

Pandemic Recovery Project

“It’s not just me”

Educator Mental Health Pilot Study



Canadian
Teachers'
Federation

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Canadian Teachers’ Federation

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“It’s not just me”



Introduction

Foundations of Mental Health Research at the Canadian Teachers’ Federation

The Canadian Teachers’ Federation (CTF/FCE) has worked to advocate for quality public education and uplift the teaching profession throughout its more than 100-year history. The CTF/FCE took a concerted focus on teacher and education worker mental health and wellbeing during the COVID pandemic, documenting teacher and education worker mental health concerns through two pan-Canadian surveys, an in-depth qualitative research study, and most recently through the Public Health Agency of Canada (PHAC)-funded Educator Mental Health Pilot Study. The seeds for mental health research within the CTF/FCE go back to 2014, however, when the CTF/FCE surveyed the membership on work-life balance – a precursor to mental health research in the profession.

Educator Work-Life Balance

In 2014, the CTF/FCE conducted a pan-Canadian survey, [Work-Life Balance and the Canadian Teaching Profession](#), that collected over 8,000 responses from teachers across the country. The study sought to better understand issues that contribute to work stress and factors that have an impact on teacher work-life balance, including the number of hours worked per week, and work intensification factors. The study found that 35% of respondents felt that work-life imbalances affected their ability to teach in the way they would like, with 79% stating that their stress had increased between 2009 and 2014. It is important to note that the results showed the unequal effects on gender, where women were more likely than men to feel torn between their work and non-workplace responsibilities.

While the survey focused on understanding the various stressors and factors that contribute to work-life imbalance, the results show that daily issues such as lack of prep time, increasingly complex class composition and class size, and increased non-teaching demands, through administrative duties or paperwork, all add up to create work-life balance challenges in the profession. Though the study did not focus on mental health specifically, it showed that positive teacher mental health is a key outcome of work-life balance in the profession, and further research would be required to better understand the connection between workplace stressors and mental health.

Pandemic Findings

The challenges in work-life balance and mental health in the profession became urgent in 2020 as the world made drastic adjustments to respond to the COVID pandemic, including adjustments to schools to attempt to maintain safety, and limit infection. The CTF/FCE responded by collaboratively developing and launching several mixed-methods research initiatives to document the effects of the pandemic on educators and students and support educators and Member and Associate Organizations as the pandemic continued.

Since Spring 2020, the CTF/FCE has used mixed methods surveys and in-depth interviews to document the effects of the pandemic on teacher and education workers’ mental health and well-being, starting with a national survey through which over 18,000 teachers participated across the country. The CTF/FCE [Canadian Teachers Responding to Coronavirus \(COVID-19\) Pandemic Research Study](#) focused on teachers’ experiences in the first months of school closures in spring 2020 to understand the role of technology, well-being, equity, pedagogy, and the pending return to school buildings on teachers’ and education workers lives and working conditions. The findings showed that teachers worried about their students physical and psychological well-being and were becoming increasingly concerned with the way the pandemic undermined their sense of identity as teachers, their sense of safety returning to school buildings, and their self-reported mental and emotional health.

The results from an October 2020 CTF/FCE [Teacher Mental Health Check-in \(2020b\)](#) survey showed that 70% of teachers had concerns with their mental health and well-being. Between the June 2020 Pandemic Research Study and the October 2020 survey, there was a 26% increase in participants’ self-reporting that they had concerns about their mental health and well-being (2020a). Additionally, there were further declines in educators’ physical health, increased issues with sleep patterns, along with decreases in overall job and life satisfaction as frontline workers.

This evidence shows that teachers and education workers shouldered responsibilities in their job that have had lingering effects, not only for their professional lives, but also in their personal lives.

In a 2021 follow-up CTF/FCE qualitative study, [“But at what cost?: Teacher Mental Health During COVID-19”](#), a strategic representative sample of 32 teachers and education workers were interviewed about their experiences working through the COVID-19 pandemic. The results showed that educators were experiencing long-term anxiety, stress, and depression due to increased expectations from work, and the entanglement of work and home life. These occupational challenges affected educators’ personal and work lives and made many educators question their future in the profession. Like the Alberta Teachers’ Association’s (ATA) research on frontline worker compassion fatigue (2022, 2021), the CTF/FCE’s (2020a, 2020b) studies show that teachers have provided crisis and trauma support for students in their care, while also living through the pandemic, putting them at higher risk of suffering from trauma related illnesses as frontline workers.

Through these studies, the CTF/FCE’s results consistently found that educators have lived through significant, sustained, and intensified periods of heightened emotional response. After a 2-year period of intensity, the CTF/FCE’s research shows that teachers and education workers need systemic supports through the next phases of pandemic recovery.

Deepening Understanding

Connections to Literature and the Need for an In-School Pilot

While the CTF/FCE’s evidence clearly indicates that educators have been working in an occupational context that has a higher potential for deteriorating mental health and well-being, there is a dearth of evidence on educators’ knowledge of, and access to, mental health support at the school level. Similarly, there is a lack of evidence on the role of school culture and leadership in supporting and implementing mental health prevention and promotion from a trauma-informed lens. This evidence is needed to understand whole school mental illness prevention and mental health promotion for school staff (including principals, vice principals, teachers, specialists, and education workers). It is also necessary to evaluate the extent to which a collegial (or all staff) model is effective for potential interventions.

For educators, the collegial model is most often used in professional development, through professional learning communities, where teachers build capacity for job-related skills and share knowledge, such as collaborative assessment and content development through peer-to-peer conferences (Hargreaves, 2019). However, less is known about schools using collegial models specifically for mental health promotion and mental illness prevention.

In Gustafson’s (2015) research on teacher collaboration in stress management, her findings suggest that “stress experienced by teachers could be mitigated by...increasing the profession’s collaborative capacity” (p. iii) and improving whole school conditions for mental health and well-being through organizational change. In the United Kingdom, the Wellbeing in Secondary Education (WISE) study (Evans et al., 2022) found that teacher wellness programs need to use individual training and support with whole school elements that “tackle system drivers of the problem” (p. 922). This approach supports the collegial model for mental illness prevention and

mental health promotion at the same time providing a possible means of leveraging “collaborative capacity” through a shift in school culture for whole school change.

Collegial support is at the heart of the profession

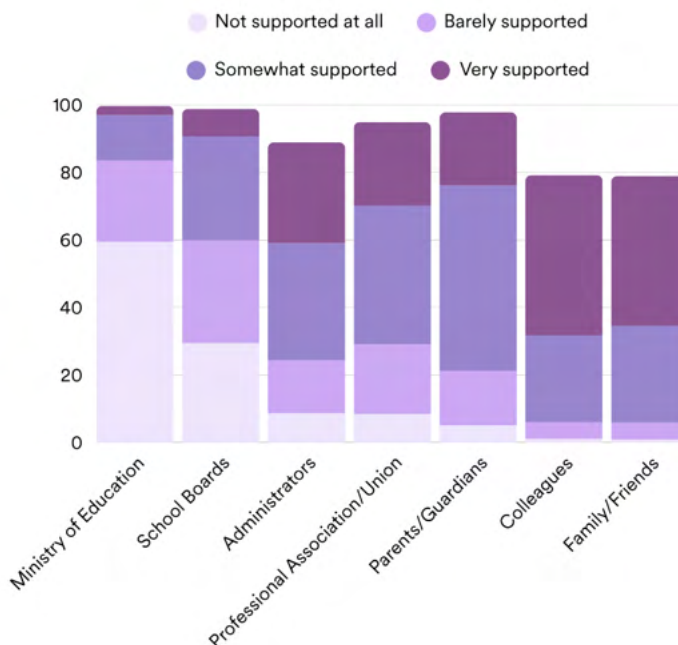
Echoing the insights above, in October 2020, the CTF/FCE’s [Teacher Mental Health Check-in](#) survey asked teachers to rank the support they received from several groups on a 5-Point Likert Scale, from “Not Supported”, to “Extremely Supported.” **Figure 1** shows that more than 14,000 educator respondents indicated that they felt the most supported by their colleagues, (68% feeling “Very” to “Extremely” supported), which was slightly higher than the support they felt from friends and family (65%) ([Teacher Mental Health Check-in](#) survey report, p. 13).

Evidence for a collegial, peer-driven intervention model has also emerged from the Saskatchewan Teachers’ Federation (STF) pandemic research, which found that school administrators¹ (principals and vice principals) felt the most supported by their administrator colleagues, and through collegial networks informally developed during focus group discussions related to leadership and mental health in the COVID-19 pandemic (Osmond-Johnson and Fuhrmann, 2022).

Authors Osmond-Johnson and Fuhrmann (2022) note that principals and vice principals who had access to established networks “spoke at length about the value of those relationships and tended to feel better supported and able to cope with the stresses of the pandemic in a more adaptable

Figure 1.

Educator mental health check-in levels of support question response breakdown.



¹ The term “administrators” was used during the study to denote the principals and vice-principals within the three pilot sites.

manner” (p. 7). Although the research did not intentionally seek to understand the role of collegial models in support, the networks built throughout the research process ended up being a significant finding for administrators’ stress reduction and the collegial focus group a potential model for administrator mental illness prevention.

Likewise, an Australian study on building a culture of collegial support (Southall, Gardner, and Baxter, 2022) used a critically reflective peer-based model that generated positive results for teachers and administrators. In this study, educator colleagues were given time in the school day to discuss the state of the profession with peers, build a community of trust and empathy, and develop a sense of agency to bring about change (p. 378). Like the STF’s research, where mental health was not a central research question, the Australian example from Southall et al. (2022) found that providing educators space and time for critical reflection resulted in improved connection between staff members, increased feelings of collegial support, emotional restoration, and empowerment (p. 380). These studies utilized collegial models for discussion, focus groups, and critical reflective circles to build a capacity for wellness through a trauma-informed, engaged, and culturally competent community approach.

The Centre for Addiction and Mental Health (CAMH) describes trauma as having lived through a significantly distressing event, which can “harm a person’s sense of safety, sense of self, and ability to regulate emotions and navigate relationships” (2022, CAMH). The prolonged stresses from living and working through the COVID pandemic have left a significant percentage of teachers and education workers in need of emotional support and resources for navigating relationships, their classrooms, and their personal lives in a post-pandemic era. The CTF/FCE (2020a, 2020b) and the ATA (2022, 2021) results indicate that teachers have lived through significant and sustained crises, and both organizations have advocated for individual and systemic supports for educators as frontline workers to guide them through the next phases of pandemic recovery.

The CTF/FCE Educator Mental Health Pilot Study was informed by these insights and focused on evaluating the potential of a whole school collegial support mental health intervention model for educator pandemic recovery. This model thereby addresses gaps in knowledge and continues to build upon existing evidence for frontline worker support.

Pilot Study Overview

The Educator Mental Health Pilot Study builds on existing research on the deterioration of educator mental health during the COVID pandemic and provides an evidence base for mental health promotion and mental illness prevention in schools, specifically designed for teachers and education workers.

This study was from December 2022 to March 2024 and included the design, implementation, and evaluation of a mental health promotion and mental illness prevention intervention program that was collaboratively developed by CTF/FCE researchers, CAMH education specialists, and University of Ottawa (UO) scientists and epidemiologists. It tested the effectiveness of an in-school, during work hours, and expert-guided intervention program to support educators in three pilot schools across Canada. Since whole school mental health programs for educators during the workday had not yet been tested, this pilot study addresses these key knowledge gaps in literature on the teaching profession and understanding for professional support.

