EXPLORING EDUCATOR MENTAL HEALTH LITERACY: A STUDY TO INFORM

PROFESSIONAL LEARNING NEEDS

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Submitted to the Graduate Faculty of

the School of Education in partial fulfillment

of the requirements for the degree of

Doctorate of Education

University of Pittsburgh

2017

UNIVERSITY OF PITTSBURGH

SCHOOL OF EDUCATION

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November 20, 2017

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University of Pittsburgh, 2017

Mental health issues have proven to be exceedingly prevalent in society. It has been reported that one in four Americans experience a mental illness in a given year, while the remaining will be exposed to a friend, family member, or colleague with a mental illness. With increased changes and pressures in all aspects of life, approximately 20% of youth ages 13 to 18 experience severe mental disorders each year (National Alliance on Mental Illness, 2013). Educators may have a unique opportunity to recognize and support students who could be struggling with mental health issues. Exploring the perspectives of educators can provide important insight in the efforts to accurately assess their readiness and identify their specific training needs related to mental health promotion in school.

The purpose of this study was to explore educators' understanding and awareness of mental health and how prepared they were to respond to issues concerning student mental health. In this study, a needs assessment framework was used to develop and implement an online inventory to teaching faculty in a small private school serving students in grades Kindergarten through 8th grade. All faculty in the school were targeted as participants for the needs assessment and 100% of the population completed the inventory. Frequency distributions were generated from their responses to evaluate the mental health literacy among educators at the

school.

In the mid-1990s, Anthony Jorm and colleagues were struck by a contrast between the understanding and help-seeking behaviors for individuals with physical diseases and mental health disorder. Multiple studies have found that the stigma associated with mental illness often prevents people from accessing treatment, particularly when compared to accessing physical health care (Knaak, Mantler, & Szeto, 2017). To draw attention to this neglected area, the term, mental health literacy, was coined and defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 182).

This study, consistent with research previously done in search of self-ratings of understanding, awareness, and comfort levels for student mental health, revealed that these educators were aware of the mental health challenges students face and recognize identifying students in need of support services as an important part of their job. However, a portion of the participant educators reported feeling overwhelmed with having to deal with student mental health issues, and their responses also indicated uncertainty in recognizing such issues. Consistent with the literature reviewed, educators in this study reported a need for more support from colleagues and more training in the area of student mental health.

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PREFACE

I would like to dedicate this dissertation and everything I do to my children, Brennan and

Abigail, who bring joy and laughter to my every day.

To Dean, without your consistent support and encouragement, this document would never have

come to fruition. You are my rock.

In addition, I would not be who I am today without the love and support of my parents,

Daniel and Jamie Liebel, who have been an endless source of encouragement and inspiration.

I would forever regret if I didn't acknowledge the support and love of my grandparents, Jim and

Betty Yates. Their unconditional love and pride was a driving force in my continued pursuit of

this dissertation and I only wish they were here to celebrate.

ACKNOWLEDGEMENTS

I have been so blessed over the years with supportive and loving colleagues and friends. I recall

early on in this process being told that having a cheerleader is imperative, and fortunately, I am

surrounded by those daily. There are too many of you to mention, but to you, I am forever

grateful.

To Sarah Capello, your editorial support and critique was a critical component in my success. I

truly thank you for taking the time to participate in this process.

I would also like to thank the members of my committee, Dr. Bachman, Dr. Kerr, Dr. Trovato,

and, Dr. Tananis. I am lucky to have worked with such an inspirational and intelligent group of

individuals during my academic career at the University of Pittsburgh. You have supported my

growth as a doctoral student and practitioner with your feedback and advice. I truly hope to

someday have someone look up to me as I do each of you.

Dr. Tananis, your role in this process has been amazing. The way you provided support and

guidance throughout and truly cared about my progress has had a tremendous impact on my life.

Thank you so very much.

1.0   INTRODUCTION

An estimated 15 million of our nation's young people can currently be diagnosed with a mental health disorder (DHHS, 2001). Given this high rate of need among our youth, there is a solid rationale for schools as a primary services delivery setting. There is clear evidence showing schools as the prevailing de facto provider of mental health services to children (Farmer, Burns, Phillips, Angold, & Costello, 2003). Further, children and families face a host of barriers that limit access to and resources for utilizing services through community-based providers (Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). The largest share of children spends significant portions of their childhood in school settings, and it is within the context of schools that key markers of intellectual, physical, social and emotional development emerge (Healthy People 2020). Schools are convenient, accessible and structurally equipped to serve children, and, next to families, schools arguably hold the most appreciable influence over children (Atkins et al., 1998).

In the mid-1990s, Anthony Jorm and colleagues were struck by the contrast between the understanding and help-seeking behaviors for individuals with physical diseases and mental health disorders. At that time, the dominant view was that the focus needed to be on training general practitioners and other primary healthcare workers to better identify and manage mental disorders. The public was not considered an important target for training and development. The term, mental health literacy, was coined and defined as "knowledge and beliefs about mental

disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 182). It is important to note that mental health literacy is not simply a matter of having knowledge. Rather, it is understanding that is linked to the possibility of actions that benefit one's own mental health or that of others. Mental health literacy has many components, including: (a) understanding of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) understanding of help-seeking options and treatments available, (d) understanding of effective self-help strategies for milder problems, and (e) first aid skills to support others who are developing a mental disorder or are in a mental health crisis (Jorm, 2012).

The general problem of interest questioned educators' understanding of primary through middle school students' mental health. The researcher wanted to know if the educators were knowledgeable regarding mental illness among students. It was also the goal of this study to identify whether the educators feel equipped to identify and meet the needs of students experiencing a mental health challenge.

1.1   BACKGROUND OF THE PROBLEM

Educator awareness of mental health disorders is becoming increasingly important, especially due to the increased rate of reported mental health disorders in children and adolescents. Because educators spend a significant amount of time with students, educator awareness of mental illness is necessary in order for students facing mental illness to thrive in their educational settings.

While it is comforting to think that all of our educators in classrooms today are well versed in their dealings with mental health disorders, this may not always be the case. Therefore, it is necessary to gather data directly from educators about their level of academic preparedness

and sense of competency in working with this population. If research on mental health issues in students is not effectively transferred to educators, this suggests major implications for educational reform.

Given the prevalence of student mental health disorders, it is imperative that we consider a benchmark of mental health literacy among educators in order to provide a rich and supportive academic environment for our students. Ideally, educators would feel confident in their awareness and capacity to address pertinent issues concerning the mental health of their adolescent students. The World Health Organization (WHO, 2014) identified mental health promotional activities in schools as one specific way to promote positive mental health. Thus, although a school system's focus is primarily on academic success, mental health plays a key role and is viewed less as a separate agenda from the instructional mission (Adelman & Taylor, 2000) than it has been in the past.

1.2   STATEMENT OF THE PROBLEM

Children's mental health is an increasing concern throughout the United States (Hornby & Atkinson, 2003). Approximately 20% of children and adolescents would receive a mental health diagnosis in any given year (DHHS, 2000, p. 20). In response to the need for expanded mental health services for children, study on the use of universal (i.e., targeting all students) and selective (i.e., targeting students at-risk) school-based interventions for mental, emotional, and behavior problems has grown considerably over the past decade (Hoagwood et al., 2007; Stormont, Reinke, & Herman, 2010; Weissberg, Kumpfer, & Seligman, 2003). Schools provide excellent settings for targeting children's mental health, their academic performance, and the

important connection between them (Greenwood, Kratochwill, & Clements, 2008). Despite the increased availability of evidence-based interventions and the importance of targeting the school setting, the widespread adoption and implementation of evidence-based practices and interventions to both promote children's mental health and intervene with children with specific issues has not occurred (DuPaul, 2003; Kratochwill, 2007; Schaughency, 2006). This research to practice gap appears to be very pronounced in the mental health field (Walker, 2004). One group of school personnel in particular, classroom educators, play a key role in understanding this gap regarding school-based mental health. For instance, educators are often the individuals in the school asked to implement school-based universal interventions as well as to refer students in need of additional supports.

The U. S. Department of Education mandates that schools provide education to all children and adolescents (Ringeisen, Henderson, & Hoagwood, 2003), including those who experience emotional or behavioral challenges. Because of governmental mandates, schools have become major providers of mental health services to children and adolescents (Ringeisen et al., 2004; Slade, 2003).

Early prevention and recognition of student mental health issues is critical (Conroy & Brown, 2004) to the social and emotional functioning of children and adolescents. Personnel development and continuous education are essential. Conroy and Brown (2004) stated that personnel working with students are in need of training in effective strategies for serving and intervening for students who are at risk and experiencing emotional and behavioral difficulties. Contrary to documented benefits of prevention at the primary, secondary, and tertiary levels of intervention (Conroy & Brown, 2004), intervention policies such as the 1997 *Individuals with Disabilities Education Act* failed to intervene with the neediest children at risk of developing an

emotional or behavioral disorder (Conroy & Brown, 2004). The *Individuals with Disabilities Education Improvement Act* of 2004 mandated schools provide services to students whose behavior disrupts their learning or the learning of other students. If an impact on children's emotional, behavioral, or academic development occurs, then a larger scale of early prevention, identification, and intervention is necessary (Conroy & Brown, 2004).

Data cited on diagnosable mental health disorders generally suggest that 12-22% of all children and adolescents under the age of 18 are in need of services for mental, emotional or behavioral problems (Adelman & Taylor, 2010). According to Darcy Gruttadaro, Director of Advocacy and Public Policy at the *National Alliance on Mental Illness,* "Most educators are not trained about mental health in their formal education and degree programs, and yet an unidentified mental-health condition often interferes with a student's ability to learn and reach their full academic potential" (NAMI, 2016). Given the amount of time children spend at school, educators are likely be the ones to identify and refer children for mental-health services. However, mental-health services can't help at-risk students if educators aren't clear on the nature of the services available and can't confidently identify the students in need of intervention. As suicide is the second-leading cause of death among adolescents and young adults, lack of appropriate mental-health interventions and treatment can mean the difference between life and death (USDHHS, 2017).

A recent study conducted in 2011 on the topic of educator roles with regard to children and young people's mental health and emotional health found that:

> Educators perceived themselves as having primary responsibility for implementing classroom-based behavioral interventions but believed school psychologists had a greater role in teaching social emotional lessons. Educators also reported a global lack of

experience and training for supporting children's mental health needs (Reinke, Stormont, Herman, Puri, & Goel, p. 1).

This study suggested that educators and their schools as whole entities should be on board when it comes to addressing mental health disorders in students. However, before a school or district moves forward in the implementation of interventions and training to support educator intervention, gathering data on the mental health literacy of the faculty is a necessary first step.

Although educators may understand that they play a role in adolescents' mental health issues within their traditional classroom settings, a study conducted in 2011 at the University of Missouri reported that not all educators felt adequately prepared to deal with such mental health disorders effectively. This study examined educators' perceptions of their roles and mental health needs within their schools as well as understanding, skills, training experiences, and training needs. This study involved 292 participants including educators from five school districts in the United States. Participants took part in an online inventory and, from the data collected, "89% of educators agreed that schools should be involved in addressing the mental health needs of children. However, only 34% of educators reported that they feel they had the skills necessary to support these needs in children" (Reinke, Stormont, Herman, Puri, & Goel, 2011, p. 9). The number of educators who had been working with or referring students with mental health issues at the time of the study by Reinke et al. (2011) amounted to 75% of all participating educators, yet 51% of participating educators admitted to having difficulty identifying children with mental health needs (p. 8).

Additionally, with the rise in mental health disorders among students, it is crucial for professional development programs to train educators accordingly. Educator participants

surveyed in the previously mentioned study agreed or strongly agreed to the fact that there is an insufficient number of school mental health professionals, and there is a lack of adequate training for dealing with children's mental health needs (Reinke, et al., 2011).

These findings are problematic because, as stated in an article titled, "Context Matters: Schools and the "Study to Practice Gap" in Children's Mental Health," schools play a critical role in the delivery of children's mental health services. Since "logistical accessibility makes schools a logical and important point of intervention for children with emotional or behavior problems," educators must be prepared to confidently deal with such issues, leaving no mental health disorders unchecked" (Ringeisen, Henderson, & Hoagwood, 2003, pp. 152-153).

1.3   PURPOSE

The purpose of this study was to explore the mental health literacy of educators in a private K-8 school in the Northeastern United States. This practitioner study was conducted in a collaborative forum with the school's administration and teachers, with three goals: (1) Identify the current mental health literacy of educators; (2) Analyze the educators' ability to recognize student mental health concerns in the classroom; (3) Determine a course of action that will achieve the desired mental health literacy of educators.

The goal of this study was to collect data that could provide information on and insight into educator understanding about mental disorders. Mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; understanding of risk factors and causes, of self-care, and of professional health available (Jorm, 1997). Such

information and insights have the potential to inform administrators on the current practices of the educators in the school as well as identify areas of professional development.

This single-site study was exploratory in nature with an emphasis on discovery as opposed to confirmation. The majority of students at the school site where from high-SES backgrounds. Recent research by Dr. Suniya Luthar (2013) of Arizona State University has illuminated the pressures and problems faced by children of more affluent families. It is widely accepted that youth in poverty are a population at risk. Research repeatedly demonstrates that low family income is a major determinate of social, emotional, and behavioral problems (Conger, 2010; Hodgkinson, 2017; Yoshikawa, 2012). Increasingly, significant problems are occurring among youth in the most prestigious schools in America. Luthar's (2013) research uncovered data that shows depression, anxiety, or somatic symptoms at rates at sometimes twice the national rate. The results are not confined to a particular area either. Across geographical areas of public and private schools, upper-middle-class children and adolescents show alarmingly high rates of serious mental health concerns.

This study is limited to the population of educators in a small private school in Northeastern United States. This study looks to assess the level of mental health literacy of those working directly with students in an effort to develop professional development and school-wide changes that support the mental health of their students.

1.4   STUDY QUESTIONS

The goal of this study was to examine educators' mental health literacy at one private school in the Northeastern United States. Specifically, the areas of mental health literacy considered in this

study included the educator's understanding, recognition, and perception of their role as it related to their role in the school. The major research questions central to the focus of this study were:

Q1. What are the educators' general understanding about student mental health?

Q2. What are the educators' perspectives about the professional help and interventions available, and do they vary when considering teacher certification levels and years of experience?

Q3. What are the educators' understanding of their role in facilitating and accessing appropriate help for a student in need of mental health support?

1.5   SIGNIFICANCE OF THE STUDY

Past research on the topic of student mental health is extensive. However, when considering educator perspectives of their understanding, ability, experience, and strategies in dealing with student mental health issues in traditional classroom settings, the research falls short. With the rising awareness of mental health issues among adolescents today, there is a need to make sure our students have access to a proper education. In order for that to occur, educators need to have proper training to support students with mental health needs and, most importantly, they need to feel prepared to do so. By exploring educator preparedness in dealing with mental health issues among adolescents in a traditional classroom setting, this study provided awareness on the topic to both future and present educators.

This study contributes to educational research through the collection and analysis of a specific schools educators' reports of their understanding of and perceived level of competence for school-based mental health prevention and intervention strategies. The current study provides

a framework for assessing the mental health literacy of educators in a process that is informative and may be used in other schools. As we continue to focus on students needs, changes in educational efforts to improve school mental health programming, it is valuable to gather data directly from classroom educators and professionals in the school to inform their practices continuing learning needs.

1.6   CONCLUSION

This chapter provided an overview of the importance of exploring current levels of mental health literacy of educators. The topic of mental health remains high on the national agenda and at the forefront of other government health initiatives. Schools are now being included in the student mental health continuum that traditionally only included community based services. Observable mental health symptoms alone may not reveal a clear need for educator intervention. Those symptoms may be even more challenging for educators and other adults to recognize as they continue to be charged with delivering advanced curricula and increasing test scores. Educators may have varying levels of literacy in the area of mental health due to personal encounters, prior education, and professional development or for other reasons. This study is thus intended to provide a baseline measure of what current mental health literacy looks like at one school by asking educators to answer related questions through an online inventory.

Chapter 2 presents a review of related literature that guided this study on mental health, the role of schools in student mental health, the mental health literacy of educators, and educator preparedness to serve students with mental health challenges. The chapter also discusses an

overview of the range of mental health behaviors that a educator may encounter with students, professiona learning programs and training for addressing these behaviors in the school setting.

2.0   REVIEW OF LITERATURE

There is an increasing recognition for the need to promote youth mental health needs (President's New Freedom Commission on Mental Health, 2003). The World Health Organization (2014) defined mental health as "a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (Mental Health: a state of well-being, para. 1). Mental health disorders, on the other hand, are defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) as "a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction…Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities" (APA, 2013, p. 20). Mental health disorders can lead to difficulties in social, emotional, family, and academic functioning and can be associated with long-term problems (Evans, Mullett, Weist, & Franz, 2005).

When conceptualizing school mental health services, it is important to note that these are not just mental health clinics in schools or providers operating independently delivering services. School mental health services are a more integrated component of the entire educational system. Ideally, they are offered by school personnel operating together to prioritize the promotion of health and prevention while working in cooperation with other community programs and services. One single profession cannot have full ownership over the field of school mental health, because the field is interdisciplinary by nature (Weist et al., 2003). Adelman and Taylor (2010)

suggested that mental health should be a focus in schools, because schools can facilitate access to mental health services for students and their families. Additionally, addressing mental health concerns for students supports effective school performance.

For most students, school is not only a place where they learn facts and skills, but it is also where close friendships are made, mentors and role models are discovered, talents are developed, and interests pursued. It is a place where students' social, emotional, and mental health can be impacted as much as their academic understanding. However, without proper training for educators, schools remain a largely untapped resource. The Executive Summary of the Surgeon General's report on mental health (Satcher, 2000) stated that, "schools are major settings for the potential recognition of mental disorders in children and adolescents, yet trained personnel are limited" (p. 96). According to the National Institute on Mental Health (NIMH) (2013), approximately twenty percent of students are suffering from a mental illness and not receiving the treatment they need. In fact, it has been suggested the number of untreated children and adolescents suffering from mental illness could actually be much higher (Flett & Hewitt, 2013). Students from disadvantaged backgrounds struggle even more and fare even worse (Atkins et al., 2010; Williams, Horvath, Wei, Van Dorn, & Jonson-Reid, 2007). Educators are a valuable resource in identifying students suffering from symptoms of mental illness, because, next to parents, they are the adults that children and adolescents see most (Meldrum, Venn, Kutcher, & Financial, 2009).

There has been an increase in the number of children being diagnosed with a mental illness (NIMH, 2013). In his 2013 remarks at the National Conference on Mental Health, President Barack Obama charged educators, leaders, and advocates of mental health awareness to bring "mental illness out of the shadows" (para. 5). These national conversations

acknowledge, and research has supported, the important role educators play in the battle against mental illness. In an effort to promote mental health awareness in schools, a solid starting point is to gather data on the mental health literacy of the professionals in the school. The following sections provide an overview of the history of mental health literacy and how it relates to this study.

2.1   HEALTH LITERACY

Health literacy is defined in the *Patient Protection and Affordable Care Act of 2010*, Title V, as "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions." This definition is almost identical to Healthy People with the only difference being the addition of "communicate" to the legislative definition (Centers for Disease Control and Prevention, 2014). The health literacy objective supported by the WHO, located in its communication Health Communication and Health Information Technology, is to improve the health literacy of the population. The communication discusses the way our society views health and how ideas about health and behaviors are shaped by the communication, information, and technology that people interact with on a daily basis. Decisions made and actions people take have considerable impact on the way health information is searched, understood, and used (Adams, 2010). As people are confronted by situations that may involve life-changing decisions about their health or a family member's health, the ability to obtain, communicate, process, and understand health information becomes more important. Limited health literacy occurs when people cannot find and use the health information and services needed. That being said, in 2014 Dr. Andrew Pleasant noted that

the idea of health literacy is still new, obtaining a level of health literacy can be difficult, and a measure of health literacy that focuses mainly in the clinical setting can be inappropriate when studying public health behaviors and outcomes (Pleasant, 2014). His presentation also noted that health literacy is socially constructed, varying across individuals and context.

