factors: knowledge and awareness, self-efficacy, and self-confidence. The questionnaire was administered to workshop participants, and a total of 35 retrospective pre-post questionnaires were completed. There were no significant outliers or missing data. The dimensionality and subscale correlations of the retrospective pre-post questionnaire were assessed following data collection and the results are reported below.

Dimensionality. The data from the pre-intervention scale were used to assess the dimensionality of the retrospective pre-post questionnaire. It was hypothesized that the questionnaire would have three components, representing the conceptually derived subscales of knowledge and awareness, self-efficacy, and self-confidence. Prior to the computations, the Kaiser-Meyer-Olkin (KMO) value and Bartlett's test of sphericity were calculated to determine the adequacy of the sampling. The pre-intervention scale had a KMO value of .653 and a significant Bartlett's test of sphericity ($\chi^2(28) = 79.51, p < .001$), suggesting that the sample is adequate for factor analysis (Kaiser, 1974).

All eight items from the pre-intervention scale were included in an exploratory principal component analysis, which was initially presented as an unrotated solution. The results of the analysis were interpreted using the eigenvalue rule (Kaiser, 1960), the scree test (Cattell, 1966), and a parallel analysis (Horn, 1965). The eigenvalue rule asserts that components with eigenvalues less than one should not be retained. This rule is widely used as a guideline for determining the number of factors or components to retain (DeVellis, 2016); however, there has been criticism that this guideline is inefficient (Furr, 2011; Ledesma & Valero-Mora, 2007) and,

¹ The Spearman-Brown Prophecy formula is $r_{XX-revised} = fr_{XX-original} / 1 + (f - 1)r_{XX-original}$ where $r_{XX-original}$ is the reliability score of the original scale and f is the factor to which the scale is lengthened or shortened.

as such, it is recommended that researchers also refer to the scree plot and the results of a parallel analysis test when deciding on the number of components to extract.

Using the eigenvalue rule, three components were extracted from the pre-intervention scale, explaining 69.4% of the total variance. A visual inspection of the scree plot revealed a leveling-off after the first component and a leveling-off after the third component, suggesting that either solution could be possible. A principal component parallel analysis was computed using a customizable syntax code for IBM SPSS Statistics (O'Connor, 2000) and specifying 500 datasets at the 95th percentile. The analysis revealed that the eigenvalue of the first component is significant, while the eigenvalues of the remaining components are non-significant. The results of this analysis support retaining only one component, explaining 38.4% of the variance. Given the inconsistencies in the solutions, the one-component and the three-component solution were both run through a confirmatory factor analysis to further assess fitness.

Table 2.

Results of the Component Loadings for the Pre-intervention Scale (N = 35)

Items	Component loadings			
	1-Component Solution	3-Component Solution		
	1	1	2	3
1. Knowledge of youth mental health problems	.613	.638		
2. Awareness of attitudes towards mental illness	.707	.819		
3. Awareness of impact of attitudes	.641	.870		
4. Ability to build healthy relationships	.683			-.785
5. Ability to help and support youth	.626			-.900
6. Confidence in ability to show empathy and acceptance	.542		.615	
7. Confidence in ability to listen attentively to youth	.642		.869	
8. Confidence in ability to respond effectively to youth	.468		.734	

Note: Principal component analysis; values < .40 are suppressed

A confirmatory principal component analysis of the one-component and three-component solutions was computed using the pre-intervention scale. The solutions are both presented in Table 2. The three-component structure was rotated using a direct oblimin (oblique) rotation to allow the components to correlate (DeVellis, 2016). In the one-component solution, all items loaded onto the one retained factor, with loadings ranging from .468 to .707. In the three-component solution, all items also loaded simply onto the components, with items 1-3 loading onto the first component (explaining 38.4% of the total variance), items 6-8 loading onto the second component (explaining 16.5% of the variance), and items 5-6 loading onto the third component (explaining 14.5% of the variance). The loadings for the three-component solution are consistent with the hypothesized subscales (e.g., items 1-3 loading on the knowledge and awareness subscale, items 4-5 loading on the self-efficacy subscale, and items 6-8 loading on the self-confidence subscale). The magnitude of the correlations between the components in this analysis ranged from .205 to .251, suggesting that there is a relationship between the subscales.

Subscale correlations. Spearman rank-order correlations (r_s) were calculated to assess the strength of the relationship between the subscales and the total scale. Spearman's correlation is a non-parametric measurement that is suitable when the data are not normally distributed, the sample size is small, or when the dependent variable is ordinal (Graziano & Raulin, 2007).

The correlation coefficients for the pre-intervention subscales and total scale are presented in Table 3. Significant correlations were found between the subscales, with one exception: the knowledge and awareness and self-confidence subscales were not significantly correlated ($r_s = .24, p = \text{n.s.}$). The significant subscale correlations had moderate strength (Cohen, 1988). All subscales were highly significantly correlated with the total scale, with coefficients ranging from .72 - .77 at $p < .001$.

Table 3.

Correlations Between the Pre-intervention Subscales of the Questionnaire

Subscales	1	2	3	4
1. Knowledge and awareness	—			
2. Self-efficacy	.42*	—		
3. Self-confidence	.24	.47**	—	
4. Total scale	.77***	.76***	.72***	—

Note: * $p < .05$, ** $p < .01$, *** $p < .001$, two-tailed

The correlation coefficients for the post-intervention subscales and total scale are presented in Table 4. All subscale and total scale correlations were highly significant. The knowledge and awareness subscale significantly correlated with the self-efficacy and self-confidence subscales at $p < .01$, while all other correlations were significant to $p < .001$. The effect sizes of the correlations were all large (Cohen, 1988).

Table 4.

Correlations Between the Post-intervention Subscales of the Questionnaire

Subscales	1	2	3	4
1. Knowledge and awareness	—			
2. Self-efficacy	.52**	—		
3. Self-confidence	.54**	.70***	—	
4. Total scale	.82***	.85***	.86***	—

Note: * $p < .05$, ** $p < .01$, *** $p < .001$, two-tailed

In all, the Spearman rank correlation coefficients demonstrate that there is a strong, positive association between the conceptually oriented subscales and the total scale. On the basis of these findings and in consideration of the conceptual design of the questionnaire, it was decided that the three subscales would all be retained as part of this measure.

Workshop Intervention Outcomes

Test of normality. A preliminary scan of participant responses indicated that many teacher candidates rated themselves highly on the eight retrospective pre-post questionnaire items. For this reason, the data from the retrospective pre-post questionnaire were first assessed graphically and numerically to test the assumption of normality. An examination of histogram charts suggested that the data were negatively skewed; therefore, the Shapiro-Wilk statistics were calculated to further assess the shape of the distribution. The Shapiro-Wilk statistics for the questionnaire responses ranged from $W = .601$ to $W = .852$ ($p = 0.00$), which confirmed that the data were non-normally distributed. As a result of these findings, the non-parametric Wilcoxon Signed-Rank test was used to analyze the data from the retrospective pre-post questionnaire (Gravetter & Wallnau, 2006; Perkins, 2002).

Tests of significance. The Wilcoxon Signed-Rank test is a non-parametric test that analyzes the sign and magnitude of the differences between two matched data samples and determines whether the median of the difference score is different from zero (Perkins, 2002). The

test can be used with data that are non-normally distributed, as it makes no assumption about the shape of the distribution. Test statistics (Z) and effect sizes (r) were also calculated. Effect size was calculated by dividing the Z value by the square root of N (where $N = 70$, as it represents the number of observations over the two time points). There were no missing data points.