The pilot study used a phased approach that ensured expert consultation and guidance, relationship building, and educator feedback throughout the study. More details on each phase appears in the Methodology section below. This section begins with research team information and funding information, as the partnership structure was integral to the project’s research design and methods. It is followed by further details on the pilot study Objectives and the Intervention Program design.

Research Partnership

The CTF/FCE recognized the importance of working with subject experts in mental health and wellbeing to advance their understanding of educator mental health for pandemic recovery. The CTF/FCE developed relationships with researchers from CAMH and UO between 2022-2023. These relationships evolved into partnership between researchers from the CTF/FCE, mental health and education experts at CAMH, and researchers from the School of Epidemiology and Public Health, Faculty of Medicine, at UO for completion of this multi-method, multi-phased, and inter-agency research design (see below). **Figure 2** further outlines the organizational structure of the partnership.

The CTF/FCE Research Team

The CTF/FCE research team included a Principal Investigator, Research Project Coordinator, and Researcher, with support from colleagues in Finance and Human Resources. The CTF/FCE was responsible for:

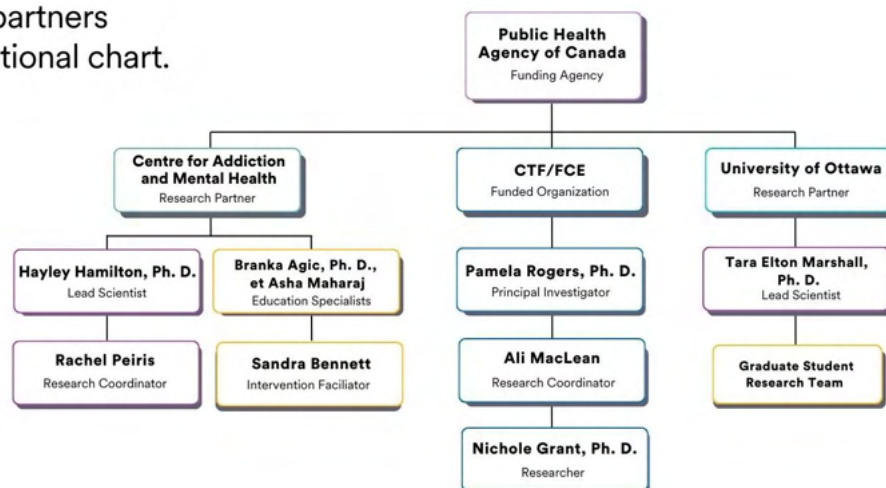
- overall project management;
- research ethics;
- participant and pilot school recruitment;
- financial oversight;
- relationship building with participating schools and their affiliated provincial teachers’ unions;
- administrator interviews and focus groups; and
- final reporting to the funder (Public Health Agency of Canada) and to the CTF/FCE Board of Directors, Executive, and Membership.

Research Partners - CAMH and UO

As research partners, CAMH and UO provided two distinctive research functions:

1. University of Ottawa researchers provided mental health subject matter expertise in the design and delivery of quantitative survey instruments, subsequent analyses, and program evaluation.
2. CAMH education specialists were responsible for adapting and delivering the mental health intervention sessions, organizing sessions with mental health experts, and developing and moderating online community discussion boards.

Figure 2.
Project partners
organizational chart.



Research Funding

This project was supported through a Public Health Agency of Canada directed funding opportunity under the Supporting the Mental Health of Those Most Affected by the COVID–19 Pandemic. This funding was for project activities between December 1, 2022, and March 31, 2024. We are grateful to the Public Health Agency of Canada for this support.

Objectives

The research partners co-developed the following overall objectives:

- 1 Determine a baseline for individual and whole school staff mental health;**
- 2 Assess school mental health cultures, including individuals’ knowledge, skills, and behaviours;**
- 3 Develop, deliver, and evaluate the impact of a virtual, five-session, group intervention model.**

These objectives work together to ensure the research project was able to develop meaningful knowledge not only of school staff mental health and individual staff levels of knowledge, skills and behaviours of mental health for their profession, but also to understand the potential impact of whole school collegial support mental health intervention model for educators.

Intervention Design

The heart of the Educator Mental Health Pilot Study was to test and evaluate a mental health intervention for educators. The pilot project used the [CAMH ECHO](#) mental health model as the basis for designing the mental health intervention program.

ECHO is a virtual training and capacity building model that has been used to support frontline healthcare workers to deliver evidence-based mental health and addictions information through 10 weekly sessions.

With this foundation, the research team developed a mental health intervention program for education workers: a 5-session virtual program delivered over the 2023-2024 school year between October and February.

Due to the short funding timeline that supported the study (14 months in total) and school logistical barriers (to be discussed in subsequent sections), the adapted Intervention Program was developed to run once a month for five sessions.

Participants took part in virtual sessions during their workday and received funding to participate (see Appendix A). The program was designed by CAMH education and mental health specialists in collaboration with CTF/FCE staff, with input from the CTF/FCE Advisory Committee on the Teaching Profession (ACTP).

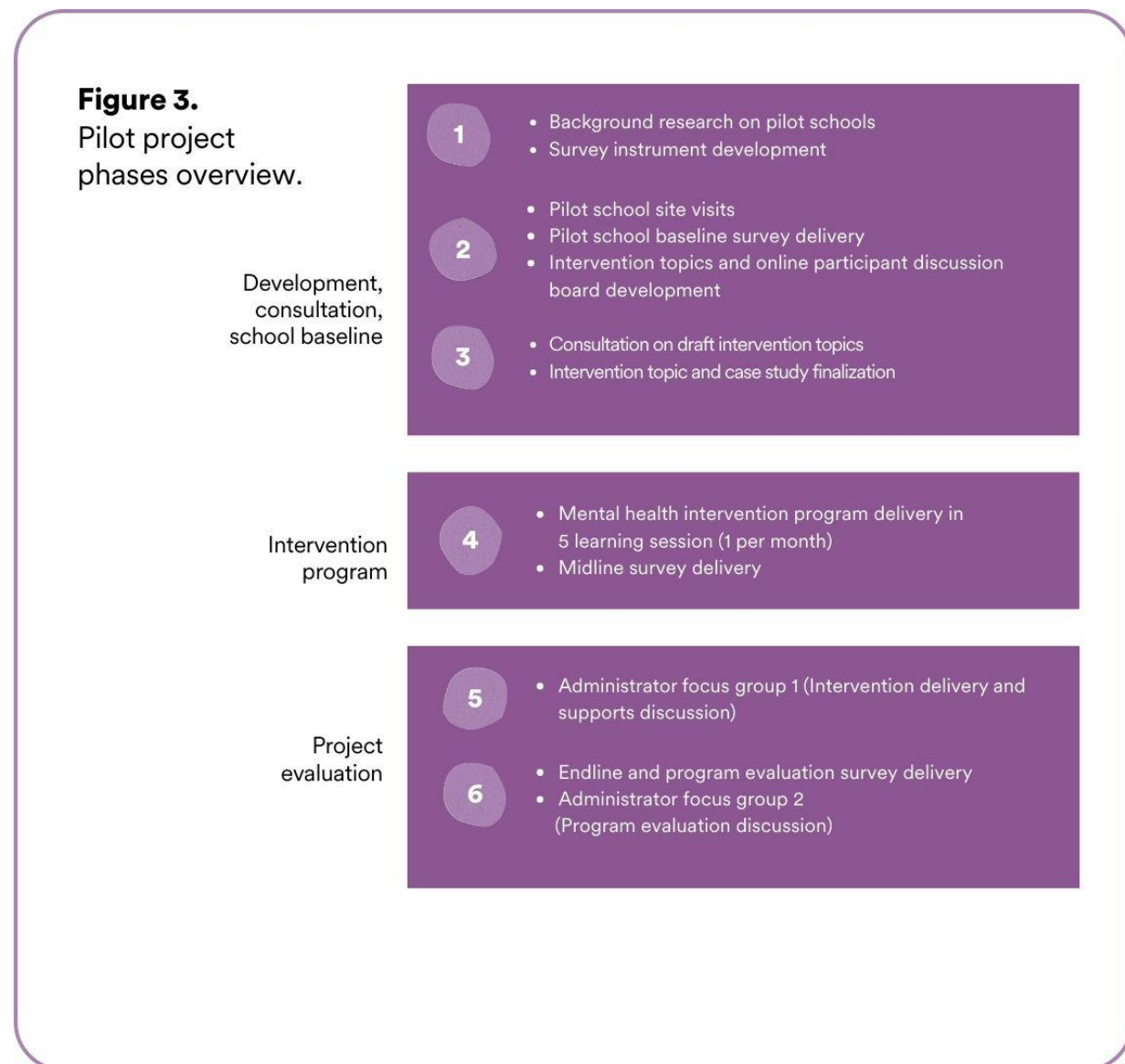
The 5 virtual sessions included the following topics:

- Session 1** Mental Health is Health
- Session 2** Emotions Matter: Building Resilience through Managing Emotional Labour, Burnout, and Compassion Fatigue.
- Session 3** Trauma, Violence, and Mental Health
- Session 4** Trauma-Informed Practice in an Educational Context
- Session 5** Educator Resilience: Developing Stress and Anxiety Management Strategies

Intervention Timeline and Activities

The intervention program design, implementation, and evaluation were divided into six phases. Key milestones needed to be achieved before the next phase could start, as the three research teams were responsible for different facets of research design, data collection, intervention implementation, and research ethics applications.

Figure 3 provides an overview of the major phases and activities, where the Methodology and Methods section below provides further details on specific activities within each phase of the project including planning, starting at Phase 0.



Methodology and Methods

Although the purpose of the Educator Mental Health Pilot Study was to provide teachers and education workers with supportive programming, the main objective of the study was to understand to what extent a collegial pilot project model for mental health promotion and mental illness prevention would be effective in practice.

The research methodology includes whole-school and participant surveys and informal administrator semi-structured interviews and focus groups in a phased approach. The pilot’s formal evaluation was based on the survey results as they related to PHAC key performance indicators (KPIs).

Research Setting

Although project researchers did visit the three pilot school sites to gather informal understandings of each school context and introduce the project to staff, all formal research was conducted via virtually secure, online formats:

1. Baseline, midline, and endline surveys were run through REDcap, a secure online platform, maintained by CAMH. The survey was open for school staff to access through an emailed individualized link for one week’s time. Staff also received reminders to complete the survey.
2. Administrator semi-structured school context interviews were facilitated in person, and follow-up focus groups were facilitated through online video conferencing tools.
3. The adapted mental health intervention program was facilitated virtually, and teachers and education workers participated by accessing the program through a secure online platform.
4. The virtual discussion boards were accessible via a secure online CAMH platform.

Methods – Phased Approach

While this project followed a phased approach, some activities naturally overlapped, but generally followed a sequential order beginning December 2022 with the funding award with PHAC and concluding with reporting to PHAC on the projects activities and results. Below is a description of each phase and the activities within each.

Phase 0 – Initial planning, recruitment

In the initial planning and preparation phase, a CTF/FCE Research Project Coordinator was hired to manage logistical aspects of the inter-agency study.