2.2   MENTAL HEALTH LITERACY

Mental health has been defined by the World Health Organization (2014) as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community (Mental Health: a state of well-being, para. 1). The more specific concept of mental health literacy was first introduced in Australia by Anthony Jorm, and, while derived from the term health literacy, it has been defined as "knowledge and beliefs about mental disorders which aid in their recognition, management or prevention" (Canadian Alliance on Mental Illness and Mental Health [CAMIMH], 2007). A review of literature on mental health literacy by the Canadian Alliance on Mental Illness and Mental Health (2007) suggests that mental health literacy represents understanding and beliefs about mental health disorders that emerge from belief systems. A review of the literature suggested that understanding and beliefs about mental disorders among lay people are poor and attitudes towards mental disorders often involve negative stereotypes and stigma. Psychosocial factors such as environmental stressors or childhood events are believed to be the primary causes of mental disorders by most people in the West (CAMIMH, 2007).

Mental health literacy has been defined as "knowledge and beliefs about mental disorders which aid in recognition, management or prevention. Mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; understanding of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking" (Jorm et al., 1997). The concept of mental health literacy was derived from notions of overall health literacy, which aims to increase understanding about physical health, illnesses, and treatments (Jorm et al, 1997).

Mental health literacy has three major components: recognition, understanding, and attitudes. A conceptual framework of mental health literacy illustrates the connections between components, and each is conceptualized as an area to target for measurement or intervention (Jorm, 2000). While some researchers have focused on a single component, others have focused on multiple and/or the connection between components. For example, a researcher may focus solely on improving recognition of disorders through an education program, whereas another researcher may focus on integrating all three components into one program. For this assessment, the areas of understanding, recognition, and perceived roles in accessing services and providing supports was explored.

Knowledge is the largest component of mental health literacy, and is divided into four sub-components:

- Risk factors: what factors put individuals greatest risk for specific mental health disorders (can be biological or environmental)

- Causes of mental disorders

- Self-treatment or self-help: what individuals can do to help themselves recover

- Professional help: where to get professional help and/or what professional help is available

Recognition is further defined as symptom or illness recognition. Symptom recognition is the ability to detect beliefs, behaviors, and other physical manifestations of mental illness, without knowing explicitly which disorder they are linked. Specific illness recognition is the ability to identify the presentation of a disorder, such as major depressive disorder (NIMH, 2011).

Jorm (2012) expanded on his original definition of mental health literacy to: recognition of developing mental disorders to facilitate early help-seeking. Mental health literacy is an overall understanding of professional help and effective treatments available, effective self-help strategies, skills to give mental health first aid and support to others. An educator with mental health literacy understands how to optimize and maintain good mental health, mental disorders and their treatment, how to decrease stigma, and enhance help-seeking efficacy. Kutcher, Bagnel, and Wei (2015) emphasize the importance of fighting stigma, maintaining good mental health, and empowering a person to improve how his or her help seeking as an extension of this idea.

Few studies have specifically targeted the mental health literacy of educators. In a recent study, Educators indicated that dealing with student mental health was within their role; however, they believed they did not have the understanding to do so (Andrews, McCabe, and Wideman-Johnston, 2014). In a study considering middle and high school educators in two small Midwestern districts (Salyers & Dinan, 2015), data from 29 online inventory participants revealed that there was a lack of training in the area of mental illness, thus demonstrating a need for professional development to increase understanding of adolescent mental illness.

A study conducted by Daniszweski, (2013) concluded, after researching 4,000 K-12 educators in a Canadian province, that educators were overwhelmed and stressed, and felt they lacked understanding and comfort to handle students with mental health issues.

The need for further development of mental health literacy among educators was highlighted as was the need for ongoing professional development for educators in a review of the literature related to mental health (Whitley, Smith, & Vaillancourt, 2013). Additionally, educators' preferences were found to be important and need to be considered when selecting material to be included in training that attempts to address the gaps in understanding (Whitley et al., 2013). Accoring to Reinke et al. (2011), early childhood and elementary educators reported a lack of experience and training for supporting the mental health needs of students.

In varying capacities and situations, the perspective of educators has been sought among studies that seek to reveal the role educators think they should play in supporting student mental health such as in the described studies. Rothi, Leavey, and Best (2008) highlighted a need for more research on good practice models for the delivery of mental health and educator training models as well as a wider inventory of educators' perceived roles and responsibilities concerning student mental health.

In a study conducted by Dittmar (2014), although 70% of respondents agreed that schools should be involved in addressing the mental health needs of students, only 43% felt they had the understanding and skills necessary to support those needs. Additionally, Dittmar (2014) reported that only 31% of elementary and secondary educators surveyed had learned behavioral interventions through undergraduate or graduate coursework.

In another study, the notion that mental health challenges are prevalent in schools and that the majority of educators and school professionals do not feel well equipped to deal with

them was supported (Yale University Center in Child Development and Social Policy, 2005). In the same study, the majority of respondents reported that some children were in need of considerable help.

In one study addressing elementary educators' views of their role in promoting students' mental health, feelings of burden were associated with students' mental health needs (Roeser & Midgley, 1997), with two-thirds of the educators reporting that they felt "somewhat to very overwhelmed" by the mental health needs of their students. The majority (99%) of educators also believed that addressing students' mental health needs was part of their role as educator.

2.2.1 Measuring Mental Health Literacy

Measurement of the concept of mental health literacy using a scale-based measure is limited by a lack of robust scale-based measures of MHL (O'Connor & Casey, 2015). Recently a new measure of MHL, the Mental Health Literacy Scale (MHLS), assessed all attributes of MHL (O'Connor & Casey, 2015). It can be concluded that there are still considerable limitations to measuring mental health literacy, considering the less than psychometrically robust measures available that assess relevant attributes of mental health literacy (O'Connor, Casey, & Clough, 2014). In a review of measures of mental health literacy (Wei, McGrath, Hayden, & Kutcher, 2015), it was noted that of the 401 quantitative studies located, the limitations included important information about other eligible studies that perhaps were missed or mistakenly excluded. It was suggested that future work focus on collaboration across disciplines, investigators, and more varied demographic and geographic groups (Wei et al., 2015).

One review of scale-based measures to measure MHL concluded that measures such as the Vignette Interview do not allow for a total or subscale score that disallows for comparisons

of attributes to target for improving MHL or for drawing individual-level conclusions. The wording of the questions in the vignette methodology may not allow accurate measurement of separated data on understanding, beliefs, or opinions (O'Connor et al., 2014). In a comprehensive review of the literature from 2013 on PsychINFo and PubMed from 1997 to 2012, Connor et al. searched terms relating to "mental health literacy" and "measures". Of the 204 full-text articles assessed for eligibility, 13 studies met the inclusion criteria. Participants included adults, young adults, children, police officers, university students, and emergency personnel. A reported limitation of this study was that the exclusion of some studies not meeting the inclusion criteria may have resulted in a limited examination of some current methodologies used to assess mental health literacy.

Reinke, Stormont, Herman, Puri, and Goel (2011) delivered an online survey to over 200 elementary school educators to identify the mental health need and practices in schools. Survey items were based on a review of related surveyss and literature, with the final items developed and based on a review process including feedback from integral and experienced groups. Content validity was established by reviews and revisions based on expert scholars in the field of mental health practices in schools.

A new scale-based measure of MHL was developed by O'Connor & Casey (2015). Their work resulted in a 35-item questionnaire that can be used to assess understanding of a variety of areas in mental health, and help-seeking behaviors with good internal and test-retest reliability and good validity. Limitations included the community sample consisting of first-year university students in psychology courses; this, within the goal of developing a brief and easily administered measure of MHL, could have resulted in an insufficient assessment of identified attributes of mental health literacy (O'Connor & Casey, 2015).

Strategies to enhance MHL have included offering a comprehensive model with an aim to enhance functional literacy, communicative literacy, and critical literacy skills. Literature relating directly to MHL comes mostly from Australia and Europe. Much of the research in the field addresses stigma, public perceptions, and education about mental health. As reported in the review of literature by the Canadian Alliance on Mental Illness and Mental Health (2007), most of the research has focused on depression and schizophrenia, with a smaller percentage of research focusing on other mental health problems, such as substance abuse or anxiety disorders. Methodologies were not analyzed in this review; however, a number of reports on assessing MHL reference vignettes describing males or females with symptoms of a particular mental illness, focusing on recognition of symptoms that will lead to the identification of a disorder.

2.2.2   Stigma and Mental Health Literacy

Social determinants that influence physical health, such as poverty, education, and social support, also influence mental health (CAMIMH, 2007). The MHL of the public is frequently assessed in terms of how closely the understanding of the public and their beliefs may reflect professional understanding. Literature on a general understanding of mental illness among lay people showed that this understanding is poor. Beliefs about causal factors of mental illness and the effectiveness of treatment and interventions may be incorrect. Fear is still felt towards people perceived to be mentally ill, and there still remains a reluctance to seek help for self and others who may struggle with mental disorders. Lay people seem to become more socially accepting of mental health problems such as depression and anxiety, but show reluctance to label these common psychiatric symptoms as mental illnesses. They tend to attribute genetic causes to them, because they are still associated with stigma if considered a mental illness. Fear and perceptions

of dangerousness have increased over time, and more people consider those with serious mental illness to be potentially violent and dangerous. Interestingly, having a medical understanding of mental disorders has been shown to increase stigma and social distance (CAMIMH, 2007). Mental health professionals have conducted a range of attitudes in relation to stigma and found that discriminatory behavior from professionals does occur. With that said, some researsh has indicated that those who have information about mental illness may be less stigmatizing and more supportive of others who are experiencing mental health problems (CAMIMH, 2007).

Cultural variations in recognition, explanation, experience, and relation to mental disorders and treatment are significant. The social environment is a large predictor of how personal beliefs of recognition and expression of the disorder are shaped. In all countries, feelings of powerlessness and low self-esteem are linked to depression. Also in all countries, it is reported that women and immigrant and refugee populations suffer higher rates of depression (CAMIMH, 2007).

2.3   MENTAL HEALTH LITERACY OF EDUCATORS

Statistically, the largest health problems of schoolchildren are related to mental health (Puolakka et al., 2014). A broad range of factors may place youth at risk including biological factors, low socioeconomic status, and exposure to violence, social isolation, family dysfunction, association with antisocial peers, parent substance abuse, and frequent residence transitions (Tandon & Solomon, 2008). However, no exact causal factors have led directly to mental illness. Although most educators believe schools and educators should play a role to support the mental health of their students, they are not regularly surveyed in the research (Reinke et al., 2011). Most

educators recognize that mental health promotion is a part of their professional role and responsibility (Graham, Phelps, Maddison, & Fitzgerald, 2011). Educators who are cognizant of their students' psychological development and well-being are better equipped to develop the critical relationship that fosters their students' learning (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010).

Educators are in a position to observe and identify behaviors that they may need to alert school counselors about, including specific behavioral red flags that may indicate serious mental health problems (Johnson, Eva, Johnson, & Walker, 2011). Educator perceptions of the needs of their students as well as the understanding, training, and experience that educators have to express a feeling of preparedness is warranted. Koller and Bertel (2006) discussed a critical need for a systemic shift from the traditional deficit-driven model, which focuses on mental illness or pathology, to a strengths-based model, which focuses more on prevention, collaboration, and interdisciplinary effort to promote wellness. An integration of academic and mental health goals will cultivate shared learning within the educational system that enhances the whole child, and can better meet the needs of students (Capella, Frazier, Atkins, Schoenwald, & Glisson, 2008). The National Association of School Psychologists recommended that in support of children's mental health, personnel, parents, and students be educated on symptoms and get help for mental health problems. It added that having information helps to lessen the stigma surrounding mental health and can enable adults and other students to recognize when help is needed. Furthermore, the WHO (2014) recommended that mental health information would be most effective if it were provided in a school environment. The agency believed that schools have the best potential for developing community awareness when it comes to a mental health education program.

Findings from the Canadian Educators' Federation (2012), from a national survey, listed

key messages from the over 3,900 elementary and secondary educators who responded to the survey. Both qualitative and quantitative responses were compiled and analyzed. In general, educators reported feeling a part of the solution but expressed a need for more assistance in the schools from mental health professionals who have an area of expertise that complements what educators could offer. Ward (2009), who explored how college faculty members perceived their roles and responsibilities in identifying and assisting students with mental health problems, suggested that the majority of faculty members viewed their teaching role as the most important. They were willing to be trained within limits and many faculty members perceived themselves as not their concern. Researchers in a descriptive study of 30 educators asked to what extent educators felt they played a role as mental health promoters. The educators felt that more training would be needed to be effective as a mental health promoter (Cornejo, 2010). Moreover, there was openness for further training, although the educators were less likely to solicit outside support from a mental health professional on their own. Cornejo (2010) defined promoting mental health as efforts to enhance understanding and skills in order to foster social and emotional development, a healthy lifestyle, and personal well-being (Adelman & Taylor, 2006).

Soberanis (2014) surveyed 43 elementary school educators in southern California to examine educators' understanding of students with mental illness. Over half of the educators reported having understanding and skills to teach the students and indicated they could use more training on appropriate interventions. Less than average understanding and skill about mental health was reported by 40% of the educators surveyed, and many educators indicated a belief that school social workers could be more of assistance to them in the school setting.

It was found that although educators believed they had the ability to be social mediators of change for youth in their school settings, the majority of educators acknowledged having

moderate to low understanding levels in critical content domains of youth suicide (Elliot, 2013). Elliot (2013) investigated the understanding of 319 secondary educators in a public-school district in the mid-Atlantic region of the United States regarding adolescent suicidal risk factors and warning signs. Another study found there were substantial links between mental illness and suicide; at time of death by suicide, 90% of individuals met the criteria for a diagnosis (Coles, Heimberg, & Weiss, 2011)

Faculty understanding and skills can play important roles in educators' interactions with students (Schwartz, 2010). Factors that may serve as guides and motivators remain rooted as one's core belief of the power to produce desired effects by actions. Research produced by DiBara (2007) revealed important insights into the perceptions of urban high school educators, for example, which included student/educator relationships as the highest importance beyond all other measures. Data were presented to support the idea that committed educators evaluated their own success through the success of their students—not necessarily on academic tests, but rather on individual gains, such as improved reading ability, attendance, or other behaviors. The researcher described that meeting the non-academic needs of students is a necessity, as well as a critical skill that is not emphasized in educator training and professional development.

Some educators reported feeling ill-equipped to handle disruptive and problematic student behaviors and may not recognize that these behaviors may be indicative of poor coping skills and deteriorating mental health conditions (Clark, Farnsworth, & Springer, 2008). Empowering faculty to identify impaired students and make appropriate referrals early on may reduce the pervasiveness of mental health conditions, prevent loss of productivity, and aid in keeping the learning environment safer (Clark et al., 2008).

Reinke et al. (2011) surveyed early childhood and elementary educators to examine their

perceptions of mental health concerns for children in their schools, barriers to providing services, and perceived gaps in services and training. They also examined educators' perceptions of their role in supporting the mental health of children, compared with other support personnel such as school psychologists. The top five student mental health concerns were: (a) behavior problems, including disruptive, defiant, aggressive, and conduct problems; (b) hyperactivity and inattention problems; (c) students with significant family stressors; (d) social skills deficits; and (e) depression. A majority of educators agreed that schools should be involved in addressing students' mental health. In response to the question "I feel that I have the level of knowledge required to meet the mental health needs of the children with whom I work," 36% disagreed, 5% strongly disagreed, 31% were neutral, 24% strongly agreed, and 4% strongly agreed. The highest percentage of those surveyed also disagreed with the statement "I feel that I have the skills required to meet the mental health needs of the children with whom I work." It was found that 75% of all educators surveyed had reported working with or referring students with mental health issues over the past year. Additionally, most educators reported having worked with disruptive and acting-out behaviors, attention problems, and hyperactivity. The results of this survey indicated a need for more training, strategies, and attention to support educators faced with students who display significant behavioral, social, and emotional difficulties. This was not the first study to discuss the apparent research of the practice "gap" in the area of mental health practices and interventions in schools. The reserachers supported the importance of understanding the educators' perspective to provide contextual influences that might be used to bridge this gap. Further, the researchers discussed how research could explore educator characteristics such as training and perceptions of school mental health as well as efficacy. They added that the use of individual interviews could add richer information on the topic, especially

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at higher-grade levels.

In a study conducted with K-12 Norwegian educators (Ekornes, 2015), the mixed-method design of three focus group interviews (n=15) and survey study (n=771) confirmed that educators perceived their role to be prominent, because they were on the front line to identify students' mental health needs and, if needed, refer them for services. However, educators were aware that the promotion of mental health requires more than simply assessing the difficulties and asking for more support and information mainly through professional collaboration. The challenges that educators listed included communication and confidentiality, time constraints, contextual presence and understanding, cross-systems contact, school leadership, and educator competence in mental health.

2.4   EDUCATOR PREPAREDNESS

Despite a possible expectation for educators to take on a role that might include awareness, recognition, and proper referral or devising plans for students with mental health issues or problematic behaviors, only a limited amount of research has explored the extent to which educators are prepared to respond to issues concerning mental health issues in their classrooms (Dittmar, 2014). Koller and Bertel (2006) added that educators are not being properly equipped with knowledge of mental illness or preventative skills to protect resiliency in students. Reinke et al. (2011) indicated that only 4% of educators strongly agreed they had the level of understanding required to meet their students' needs in support of their mental health. Most educators reported having little or no child mental health training (Dittmar, 2014). Much of the training in the form of professional development was centered on being reactive versus proactive

and lacked any strategies for prevention (Koller & Bartel, 2006). The lack of education in this area as reported by the educators (Walter et al., 2006) was positively related to limited understanding and self- efficacy in managing the mental health problems of students.

It is believed that education programs have the utmost potential to influence change on educators (Reinke et al., 2011). It is problematic if 51% of the 75% of educators, who agreed that they had worked with or referred students with mental health issues at the time of Reinke et al.'s study, reported having difficulty identifying children with mental health needs. Educator preparation is essential to promote the efficacy and success of students (Darling-Hammond, 2000) and can extend educators' personal beliefs and philosophies to impact their own understanding and interactions with students.

According to Andrews (2012), a majority of participants did not feel prepared coming out of their educator training programs. They reported feeling more prepared because of experiences in the classroom. Confidence and lack of understanding on the subject of mental health were also reported. In order to gain a better understanding of the knowledge and perceived roles of dealing with students who experience mental health challenges, Andrews, McCabe, and Wideman-Johnston (2014) explored teacher education programs and other accessible resources that educators might reference, as well as barriers to the continued learning of educators related to issues of mental health. Educators participated in an online inventory of Likert-style questions. They found that educators thought it was within their role to deal with mental health issues; however, many did not have the knowledge to do so. The education supporting student mental health that is being offered in teacher education programs is clearly lacking (Kidger, Gunnell, Biddle, Campbell, & Donovan, 2010). Available resources are not being regularly accessed, because educators are unaware of them. An educator's potential to support mental health and

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well-being will be impacted by his or her understanding and experience, as well as the availability of resources (Kidger et al., 2010).

The question of professional preparedness for any field after the completion of a four-year college degree with minimal or no practical experience is a concern. However, the expectation for educators is to provide all students with a quality education that ensures that students can demonstrate mastery of the required standards in each subject area at their appropriate grade level. With the pressure of high level accountability from federal legislations such as *Every Student Succeeds Act* (ESSA, 2015), it would be expected that teacher education and professional development programs throughout the nation are providing educators with the most current, empirically-supported strategies and preparing them with the necessary fundamental skills to work with all students, and most particularly those who are at-risk of failure. However, Koller et al. (2004) noticed a disconnect between training and practice, especially in school mental health, and found that in-service "educators' perceptions of what is important to their success differed dramatically from what was in included in their undergraduate preparation" (p. 42). Rather, the focus of educator preparation has mainly been on educational practices with minimal attention on mental health (Adelman & Taylor, 2000b). Once in the schools, educator opportunities to enhance their understanding and skills are limited to "one-shot workshops" with minimal effectiveness (Darling-Hammond, 2008 p.9). However, with a national movement towards strengthening mental health services provided to youth in schools (Schaeffer et al., 2005; Weist & Chistodulu, 2000), there is potential for significant reform in training and professional development and effective bridging between researchstudy and professional practice.