A Wilcoxon Signed-Rank test was first performed on the total retrospective pre-post intervention scale. The test outcomes for the total scale are displayed in Table 5. The total scale results of the Wilcoxon Signed-Rank test indicate that the impact of the workshop intervention was significant, $Z = -4.505$, $p = .000$, $r = -.54$. The effect size of the finding is large.

Table 5.

Total Scale Wilcoxon Signed-Rank Test Results and Test Statistics (N = 35)

		Ranks			Test statistics	
		N	Mean rank	Sum of ranks	Z*	Asymptotic significance**
Total scale, Post-intervention –	Negative ranks ^a	2	9.75	19.50	-4.505	.000
Total scale, Pre-intervention	Positive ranks ^b	29	16.43	476.50		
	Ties ^c	4				
	Total	35				

* Based on negative ranks.

** $p < .05$, two-tailed.

a. Post-intervention < Pre-intervention.

b. Post-intervention > Pre-intervention.

c. Post-intervention = Pre-intervention.

Subsequently, Wilcoxon Signed-Rank tests were performed on the three conceptually-derived subscales of the retrospective pre-post intervention questionnaire. The test outcomes for the questionnaire subscales are displayed in Table 6. The results of the Wilcoxon Signed-Rank test indicate that participants were more aware of youth mental health difficulties, such as anxiety, depression, and self-harm, as well as their own attitudes towards mental health issues after the workshop intervention, $Z = -3.992$, $p = .000$, $r = -.48$. The effect size is medium, bordering on large, according to Cohen's (1988) criteria. In terms of participant self-efficacy ratings, the results showed that participants rated their belief in their ability to build healthy relationships with students and their ability to help and support youth in distress as higher following the workshop, $Z = -2.954$, $p = .003$, $r = -.35$. This effect size was also medium.

Participants also answered three questions related to their self-confidence in engaging with youth in distress. The results indicated that confidence in showing empathy and acceptance to youth in distress and confidence in listening and responding to youth in distress was higher after the workshop intervention, $Z = -3.982$, $p = .000$, $r = -.48$. The effect size of this finding is medium, bordering on large.

Table 6.

Subscale Wilcoxon Signed-Rank Test Results and Test Statistics (N = 35)

Ranks				Test statistics		
		Mean	Sum of			
		N	rank	ranks	Z*	significance**
KA subscale, Post-intervention – Negative ranks ^a		1	7.00	7.00	-3.992	.000
KA subscale, Pre-intervention	Positive ranks ^b	21	11.71	246.00		
	Ties ^c	13				
	Total	35				
SE subscale, Post-intervention – Negative ranks		1	12.50	12.50	-2.954	.003
SE subscale, Pre-intervention	Positive ranks	15	8.23	123.50		
	Ties	19				
	Total	35				
SC subscale, Post-intervention – Negative ranks		2	6.50	13.00	-3.982	.000
SC subscale, Pre-intervention	Positive ranks	22	13.05	287.00		
	Ties	11				
	Total	35				

Note: KA = knowledge and awareness; SE = self-efficacy; SC = self-confidence

* Based on negative ranks.

** $p < .05$, two-tailed.

a. Post-intervention < Pre-intervention.

b. Post-intervention > Pre-intervention.

c. Post-intervention = Pre-intervention.

Workshop Feedback Results

In the second part of the questionnaire, participants were asked to provide feedback on their workshop experience to help improve the workshop content for future presentations. The

first half of this questionnaire asked participants to respond to five statements about the workshop according to a 5-point Likert scale from “strongly disagree” to “strongly agree.” Participant responses were statistically analyzed to obtain the frequency of each response, as well as the mean response rates. There were no missing data points.

Participants were also asked to respond to four open-ended questions. The questions asked participants to specify what they most liked and disliked about the workshop, identify what might have been missing from the workshop content, and comment on their overall workshop experience. Not all participants responded to every question.

Participant short-answer responses were explored using a summative content analysis to identify content that appeared more than once ($n \geq 2$) among participant responses. The responses were subsequently examined using latent content analysis. Participant responses with similar meanings or interpretations (e.g., “great workshop” and “excellent workshop”) were grouped together into the same response category during the quantification process and commonly labelled. Unique feedback that was not quantified in the first stage (i.e., $n = 1$), but was determined to be pertinent to the workshop and actionable, was also retained. An example of a non-pertinent response that was excluded during the latent content analysis was a recommendation from one participant to integrate content into the workshop on how to support actively suicidal youth. This response was determined to be non-pertinent because training in suicide awareness and intervention is a significant endeavour that is beyond the scope of this training. Feedback was determined to be non-actionable if it was vague (e.g., one participant reported disliking the “activities” but did not provide any additional information) or difficult to interpret (e.g., comments such as “Thumbs up!”).

Quantitative workshop feedback results. The results of the quantitative feedback questions (see Figure 1) indicate that a large majority of respondents either agreed (48.6%) or strongly agreed (45.7%) that the workshop was useful and informative ($M = 4.40$, $SD = .604$). Eighty-eight percent of respondents either agreed or strongly agreed that they learned new information and concepts during the workshop that will be helpful for their future work ($M = 4.31$, $SD = .832$); only two participants disagreed with this statement. An identical number of participants reported that they would recommend the workshop for teachers-in-training and in-service teachers ($M = 4.43$, $SD = .778$), with the majority (57.1%) of respondents strongly agreeing that they would recommend the workshop to both groups. There was one participant

(2.9%) who disagreed with recommending the workshop and three participants (8.6%) who responded neutrally. Lastly, a large majority of the participants (94.3%) either agreed or strongly agreed that the workshop was enjoyable ($M = 4.46$, $SD = .611$).