Research agreements were created and signed between the three research entities: CTF/FCE, CAMH, and UO.

An initial Research ethics board application was prepared and submitted to the PHAC Research Ethics Board, under Dr. Pamela Rogers (see Appendix A for further information regarding the research ethics for this project as well as see Appendix B for the PHAC certificate of ethical approval). At this stage, the CTF/FCE announced the project funding via a press conference and through snowball sampling, invited potential Member Organizations to submit possible schools that could fulfill the project’s objectives and sampling criteria (see next page).



Representative Sampling and Recruitment

The program design included from three to five pilot schools to run the Intervention Program. Since PHAC funding was provided for 14 months, inclusive of reporting and REB approvals, the research team decided to run the program in three schools to best manage time, resources, and factors that could potentially affect the project implementation.

PHAC demographic requirements included schools having official language representation (including education in a French minority context), regional, urban/rural, and other differences, such as elementary/secondary grade levels, and varying student and staff populations.

Potential pilot schools identified by CTF/FCE Member Organizations also needed to meet the selection criteria that their school board or district approved teacher and educator participation in the study.

The target population of K-12 public education workers is primarily comprised of educators who identify as women. The mean age of teachers (n= 13,750) who completed the CTF/FCE Teacher Check-in Survey in October 2020 (CTF/FCE, 2020) was 41-45 years old, 82% of whom identified as women, 15% identified as men, 1% identified as non-binary, and remaining respondents preferred not to identify. From an internal CTF/FCE 2021 teacher population study, the disparity between teachers who identify as women and men has remained consistent over the last two decades. This population has shown to be a significantly feminized workforce. Researchers were aware that participants would likely be overrepresented by women in the teaching profession.

Schools were recruited with help from the Newfoundland and Labrador Teachers’ Association (NLTA), The Manitoba Teachers’ Society (MTS), and The Alberta Teachers’ Association (ATA), and were contacted by researchers after the CTF/FCE received the first round of REB approval in spring 2023.

Three K-12 public schools were chosen based on their representative mix of demographic factors, and the provinces involved (Newfoundland and Labrador, Manitoba, Alberta) were also chosen because of the status of administrators in the provincial teachers’ union; all administrators were in the same union as teachers in this study.

School-level Sampling and Recruitment

Participants from each pilot school site were recruited through a whole staff voluntary selection that includes an informed consent process (see Appendix C School Recruitment Poster). It was expected that one to four administrators from each school would likely be involved in the project, and between 4-25 teachers and education workers from each school would participate in the Intervention Program. This variation in Intervention Program participants was dependent on voluntary participation and school staff size (see below). All school staff from the three schools were eligible to participate in the pre-intervention baseline assessment survey (Phase 3), to understand whole school staff mental health knowledge and culture. All teachers and education workers who worked in classrooms with students were eligible to be an Intervention Program participant.

Phase 1 – Background research, survey development

After pilot schools were identified and confirmed, CTF/FCE researchers compiled demographic information to develop school profiles for each pilot site. The background research included information from Statistics Canada, school websites, provincial Ministries of Education, teachers’ unions, and school boards. These school profiles assisted CAMH education specialists in understanding the research context and developing survey instruments.

Survey Design

The baseline, midline, and endline surveys were collaboratively developed between CTF/FCE, CAMH, and UO researchers. Surveys were designed for educators, and because of this, the CTF/FCE vetted language, terminology, and provided translation to allow for English and French survey participation.

The baseline survey included mental health diagnostic tools for generalized anxiety disorder (GAD-2), depression (PHQ-2), and post-traumatic stress disorder (PCL-C) to enable a comparison throughout the study. This survey was also the method of voluntary recruitment for the Intervention program. Demographic data was collected as a requirement through PHAC. However, since the number of participants in the mental health intervention was relatively small (n=52), disaggregated analyses per pilot school cannot be reported. Where possible, disaggregated analyses are provided for participating pilot schools where it meets ethical requirements (i.e., minimum n=10 for any reporting).

Phase 2 – Visits, baseline delivery

To build relationships with schools, better understand the school and staff culture, and to meet some staff, CTF/FCE Principal Investigator, Research Project Coordinator, and Researchers visited the three pilot schools.

While at the schools, CTF/FCE researchers also completed an introductory semi-structured interview with school principals and vice-principals at each pilot school. This 30-minute initial interview with key informants helped gather data on existing school mental health programs and resources, provided evidence for each school’s staff needs, and established relevant context-specific information. CTF/FCE researchers provided CAMH teams with an overview of visits and interview analyses to further inform intervention development.

A whole school staff baseline mental health survey was administered mid-September 2023 through the secure online platform, REDcap, hosted on a CAMH server. The survey was open for 10 days. The survey provided baseline mental health data for the whole school staff, as principals and vice principals, teachers, and all education workers and support staff were invited to participate in the survey. CAMH subject matter experts administered the survey, collected, and analyzed the quantitative mental health data.

Survey Analysis

A CAMH statistician completed statistical analyses, and all analyses were provided to CTF/FCE through the CAMH research coordinator. All raw data was held on the REDcap platform at CAMH, and analyses were shared between research partners. Baseline results were used to determine the overall effectiveness of the 5-session mental health intervention, as intervention participants also completed a mid- and end- intervention survey with the same mental health self-assessment questions. Results are shared in the Pilot Study Results Section.

Phase 3 – Consultations, intervention finalization

The CTF/FCE Research team and CAMH education specialists consulted with CTF/FCE’s Advisory Committee on the Teaching Profession (ACTP), which is comprised of practicing classroom teachers from across the country. An initial list of potential topics for the five intervention sessions for the pilot study based on CAMH education specialists’ expertise and insights from the [CAMH ECHO program](#), along with CTF/FCE and other education union members’ teacher and educator mental health research, was developed and shared with the ACTP during this consultation. The feedback from the advisory committee provided key insights for adapting the proposed intervention topics for teachers and education workers professional contexts and realities.

Based on these consultations, CAMH education specialist team designed the adapted mental health intervention program. The team created five 75-minute online sessions based on intervention topics established through the Advisory Committee consultation. Each session was organized to support participants to engage in the content of the session and collaboratively work through case studies to support knowledge and capacity building for individual and peer mental health support. The CAMH education specialist team also developed an accompanying online discussion board that was available to support participants and extend their engagement outside

of the five virtual intervention sessions. A separate virtual discussion board was developed for each school and participation was completely voluntary.

Phase 4 – Intervention programming, midline survey

The 5-session mental health intervention programming occurred once a month between September 2023 and January 2024, run and moderated by CAMH education specialists. Alongside the one mental health session per month, CAMH education specialists moderated the online community discussion board for pilot school participants.

At the mid-intervention point, November 2023, CAMH subject matter experts administered a mid-intervention survey with intervention participants to track mental health data, and to record fall-off statistics.

Phase 5 – Administrator focus groups

In June 2023, the CTF/FCE research team facilitated the first of two 60-90-minute focus groups for pilot school administrative leaders (principals and vice-principals). Following the findings from the STF administrator study (Osmond-Johnson and Fuhrmann, 2022), that showed school administrators were lacking support from peers, the pilot study focus groups provided an inter-pilot school support network for school leaders, a space to ask questions, and offered organizational and logistical support prior to the intervention implementation in Phase 4. The semi-structured qualitative focus group data was not recorded, but results informed the study's implementation and provided insights into the types of tasks and concerns that administrators will need to grapple with when delivering similar programming.

Phase 6 – Endline survey, program evaluation, reporting

Between the end of January and early February 2024, CAMH subject matter experts ran an endline assessment survey with intervention participants to determine self-reported changes in mental health over the five intervention sessions and ask participants for feedback on the pilot project.

CTF/FCE researchers facilitated the second administrator focus group in March 2024, during which principals and vice-principals from the three pilot school sites provided feedback on the pilot program in terms of logistics, supporting staff, how to improve the pilot, and their experiences as administrators supporting such a pilot project. These insights informed reporting and recommendations towards overall project evaluation.

Between March and May 2024 CAMH and UO researchers completed a program evaluation out of the whole staff baseline, mid-intervention, and endline surveys, informed by discussion board participation and usage data, as well as administrator focus group results. In May 2024, the CTF/FCE closed their PHAC REB and PHAC funding files as the project was considered completed.

Pilot Study Results

“It’s not just me”

The Educator Mental Health Pilot Study formal research results were compiled from baseline and endline surveys, key performance indicators set by PHAC, and participant feedback provided via surveys and follow-up conversations post-mental health intervention.

Attendance at the five learning sessions averaged 95% (ranging from 93-100% for any given school). Response rates on the mid-intervention assessment and endline survey were also high – 100% and 98%, respectively. Further, the ACTP advising for the design of the mental health intervention and development of case study enabled learning session content that was relevant to the education sector and resonated with educator participants (86% of participants agreed the case studies were relevant to their experiences).

Overall, the results indicate evidence of significant changes in precursors to behavioural change (knowledge and skills). Behavioural outcomes (compassion fatigue, burnout, resilience) were not significantly different. This means participants gained knowledge and skills that are required to see behavioural change at a later point. However, given the truncated ECHO program adaptation – five sessions instead of ten – and the follow-up occurring not long after the study itself (one month), it is unsurprising that behavioural change could not be captured during this time. Changes to knowledge and skills as precursors to behaviour change are nonetheless reflected in the feedback received from intervention participants, who identified that the learning sessions on compassion fatigue, burnout, trauma-informed practice, stress, anxiety, and depression were the most effective sessions for them as educators. However, a surprising finding was that for younger career participants (those under the age of 40), self-reported levels of their anxiety decreased over the length of the project. While this was an unexpected result, this means that there is potential for this program to reach earlier career educators to reduce anxiety.

Significant to the collegial model for the pilot, participant feedback and conversations from administrators showed teachers and education workers in these pilot schools learned that their struggles were not theirs alone – the title of the document, “It’s not just me”, reflects this sentiment. Creating a community of practice, bringing colleagues together to learn essential mental health content, and seeing that the whole staff could benefit from sharing their experiences in a safe environment illustrated that mental health is a whole school experience as much as it is individual.

Focus Groups

Administrator focus groups were held in June 2023 and March 2024. While the focus groups were informal and were not recorded nor analyzed, the information discussed informed program implementation and evaluation, built a network amongst administrators, and highlighted the need for developing collegial supports for administrators across schools and regions.

Baseline Survey

In September 2023, 161 staff members from three pilot schools across three provinces (Newfoundland and Labrador, Manitoba, Alberta) participated in an online baseline survey on their self-reported mental health. This baseline survey included 15 demographic questions, along with questions from the General Anxiety Disorder screening tool (GAD-2), Patient Health Questionnaire screening tool to determine potential levels of depression (PHQ-2), the self-report PTSD rating scale (PCL-C), as well as 17 questions on mental health contexts in their school. These last mental health questions were developed with the ACTP to ensure they reflected educator realities and contexts.

Participation

As displayed in **Figure 4**, 31% of baseline survey participants identified as men, and 69% women. **Figure 5** shows participant ages ranging from early career teachers and education workers, 18-29 years of age, to participants over the age of 50.

Most participants identified as being white (89%) and 11% identified as racialized. Data collected on race, sexual orientation, disability, language, income, household size, education level, relationship status, and employment status are not reported due to low sample size and/or privacy concerns.