Additional problems have emerged by assessing educator quality through measures of standardized test performance in content understanding, versus their pedagogic skills and individual student progress (Smith, 2008). Undoubtedly, this presents challenges for educators to concentrate sufficient energy on the developing their understanding and abilities in non-content related areas, such as mental health. Smith (2008) argued that "it assumes that test outcomes are the most tangible outcome of schooling, it pays little regard to the school's and its educators' role in helping form socially and morally responsible citizens" (p. 621).

Dr. Darling-Hammond (2006), one of the nation's leading researchers in education, particularly in educator preparation, clearly identified and defined an effective model for educator education programs, which include three major areas of development:

(a) understanding of learners and how they learn and develop within social contexts,including understanding of language development; (b) understanding of curriculum content and goals, including the subject matter and skills to be taught in light of disciplinary demands, student needs, and the social purposes of education; and (c) understanding of and skills for teaching, including content pedagogical understanding and understanding for teaching diverse learners, as these are informed by an understanding of assessment and of how to construct and manage a productive classroom. (p. 303)

In particular, the understanding of teaching diverse learners is an essential element for students with mental health concerns. Educators need to acquire the skills to better engage students with mental health disorders and understand how to address the behavioral issues that often are associated with these students.

A significant factor in identifying educator preparedness is attainment of certification through alternative versus traditional means, in which the latter tends to involve no student teaching experience, thus failing to provide entering educators with direct modeling from experts (Darling-Hammond, 2010). Darling-Hammond, Chung, and Frelow (2002) addressed the connection between educators' sense of preparedness and efficacy, and found some improvement in educators' responses from prior decades, which may reflect positive reforms in educator preparation programs. However, there continues to be an inequitable distribution of well-qualified educators throughout the country (Darling-Hammond, 2010). Lack of modeling is acutely problematic for the necessity of educators being well prepared for managing diverse classrooms and serving students with varying needs, including mental health concerns. Effective educator education programs expand the opportunities for prospective educators to engage more in classrooms, study empirical research, and conduct their own inquiries – through the vision of "the professional educator as one who learns from teaching rather than one who has finished learning how to teach" (Darling-Hammond, 2000, p. 170). This perspective of the educator as a continual learner is an essential quality that reinforces the value of each individual student. It is critical in the diverse culture of American classrooms to be knowledgeable of individual differences and how learning is impacted by diverse backgrounds, as well as evidence-based methods that are designed to address challenges effectively within the classroom. This understanding comes from beyond textbooks and coursework through experiential lessons through intensely supervised clinical work (Darling-Hammond, 2006). Furthermore, in addition to school educators needing to be well-prepared to take on the intense mentoring roles for student educators, tertiary faculty need to should be on board with their expanding roles as

secondary models for these students and openly engage them in the wider circle of the faculty team (Cochran-Smith, 2015).

In addition to pre-service training, it is necessary for educators to continue to learn and enhance their skills through ongoing professional development opportunities, so they can provide the most current, effective, empirically based strategies to their students. Kennedy (2010) described several benefits to schools incorporating systematic professional development opportunities and creating a learning community where educators share their growing expertise with colleagues. The same is true for teacher educators who are preparing the next generation of educators. Cochran-Smith (2003) explained "the education of teacher educators is a process that needs to be conceptualized as extending across the professional lifespan and not one that occurs at fixed point in time prior to taking on the role" (p. 22) and utilized the term, unlearning, as a significant part of this process, because it signifies the wisdom gained from comprehensive inquiry and reflection that extends beyond assumptions, precedent, and habitual behaviors.

A major challenge identified by O'Connell (2009) was that school-based intervention programs that are designed to help diminish behavioral issues are dependent on the educators who are responsible to implement them, which is then dependent on the skill and comfort level of those educators. O'Connell concluded that advanced training in behavior and emotional factors that impact classroom management is valuable for general educators' self-efficacy and competence, particularly with at-risk students. The responses from educators who did not receive advanced training reported feelings of anger, stress, helplessness, irritation, and hurt, which then O'Connell connected to the current study on educator attrition rates. Finally, O'Connell reinforced the importance of educators undergoing training that enhances self-awareness about the interplay between their perceptions and their responses to behaviorally challenging students.

Ongoing professional development is clearly valuable for keeping in-service educators up-to-date with current empirically supported data and methodologies. However, Yamagata-Lynch and Haudenschild (2009) cautioned that the traditional top-down approach is ineffective, and without an aligned set of goals between the district coordinators of training and the educators who are expected to implement, there will be resistance and challenges that impede growth. The authors urged that professional development efforts would be more successful when the coordinators and educators are engaged in discussion and systems analysis together in order to formulate joint goals and activities that will address the needs of the individuals and the institution. When educators are involved in this process, they are much more likely to feel motivated to implement the activities in their everyday teaching. It is clear that the research on educator preparation has evolved in recent years towards better understanding the needs of today's diverse classrooms.

2.5   THE ROLE OF CLASSROOM EDUCATOR AND SCHOOLS

Although schools may not be designed traditionally to provide intensive mental health services to children, they are in a position to create a system that fosters positive mental health. They are being called on to do so as they are viewed as ideal settings to reach vulnerable and undiagnosed adolescents with a prevention and promotion approach which effectively avoid stigmatization that may result from targeted interventions (Gueldner & Merrell, 2011). The school environment and the curriculum play a significant role in a student's overall health and have the ability to influence well-being in a positive way (Jenkins, Meltzer, Jacobs, & McDaid, 2010). It is imperative that educators "are equipped with the practical tools and understanding required to

recognize and intervene appropriately in situations where mental illness may be a concern" (Meldrum et al., 2009, p. 3).

An inherent gap exists between what research has shown to be considered best practices in identifying and addressing mental health needs of students and how they are carried out in the schools (Weare & Nind, 2011). Barriers most often cited by educators (Reinke et al., 2011) include a lack of funding for school-based mental health programs as well as an insufficient number of mental health professionals in the schools and a lack of training for educators. Stormont et al. (2011) showed that a vast majority of educators surveyed were unable to even identify specific evidence-based interventions from a list because they had never heard of them. Atkins, Hoagwood, Kutash, and Seidman (2010) proposed a new agenda for school mental health services that considered the school context as a means of promoting the mental health of children and considered a primary goal for services to be the child's adaptation to school. They offered a new set of priorities, including using naturalistic resources to implement and sustain learning and emotional and behavioral health. They concluded that the current model of school-based mental health is too overly focused on conventional definitions of mental health practice, providing inadequate attention to contextual issues that can influence schooling and mental health, and called for collaboration with educators to understand how to best effect change and create a strong research agenda for support.

Although many schools depend on universal screening measures to assess reading ability in order to develop targeted interventions, there is still a great deal of reluctance about the appropriateness and ability of school personnel to provide mental health services to students (Pennington, 2013). As the pressure increases for educator and school success as measured by performance on high-stakes tests and educator evaluation procedures, varying administrative

agendas, motivations, and priorities surrounding the schooling process may be cause for concern when a situation arises requiring the appropriate means to handle a mental health problem (Penningon, 2013).

Both the No Child Left Behind Act (P.L. 107-110, 2001) and the more recent Common Core State Standards (National Governors Association Center for Best Practices, Council of Chief State School Officers, 2010) initiative were set to measure the success of schools, educators, and students based primarily on high-stakes test scores. These tests are said to be extremely challenging and some educational experts fear it will lead to large percentages of student failures as a result. A 2013 article by the Editors of *Rethinking Schools* stated:

> Reports from the first wave of Common Core testing are already confirming these fears. This spring students, parents, and educators in New York schools responded to administration of new Common Core tests developed by Pearson Inc. with a general outcry against their length, difficulty, and inappropriate content. Pearson included corporate logos and promotional material in reading passages. Students reported feeling overstressed and underprepared—meeting the tests with shock, anger, tears, and anxiety. Administrators requested guidelines for handling tests students had vomited on. Educators and principals complained about the disruptive nature of the testing process and many parents encouraged their children to opt out. (para. 13)

Other initiatives in schools such as Multi-Tiered System of Support (formerly known as RTI), MTSS, have surfaced due to changes to the *Individuals with Disabilities Education Act* (IDEA). This public health framework, MTSS, promoted the use of three tiers of intervention related to primary, secondary, and tertiary prevention (Fuchs & Fuchs, 2006; Hoover, Baca, Wexler-Love, & Saenz, 2008). MTSS began as a special education initiative; however, the goals of the policy

have become focused on an increased direct involvement of regular education teachers in the assessment of at-risk students and enabling school districts to use the MTSS framework as a tool to develop school-wide strategies that help all children achieve positive academic and behavioral outcomes (Vaughn & Fuchs, 2003). Many of these interventions have focused on the classroom management strategies of educators and their abilities to deliver the social-emotional learning curriculum in their classrooms (Lindsey, White, & Korr, 2006).

Franklin, Kim, Ryan, Kelly, and Montgomery (2012) discussed how MTSS has changed the way special education and general education teachers function. For example, it has caused their roles to overlap more frequently as well as increase the workload of general education teachers by expecting them to help students with serious behavioral challenges and/or mental health disorders (Fairbanks, Simonsen, & Sugai, 2008; Horner et al., 2009; Simonsen et al., 2010).

In a typical MTSS framework, the school first implements universal strategies, called "Tier 1," in every classroom. The general education teacher is expected to learn and apply the best classroom management strategies, based on the principles of applied behavioral analysis. The school then offers "Tier 2," which involves selective interventions consisting of small group instruction or intervention. Continuous progress monitoring with data-based assessments beyond the universal level is used to assess the progress with this intervention. All students in a school that implements the MTSS approach are said to receive Tier 1 interventions, whereas only approximately 20% may be referred to a Tier 2 intervention (Frey, Lingo, & Nelson, 2011). Tier 3 interventions are more intensive and may lead to the point of being recommended for special education services.

Franklin et al. (2012) reported that educators might play a central role in the

implementation of strategies and interventions rooted in the MTSS framework, although their effective role in the implementation of MTSS concerning mental health interventions remains a point of disagreement within the educational literature. This is because of reports that many educators may lack understanding and training in mental health and are not well equipped to carry out behavioral interventions (Frey et al., 2011). Researchers have suggested that educators may also be effective in implementing both MTSS and evidence-based mental health practices if educator efficacy is increased, if educators are carefully trained, and if educators are provided with the appropriate supports as well as supervision by administration alongside mental health professionals in order to execute and sustain the interventions (Durlak et al., 2011). The classroom management practices of educators are highlighted the most as an effective behavioral intervention. Effective classroom management has been shown to decrease children's behavior problems and to offer promise towards implications for the prevention and development of more serious emotional and behavioral disorders (Hester et al., 2004, Leflot, van Lier, Onghena, & Colpin, 2010, Myers, Simonsen, & Sugai, 2011; Pierce et al., 2004). According to Simonsen et al. (2010), because of the change that MTSS has caused in the way that special education and general education teachers function, their roles have overlapped more frequently and increased the workload of general education teachers.

Although language describing the abovementioned initiatives may include tending to the whole child as a learner, these programs are still based on numbers, tests, and observable behaviors that may be considered disruptive from a classroom management standpoint. One of the concerns about students with emotional and behavioral disorders (EBD) in the United States and dismal student outcomes, was the current trend towards high-stakes testing and how the one-size-fits-all approach does not adequately address the individual needs of students with EBD.

Mihalas et al. (2009) also suggested that educators lack necessary preparation skills to meet the needs of students with EBD, that services are fragmented, and that instructional practices do not match the needs of the students.

The more recent passage of *Every Student Succeeds Act* (ESSA, 2015) to replace *NCLB* adds nonacademic accountability indicators and addresses barriers to learning, teaching, and re-engaging disconnected students. The reauthorization replaces what has been described as a confusion of programs with a "Student Support and Academic Enrichment Grant" that provides states and districts with flexibility in how students and families are assisted (Center for Mental Health in Schools, 2016).

According to the Center for Mental Health in Schools (2016), the national initiative advocates: Ending the disorganization of student and learning supports (i.e., by unifying student and learning resources into a component to address barriers to learning and teaching and re-engage disconnected students); Expanding school improvement policy from a 2 to a 3 component framework (i.e., making student and learning supports a third primary and essential component that is fully interwoven with the instructional and management components); Operationalizing the third component into a unifying, comprehensive, and equitable intervention framework (i.e., designing a cohesive intervention framework that encompasses both a full continuum of subsystems and organized set of content); Reworking the existing operational infrastructure (i.e., ensuring leadership and workgroups dedicated to planning, daily implementation, and multi-year development of the intervention framework); Facilitating implementation of essential systemic changes (i.e., ensuring stakeholder readiness, initial implementation, institutionalization, sustainability, and renewal); Facilitating development of an effective school, home, and community collaborative infrastructure (i.e., ensuring leadership and

workgroups to work on weaving together existing resources used to confront barriers to equity of opportunity).

The Center for Mental Health in Schools (2016) added six ideas that need to be abandoned as schools move forward to improve fairness of opportunity:

(1) Escape the idea that effective school improvement can be accomplished without ending the ongoing marginalization in school policy of efforts to develop a unified, comprehensive, and equitable system of student/learning supports.

(2) Escape the idea that addressing barriers for the large number of students in need can be accomplished through providing direct services and wrap-around practices. (Much greater attention must be given to classroom, school-wide, home, and community interventions that can reduce the need for such services).

(3) Escape the idea that improving student and learning supports mainly involves enhancing coordination/integration of interventions. (The focus must be on transforming student and learning supports into a unified and comprehensive system that is fully woven into school improvement policy and practice).

(4) Escape the idea that adopting a continuum/pyramid of interventions is a sufficient framework for transforming the nature and scope of school-based student/learning supports. (The content focus of such supports must also be framed along with the continuum).

(5) Escape the idea that co-locating community resources on a school campus will significantly improve student and learning supports. (The need is for systematically weaving school, home, and community resources together with a view to filling critical intervention gaps and enhancing home and community engagement).

(6) Escape the idea that development of a system that transforms and sustains how schools address student and learning supports can be accomplished without a well-designed strategic plan for systemic change and by personnel who have the capacity to effect the changes (Center for Mental Health in Schools, 2016).

Little research has investigated educator involvement in school mental health services and the efficacy levels associated with educators as providers (Franklin et al., 2012). A systemic review of reviewed published articles from January 1999 to September 2010 examined the extent to which educators were the primary school-based service providers, or if they collaboratively worked with other professionals to provide services, and at what levels of interventions within the MTSS framework applied to the interventions. The authors concluded that of the 49 school mental health studies that were analyzed, educators were actively involved in 40.8% of the evaluated mental health interventions. Educators were the sole providers of interventions in 18.4% of the studies. Many of the interventions were at the Tier 1 level, representing universal, preventative whole class interventions. There was no wide variation in outcomes upon further investigation of the interventions delivered by educators, compared with other personnel such as school mental health professionals, and there was no clear advantage of one type of personnel over the other (Franklin et al., 2012).

Evidence-based practices as they apply to School Mental Health (SMH) were reviewed by Owens et al. (2014). This research agenda emphasized important contextual issues to be considered during the implementation of mental health interventions in schools. Professional development and coaching for school professionals regarding Evidence-Based Practices (EBPs), the integrity of EBPs that schools implement, and the sustainment under typical school conditions were reviewed as important components. Also noted were identified gaps, such as the difficulty of school professionals to know which EPB

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might fit most compatibly within their school context or how to train personnel for the best high-quality implementation and sustain interventions over time (Owens et al., 2014). The wide variability in dosage and/or integrity by school mental health providers was reviewed using an Implementation Science (IS) approach defined as "the scientific research of methods to promote the systematic uptake of research findings and other [EBPs] into routine practice and, hence, to improve the quality and effectiveness of health services" (Eccles & Mittman, 2006, p. 1).

2.5.1 Educator Perceptions and Professional Practice

There are numerous measures to evaluate the effectiveness of professional practice, but the purpose of this study involves assessing the understanding and perceptions of educators regarding school mental health and how they relate to their role with at-risk students. Whatever other factors serve as guides and motivators, they are rooted in the core belief that "one has the power to produce desired effects by one's actions" (Parjares and Urdan, 2005, p. 270). Therefore, if educators have confidence in their understanding and ability to work effectively within an environment inclusive of students with major mental health challenges, their personal efficacy will positively impact their success within the classroom. De la Torre Cruz and Casanova Arias (2007) described "educator efficacy" as a construct based on Bandura's concept of perceived self-efficacy, which has received a great deal of research attention in recent decades among educational psychologists. In summary of their research, more experienced educators reported significantly higher levels of perceived self-efficacy than prospective educators. More experienced educators with higher self-efficacy report less stress, feeling better prepared, and find their profession less difficult than educators with low efficacy. It is important to note that

these educators tend to have an internal locus of control for the reinforcement of their activities; therefore, they are not as easily impacted by external influences.

Educators' concepts of themselves are highly impacted by the uncertainties inherent in the profession, which are due to the unpredictable nature of human relationships (Hesling, 2007). Overall, reactions from educators to these uncertainties and dilemmas of teaching are negative, manifesting self-blame, sense of inadequacy, anger, despair, etc., and are considered to be a leading cause of the attrition rate of the profession (Hesling, 2007). However, there has been research to demonstrate how educators' appropriate responses to these uncertainties can lead to substantial professional growth and improved student learning. Hesling (2007) argued the value in acknowledging the benefits and challenges of these uncertainties and to train educators in collaborative reflective practice. "If they are not explicitly mentioned in educator training and professional development, it is likely that educators will continue to feel that the uncertainties they experience are anomalous, indications that they are not teaching well, or are aspects of the job which should and will vanish with time and increased expertise and experience" (Hesling, 2007, p. 1330). Educators are warned not to ignore or minimize their uncertainties because this will in turn diminish their opportunities to improve their practice.

Brown and Kraehe (2010) highlighted a key element in educators' perceptions that relates to improving self-efficacy, "educators have a responsibility to understand their role in reproducing (or challenging) inequalities in schools" (p. 110). The authors' investigation demonstrated how educators can gain valuable understanding of sociocultural factors in educational practice, as well as the complexity of implementing equitable practices among diverse students. However, the training involved can backfire, because educators may slip into deficit thinking about their minority students. Therefore, careful introspection is an invaluable

part of training educators to challenge them to rethink their own personal experiences, belief systems, and perspectives.

This kind of communication follows the model of collaboration described by Conderman and Johnston-Rodriguez (2009) in regards to educators' roles in meeting the accountability standards for students according to the *Individuals with Disabilities Education Improvement Act* (IDEIA: 2004). The revision of the initial federal legislation of 1994 addressed the necessity of collaboration among educators, but as Conderman and Johnston-Rodriguez illustrated, the collaborative process between general and special education educators requires more attention, particularly in preparation programs and field-based experiences. In particular, the authors found that beginning general education teachers expressed less competence in skills associated with providing accommodations and modifications for students with disabilities, and schools need to adopt a collaborative culture that encourages veteran and special education teachers to mentor new educators to better meet the needs of all students.

DiBara's (2007) research revealed valuable insights about the perceptions of urban high school educators, which included student/educator relationships holding the utmost importance beyond all other measures. Committed educators evaluate their own success through the success of their students, not necessarily on academic tests, but rather individual gains (such as improved reading ability, attendance, behaviors, etc.). The author accentuated how effective educators described the necessity of meeting the non-academic needs of students as precursory to their academic goals, and this is a critical skill that is not emphasized by training and professional development. DiBara urged that educator training needs to incorporate a deeper understanding of these multiple roles they will play every day as well as offer insight to what they can and cannot expect within these challenging roles. In addition, DiBara recognized the deficiencies in schools

within high poverty areas and suggested placing more resources, including trained specialists, to provide the necessary supports to educators in these settings. DiBara offered several suggestions for ongoing professional development. They include: explicit discussion of important student-related topics such as: a) the kinds of stresses students are under, b) how and when educators themselves can offer students support for personal, as well as academic issues, c) how and when to connect students to other school-based and community services. (p. 28)

DiBara further identified the need for establishing guidelines and continuing conversations at the professional level where educators strengthen their personal connections with students, while maintaining professional boundaries, as well as grading students' work with high expectations and rigor, while maintaining sensitivity to individual circumstances. Finally, DiBara concluded that is imperative to develop "collegial communities which can support and challenge educators around their professional commitments" (p. 29), in order to promote a healthy balance for in-service educators and prevent burnout.