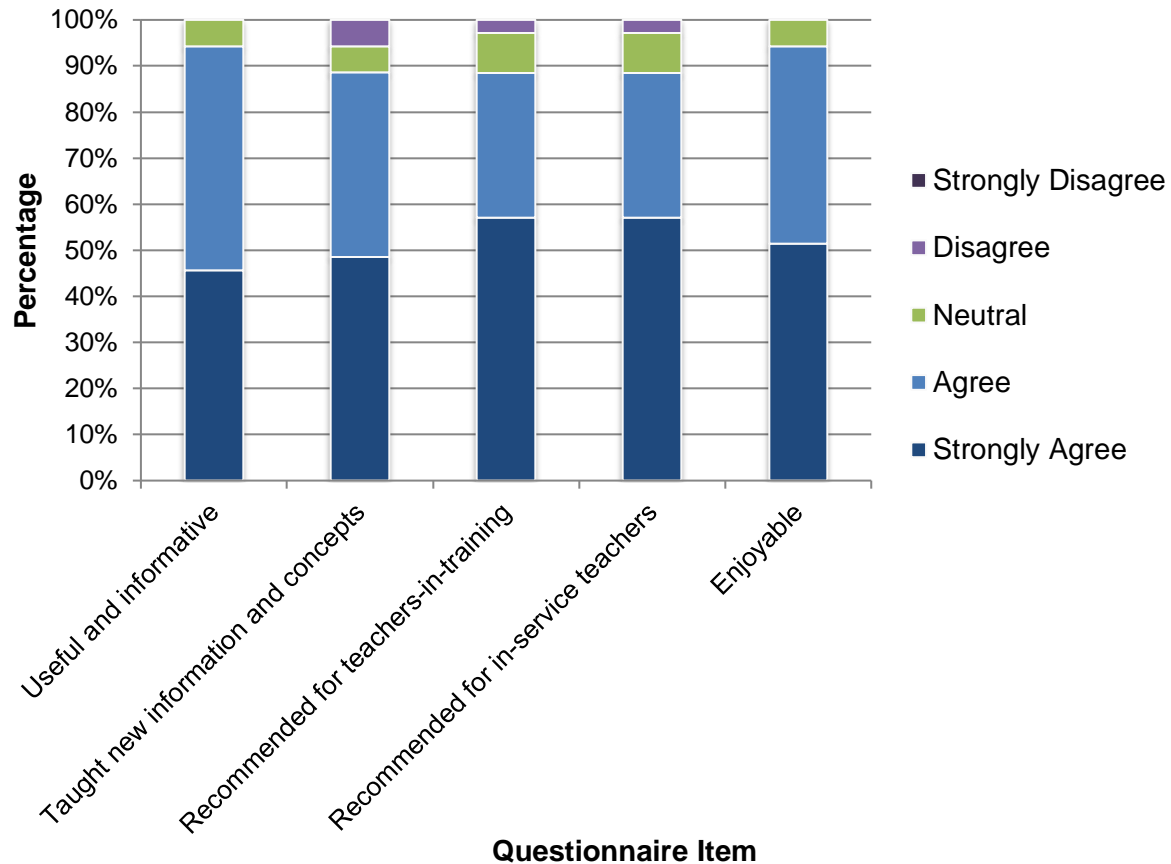


Figure 1. Percentage (%) of respondents ($N = 35$) who agreed or disagreed with statements about the mental health literacy and communication skills workshop.

Qualitative workshop feedback results. Participants were invited to answer four open-ended questions on the workshop feedback questionnaire. The first open-ended question asked participants to provide feedback on what they liked about the presentation. Thirty-three participants responded to this question, providing a total of 42 words and phrases for analysis. Of this content, eight words and phrases were repeated at least twice (for response frequencies, see Table 7). There were six additional responses that were determined to be pertinent and actionable despite only being mentioned by one participant. There was no content excluded during the analysis of these responses.

Table 7.

Content Identified from Open-ended Question: What Did you Like? (n=42)*

What did you like about the workshop?	<i>n</i>
1. Participating in the practical communication activities / exercises	14
2. The information on how to observe and respond to youth in distress	7
3. The usefulness and relevance of the workshop content	4
4. The detail provided on different mental health difficulties	3
5. The concrete examples that were provided	2
6. The information provided on empathy / the empathy video	2
7. The opportunity for collaborative discussion	2
8. The organization / structure of the workshop	2
9. The break	1
10. The mindfulness activity	1
11. The pace of the workshop	1
12. The presenter	1
13. The strategies for building healthy relationships	1
14. The strategies for identifying the signs and symptoms of mental health difficulties	1

** Content has been paraphrased for consistency and clarity*

Participants were also asked to provide feedback on what they disliked about the workshop presentation. Twenty-two responses, with a total of 26 different words or phrases, were analyzed. There were fifteen responses included during the preliminary analysis and an additional three unique responses were determined to be pertinent and actionable (see Table 8). There were eight items excluded for being non-pertinent ($n=1$) and non-actionable ($n=7$).

Table 8.

Content Identified from Open-ended Question: What Didn't you Like? (n=21)*

What didn't you like about the workshop?	<i>n</i>
1. The workshop could be more interactive or engaging	6
2. I wanted more depth to the workshop content	4
3. I wanted more time to practice the communication exercises	3
4. The content was too common sense	2
5. I wanted more demonstrations of proper ways to communicate with youth	1
6. The role-playing made me feel less equipped to intervene with youth in distress	1
7. The role-playing made me feel uncomfortable	1

** Content has been paraphrased for consistency and clarity*

The third question asked participants to identify what was missing from the workshop content. A total of 21 participants responded to this question and 22 words or phrases were extracted during analysis. Eleven responses qualified for inclusion in the frequency count and two unique responses were retained (see Table 9). A total of nine responses were eliminated for being non-pertinent ($n=8$) or non-actionable ($n=1$).

Table 9.

Content Identified from Open-ended Question: What was Missing? (n=13)*

What was missing from the workshop content?	<i>n</i>
1. Testimonies from youth or teachers	4
2. More depth and more time for activities	3
3. More examples / demonstrations of proper communication responses	2
4. Information about interacting with the school board and resource department	2
5. More debriefing after the communication exercises	1
6. More examples about older students	1

** Content has been paraphrased for consistency and clarity*

As a final question, participants were invited to comment on their overall workshop experience. A total of 46 words and phrases were identified within 27 participant responses. The majority of responses ($n = 40$) were quantifiable and two unique comments were ascertained to

be pertinent and actionable (see Table 10). The remaining four responses were eliminated for being non-actionable.

Table 10.

Content Identified from Open-ended Question: General Comments (n=42)*

Please comment on your general workshop experience	<i>n</i>
1. The workshop was great / good / excellent / pleasant / enjoyable	15
2. The workshop was useful, informative and relevant	14
3. The workshop helped me reflect on youth mental health issues in school settings	4
4. The workshop was well organized and well presented	4
5. I already knew most of the workshop content	2
6. It is useful for educators to be on the same page	1
7. The workshop was too short	1

** Content has been paraphrased for consistency and clarity*

Discussion

Educators are well positioned to connect and intervene with youth in distress due to bullying and mental health difficulties given that educators spend a considerable amount of time with students and have substantial opportunities to build healthy, trusting relationships with youth. In order to support educators in this complex, demanding, and instrumental role, pre-service and in-service professional development training is required. Accordingly, the objectives of the current study were to: develop and refine a workshop for pre-service teachers on mental health literacy and communication skills for building positive relationships with youth; create a data collection instrument to assess the workshop intervention; pilot-test the workshop and the data collection instrument with teacher candidates; evaluate the workshop intervention; and collect feedback on the workshop in order to refine the presentation format, content and delivery. The results from this pilot study suggest that this workshop can improve educator knowledge and awareness of youth bullying and mental health difficulties, and increase educator self-efficacy and self-confidence to engage and intervene with youth in distress using empathy and effective communication skills.

Questionnaire Development

One objective of the current study was to develop and pilot-test a retrospective pre-post questionnaire. The questionnaire was developed as part of the current study to collect information on the specific constructs included in the workshop intervention, namely: knowledge and awareness of youth mental health difficulties, and self-efficacy and self-confidence in interacting and intervening with youth in distress. The development of the questionnaire was informed by scale development principles and literature on retrospective pre-post questionnaire design. Following the piloting of the questionnaire with a sample of 35 teacher candidates, the psychometric qualities of the questionnaire were assessed.

The internal consistency of the individual subscales was acceptable and the alpha values for the total scales and most sub-scales were high. The questionnaire could benefit, however, from additional items. In designing the questionnaire, the items and overall questionnaire were kept brief to minimize potential response fatigue; however, there may have been psychometric costs associated with this choice (Furr, 2011). If a longer questionnaire can feasibly be completed by participants in future administrations, the addition of a few items could improve the alpha values of the subscales. Specifically, at least one additional item should be added to the self-confidence subscale and a lengthening of the total scale should be considered to improve the internal consistency of the subscales.