Participants were mostly teachers (58%), with 22% educational assistants, and 20% other school staff, including administrators, specialists, and custodial staff. In terms of participant experience, most (43%) had between 5-15 years of experience, with 31% at 15+ years, and 27% under 5 years.

Figure 4.

Baseline participation
gender breakdown.



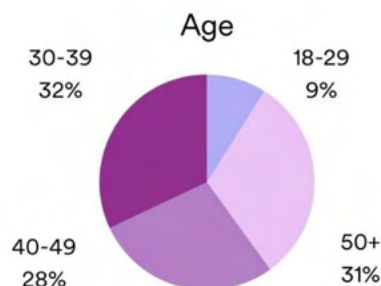
Gender

Approx. 31% men

69% women

Figure 5.

Baseline participants age ranges breakdown.



Baseline Mental Health

The results from the baseline survey conducted in September 2023 showed that even at the beginning of the school year, the numbers for anxiety, depression, and PTSD were alarming. As **Figure 9** (below) shows, the project baseline data found high rates of anxiety amongst the staff in all three school (37%) and notable rates of depression (18%) and PTSD (21%). School staff also reported that workplace violence and trauma (36%) and job demands (56%) had a negative impact on their mental health.

When it comes to participants’ overall mental health, aggregate data shows 30% of participants indicating it is “fair / poor” with ranges from 67% to 76% feeling good or excellent (**Figure 6**). Participants stated that many engaged in self-care in the two weeks prior to the survey (89%), that 36% had experienced workplace violence or trauma that had impacted their mental health, and that job demands had a negative impacts on 56% of participants’ mental health (see **Figure 7**).

Figure 6.

Overall mental health baseline results by pilot school.

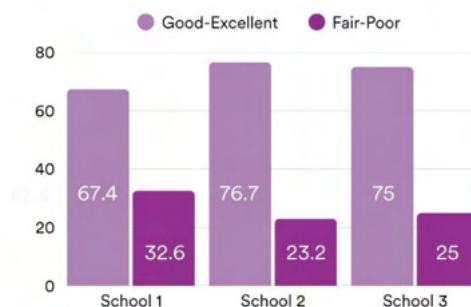


Figure 7.
Collegial support
levels from
baseline survey.



85%

would encourage colleagues to
seek out resources outside the
workplace to support their own
mental health

In-school mental health supports

Participants were asked details pertaining to workplace mental health backings, including support they receive from their colleagues. For resources that are provided by the workplace, 74% answered that they would use mental health resources provided by the workplace to support their own mental health and 73% said that they would encourage their colleagues to seek out workplace supports. Further, 85% answered that they would encourage colleagues to seek mental health supports outside of the workplace if they thought that was helpful or necessary.

The baseline survey provided a benchmark for participant mental health and knowledge about the topics that made up the mental health intervention sessions.

Figure 8.

Factors impacting mental health from baseline survey.



89%

engaged in self-care
in last 2 weeks



36%

workplace violence
or trauma had a
negative impact on
mental health



56%

job demands had a
negative impact on
mental health

Figure 9.

Baseline mental health status results.

ANXIETY

The GAD-2 assessment is a standardized tool to identify symptoms indicative of generalized anxiety disorder (GAD).



37%

**have symptoms
indicative of anxiety**

DEPRESSION

The PHQ-2 assessment is a standardized tool to identify symptoms indicative of depression.



**Almost 1 in 5 have symptoms
indicative of depression**

POST-TRAUMATIC STRESS DISORDER

The PCL-C assessment is a checklist to assess levels of PTSD in the general public.

- Unlikely or some symptoms of PTSD
- Indicates PTSD



**21% have symptoms
indicative of PTSD**

Midline Survey

The midline survey was launched after the third intervention session in November 2023. This survey asked only evaluatory questions related to the Intervention Program and their participation.

Some open text feedback regarding what resonated during the Intervention Program learning sessions included:



“I have enjoyed the connections we make through the content presented with case studies relevant to our careers and experiences. I have often been able to relate back to previous personal experiences through the case studies, thus allowing me better retention and application.”

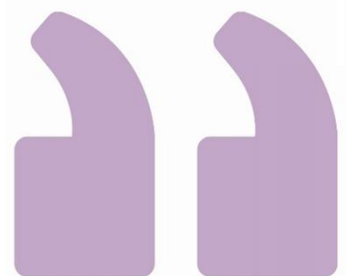
“Knowing that other people feel the same way as I do makes me feel that it’s ok to feel stress. I feel comfortable talking to colleagues about stress/trauma that may be affecting their overall health.”

“I think the compassion fatigue stands out to me the most. This is the first time I’ve heard this term – totally makes sense... I just haven’t heard it in this much detail before. 😊”

Intervention Program participants were also asked about some professional factors that negatively impacted their ability to attend the learning sessions. All of the comments received mentioned the added workload of attending, particularly in preparing lesson plans for substitute teachers.

“The sub plan writing is an additional mental load for us to bear, as well as consistently missing the same classes is an unfair burden to those students.”

“[attending the learning sessions] caused more stress to make sure everything was in place/extra time to catch up afterwards. In a job where there already isn’t enough time to do it all, I did feel more stress by participating in the sessions.”



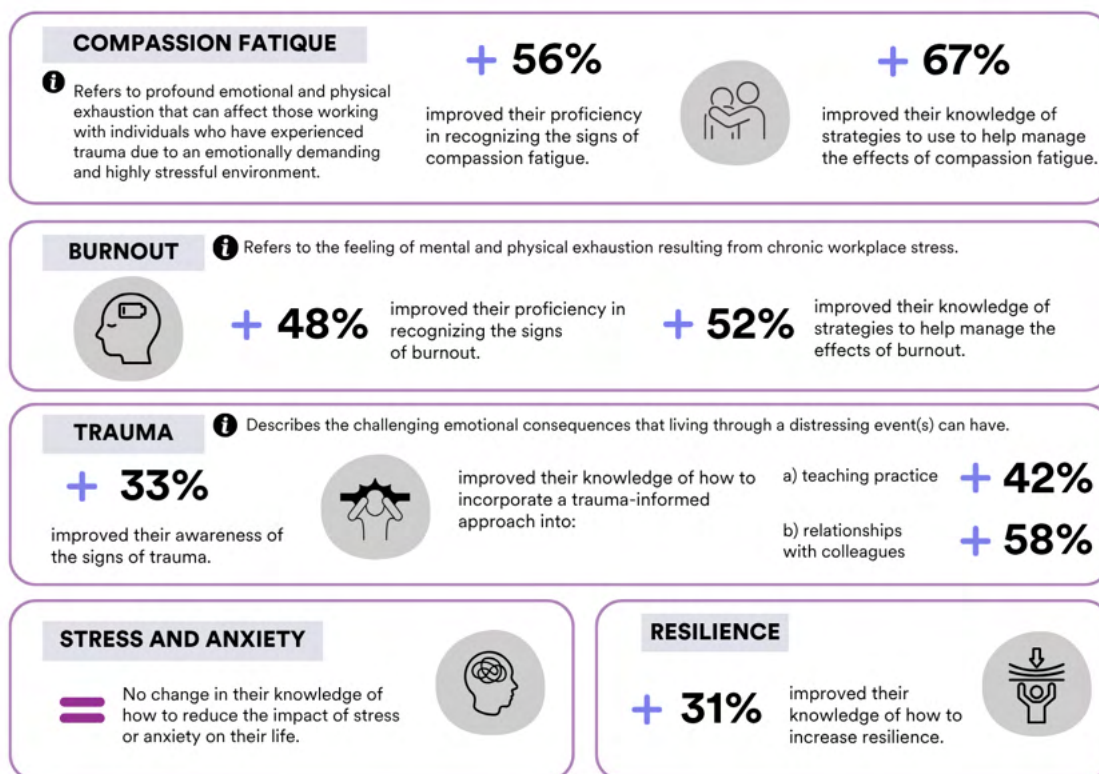
The following section provides an aggregate comparison of baseline and endline findings, an overview of satisfaction with the project itself, and project limitations.

Endline Survey

The Endline Survey was distributed to Intervention Program participants after their last session between January and February 2024. The endline survey asked participants the same mental health questions along with program evaluation questions to determine any changes in mental health knowledge and skills as well as understanding the potential successes and challenges with the Intervention Program and the pilot project overall.

Overall results indicate there was no statistically significant change in rates of anxiety, PTSD, depression, or in self-reported assessment of participant mental health. There were increases in knowledge and proficiency for intervention content from the five sessions. **Figure 10** provides a visual for the increases that were noted for each of the intervention sessions.

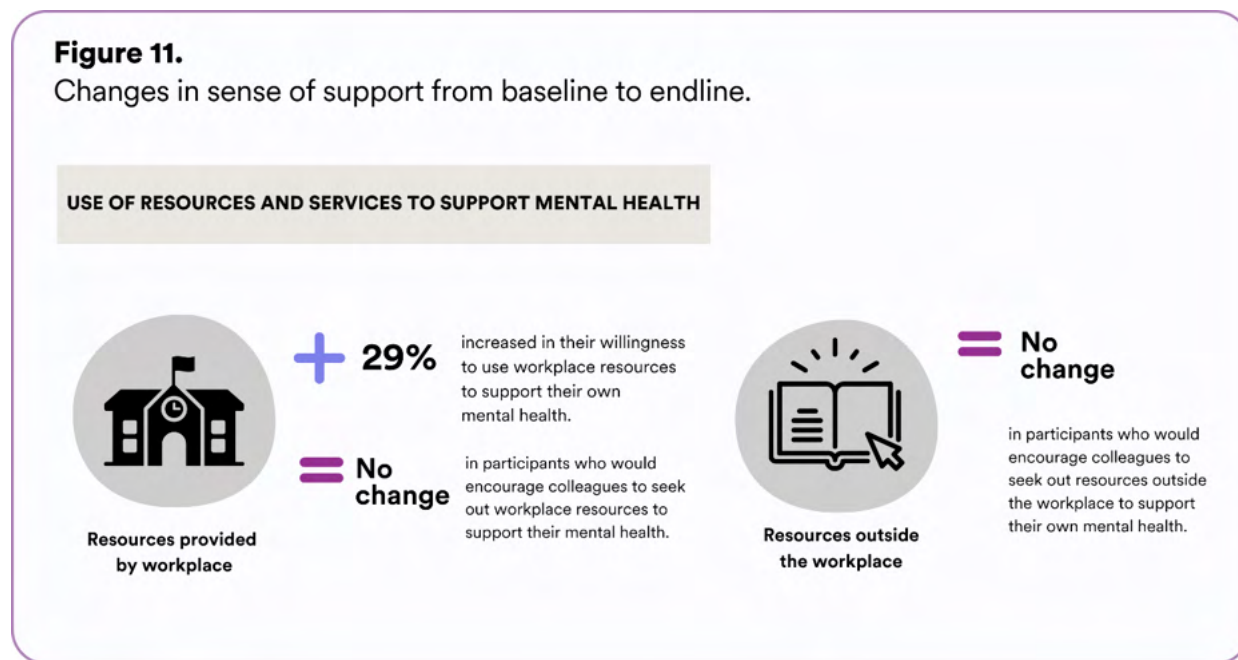
Figure 10.
Endline changes in mental health status from baseline.