To be more specific to the population of this research, it is necessary to investigate how educator perceptions factor into the education of students with or at-risk of mental health diagnoses. Jordan, Glenn, and McGhie-Richmond (2010) studied inclusion research and identified how general epistemological beliefs about the nature of ability, disability, and learning affect educators' decision-making in practice. This is critical for training of new educators and professional development opportunities for in-service educators. Left to their own belief structures, some may actually be hindering the development of students with or at-risk of disabilities. Liljequeist and Renk (2007) explored the relationships among educators' perceptions, characteristics, and students' emotional and behavioral problems. Their findings indicated that educators were more bothered by and attributed greater student control to

externalizing behavioral problems rather than internalizing behavioral problems. Educators need to be cognizant of this tendency, because they are more likely to overlook students who may need intervention because of their display (rather, their lack of display) of emotions. However, it is important to note that the finding of greater perceived student control of externalizing behaviors "may reflect the popular conception of a biological basis to anxiety and depressive disorders, leading some to assume that such symptoms are beyond personal control" (Goodwin, 2015, p. 568). This would indicate a great need to better inform educators about psychological disorders that affect children and adolescents, and especially the interventions that can be implemented within the school to help students improve their coping skills for the behavioral symptoms of these disorders.

An unexpected finding from Ang et. al (2008) was that more experienced educators with higher self-efficacy reported lower perception of themselves as being a source of affective support for their students. The authors highlighted current research on at-risk students and the necessity for training programs and ongoing professional development for in-service educators to engage the "whole child," including the psychological and social needs, not just the cognitive/academic needs.

An important conclusion from research is that primary and secondary school experiences of educators are significantly related to their expectations of their future profession (Malmberg, 2006). This is valuable for teacher educators to consider when training their students for the complex and diverse reality of modern public education. Breaking through perceptual barriers and focusing on developing educators' intrinsic motivation are critical components of development. The education field is intrinsically complex and becoming more challenging with each generation, but the evidence is clear that

strong educator efficacy can be developed through authentic practical experience with highly skilled supervising educators who engage in realistic conversations and supportive collegial relationships with pre-service and novice educators.

2.6   MENTAL HEALTH IN SCHOOL-AGED CHILDREN

The 2001 No Child Left Behind (NCLB) Act, a federal education law, and the 2003 report from the New Freedom Commission on Mental Health spawned intensive research activity related to children's mental health. Both highlighted mental health disorders as a barrier to learning and called educators and researchers into action. Although schools are not the only (and in some cases not even the tertiary) agency involved in addressing these challenges, their mandate to educate all, places them in a position of responsibility (Adelman & Taylor, 2002).

A commonly cited source by government publications is a study conducted with the goal to produce nationally representative data on the prevalence of mental health disorders among youth (Merikangas, 2010). Given the sample of over 10,000 US adolescents, anxiety disorders were the most common condition (31.9%), followed by behavior disorders (19.1%), mood disorders (14.3%), and substance use disorders (11.4%). Among adolescents, it was reported that approximately 40% of students diagnosed with a mental health disorder also met criteria for another disorder. Overall, one out of every five adolescents in the U.S. meets criteria for a mental health disorder (Merikangas et al., 2010). Yet, despite the negative outcomes of untreated mental health disorders, it is estimated that only one-fifth of the adolescents in need

of mental health services receive them, and most of the services received are obtained at school (Burns et al., 1995).

When evaluating children and adolescents, a clinician will refer to criterion specific to the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association (APA, 2013), that includes the presence of a diagnosable mental, behavioral, or emotional disorder of sufficient duration. The DSM offers a common language and standard criteria for the classification of mental health disorders. It is used by clinicians, researchers, psychiatrists, health insurance companies, the legal system, and policymakers. The DSM is now in its fifth edition, DSM-5, published on May 18, 2013.

The current version of the DSM characterizes a mental disorder as "a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction…Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities" (p. 20). It also notes that "no definition can capture all aspects of all disorder" (p. 20).

The following section describes the wide range of symptoms that might be representative of a diagnosable mental illness. The sampled descriptions of symptoms were gathered from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) unless otherwise cited. The following descriptions were chosen to convey the vastness of some reported symptoms. Although some of the following conditions may be diagnosable into adulthood, most of them are categorized as a more common adult disorder with initial onset possible before adulthood or a childhood disorder (developmental).

Depression: Somatic complaints are strongly related to depression (Bohman et al., 2010). Headache is the most common and then frequent abdominal pain. Adolescents with daily

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physical pain are likely 50% at-risk for depression. Specific symptoms, at least five of these nine, are present nearly every day: depressed mood or irritable most of the day; nearly every day as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful); decreased interest or pleasure in most activities most of each day; significant weight change (5%) or change in appetite; change in sleep: insomnia or hypersomnia; change in activity either psychomotor agitation or retardation; fatigue or loss of energy; guilt/worthlessness such as feelings of worthlessness or excessive or inappropriate guilt; concentration problems as diminished ability to think or concentrate; or more indecisiveness and suicidality, such as having thoughts of death or suicide or having a suicide plan.

Eating Disorders: Adolescent and young women are susceptible to eating disorders, according to the NIMH, because at this time women are more likely to diet to remain slim and try dieting techniques.

Anxiety: Anxiety becomes a disorder when the symptoms become chronic and interfere with one's daily life and ability to function. People suffering from chronic anxiety often report the following symptoms: muscle tension, physical weakness, poor memory, sweaty hands, fear or confusion, inability to relax, constant worry, shortness of breath, palpitations, upset stomach, and poor concentration(Grohol, 2013) .

Attention Deficit Hyperactivity Disorder (ADHD): The main features of ADHD are inattention, hyperactivity, and/or impulsivity. Specific diagnostic symptoms of hyperactivity-impulsivity are (Grohol, 2013): often fidgets with or taps hands or feet or squirms in seat; often leaves seat in situations when remaining seated is expected (e.g., leaving seat in classroom or in their workplace); running or climbing in situations where it is inappropriate; blurting out answers before hearing the whole question; talking excessively; interrupting or intruding on others;

having difficulty waiting in line or taking turns; being unable to play or engage in leisure activities quietly; and feeling very restless, as if "driven by a motor," and talking excessively.

Diagnostic symptoms of inattention are (Grohol, 2013): not giving close attention to details or making careless mistakes in schoolwork, work, or other activities; often has difficulty sustaining attention in tasks or play activities; often does not seem to listen when spoken to directly; often has trouble organizing tasks and activities; often skips from one uncompleted activity to another, such as fails to meet deadlines; produces messy, disorganized work; has difficulty keeping organized, becomes easily distracted by irrelevant stimuli, like sights and sounds or unrelated thoughts; fails to pay attention to instructions and makes careless mistakes; does not finishes work, chores or duties; loses or forgets things needed for a task, like pencils, books, assignments or tools; avoids, dislikes, or is reluctant to engage in things that take a lot of mental effort for a long period of time; and is often forgetful in daily activities, such as doing chores, running errands, returning calls, paying bills, or keeping appointments.

Oppositional Defiant Disorder (American Academy of Child and Adolescent Psychiatry, 2009): is one of a group of behavioral disorders called disruptive behavior disorders (DBD). These disorders are called this because children who have these disorders tend to disrupt those around them. ODD is one of the more common mental health disorders found in children and adolescents. Physicians define ODD as a pattern of disobedient, hostile, and deviant behavior directed toward authority figures. Children and adolescents with ODD often rebel, are stubborn, argue with adults, and refuse to obey. They have angry outbursts and have a hard time controlling their temper. Even the best-behaved children can be uncooperative and hostile at times, particularly adolescents, but those with ODD show a constant pattern of angry and verbally aggressive behaviors, usually aimed at parents and other authority figures. The most

common behaviors that children and adolescents with ODD show are defiance, spitefulness, negativity, hostility and verbal aggression (AACAP, 2009).

Although there has been a national movement to improve mental health services provided to the school-age population (Schaeffer et al., 2005), a disparity in the quality of educators employed for diverse learners continues (Darling-Hammond, 2008). Educators may have a background in traditional learning theory and strategies for instruction; however, preparation for handling student mental health challenges may be lacking (Koller et al., 2006).

2.6.1   Prevalence Rates

In the past ten years, research has reported substantial increases in the use of services among children and adolescents. The *Mental Health Surveillance Among Children* study reported a 24% increase in inpatient mental health and substance abuse admissions among children during 2007–2010. Over the same timeframe, there was evidence of increases in use and cost of these services and psychotropic medications for teenagers specifically over the same period (Perou, et al., 2013). A second nationally representative study conducted by Merinkengas, reported that in 2010, mood disorders were among the most common primary diagnoses among adolescents in the United States. From 1997-2010, the rate of hospital stays among adolescents for mood disorders increased 80%, going from 10 to 17 stays per 10,000 population (Pfuntner, Wier, & Stocks, 2013).

Because medication is often prescribed to treat mental health problems, the CDC and National Center for Health Statistics conducted a study to explore the sociodemographic characteristics of medicated children 6-17 years of age and parental reports of the perceived benefit of medication. The results indicated that 7.5% of children used prescribed medication. A

higher percentage of males (9.7%) used medication for emotional or behavioral difficulties compared with females (5.2%). While older females were more likely to be medicated, there was no difference among males. The highest percentage of medicated children was among non-Hispanic white (9.2%) children, followed by non-Hispanic (7.4%) black, and Hispanic (4.5%) children (Howie, Pastor, & Lukacs, 2014).

In the same publication, the National Center for Health Statistics presented a data brief that described differences between boys and girls in the use of non-medication mental health services in various school and non-school settings among adolescents aged 12–17 with serious emotional or behavioral difficulties (Howie et al., 2014). Among adolescents, boys (5.4%) were more likely than girls (3.2%) to have a serious emotional or behavioral difficulty and receive non-medication mental health services in the past six months. Among adolescents with serious emotional or behavioral difficulties, boys (75%) were more likely that girls (64.7%) to receive non-medication mental health services. Of additional interest from this data is the statistic that about one in three adolescents aged 12-17 received both school and non-school mental health services. Approximately 21% of adolescents received school services only while 15% received non-school services only, with boys being more likely than girls to receive school services only (Howie, et al., 2014).

Pratt and Brody (2014) reported that 7.6% of Americans aged 12 and older reported having moderate to severe symptoms of depression in the past two weeks during between 2009-2012. In the same study, it was noted that females had higher rates of depression in every age group. The rate of depression increased by age with the lowest percentage among youth aged 12-17 years (5.7%).

The National Survey of Children's Health (NSCH) collects information on the physical and emotional health of noninstitutionalized children and adolescent 17 and younger and has been used to produce state and national estimates (Blumberg, Foster, & Frasier, 2009). The most recent survey was conducted in 2011-12. The number of surveys collected was between 1,811-2,200 for each state with a total of over 95,000 surveys collected. The 2011-12 NSCH focused on gathering the presence of mental health problems or conditions among children and adolescents aged 2–17 years. Parents or guardians were asked about common mental health disorders among children and whether they had ever been told by a doctor or other health-care provider that their child had each condition and whether the child still had the condition. When it was reported that a child or adolescent had a current mental health diagnosis, parents were asked to rate the severity of their child's condition as mild, moderate, or severe. Information about whether their child received mental health treatment or counseling or took medications was also gathered. Among respondents, 7.6% had children currently taking medication for ADHD, emotions, concentration or behavior (NSCH, 2014).

The National Youth Risk Behavior Surveillance System (YRBSS) was developed in 1990 and has been conducted annually to monitor priority health-risk behaviors among children and young adults in the United States (CDC, 2015). The risk behaviors of interest are those that significantly contribute to the leading causes of death, disability, and social problems. These behaviors include: 1) behaviors that lead to unintended injury and violence; 2) unintended pregnancy and sexually transmitted infections; 3) alcohol and other drug use; 4) tobacco use; 5) unhealthy dietary behaviors; and 6) inadequate physical activity. CDC conducts the national YRBSS to determine the prevalence of health risk behaviors, assess whether health risk behaviors increase, decrease or stay the same over time, examine the co-occurrence of health risk

behaviors, provide data among subpopulations of youth on a national, state, territorial, tribal and local level. In 2015, a total of 15,713 questionnaires were completed by students in grades 9-12 in 148 schools. In 2015, the student response rate was 86%, the school response rate was 69%, and the overall response rate was 60% (CDC, 2015).

The national YRBSS assesses several categories of behaviors that are associated with children's mental health, including behaviors that contribute to unintentional injuries and violence, bullying, sexual behavior, body weight, nutrition, and physical activity. Indicators of mental health covered by YRBSS include feeling sad or hopeless; tobacco, alcohol, and other drug use; and suicide-related behaviors. One symptom of depression, feeling sad or hopeless, is assessed in the survey. During the 12 months before the survey, 29.9% of students nationwide had felt so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing some usual activities. The prevalence of having felt sad or hopeless was higher among females (39.8%) than males (20.3%) students; higher among white females (37.7%), black females (33.9%), and Hispanic females (46.7%) than white males (19.2%), black males (17.6%), and Hispanic males (24.3%) students. When considering results by grade, the prevalence of feeling sad or hopeless was higher among 9th-grade females (41.5%), 10th-grade females (40.1%), 11th-grade females (40.9%), and 12th-grade females (36.3%) than 9th-grade males (16.7%), 10th-grade males (19.2%), 11th-grade males (22.1%), and 12th-grade males (23.9%) students, respectively (CDC, p. 12).

According to the National Survey on Drug Use and Health (NSDUH, 2012), 3.1 million youth aged 12 to 17 (12.7 percent) received treatment or counseling for problems with emotions or behaviors in a specialty mental health setting (inpatient or outpatient care) in the past 12 months. The 2012 percentage was similar to those in 2002 through 2011 (ranging from 12.0 to

13.5 percent). Among these youth, the most likely reason for receiving services was feeling depressed (50.7 percent), followed by having problems with home or family (29.1 percent), then by breaking rules and "acting out" (24.2 percent), thinking about or attempting suicide (23.8 percent), feeling very afraid and tense (22.7 percent), which was followed by having problems at school (19.7 percent) and having trouble controlling anger (18.9 percent) In the same year, 3.2 million youth (12.9 percent) received mental health services in an education setting, which was higher than the 2011 estimate (2.9 million youth or 11.9 percent). Among these youth, the most likely reason for receiving services was feeling depressed (37.9 percent), followed by having problems at school (24.4 percent), then having problems with friends (20.3 percent), breaking rules and "acting out" (19.9 percent), having problems with home or family (18.1 percent), and feeling very afraid and tense (16.7 percent). Females were more likely than males to use outpatient specialty mental health services (14.5 vs. 8.7 percent), education services (15.2 vs. 10.7 percent), and general medical-based services (3.4 vs. 1.7 percent). Between 2011 and 2012, the percentage of adolescent males receiving outpatient specialty mental health services decreased from 9.7 to 8.7 percent, and the percentage of females receiving services in an education setting increased from 13.0 to 15.2 percent.

Despite the prevalence of mental health issues in children and adolescents, many do not receive the help they need. Weist, Goldstein, Morris, and Bryant (2003) reported that approximately four-fifths of children and adolescents who needed mental health services did not receive them. Of approximately 2.2 million youth ages 12-17 who reported a major depressive episode in the past year, only about 40% received any type of treatment (Foster et al., 2005). Of the students who reported receiving help, approximately two-thirds of services were received in school (Foster et al., 2005). This same study indicated that two-thirds of U.S. school districts

reported an increase in the need for mental health services since the previous year (Foster et al., 2005). Given the increased prevalence of mental health disorders and the fact that the majority of mental health help students receive are provided by schools, there is support for schools as a primary place for mental health services.

2.6.2   Mental Health in Private Schools

To teach their children the necessary skills for an ever-changing world, many parents are choosing private school education. With options ranging from charter schools to alternative schools, there is almost certainly a school to suit each and every child (Our Kids, 2017).

One of the benefits of private schools is that they provide exceptional and challenging educational experiences through extracurricular activities, honors and advanced placement courses, and gifted programs, just to name a few. Private school students constantly score higher on standardized tests and college entrance exams, and many schools have close to a 100% of students attending their university of choice (Our Kids, 2017).

A 2002 comprehensive study on class size by educational researchers, Bruce Biddler and David Berliner, showed that the smaller the class size, the better the average student performs on academic achievement tests. The gains from smaller class sizes are stronger the longer a child is exposed to them. Private schools vary greatly in size, but depending on their teaching style, almost all focus on the importance of small class sizes to help students advance their strengths.

In a study completed by the Fraser Institute in 2007, 91% of parents surveyed said the dedication of the educators was their main reason for choosing private school. Instructors are both qualified and passionate about their subjects and often hold advanced degrees in their field. Within the tight-knit school community, students have close relationships with their educators

who commonly act as role models. In addition, small class sizes make personnel members more readily available for extra help or to further challenge individual students. Whether a student is attending a public or private school, educators' mental health literacy is a key consideration for ensuring a supportive environment for children and adolescents.

2.7   SUMMARY

Student mental health can impact academic and social progression. Schools often serve as a front-line resource, recognize, and service such needs. Details of mental health literacy and its impact on school achievement were discussed in this chapter, as well as how educators mental health literacy can contribute to the promotion of student mental health in children and adolescents. A number of government and public health sources emphasized the importance of using evidence-based programming in the operation of such programs. The literature within the review of literature was a description of current mental health issues and how school mental health programs can be an integral member of collaboration used to resolve socio-emotional and behavioral problems in children. Evidence-based approaches have been reviewed and considered for their transportation into schools while considering best practice elements of effective school based program.

Given the high rate of at-risk students, the evidence is clear for the need of mental health literacy among educators in schools. Educators and community mental health providers and families have the same desired outcomes including high school completion, postsecondary education, and employment. These are all indicators of healthy, happy, and productive citizens. However, we continue to struggle in the development and integration of effective systems that

delivers consistent outcomes. A needs assessment as a means to research a schools current environment related to student mental health can be an important component of the decision-making process to help schools identify their prevention and early intervention needs as well as program selection.

Both private and public school systems have supports in place for educators to identify and intervene when a student is exhibiting behavioral concerns. The key component in students accessing supports for success often rely on the educators knowledge of resources, supports, and how to access those within the system. Through teacher education and ongoing learning through professional development programs, educators have an opportunity to develop the knowledge and understanding on how to support students in need.

Collaboration among professionals within the school, as well as in community, is another important component for consideration, especially within the context of school mental health. Educators, counselors, nurses, administrators, psychologists, and family members play key roles in implementing effective school-based mental health services. At the front lines, educators are in an ideal position to identify and refer students who are need of additional support. Currently, many mental health treatment facilities operate separately from schools, which can contribute to barriers for students to receive appropriate treatment. Educators can still play a significant role in the identification process and they are also the ideal implementers of preventative whole school interventions. While there are research initiatives that demonstrate the cost effectiveness of merging these systems, change is met with a lot of resistance, especially in the political arena. Therefore, educators remain students' best chance for intervention. However, educators need to be knowledgeable, well-trained, and feel confident in their skills to work effectively with the mental health challenges of their students.

3.0 STUDY METHODS AND DESIGN

3.1 INTRODUCTION

This chapter discusses the study methods that were employed to address the study questions. The questions were explored using a needs assessment approach that focused on educators at a single K-8 private school in the northeast region of the United States. The chapter topics include: (a) study questions, (b) setting and participants, (c) instrument, (d) procedures, I data collection, (f) data analysis, and (g) conclusions.