The additional questionnaire items could be derived from further study of the learning outcomes of the workshop intervention. For instance, the self-efficacy subscale item that states “I believe I have the ability to help / support youth in distress” could be divided into two items, one that assesses ability to support youth in distress due to bullying and another that assesses ability to support youth in distress due to mental health difficulties, to better evaluate these distinct constructs. The questionnaire may also benefit from the inclusion of an item that assesses the ability of participants to identify the signs and symptoms of students in distress. Alternatively, inspiration for new questionnaire items may be found in the existing literature on mental health literacy. For example, in a recently published article, Fortier et al. (2017) administered the *Mental Health Literacy and Capacity Survey for Educators* to a large sample of educators following a school board-wide mental health literacy intervention. The questionnaire, which was developed specifically to measure the impact of their intervention, assessed participant knowledge, comfort, and awareness of mental health issues related to supporting youth in the

classroom. The comfort subscale of this questionnaire had items related to accessing appropriate resources and talking to students about mental health that are conceptually aligned with the current study's self-confidence subscale and could improve the psychometric properties of this subscale and the retrospective questionnaire as a whole.

The results of the exploratory (principal component) analysis and parallel analysis indicated that one-component and three-component solutions were both viable. The one-component solution explained 38.4% of the total variance and was supported by the results of the parallel analysis, while the three-component solution explained 69.4% of the total variance and was identified using the eigenvalues rule. In the current study, the three-component solution is the most compelling solution overall, as it explains a larger proportion of the variance, has stronger component loadings, and is consistent with the conceptualization of the constructs underlying the questionnaire and the research objectives. The psychometric evidence in combination with the conceptual design of the workshop and the research together seem sufficient to provisionally accept the 3-factor solution of the questionnaire. In order to further assess dimensionality and determine if the model is the best representation of the underlying data, the questionnaire, including the revisions proposed above, needs to be administered to a larger sample and reassessed psychometrically.

In all, the findings suggest that the retrospective pre-post questionnaire is a reliable and useful scale for assessing participant knowledge, awareness, self-efficacy, and self-confidence following a mental health literacy and communication skills workshop. Nevertheless, more validation of the scale, with a larger sample size, is required to more thoroughly assess the proposed three-component model and more precisely evaluate the psychometric properties of the scale.

Workshop Intervention

The workshop development phase was an iterative process that involved a thorough review of the existing literature on bullying and mental health literacy and effective communication skills for building healthy relationships with youth. Consultation with professionals in education and counselling was fundamental and helped to refine the workshop content prior to the pilot-testing phase. In the pilot-testing phase, the workshop intervention was delivered to two groups of teacher candidates and following the intervention, participants completed a retrospective pre-post questionnaire to assess for changes in participant knowledge and awareness, as well as self-

efficacy and self-confidence to interact and intervene with students in distress. A total of 35 participants completed the retrospective pre-post questionnaire. Feedback on the workshop content was also collected from participants post-intervention to determine whether teacher candidates found the presentation useful, informative, and relevant.

Results from the retrospective pre-post questionnaire that was completed by participants immediately following the workshop reveal that the workshop intervention significantly improved participant knowledge of mental health difficulties and awareness of personal attitudes towards youth in distress due to bullying and mental health difficulties. The effect size for these findings was moderate, bordering on large. These findings lend support to the second hypothesis, which predicted that the workshop would result in meaningful changes in participant knowledge and awareness of youth bullying and mental health difficulties. This finding is consistent with extant research that has reported that mental health literacy training programs can increase participant knowledge and awareness of mental health difficulties (Anderson & Pierce, 2012; Kelly et al., 2007) and that training programs specifically targeted towards educators can increase knowledge, awareness, and the ability to recognize mental health difficulties in students (Atkins & Rodger, 2016; Fortier et al., 2017; Kutcher et al., 2013). In their study, Atkins and Rodger (2016) found that educators who participated in an elective mental health literacy course reported a greater understanding of the prevalence of mental health difficulties among youth, a better appreciation for the difference between mental health and mental illness, and an improved understanding of the impact of mental health difficulties on academic performance and other school-related outcomes. Similarly, Kutcher et al. (2013) found that mental health literacy training significantly increased the general mental health knowledge of educators and improved their attitudes towards mental illness. In the current study, participants also reported being more aware of mental health difficulties, including anxiety, depression, self-harm, and bullying outcomes, immediately following the intervention. Additionally, participants reported an increase in their awareness of their own attitudes towards mental illness and a better understanding of how their personal attitudes impact their interactions with youth.

A second finding of the current study was that the workshop intervention significantly enhanced participant self-efficacy to build healthy relationships with youth and support youth in distress. Participant self-confidence to interact and intervene empathetically and use effective communication skills in interactions with youth also increased significantly following the

workshop. The effect sizes for these findings were moderate at .35 and .48, respectively. These findings lend support to the third hypothesis, which predicted that the workshop would result in meaningful changes in participant self-efficacy and self-confidence. Extant research also suggests that mental health literacy training can increase perceived comfort, confidence, and self-efficacy in addressing bullying (Benítez et al., 2009) and mental health difficulties (Dods, 2016; Fortier et al, 2017; Kutcher et al., 2013; Wei & Kutcher, 2014). In particular, Fortier et al. (2017) found that educators who participated in mental health literacy programming felt more comfortable being able to provide support to youth in distress, talk to students about mental health issues, and access school supports and resources for students experiencing mental health difficulties.

The results of this study also complement mounting evidence that educator training programs that focus on developing effective communication and relationship-building skills can be effective and meaningful (Aspy et al., 2014). This workshop is one of the first evaluated interventions to offer training to educators on effective communication skills for listening, understanding, and responding to youth in distress. The finding that this workshop intervention increased educator confidence in interacting empathetically, as well as listening and responding effectively, has important implications for training educators in mental health literacy. These types of responses are critical to the development of strong, trusting, and caring student-teacher relationships (Bouchard & Smith, 2017; Kalafat, 1998; Lyons, 2014a; Noddings, 2015). Although the results of this study are preliminary, the finding that workshop participants most enjoyed and benefitted from the practical exercises on communication skills such as active listening, observing, and responding suggests that this training could contribute to the professional development needs of educators and add value to existing programs in mental health literacy for teachers.

In fact, the workshop feedback collected from participants post-workshop was overwhelmingly positive. The vast majority of participants reported that the workshop intervention was useful and informative, taught new information and concepts, and was enjoyable. Moreover, a few participants specifically noted that the usefulness and relevance of the content was what they most liked about the workshop presentation. Most participants reported that they would recommend the workshop for teacher candidates and in-service teachers. In particular, it was noted that the workshop was a good reminder of the importance of

mental health in education, as well as the role of educators in supporting youth in distress. These results are all consistent with the primary hypothesis that the workshop would be useful, informative, and relevant to teacher candidates. The findings justify continuing to refine and disseminate the current workshop for pre-service educators. The usefulness and relevancy of the workshop for in-service educators should also be tested in a future study.