The compassion fatigue session dealt with information pertaining to the emotional and physical exhaustion that can affect those working with individuals who have experienced trauma due to emotionally demanding or stressful environments. Between the baseline and endline surveys, 56% of participants improved their proficiency in recognizing the signs of compassion fatigue and 67% improved their knowledge of strategies to manage the effects of compassion fatigue.

Due to chronic workplace stress, individuals can experience burnout. Participants improved their proficiency in recognizing signs of burnout by 48% and improved their knowledge of strategies to management the effects of burnout by 52%. Similarly, for trauma, teachers improved their awareness of the signs of trauma by 33% as well as their knowledge of how to incorporate a trauma-informed approach in their teaching practice by 42% and in their relationships with colleagues by 58%. For stress and anxiety, participants did not show any statistically significant change in their knowledge of how to reduce the impact of stress and anxiety on their life but did improve their knowledge of how to increase resilience by 31%.

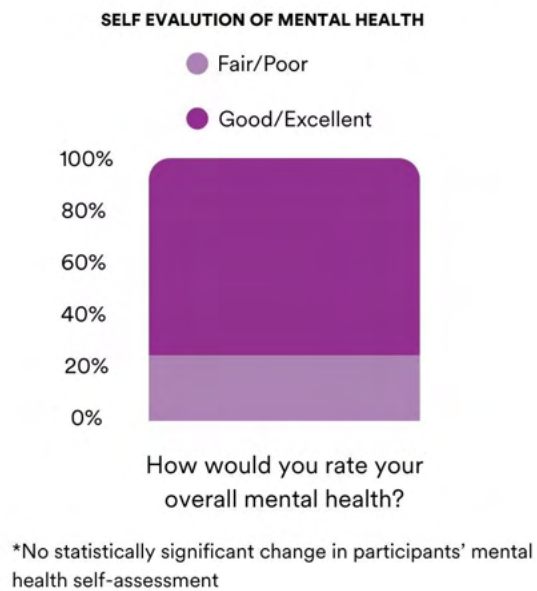
For mental health resources and support usage (**Figure 11**), there was only a change for individual participants’ willingness to use workplace resources to support mental health. The change was an increase of 29%, meaning that specifically for workplace resources, one-third of participants would be more likely after the mental health interventions to support their own mental health through resources supplied by the employer.



Compared to the baseline assessment, there was no change in the way participants self-assessed their mental health by the end of the project. However, there was some change for self-care, which increased from 89-96% between the baseline and endline surveys. There were also increases in the effect that workplace violence or trauma was having on mental health, an increase from 36-42%, as well as the impact of job demands on mental health, which changed from 56% to 71%. Since the baseline survey took place in September and the endline in the middle of the school year (February), this could account for some of the increase in the self-reporting, simply due to the different times of the year and the differences in workload between those times. Although the increases are noted for the impacts of violence and job demands, 75% of participants still self-reported good to excellent mental health (**Figure 12**).

Figure 12.

Overview of further endline results.



96%

engaged in self-care in last 2 weeks



42%

workplace violence or trauma had a negative impact on mental health



71%

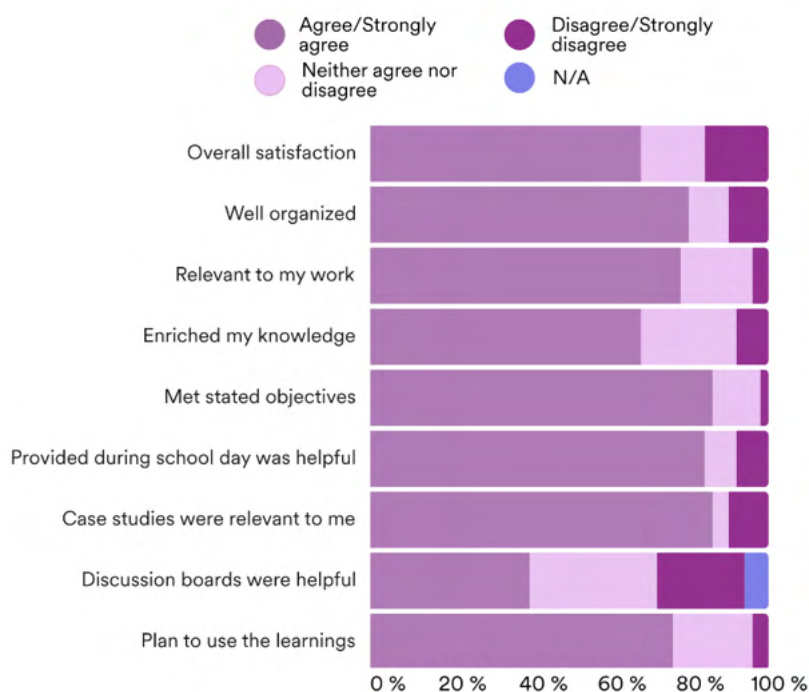
job demands had a negative impact on mental health

Intervention Program Participant Feedback

Participants provided feedback in terms of their level of agreement with aspects of the pilot study and the intervention program in particular (quantitative results) along with qualitative evidence to explain their insights further. Quantitatively (Figure 13), 68% of participants were satisfied with the intervention and 65% would recommend it to others, while 78% felt that it was relevant to their work. Eighty four percent (84%) reported it was helpful that the intervention was provided during the school day.

When asked about certain aspects of the intervention, 86% found the case study discussion relevant, while only 40% found the online discussion boards helpful. Participants noted time and workload constraints and the fact that participants could more easily speak to their colleagues in person than go online on their own time to participate in a virtual conversation as some factors why they did not actively participate online, nor wanted to participate.

Figure 13.
Project evaluation results
overview.



In terms of qualitative feedback, participants provided a range of responses, from appreciation and gratitude for the presenters and content, to suggestions to improve the sessions. Most often, participants described how the sessions made them realize that they were not alone, and that many teachers and education workers were experiencing similar feelings and experiences.

Some criticisms of the program included the online discussion board, which did not appeal to many participants for reasons provided above. As noted in **Figure 15**, one participant stated that they had “too much on their plate” so trying to add in yet another digital platform when time was already tight was not feasible. Another suggested that while hearing mental health experts was helpful, it would benefit the group by having teachers or education workers help or co-facilitate sessions to discuss strategies that have been proven in practice.

When asked if they would recommend the program, the majority (65%) said yes, they would recommend, with 20% neither agreeing nor disagreeing. Some participants (16%) said they would not recommend the program (**Figure 14**).

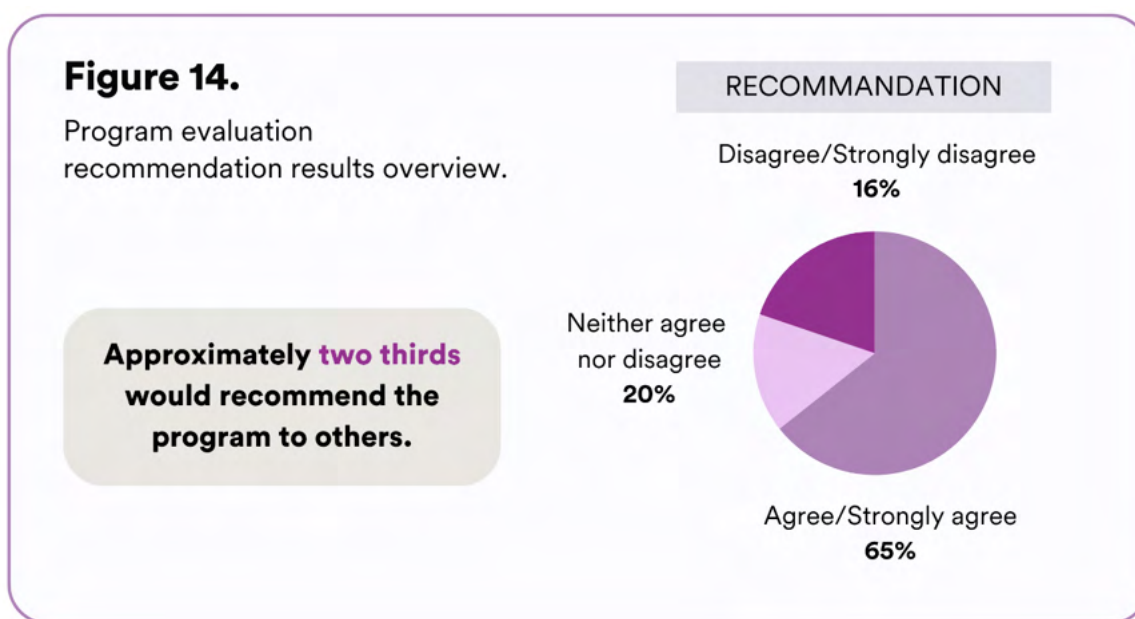


Figure 15.

Qualitative results from project evaluation.

FEEDBACK

"The sessions gave me the push I needed to seek out a psychologist (something I was putting off for a while)."

"Too much on my plate. [The discussion boards were] just one more thing to do. Not enough time in a day."

"It felt better hearing others and finding out I wasn't the only one having these feelings/challenges."

"Thank you for taking the time to work with us!"

"It really made me realize that my struggles are commonly felt across the staff"

"Very thoughtful experience and great presenters."

"I also liked hearing about other people's personal experience."

"I think a lot of the presentations we got were great, but perhaps [...] we could hear presentations from teachers who have successfully utilized different strategies to manage these issues."

"I liked that it was tailored to teacher mental health specifically."

Pilot Evaluation

Successes

- School administrators provided strong support for the project and championed the project among school staff. This enabled a smooth roll-out of activities and contributed to high intervention participation rates.
- Overall, 74-77% of all school staff completed the baseline survey, and 60% of eligible staff volunteered to participate in the intervention. Attendance at the learning sessions averaged 95% (ranging from 93-100% for any given school).
- Response rates on the mid-intervention assessment and endline survey were also high – 100% and 98%, respectively.
- The case study approach also was a success; using teaching-specific instances in conversations to highlight the session content was beneficial for learning and participants appreciated the curated content.
- Pairing with the CTF/FCE ACTP was a success. The group helped guide the project and highlight potential logistical pitfalls to avoid.
- High rates of interest from school staff to participate in the project led to the creation of two learning session groups in the largest of the three pilot schools; one in the morning and one in the afternoon. This enabled school administrators at that school to manage supply teacher coverage for participants and allowed participants to switch from one group to the other if they had scheduling conflicts, thus decreasing absences overall.
- Administrators acknowledged that the payment of release time (supply teacher coverage) for participants was crucial to enable staff to participate in the monthly learning sessions. Without supply teacher coverage, most educators would not have been able to participate during the school day.
- Further, compensating school staff for baseline survey completion and intervention participants helped increase survey response rates and generated high interest in the project.
- Funding for school visitations set the tone for the project in Spring 2023. CTF/FCE researchers being present in schools, meeting staff, administrative teams, and in two instances, guidance and school support teams helped to build relationships that grew throughout the project.
- Administrator focus groups also created a community for discussion and led to insights into what is possible by sharing tips and strategies in implementing this project and other mental health initiatives.

- Education workers were purposely included in the study design. This meant that both teachers and education workers had access to the intervention sessions and same level of compensation. This was an important aspect of the program.