Organizational needs change. Needs assessments can contribute to guiding that process. A needs assessment can provide guidance in the prioritization and use of resources to address important needs (Mertens & Wilson, 2012). This study provided an opportunity for educators to participate in the completion of an inventory examining the internal dynamics and capacities a school as they relate to student mental health. Results are designed to provide the school with a snapshot of the current mental health literacy of their educators that can be used to make informed decisions on the potential training needs and inputs necessary to support positive mental health in the school

As an experienced mental health professional, it was of great interest to me to gain a data-supported understanding of the viewpoints of educators who do not have a classroom wellness curriculum provided on a daily basis. Choosing a voluntary, confidential, and somewhat general approach to requesting information about educators' understanding and recognition was

an effective way to gain insight into the current level of mental health literacy among the educators. The results from the inventory can be used by administration to develop ongoing training and staff development to ensure an environment that supports at-risk students. Keeping in line with the study, it was the researcher's belief that there was a need for basic understanding, awareness, and comfort among all adults who are in such close contact with children for many hours a day. Collecting data from the source—the educators—provides a snapshot to open an avenue for conversation, programmatic change, shared understanding, and ultimately a safer environment for school community members.

The following research questions were addressed in this study:

Q1. What are the educators' general understanding about student mental health?

Q2. What are the educators' perspectives about the professional help and interventions available, and do they vary when considering teacher certification levels and years of experience?

Q3. What are the educators' understanding of their role in facilitating and accessing appropriate help for a student in need of mental health support?

3.2   SETTING AND PARTICIPANTS

The setting for this study is a private K-8 school known for providing a learning environment that is grounded in community, diversity, progressive and experiential education, individualized instruction, and low educator-student ratio. The school practices a child-centered approach to learning that focuses on the social, emotional, and academic needs of each individual as well as school-identified priority needs. A consideration for the academic, social, and emotional needs of

different age groups means children experience a variety of classroom structures as they move through the grade level in their school. The site for the study was established due to the mutual interests between the researcher and the school administration as well as a professional working relationship spanning almost a decade.

The population for the study consisted of educators, and support personnel who were currently employed at the study site. The entire faculty was invited to participate in the online inventory. Participants were also informed that their participation in this study would be completely voluntary and that their responses would be kept anonymous and confidential to ensure no link to any individual. All participants were adults over the age of 21. The researcher collected data via Qualtrics and no identifiers were attached to inventory responses. Qualtrics is an online inventory management system the University of Pittsburgh purchased for student use during coursework and dissertation study. Faculty were informed of the researcher's efforts to minimize possible risks involved with participation. The researcher informed participants that they could cease completion of the inventory by closing out of it at any time without penalty.

The faculty that work directly with the students including classroom educators, support personnel and administrators served as the target population (Jacobsen & O'Connor, 2006). This was considered the accessible population, the group from which the researcher could collect the data. Educators and support personnel were invited to take an online inventory that was estimated by Qualtrics to take no more than 15 minutes to complete. Following an email invitation to complete the inventory from their school administrator, the researcher joined team meetings within a two-week period to offer technical support for online completion and to provide written copies of the inventory for completion. This two-tiered approach to data collection resulted in a 100% completion rate by the educators in the school. Participants were

asked to identify the capacity in which they interact with students, among the 41 total partcipants, 68% (n=27) identified as educators and the remaining participants identified as support personnel such as social worker, counselor, etc.

A small group of educators (n=17) who were not part of the study were asked to complete the inventory in order to test the final version. It was intended to give provide a sense of responses that will be received in the actual study as well as identifying any issues prior to the actual inventory period. The participants targeted to test the inventory had deep knowledge and expertise about mental health literacy and the education system. Clarifications from this group led the researcher to make minor changes to the inventory introduction, the order of the questions in the inventory demographic section and modifications to the Likert Scale options.

3.3   INSTRUMENT

The inventory used to collect data for this study was compiled by using a collaborative approach. The participants identified to participate in the choosing and develop of questions were identified by the school administration as key-leaders in the building with knowledge on student mental health. According to Soriano (2015) an inventory is a common measure used in needs assessments. The final inventory included items across three main categories: (1) participant demographic information; (2) participants' perceptions toward the role of schools in children's mental health; and (3) participants' understanding of mental health and perceptions of schools' role in addressing mental health.

A needs assessment planning team, made up of stakeholders identified by the school administration, designed a customized inventory intended to develop a clear understanding of the

school's environment at a specific time. Essentially, it was the schools interest to identify the gap between the current mental health literacy and the desired literacy among eductors to serve as a guide for future professional development plan. At the initial meeting with stakeholders, the researcher presented five sample surveys to draw from to develop a customized inventory specific for this study. In 2015, Wei, McGrath, Hayden, and Kutcher conducted a thorough review of the studies that evaluate mental health literacy. The most widely used measures include the Mental Health Literacy Questionnaire (MHLQ) by Jorm and colleagues (1997) and the Mental Health Understanding Schedule (MAKS) (page 5). Among the help-seeking measures, the most widely used was again the MHLQ by Jorm and colleagues (1997). Due to the popularity and validity of both the MHLQ and the MAKS, this study gained permission to use both as a source for developing a personalized inventory for this needs assessment. Through a series of meetings and dialogue a customized inventory was developed collaboratively with stakeholder input for implementation (Appendix A). The surveys used to frame the inventory used in this study will be discussed in the following section.

Stated earlier, there were two surveys that were considered by the formal planning team that stemmed from Anthony Jorm's work. To draw on this work, the researcher gained permission and obtained copies of validated inventories used in Jorm's prior researchstudy. Jorm and colleagues granted permission and provided copies of surveys used in prior research. Both the National Survey of Mental Health Literacy in Young People and the Youth Mental Health Opinions Quiz were included in a packet that was provided to the stakeholders for reference (Appendix B). Each question included in the inventory developed by Jorm and colleagues was written using their specific language and may not be the language chosen by the researcher.

Another researcher was referenced in a significant number of studies related to mental health literacy. Dr. Evans-Lacko and colleagues at the Kings College Centre for Innovation and Evaluation in Mental Health have conducted extensive research in the area of community mental health. In addition to gaining permission to use the Mental Health Understanding Schedule (MAKS), Dr Evans-Lacko recommended the Reported and Intended Behavior Scale (RIBS) as well as the Community Attitudes Toward the Mentally Ill (CAMI) (Appendix C). All of the above-mentioned scales were presented to the planning committee for reference. Each question included in the inventory developed by Dr. Evans-Lacko and colleagues was written using their specific language and may not be the language chosen by the researcher.

The purpose of this study was to examine educators' perceptions of current mental health needs in their schools; their understanding, skills, training experiences and training needs; their roles for supporting children's mental health; and barriers to supporting mental health needs in their school settings. Reinke, et al. (2011) published an article focusing on supporting children's mental health in school with a focus on educator's perceptions of their roles, barriers and needs. Permission was also obtained to use this inventory instrument for reference when developing an inventory tailored to this site (Appendix D). Each question included in the inventory developed by Dr. Reinke and colleagues was written using their specific language and may not be the language chosen by the researcher.

The original language of each of the above-mentioned surveys was maintained in the final inventory used for this study. Throughout the planning and development of the inventory, pre-testing to the professionals working in mental health and education settings, as well as the implementation of the survey, no one rejected or identified the language as inappropriate or stigmatizing.

3.3.1 Demographics

Demographics described the participants in the study and included their educational history and background information. The demographic items included: (a) gender, (b) capacity currently work/interact with students, (c) discipline/field of highest degree, (d) highest level of education, I year highest degree was attained, and (f) how many years of experience, including current job, working in a school. The highest degree obtained and years of experience working in a school were used to provide specific information regarding subgroups within the school.

3.3.2 Data Collection and Analysis Plan

Study Questions	Evidence	Design and Method	Literature
Q1. What are educators' general understanding about student mental health?	Assessment of educator knowledge of mental health, symptom recognition, and personal/perceived stigma	Educator Mental Health Literacy Inventory* Questions 2,3,5,8,9,10,11,12,14,24, & 25 Launched through the Qualtrics inventory system. Descriptive statistic calculation for frequencies, percentages, means, and SD	Canadian Alliance on Mental Illness and Mental Health (CAMIMH). (2007). Mental health literacy in Canada: Phase One draft report Mental Health Literacy Project. Canadian Educators Federation. (2012). Understanding educators' perspectives on student mental health. Grohol, J. (2013). Childhood and teenager ADHD symptoms. *Psych Central*. O'Connor & Casey (2015). The Mental Health Literacy Scale (MHLS): A new scale-based measure of mental health literacy. Psychiatry Res. 2015 Sep 30;229(1- 2):511-6
Q2. What are educators' perspective about the professional help and interventions available and do they vary when considering teacher certification levels and years of experience?	Assessment of educator personal beliefs about their confidence in available treatment and helping services for students. Assessment of educator confidence specific to degree and years of experience.	Educator Mental Health Literacy Inventory* Questions 4,6,7,16,17,26, &27 Questions 31 & 33 Launched through the Qualtrics inventory system. Descriptive statistic calculation for frequencies, percentages, means, and SD	Andrews, A. L. (2012). *Ready set . ready yet? Educator readiness in dealing with mental health issues*. Available from ProQuest Dissertations & Theses Global. Franklin, C. G. S., Kim, J. S., Ryan, T. N., Kelly, M. S., & Montgomery, K. L. (2012). Educator involvement in school mental health interventions: A systematic review. *Children and Youth Services Review, 34*(5), 973-982. Simon, A.E., Pastor, P.N., Reuben, C.A., Huang, L.N. & Goldstrom, I.D. (2015). Use of mental health services by children ages six to 11 with emotional or behavioral difficulties. *Psychiatric Services,* 66(9). 930- 937.
Q3. What are educators' understanding of their role in facilitating and accessing appropriate help for a student in need of mental health support?	Assessment of educator perceptions of their role in providing and accessing helping services for students.	Educator Mental Health Literacy Inventory* Questions 7,13,15,18,19,20,21,22, & 23 Launched through the Qualtrics inventory system. Descriptive statistic calculation for frequencies, percentages, means, and SD Open-ended questions coded for common themes and labeled. Analysis of general themes for assignment of meaning was completed.	Andrews, A., McCabe, M., & Wideman-Johnston, T. (2014). Mental health issues in the schools: Are educators prepared? *The Journal of Mental Health Training, Education, and Practice, 9*(4), 261. Johnson, C., Eva, A. L., Johnson, L. & Walker, B. (2011). *Don't turn away: Empowering educators to support students' mental health.* The Clearing House: A Journal of Educational Strategies, Issues and Ideas, 84(1). Meldrum, L., Venn, D., & Kutcher, S (2009). Mental health in schools: How educators have the power to make a difference. *Health and Learning Magazine, 8,* 3-5.

*The Educator MHL Inventory was developed in collaboration with stakeholders
Figure 1. Data Collection and Analysis

3.4   PROCEDURES

The University of Pittsburgh's Qualtrics System was used to deploy the inventory, and analyze the data gathered from the inventory in order to help identify the understanding, recognition and perceptions of educators related to student mental health. Additionally, response rates and participant tracking was conducted through Qualtrics. Each participant received a unique URL to participate in the inventory.

Prior to beginning the data collection, the researcher secured approval under exempt review from the University Institutional Review Board (Appendix E) to conduct the study. The same protocol was followed to gain permission to conduct this study at the school site. Upon IRB approval, a planning meeting was scheduled with identified stakeholders within the school school to provide input and decision-making on the inventory content. This meeting occurred on April 10, 2017. At that time, the stakeholders were provided several instruments previously used in mental health literacy study. A dialogue and discussion of the content of each inventory resulted in the final inventory that was used for this study (Appendix A). Through this collaborative process, the stakeholders were able to select specific question as well as develop individualized questions to suit their specific needs.

All participants were provided with a thorough overview of the study through the process of informed consent and participants' rights. A traditional invitation letter via email was the chosen method of communication to faculty. Participants were informed of the purpose of the study as well as possible risks and efforts to minimize risks, and were asked to provide informed consent by accessing the link to the inventory. A statement at the top of the actual inventory clearly detailed that by filling it in, the participant consented to participate but would not waive any rights as a study participant. Additionally, participants were notified that their involvement

in the study was strictly voluntary and their contributions would be used for study purposes only. All identities remained confidential. The inventory window was planned for the months of May and June 2017. The researcher's contact information and office hours were on all materials. Participants were able to save the progress they had made and return to the inventory in the event they had to close it out due to busy schedules during the school day.

This study allowed participants to take the inventory online or in paper format A total of 41 participants complete the inventory with a majority using the online link (n=35) and only six submitting the inventory in paper. An advantage of inventory methodology in that it is relatively unobtrusive and easily administered and managed (Fowler, 1993). Additionally, inventories are effective in producing large amounts of data that may be stratified based on various characteristics, such as the demographic questions of the inventory (Hesse-Biber and Leavy, 2006). All inventory data were housed in the Qualtrics database to which only the researcher had access. All paper submissions of the completed inventory were immediately entered into Qualtrics and destroyed.

The inventory was accessible online in order to generate a larger number of responses to produce information across a broader range of inventory topics. The measures of understanding, self-perceptions, and other constructs were explored through a Likert-scale response format. Likert scales measure a participant's level of agreement or disagreement to items related to the topic of interest (Tashakkori & Teddlie, 2008). A traditional Likert scale is a 5-point scale, with a variant of neither agree nor disagree as the midpoint of the scale. Other questions invited participants to "check all that apply."

3.5   DATA COLLECTION

The study was intiated by sending an email to the administrator of the participating school. The email informed him of the study and asked for approval to conduct study within the school school. Although the administrator had indicated prior interest in participating in such study, a brief meeting was held to discuss the goals of the study, needs assessment timeline, and potential stakeholders to collaborate on the development of the inventory.

Once IRB approval was obtained, the researcher sent an email with approved scripting to the administrator. He then forwarded the invitation email to faculty and encouraged participation. The letter for educators invited potential participants to the needs assessment and provided basic information about the process as well as the confidentiality of collected data. The email invited educators to complete an online inventory by clicking on a link in the text of the email. The link redirected participants to the Qualtrics System, which is provided for student study through the University of Pittsburgh. Educators were informed that the inventory, if desired, could be completed over the phone or in a face-to-face environment by contacting the researcher through the provided phone number or email address.

Due to the timing of implementation of the inventory, it was recommended by the stakeholders that data collection occur face-to-face approximately two weeks after the initial email was sent. To comply with this IRB approved recommendation, the researcher coordinated visits to the school's faculty team meetings to facilitate face-to-face completion of the inventory. During the face-to-face visits, participants were provided an option to use the URL and complete the inventory online (using their laptops or other electronic device) or to complete a paper version. It is likely that administering the inventory in-person significantly increased the

response rate for the inventory (100%). The majority of participants opted to complete the inventory via Qualtrics during the scheduled meeting with only twelve participants using paper format. Once collected, the inventories that were completed on paper were entered into Qualtrics by the researcher within one week. Participants were instructed to avoid placing any additional identifying information on the inventories beyond demographics. Paper copies were destroyed once entered into Qualtrics.

3.6   DATA ANALYSIS

Following the review of returned inventories, the process of data reduction or the process of selecting, simplifying and transforming the data began. Descriptive statistics were calculated for each question using frequencies, percentages, means and standard deviations. Most of the data collected are presented in tables with percentages of respondents and top areas identified within the results section. Tables and figures are included to present the data. Each question includes an introduction to the question and, when possible, a comparison to data from the literature review. Additionally, the inventory provided an opportunity for open-ended responses from participants. The answers to open-ended questions were coded for common themes and labeled to use for the assignment of meaning to the descriptive information provided in the responses. The general themes along with sample statements are displayed in a table format.

3.7   CONCLUSION

The purpose of this study was to examine educators' perceptions of current mental health needs within a prestigious private school in the Northeastern United States. The focus was two-fold: (1) Identify the current and desired mental health literacy of educators; (2) Analyze responses for variation in participants based on years of service and degree. Additionally, part of this investigation was designed to uncover educators' perceptions of their roles versus the roles of other professionals within the school in addressing the mental health needs of students. Of particular interest to the study was uncovering any patterns of student mental health ideas related to years of service and degree of the educator.

4.0   FINDINGS

4.1   INTRODUCTION

The purpose of this study was to conduct a needs assessment that began with a collaborative approach in the development of the inventory that was used. The overall goal was to analyze the levels of recognition and the sub-components of understanding specific to mental health literacy among educators in a specific private K-8 school. This study used an online inventory developed through a team approach to ensure the content was relevant to the school. Questions were collaboratively developed with an identified group of key leaders from the school using the prior surveys on mental health literacy discussed in Chapter 3.

The findings of this study are in the following order. First, the demographics are presented for the sample population. Following are the findings specific to the research study questions that focus on general understanding of student mental health, and educator perspectives on the professional help and interventions available.

4.2   DEMOGRAPHIC INFORMATION

Educators answered several questions on their training, education, and years of service. It is hypothesized these specific variables relate to the overall mental health literacy among the educators in the school (see Table 1). Participants were currently employed educators (n=41) in

the small private school. When asked "How many years of experience, including your present job, do you have working in a school, only 39 participants answered. The average years of service was 21.41 years and the median number of years working in a school was 9. Most of the educators in the school hold a Master's degree (n=35), and the remaining faculty hold a Bachelor's degree or Doctorate degree (n=5).

Table 1. Educator Background Data

Variable	Frequency	Percentage
Gender		
Female	28	73.7%
Male	10	26.3%
Role in School		
Educator	36	85.7%
Special Educator	6	14.3%
Field of Study		
Education	32	62.1%
Other	7	37.9%

4.3 WHAT ARE EDUCATORS' GENERAL UNDERSTANDING ABOUT STUDENT MENTAL HEALTH?

4.3.1 General Understanding

Educators answered questions that assessed their general understanding about student mental health problems. Questions consisted of statements on a 5-point Likert Scale ranging from "Strongly agree" to "Strongly disagree" with an option to choose "Neither agree or disagree." When prompted to answer the following question, "People with mental health problems tend to have a better outcome if others are not critical of them," 15 (37.5%) respondents replied with strongly agree, 16 (40%) agree, four (10%) neither agree nor disagree, five (12.5%) disagree, and zero respondents indicated strongly disagree. Although the quality and effectiveness of mental health treatments and services have improved greatly over the past 50 years, therapeutic

revolutions in psychiatry have not yet been able to reduce stigma. Stigma is universally experienced, isolates people and delays treatment of mental illness, which in turn causes great social and economic burden (Shrivastava, Johnston, & Bureau, 2012). Noting that the majority of respondents replied with either agree or strongly agree, seems evident they understand and appreciate the negative impact of stigma and others being critical on a persons mental health outcome.

When prompted to answer the following question, "Depression tends to show up earlier in a young person's life than anxiety," zero respondents replied strongly agree, one (2.5%) agree, 20 (50%) neither agree nor disagree, 16 (40%) disagree and three (7.5%) respondents indicated strongly disagree. According to Johns Hopkins Health Library, major depressive disorder can develop at any age with the average age of onset occurring in the mid-20s. Additionally, generalized anxiety disorder can begin at any, though the risk is highest between childhood and middle age (Mental Health Disorder Statistics, 2017). Given the number of participants that responded disagree and strongly disagree, it is evident that the educators who completed this needs assessment understand the onset of anxiety and depression among the students in their school. Additionally, administrators may consider employing training to provide educators with a deeper understanding of suicide prevention and intervention.

Participants responded to the following statement, "It is not a good idea to ask someone if they are feeling suicidal in case you put the idea into their head," one respondent (2.5%) replied strongly agree, eight (20%) agree, ten (25%) chose neither agree nor disagree, 16 (40%) disagree and five (12.5%) of respondents indicated strongly disagree. In a study conducted by Dazzi et al. (2015) their findings suggest that asking and talking about suicide may in fact reduce, rather than increase suicidal ideation, and may lead to improvements in mental health and treatment-seeking.

Overall, the majority of the educators shared an understanding of the positive outcomes related to talking with an at-risk student about suicide; however, there is a substantial number of educators that agreed with the statement. This would lead to the suggestion of professional development in suicide prevention and intervention trainings in the school.