In terms of the best elements of the workshop, several participants reported enjoying the communication exercises and practical activities, the concrete examples and details provided on how to intervene and respond to youth in distress, and the opportunity to discuss the importance of having conversations with youth about bullying and mental health difficulties. In an effort to improve the workshop content for future administrations, participants were also invited to provide constructive feedback. The most pertinent and actionable recommendations were to lengthen the workshop in order to devote more time to the practical exercises, provide more depth of information about youth bullying and mental health difficulties, and offer more opportunities for interaction and collaboration among participants. This feedback is consistent with research on effective professional development, which has found that high quality professional development activities are longer in duration, focus on covering specific content, and are infused with active learning opportunities (Garet, Porter, Desimone, Birman, & Yoon, 2001; Snow-Renner & Lauer, 2005). Active learning offers participants the opportunity to “become actively engaged in meaningful discussion, planning, and practice” (Garet et al., 2001, p. 925). Research on high quality professional development activities has shown that participants who engage in active learning have increased knowledge and skill following the training intervention (Desimone, Porter, Garet, Yoon, & Birman, 2002; Garet et al., 2001; Penuel, Fishman, Yamaguchi, & Gallagher, 2007).

In general, the examination of the retrospective pre-post questionnaire data suggests that the workshop intervention was successful in improving participant knowledge and awareness, self-efficacy, and self-confidence. These findings suggest that this workshop intervention can help teacher candidates feel more confident and capable in interacting and intervening with students in distress due to bullying and mental health difficulties. In addition, according to participant feedback, the interactive and detailed parts of the workshop were the most helpful, informative, and relevant, which justifies expanding the length of the workshop to three hours to include even more opportunities for active learning. During the additional workshop time, the

facilitator should engage the participants in a more in-depth discussion about the workshop content, provide more demonstrations of the communication skills to be practiced, and offer more time for participants to try out the communication skills and obtain feedback from their peers and the facilitator. These specific revisions are consistent with recommendations from research on active learning in professional development activities (e.g., Desimone et al., 2002; Garet et al., 2001) and align with the feedback provided by the participants in the workshop pilot. Nevertheless, the supposition that these revisions will improve the usefulness and relevancy of the workshop will need to be tested in a future study.

Limitations

There are several limitations to the current study. The most notable limitation relates to the generalizability of the findings. The current study was conducted with a small group of participants from a relatively homogenous group of individuals in one Teacher Education program, and as such, the findings may not generalize to other groups. The small sample size also limited the psychometric tests that could be performed on the retrospective pre-post questionnaire, which meant that full validity tests on the hypothesized component structure of the questionnaire could not be completed.

There were also limitations introduced as a result of delivering the workshop to teacher candidates. In particular, the curriculum of the teacher education program is busy during the winter semester, given that teacher candidates only have a few weeks of classroom instruction before starting their school practica. As such, the workshop needed to be delivered within a two-hour time frame, which did not provide sufficient time to cover the workshop content in depth, or leave adequate time for collaboration, discussion, and debriefing after the practical exercises. Several participants noted this limitation in their workshop feedback responses.

The design and administration of the retrospective pre-post questionnaire also introduced limitations into the study design. More specifically, the retrospective pre-post questionnaire was designed as a brief instrument to limit response fatigue, as participants were also being asked to complete a mixed-methods workshop feedback questionnaire and a demographics questionnaire. According to Furr (2011), scales with very few items can suffer psychometric costs and limit the reliability of a questionnaire. As such, the psychometric properties of the questionnaire may have been negatively impacted. In future administrations, the addition of several psychometrically

equivalent items to the questionnaire, especially within the self-confidence subscale, could help to enhance the overall psychometric properties of the measure.

The questionnaire also relied on self-report of participant knowledge and awareness, self-efficacy, and self-confidence pre- and post-workshop intervention. Although the retrospective pre-post questionnaire was designed in such a way to allow respondents to reflect more accurately on the degree of change in their knowledge or skill that was due to the intervention, the results may still have been affected by self-report biases. The questionnaire measure was also administered directly following the workshop intervention and as such, it only captured the immediate changes in participant knowledge and awareness, self-efficacy, and self-confidence. A future study would benefit from a longitudinal assessment to determine whether there is any fluidity in participant self-report of these constructs once the educators return to the classroom.

Finally, the assessment of participant self-efficacy and self-confidence was used as a proxy for behavioural intention on the retrospective pre-post questionnaire, but it is unclear whether or not these intentions will translate into actual behaviour change in the classroom. In fact, the assumption that training individuals in mental health literacy will increase their actual support of individuals in distress has yet to be adequately empirically tested (Anderson & Pierce, 2012). Furthermore, the study did not assess actual impact of the training on educator behaviour in the classroom. Future studies would benefit from exploring whether training educators on mental health literacy and communication skills has an impact on student perceptions of the quality of student-teacher interactions. As a pilot study, however, this research has identified several valuable conclusions.

Implications for Research and Practice

The findings of the current study highlight several important implications for future research and practice. Specifically, future research should include: a) further developing and refining the workshop intervention and questionnaire measures; b) quantitatively testing the findings with a larger, more diverse sample; c) conducting a longitudinal study to determine whether increases in participant knowledge and awareness, self-efficacy, and self-confidence are maintained over time; and d) conducting a study to determine whether participant increases in knowledge and awareness, self-efficacy, and self-confidence following the workshop intervention translate into actual participant behaviour change.

The findings from the current study also provide support for initiatives aimed at training educators in mental health literacy knowledge and effective communication skills. The feedback from workshop participants also highlights the importance of providing this workshop on mental health literacy and communication skills training to teacher candidates and teachers as professional development.

Conclusion

The findings from the current study are consistent with existing evidence that demonstrates that training educators in mental health literacy is important for preparing pre-service and in-service teachers for their emerging role within the teaching profession (Atkins & Rodger, 2016; Fortier et al., 2017; Kutcher et al., 2013; Wei & Kutcher, 2014). The results of the current study also suggest that providing educators training in communication skills for building healthy, trusting relationships with youth can help educators feel more prepared and confident for their emerging role as mental health supporters in schools. As one of the first evaluated training opportunities to integrate mental health literacy content with effective communication skills training, the results of this pilot study are encouraging as they provide support for continuing to investigate the value and impact of this workshop intervention. The results of the current study also demonstrate that a workshop on mental health literacy and communication skills for developing strong, trusting relationships with youth is a valuable and useful contribution to teacher candidate education.

Currently, there are only a few teacher education programs in Canada that offer courses in mental health literacy to teacher candidates (Rodger et al., 2014). As the findings of the current research suggest, establishing a baseline understanding of youth mental health and mental health literacy is critical for preparing teacher candidates for the teaching profession. In fact, the integration of mental health literacy and communication skills training into teacher education has several advantages. Firstly, it legitimizes the educational value of the material and substantiates the important role that educators play in supporting youth mental health and intervening in situations where students are experiencing distress due to bullying or mental health difficulties. Secondly, this training has the potential to enhance the ability of teacher candidates to positively impact the social-emotional development of the young people in their school. Thirdly, training educators in mental health literacy and communication skills may help to strengthen student-teacher relationships, thereby helping to establish a trusted help-seeking pathway to better

promote help-seeking by youth in distress. Finally, offering this training to teacher candidates may help to address the concerns that in-service teachers are reporting about the lack of training and professional development opportunities focused on universal school-based initiatives that address youth bullying and mental health difficulties (Froese-Germain & Riel, 2012).

Given that universal initiatives that support youth mental health and well-being are increasingly being delivered in school settings, providing training to teacher candidates on this subject could help pre-service teachers feel more knowledgeable, prepared and confident in their role in facilitating mental health promotion, prevention and intervention initiatives in their schools. Consequently, teachers may become more willing and able to strengthen their relationship with students and take on the complex, demanding, and vital role of supporting young people in distress due to bullying and mental health difficulties. By *being with* students, educators can make a valuable contribution to the mental health and well-being of young people and help to reduce the negative impact of bullying and mental health difficulties on our youth.