Challenges and Barriers to Implementation

Supply teacher availability

The primary barrier to participation was the significant shortage of supply teachers to allow educators to participate during the school day. This, coupled with the nationwide shortage of teachers, limited the number of educators that principals at each school could permit to participate, despite high levels of interest. It was expected that approximately 25% of each school’s staff would be interested in taking part in the project. However, this number was much higher – up to 65-70% for one of the pilot schools. It was not possible to accommodate the high level of interest due to the supply teacher shortage, and since the intervention sessions were developed for smaller groups for discussion, we would have needed to have more sessions with experts that would have gone above what was possible for scheduling.

Intervention participants feedback also centered around themes of arranging substitute teachers, as well as scheduling conflicts, and pressures or obligations within the classroom. For instance, when asked to describe the professional and personal factors that negatively impacted their ability to attend the learning sessions, some participants responded with the following situations:

“Sub plans. Helping to set up a Provincial Achievement Test made me late for one of the sessions.”

“Time away from classroom is a challenge in high level science classes that move at a fast pace.”

“I missed our first session as I was helping a student who was dealing with a crisis at the time.”

*“Finding a substitute and the stress of having to make a sub plan for while I was gone.
As well as the lower quality of education my students were getting during those sub days.”*

“Conflicts with coaching....”

*“I missed one session due to student needs because one of the sessions occurred during
Exam Prep time”*



Substitute teachers were arranged by principals and reimbursed by the CTF/FCE. Scheduling conflicts were accommodated for one school which offered learning sessions in the mornings and in the afternoons (i.e., educators were able to switch from one session to the other when they were not able to attend their regularly schedule session).

Teacher and education worker shortages nation-wide limited the amount of flexibility administrators could give their staff to participate in the learning sessions during the school day. Each school communicated a threshold for the number of intervention participants based on supply teacher availability on any given day, which we accommodated. This resulted in only being able to include about half of all eligible staff who expressed an interest in participating in the intervention (52 intervention participants out of 100 who signed consent forms). One school had a particularly limited pool of supply teachers and education workers and could only allow five teachers to participate in the learning intervention. The project also accommodated school schedules when booking the monthly interventions, to ensure the highest possible rates of participation.

Administrators were asked to identify their preferences for scheduling and the CTF/FCE worked with CAMH education specialists to book learning session facilitators for those times. In most cases, all learning sessions (five) were scheduled within the same week for all pilot schools, with the exception of the 4th learning session which was scheduled over 2.5 weeks to factor in school exam schedules.



Discussion

Recruitment and Retention

Mental health and well-being are necessary prerequisites for an engaged teaching workforce. With increasing workloads, violence, and day-to-day stressors, educators are running out of energy to sustain themselves, their students, and their communities. The connection between recruitment, retention, and mental health is increasingly recognized as critical for having a stable and effective education workforce. As noted in the introduction, high levels of stress, burnout, and mental health challenges are prevalent in the teaching profession, often exacerbated by demanding workloads, insufficient resources, a lack of support, and working through a global pandemic without proper recuperation.

These factors not only deter prospective teachers from entering the profession but also contribute significantly to attrition rates, as experienced educators leave the field to protect their well-being and to find meaningful work elsewhere. Addressing mental health is therefore essential in creating a supportive work environment that attracts and retains dedicated professionals, ensuring that schools can maintain a consistent, high-quality teaching staff. This being said, there are broader implications for public education systems and innovative ways to support teacher and education worker mental health are not only needed on the individual level, but necessary to contribute to the overall health of the system.

Mental Health in French First Language Minority

Settings

As a national, bilingual organization, the CTF/FCE deliberately recruited one French first-language in a minority setting school to represent educators working in Francophone minority settings. A large proportion of staff at this pilot school identified as Francophone (50%) and a further 20% felt equally comfortable in both English and French. In contrast, at the two other pilot schools, only 3.7% identified as Francophone. All project materials for study participants were available in both English and French, including recruitment materials, consent forms, survey tools, and emails.

The Intervention program was delivered in English at all 3 pilot schools due to CAMH facilitator availability. However, simultaneous translation was made available at the French pilot school. Notably, most participants at that school chose to engage in English during the learning sessions, possibly because they felt comfortable doing so, or because of the technological limitations of the simultaneous translation. This highlights the importance of identifying French speaking facilitators in future iterations of this program when delivered in Francophone settings.

A further consideration is the possibility of French minority language pilot schools partnering with one another for future rollout. While there are teacher supply shortages across Canada, this issue is exacerbated in French minority language boards and schools. To allow for greater participation, while also having equal opportunity for participation in discussion sessions during the intervention and online, schools could combine to share their unique experiences with one another while building community across districts or regions.

Pedagogical Considerations and Pedagogical Design

Open-ended feedback from the endline survey and administrator focus groups showed that while the program was successful, participants felt that they could improve the design by being involved to help create and deliver the content. This does not mean that mental health experts would not be involved, but the pedagogical design did not consider educators’ needs and wants. Since the sessions were virtual, administrators suggested training one or two school staff to learn the content and to design engaging interactive sessions around the content since they best know their colleagues.

Pedagogically, it was not possible to differentiate instruction through the virtual delivery and as a pilot study. However, since participants might be at different levels with their knowledge about mental health and well-being, either offering beginner, intermediate, or advanced varieties could ensure that the context is tailored to different needs. This could extend knowledge for all educators who want to participate and could offer an option for those who want to further their knowledge to develop strategies and ways to support themselves, their colleagues, and students.

Interorganizational Partnerships

The CTF/FCE collaboratively designed and delivered the Educator Mental Health Project with CAMH and UO as research partners. This was the first time the CTF/FCE paired with health experts and researchers to study mental health and the teaching profession. The partnership offered significant strengths and essential learnings to be reflected on when moving forward with future collaborations.

Strengths

- Interdisciplinarity – expertise from public education, public health, healthcare worker education, and medicine was a powerful combination for understanding the complex issue of mental health in public education. This allowed for a more comprehensive study than if any of the researchers were acting alone.
- Although this was an initial pilot study that was required to meet specifications from the funder, working across industries offered a unique possibility for innovative solutions based on past experiences and best practices.
- Collaboration between these fields can lead to recommendations that are not only practical for the education sector but also informed by the latest healthcare research. This can improve the effectiveness of interventions designed to enhance teacher and education worker mental health and well-being.
- The involvement of CAMH and UO researchers can lend additional credibility to the findings, making them more convincing to policymakers and stakeholders who are concerned with the well-being of teachers as part of a broader public health goals.

Essential Learnings

- Working across disciplines can be challenging due to complex coordination and differences in research methods, differences across contexts, and priorities.
- Ensuring that education and health researchers’ goals were aligned and that multiple perspectives were understood required intentional coordination and discussion throughout all project stages.
- Learning about and understanding the difference in health care and public education politics was necessary.
- Interdisciplinary research partnerships often require more time and resources to coordinate effectively, which can strain budgets and timelines. While this complexity can slow research processes down, potentially delaying the delivery of actionable findings, in this instance, we were successful in working toward PHAC timelines and goals.

Educator Mental Health

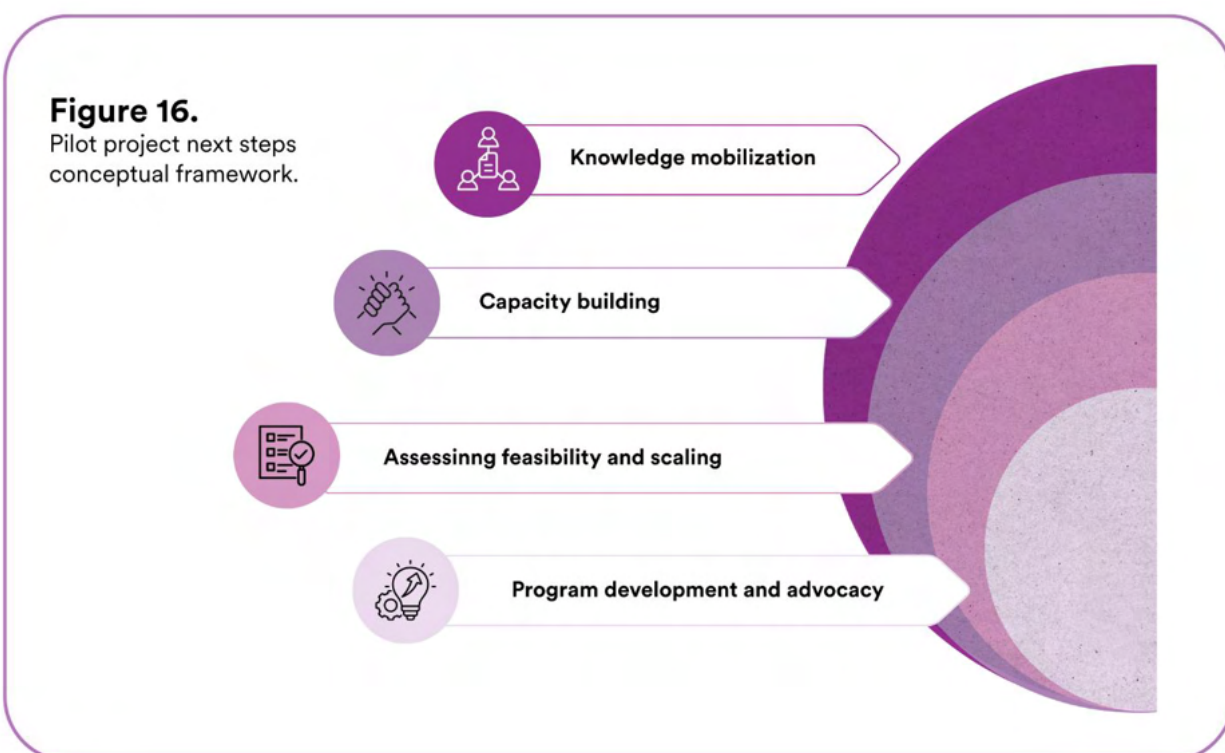
Moving beyond a pilot study

Conclusions show that while the program was successful in each pilot school, every context had specific needs and desires that could not be fully achieved from one pilot project alone. We know that there is a growing need for educator mental health resources, programming, and interventions in K-12 public school across Canada, and that educator mental health is essential for retention and recruitment efforts in the profession.

Feedback from participants and administrators consistently showed that the Educator Mental Health Pilot Study was an innovative way to deliver essential mental health information to teachers and education workers during their workday. This section provides details on actions and initiatives to leverage the insights of this project to build educator mental health capacities across the country.

This section is divided into 4 complementary actions (see **Figure 16**).

Below provides further details on each of these actions in terms of what has already been accomplished at the time of this report as well as objectives, timeline and funding needs, staff complement requirements, and key activities.



1. Knowledge Mobilization

As of June 2025, the results have been shared with the CTF/FCE Board of Directors, the CTF/FCE Executive, and delegates at the 2024 CTF/FCE Annual General Meeting. Staff have also provided the following activities:

- A research-sharing session at the 2024 CTF/FCE Women’s Symposium in Fredericton, New Brunswick.
- A Project Summary at the 2024 CTF/FCE National Staff Conference, National Teachers’ Research Network (NTRN) meeting.
- A promotional post card on the project’s results along with a CTF/FCE [Perspectives Blog](#) post on the project, launched as part of the CTF/FCE’s 2024 World Teachers’ Day event.

Along with baseline results and school culture reports, this report will also be shared with participating pilot schools.