When considering exposure to trauma and student mental health, participants rated the following statement, "If a young person experiences a trauma, it is best to make him or her talk about it as soon as possible," using a 5 point Likert scale ranging from "Strongly agree" to "Strongly disagree" with an option to choose "Neither agree or disagree." Among the participant responses (n=40), one (2.5%) replied strongly agree, two (5%) agree, 14 (35%) neither agree nor disagree, 13 (32.5%) disagree, and ten (25%) strongly disagree. According to a publication produced by the American Psychologial Association (2008), children and families are not always ready for treatment when offered, and some may prefer not to engage in treatment at all following a traumatic event. Additionally, most children and adolescents with traumatic exposure or trauma-related psychological symptoms are not identified and consequently do not receive any help. The majority of children and adolescents manifest resilience in the aftermath of traumatic experiences (APA, 2008). The majority of the educators indicated an understanding that a young person may not be ready to talk about a traumatic event right away; however, there is a significant number of educators who were unsure and even agreed with the statement. This would lend to the support of professional development focusing on working with students that have experienced trauma.

4.3.2 Risk Factors

To assess the educators' understanding of the impact of risk factors on a young person's life, they answered the following question: "Trauma is a risk factor in almost every type of mental illness" using a 5-point Likert scale. Among the 40 participant responses, six (15%) replied strongly agree, 21 (52.5%) agree, six (15%) neither agree nor disagree, five (12.5%) disagree, and two (5%) strongly disagree. According to a recent National Institute of Mental Health publication, trauma is a risk factor related to mental illness (Mental Health Information, 2017). It would seem that a majority of the educators have a clear understanding of the impact of trauma on a child or adolescent's mental health.

4.3.3 Self-Care

Participants responded to the following statement, "Exercise can help relieve depression and anxiety disorders," using a 5-point Likert scale ranging from "Strongly agree" to "Strongly disagree" with an option to choose "Neither agree or disagree." The greatest number of responses at 22 (55%) was strongly agree and 17 (42.5%) agree. Only 1 (2.5%) participant indicated neither agree or disagree.

Self-help strategies are actions that a person can take on his or her own to deal with a mental health disorder. Self-help strategies are sometimes used under the guidance of a health professional as part of psychological therapy (e.g., use of a book or website providing cognitive-behavior therapy). However, more often self-help strategies are informally used without any professional guidance. Not only are self-help strategies endorsed as likely to be helpful, they are also commonly used in practice (National Institute of Mental Illness, 2017). It is clear that the

educators in this school understanding and appreciate the value associated with self-help strategies.

4.3.4   Symptom Recognition

Community surveys of mental health literacy show that many people are unable to recognize mental disorders. The methodology typically used in these surveys is to present participants with a case scenario describing a person with a mental disorder and then asking what mental health diagnosis might be contributing to the behaviors (Jorm, 2011).

During the development phase of the needs assessment inventory, the team of key leaders from the school expressed a concern about educators' recognition of autism spectrum disorders. As a result, a question was collaboratively developed that provided information on a five-year-old displaying behaviors characteristic of someone with a diagnosis (APA, 2013). The following scenario was presented:

> *Tommy is a 5 year old boy. He has difficulty communicating with his peers and frequently fails to respond when people speak to him. Tommy never initiates conversations and rarely makes eye contact with other individuals. Periodically, Tommy becomes upset and loses his temper throughout the school day. His older brother, Matthew, exhibits signs of autism, including certain repetitive behaviors, difficulty with social skills, and behavioral problems. Despite these barriers, Matthew has been successfully integrated into a general education classroom. Mrs. Penny, Tommy's educator, has been unable to find effective teaching strategies to work with Tommy, He rarely listens to Mrs. Penny and has difficulty interacting with the other students in the class. At home, Mr. and Mrs. Johnson have noticed that Tommy loses his temper more frequently in the last year. They*

have learned that the methods that helped Matthew change his behavior do not seem to be effective with Tommy.

Participants identified which behaviors the student was expressing and could choose multiple responses. The results of participant answers are displayed in Table 2. The educators were able to choose more than one answer with a high number choosing to do so. In the scenario, the student exhibited severe delays in language and social relationships. Participants could have identified his anger outburst as inconsistent patterns of sensory responses; however, not included in the scenario were intellectual functioning and marked restriction of activity or interests. During the planning meeting, the stakeholders indicated a concern that faculty may not have a clear understanding of Austism Spectrum Disorders.

Table 2. Symptom Recognition of Austism Spectrum Disorders

Variable	Frequency	Percentage
Severe delays in language development	20	23.8%
Severe delays in understanding social relationships	36	42.9%
Inconsistent patterns of sensory responses	14	16.7%
Uneven patterns of intellectual functioning	4	4.8%
Marked restriction of activity or interests	10	11.8%

To further assess participants' ability to recognize symptoms, the following scenario was presented:

Johnny has always been impatient. In primary school, both his educators and his parents would always have to coerce him to behave appropriately. Lately his behavior is getting worse. He refuses to do what you tell him to do, whether it's completing coursework in class or getting along with other students in the class.

Participants could choose more than one potential diagnosis. When asked to choose which diagnoses the students symptoms align with, the responses among participants was equally distributed among the choices. Given the high frequency response including "not

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sure/don't know" among participants, the area of symptom recognition is another potential focus

for professional development.

Table 3. Symptom Recognition First Scenario

Variable	Frequency	Percentage
Depression	13	11.9%
Anxiety	22	20.1%
Stress	19	17.4%
Attention Deficit Disorder	21	19.3%
Conduct Disorder	16	14.7%
Not Sure/Don't Know	18	16.5%

Later in the inventory, participants were provided another scenario related to a five-year-old student exhibiting behaviors in the classroom and at home. Participants were asked to choose from a list of possible diagnoses.

Tommy is a 5-year-old boy. He has difficulty communicating with his peers and frequently fails to respond when people speak to him. Tommy never initiates conversations and rarely makes eye contact with other individuals. Periodically, Tommy becomes upset and loses his temper throughout the school day. His older brother, Matthew, exhibits signs of autism, including certain repetitive behaviors, difficulty with social skills, and behavioral problems. Despite these barriers, Matthew has been successfully integrated into a general education classroom. Mrs. Penny, Tommy's educator, has been unable to find effective teaching strategies to work with Tommy. He rarely listens to Mrs. Penny and has difficulty interacting with the other students in the class. At home, Mr. and Mrs. Johnson have noticed that Tommy loses his temper more frequently in the last year. They have learned that the methods that helped Matthew change his behavior do not seem to be effective with Tommy.

Again, participants were able to choose more than one diagnosis for the second scenario. The frequency distribution of their responses is detailed in Table 4. The highest response for this

scenario, was Autism Spectrum Disorder with 28 (28.6%) indicates the educators ability to identify behaviors associated with ASD.

Table 4. Illness Recognition Second Scenario

Variable	Frequency	Percentage
Depression	8	8.2%
Anxiety	19	19.4%
Stress	10	10.2%
Attention Deficit Disorder	11	11.2%
Autism Spectrum Disorder	28	28.6%
Conduct Disorder	17	17.4%
Not Sure/Don't Know	18	16.5%

4.3.5   Conclusions

With each scenario, a significant number of educators chose more than one diagnosis leading the researcher to believe a level of uncertainty may have existed. Trudgen and Lawn (2011) reported great concern about the understanding that educators had concerning the mental health of their students. They recommended that universities train educators in mental illness in children. For improving understanding on early symptoms of child mental illness, Daniel, Gupta and Sagar (2013) recommended training modules on early symptoms of psychiatric disorders as an effective method for primary school educators. On the other hand, this result could have been due to the amount of limited information in the scenario which only provided a snapshot of the student.

Specific to this study, general understanding and awareness of mental health and risk factors could have affected the educators' decision-making process when considering knowing when or how to make a referral. Additionally, outcomes of this needs assessment suggest educators are confident in the school counselor's ability to make referrals regarding student mental health. The remaining professionals in the school, often used as a referral resource, were

indicated as being used; however, participants used them at a much lower rate than school counselors. Based on the percentages of resources being accessed to support student mental health, participants in this school access necessary resources in their school to support student mental health access and participate in the decision-making process.

The range of awareness concerning early signs of mental illness symptoms and the risks that a student might face due to these symptoms was highly varied. Educators in this school reported taking approximately three separate actions when they recognized that they might have a student with significant emotional or behavioral challenges. The reported strategies and approaches taken in response to an emotional or behavioral situation varied by participant but overall fell into patterns of referring to helping services in the school, talking about the issues presenting to the student, other faculty, and family members, as well as taking the initiative in the classroom to try and uncover reasoning behind the behavior.

4.4   WHAT ARE EDUCATORS' PERSPECTIVES ABOUT THE PROFESSIONAL HELP AND INTERVENTIONS AVAILABLE, AND DO THEY VARY WHEN CONSIDERING TEACHER CERTIFICATION LEVELS AND YEARS OF EXPERIENCE?

4.4.1   Strategies and Approaches for Help

Participants answered combination of questions to evaluate actions they would take or have taken to access helping services for their students. To highlight the greatest frequencies from

Table 5 below, 37 (30.8%) respondents would refer a student to the school counselor, 23 (19.2%) to the student services committee, 15 (12.5%) would refer to both the learning specialist or the nurse, 19 (15.8%) to the team leader, and 11 (9.2%) to the director/assistant director. The trend in these responses exhibits a high level of confidence with the school counselor and a lower level of confidence among the remaining professionals among the entire faculty.

When prompted to answer the following statement, "I have recommended a student to support services," 17 (42.5%) participants answered strongly agree and agree. The faculty consider student support services as a valued resource in their building.

Among the participant reactions to the statement, "I have identified a student with mental health issues," 11 (27.5%) responded strongly agree, 14 (35.0%) agree, eight (20.0%) neither agree nor disagree, and 16 (15%) replied disagree. Given the high number of students referred to student support services yet an even distribution of students being identified with mental health issues, this would suggest the faculty obtain helping services for students that are either experiencing academic difficulty or an issue in the classroom that they are uncertain. Again, providing the faculty with professional development on child and adolescent mental health issues would be encouraged based on these results.

Table 5. Educators' Accessing Services

Variable	Frequency	Percentage
Within my school, I would refer to the following		
Counselor	37	30.8%
Student Services Committee	23	19.2%
Learning Specialist	15	12.5%
Director/Assistant Director	11	9.2%
Nurse	15	12.5%
Team Leader	19	15.8%
I have recommended a student to support services		
Strongly agree	17	42.5%
Agree	17	42.5%
Disagree	5	12.5%
I have identified a student with MH issues		

Table 5 continued

Strongly agree	11	27.5%
Agree	14	35.0%
Neither agree nor disagree	8	20.0%
Disagree	16	15.0%
I recommend students with MH issues to student support services often		
Strongly agree	4	10.3%
Agree	8	20.5%
Neither agree nor disagree	11	28.2%
Disagree	13	33.3%
Strongly disagree	3	7.7%

Once participants indicated which personnel and/or supportive services they would recommend and help students access, they also rated their confidence in the type of help they would receive from each of the professionals in their school. Overall, the greatest amount of confidence among the participants was in the learning specialist, counselor, student services, and community. The participants identified a fair amount of confidence in the team leader, director, and nurse.

Table 6. Confidence in School Supports

	Counselor	Student Services Committee	Learning Specialist	Director	Nurse	Team Leader
Very Confident	64.1%	58.8%	76.9%	40.0%	28.6%	54.6%
Fairly Confident	23.1%	20.6%	7.7%	33.3%	39.3%	27.3%
Slightly Confident	10.3%	5.9%	12.8%	13.3%	14.3%	12.1%
Not confident at all	2.6%	8.8%	00.0%	10.0%	10.7%	6.1%
Not sure/Don't know	00.0%	5.9%	2.6%	3.3%	7.1%	00.0%

4.4.2 Degree Earned

To evaluate the participant responses further, data were coded and disaggregated to develop a deeper understanding of the participants general mental health literacy while also considering the difference by degree earned and years served. The specific areas considered for this study were variations in responses related to degree earned and years of experience. The results of participant response to four questions specific to supportive behaviors are explained in detail.

When asked the highest degree earned by the participants, the majority (87.5%) responded by indicated they held a master's degree. Those idenfied as holding a bachelor's degree or a doctorate degree made up 12.5% of the participants that completed the survey.

The following statement was prompted, "I recommend students with mental health issues to student support services often," of the 39 participant responses, 41.0% (n=16) responded strongly disagree and disagree, 30.7% (n=12) responded strongly agree and agree, and 28.2% (n=11) responded neither agree nor disagree. Participants with a bachelor's degree or a doctorate degree were equally split among agree, neither agree nor disagree, strongly disagree or disagree. The largest number of participants holding a master's had balanced responses between strongly disagree and disagree at 37.1% (n=13) as well as strongly agree and agree at 34.3% (n=12). Additionally, 28.6% (n=10) indicated neither agree nor disagree. Given the balanced response among all of the variables between both the masters level faculty and the remaining participants, degree earned does not seem to contribute to the number of referrals to student support services and confidence levels in colleagues.

On the other hand, participants were presented the statement "Identifying students in need of support services is an important part of my job" and were asked to answer using the same 5-point Likert scale. Among the 40 participant responses, 90% (n=36) responded strongly agree and agree, 2.50% (n=1) responded disagree, and 7.50% (n=3) responded neither agree nor disagree. Participants with a bachelor or a doctorate degree responded equally at 50% agree and 50% strongly agree or agree. The largest number of participants, those holding a master's, responded 88.88% (n=32) strongly agree and agree and only 2.78% chose disagree. Additionally, 8.33% indicated neither agree nor disagree. The masters level hold great value in the supportive

services available for students while those with bachelors and master's degrees are varied in their response.

Lastly, "Having to deal with my students' mental health issues is overwhelming to me" was another statement to which participants responded. The responses of all participants were 28.21% (n=11) agree, 33.33% (n=13) neither disagree or agree and 30.77% (n=12) disagree. Only 7.69% (n=3) indicated strongly disagree. When considering their responses specific to degree, the participants holding a master's degree indicated 32.35% (n=11) agree that dealing with students mental health issues is overwhelming while 32.35% (n=11) chose disagree, 29.42% (n=10) chose neither agree nor disagree. There were 5.88% participants who chose strongly disagree among the bachelor's and doctorate degree participants.

4.4.3   Years of Experience

Participants were asked to indicate their number of years of experience, including their present job, that they had working in a school. To analyze the data, responses were categorized into the following groups: 1-5 years, 6-10 years, 11-15, years, 16-20 years, and over 20 years of experience. Among the responses, 28.21% (n=11) had one to five years of experience, 20.51% (n=8) had six to ten, 12.82% (n=5) had 11 to 15, 20.51% (n=8) had 16 to 20, and 15.38% (n=6) had 20 or more. Table 7 shows the participants responses by years of experience to the statement "I recommend students with mental health issues to student support services often." When considering years of service, educators having been in a school for 16-20 years have an even split between agree and disagree when considering frequency of recommending to support services. While those with 20 or more years have a high frequency of agree, they also have a considerable number of responses disagreeing with the statement. Overall, there doesn't seem to

be a significant variance when considering years of service and use of supportive services in the school. However, this balanced response lends further research into why faculty aren't recommending to support services often.

Table 7. Recommending to Student Support Services Often

Variable	1-5	6-10	11-15	16-20	20 or more
Strongly Disagree	0.00%	0.00%	0.00%	0.00%	33.33%
Disagree	45.45%	12.50%	60.00%	37.50%	16.67%
Neither	27.27%	50.00%	20.00%	25.00%	16.67%
Agree	18.18%	25.00%	0.00%	12.50%	33.33%
Strongly Agree	9.09%	12.50%	20.00%	25.00%	0.00%

Table 8 shows the participant responses by years of experience to the statement "Recommending students in need of support services is an important part of my job." Across all categories, the majority of educators either agreed or strongly agreed that recommending to support services is an important part of their job. Because the faculty recognize that obtaining help for students in need is an importance resource, yet the frequency of doing so is split across categories, further discussion with the educators regarding the reason behind their disagreement with making recommendations is worthy of consideration.

Table 8. Recommending is an Important Part of My Job

Variable	1-5	6-10	11-15	16-20	20 or more
Disagree	0.00%	12.50%	0.00%	0.00%	0.00%
Neither	0.00%	12.50%	0.00%	12.50%	16.67%
Agree	63.64%	37.50%	20.00%	50.00%	50.00%
Strongly Agree	36.36%	37.50%	80.00%	37.50%	33.33%

Table 9 shows the participant responses by years of experience to the statement "Having to deal with my students' mental health issues is overwhelming to me." As evidenced by the frequencies below, the faculty having worked in a school for six to 10 years showed a 50% agreement with feeling overwhelmed with student mental health. Those having worked five years and under as well as 11 years and over had indicated an overall disagreement with feeling

overwhelmed. This agreement among participants feeling overwhelmed within the category of six to 10 year is worthy of additional research.

Table 9. Student Mental Health Issues is Overwhelming

Variable	1-5	6-10	11-15	16-20	20 or more
No Answer	0.00%	0.00%	0.00%	12.50%	0.00%
Strongly Disagree	0.00%	0.00%	20.00%	12.50%	16.67%
Disagree	27.27%	12.50%	60.00%	12.50%	66.67%
Neither	54.55%	37.50%	20.00%	25.00%	16.67%
Agree	18.18%	50.0%	0.00%	37.50%	0.00%

4.4.4   Conclusions

This inventory, consistent with studies previously completed using self-ratings of understanding, awareness, and comfort levels for student mental health, revealed that educators were aware of the mental health challenges students are facing and recognize identifying students in need of support services as an important part of their job. However, a portion of educators reported feeling overwhelmed with having to deal with student mental health issues. Rothi et al. (2008), among other studies, found that educators did not feel appropriately equipped and did not have proper training for the task of finding help and providing support for adolescents with mental health concerns. Similarly, a study of educators' perspectives of providing help to students, the theme of feeling unsupported by colleagues or having limited understanding and skills arose (Alisic, 2012). These results echoed Andrews et al. (2014), which also found it necessary to include mental health courses in educator preparation programs and to continue education through ongoing, targeted professional development.

Several findings that emerged from the data analysis showed that less than half of the educators reported "strongly agree" and "agree" in identifying students with mental health needs while the remaining educators reported not agreeing with the statement. In addition, awareness of steps necessary to access services showed a wide distribution across the scale. This may imply

that although there is a general awareness of student mental health "issues," what actions to take may not be clear.

The majority of respondents were knowledgeable about appropriate referrals to make to support student mental health within their school. These findings are similar to a study conducted by Andrews et al., (2014) which reported that 97% of educators strongly agreed with the statement that they should be aware of how to react to mental health challenges, while only 26.6% felt they and their colleagues had the necessary understanding and skills to do so. The same study reported that educators clearly understood the seriousness of student mental health needs as well as its impact on academics, where conversely, only 36% strongly agreed or agreed that they were confident in their understanding when dealing with students with mental health challenges (Andrews et al., 2014). Educators must be prepared to handle emotional or behavioral problems confidently (Ringeisen et al., 2003). Reinke et al. (2011) found that 75% of early childhood and elementary educators worked with or referred students with mental health problems, yet 51% of the participating educators admitted having difficulty identifying children with mental health needs.

Educators reported on support services in the school as well as behaviors related to linking at-risk students. Overall, a significant number of educators indicated they would refer to support services. However, when asked if they refer to support services often, only a third indicated agree/strongly agree.

When considering which support services in the school are most often accessed, almost half of the participants indicated they would reach out to the Counselor and/or Student Services Committee. This response is in-line with the majority of schools in the United States. Although contemporary schools are readied with diverse means to meet the mental health needs of

students, in the majority of schools, it is solely the school counselor who provides the mental health service to students, often in the form of preventative care (Brown & Trusty, 2005). Additionally, school counselors are charged with providing services that respond to immediate student needs, which can be delimited by the scope of the school counselor's total responsibilities in the school. Fortunately, responses among participants also showed that educators reported high confidence levels in the support services available to them in the school which shows the sole responsibility isn't falling on the school counselors and the school has a variety of in-school supports available to educators and students.

4.5 WHAT ARE EDUCATORS' UNDERSTANDINGS OF THEIR ROLE IN FACILITATING AND ACCESSING APPROPRIATE HELP FOR A STUDENT IN NEED OF MENTAL HEALTH SUPPORT?

4.5.1 Perception of Role

Educator perceptions of the needs of their students is another important area related to mental health literacy. To evaluate this area, participants answered several questions focusing on actions taken by educators related to student mental health as well as the perception of their role (see Table 10). When provided with the following statement, "Identifying students in need of support services is an important part of my job, "the majority of respondents either strongly agreed at 42.5% (n=17) or agreed at 47.5% (n=19). After considering the following the statement, "Having to deal with my students' mental health issues is overwhelming to me" participants choose agree, neither agree nor disagree, and as indicated in Table 10.

Table 10. Educator Perceptions

Variable	Frequency	Percentage
If you had a student like "Johnny" would you get help?		
Yes	35	87.5%
Maybe	4	10.0%
No	1	2.5%
Where would you seek help for a student?		
Parent(s)/Guardians(s)	35	87.5%
Educator/Colleague	38	95.0%
Service (either in school or community)	26	65.0%
Identifying students in need of support services is an important part of my job		
Strongly agree	17	42.5%
Agree	19	47.5%
Neither agree nor disagree	3	7.5%
Disagree	1	2.5%
Strongly disagree	0	00.0%
Having to deal with my students' mental health issues is overwhelming to me		
Strongly agree	0	00.0%
Agree	11	28.2%
Neither agree nor disagree	13	33.3%
Disagree	12	30.8%
Strongly disagree	3	7.7%

Using the "Tommy" scenario, participants were asked to identify all of the in-school supports that they would go to for help while also indicating their confidence levels of those supports in their school (see Table 10). Three respondents indicated they would go to the parents, a previous educator, and peers for help. Thirty-four (85%) of the participants indicated Counselor, 27 (67.5%) replied Student Services Committee, 36 (90%) Learning Specialist, five (12.5%) Director/Assistant Director and Nurse, and 21 (52.5%) Team Leader. The faculty sit on a team specific to their grade and content area with a senior faculty member identified as the Team Leader. The teams meet weekly throughout the school year for planning and supervision.

The inventory also provided an opportunity for participants to answer an open-ended question related to accessing services and help-seeking behaviors. Participants were asked to consider what actions they would take regarding the "Johnny" student scenario. This open-ended question provided an opportunity to gain insight into information that may not have been

gathered in the closed-ended questions. The responses were reviewed for common themes and categorized by patterns in the responses as well as the topics covered in the response. The answers provided by personnel were categorized into three themes. Details on the themes and sample answers are provided in Table 11.

Table 11. Help Seeking Behaviors

Variable	Sample Response
Refer	"Refer." "Refer him to counselor." "Refer to Student Services."
Talk	"I would ask Johnny to talk about the patterns that have developed." "Talk to him and try and figure out his interests so I can engage him." "I would contact home and see what kind of information they could share."
Intervene	"I would observe behavior over a period of time to identify possible triggers." "I would try to make connections and form a relationship with him." "Try to set up a situation where there is a win-win outcome."

4.5.2 Conclusions

The majority of educators chose "strongly agree" and "agree" when presented with, "Identifying students in need of helping services is an important part of my job." These data were consistent when considering the degree of participants and years of experience. Similarly, Reinke et al. (2011) found that 89% of 292 educators surveyed agreed that schools should be involved in addressing the mental health needs of children; however, a mere 34% of educators in that same study reported that they felt they had the skills necessary to support those needs. Studies such as Trudgen & Lawn (2011) concluded that education bodies and teaching universities are responsible for training educators and providing ongoing professional learning in the area of student mental health. Daniel, Gupta, and Sagar (2013) and Wolpert et al., (2015) supported

methods and initiatives that may improve primary educators' understanding about mental health and implementing targeted mental health interventions in a meaningful way. Weare and Nind (2011) also produced findings that support the development of interventions with high impact that include integration of universal and targeted initiatives, and also include skill development over several years.

Vastanis, Humphrey, Fitzgerald, Deighton, and Wolpert (2013) found that the highest frequency of form of help that primary and secondary members of a school personnel would carry out was to listen to the child's problems and offer understanding and general support. In the same study, of 599 primary and 137 secondary schools, over 99% of respondents reported that a child would be able to see someone in the school for help, as reported in the current study as "access to school services." However, when analyzing short answers from educators when presented the "Johnny" scenario and asked what they would do, only 21% (n=9) indicated they would initiate a conversation with the student.

Of particular interest when analyzing the open-ended question discussed above were the answers given by participants under the specific theme of "refer." While the participants consistently reported their comfort in accessing services for their students, the answers generally fell within school supports. Only one of the answers considered referring the student to a community support (i.e. therapist) while the remaining answers focused on referring the student to the school counselor and student services committee. Koller and Bertel (2006) discussed a critical need for a systemic shift from the traditional deficit-driven model, which focuses on mental illness or pathology, to a strengths-based model, which focuses more on prevention, collaboration, and interdisciplinary effort to promote wellness. Disconnects between school and community-based mental health providers create some of the biggest problems in mental health

care for students. The reality is that, to improve our system of mental health services, neither sector can afford to go it alone. Both are necessary elements of the continuum of mental health care and may have a greater impact working in concert (Brock & Brant, 2015).

5.0   DISCUSSION

The results from the descriptive statistics analysis in the present study indicate that a majority of educators in the school take students' mental health issues seriously and regard mental health topics as relevant to their jobs. These results are directly in line with the prior research on the mental health literacy of educators (Hesling, 2007). Overall, whether they are in elementary, middle/junior, or senior high schools, educators believe that dealing with student mental health is within their role. Also in line with prior research was a general lack of understanding or comfort is handling situations dealing with mental health (Reinke et al. 2011).

The findings of this study show a gap in educator general understanding related to the ability to preserve optimal levels of student mental health in the classroom. This was evidenced during the initial planning meeting with the committee when the identified stakeholders requested professional development related to student mental health regardless of the assessment outcomes. This perspective of the educator as a continual learner is an essential quality that reinforces the value of each individual student.

Another area of particular interest in this study was to assess the educators' perspectives on the professional interventions available. In most of the research, educators report feeling a part of the solution when it comes to student mental health but express a need for more assistance in schools from mental health professionals who have an area of expertise that complements what educators can offer. The setting for this study showed that the majority of educators have an overall sense of support when considering where to obtain services, advice,

and support for at-risk students. The primary source of support for educators was the school counselor and Student Support Services. There was no indication among participants that outside supports or mental health professionals are involved or accessed by the educators in the building. Effeective school-linked and school-based mental health collaborations overcome many obstacles by coordinating resources among schools, the community, and county agencies (Klein, 2014). As evidenced in the setting for this study, an effective approach to linking youth to mental health services is to provide services where student are; however, building a partnership between the school and community mental health system could be a first step in expansion for the school (Klein, 2014).

When considering educators' educational background and years of experience, it was interesting that the educators views specific to this assessment were in line with the research related to educator self-efficacy. Research suggests that more experienced educators feel more effective and prepared, report less stress, and find their profession less difficult than those newer to the field (Cruz & Arias 2007). The educators with 11 years or more indicated an overall disagreement, feeling overwhelmed in relation to student mental health issues. This results seems to indicate a need for additional training and support for the educators, regardless of the number of years they've been in the field. While it's not necessary for them to become experts in diagnosis or treatment, instruction in mental health or the warning signs related to a struggling student could be an invaluable offering to the school. A number of programs designed to instruct teachers in indentifying and responding to mental-health and behavioral challenges already exist. For example, the American Psychiatric Foundation's "Typical or Troubled?" program trains school staff members to identify signs of trouble among adolescents (APA, 2006). Another great staff development offering that addresses student mental health for educators is Youth Mental

Health First Aid (National Council for Behavioral Health, 2017). Either training opportunity would be a great start for the school to consider as a means to provide teachers with the tools to feel effective rather than overwhelmed.

Teaching is a difficult job with expectations and demands coming from all sides. Educators juggle content standards, the social and emotional needs of students, behavior, and often trauma, but they also have an opportunity to be the first school-based help when students have mental health problems. Paying attention to all these elements helps create a well-run, high functioning classroom, but dealing with all of them well can feel completely overwhelming.

5.1   LIMITATIONS AND STRENGTHS

While the findings from this needs assessment are informative to the field, it is important to note that the sample is limited to educators from within one school. For this reason, these findings cannot be generalized to the broader community. However, because the study was intended to inform a specific population on the needs and strengths of the school community related to student health literacy, the study has strength. Additionally, the inventory developed in collaboration with stakeholders from the school provides a foundation for future use in other schools.

Social desirability bias and educators not wanting to be perceived as insensitive to the needs of students may have led to some socially acceptable answers that may not be true to actual feelings. However, given the goals of the needs assessment, the inventory successfully

identified priority needs in the school that can be used to inform the creation of an appropriate professional development plan.

A needs assessment process provided a systematic means of gathering data about a problem experienced by more than a few students in a school. It provided a broader context for the problems that students may have experienced. The study provided a databased means of communicating about mental health literacy in a broader context in a way that administrators, educators, and community members can understand. By using a needs assessment framework, a systematic data collection process was developed collaboratively using key leaders in the school, which resulted in buy-in and participant enthusiasm.

The data collection process developed by the committee can be viewed as a strength. While schools can provide a comprehensive sampling frame for studies, recruitment is challenging. Multi-level approaches that engage multiple school stakeholders has been recommended and supports the use of both online recruitment as well as face-to-face data collection. By offering multiple strategies and opportunities to complete the inventory, this study was able to engage 100% of the population in the target school.

5.2   RECOMMENDATIONS AND IMPLICATIONS FOR PRACTICE

Educators today are called upon to do much more than just teach their area of expertise. Educators often play a critical role in the lives of children beyond the classroom. They can be an outlet, a source of support and help when kids really need it. This is especially true for children and adolescents experiencing mental health challenges. However, in order for educators to be effective for such students, they need to have the understanding and skills to effectively

recognize the symptoms of a student experiencing mental health issues or even distress. For optimal impact, skills training should be integrated into a whole-school, multi-modal approach that includes efforts to improve school culture, educator education, liaison with parents, parenting education, community involvement, and collaboration with outside agencies (Weare & Nind, 2011).

Educators may need more training and direction to serve their students in an effective and compassionate manner. When an educator identifies a student as being in distress, he or she interacts with the student by offering support in a variety of ways. Where the educator should go, with whom the educator should speak, and whether the educator is privy to a level of information all should be clarified to prevent delay of services. It is recommended that continued work on mental health promotion and problem prevention be supported, continued, and expanded. One definitive way to develop a school-wide mental health promotion program would be to implement evidence-based training such as Youth Mental Health First Aid (Jorm, 2005) to all professionals in the school. It could then be reasonable that the educator as a "first responder" be provided and adequately trained with appropriate guidelines, language, and contacts in order to feel equipped to manage students who are facing mental and emotional challenges in the classroom. A clear path and line of communication between educators and support personnel suggest that each specially trained population has the opportunity to contribute to a case through what he or she has been trained to do. It is important to preserve the instructional time that an educator has with his or her students and to respect the preparation and planning time that an educator utilizes for his or her students. For example, once the educator as a "first responder" indicates to support personnel that a student needs follow up, the request should activate a well-organized chain of events with the support personnel (Jorm et al., 2005). Acting as a "first

responder" should suggest no additional responsibility or expectation for particular outcomes when a student requires further assistance. Essentially, the idea is that everyone in the school would have the understanding to recognize when a student is experiencing a mental health issue and take it upon themselves to initiate contact and provide support until a mental health professional can intervene (Jorm, et al., 2005). Implications for policy and practice include the following: 1) integrate the development of interventions with greater impact on mental health issues into the general classroom curriculum rather than implemented in isolation; 2) provide skills training for educators; 3) understand that behavioral strategies alone are unlikely to be effective, as are information-only strategies; and 4) use active teaching methods applying interactive methods such as games, simulations, and small group work over didactic teaching methods (Jorm et al., 2005)

As noted in the findings, only one participant suggested connecting with outside providers and resources when accessing help for students. Although it can be assumed the school has a solid continuum for support in place, recommendations for practice include collaborating with community agencies to screen students for mental health challenges in order to develop a plan to address their identified challenges at initial enrollment in the high school setting. Coordinated school health and wellness programs should be implemented that would provide and utilize support personnel and services, such as health educators and clinical personnel, including psychologists, social workers, and school nurses. Educators could then be supported by a coordinated effort, and students could be identified earlier in order to receive appropriate services and plans. A plan to re-evaluate programs, personnel training, and professional development with clear expectations and assessment is crucial for the success and longevity of implemented efforts.

5.3   IMPLICATIONS FOR FUTURE STUDY

Because this study used a collaborative framework to develop an inventory specific to student mental health literacy in their school, the process might be replicated in other schools to assess educators' mental health literacy. While the process might remain the same, the inventory would likely look different in order to gather site-specific data. Upon completion and review of the final inventory, the researcher could provide greater direction and insight into the wording used throughout the inventory to ensure it does not contribute to the stigma of mental health.

Additionally, particular aspects of what is already being done in schools, implemented, and offered to students and their levels of effectiveness could be investigated separately in order to shed light on work that districts such as this one are currently engaged in with the intention of making positive changes to support the mental health of students. It would be interesting to look further into the organizational structure of an educational setting and draw out the more specific understanding, skill sets, and dispositions of both educators and administrators specific to supporting students' mental health. Including students, parents, and community leaders in an investigation would present a more comprehensive view of a system that either promotes or hinders development in work to prevent distress along with promoting mental wellness and resilience in high socioeconomic areas of the country.

It is important that researchers, school communities, and educator preparation program coordinators develop a discourse around the mental health of adolescents. The findings of this study were based on: (a) an objective assessment tool and (b) descriptions of current practices and needs of educators attempting to aid students. In addition to other studies yielding the same or similar results, the groundwork for a discussion around strategies about comprehensive ongoing planning, training, and implementation of effective prevention and intervention planning

is reasonable and justified. Research and evidence-based school programs are available in order to facilitate school district conversations about student mental health and should be explored and tailored to meet the specific needs of a targeted population. Interventions that have the most impact should be integrated across the entire school not isolated in individual classrooms (Weare & Nind, 2011). Educating parents, educators, and involved community organizations and agencies during implementation have been most successful (Weare & Nind, 2011). Further, an assessment of current school health personnel and their understanding of and current impact on the school community could provide an initial avenue to involve students in the mental health education movement. This invites a larger presence of the importance of advocating for the role of optimal mental health of our school communities.

Ongoing professional learning is needed to ensure that mental health training is part of every educator's central skill set in order for all educators to confidently promote the optimal mental health of their adolescent students, identify emerging mental health problems, and adequately access support that is available to them. It is clear from this assessment that educators are concerned for their students. To continue including educators in the process of developing and implementing evidence-based interventions may soon begin to close the study to practice gap and add greatly to the lives of our students.

Future research should explore connections between educator characteristics (e.g., training) and their perceptions of school mental health. Past research has documented that position (educator vs. aid) and educational level (graduate vs. undergraduate) are associated with educators' ratings of importance of behavioral supports for preschoolers with behavior problems (Stormont & Stebbins, 2005). Further research on this topic can help inform specific training needs for subgroups of educators. Additionally, pre-, and post-assessments of implementation

and maintenance of skills, as well as acceptability of the training and program or practice, following trainings for educators focused on school-based mental health would provide information on whether educators find the information useful and if they transfer it to practice.

Another area needing further research is the similarities and differences in the perceptions of mental health promotion in school among educators employed in various roles within schools. Previous studies assessing educators' perceptions of mental health promotion have mainly focused on educators and paraprofessionals who directly interact with students and their families. Although front-line school personnel play important roles in mental health promotion, their influence on systemic and structural factors that impact the daily operation of schools is limited. Successful mental health promotion efforts in schools necessitate multi-sector efforts and interdisciplinary collaboration that require skillful management and effective leadership at the school and district levels (Lean, 2010; Weist et al., 2012). Weist et al. (2012) noted that this collaborative effort can be disrupted by the marginalization of mental health goals in school settings as well as other issues related to resources and funding. Territorial competitions and duplicated roles among school personnel and mental health professionals can also interfere with the effective collaboration necessary for mental health promotion in schools.

APPENDIX A

EDUCATOR MENTAL HEALTH LITERACY INVENTORY

Dear Participant,

The purpose of this research is to conduct a needs assessment regarding educator mental health literacy. The results of this needs assessment are intended to assist in the planning for professional development. For that reason, we are asking you to complete a brief (10 minute) questionnaire. If you are willing to participate, our questionnaire will ask about background (e.g. age, years in education, professional development related to the topic), as well as your knowledge, attitudes, and beliefs about mental health problems that your students may experience. There are no foreseeable risks associated with this project, nor are there any direct benefits to you. This is an entirely anonymous questionnaire, and so your responses will not be identifiable in any way. All responses are confidential, and results will be kept under lock and key.

Throughout the survey, we use the term "mental health problem." We define mental health problem as a disorder or illness that:
      a. Affects a person's thinking, emotional state, or behavior
      b. Disrupts the person's ability to
          1. Work or attend school
          2. Carry out daily activities
          3. Engage in satisfying relationships

Your participation is voluntary and you may withdraw from this project at any time. This study is being conducted by Jennifer Ely, who can be reached at jenniferely@pitt.edu if you have any questions. Thank you for taking the time to participate in this needs assessment!

Q2 People with mental health problems tend to have a better outcome if others are not critical of them.
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q3 Trauma is a risk factor in almost every type of mental illness
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q4 Exercise can help relieve depression and anxiety disorders
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q5 Knowledge about the impact of medication for youth is limited compared to what we know about adults
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q6 One of your students was a victim of abuse some years ago and has since been diagnosed with an anxiety disorder. You're with him/her when they break into a sweat, doubles over as if in pain and starts to hyperventilate. Do you:
- ○ Move with him/her to a quiet place, provide reassurance, and help with slowing breathing
- ○ Give him/her some alone time because giving him/her attention during these episodes will only encourage similar behavior in the future
- ○ Take the student somewhere quiet and help him/her calm down with a beverage. Gently point out that his/her abuser is gone and fears are unfounded

Q7 Within my building, I would refer a student to the following person(s) if I am concerned about their mental health (select all that apply)...
- ❑ Counselor
- ❑ Student Services Committee
- ❑ Learning Specialist
- ❑ Director/Assistant Director
- ❑ Nurse
- ❑ Team Leader
- ❑ Unsure

Q8 If a young person experiences a trauma, it is best to make him or her talk about it as soon as possible
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q9 Depression tends to show up earlier in a youth person's life than anxiety
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q10 It is not a good idea to ask someone if they are feeling suicidal in case you put the idea into their head
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q11 The average age of onset for schizophrenia is 18 years for men and 25 years for women
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q12 They may not need it right away, but eventually everyone with a mental health problem needs professional treatment
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q13 Please read this brief scenario and answer the following question regarding Johnny:

Johnny has always been impatient. In primary school, both his teachers and his parents would always have to coerce him to behave appropriately. Lately his behavior is getting worse. He refuses to do what you tell him to do, whether it's completing coursework in class or getting along with other students in the class.

If you had a student like Johnny, what would you do? _____

Q14 Please read this brief scenario and answer the following question regarding Johnny:

Johnny has always been impatient. In primary school, both his teachers and his parents would always have to coerce him to behave appropriately. Lately his behavior is getting

worse. He refuses to do what you tell him to do, whether it's completing coursework in class or getting along with other students in the class.

What, if anything do you think is wrong with Johnny (select all that apply)?
- ❑ Depression
- ❑ Anxiety
- ❑ Stress
- ❑ Attention Deficit Disorder
- ❑ Conduct Disorder
- ❑ Not Sure/Don't Know

Q15 Johnny has always been impatient. In primary school, both his teachers and his parents would always have to coerce him to behave appropriately. Lately his behavior is getting worse. He refuses to do what you tell him to do, whether it's completing coursework in class or getting along with other students in the class.