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Appendix A

File Number: 08-16-32

Date (mm/dd/yyyy): 11/21/2016



Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Certificate of Ethics Approval Social Science and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
David	Smith	Education / Education	Supervisor
Jennifer	Neufeld	Social Sciences / Psychology	Student Researcher

File Number: 08-16-32

Type of Project: Master's Thesis

Title: Meeting the mental health needs of students in the classrooms: A counselling skills and mental health literacy workshop for educators

Approval Date (mm/dd/yyyy)

11/21/2016

Expiry Date (mm/dd/yyyy)

11/20/2017

Special Conditions / Comments:

N/A

File Number: 08-16-32

Date (mm/dd/yyyy): 11/21/2016

**Université d'Ottawa**

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: <http://recherche.uottawa.ca/deontologie/submissions-and-reviews>.

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: <http://recherche.uottawa.ca/deontologie/submissions-and-reviews>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Germain Zongo

Protocol Officer for Research Ethics

For Dr. Barbara Graves, Chair of the Social Sciences and Humanities REB

Appendix B

Email Introduction for Professors

Dear Professor:

My name is Jennifer and I am a student in the M.A.(Ed) Counselling Psychology program. I am currently working on my thesis research, which involves designing and piloting a workshop on educator mental health literacy and communication skills for building healthy relationships with youth in distress due to bullying or mental health difficulties.

I am writing to ask whether you would be interested in having a three-hour workshop on this topic presented as a lecture in your PED XXXX course. The workshop focuses on improving educator mental health literacy by providing information about youth mental health and bullying, stigma and mental health, and signs of mental health and bullying difficulties in youth. The workshop will also include an interactive component wherein students will have the chance to practice effective communication skills for building healthy relationships with young people. The training is designed to align with the Ontario Ministry of Education's focus on child and youth mental health. Following the workshop presentation, I would administer a brief questionnaire to the students in your class who volunteer to participate in the study.

If you are interested in having the workshop included as part of your PED XXXX course this semester, please let me know a few dates that would be suitable for you and your students. If you have any questions or require more information about the workshop or my research study, please do not hesitate to let me know.

Thank you for your time and consideration.

Sincerely,

Jennifer

Email: [insert email address]

Appendix C

Introduction Text for Participants (to be posted online)

Dear student:

My name is Jennifer and I am a student in the M.A.(Ed) Counselling Psychology program. I will be presenting a workshop in your classroom on [insert date]. The workshop will focus on providing you with information about youth mental health and bullying, as well as effective communication skills for building healthy relationships with youth. The training is designed to align with the Ontario Ministry of Education's focus on child and youth mental health. The workshop content will be included as part of your course curriculum; however, the content of the workshop will not be part of the course evaluation.

Following the workshop, I would like to administer a few questionnaires to obtain your feedback on the workshop content and experience. Your participation in the data collection component of the presentation should only take 10-15 minutes and will be entirely voluntary. The content of the questionnaire will not be part of the course evaluation. The data that is collected will contribute to my Master's thesis research, which focuses on identifying ways to support teachers working with youth in distress as a result of mental health or bullying problems.

If you have any questions about the workshop or data collection component, please contact me at: [insert email address]

I look forward to meeting with you all!

Jennifer

Email: [insert email address]

Appendix D

Mindfulness Introduction

For this exercise, I'm going to ask you to reflect on your answers to a series of questions about your attitudes towards mental health. We'll be creating a mindful moment so that you connect with your personal experience.

Mindfulness is an activity that you can use with your students in the classroom. In fact, there is research being done at CHEO that highlights the importance of introducing mindfulness to youth who are struggling. There was news coverage in Ottawa last week about CHEO's YouthNet program that will be studying the effects of mindfulness on youth.

The goal of today's exercise is to learn more about yourself, so your answers are your own – and you won't be asked to share any part of your experience. If at any point, you wish to no longer continue with the activity, that's absolutely your choice. I would just ask that you sit quietly, so as not to disturb the experience of the others around you.

Mindfulness Script

So, to start, I will ask you to make yourself comfortable in your chair. I invite you to close your eyes, or if you prefer, lower your gaze.

Allow yourself to switch from the usual mode of doing to a mode of non-doing. Of simply being. As you allow your body to become still, bring your attention to the fact that you are breathing. And become aware of the movement of your breath as it comes into your body and as it leaves your body. Not manipulating the breath in any way or trying to change it. Simply being aware of it and of the feelings associated with breathing. And observing the breath deep down in your belly. Feeling the abdomen as it expands gently on the inbreath, and as it falls back towards your spine on the outbreath. Being totally here in each moment with each breath. Not trying to do anything, not trying to get any place, simply being with your breath.

You will find that from time to time your mind will wander off into thoughts, worries, or memories. Every time you find your mind wandering off the breath, gently bringing it back to the present, back to the moment-to-moment observing of the flow of your breathing. Using your breath to help you tune into a state of relaxed awareness and stillness.

As you tune into your breath, I'd like you to consider the following questions:

1. What is my attitude towards mental illness?
2. Who do I know who is close to me who struggles with mental health? Can you see this person in your mind's eye? How have you responded to them? What do you think of that person?
3. Can you now visualize someone in the community that you have seen who appears to struggle with mental illness? What thoughts and feelings come to mind? The last time

you saw that person did you feel.... Motivated to help? ... Dismissive? ... Disconnected from them? ... An interest in giving them something? ... Scared? ...

4. Now, please consider how your attitude towards mental health and illness might translate into helping kids? And ask yourself: What do I bring to this?
5. Based on your reflections on these questions, is there anything within the domain of youth mental health that you want to be more aware of after today's workshop? Please use this reflection as your intention or learning goal for today's workshop. Take a moment to find that intention.

Now you can start to bring your awareness back into the room and when you're ready, you can open your eyes.

Appendix E



1 SELF-AWARENESS AND MENTAL HEALTH ISSUES

PRESENTATION AGENDA

- 1 AWARENESS, SELF-AWARENESS AND MENTAL HEALTH ISSUES
- 2 MENTAL HEALTH ISSUES IN YOUTH
- 3 MENTAL HEALTH IN THE CLASSROOM
- 4 COMMUNICATION SKILLS FOR BUILDING HEALTHY RELATIONSHIPS WITH STUDENTS

2 MENTAL HEALTH ISSUES IN YOUTH

Childhood and adolescence are **critical periods** of human development and growth

The onset of a mental health problem can seriously **impair** a child's ability to be successful in **school** and in his / her relationships with peers

2 MENTAL HEALTH ISSUES IN YOUTH

MENTAL HEALTH - MENTAL ILLNESS CONTINUUM

HEALTHY	MENTAL HEALTH PROBLEMS	ILLNESS
Well-being	Mild to moderate distress	Severe distress
Resilient coping to mild distress No impairment	Mild to moderate distress Mild to moderate impairment	Severe distress Substance use leading to severe impairment

2 MENTAL HEALTH ISSUES IN YOUTH

Half of all mental health disorders are diagnosed before 14 years of age

75% of all disorders are diagnosed before 24 years of age.