The CTF/FCE continues to draw upon the insights and learnings of this project for further knowledge mobilization, collaborations, and research work. The chart below provides an overview of needs and resources to continue knowledge mobilization for the project findings:

Objective	Timeline and Funding	Staff Complement	Key Activities
Continue to share project findings	One or two years Internal CTF/FCE funding	Existing staff in Research, Public Affairs, and Governance	Publications Sharing with networks Leveraging events as connection points Podcasts/short form information videos/webinars

2. Capacity Building

Along with knowledge mobilization activities, building capacity to support mental health programming for teachers and education workers becomes a key potential next step out of this project. The table below provides an overview of possible capacity building needs and activities.

Objectives	Timeline and Funding	Staff Complement	Key Activities
Build on findings Support MOs to create programs for teacher and education worker mental health	Two to three years Internal CTF/FCE funding	Existing staff capacity in Research/ Governance Potential coordination capacity needed	In-person and virtual collaboration with duty holders Provide guiding principles for mental health interventions in schools Engage in partnership development with mental health experts

3. Assessing Feasibility and Scaling

The research team has an ongoing interest in exploring whether small modifications to the model to facilitate implementation at scale will produce similar results. Potential modifications to the programming include:

- More frequent sessions (e.g., every two weeks vs. monthly) or more sessions in total (8-10 sessions vs. 5).
- Combining several online groups to facilitate inter-school, district, and regional learning.
- Combining educators from different French first language schools in a minority context.
- Testing the intervention in more schools with different demographics and contextual challenges.
- Including administrators (school leadership) in a combined or separate intervention session.

These elements are important considerations for programming prior to considerations of scale-up to ensure project feasibility in more contexts and in different school communities with differing needs.

In terms of overall considerations for feasibility and scaling, the table below provides an overview of major objectives and considerations for this further work:

Objective	Timeline and Funding	Staff Complement	Key Activities
Address feasibility across school contexts Scale-up intervention design to reach more educators and administrators	Three to five years Further funding would be required — federal funding options (e.g., PHAC or Health Canada)	Further coordination and research capacity to manage partnership needed for scale up implementation	Program and financial management Partnership development with mental health experts and school communities

Scaling up

While funding will need to be secured to scale up the current mental health model, there are various potential values to pursue in scale up. It is likely that different types of schools will require differentiated implementation methods to best meet their needs, so scaled up programming would need to be flexible and agile enough to offer various ways to participate. Some potential methods include:

- A virtual-only program that takes on one to five staff per school per year. This will allow more schools to participate and will make the virtual discussion board a place for exchanging ideas across regions.
- In-person debrief sessions – using the same method as the pilot but adding in-person debrief conversation to further build community and connection between participants.
- Using the pilot format, rotate participation throughout the school based on department (for secondary schools) or grade-level(s) (for elementary schools). This would allow for same-grade or department learning and more option to discuss in smaller groups after.

- One of the findings from the program was the potential benefit for new teachers (less than five years’ experience). Unions could potentially offer the program to new teachers as part of their own pilot.
- Offering the sessions to administrators and specialists to build capacity across schools and/or regions.

4. Program Development and Advocacy

To further develop the potential of the programming based on the pilot study and work towards pan-Canadian advocacy for educator mental health out of the programming results, the CTF/FCE would require on-going supports and collaborative partnerships. The table below outlines the potential considerations and requirements:

Objective	Timeline and Funding	Staff Complement	Key Activities
Support scalable and adaptable intervention programming	Five years Federal funding options (e.g., PHAC or Health Canada)	Coordination and research capacity to manage partnerships and implementation	Ongoing program management Financial oversight

Recommendations for Mental Health Programming in Schools

Prior CTF/FCE research and this study’s baseline data both indicate a clear need to address educator mental health in Canada. The Intervention Program was able to demonstrate impact in many key areas, including knowledge and skills development around mental health topics.

The pilot study successfully tested the feasibility of implementing this intervention in a school setting during the workday. The short-term nature of this pilot study means that longer-term impact, particularly on educator behaviour change for mental health, is yet to be determined.

Based on the results of the project, some components that we recommend being continued are:

- Mental health content that is specifically adapted to the teaching profession and public education context, with input from teachers and education workers.
- Content focused on compassion fatigue, burn-out, stress, resilience, and trauma.
- Release time/supply teacher coverage to enable educators to participate during the school day.
- Partnerships with school administrators across schools.
- Tailored programming for administrators.
- Flexible scheduling for participants.
- Research partnerships between health and education.

The CTF/FCE will continue to reflect on the impacts of this pilot study for educators’ mental health knowledge and skills and provide further insights as they become available.

Conclusion

Community Building as Antidote

One of the strengths of the Educator Mental Health Pilot Study was how schools could focus on teacher and education worker mental health by fostering a staff culture of mental health awareness throughout the school year. Administrators described that, although only a percentage of staff were involved in the intervention, they started hearing more conversations among staff who were sharing their experiences in the project, and it was an entry way for having whole school mental health days and focused sessions during professional development or staff meetings. In one instance, a teacher openly discussed how the program led them to seek external mental health support once they learned more about anxiety and burnout, and this was supported by their colleagues and administration who were also involved in the conversation.

Although the pilot intervention program was only 5 months, there were indications that the whole staff or community model could be beneficial in moving forward. It is important to note that while learning about mental health and well-being will not undo difficult working conditions, classroom complexity, underfunding, or violence in schools, creating staff teams that feel supported and have knowledge and awareness about their own mental health needs is vital for creating safer and more supportive conditions for teachers and education workers in their workplaces. While the pilot study did not solve all mental health and well-being issues in public education, it has been an intentional and positive step in the direction for truly supporting educators.

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Appendix A

Ethics

The following provides further details on the ethical contexts and considerations within the pilot study and evaluation.

Participant Time Commitment

The time commitment for all components took place during school work hours, with the exception of the online discussion forum, which teachers and education workers could choose to engage outside of working hours if so desired. The study participants’ expected time commitment is outlined in the table (Figure 17), below:

Staff	Activities	Time Commitment
Administrators	• In-school logistics • Organizing supply teachers needed for intervention participants • Key informant interview • Focus groups	• Ongoing throughout the intervention (September-February) • 30-minute interview • 2 x 90 minute-focus groups
Whole school staff	• Pre-intervention baseline survey	• Approximately 25 minutes
Teachers and education workers (intervention participants)	• 5 virtual intervention sessions • Online discussion forum • Mid-intervention survey • Endline survey	• 5 x 75-minute sessions • Variable • 1 x 20-minute midline survey • 1 x 20-minute endline survey

Figure 17. Participant time commitment overview.

Compensation and Justification

Teachers and education workers, along with many other frontline workers, have been overburdened with continuing to work throughout the COVID pandemic but also with supporting and participating in research initiatives that look to understand and document its effects on school systems (Patel et al., 2020). In this research project, we acknowledged these realities by providing

compensation for participation and for preparation time required for teachers to plan for classes they would miss when attending mental health intervention sessions. The breakdown of compensation and particular justifications for each type of participation appears in the table below (Figure 18).

Staff	Justification	Compensation
Administrators	To compensate for administrators’ time to participate in two focus groups, key informant interview, and for organizing in-school logistics for intervention participants.	\$900 honorarium (\$450 in July 2023, \$450 in February 2024)
Whole school staff	To encourage widespread participation in the baseline assessment by whole school staff.	\$150 gift card
Teachers and education workers (intervention participants)	To compensate for teachers’ preparation time and time needed to participate in intervention sessions and discussion board.	\$450 honorarium

Figure 18. Participant compensation breakdown.

Consent

Free and informed consent was gained for participants at each stage of the project. Depending on the project stage, various research teams were responsible for the informed consent process. In the case of Francophone contexts, survey instruments, information and consent forms were made available in French, and interpretation was provided during intervention sessions. As seen in Figure 19 below, the CAMH consent communication plan included a screening tool to determine eligibility for the baseline survey and for the intervention. For those who were eligible to take part in the intervention, consent was first obtained at the time of the baseline survey. Figure 20 further explains the consent process and responsibilities for research partners.

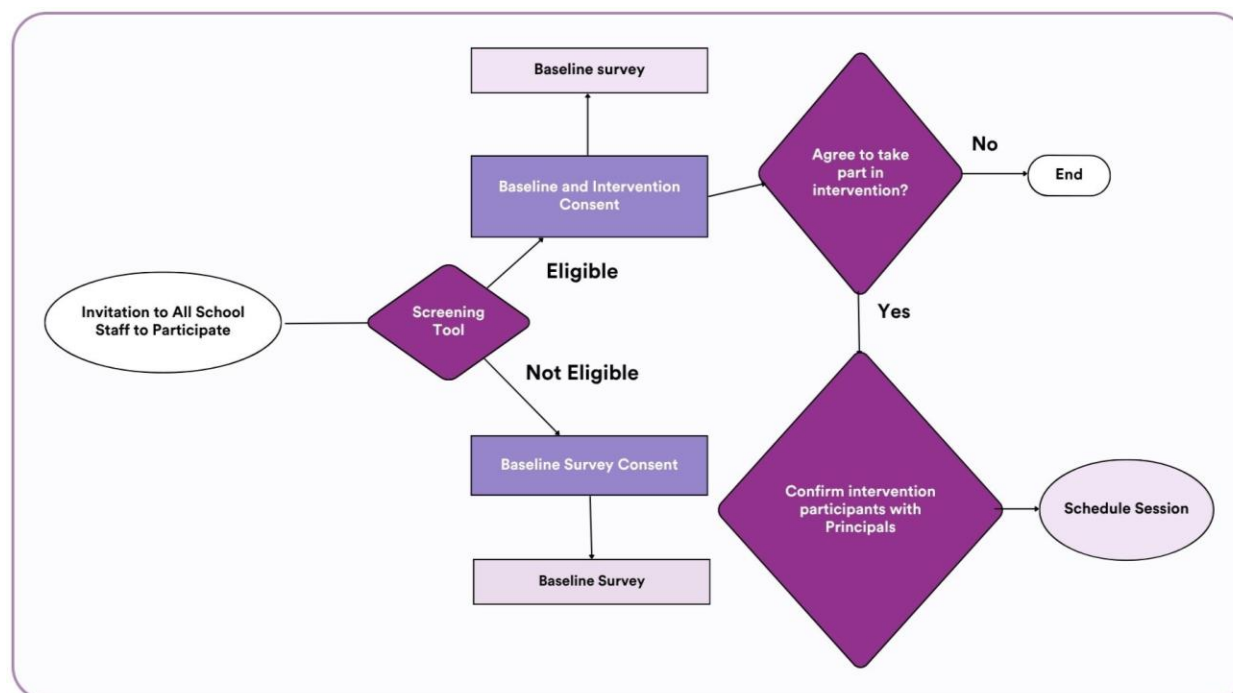


Figure 19. CAMH Consent communication plan.