If you had a student right now like Johnny, would you go for help?
- ○ Yes
- ○ Maybe
- ○ No

Q16 Please read this brief scenario and answer the following question regarding Johnny: Johnny has always been impatient. In primary school, both his teachers and his parents would always have to coerce him to behave appropriately. Lately his behavior is getting worse. He refuses to do what you tell him to do, whether it's completing coursework in class or getting along with other students in the class.

Where would you go to seek help (select all that apply)?
- ❑ Parent(s)/Guardian(s)
- ❑ Teacher/Colleague
- ❑ Service (either in school or community)
- ❑ Would seek help from other _____

Q17 Please read this brief scenario and answer the following question regarding Johnny:

Johnny has always been impatient. In primary school, both his teachers and his parents would always have to coerce him to behave appropriately. Lately his behavior is getting worse. He refuses to do what you tell him to do, whether it's completing coursework in class or getting along with other students in the class.

How confident would you be in your ability to ask for help from person(s)/service(s)?

	Parent(s)/Guardian(s)	Teacher/Colleague	Service (either in school or community:	Other
Very Confident	O	O	O	O
Fairly Confident	O	O	O	O
Slightly Confident	O	O	O	O
Not Confident At All	O	O	O	O
Not Sure/Don't Know	O	O	O	O

Q18 I have recommended a student to support services before.
O Strongly agree
O Agree
O Neither agree nor disagree
O Disagree
O Strongly disagree

Q19 I have identified a student with mental health issues in the past.
O Strongly agree
O Agree
O Neither agree nor disagree
O Disagree
O Strongly disagree

Q20 I recommend students with mental health issues to student support services often
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q21 Identifying students in need of support services is an important part of my job.
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q22 Recommending students with mental health issues is an important part of my job.
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q23 Having to deal with my students' mental health issues is overwhelming to me
- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q24 Please read this brief scenario and answer the following question regarding Tommy:

Tommy is a 5 year old boy. He has difficulty communicating with his peers and frequently fails to respond when people speak to him. Tommy never initiates conversations and rarely makes eye contact with other individuals. Periodically, Tommy becomes upset and loses his temper throughout the school day. His older brother, Matthew, exhibits signs of autism, including certain repetitive behaviors, difficulty with social skills, and behavioral problems. Despite these barriers, Matthew has been successfully integrated into a general education classroom.Mrs. Penny, Tommy's teacher, has been unable to find effective teaching strategies to work with Tommy, He rarely listens to Mrs. Penny and has difficulty interacting with the other students in the class. At home, Mr. and Mrs. Johnson have noticed that Tommy loses his temper more frequently in the last year. They have learned that the methods that helped Matthew change his behavior do not seem to be effective with Tommy.

What, if anything, do you think is wrong with Tommy (select all that apply)?
- ❑ Depression
- ❑ Anxiety
- ❑ Stress
- ❑ Attention Deficit Disorder
- ❑ Autism Spectrum Disorder
- ❑ Conduct Disorder
- ❑ Not sure/Don't know

Q25 Please read this brief scenario and answer the following question regarding Tommy:

Tommy is a 5 year old boy. He has difficulty communicating with his peers and frequently fails to respond when people speak to him. Tommy never initiates conversations and rarely makes eye contact with other individuals. Periodically, Tommy becomes upset and loses his temper throughout the school day. His older brother, Matthew, exhibits signs of autism, including certain repetitive behaviors, difficulty with social skills, and behavioral problems. Despite these barriers, Matthew has been successfully integrated into a general education classroom.Mrs. Penny, Tommy's teacher, has been unable to find effective teaching strategies to work with Tommy, He rarely listens to Mrs. Penny and has difficulty interacting with the other students in the class. At home, Mr. and Mrs. Johnson have noticed that Tommy loses his temper more frequently in the last year. They have learned that the methods that helped Matthew change his behavior do not seem to be effective with Tommy.

Is Tommy exhibiting any characteristics of autism (select all that apply)?
- ❑ Severe delays in language development
- ❑ Severe delays in understanding social relationships
- ❑ Inconsistent patterns of sensory responses
- ❑ Uneven patterns of intellectual functioning
- ❑ Marked restrictions of activity or interests

Q26 Please read this brief scenario and answer the following question regarding Tommy:

Tommy is a 5 year old boy. He has difficulty communicating with his peers and frequently fails to respond when people speak to him. Tommy never initiates conversations and rarely makes eye contact with other individuals. Periodically, Tommy becomes upset and loses his temper throughout the school day. His older brother, Matthew, exhibits signs of autism, including certain repetitive behaviors, difficulty with social skills, and behavioral problems. Despite these barriers, Matthew has been successfully integrated into a general education classroom.Mrs. Penny, Tommy's teacher, has been unable to find effective teaching strategies to work with Tommy, He rarely listens to Mrs. Penny and has difficulty interacting with the other students in the class. At home, Mr. and Mrs. Johnson have noticed that Tommy loses his temper more frequently in the last year. They have learned that the methods that helped Matthew change his behavior do not seem to be effective with Tommy.

If you had a student in your classroom like Tommy, where would you go for help (select all that apply)?
- ❑ Counselor
- ❑ Student Services Committee
- ❑ Learning Specialist
- ❑ Director/Assistant Director
- ❑ Nurse
- ❑ Team Leader
- ❑ Other _____

Q27 Please read this brief scenario and answer the following question regarding Tommy:

Tommy is a 5 year old boy. He has difficulty communicating with his peers and frequently fails to respond when people speak to him. Tommy never initiates conversations and rarely makes eye contact with other individuals. Periodically, Tommy becomes upset and loses his temper throughout the school day. His older brother, Matthew, exhibits signs of autism, including certain repetitive behaviors, difficulty with social skills, and behavioral problems. Despite these barriers, Matthew has been successfully integrated into a general education classroom.Mrs. Penny, Tommy's teacher, has been unable to find effective teaching strategies to work with Tommy, He rarely listens to Mrs. Penny and has difficulty interacting with the other students in the class. At home, Mr. and Mrs. Johnson have noticed that Tommy loses his temper more frequently in the last year. They have learned that the methods that helped Matthew change his behavior do not seem to be effective with Tommy.

How confident would you be in the help you will obtain from the person(s)/service(s)?

	Counselor	Student Services Committee	Learning Specialist	Director/Assistant Director	Nurse	Team Leader	Other
Very confident	O	O	O	O	O	O	O
Fairly confident	O	O	O	O	O	O	O
Slightly confident	O	O	O	O	O	O	O
Not confident at all	O	O	O	O	O	O	O
Not sure/Don't know	O	O	O	O	O	O	O

Q28 Your gender:
O Female
O Male

Q29 In what capacity do you currently work/interact with students?

- ❏ Teacher
- ❏ School psychologist
- ❏ Counselor
- ❏ Special Educator
- ❏ Social Worker
- ❏ School Nurse
- ❏ Coach
- ❏ Administrator/Principal/Assistant Principal
- ❏ Other (please specify) _____

Q30 Discipline/field of highest degree:

- ❍ Education
- ❍ Special Education
- ❍ School Counseling
- ❍ School Psychology
- ❍ Clinical Psychology
- ❍ Counseling Psychology
- ❍ Social Work
- ❍ Nursing
- ❍ Administration
- ❍ Other (please specify) _____

Q31 Your highest level of education:

- ❍ High school graduate
- ❍ Associate's degree
- ❍ Bachelor's degree
- ❍ Master's degree
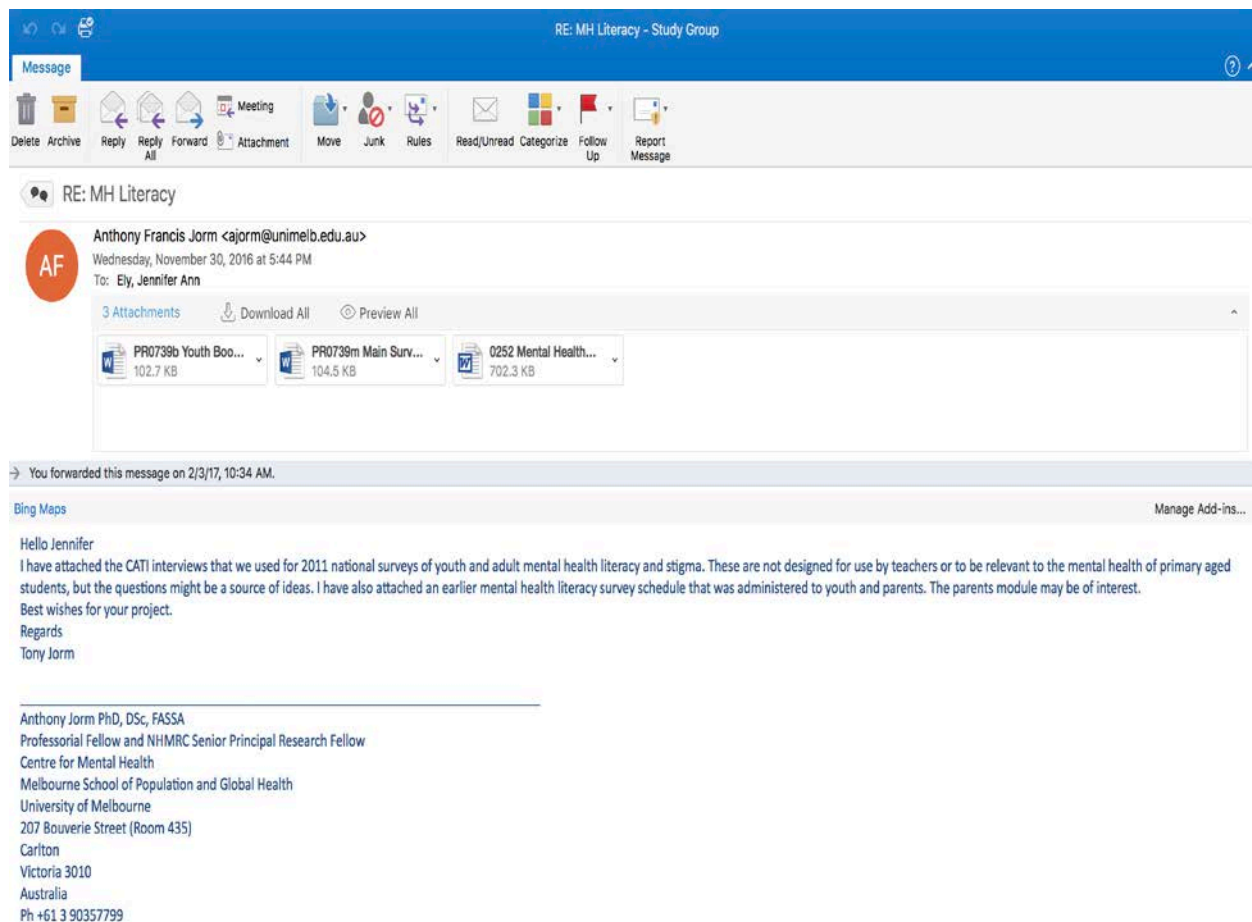- ❍ Doctorate degree

Q32 Year degree was awarded? (e.g. 2007)

Q33 How many years of experience, including your present job, do you have working in a school?
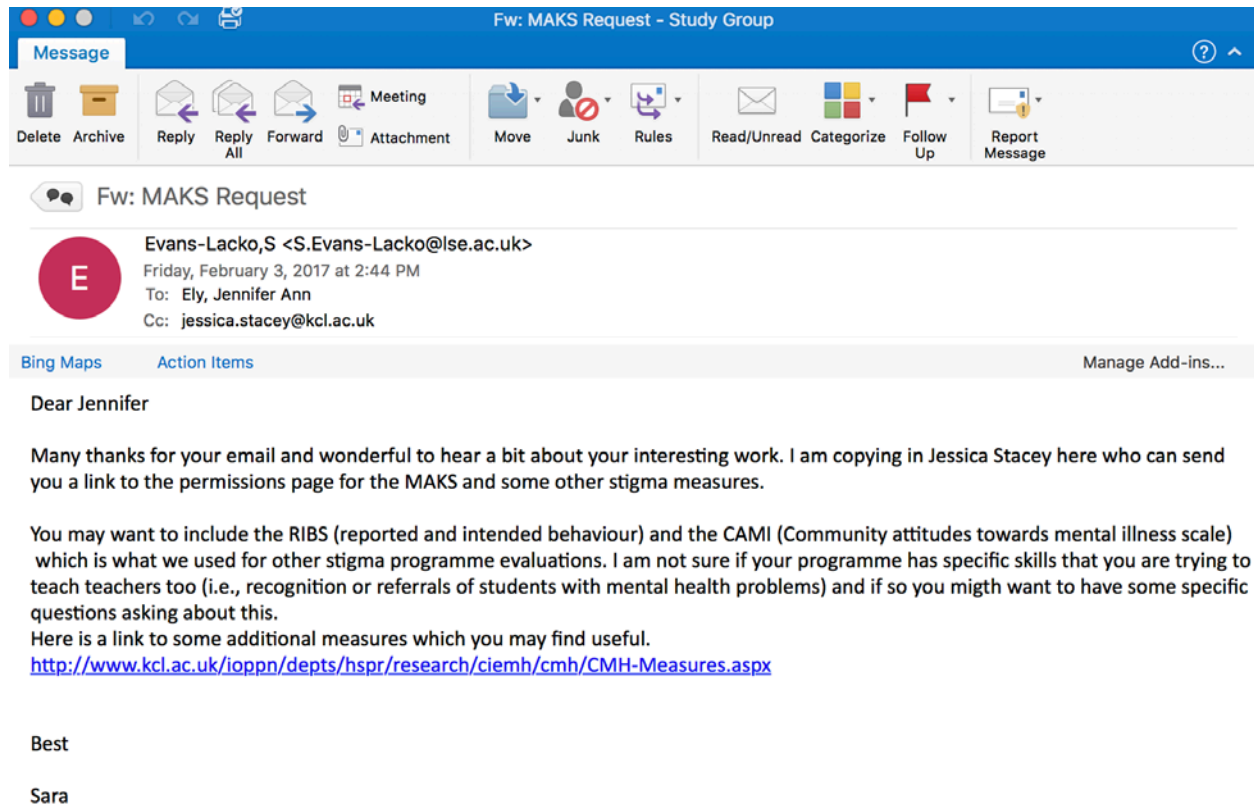
    Years

APPENDIX B

PERMISSION TO USE "NATIONAL INVENTORY OF MENTAL HEALTH

LITERACY IN YOUNG PEOPLE"

APPENDIX C

PERMISSION TO USE MENTAL HEALTH UNDERSTANDING

SCHEDULE/RBS/CAMI

Fw: MAKS Request

Evans-Lacko,S <S.Evans-Lacko@lse.ac.uk>
Friday, February 3, 2017 at 2:44 PM
To: Ely, Jennifer Ann
Cc: jessica.stacey@kcl.ac.uk

Dear Jennifer

Many thanks for your email and wonderful to hear a bit about your interesting work. I am copying in Jessica Stacey here who can send you a link to the permissions page for the MAKS and some other stigma measures.

You may want to include the RIBS (reported and intended behaviour) and the CAMI (Community attitudes towards mental illness scale) which is what we used for other stigma programme evaluations. I am not sure if your programme has specific skills that you are trying to teach teachers too (i.e., recognition or referrals of students with mental health problems) and if so you migth want to have some specific questions asking about this.
Here is a link to some additional measures which you may find useful.
http://www.kcl.ac.uk/ioppn/depts/hspr/research/ciemh/cmh/CMH-Measures.aspx

Best

Sara

APPENDIX D

PERMISSION TO USE "HELPING SCHOOLS IDENTIFY CURRENT NEEDS AND

BEST SELECT BEST PRACTICES IN SCHOOLS"
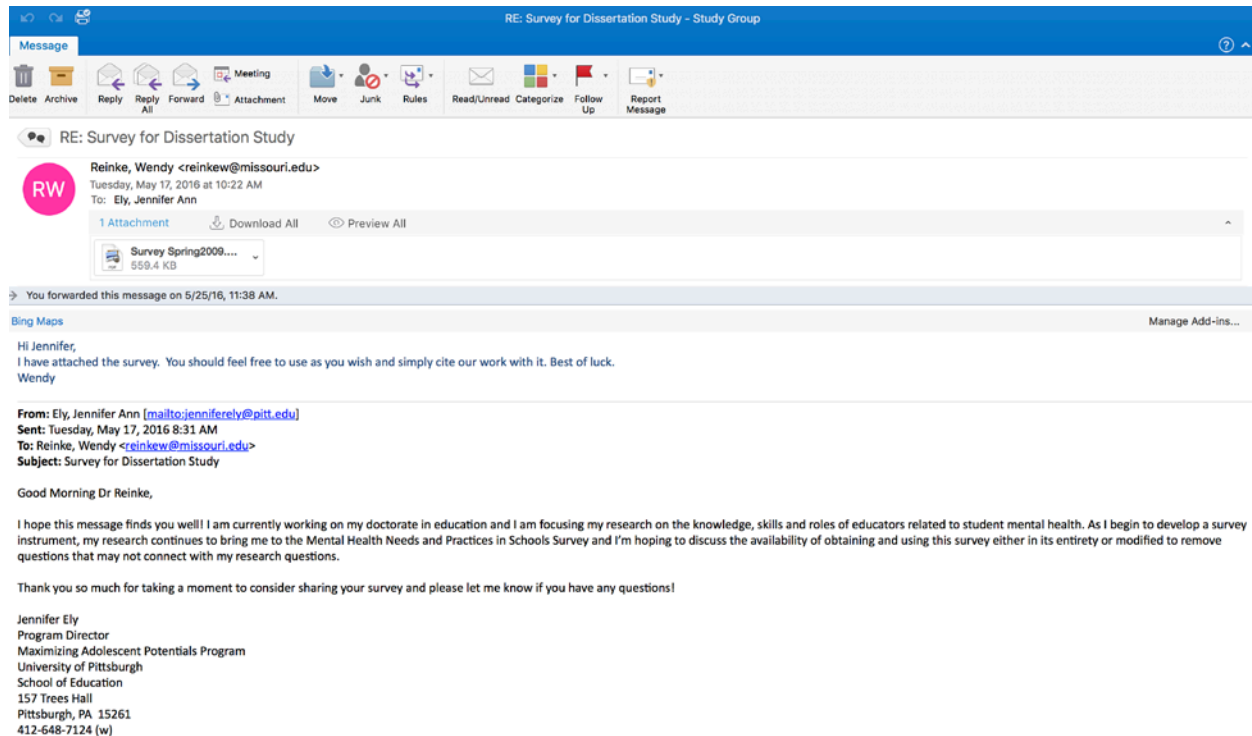
APPENDIX E

INSTITUTIONAL REVIEW BOARD EXEMPTION

Memorandum

To: Jennifer Ely
From: IRB Office
Date: 5/19/2017
IRB#:   PRO16110555
Subject: A Needs Assessment Exploring Mental Health Literacy Among Educators

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The above-referenced project has been reviewed by the Institutional Review Board. Based on the information provided, this project meets all the necessary criteria for an exemption, and is hereby designated as "exempt" under section

45 CFR 46.101(b)(2)

Please note the following information:

- Investigators should consult with the IRB whenever questions arise about whether planned changes to an exempt study might alter the exempt status. Use the "**Send Comments to IRB Staff**" link displayed on study workspace to request a review to ensure it continues to meet the exempt category.
- It is important to close your study when finished by using the "**Study Completed**" link displayed on the study workspace.
- Exempt studies will be archived after 3 years unless you choose to extend the study. If your study is archived, you can continue conducting research activities as the IRB has made the determination that your project met one of the required exempt categories. The only caveat is that no changes can be made to the application. If a change is needed, you will need to submit a NEW Exempt application.

Please be advised that your research study may be audited periodically by the University of Pittsburgh Research Conduct and Compliance Office.

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