2 MENTAL HEALTH ISSUES IN YOUTH

1 in 5 children and youth are diagnosed with a mental illness

3 MENTAL HEALTH IN THE CLASSROOM

Common symptoms of anxiety disorders:

- Racing pulse and heart palpitations
- Shortness of breath
- Blushing
- Nausea or vomiting
- Trembling, shaking, muscle tension
- Dizziness
- Difficulties with sleep
- Inability to concentrate

3 MENTAL HEALTH IN THE CLASSROOM

Anxiety may manifest as:

- Perfectionism (or excessive worrying about grades)
- Absences from school
- Procrastination or avoidance of tasks
- Feelings of being overwhelmed
- Frequent bouts of tears, easily frustrated
- Worries about time limits or changes in routine
- Physical aches and pains (stomach aches, headaches)
- Refusal to join social activities

3 MENTAL HEALTH IN THE CLASSROOM

DEPRESSION



3 MENTAL HEALTH IN THE CLASSROOM

Common symptoms of depressive disorders:

- Loss of interest and lack of pleasure in activities
- Withdrawal from social situations
- Ongoing feelings of sadness, worthlessness, or guilt
- Changes in appetite, or unexplained changes in weight
- Lack of energy
- Sleep disturbances
- Thoughts of suicide

3 MENTAL HEALTH IN THE CLASSROOM

Depression may manifest as:

- Ongoing sadness that persists for weeks or months
- Low energy and loss of interest in activities
- Complaints of fatigue or aches / pains
- Irritability or feelings of frustration
- Fidgeting and restlessness, distracting other students
- Difficulty thinking, concentrating, or remembering
- Negative talk about the future, suicidal thoughts
- Substance abuse

3 MENTAL HEALTH IN THE CLASSROOM

SELF-HARM



3 MENTAL HEALTH IN THE CLASSROOM

Some youth self-harm in order to:

- Cope with anxiety or depression
- Cope with loss, trauma, violence, or other difficult events
- Turn emotional pain into physical pain
- Feel 'real' and counter feelings of emptiness / numbness
- Punish themselves
- Feel a rush of euphoria
- Regain control over their bodies
- Simply feel better

3 MENTAL HEALTH IN THE CLASSROOM

Self-harm may manifest as:

- Low self-esteem
- Problems handling or expressing emotions
- Problems with peer and family relationships
- Isolation from peers
- Complaints that others do not listen
- Refusal to wear short sleeves or to change for gym
- Wearing pants or long-sleeve shirts in warm weather
- Frequent unexplained injuries

3 MENTAL HEALTH IN THE CLASSROOM



BULLYING

- intentional
- aggressive
- power difference
- repeated

3 MENTAL HEALTH IN THE CLASSROOM

Emotional and behavioural signs of being bullied:



- Afraid to go to school
- Appears anxious or fearful
- Low self-esteem
- Appears unhappy, irritable
- Complains of feeling unwell (headaches, stomach aches)
- Low interest or performance in activities at school
- May appear isolated from the peer group

3 MENTAL HEALTH IN THE CLASSROOM



Emotional and behavioural signs of bullying others:

- Aggressive with others
- Low concern for others' feelings
- Bossy and manipulative behaviour
- Secretive about activities
- Holds positive view of aggression
- Easily frustrated and quick to anger
- Does not recognize impact of actions

3 MENTAL HEALTH IN THE CLASSROOM



Observe the behaviour of concern

↓

Document the behaviour

Frequency
Duration
Intensity

↓

Talk to the student

↓

Share your concerns with others

PRESENTATION AGENDA

**PRESENTATION
BREAK**

PRESENTATION AGENDA

- 1** AWARENESS, SELF-AWARENESS AND MENTAL HEALTH ISSUES
- 2** MENTAL HEALTH ISSUES IN YOUTH
- 3** MENTAL HEALTH IN THE CLASSROOM
- 4** COMMUNICATION SKILLS FOR BUILDING HEALTHY RELATIONSHIPS WITH STUDENTS


4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS



Teacher Involvement:

- Listening
- Observing
- Responding
- Empathy

4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS



Positive youth development

4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS



SHORT

4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

EMPATHY

- To be able to see the world as the student sees it
- To be non-judgmental
- To understand the student's feelings
- To communicate your understanding of the student's feelings




4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

1. ACTIVE LISTENING
2. OBSERVING
3. RESPONDING
(Questioning & Paraphrasing)



4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

SMALL GROUP EXERCISES: Triads



4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

ACTIVE LISTENING

Listening with conscious effort to hear and understand, so you can receive the complete message.



Active listening involves:

- Eye contact
- Ignoring external distractions
- Putting own thoughts on hold
- Showing you are listening

4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

SMALL GROUP EXERCISE: Active Listening



4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

OBSERVATION

Watching the other person with conscious effort to understand the unspoken, non-verbal message.

Unspoken messages can be transmitted by:

- Physical appearance
- Behaviour and gestures
- Initial comfort or awkwardness
- Appearance of comfort or nervousness




4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

RESPONDING

Verbally responding to the other person with conscious effort to ensure that you have understood the message.

Response variations:

- 1) Questioning
- 2) Paraphrasing



4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

RESPONDING: Questioning

Closed-ended Questions

Request a minimal response (yes / no) or ask for specific information.

How long have you been feeling this way?
 Are you feeling better today?
 When would be a good time to talk more about this?

4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

RESPONDING: Questioning

Open-ended Questions

Request elaborate response; these questions cannot be answered with Yes / No

What happens when you start feeling this way?
 Can you think of ways that I might support you?
 Can you describe your difficulties in more detail?
 What did you do when she said that?

4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

LARGE GROUP EXERCISE: Questioning



4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

RESPONDING: Paraphrasing

Rephrasing a person's response using your own words.

A paraphrase neither adds nor detracts from the original message.



4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

RESPONDING: Paraphrasing

Steps in Paraphrasing:

1. Recall the message and restate it to yourself
2. Identify the content part of the message
3. Select an appropriate beginning: "It sounds like..."
 "You think..." or "I hear you saying..."
4. Translate the key content into your own words
5. Confirm the accuracy of the paraphrase

4 COMMUNICATION SKILLS FOR HEALTHY RELATIONSHIPS

SMALL GROUP EXERCISE: Paraphrasing



PRESENTATION SUMMARY

1 AWARENESS, SELF-AWARENESS AND MENTAL HEALTH ISSUES	2 MENTAL HEALTH ISSUES IN YOUTH	3 MENTAL HEALTH IN THE CLASSROOM
4 COMMUNICATION SKILLS FOR BUILDING HEALTHY RELATIONSHIPS WITH STUDENTS		

PRESENTATION SUMMARY
4 THINGS TO REMEMBER

1) Self-awareness and knowledge of mental health problems in youth can help you better identify youth who are struggling	2) A significant number of youth need help dealing with anxiety, depression, self-harm and bullying difficulties	3) Teachers have a critical role in identifying difficulties and intervening / providing initial support to youth
4) Using effective communication skills (active listening, observing, and responding) can help you build healthy, trusting relationships with young people		

RESOURCES

Mental health resources
 Canadian Mental Health Association (www.cmha.ca)
 Centre for Addiction and Mental Health (www.camh.ca)
 Children's Mental Health Ontario (www.kidsmentalhealth.ca)

Bullying resources
 Promoting Relationships and Eliminating Violence (www.prevnnet.ca)
 Stop a Bully (www.stopabully.ca/teacher-resources.html)

Educational resources
 Orientation to Child-Youth MH Services; by The F.O.R.C.E
 School-based MH in Canada; by Mental Health Commission of Canada
 Supporting Minds (2013); by Ministry of Ontario

Appendix F

Description of Research Project: Meeting the Mental Health Needs of Students in the Classroom

This research project is being directed by:

Jenn Neufeld (Master's student)
Faculty of Education, University of Ottawa
Email:

Under the supervision of:

Dr. David Smith
Faculty of Education
University of Ottawa
200 Lees Avenue
Ottawa, Ontario K1N 6N5
Email:

The primary objective of this Master's thesis project is to develop and pilot-test a workshop for pre-service teachers on mental health literacy and communication skills. In other words, we are interested in investigating whether a workshop on educator mental health literacy and communication skills for building healthy relationships with youth is a useful and valuable professional development opportunity for pre-service and in-service teachers.