Staff	Consent Plan and Responsible Parties
Administrators <i>Key informant interview; Focus groups</i>	CTF/FCE researchers obtained oral informed consent from the interview participants. Participants were provided with information on any potential harms and/or benefits in participating, on the treatment of data, including its purpose and usage in informing the pilot study. School administrators had the right to end the interview at any point and the right to withdraw their answers. In the case of withdrawal, the participant had the right to ask for their data to be destroyed. This was outlined in the informed consent document. CTF/FCE researchers facilitated school administrators’ discussion in two focus groups and obtained oral consent before proceeding in the sessions. The purpose of the sessions was to provide a space for support and feedback for school leaders, and only summaries were shared among the research team and research partners. Participants were informed that should they want to withdraw from the focus groups, their data would be kept as disentangling content from focus group data would compromise whole group results.
Whole school staff	CAMH subject matter experts obtained informed consent for baseline survey participants at the beginning of the online survey. Participants were informed of potential harms and benefits for

<i>Baseline survey</i>	participating and could end their participation from the survey at any point. The data would be analyzed up until the point of drop off. If a participant did not want their responses included in the analysis, instructions for contacting the CAMH subject matter expert were included in the informed consent section. In this case, the data would be deleted.
Teachers and education workers <i>Intervention; Midline and endline surveys; Discussion forum</i>	CAMH education specialists obtained written informed consent from intervention participants. Participants were informed of any potential harms and benefits and that they had the right to withdraw from the intervention (any of the five sessions and/or discussion board) at any point. Should they so choose, participants could return to subsequent sessions if they missed or withdrew from an earlier session. No content from the intervention sessions was recorded or analyzed. CAMH Subject matter experts obtained written consent from intervention participants before beginning mid-intervention and endline assessment surveys. This was obtained through the introductory page of the online survey, in which participants were re-informed of the potential harms and benefits and that they may stop participation at any point of the survey. If participants also wanted to withdraw their answers, they could request their data to be deleted through the research contact information provided. CAMH education specialists obtained written informed consent from intervention participants before using the online moderated discussion board. Participants were informed of any potential harms and benefits, including the inability to provide anonymity between participants in discussion board spaces, and that they had the right to withdraw or not participate in the online board if they so choose. No content from the online boards was recorded or analyzed, but frequency and usage data, such as number of times logging onto the platform, frequency of posts, and time spent on the platform for each participant was anonymously recorded for the program evaluation.

Figure 20. Consent Plan and responsible parties.

Potential Harms and Benefits

It was not expected that participants would experience any anticipated harm. Rather, they were expected to benefit from the pilot study in terms of improved mental health and/or prevention of mental illness through self-reports from baseline to endline, developing and/or furthering a supportive school culture towards whole school mental health, and an enhanced capacity to address mental illness and trauma. It is possible that individual experiences around mental health prior to the intervention could contribute to a varying degree of benefit from the program, and

that some individuals may have encountered emotional/psychological challenges in addressing trauma and mental illness. Stigmas around mental illness and trauma may also have been experienced through the course of participation.

Mitigation Strategies:

CAMH’s (2021) Health Equity and Inclusion Framework for Education and Training was applied to virtual sessions to ensure that learning environments:

- respect learner diversity and accommodate different abilities and needs;
- foster inclusion and are free of biases/stereotypes/stigmatizing language;
- consider populations facing multiple health and social challenges and unmet service needs; and
- promote health equity and cultural competency principles in practice.

Virtual sessions were led by trained mental health professionals from CAMH who were able to respond appropriately to participant distress. Similarly, the online discussion boards were facilitated and monitored by CAMH psychologists who could respond effectively to situations of distress.

Trauma-Informed Lens

Research design and methods were developed with the understanding that some participants have had experiences with mental illness either personally, or in their lives otherwise, and required tailored supports that foster safety, respect, and empowerment. The assessment methods and the collegial model of intervention were developed to ensure participants felt safe, respected, and validated. Self-assessments by individual school staff and school culture assessments were based on a foundational understanding of the importance of trauma in the behavioural, emotional, and physical stressors, and in coping strategies. A trauma-informed lens builds the capacity to understand mental health promotion and prevention personally, and within the larger school context.

Limitations and Potential Biases

Limitations

1. As the study was only implemented in three pilot schools, it was not possible to capture all the varying degrees of diversity of K-12 school education workers’ experiences across Canada. Researchers attempted to identify three pilot schools with different characteristics (French/English, urban/rural, size of school population, elementary/secondary, region, etc.) to address this limitation as best as possible.
2. Recruitment of pilot schools was done via Member Organizations, with an understanding of the goal of representativeness of the characteristics mentioned above. Identification through these channels relied on snowball recruitment strategies through personal networks.
3. The need for substitute teachers to cover for teacher participation in the intervention was expected to narrow the selection of schools for consideration, given known supply teacher shortages across various regions.
4. Participant self-reporting methods have been noted to carry some limitations dependent on the particular measures being employed for self-reporting (Chan, 2008). Self-reports were also a necessary element of the intervention program evaluation, especially where

clinical diagnosis was not the aim. CAMH education specialists and University of Ottawa researchers employed self-reporting measures with established validity for general populations such as the Generalized Anxiety Disorder (GAD-2) screening (Löwe et al., 2008), the Patient Health Questionnaire (PHQ-2) (Kocalevent, et al., 2013), and the civilian PTSD Checklist (PCL-C) (Conybeare, et al., 2012) in the development of the baseline, mid-intervention, and endline assessments. Measures of program success that are less prone to respondent bias, such as participant recommendation of the program to their peers, were also used.

Potential or perceived biases:

1. The CTF/FCE does not employ study participants, nor is it perceived to influence the employment status of any participants. The CTF/FCE is a member-based organization upholding teachers’ rights, and data generated from this research study may be used for advocacy and future collective bargaining.
2. Member Organizations (as unions of the participants) were perceived to be acting in participants’ best interests and are therefore not a neutral third party. Aside from assistance in identifying potential pilot schools in their jurisdiction, Member Organizations did not participate in the project.
3. Given the real and/or perceived power dynamics between education workers and school administrators, administrators only participated in the key informant interview, administrator focus groups, and baseline survey, but not in the intervention or online discussion boards. Administrators did not have access to data from the intervention sessions or discussion boards.
4. Though input from education workers was needed in the design/adaptation of the intervention, their direct involvement could affect their assessment of the intervention. For that reason, researchers consulted the Advisory Committee on the Teaching Profession, consisting of educator members from CTF/FCE’s Member Organizations from schools who would not be participating in the intervention or assessment but would contribute to the design and adaptation of it.

Appendix B

PHAC Ethics certificate



CERTIFICATE OF ETHICS REVIEW	
Type of Review: Initial Review of Research	
Principal Investigator: Pamela Rogers Principal Investigator, Research and Professional Issues Canadian Teachers' Federation 2490 Don Reid Drive Ottawa, ON K1S 1E1	
Project Title: Educator Well-being during Pandemic Recovery: Supporting the Mental Health of Teachers and Education Workers	
Project File Number: REB 2022-044P	
Contact Department/Agency: PHAC	
Document Name: List of all documents submitted to the REB: REB Application Research Protocol School Recruitment Poster Project Budget Recruitment Scripts and Consent Texts Draft Collaborator Agreements CV's PHAC Contribution Agreement Date: February 28, 2023	
Answers to the REB questions/observations and additional material provided on March 22, 2023 Email response from PI Revised Research Protocol Revised Recruitment Scripts Administrator Consent Form CAMH Baseline Survey and Intervention Consent Form Focus Group Guide CAMH Research Collaboration Agreement UOttawa Research Collaboration Agreement	
ETHICS REVIEW: Your application submitted to the Health Canada and Public Health Agency of Canada Research Ethics Board (REB) regarding the above-referenced research project was reviewed on March 16, 2023, and your responses to the REB members' questions were reviewed on March 28, 2023. The most recent versions of the documents listed above were found to meet ethical requirements for research involving humans.	

 _____ Glenn Griener, Ph.D. Chair, Research Ethics Board	Date: March 28, 2023
Certificate Expiry Date: April 6, 2024	
Principal Investigator's responsibilities: I confirm that I will: 1. Carry out the research in accordance with the above-referenced protocol approved by the REB; 2. Obtain an annual ethical review until the research is complete (The certificate is given for one year); 3. Seek ethics review of the REB for any amendment or modification of the research protocol or consent form; 4. Report immediately to the REB Secretariat, any adverse or unexpected events resulting from the research involving humans; and 5. Submit an end of project report to the REB Secretariat upon termination or completion of the project	
Pamela Rogers Digitally signed by Pamela Rogers DN: cn=Pamela Rogers, o, ou, email=progers@ctf-fce.ca, c=CA Date: 2023.04.06 14:56:38 -0400 _____ Principal Investigator	April 6, 2023 _____ Date
Once signed, please return a copy of this certificate to the REB Secretariat.	

Research Ethics Board Secretariat 9 th Floor, Room 941C (0909C) 70 Colombine Driveway Brooke Claxton Building Tunney's Pasture Ottawa, ON K1A 0K9 Tel: (613) 941-5199 Email: reb-cer@hc-sc.gc.ca

Appendix C

Intervention Program In-School Recruitment Poster

TEACHER & EDUCATION WORKER MENTAL HEALTH PROJECT

CALLING ALL CLASSROOM EDUCATORS!

Your school is one of three pilot schools across Canada to run a groundbreaking mental health promotion and mental illness prevention project.

The Canadian Teachers' Federation understands that it can be difficult for educators to find the time to access services outside of school hours. That's why this pilot project is taking place during the work day, to make mental health support accessible to teachers and education workers.

Mental health specialists from the Centre for Addictions and Mental Health (CAMH) the University of Ottawa are collaborating with the Canadian Teachers' Federation to deliver this project in your school, funded by the Public Health Agency of Canada.

Starts September 2023!

WHAT IS INVOLVED?

- SCHOOL MENTAL HEALTH CULTURE & BASELINE ASSESSMENT
- FIVE EDUCATOR MENTAL HEALTH INTERVENTION SESSIONS (~1HR PER MONTH)
- MODERATED ONLINE COMMUNITY DISCUSSION BOARD
- MID-AND POST-INTERVENTION EVALUATION SURVEY

HOW DO I LEARN MORE?

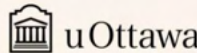
Ask your Principal, or reach out to:
Ali MacLean at the Canadian Teachers' Federation by email or phone.

 amaclean@ctf-fce.ca

 (613) 688-4322 ext. 133

WHAT ARE THE BENEFITS?

- MENTAL HEALTH PROMOTION AND PREVENTION PRACTICES FOR WHOLE SCHOOL STAFF. TOPICS INCLUDE:
 - THE TRAUMA-INFORMED EDUCATOR AND LEARNING ENVIRONMENT
 - EDUCATOR BURN-OUT, COMPASSION FATIGUE AND EMOTIONAL LABOUR
 - STRESS, ANXIETY AND DEPRESSION
 - DE-STIGMATIZING MENTAL ILLNESS
 - ALIGNING WELLBEING & RESILIENCE
- RELEASE TIME FUNDING FOR STAFF TO PARTICIPATE IN EXPERT-LED MENTAL HEALTH SESSIONS DURING THE SCHOOL DAY
- \$150 GIFT CARD FOR BASELINE SURVEY RESPONDENTS
- \$450 HONORARIA FOR INTERVENTION PARTICIPANTS







Founded in 1920, the Canadian Teachers' Federation (CTF/FCE) is a national alliance of provincial and territorial teachers' organizations, representing more than 370,000 teachers and education workers across the country. The CTF/FCE is also a proud affiliate of Education International, the global federation that represents more than 33 million educators worldwide.

www.ctf-fce.ca