The workshop will be presented during your regular class time, and in your classroom, on January 30th, 2017. The first part of the workshop will provide instructional information on youth mental health problems and bullying, as well as the signs and symptoms of mental health and bullying difficulties in youth. The second part of the workshop will be experiential and will allow you to practice effective communication skills for developing healthy relationships with youth.

Participating in the research component of this study requires approximately 15 minutes of your time at the end of the class lecture. You are being asked to complete three separate questionnaires to provide feedback on the workshop content and your personal experience of participating in the workshop training.

Participation in this study will have no impact on your performance in the course in which this study will be conducted. The content of the workshop and the questionnaire will not be part of the course evaluation. You are free to terminate your participation in this project at any time without fear of any negative consequences for you whatsoever. Please note that if you elect to withdraw after submitting your questionnaire, it will not be possible for your data to be removed, given that the data will be collected anonymously.

Participation in this study presents no conceivable risks to your physical or psychological well-being; however, the topic of youth mental health and bullying may cause you some discomfort. Should you wish to speak with someone following the workshop, please see the list of resources at the end of this document.

There are several potential benefits to participating in this study: you will gain knowledge of bullying and youth mental health, you will learn about effective communication skills for building healthy relationships with youth, and you will have the opportunity to practice communication skills in a safe environment.

To thank you for your contribution to the research project, you will be given the option to enter your name in a draw to win a gift card valued at \$50 (one gift card per class participating in the project). The draw is open to all participants who enter their name in the draw, regardless of whether they decide to withdraw from further participating in the research project.

Upon completion of the study, a name will be randomly selected amongst those who have entered from each class and the person whose name is drawn will be informed by email. To win the prize, the person must correctly answer a skill-testing question. If the person cannot be reached within 14 days from the date of the draw, the prize will be awarded to the second name that is randomly selected and so on until the prize has been awarded. The odds of winning the prize will depend on the number of eligible entries. The prize must be accepted as awarded or forfeited and cannot be redeemed for cash.

We reserve the right to cancel the draw or cancel the awarding of the prize if the integrity of the draw or the research or the confidentiality of participants is compromised. This draw is governed by the applicable laws of Canada.

All information that you provide to the researcher will be treated in a strictly confidential manner. Moreover, your identity will remain anonymous. Only aggregate results from this study will be publicized. The name and email address that you provide when you enter the draw is collected for the purposes of contacting you if your name is selected in the draw. Your name and the contact information you have provided will be kept confidential and then destroyed once the prizes have been awarded.

The raw data collected will be kept for five years following the publication of the results, in a locked cabinet in Dr. Smith's office at the Faculty of Education.

Please feel free to contact the Master's student conducting this research at any time with questions and/or concerns about the study:

Jennifer Neufeld,

and /or the project supervisor:

Dr. David Smith,

You can also direct any questions or comments about the ethical conduct of the researcher to the Protocol Officer at the University of Ottawa:

Tabaret Hall, Room 154
Ottawa, Ontario
K1N 6N5

Phone: 613-562-5800

If you feel any discomfort or distress following your participating in the workshop or research component of this study, please contact SASS Counselling & Coaching to access counselling services, which are free for all University of Ottawa students:

SASS Counselling & Coaching, University of Ottawa
100 Marie-Curie Private, 4th floor
Phone: 613-562-5200

Appendix G

Informed Consent

I have read the letter describing the research project. I understand the purpose of the study and what is required of me. I have been informed that my participation is voluntary and that my identity will remain confidential.

I understand that by filling out the questionnaires and submitting my responses, I am consenting to participate in the research. I am aware that I may withdraw from the study at any time without any negative consequence. If I withdraw after submitting my questionnaire, I understand that my data cannot be removed due to the anonymity of the data collection.

I am aware that I may keep this statement of informed consent for my own records.

Appendix H

Workshop Contribution

In responding to the questions in the following section, please compare yourself now and before the workshop. **Knowing what you know now**, how would you rate yourself before the workshop and how would you rate yourself now?

Please mark an **X** in the box next to the most correct response 'before the workshop' and 'after the workshop.'

	Before the workshop					After the workshop				
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I am aware of youth mental health problems, such as anxiety disorders, depression and self-harm										
2. I am aware of my own attitudes towards mental illness										
3. I am aware that my attitudes toward mental health problems can impact how effectively I can help youth in distress										
4. I believe I have the ability to build healthy relationships with youth in my school										
5. I believe I have the ability to help / support youth in distress										
6. I am confident that I can show empathy and acceptance towards youth in distress										
7. I am confident that I can listen attentively to youth in distress										
8. I am confident that I can respond effectively to youth in distress										

Workshop Feedback

The following section asks for feedback on the workshop in order to improve the workshop content for future presentations. Please mark an **X** in the box next to the most correct response.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I found the workshop useful and informative.					
2. I learned new information and concepts that will be helpful to me in my work.					
3. I would recommend this workshop to other teachers-in-training.					
4. I would recommend this workshop to in-service teachers.					
5. I enjoyed the workshop.					

6. What did you like about the workshop?

7. What didn't you like about the workshop?

8. What was missing from the workshop content?

9. Please comment on your general workshop experience.

Participant Information

The following section asks questions about you. Your responses to these questions will give us a better understanding of the personal characteristics of our research participants and will not be used to identify you. Please mark an **X** in the box next to the most correct response.

1. What is your gender?

Male Female Other (please specify): _____

2. What is your age?

20 – 24 25 – 29 30 – 34 35 - 39 40 – 49 50+

3. What is your highest attained level of education to date?

Bachelor's degree Master's degree Graduate certificate Doctoral degree

4. In which division of the Teacher Education program are you currently enrolled?

Primary / Junior Junior / Intermediate Intermediate / Senior

5. In which semester of the Teacher Education program are you currently enrolled?

1st 2nd 3rd 4th

6. a) Have you completed a practicum as part of your Teacher Education program?

Yes No

b) If yes, how many practica have you completed?

1 2 3 4 or more

7. a) Did you acquire any teaching experience prior to the Teacher Education program?

Yes No

b) If yes, please estimate the cumulative duration of your previous experience.

1 – 5 months 6 – 11 months 1 – 2 years 2 – 3 years

3 – 5 years 5 – 10 years 10+ years

Appendix I

Draw Entry

If you wish to participate in the draw, please write your full name and email address below.

The name and email address that you provide to enter the draw are only collected for the purposes of contacting you if your name is selected in the draw. Electing to enter the draw does not change the anonymity of the survey. The name and contact information you provide will be kept confidential and then destroyed once the prizes have been awarded.

Name:

Email Address:

Request for Research Findings

If you wish to receive a summary of the findings of this study, please write your name and full mailing address below.

Name:

Mailing Address:
