ACCEPTANCE

This dissertation, A MIXED METHODS STUDY OF GENERAL EDUCATION TEACHERS' ATTITUDES, BELIEFS, AND KNOWLEDGE REGARDING STUDENT MENTAL HEALTH, was prepared under the direction of the candidate's Dissertation Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree of Doctor of Education in the School of Education, Concordia University Irvine.

Belinda Dunnick Karge, Ph.D.

Margaret Christmas Thomas, Ph.D., L.M.H.C., L.M.F.T.

Jessica Kwek Medrano, Ed.D.

The Dissertation Committee, the Dean, and Executive Director of the Doctor of Education Program of the School of Education, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty.

Kent Schlichtemeier, EdD
Dean

Dwight Doering, PhD
Executive Director of the Doctor of Education Program

COPYRIGHT PERMISSION AGREEMENT

Concordia University Library
1530 Concordia West
Irvine, CA 92612
www.cui.edu/library
librarian@cui.edu

I, Beth Raposa, warrant that I have the authority to act on any copyright related matters for the work, A MIXED METHODS STUDY OF GENERAL EDUCATION TEACHERS' ATTITUDES, BELIEFS, AND KNOWLEDGE REGARDING STUDENT MENTAL HEALTH in format dated December 15, 2019 to be included in the Concordia University Library repository, and as such have the right to grant permission to digitize, republish and use the said work in all media now known or hereafter devised.

I grant to the Concordia University Library the nonexclusive worldwide rights to digitize, publish, exhibit, preserve, and use the work in any way that furthers the educational, research and public service purposes of the Concordia University.

This Agreement shall be governed by and interpreted in accordance with the laws of the State of California. This Agreement expresses the complete understanding of the parties with respect to the subject matter and supersedes all prior representations and understandings.

ACCESS RESTRICTIONS
My electronic thesis or dissertation can be made accessible via the Concordia University Library repository with the following status (select one):

X Option 1: Provide open access to my electronic thesis or dissertation on the internet

□ Option 2: Place an embargo on access to my electronic thesis or dissertation for a given period from date of submission (select one):

□ 6 months □ 1 year □ 3 years

Permission Granted By:

Beth Raposa, M.A., C.A.G.S — Signature of Candidate

[redacted]

February 03, 2020

beth.raposa@eagles.cui.edu

VITA

Beth Raposa

ADDRESS [redacted]

EDUCATION

EdD	2019	Concordia University, Irvine Educational Leadership
CAGS	1998	University of Massachusetts, Boston Major: School Psychology
MA	1994	University of Rhode Island, Providence Major: Counseling and Educational Psychology
BA	1991	Northeastern University, Boston Major: English
2013		Single Subject Teaching Credential California State University, Dominguez Hills, Carson
2011		Administrative Services Credential, Tier I California State University, Dominguez Hills, Carson
1999		Pupil Personnel Services Credential University of Massachusetts, Boston

PROFESSIONAL EXPERIENCE

2016 - Present	Specialist, Special Education Norwalk La Mirada Unified School District
2000 – 2016	School Psychologist Palos Verdes Peninsula Unified School District
1994 – 1997	Social Worker Massachusetts Department of Social Services

A MIXED METHODS STUDY OF TEACHERS ATTITUDES, BELIEFS, AND KNOWLEDGE REGARDING STUDENT MENTAL HEALTH

by

Beth Raposa, M.A., C.A.G.S.

A Dissertation

Presented in Partial Fulfillment of
Requirements for the
Degree of
Doctor of Education
in
Educational Leadership
December 15, 2019

School of Education
Concordia University Irvine

ABSTRACT

This mixed methods explanatory sequential design research study will address the hypothesis that teachers want to help students with mental health issues in their classrooms, but do not have the training and knowledge to feel competent doing it. Surveys were used to compile data on teachers' attitudes and knowledge and perceived roles when working with students, as well as training and experience regarding students with mental health issues. Identifying and understanding the mental health issues that students' experience is crucial in the treatment of the whole child. The participants were 162 general education teachers from six middle schools in the same district. The participants were asked to complete a pre-test survey consisting of questions about general education teachers' feelings regarding students in their classes who have mental health issues as well as how much they know about child and adolescent mental health and the amount of instruction they received in their pre-service credential programs. The reason for collecting both qualitative and quantitative data was to assess if changes occurred after the intervention was given to the teachers from the middle school selected for the professional development. After the pre-test survey, general education teachers from one of six middle schools were given a two-session intervention in the form of a presentation outlining the components of several common mental health disorders and suggestions and strategies for what teachers can do to support these students. A post-test was conducted with just the teachers who attended both intervention sessions. Five random answers to open-ended questions on the post-test survey were analyzed and coded for common themes.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF FIGURES (continued)

LIST OF FIGURES (continued)

ACKNOWLEDGMENTS

Thank you to Concordia University for the guidance, patience and support that allowed me to bring this research to light in the field of education. It is an honor to present the findings about student mental health and its impact on educators. This experience has given me the opportunity to address an important issue in the field of education. The professors who teach in the Educational Leadership doctoral program have such a wealth of knowledge and experience and I was very inspired by their dedication to education.

I would like to thank the members of my dissertation committee. Dr. Medrano, Dr. Karge, and Dr. Christmas Thomas. They were incredible supports and resources as I went through this process. I felt their encouragement and belief in me every time I met with them to discuss my research and in the insightful feedback they provided when reading each part of my dissertation. I am so grateful to have these three brilliant women in my life as role models as I embark on the next chapter in my career. I especially want to thank Dr. Karge for her patience, support, and encouragement. Dr. Karge never stopped pushing me forward, even at times when I wanted to quit.

I would also like to thank the wonderful women in Irvine Cohort 3 who have become like family to me. Each of these amazing women supported and guided me throughout each phase of the doctoral program at Concordia. I am very grateful to have them in my life. I give a special thank you to Nnenna Okpara and Catherine Nolan who motivated and assisted me when I was nearing the end of completion. I also would like to thank my children, Zoey and Jasper Belliveau for believing that I could do this and being patient and understanding when my studies kept me from doing other things

CHAPTER 1: INTRODUCTION

Background of the Study

Some estimates indicate 13% to 20% of children younger than 18 years of age experience a mental disorder in a given year, and surveillance during 1994–2011 has shown that the prevalence of these conditions is increasing (Center for Disease Control, 2011). Often, schools are the only place where a child or adolescent can get help for their emotional issues. According to statistics collected from the National Alliance on Mental Health (2018), one in five children lives with a mental health condition. Many mental health conditions emerge during a student's adolescent years and half of these individuals experience symptoms by the age of 14. This number jumps to 75% by the age of 24. Of these, one in five youth living with a mental health condition, receive needed services. Undiagnosed, untreated or inadequately treated mental health conditions can affect a student's ability to succeed, both academically and socio-emotionally (Jensen, 2008). The National Alliance on Mental Health (2018) reports schools provide a unique opportunity to identify and treat mental health conditions by serving students where they already are. School personnel play a vital role in recognizing the early warning signs of an emerging mental health condition and in linking students with the appropriate services and supports.

Students with mental health conditions face barriers to getting the help that they need. One obstacle is a lack of training for pre-service teachers in the area of student mental health disorders (Mrachko, Kostewicz, & Martin, 2017). Students are graduating from colleges and universities without adequate instruction in student mental health disorders and classroom management (Trudgeon, 2011). Less experienced teachers may be given the hardest classes to teach. New teachers are often assigned to a teaching schedule that does not include a nonteaching

period, teaching subject matter that is not part of their credential area, or teaching classes that are less desirable or have the most behavior problems (Renard, 2003). When given these types of situations, beginning teachers can become overwhelmed and discouraged; many leave teaching after their first year. These challenging assignments leave new teachers unprepared to educate all children, especially those suffering from some form of mental illness.

With the pressure from national and state edicts to improve academic achievement, little time is spent on training and professional development on the subject of students with mental health problems. Reinke, Stormont, Herman, Puri, and Goel (2011) reported that teachers are feeling pressure to support higher levels of academic achievement but finding it difficult when they have students in their classes who need support outside of the academic realm. These students often go undiagnosed and are placed in general education classes where students with learning disabilities and behavioral issues are also in attendance. "This puts enormous pressure on teachers, who are not trained to deal with these issues and even if they were, they could not handle the magnitude of problems on any given day" (Malti & Noam, 2008, p. 19).

Statement of the Problem

Identifying and understanding the mental health issues that students experience is something that new and veteran teachers feel ill-equipped to handle. Problems arise when a student with a mental health disorder attends general education classes, and the teacher does not feel skilled enough, does not understand the condition, and does not know how the teacher can support the student with a mental health issue (Dikel, 2014). They possess a limited knowledge base, but it lacks a depth of understanding. They may be able to recognize common signs or symptoms of a mental health disorder such as inattention,

hyperactivity, persistent sadness, or oppositional behavior, they are not able to acknowledge subtleties and to what degree their students are affected. A teacher may sense that something is going on with a student but may not have the skill to address these issues (Jennings & Greenberg, 2009).

There are many evidence-based social and emotional interventions (What Works Clearinghouse) though many school districts do not adopt or utilize these programs with fidelity or at all (Reinke et al., 2011). Teachers are struggling with having the time or the training to implement these programs. They do not understand their roles regarding supporting a student with mental health needs. There is a small group of researchers that have looked at teachers' attitudes and beliefs in the area of using evidence-based practices for whole group instruction. There is limited research on different mental health disorders and how teachers can identify and respond to students who have a mental illness. Prior research has shown that though teachers were able to recognize some emotional and behavioral issues with students that the identifications were significantly less accurate in differentiating between the types of mental health disorders (Soles, Bloom, Heath, & Karagiannakis, 2008). The majority of general education teachers have not received pre-service training in their credential programs nor have they received professional development opportunities once they are hired to teach student mental health (Daniel, Gupta, & Sagar, 2013).

Often, teachers are not informed or aware of their roles and responsibilities regarding servicing students with mental health disorders. A teachers' role breadth is highly subjective and the way in which they perceive their role can determine how they will act towards a student (McAllister, Kamdar, Morrison, & Turban, 2007). Bandura researched for many years on teacher self-efficacy. In his research Bandura found that a teacher’s perceived competence will

impel whether or not they use coping skills and how long they can maintain their use of their coping skills when they are confronted with difficult situations (Bandura, 1977). Teachers do not feel they are prepared to work with a fully included students with mental health needs and require professional development and training to increase their self-efficacy (Reis & Cornell, 2008).

An experience that was shared with the researcher from a middle school teacher in an upper-middle-class district involved one of her students who had taken her life. The teacher was an experienced educator who thought she knew her students well. She was shocked and devastated when this student committed suicide. The teacher did not see any signs that the girl was feeling so hopeless. There was nothing outwardly shown that would have predicted this would happen. The student was a class leader, very compliant, and a hard worker. After the suicide, the teacher heard from school staff that the student had a diagnosis of ADHD and had been taking medication to treat the symptoms. She had been in private counseling, a fact that her parents had not shared with school personnel. She was a gifted athlete but had been sidelined by a significant injury and was not able to play softball. Her injury resulted in lots of free time afterschool. During this time, she began spending time with students who did not have the best influence on her. Her boyfriend had broken up with her the week before the suicide. This experienced teacher took her death very hard and continued to carry the burden of self-blame for not recognizing her student was in that much pain.

Purpose of the Study

Teachers working in K-12 public schools face challenges on a daily basis. These problems are varied and ever-changing. A day in the life of a teacher can start out smoothly, and just as quickly evaporate, leading to a stressful and disheartening state of mind. There are high expectations placed upon general education teachers from the district and state levels to increase their students' achievement, regardless of factors other than learning that may affect academic results (Slee, 2006). Once this research study is completed, it has the potential to educate those people who are working with students with mental health issues and create an open dialogue with teachers about mental health disorders so that they can better all students. The hope is that there is a better understanding of how teachers' attitudes, beliefs, and knowledge impact students with mental health disorders in their classrooms. Many teachers want to be able to identify and work with their students who are struggling socially and emotionally. They have not been given the tools either in their preservice teaching programs or with training and professional development opportunities at their school site. The hope is that this research study will provide teachers the tools and knowledge base they need to confidently support their students who need help.

The purpose of this research study is to gain a better understanding of how general education teachers feel about having students with mental health disorders in their classrooms. The researcher also wants to know how much preparation these teachers received during their teacher training programs and how confident they feel to identify and support these students in the general education environment. This study will examine teachers' self-efficacy and their willingness to change their beliefs and attitudes after completing professional development sessions in the area of student mental health.

Research Questions

The following research questions are addressed in this study:

1. What are teachers' attitudes and beliefs towards students in their classroom who are exhibiting symptoms of a mental health disorder?
2. What level of training on childhood and adolescent mental health issues was provided in teachers' credential programs and job site professional development?
3. What level of training on childhood and adolescent mental health issues was provided as job site professional development?
4. What do teachers perceive their roles to be in the treatment of students with mental health issues?

The researcher hypothesizes that most general education teachers want to teach and support all of the students in their classes. They empathize with their students who are struggling in the area of social-emotional functioning, but they feel ill-prepared and ill-equipped to identify students with mental health disorders and to manage the symptomology of these disorders. The researcher predicts that once these general education teachers have received professional development in the area of identifying and supporting children and adolescents in their classrooms, they will have a shift in attitudes and beliefs and be better able to understand and work with their students.

Theoretical Framework

Over the last seven years, the number of students with emotional and social disorders has increased (Center for Disease Control, 2011). Students with emotional disorders are placed in various settings within the public school setting including:

•Students with diagnosed mental health disorders that are in the general education setting and do not qualify for special education services, but still may be affected at times by their mental health condition in school during their K-12 experience. (17%)

•Students may not qualify because their mental health disorder was never severe enough to significantly affect their education, but it still may affect their classroom performance over the course of the K-12 experience through anxiety, depression, mood disorders etc.

•Students who have undiagnosed mental health issues that would qualify for special education services go undiagnosed and unplaced and receive their education in a general education setting.

•Students who move frequently or did not show symptoms during their initial placement in elementary school, may not have access to medical services to receive treatment.

•Students who qualify for special education but may not have received a mental health diagnosis.

•School may have placed student in special education but the student's family has been unable to access mental health care 1%.

•Students who have received a mental health diagnosis and qualify for special education.

•Student has qualified for special education placement and has accessed mental health.

McCray and McHatton (2011) wrote that there is a continuing trend toward moving students with disabilities out of special education classes with the end goal of full inclusion. These students may have specific learning disabilities, communication disorders, cognitive deficiencies, or emotional disturbances. Wasburn-Moses (2005) discussed the Study of Personal Needs in Special Education; a survey of educators found that 96% of general education teachers indicated they have taught or are currently teaching students with varying disabilities.

Educators are spending all or part of their days with students struggling with a range of mental health disorders. These teachers can be advocates for their students regarding acquiring

services and support for them. With 17% of students with a diagnosable disorder and 1% in an emotional disturbance placement with varying levels of LRE in between, educators are in placed in positions to recognize the signs and symptoms of student mental health issues. Having the ability to identify these students who struggle with social and emotional problems allows them to bolster opportunities for the education of the whole child as they grow and develop.

This research topic was selected because of the statistical data reported in the above paragraph showing significant increases in the presence of students with a range of psychiatric or behavioral issues whom public school staff is responsible for educating using the same academic standards as typically developing students in the district. Secondary level teachers, more so than primary level teachers, have the majority of the mentally ill student population as students due to the age of onset of most mental health disorders. Understanding the needs of general education teachers in their knowledge of student mental health and providing professional development opportunities on the topic of student mental health. They also need to define their roles as gatekeepers in charge of children with psychiatric and behavioral issues and gain a better understanding of how they feel and what they believe about these students in their general education classes. From the information garnered from this research study, it is hoped that there will be a better understanding of what teachers need to learn to be comfortable and confident in their ability to differentiate instruction and will provide insights into how we train and support current teachers and those working to become teachers.

To establish a school and classroom system for students who are experiencing social and emotional challenges, general education teachers need to have the knowledge, training, and experience to adequately support these students in the regular education setting (Killoran, Woronko, & Zaretsky, 2014). For the most part, teachers have been found to endorse the

involvement of schools in addressing the mental health needs of students and recognize that as educators they must care for and support the psychological well-being and concerns of their students (Stormont & Reinke, 2014). Though the vast majority of teachers share common goals for their students, in theory, their perceived efficacy in their ability to support mentally ill students can have an impact on how they act and react when faced with issues related to the mental illness. Perceived self-efficacy refers to how a person feels about their ability to carry out a particular type of behavior (Bandura, 1977: Mazzer & Rickwood, 2015). It is hypothesized that if some teachers do not feel confident or comfortable with something for which they have had no exposure, they will resist; either passively or not, or become anxious due to lack of understanding.

Tschannen-Moran and Hoy (2001) defined a teacher's self-efficacy as "a teacher's judgment of his or her capabilities to bring about desired outcomes of student engagement and learning, even among those students who may be difficult or unmotivated" (p. 783). Bandura's (1997) research on self-efficacy for teaching led to the belief that teachers with high efficacy can teach any student, even the most challenging ones. Teachers with low efficacy feel that if the student is unmotivated or resistant to engaging in class, then there is nothing that they can do to get their students involved in their learning. This belief is an essential factor in predicting student outcome. Tshannen-Moran, Hoy and Hoy (1998) found that teachers with high efficacy invest in the idea that all students can learn. These teachers are more persistent and spend more time despite the barriers they face when they have students in their classes who challenge their pedagogy (Yost, 2006). These teachers are more likely to try new strategies by researching and consulting with other teachers or student support staff. They do not give up after trying

something new; they keep exposing their difficult students to different methods with the hope that one approach will be successful.

Various studies completed on teacher efficacy have primarily focused on an academic subject rather than a student. Petersen and Treagust (2014), Tosun (2000), and Buss (2010) looked at primary teachers' efficacy towards science instruction. The resulted concluding that teachers teach science less than any other subject due to lack of confidence in their skills and negative beliefs about teaching science. In their research, Appleton and Kindt (2002) found that preservice teachers who graduated with higher self-efficacy had better results as teachers of science at the primary grade level. Due to these findings, Avery and Meyer (2012), and Liang and Richardson (2009) looked at how to improve teacher's self-efficacy in teaching science. The consensus of their studies was that if preservice teachers were required to take science methods classes (i.e., courses that teach teachers how to teach science) and received internship experience in which they practiced teaching science lessons, then had a better likelihood of higher self-efficacy than those who did not.

Bandura (1997) proposed four factors that he found may change teacher efficacy. These four elements are enactive mastery experiences (authentic experiences where a teacher can demonstrate success in a task), vicarious experiences (success is modeled by another person), verbal persuasion (when significant others have confidence that the new teacher will be successful), and physiological/affective states (the level of one's coping skills when tired and stressed). All of the above research has led to the conclusion that by allowing teachers to practice with the help of an expert, have things modeled for them by an expert, have positive feedback from an expert, and have positive coping skills when faced with obstacles such as stress and fatigue.

Bandura and his predecessors' findings guided this research study with the idea that if teachers face a challenge in which they had not had any experience or were not successful when they once tried, then they will not want to attempt it again. The majority of teachers want all students to succeed, not just the well-behaved, hard-working, and intelligent students. Unfortunately, human nature tries to protect one from feelings of failure and rejection which makes it difficult to attempt the unknown. A teacher can have positive effects on a student with mental health challenges. Teachers need support and guidance from someone who has been successful, received professional development opportunities to enhance their background knowledge in child and adolescent mental health, and can practice different instructional methods with the support and understanding of others.

Significance of the Study

Given the increase in the number of children and adolescents who have mental health issues there is a need for education and strategies for teachers to provide support and find help for their students in crisis. In June 2017, Congress passed the Mental Health in Schools Act with the focus on comprehensive mental health programs and staff development for school and community service personnel working in schools.

One of the reasons this study is critical is that in addition to the increase in student mental health issues, many students do not have access to mental health services outside of the school environment. School mental health may be the only opportunity for these students to have access to treatment. Poverty, homelessness, and family dysfunction are barriers to getting care (Owens et al., 2002). Training teachers to better understand the causes and symptoms of a range of mental illnesses, and the strategies to work with these students is crucial. Training teachers will

also create new knowledge so that teachers can build empathy and compassion for students and view them in a different light. Anxiety about having a student with mental illness can be alleviated once the teacher understands various mental health conditions and how they manifest in their students.

Definition of Terms

The following terms were used in this study and are defined below. Many of these terms are used in education and will thus be familiar to the audience of this paper, but it is essential to clarify the terms used in this dissertation.

Special Education: The practice of instructing students with special educational needs in a way that addresses their individual differences and needs.

Individual Education Program (IEP): A written education plan designed to meet the unique needs of a student who is disabled.

Behavior: One's verbal and physical responses, the ways that one acts and conducts themselves.

Behavioral: The scientific approach to dealing with assessment and intervention.

Mental Health: An individual's psychological and emotional state.

Mental Health Issues/needs: Any psychological, social, emotional, or behavioral problem that interferes with the student's ability to function.

Mental Illness: Mental illness is a condition that impairs an individual's emotional state. Their thought processes, feelings, and behaviors are altered to varying degrees.

Childhood Mental Disorder: Serious changes in the way children typically learn, behave, or handle their emotions which cause distress and problems getting through the day. Symptoms

usually start in early childhood, although some of the disorders may develop throughout the teenage years. The diagnosis is often made in the school years and sometimes earlier. However, some children with a mental disorder may not be recognized or diagnosed as having one (CDC, 2013).

Learning Disability: A developmental disorder that begins by school-age, although it includes reading, writing, and math (American Psychiatric Association, 2013).

Mental Health Intervention/Practice: Any support or service provided to students who are at risk for or are identified as having psychological, social, emotional, and behavior problems, or to prevent these issues.

School Mental Health Services: School mental health services promote the psychological health of all students, providing protective support to students at risk and supporting educational environments that allow students to cope with challenges and problems (Williams, White, & Sinko, 2010).

Stigma: A significant barrier to seeking mental health services in schools as students are afraid of the stigma associated with mental health problems.

The System of Care: Students in need of the most intensive therapeutic interventions may require a system of care where all stakeholders working with the student develop a coordinated process of maintaining open and regular lines of communication.

Emotional Disturbance (ED): One of the 13 eligibility categories where a student can qualify for special education services if he or she meets the California Education Code eligibility criteria. Emotional Disturbance means a condition exhibiting one or more of the following characteristics, over a long period and to a marked degree, that adversely affects educational performance: (A) An inability to learn which cannot be explained by intellectual, sensory, or

health factors; (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (C) Inappropriate types of behavior or feeling under normal circumstances; (D) A general pervasive mood of unhappiness or depression; or (E) A tendency to develop physical symptoms or fears associated with personal or school problems. ED includes schizophrenia. The term does not apply to children who are socially maladjusted unless determined that they have an emotional disturbance. (California Department of Education, 34 CFR Sec. 300.8(c)(4)).

Eligibility: Is based on a comprehensive evaluation system for students that have a disability. The eligibility determines what special education and related services.

Evidence-Based Interventions: Treatment approaches, interventions, and services, which have been systematically researched and shown to make a positive difference in children (Association for Children's Mental Health, 2004).

Full Inclusion: Students with special education needs attend the general education program, enrolled in age-appropriate classes 100 % of the school day. Types of special education needs vary but may include learning disabilities, cognitive deficiencies, communication disorders, or emotional disturbance.

Nonpublic school: A private, nonsectarian and certified by the state of California to provide special education services to students that have IEPs and are struggling academically, behaviorally and socially.

Behavior Intervention Plan (BIP): A behavior plan that is designed to teach and reward positive behaviors. The behavior plan can help prevent or stop problem behaviors in school.

Individuals with Disabilities Education Act (IDEA): A federally mandated law guaranteeing that appropriate services are provided to students who are disabled.

Clinical Disorder: A specific DSM-5 diagnostic category of abnormal thinking, emotion, or behavior that is beyond the realm of reasonable functioning and causes significant dysfunction for the affected individual.

Emotion: Refers to feelings that are distinguished from cognitive states of mind. The existence of emotions would not be considered clinical unless the feelings were a manifestation of a psychiatric disorder.

Counseling: A supportive service, assisting a student in succeeding in the school Environment.

Therapy: The actual treatment of a mental health disorder, e.g., providing psychotherapy to treat Major Depression.

Skills Training: Teaches specific skills that can be mastered and practiced (e.g., social skills, organizational skills, daily living skills, etc.).

Limitations of the Study

There are limitations to this research study that the researcher includes to avoid misrepresentation of the findings. Results may be skewed due to self-selection bias, meaning that teachers who chose to participate may have held different perceptions than those who decided not to participate. A variable that can impact my research findings is that the school district which joined in the study is comprised of two geographical areas in Southern California. Socio-economic differences between the two cities may have altered teacher's perceptions of what constitutes a mental health or behavioral issue. Four classrooms are a part of the entire K-8 district classrooms that are specifically designed to provide a therapeutic school environment for students with social/emotional problems. General education teachers who teach at these two

schools (one elementary, one middle) may have different attitudes and beliefs about students with mental health needs given their exposure to significantly mentally impaired children and their observed behaviors.

The school district that services these two cities has low to middle-class families living in one city and the other has middle to upper-class families. This sample of teachers is not representative of the entire state population as the state of California has a range of socioeconomic levels starting with families living at the poverty level to families who are very wealthy. A major determinant of outcomes for children, youth, and their families who live in poverty are disproportionately affected by mental health challenges, which effects the ability of children and adolescents to succeed in school and places them at risk of involvement with child welfare and juvenile justice agencies (National Center for Children in Poverty, 2014).

It is possible that participants and nonparticipants were emotionally triggered by the survey questions due to their own negative or even traumatic experiences in the past involving depression, anxiety, or other mental disorders.

Delimitations

The delimitations applied to this research study are to use only general education teachers in grades K-8. Although there is research on general education and special education teachers' attitudes, beliefs, and knowledge of childrens' mental health, only general education teachers completed the survey as they typically receive little or no training in child behavior and social/emotional issues in their preservice program. High school teachers did not participate in the survey as mental health issues/needs of high school students can be very different than ones of younger students. Because of their experience with these various mental health issues,

teachers in elementary and middle school may view children with mental illness differently than high school teachers.

Another delimitation of this research study exists in the researcher's use of only one school district. One school district does not address the possibility that teachers may have had exposure to more professional development training opportunities and have a more substantial number of support staff members working at the school based on the funding the district receives.

Assumptions

Most teachers want to improve their effectiveness with their students with mental health issues. Given the research, we can assume that teachers have little to no knowledge of evidence-based programs and practices for students with mental, emotional and behavioral needs. Stormont et al., (2011) wrote, “we expected that teachers would have limited knowledge of these resources within their school to support children with emotional and behavioral needs (p. 140). Most elementary and middle school teachers need guidance and training when dealing with mentally ill students.

Organization of the Study

This research study is presented in five chapters. Chapter 1 includes the background of the study, statement of the problem, the purpose of the study, definition of terms, theoretical framework, research questions, limitations, delimitations, and the assumptions of the study.

Chapter 2 presents a review of the literature, which includes historical background of charter schools, the role of administrator, inclusion practices, mainstreaming efficacy and charter

school inclusion practices. Chapter 3 describes the methodology used in this research study. It includes the selection of participants, instrumentation, data collection and data analysis procedures.

Chapter 4 presents the study's findings including demographic information, testing the research questions, confirmatory factor analysis and results of the data analyzes for the three research questions. Chapter 5 provides a summary of the entire study, discussion of the findings, implications of the findings for theory and practice, recommendations for further research, and conclusions.

CHAPTER 2: REVIEW OF LITERATURE

This review of literature is to examine the history, methods, and effects of mental health disorders in the field of education. Chapter 1 presented four research questions and terms that better clarify the current research in mental health. Chapter 2 explores a detailed look at the history of special education and inclusion. This chapter includes a discussion of teachers' attitudes, need for professional development, and roles and responsibilities to children and adolescents experiencing mental health disorders. The review identifies particular types of mental disorders prominent in current research. Chapter 2 also examines students with mental health issues and their ability to access the curriculum and the specific components that make up the learning profile of these children and adolescents. Finally, the review provides an in-depth look at the strategies and interventions that may be helpful to teachers in the educational setting.

History of Special Education

The inclusion of students with disabilities within the general education setting has seen significant changes over the last century. Educators at the turn of the century believed that children with disabilities could not be educated. They stayed at home while their siblings and other children attended school (Reynolds, 1989). According to information gathered from the Minnesota Governor's Council on Developmental Disabilities (2007), children with disabilities were warehoused into residential facilities and institutions under the guise of special education. any of these children remained institutionalized for the remainder of their lives.

A nationwide public school system was created in 1918 though it did not include educating children with disabilities. Innovative educators and children's rights advocates formulated the idea of training individuals to specifically teach children with disabilities. Parents,

dissatisfied with the marginalization of their children by the public school system, created schools and pushed the inclusion movement along through the 1950s (Yell, Rogers, & Rogers, 1998). In 1954, the Supreme Court in the case of Brown v. Board of Education ruled that public schools could not any longer segregate students by race. Unfortunately, this ruling did not include desegregation by disability. As a response to the Brown case, parents created a movement that led to legislation in support of educational and job training for special education students. Despite this, only one in five children could go to school due mainly to inadequate teacher training and a lack of disability awareness.

The Rehabilitation Act of 1973 and its amendments of 1986 and 1992, made it against the law to ban children from an education at any federally funded school (Crespi, 1990). Public Law 94-142, the Handicapped Child Act was passed to ensure children received a free and appropriate public education (FAPE) in the least restrictive environment. In 1990 the legislation was re-authorized, and the name change was put forth to focus on the person first, and secondary the disability. It was renamed the Individuals with Disabilities Education Act (IDEA) (Martin, Martin & Terman, 1996). IDEA was last reauthorized in 2004, and its primary focus is keeping students in general education and onto post-secondary plans (Yell, Shriner, & Katsiyannis, 2006). One of the significant changes included in the reauthorization of IDEA 2004 was adding parental responsibility. Parents and students are responsible for many new obligations, communicating to them they are directly accountable for their actions (Turnbull, 2005). IDEA 2004 provides guidelines for ensuring FAPE, but there is variability among how schools use these instructions. Some school cultures have more positive attitudes towards students with disabilities than others (Idol, 2006). There is hope that more schools will follow the guidelines of

IDEA 2004 if the school site staff learns why students with disabilities deserve the same educational experience as typically developing students.

Under the current educational system, students with disabilities are placed into two groups: (a) those with individualized education plans (IEPs), who are eligible under both the Individuals with Disabilities Education Act and Section 504, and (b) those with 504 plans, who qualify under Section 504 only (Zirkel & Weathers, 2015). The IEP makes it possible for children with a disability to get equal access to the same education as their typical peers. This legal educational document allows for modifications and accommodations to be made to adjust to the individual student needs (Zirkel, 2012). The accommodations may include elements such as allowing extra time for class assignments, student pull outs for specific subjects, and student instruction in a separate environment where their learning needs may be met. Needs of the students must be specific and have adverse effects on their overall educational performance. The students with IEPs qualify and become eligible for special education programs after meeting the following three steps. The first step is evaluation and identification of the student with an educational need. It is essential to ascertain that the student meets the criteria to be designated as a student with a unique need that is covered under the IEP. Under the IDEA, the law requires that students who qualify as having unique and specialized educational must be eligible under 13 conditions. The conditions including specific learning disabilities (SLD), other health impairments (OHI), emotional disturbance (ED), speech or language impairment, visual impairment including blindness, deafness, hearing impairment, deaf-blindness, orthopedic impairment, traumatic brain injury, and multiple disabilities (Cortiella & Horowitz, 2014).

It is important to note that having a disability does not immediately qualify a student for special education services. Instead, in addition to the classification of the disability, the student's

educational performance must also be negatively affected due to the limitation. Once evaluation and identification have been determined, the next step for the eligibility process for an IEP is that specific goals are made to monitor student's short and long-term progress. The third and final step is the determination of the student's placement, and this is a crucial stage in this process. With students entitled under FAPE, placement must be the least restrictive environment. The makeup of the IEP team should include the following participants: parents/guardians, student (if age appropriate) special and general education teachers, administrators, and any other specialized service providers. These team members make decisions about the most appropriate specific placement option, setting or facility for the student. The placement is determined on the best setting where IEP goals and objectives can be achieved. Bartlett, Weisenstein, and Etscheidt (2002) suggested that student placement is a controversial issue, which has been the subject of many due process hearing and court cases. Due to the importance of appropriate placement, the IDEA includes three additional procedural provisions that must be followed during a placement decision. These requirements indicate that placement decisions are essential. The first procedural provision is that parents/guardian must give informed consent for their student to be placed in special education. Next, parents must receive prior written notice for each subsequent proposal to change student placement. Lastly, parents may challenge recommendations for placement change in due process or mediation hearings.

Section 504, on the other hand, is a nondiscrimination provision that was included in the Rehabilitation Act of 1973 (Huefner, 2000; Yell et al., 1998). Section 504 extends protections from discrimination to all persons with disabilities in any agency that receives federal funding. Because virtually every public school and many private schools, in the United States, are given federal funding, they are subject to the rules and requirements of Section 504. Those schools

cannot discriminate against students with disabilities. Discrimination against a student with a disability is characterized by the student not being allowed equal access and benefits from the public educational programs and facilities. Section 504 eligibility is broader than an IEP as it includes students with disabilities outside of the 13 eligibility categories of IDEA. Section 504 plans are used for short-term disabilities requiring accommodations such as the use of the school elevator for a student with a broken leg or long-term for a student with a medical diagnosis that is ongoing such as ADHD. Therefore, students in the public school with a disability are protected under Section 504 even if they are not protected by the IDEA. Section 504 covers students with disabilities protected by the IDEA. The decision for a Section 504 agreement includes less detail than the IDEA. To meet the criteria for a Section 504, students need to meet the following three criteria (a) any physical or mental impairment (without a restricted list) that (b) substantially limits (c) one or more major life activities (with specific examples that extend beyond learning, such as walking or breathing) (Zirkel, 2012).

According to a report by the Center for Mental Health at UCLA by Taylor and Adelman (2004) school policymakers have a "lengthy (albeit somewhat reluctant) history of trying to assist teachers in dealing with problems that interfere with schooling" (p. i). In the middle of the 20th century, the National Institute for Mental Health expanded its attention on mental health in educational institutions by putting out a treatise on the subject. Since then, educators have attempted to create programs and initiatives to support students with social and emotional issues in school. Over the past 20 years, there has been an increase in the efforts to connect schools with community service agencies. As stated in the Taylor and Adelman (2004) UCLA report, this collaboration of school-linked service providers has expanded interest in "social-emotional learning and protective factors as ways to increase students' assets and resiliency and reduce risk

factors" (p. i). In the mid-1990s, the U.S. Department of Health and Human Services created the *Mental Health in Schools Program*. This program was developed so that policymakers, mental health experts, and educators can improve how schools respond to student mental health. The year 1995 brought about the establishment of two national centers; one at UCLA and one at the University of Baltimore to research ways to support educators and families of students with mental health disorders.

The majority of K-12 public schools in the United States have student services procedures that address at-risk students such as drop-out prevention, drug and alcohol use, and attendance issues (Carswell, Hanlon, O'Grady, Watts, & Pothong, 2009). Unfortunately, there are not enough resources to help with the increasing number of children and adolescents with mental health and social and emotional issues. If the school does have a program to address these issues, there is often too many students in need of help in comparison to the number of support personnel employed at the school (Malti & Noam, 2008). These programs are also usually the first thing to dismantle when budget cuts are needed. The UCLA report (2004) includes a description of how student support services and school health initiatives are not seen as a top concern in the ranking of school-based services. There is focused attention on keeping these initiatives going when a tragic event, such as a school shooting, happens. Unfortunately, the momentum to prioritize these programs is not sustainable as soon as the public outcry towards the event dissipates (Walker, 2004).

Barriers to Inclusion for Students with Disabilities

According to information located on the United States Department of Education Office of Special Education and Rehabilitation Services website, there have been significant changes in

inclusion over the past 25 years. There have been significant changes as awareness of students with disabilities has increased. The idea of inclusion has moved from little attention to laws and programs required by the federal government. The Individualized Education Programs (IEPs) and Section 504 plans are key tools for providing accommodations in the American educational system (Scanlon & Baker, 2010).

Researchers Summey and Strahan (1997), Bucalos and Lingo (2005), and Boling (2007) have all argued that a main barrier to inclusion is that many general education teachers are not equipped to instruct students with disabilities. In their 1997 study, Summey and Strahan describe marginalized students with special needs as only "superficially engaged in academic tasks because they have depended on others for help." Similarly, Bucalos and Lingo (2005) write, "some teachers remain philosophically opposed to making accommodations in the general education classroom for students with disabilities because they believe students need to learn to cope with academic demands" (p. 2). More recently Boling has added to the conversation by determining that teachers graduate without this knowledge and training, which may cause anxiety about their abilities to teach students with a range of disabilities (Boling, 2007).

With the advent of the Common Core curriculum, students are expected to use higher-order thinking and problem-solving skills. Many general education teachers feel unprepared to have students with disabilities in their class. A lot of this stems from the lack of special education instruction in teacher training programs.

Students with mental health disorders are not defined solely by their diagnosis. The student lives with the disorder, but it does make it all encompassing to the student. Dikel, (2004) writes that it is appropriate for a teacher to view his student as an "individual who has a mental health disorder, rather than being a mentally ill person" (p.125). One of the indicators for

successful inclusion programming is the teachers' "perceptions of their skills in making instructional and curricular modifications, as well as their skills in student discipline and classroom management" (Idol, 2006). For inclusion to work for a teacher who has a student with a mental health disorder, whether receiving special education or not, a teacher needs to be able to find qualities unrelated to the mental health condition that she can connect with and build a relationship with the student.

Teacher Attitudes Towards Students with Social and Emotional Issues

School professionals need to be prepared to support children with emotional and behavioral problems (Stormont, Reinke, & Herman, 2011). It is vital that teachers are given resources that are evidence-based to help support their students with emotional difficulties (Lambros, Culver, Angulo, & Hosmer, 2007). According to the World Health Organization (2004), there are as many as one in five at risk for or currently exhibiting mental, emotional, or behavioral problems. With such high odds, there is an increased need for those interacting with students to work to know about psychological and emotional disorders. There appears to be a gap with evidence-based treatment approaches, intervention, and services, which would undoubtedly make a positive difference in the lives of children in a school environment (Stormont et al., 2011). Knowledge of mental disorders and interventions are essential for teachers to know even if they are not the specific implementers of specific interventions. Teachers tend to be at the front line of those recommending students for supports. If they were aware of the features of the mental issues, they might be able to refer the students who need help to the correct provider who can support the student's emotional needs better. Therefore, an understanding of mental disorders can lead a teacher to make appropriate referrals which

ultimately will result in students getting adequate support by the correct service provider (Rones & Hoagwood, 2000).

Interestingly, to date, there has been limited research that has investigated the general education teachers' knowledge of evidence-based interventions and programs specifically for children with mental and behavioral needs (Stormont et al., 2011). Teachers' knowledge of data and resources used by schools to monitor the needs of children with mental, emotional and behavioral requires further examination (Stormont et al., 2011).

Weist and Evans (2005) discussed the significance of *Expanded School Mental Health (ESMH*) programs to offer supports to students with mental concerns. There is a developing body of research that ESMH can positively affect student outcomes in a variety of areas such as student discipline reduced symptoms severity and improved system capacity (Ball & Anderson-Butcher, 2014). ESMH is intrinsically linked to the social, emotional learning and achievement of students. As key players in the ESMH service delivery and student learning, teachers' perspectives are of particular importance. They are involved in the promotion of the whole child development along with the entire prevention and intervention continuum (Ball & Anderson-Butcher, 2014; Franklin, Kim, Ryan, Kelly, & Montgomery, 2012). Often, teachers are the first to identify early signs of mental and emotional difficulties in students with regards to truancy and other behavioral issues. This early identification can lead to referral and linkage to other student support interventions (Anderson-Butcher, 2006). Teachers' ability to implement student support strategies is affected by several factors such as school infrastructure, politics, and teachers' instructional capacity (Ball & Anderson-Butcher, 2014). Another factor that prevents teacher assisting student emotional needs is the perceived "burden" of mental health needs of the students in the school (Ball, 2011). Consequently, Ball believes teachers feel inexperienced and

overwhelmed by their student's mental health needs. Teacher stress as it relates to working with students with mental health may be significant especially without specific training for supporting student needs in this area.

Currently, in the United States, the prevalence of emotional and behavioral disorders among the general population of school-age children has been estimated to be between 6% and 10% (Soles et al., 2008). Burns et. al. (1995) pointed out that only 1% of students with mental health issues are receiving services for social, emotional and behavioral difficulties. He has suggested that this lack of resources creates an area where there is a significant discrepancy between the area of need and services provided to those in need of assistance. It is essential that as the educational realm progresses that a greater emphasis is placed on the combination of social, emotional, behavioral and academic difficulties with a focus on co-morbidity in a manner that recognizes the interdependence (Soles et al., 2008). It is therefore critical that teachers who are the forefront of referrals be able to adequately identify and have an understanding of the complexities of students with emotional and behavioral disorders (Soles et al., 2008). Increased knowledge in this area could serve to close the gapping service gap currently seen.

Teachers face tremendous pressure to have high achieving students in their classrooms. Given this, it often makes teaching more difficult and frustrating when there are students in the classroom who learn and behave differently than the average student (Collie, Shapka, & Perry, 2012). According to Slee (2006), when educators feel compelled to "raise student performance, disability can easily become understood as a ‘threat' in the school setting" (p. 238).

There are several barriers for teachers with regards to providing services to students with emotional and behavioral disorders. Teachers often have daily contact with students and are at the forefront of those able to observe emotional de-regularities with students. Prior research has

shown that though teachers were able to recognize some emotional and behavioral issues with students, the identifications were significantly less accurate in differentiating between the types of student issues (Soles et al., 2008). Teachers without adequate training can misidentify student needs and make an incorrect and inappropriate recommendation or lack of recommendations for intervention (Bruns, Walrath, Glass-Siegel, & Weist, 2004).

The first general issue often faced by teachers is with the broad conceptualization of psychological problems. Often, the skills need to recognize emotional and behavioral problems are undeveloped (Soles et al., 2008). While there is not a standard for the definition of these issues with students, there are some commonalities, and they include behavior extremes that fall outside the societal norms. The symptom of these behaviors often affects a student's educational functioning as it hurts them (Soles et al., 2008). While in the research of students with emotional and behavioral issues has continued in the psychological field, little research has been conducted with regards to teacher training and teacher perceptions of students with mental health issues. The research that has been done in this area, has cited that teachers have negative and stereotypic expectations of a student with mental health issues (Soles et al., 2008). Marlowe, Maycock, Palmer, and Morrison (1997) discussed that teachers often described their interactions with students with emotional and behavioral disorders as excessively negative. These negative feelings often led to helplessness on both the part of the teachers and the students. These feelings inadvertently affected student progress and hurt the students. Not to disregard teacher concerns and apprehension, students with emotional and behavioral issues do often present as conduct and oppositional, and this does create an environment that could cause a threat to their authority. This leads to teachers feeling intimidated and unqualified to address student needs. It is important to note that the teacher's perception of difficulty when supporting students with

emotional and behavioral needs has a direct correlation with the contact the students receive to help with their mental health issues. Several researchers found that teacher perception of the difficulty to address a student's mental health needs was a direct predictor of the contact that students had with providers (Soles et al., 2008). Best (2006) detailed one interviewee teacher who considered a "general lack of awareness to be accompanied by a desire not to be aware because of massive anxieties which it would raise if acknowledged" (p. 167). Best (2006) also reported that the "pressures on teachers in under-resourced schools to deal with large classes …. To see this as a "big can of worms" which would be better left unopened" (p.167).

Lack of Mental Health Training in Preservice Credentialing Programs

Among preservice teachers enrolled in a teacher credential program, some different attitudes and beliefs may influence their pedagogy once they enter into their first teaching position. Among these various perspectives that preservice teachers possess, the existing beliefs they bring into teaching, both from their own experiences and their preservice experiences, are their feelings towards inclusion and student with disabilities. Many students with mental health issues fall under a disabilities program such as IDEA. Not all students with mental health issues meet criteria for emotional disturbance as defined in IDEA. Killoran et al. (2014) write that "effective inclusive teachers hold positive attitudes towards children with disabilities, are skilled in delivering curriculum to a diverse population, and feel confident in their ability to promote inclusivity" (p. 427) in their classrooms. At variance with the above statement, is the influence an ineffective teacher brings to the classroom when they are not in support of having students with disabilities of various types, including mental health disorders, and do not have favorable

attitudes towards diverse learners. These types of teachers can have a devastating impact on their students' ability to be successful.

Preservice teachers need exposure to the principles of inclusive education while in their credential program. Killoran et al. (2014) state that the foundation of "positive, equitable, and inclusive attitudes towards the education of students with disabilities can be laid in preservice teacher-preparation programs" (p. 428).

There are three fundamental problems identified in learning to be an educator who embraces differential instruction. Darling-Hammond (2006) outlined these as new teachers must understand teaching in ways that differ from their own experience as students, new teachers must not only think like a teacher but also act as a teacher, and new teachers must learn to understand and acknowledge that their students are individuals which varying needs. For a teacher-preparation program to be successful, these fundamental concerns need to be a focus, and new teachers need to be encouraged to use instructional strategies that cultivate inclusive classroom environments. Shippen, Crites, Houchins, Ramsey, and Simon (2005), cited research from several sources indicating that preservice teachers "do not feel adequately prepared to serve students with disabilities in general education classrooms" (p. 92).

There is a misconception among many new teachers that special education teachers are equipped with various teaching strategies that only they know. The majority of special education teaching programs focus more on academic remediation and offer similar courses to general education teaching programs in the area of classroom management and child and adolescent mental health issues. New teachers cannot take a hands-off approach to working with their students who are struggling with behavioral or social-emotional problems, in the hopes that a specialist will take over the "burden" of working with these types of students. According to

Roberson, S. (2011), it is critical that preservice teachers "reconfigure their preconceptions of students and their abilities to allow them greater flexibility" for learning. (p. 900). Preservice teachers may be led to believe that every student enters their classroom with qualities that should surpass expectations and that these abilities are valid. Collaboration with special education teachers and other specialists to support struggling students and building relationships with students may be extremely beneficial.

Because many preservice programs do not train teachers to recognize symptoms of childhood mental health disorders, it can be very challenging when starting off in the classroom as a first-year teacher. Daniel et al. (2013) reported that by the year 2020, "childhood neuropsychiatric disorders will increase by more than 50% internationally to become one of the five most common causes of morbidity and disability among children" (p. 368). These researchers feel that "university-based preservice educational programs do not adequately prepare the teachers to have sufficient knowledge and skill for identifying a wide variety of symptoms related to mental health disorders among children" (p. 368). In their research, Daniel et al. found that more than half (67%) of preservice teachers surveyed reported that they were not confident in identifying a child with childhood psychological disorders. All of the preservice teachers surveyed indicated that they felt the need for having frequent in-service training on childhood psychiatric disorders.

One of the first mind shifts that needs to occur when many preservice and new teachers are in classrooms is to dispel the myth that children are bad because they misbehave. These teachers may not understand the theory that behavior is a form of communication just like any other way students communicate with teachers and peers (Solter, 1998). Killoran (2004) has wrote, it can be difficult for people to put aside personal feelings of hurt or frustration when a

child exhibits behavior deemed to be inappropriate. Before developing the mindset that these types of students are not able to learn, an educator needs to understand that children and adolescents with behavior possibly caused by a mental health disorder are trying to communicate their wants, needs, and frustrations, but their emotional dysregulation keeps them from doing this in a socially acceptable way.

As more and more children and adolescents are identified as having a mental health disorder, the need for teacher credentialing programs to prepare these new educators for a time when they have a student with social and emotional issues in their class. Trudgen and Lawn (2011) have felt that "education bodies and teaching universities responsible for training teachers and providing ongoing professional learning need to ensure that mental health training is part of every teacher's core skill set" (p. 140). Teacher training will help teachers confidently discuss and educate their students on emotional well-being, identify signs and symptoms of a burgeoning psychiatric disorder, and collaborate with school site support staff and parents to ensure the student is referred for services that meet their unique needs.

Educators Roles and Responsibilities

Although schools are not mental health treatment facilities and teachers are not mental health clinicians, they are continually tasked with addressing the needs of their students' mental health issues. In his work with school districts across the United States, Dikel (2014), has experienced a need for mental health plans that outline necessary procedural steps and an accountability process so that assumptions about who is responsible for what is defined. Dikel wrote that the existence of these plans will significantly ensure student success in their educational placement. For example, when there is not a procedure in place for who the person

responsible for getting a release of information to speak with a student's mental health doctor, valuable information such as how a student is behaving on newly prescribed medication, does not happen. A teacher may assume that is the role of the school psychologist, but if the school psychologist was not at the school site team meeting to discuss this student, how would they know a release is needed? Defined roles and responsibilities are critical so that the student's odds of success are in their favor.

When defining school staff roles and responsibilities, every school site will be different as the make-up of their staff differs from school to school or district to district. Behaviorists, school psychologists, and school counselors specialize in supporting students with mental health issues. They are necessary people who should be a part of the school's mental health team. It would be highly beneficial if all teachers were given clear and concise information at the start of each school year in terms of who the mental health support staff is, what are their roles, and when should a teacher consult with them when they feel a student is in need of mental health support (Dikel, 2014). There can be no room for assumptions on who does what, it needs to be defined with little room for misinterpretation.

Many teachers, especially with low self-efficacy when it concerns student mental health issues are uncertain when they should contact administrators and support staff and when they are expected to handle the situation within their classroom environment. Teachers perceived role breadth refers to whether a teacher regards particular behaviors as part of their job (McAllister et al., 2007). The amount of involvement a teacher wishes to engage in is based on individual preference and comfort. The way teachers perceive their role can determine how they will act towards the student and how much they will involve themselves in the process of supporting the student with a mental health disorder. Kidger, Araya, Donovan, and Gunnell (2012) reported

that teachers were happy with their defined role when it came to identification and support of students with mental health issues. In a research study of over 500 teachers, Graham, Phelps, Maddison, and Fitzgerald (2011) found that most teachers felt they are a pivotal part of a student's social and emotional well-being. Most of them reported dedication to learning via professional development opportunities if they were allowed the time off from the classroom to do so. Graham et al. (2011) found that less than 2% expressed feeling that a student's social and emotional well-behaving was not part of their job duties and felt burdened when asked to support these students.

Mazzer and Rickwood (2015) conducted a research study to look at teachers perceived role breadth and efficacy assisting in the area of student mental health. Results of the study performed using 21 Australian teachers as participants revealed that teachers felt supporting student mental health as a part of their job duties though acknowledged a lack of knowledge and skills in the area of student mental health. These teachers' responses indicated they are frequently involved with identifying students' mental health issues and that they felt responsible for educating all students in the area of mental health and providing a trusting and safe environment for their students. The teachers also expressed barriers to supporting their students with mental health issues due to lack of time, ever increased focus on academic performance and large class sizes. One of the teachers interviewed shared:

> I think it is hard, especially if it is a lot of kids with a lot of problems. You still have all of that stuff you need to get through within a day, and then you are supposed to fit in other things that are for their wellbeing (p. 7).

Another teacher shared:

> There is also the confidentiality issue, where if a student really doesn't want me to

> pass that information on, unless it is something to do with mandatory reporting, I won't. I will respect their wished. And that's where it does get a little bit tricky sometimes to make sure they get help (p. 7).

Though the majority of teachers feel that they should have a role on a student's mental health team, some may think that they were required to do something in which they did not feel qualified. Expecting a teacher to perform specific acts in which they have not been trained or are not confident in their skills, can lead to active resistance mitigated by anxiety and fear. Askel-Williams and Lawson (2013) reported that if teachers feel uncertain about their knowledge in the field of social-emotional education, then their situation could well be like that of any teacher asked to teach a subject area in which they have not been trained.

Need for Professional Development

In the majority of school districts, the focus of professional development has been in the area of curriculum and instruction. As more and more teachers are being expected to support fully included students in their classes with mental health issues, it seems apparent that teachers need to have exposure to professional development opportunities where they can increase their knowledge in the area of child and adolescent mental health disorders. In a study of teachers' knowledge and confidence in the area of mental health, only one-third to one-half of teachers surveyed indicated that their knowledge and confidence in the area of student mental health was of high quality (Askel-Williams & Lawson, 2013). Askel-Williams and Lawson (2013) provided 37 teachers with professional development using the KidsMatter program. Dix, Slee, Lawson, and Keeves (2012) describe the KidsMatter program as a mental health initiative that promotes mental health education for students and mental health training for staff. A growing body of

evidence indicates that school-based mental health programs is advantageous for universal, targeted, and indicated initiatives, and can have positive effects on students' social and emotional skills (Durlack, Weissberg, Dymnicki, Taylor, & Schellinger (2011). According to Wastell and Shaw (1999), other studies reviewed suggest that teachers felt more prepared and self-confident after receiving training or in-service opportunities. Reis and Cornell (2008) conducted research comparing teachers and counselors on measures of their understanding of suicide and suicide prevention after they completed statewide training in the subject matter. The counselors and teachers completed a follow-up survey five months after the training. The results showed that the teachers and counselors demonstrated a greater understanding of suicide risk factors than did a control group of teachers who did not receive the training. Those trained also reported an increased feeling of confidence in working with suicidal students.

In another study, Wyman, Inman, Brown, Cross, and Schmeek-Cone (2008) performed a group-based randomized trial study with 32 schools that looked at the impact of professional development on a stratified random sample of 249 teachers a year after the training. The results indicated that the professional development increased self-reported knowledge and feelings of improved self-efficacy. The most substantial increase was found in the teachers who had the weakest understanding of student mental health before the training.

Research has shown that when teachers feel confident and have strong self-efficacy, they feel more capable being responsible for their students' well-being. A school has a duty of in loco parentis. In loco parentis is a legal term which refers to the responsibility that an adult or school assumes toward a student enrolled in that school, of whom they are not a parent to that student, but to whom the adult or school remains obligated to provide care and supervision (Hannon, Wood, & Bazalgette, 2010). Districts and school personnel can be held legally responsible if

they fail to act on a student in need of help such as a student who is possibly suicidal (Milsom, 2002). Milsom (2002) looked at court cases where teachers who had not had training or education in psychiatric or medical fields were not held liable for not recognizing a student has a mental health disorder. Despite this, in these types of cases, though the staff member was not held responsible, the school district was found negligent because they failed to train their staff in recognizing student mental health issues. It is vital that school districts do not make assumptions that their teachers, through their preservice credential programs, understand how to recognize and support students with mental health needs, as research has shown teachers get very little or no training in this area. At-risk students could be identified if staff members were well-trained and could make the proper referrals to get the students help.

Professional development and training in the area of student mental health are critical in improving the odds that mentally ill students can be successful despite their challenges. Boling (2007) conducted a study on how one teacher's understanding of full inclusion for special needs students changed after exposure to specialized training. The research led to the conclusion that these teachers experiences before training "highlighted how insecurities about teaching could be intertwined with a lack of knowledge of the pedagogical approaches that support inclusive learning environments" (p. 228).

In a research study conducted by Graham et al. (2011), 508 teachers completed surveys with the majority of teacher responses (31%) coming from teachers who had been teaching for between 21 and 30 years. Results of the study that looked at teachers views on supporting children's mental health in schools indicated that 44% of the teachers surveyed believed that mental health training is critical and 45% of the teachers viewed mental health education as very important. On the opposing side, 11% of teachers felt their schools saw mental health training as

of little importance. Also, 25% of the teachers were not aware that their school had any mental health initiatives and 30% felt that counseling at school for children was very difficult to access. Teachers responses also indicated that only 22% of teachers felt very confident in dealing with significant mental health issues in their classroom (ex. A student experiencing depression). Many teachers expressed the importance of the need for additional support and training as well as better resources to help students experiencing mental health issues. They reported that they needed instruction, for example in the ability to recognize the signs and symptoms of mental health problems. One of the respondents who reported feeling confused and frustrated regarding supporting a student in her class with a mental health disorder commented "I deal with this every day (depression, anger, withdrawal, relationship problems). I am unsure how to deal with it. I become concerned that I am underacting, overreacting, or not supporting the issues correctly. I have sought to improve my skills, but training is expensive and nearly non-existent" (Graham et al., 2008, p. 490). This study further emphasizes that training teachers in the area of student mental health should be a priority for educational systems.

Teachers and related service personnel need access to training and information concerning mental health issues as they arise during the developmental years and in the context of changing environmental expectations and demands that may intensify stress on emotionally fragile children or children with particular disabilities. Teachers also need support for taking the time to get expert consultation and resources must be readily available for teachers so that they can capably individualize support for one child while meeting various classroom needs. (Sedensky, 2013).

Mental Health Disorders

Mood Disorders

Mood disorders affect all populations; from the very young to the very old. Mood disorders can significantly disrupt everyday life. For school-age children, mood disorders manifest in different ways; from the very lows occurring with depression to the ups and downs associated with bipolar disorder. Symptoms of a mood disorder can be mild or severe. Mood disorders are characterized by a significant disturbance in a person's persistent emotional state or mood. The two primary types of moods are depression and mania (Lane, 2017). Thus, most mood disorders fall under the broad categories of depressive disorders and bipolar disorders.

Major Depression

The word depressed is an adjective commonly used by many people to describe everyday sadness or disappointment (e.g. "My house is so messy it makes me depressed"). There is a more serious and detrimental state of depression that affects many children and adolescents. According to a 2015 National Institute of Health study, 3 million teens aged 12 to 17 in the United States have had at least one major depressive episode in the past year. That amounts to 12.5% of the United States population who are diagnosed each year with major depression. Depression can be hereditary. According to Billings and Moore (1983), children with parents who suffer from depression are two to four times more likely to experience depression. A child's environment can also cause a child's depressive; whether it be situational or chronic. A major life change could cause situational depression for a child that personally impacts their life. Parental divorce, loss of

housing, or death of an immediate family member can cause children to develop situational depression. This type of depression is usually not long lasting if the student has support from home and school. Major depressive symptoms in children and adolescents are a persistent sad or irritable mood, loss of energy, decreased interest in daily activities, persistent feelings of worthlessness or guilt, withdrawal, and possible recurrent thoughts of suicide. They may also gain weight or lose weight, have disturbed sleep patterns, increased defiance or oppositional behavior, and has difficulty concentrating. Crundwell and Killu (2010) reported that the average age of onset of major depression is age 14. The "earlier the onset of depression, the more protracted and severe the course of the disorder usually is" (p. 46).

Depression is significantly correlated with lower grades, and students with higher ratings of depression are less likely to graduate from high school. Students may experience cognitive issues and have a low tolerance for frustration and have negative thought patterns. Students with depression give up easily and often do not attempt things they perceive as difficult. The significant features are similar to adult depression, but irritability is more prevalent in depressed youth. Crundwell and Killu (2010) wrote that teachers often "overlook children with depression because symptoms like a sad mood or fatigue are more internal than the kinds of disruptive behavior shown by kids with more externalizing disorders, such as ADHD or ODD" (p. 47). They often don't ask for help because they feel hopeless that anyone can help them. They fly under the radar. Conners-Burrow, Johnson, and Whiteside-Mansell (2009) researched a cross-sectional study of 5th through 11th graders and found that teachers' support was correlated with fewer depressive symptoms when parents are not supportive.

Often, younger children and adolescents experiencing depression can behave in ways that may present as irritable or aggressive. This behavior can alienate the teaching staff as well as

peers, resulting in a worsening of the depression (Muris, Meesters, van Melick, & Zwanbag, 2001). Students who are experiencing depression are often unmotivated and lack the initiative to complete work. Teachers who do not understand the actual cause of the student's behavior may see the student as lazy or disinterested in learning, which can fail to have positive interactions with the student and ability to build a trusting relationship (Dikel, 2014). According to Testa, Miller, Downs, and Panek (1992), students with mental health issues are afraid of being rejected by peers. Aggressive students who provoke their peers are likely to be shunned by them, and it is this rejection that is felt to cause depression. Having a relationship with a teacher that they feel safe to express their feelings is often the only positive thing the student experiences. Rueger, Katz, Risser, and Lovejoy (2011) and Chen, Greenberger, Farruggia, Bush, and Dong (2003) found that the majority of teens in the U.S. report having non-parental adults such as teachers in their lives. Rueger et al. (2011) reported that "90 percent of those teens deemed these adults as important sources of support, with one-third of these teens indicating these non-familial sources as "truly key persons" (p. 2). Some research suggests that support from teachers offers protection above and beyond the effects of parents (Colarossi & Eccles, 2003). When parental support is low or not there, Rueger, Chen, Jenkins, and Choe (2014) describe studies completed that looked at the presence of even one caring non-familial adult, such as a teacher, who can be protective when support from parents is lacking. Li, DiGiuseppe, and Froh (2006) found that girls experience higher levels of depression than boys during adolescence.

During the last year of middle school, many teachers are in the mindset that they need to prepare students for high school, thus push students to be more independent. Withdrawing their support to students may be detrimental to students' emotional health (Cauley & Jovanovich, 2006). When a low level of parent support combined with a reduced level of teacher support,

students can become more at risk for depression. Although youth want to rely less on adults, the results from the Rueger study show the continued importance of adults in the lives of children and adolescents.

In an article written by Crundwell and Killu (2010), the authors describe a student who has transitioned to a much larger school. She has lost interest in most of her daily activities, cries often, and has a difficult time concentrating. Her grades have dropped. She has not made any friends and spends her extra time at school with a select few teachers. Her peers describe her as irritable and resistant to their friendly overtures. She has told her teacher that her parents are fighting. She is anxious about the demands of high school. She has no one at home to turn to, and she feels lonely at home. She told her teacher that she thinks of death as a way out of loneliness. The girl described above is presenting as depressed. This student's prognosis may not have a healthy outcome as she is having thoughts of suicide. She is feeling isolated and alone both with peers and with her parents who appear preoccupied with other issues. Being able to trust her teacher to share her feelings is extremely important as it may lead to the student allowing other support staff to intervene in acquiring treatment for her. Treatment for childhood depression is typically therapy and medication. Research indicates that a combination of the two has been most successful in decreasing the symptoms of a depressive episode.

Schools play a crucial part in prevention and identification of students presenting as depressed. Schools house students for the majority of their day, see them over an extended time grow and develop, often have counselors and school psychologists on campus, and can play a role in community outreach in conjunction with parental involvement (DeSocio & Hootman, 2004). There are challenges that teachers face in identifying and seeking support for a student with a mental health condition. The significant problem is that most teachers have not been

trained in recognizing the signs and symptoms of depression (Moor et al., 2007). Professional development sessions at school sites typically focus on academics. Mental health is not at the forefront of a school's priorities. Teachers may not realize that a student's depression is affecting his academic achievement. Desroches and Houck (2013) share the viewpoint that this lack of training and knowledge makes it "less likely that teachers and other school personnel would realize that the topic of depression was even in their professional purview" (p.13). Lacking confidence and understanding in this area, teachers may feel uncomfortable identifying and supporting a student with depression in their classroom.

Bipolar Mood Disorder

Though less common than depression, bipolar mood disorder affects children and adolescents causing significant behaviors and thought processes that impact all areas of a child's life. Bipolar Mood Disorder is characterized by recurrent episodes of mania or hypomania with and without bouts of depression. Children and teens with a diagnosis of bipolar disorder may experience symptoms of psychosis (presence of hallucinations and delusions) (Upthegrove et al., 2015). These symptoms may also exist during the depressive phase of the illness.

When the child or adolescent is experiencing a manic episode, they may present with intense feelings of elation, grandiosity, and or increased goal activity (Leibenluft, Charney, Towbin, Bhangoo, & Pine, 2003). Different from age-appropriate happiness that children may feel (e.g., going to Disneyland, presents under the Christmas tree), elation related to mania is recurrent, does not match up with what is going on (e.g., a student is laughing hysterically to themselves while the teacher is giving instruction). Children often feel that they are more capable of doing certain things that they actually are (e.g., being the best baseball player on the team). A sign a child may be experiencing a manic episode is when a child's feelings of grandiosity increase to a pathological level (Leibenluft et al., 2003). For example, a child may run into traffic because they believe they are an invincible superhero or may believe they are the smartest student in the grade despite earning low grades on every test. It is essential for teachers to recognize when one of their students is displaying unusual behavior or is portraying themselves very differently than who they are in reality. The last sign that a child is experiencing a manic episode is the presence observable, significantly increased goal activity (Wozniak et al., 1995). The increased goal activity appears in a child's behavior in the classroom as intensely driven

creative energy such as drawing and writing, engaging in multiple tasks at the same time in a frenzied manner, or arranging and rearranging things on the desk.

On the opposite end of mania is depression. When a child is cycling into depression, he/she will exhibit very similar symptoms as a child experiencing a major depressive episode. The difference is that the depressive episode may not last as long with bipolar or may cycle back and forth throughout the day with brief interludes of manic and depressive behavior (Dikel, 2014). Children who are in a depressive cycle may not present the same way that an adult displays when they are depressed. Younger children may not indicate they are feeling unhappy but may say they are bored or act irritably. A child may have an intent to commit suicide but are not taken seriously because of their weaker action plans for doing so. For example, a child may hold his breath or put his head under the water.

Birmaher and Brent's (2007) research on childhood bipolar disorder led to a finding that children may have difficulty explaining how they are feeling, and together with the increased irritability and other symptoms of depression (e.g., fatigue, sleep problems), may make the child more likely to display behavior problems. They may rebel against authority figures (e.g., not doing homework), and exhibit reduced frustration tolerance and repeated temper outbursts. Depressed adolescents may act irritable, oppositional, get in trouble at school or with the police, have frequent absences from school, and sometimes abuse alcohol and drugs (Mufson, Dorta, Moreau, & Weissman, 2011). Due to this, many teens are thought to have behavior disorders when in reality they are experiencing physiological signs of mental illness. It is important not to label a student as having a behavioral disorder when in fact they are experiencing significant mood dysregulation that is beyond their control. According to Dikel (2014), the life stressors that

resulted from having the mood disorder then exacerbate the individual's mood difficulties, causing a vicious cycle that increasingly worsens.

Recent studies have shown sharp increases in the rates in the diagnoses of bipolar in children and adolescents (Blader & Carlson, 2007). Prior to adolescents receiving a diagnosis of bipolar, these teens were more than likely diagnosed with depression, ADHD, or disruptive behavior disorders. Because of the severity of this mental illness, it is crucial that children and teens are identified as having traits similar to bipolar and are referred to treatment to make a proper diagnosis. Delaying treatment correlates to a decreased likelihood of full recovery and poor outcome (Leverich et al., 2007).

In his research on bipolar in children and teens, Birmaher (2013) noted important developmental differences between children and adolescents that impact symptom presentations. For example, children tend to have more rapid fluctuations in their mood, mixed presentations, behavior problems, and separation anxiety than adolescents. In contrast, adolescents have more distinct manic and depressive episodes, suicidality, substance abuse and panic disorder.

Treatment for bipolar disorder in children and adolescents includes psychotropic medication management and therapy (Dikel, 2014). Family therapy is also an essential piece of the treatment plan as it helps parents understand their child's illness. Stress is a known trigger for mood cycling, so strengthening coping skills and adaptive behavior can be facilitated by the classroom teacher and addressed in therapy with the school psychologist or counselor (Dikel, 2014).

Disruptive Mood Dysregulation Disorder

In response to the concern about over-diagnosing bipolar disorder, the American Psychiatric Association included a new diagnosis in the Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM-5) of Disruptive Mood Dysregulation Disorder (DMDD). The DSM-5 lists DMDD as a mental health disorder that applies to children ages 7-18 who have chronic, severe persistent irritability. The irritability manifests itself in two ways. The first is frequent temper outbursts. These outbursts usually happen as a response to frustration and can be either verbal or behavioral. The behavioral outbursts take the form of aggression against property, self, and others. They must frequently occur, on average three or more times per week over one year in at least two settings, such as home and school. They must be developmentally inappropriate. The second manifestation of the severe irritability consists of chronic, persistently irritable or angry mood that is present in between the severe temper outbursts. This irritable or angry mood must be present most of the day, nearly every day, and noticeable by others in the child's environment.

In the classroom, a student with Disruptive Mood Dysregulation Disorder may have fits of rage that can sometimes manifest into physical aggression towards people or to classroom objects. These outbursts are typically caused by the student's dysregulated reaction to something that frustrates him, but would usually not frustrate most other students (Dikel, 2014). The student will display an angry or irritable demeanor with low frustration tolerance. Interactions with classmates and staff are strained, and classmates most often keep their distance for fear of getting attacked. Dikel (2014) writes, "although students who have this disorder may appear oppositional, it is the mood disorder and not a pattern of oppositionality per se that is driving the behavior" (p. 63). As the actions of the student derive from a mood disorder, typical treatment

strategies do not work as well. Individual family therapy and psychopharmacology similar to what is prescribed for a child or adolescent diagnosed with bipolar disorder or depression.

Attention-Deficit, Hyperactivity Disorder

Children and adolescents diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD) will present as mainly hyperactive, inattentive or a mix of the two. As far back as 1775 when a German doctor described an attention disorder as a person who "studies his matters only superficially, his judgments are erroneous, and he misconceives the worth of things because he does not spend enough time and patience to search a matter" (Barkley & Peters, 2012). Dikel (2014) describes ADHD as the most common specific psychiatric diagnosis in children and adolescents. It is a neurobehavioral disorder, is diagnosed two to four times more frequently in boys than girls and affects at least 3-5% of children globally. The DSM-5 (2013) estimates that the prevalence of ADHD in most cultures as being 5% of children. The Centers for Disease Control and Prevention conducted research in 2013 that led to findings of one in five high school age boys in the United States, and 11% of school-age children overall have been diagnosed with ADHD (Perou et al., 2013). This large percentage should lead to concerns about over-diagnosis of ADHD in children and adolescence. The consequences of academic failure for an individual with ADHD and subsequent occupational failure in adult life are widely discussed within the literature (Kendall, 2016).

Symptoms found in children with ADHD are divided into three criteria; inattentive type, hyperactive-impulsive type, or inattentive hyperactive-impulsive combined type. According to the DSM-5, if the individual has six or more symptoms from both lists, he would be diagnosed with ADHD – combined type. If the individual has six or more symptoms from one list but not

the other, he is considered for a diagnosis of ADHD, predominantly inattentive or ADHD-predominantly hyperactive-impulsive.

Children and adolescents with the inattentive type of ADHD have poor attention to details, difficulty sustaining attention, not seeming to listen when spoken to, failure to finish tasks, disorganization, procrastination of work that requires sustained mental energy, loses things, significant distractibility, and forgetfulness (Cook, 2005).

Children and adolescents with the hyperactive-impulsive form of ADHD have difficulty remaining seated, are restless, blurt out answers, fidget, have excessive physical movement and excessive talking (Lee, 2014). They are prone to interrupt when someone else is talking and have a difficult time waiting their turn. The DSM-5 states that the symptoms of both types of ADHD and the combined form need to have been present for at least six months, are developmentally inappropriate, and have a significant impact on social and academic activities or tasks.

A child or adolescent diagnosed with ADHD may face multiple challenges in school. For students with the hyperactive-impulsive type of ADHD, their impulsive and restless behaviors make them more noticeable by the teacher than those with the inattentive type of ADHD. These students are often quietly daydreaming and typically do not stand out. The children with hyperactive-impulsive type ADHD may engage in disruptive behaviors that distract peers and may have a difficult time settling down and starting a task. They tend to be boys. There is a 3:1 ratio of males to females in this group, compared to a 2:1 or less in the inattentive group (Dikel, 2014). Their impatience and frustration with an inability to engage in learning challenge their teachers' ability to focus on the students that are involved in their education.

Teachers often have negative attitudes towards students with ADHD regarding academic achievement, and this can impact upon the educational outcomes of the student (Eisenberg &

Schneider, 2007). However, as Wiener et al. (2010) acknowledge, how the teacher reacts to these behaviors is crucial, and detrimental responses from teachers can impact students. This negativity can also affect the self-esteem of students with ADHD (Castens & Overbey, 2009), and their low self-esteem may manifest itself in different behaviors, such as aggression or a sense of defeat (Kendall, 2010). Furthermore, Sherman, Rasmussen, and Baydala (2008) discuss how a negative response given by teachers to behaviors by students with ADHD can make these children feel embarrassed and socially isolated. The teacher who is patient and has a positive attitude towards a pupil with ADHD will have a positive impact on the academic achievement of that student.

Bell, Long, Garvan, and Bussing (2011) reports that often teachers have limited knowledge and understanding about aspects of ADHD and the impact it can have on the lives of children and adolescents. For many children and young people, it is only following a diagnosis of ADHD that subsequent support is put in place for them (Travell & Visser, 2007). The literature discusses the importance of professional development about ADHD and behavior management strategies that can support students in the classroom (Kendall, 2016). Laver-Bradbury (2012) discusses the consequences of children with ADHD who are often sent out of the classroom which can lead to a cycle of deterioration regarding academic accomplishments, problems with conflict resolution, and can also lead to endless school non-inclusion which can impact students' future as adults.

In a research study conducted by Kendall (2016), 12 students who attended an ADHD support group were interviewed about their perceptions of having ADHD and how it impacts them in the classroom. Students reported that when they received a diagnosis of ADHD, it helped them access support at school. The children also responded that this support was not

consistent from all teachers. For some of the interviewees, they were regularly shouted at by individual teachers, and this hurt their self-esteem and learning. Raising voices and yelling at children as a strategy of motivating them to comply with a directive is ineffective and can lead to an increase in adverse behaviors (Kapalka, 2005). The teachers who maintained a positive approach to the students and related to them in a calm and understanding manner were perceived as supportive, and the students were more willing to follow directives from the teacher. The need for teachers to create positive strategies was deemed to be very important by the students in Kendall's 2016 study.

Anxiety Disorders

In today's world, feeling a little anxiety can be helpful. It can help motivate a person to complete an essay for school or to prepare for a job interview. Everyone feels anxious at one point or another. When the level of anxiety that someone is feeling becomes so intense that it interferes with daily living, then it becomes a disorder. One type of anxiety disorder that affects children and adolescents is generalized anxiety disorder (GAD). Nutter and Pataki (2017) describe Generalized Anxiety Disorder (GAD) as persistent, excessive, and unrealistic worry that is not focused on a specific object or situation. Children with GAD frequently worry and feel it more intensely than other children who have experienced the same thing. They may worry excessively about their ability to succeed at school or in sports, worry about personal safety and the safety of family members, or about natural disasters and future events. The focus of worry may shift, but the inability to control the worry persists. Because children with GAD have a hard time "turning off" the worrying, their ability to concentrate, process information, and engage successfully in various activities may be impaired. In addition, problems with insecurity that

often result in frequent seeking of reassurance may interfere with their personal growth and social relationships. Further, children with GAD often seem overly conforming, perfectionistic, and self-critical (Nutter & Pataki, 2017).

A child or adolescent with an anxiety disorder has difficulty coping at home, at school and in social situations. Dikel (2014) reports that a student's anxiety disorder interferes with the normal developmental process. For example, a teen with a severe social anxiety disorder will often avoid social activities such as school dances or outings with peers. Anxiety disorders are the most common psychiatric disorders affecting children and adolescents, yet they usually go unnoticed by medical and mental health professionals. According to Mychailyszyn et al. (2011), research indicates that 10% -30% of children in the general population report distressing levels of anxiety. Only 30% of children with anxiety disorders receive treatment (Chavira, Garland, Yeh, McCabe, & Hough, 2009). The lack of treatment may be because children do not typically seek support for their mental health issues on their own (Headley & Campbell, 2011). This lack of treatment is in stark contrast to the 40% - 75% of children who receive treatment for depression and other externalizing disorders. Children are dependent on adults to identify concerns and access treatment. Teachers are in an excellent position to recognize anxiety in children. They may understand atypical responses having taught children with various types of positive and negative behavior. Anxiety can also be comorbid with other mental health conditions such as depression or behavioral disorders. Anxiety is often the underlying cause of behavioral difficulties in students. A child with an anxiety disorder is at significant risk of school failure.

A student with anxiety may have symptoms including psychosomatic feelings such as headaches and stomach aches. He may frequently visit the health care office; often attempting to

go home from school early. He may ask many questions about school assignments and may worry excessively about his academic performance. He often requires constant reassurance regarding instructions and directives from the teacher. Frequently, students with an anxiety disorder are often so preoccupied with their thoughts and worries that it distracts them from focusing on instruction. This lack of focus may cause them to fall behind in their studies.

Another type of anxiety disorder that students may struggle with is social anxiety. Elia (2017) describes social anxiety disorder as children who are terrified that they will humiliate themselves in front of their peers by giving the wrong answer, saying something inappropriate, becoming embarrassed, or even vomiting. In some cases, social anxiety disorder emerges after an embarrassing occurrence. In severe cases, children may refuse to talk on the telephone or even refuse to leave the house. Mychailyszyn (2011), writes that the characteristics of social anxiety or social phobia are a pronounced and incessant fear of performance or social situations. Social anxiety manifests itself in children and adolescents including crying, clinging to a familiar adult, freezing, tantrums, and even significant internalizing behavior that results in selective mutism. Tomb and Hunter (2004) report that "unlike adults, children with social phobia do not have the option of avoiding situations they fear and may not be able to pinpoint the nature of their anxiety" (p. 91). Social anxiety typically begins in adolescence. Sometimes these teens exhibited childhood symptoms of shyness and inhibition. Tomb and Hunter (2004) write that onset of symptoms may start after a stressful or mortifying event. They add that with teen onset, a student's social anxiety can lead to impaired social skills and academic achievement. Teachers can get support from school site support personnel such as the school counselor or school psychologist if they have a student with social anxiety in their class. These staff members can provide information to increase a teacher's awareness of the symptoms of social anxiety and offer

classroom strategies to teachers, so they are better able to support the anxious student in their class. As teachers learn more about anxiety disorders, they will be able to pinpoint those students who may have social anxiety and get them referred for treatment quickly.

Children and adolescents with anxiety disorders may feel extreme distress that causes fear of coming to school. School refusal behavior is defined as any child-motivated refusal to attend classes or difficulty remaining in class for the entire day (Kearney, Chapman, & Cook, 2005). School refusal behavior affects the whole family because the lack of attendance at school can cause legal and academic problems, conflict with school personnel, loss of wages for parents who may have to stay home with their child or attend meetings at their school. Kearney (2003) describes school refusal behavior as a heterogeneous, dimensional construct consisting of extended absences from school, periodic absences from school or missed classes, chronic tardiness, and intense dread about going to school that precipitates pleas for future nonattendance. Episodes of school refusal behavior may include any of these forms and may change on a daily basis. School refusal behavior is an umbrella term that subsumes constructs such as truancy, school refusal, and school phobia. Gottfredson, Gottfredson, Payne and Gottfredson (2005) cite the National Center for Education Statistics for 2005, 19% of fourth-graders and 20% of eighth-graders missed at least three days of school in the past month. Also, 7% of fourth-graders and 7% of eighth-graders were absent at least five days in the past month. School absenteeism is not gender-specific but more common among minority students, students with disabilities, and students coming from low socioeconomic households.

Kearney (2003) developed a continuum of school refusal behavior that starts out as a minimal issue and progresses to a significant problem which impacts educational and life functioning. The continuum includes school attendance under duress and pleas for

nonattendance, repeated misbehaviors in the morning to avoid school, repeated tardiness in the morning followed by attendance, periodic absences or skipping of classes, repeated absences or skipping of classes mixed with attendance, complete absence from school during a specified period of the school year, and total absence from school for an extended period.

Absenteeism due to school refusal behavior is challenging to track because the behavior includes complete and half-day absences, tardiness, and anxiety-based difficulties attending school. Indeed, a key problem in this area is that school districts often inconsistently identify, collect data, and report when students are not at school. Many children and adolescents with school refusal behavior exaggerate actual low-grade illnesses that may be caused by anxiety. Many of these symptoms are inflated by the child to gain attention from caregivers or to make parents think the child is sicker than they are (Kearney & Bensaheb, 2006). A research study completed by McShane, Walter, and Rey (2001) involved 151 students aged 10 –17 years with school attendance difficulties. Psychiatric diagnoses identified as a factor in the students' school refusal behavior included mood (30%/15%), anxiety (28%/14.5%), and disruptive behavior (18.5%/11.5%) disorder. The most common specific disorders among the students were major depression (31.8%), dysthymia (25.2%), oppositional defiant disorder (23.8%), and separation anxiety disorder (22.5%). Although only 4.6% of the total sample had a learning disorder, 31% reported that academic difficulties were associated with the onset of school attendance difficulties. Also, 37% of the sample had a physical illness as well as 18% of mothers and 14% of fathers. One-fifth reported that physical illness was associated with the onset of school attendance difficulties. Maternal (53%) and paternal (34%) psychiatric disorders were present in many cases as well.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is caused by a person who has experienced a traumatic event. Children and adolescents with PTSD often do not have a prior history of mental health issues (Dikel, 2014). PTSD was once labeled an anxiety disorder in the DSM-IV-TR. The DSM-5 does not list PTSD as an anxiety disorder but lists it under the category of trauma and stress-related disorders. The reason for the category change is because some people do not feel anxiety after exposure to a traumatic experience (O'Donnell, 2014). Instead, they feel angry, detached, dysphoric, and disassociated (DSM-5, 2013). To be diagnosed with PTSD, a person over the age of six must have experienced an accidental or threatened death, serious injury or sexual violence. The child or adolescent with PTSD have either participated in the traumatic event, witnessed the incident, was told that the event involved a close family member or friend, or endured repeated or acute exposure to traumatic details of the incident (Dikel, 2014).

A child with PTSD may act out the trauma in their play. An adolescent who is diagnosed with PTSD will have symptoms of repeated, intrusive memories of the incident. He may experience nightmares or flashbacks. He may feel anxious or experience physical symptoms when met with details of the trauma. The child or adolescent will avoid situations or feelings that remind them of the trauma or make them feel unsafe. A child might blame himself for the ordeal and feel detached from other people or feelings of happiness and contentment. The ability to concentrate is often impaired, and the child may have a pronounced startle reaction.

In a research study conducted by Thomason, Marusak et al. (2015), the scientists found that trauma and stress injure the brain, cause cognitive, behavioral, emotional, and somatic problems and are strong indicators of psychiatric illness. The amygdala is critical for recognizing the possibility of threats and heightened alertness (Zald, 2003). The amygdala is responsible for

activating the physiologic stress response (Thomason et al., 2015). Divergent from that, the prefrontal cortex is responsible for regulating emotion. Thomason and his colleagues found that the amygdala and the prefrontal cortex of children who have experienced trauma can lose direct connection with each other. Thomason et al. looked at a similar study that found a decreased ability to regulate emotional discord and the lack of negative front amygdala connectivity during conflict modulation in children who have experienced trauma. Early trauma can change the way the brain functions and negatively impact feelings and emotions. The most common treatment for children and adolescents is cognitive behavioral therapy and medication for the treatment of PTSD.

At school, the child or adolescent with PTSD may experience significant anxiety when his classmates talk about safety from abuse. He might feel extreme anxiety if someone at the school looks or acts like the abuser. The student may become withdrawn, shut down, and disengaged from learning. A small child may act out the trauma in make-believe play or their artwork.

Strom, Schultz, Wentzel-Larsen, and Dyb (2014) researched adolescent academic performance after the 2011 mass shooting in Utoya, Norway when 77 people were killed (many teenagers) by Anders Breivik, a mentally ill rampage shooter. The results showed that trauma-exposed students performed worse academically the year after experiencing the attack. They also had lower grades than the national grade point average, going down 4.3 points. These results can be seen from the perspective of how the exposure to trauma can affect students negatively. The majority of the students felt that their lives were in danger, many witnessed people dying, and as many as 75% of the respondents reported that they had lost someone close to them. The researchers expected this to happen in terms of how their school performance was affected as the

adolescents returned to school four weeks after the event. The researchers found that their academic achievement may have been affected by posttraumatic stress reactions, grief, lack of sleep, and distress after exposure the traumatic experience.

A form of PTSD is Acute Stress Disorder. Children and adolescents with an Acute Stress Disorder may experience substantial distress during the immediate aftermath of a traumatic event such as a car accident or in response to a school shooting. Friedman (2015) writes Acute Stress Disorder can include experiencing nightmares and avoiding people and places that may remind them of the trauma. If the symptoms last for one month or more and are intense in nature, a referral should be made to a mental health professional to determine if the child has a diagnosis of PTSD (Friedman, 2015)

Oppositional Defiant Disorder

According to the American Psychiatric Association (2000), between 2% and 16% of children are diagnosed with Oppositional Defiant Disorder (ODD). To meet criteria for ODD, the child or adolescent must have a pattern of angry and irritable mood, argumentative or defiant behavior, or vindictiveness, lasting for at least six months. A child with a diagnosis of ODD will engage in verbal or physical altercations with adults and peers. The child will have difficulty handling directives from authority figures and will display defiant behavior as a result. The student will be in an agitated state throughout the school day and will be easily bothered by things that would not annoy a typical peer. The child or adolescent may blame others for his/her misdeeds and get revenge against the person who he believes wronged him (Dikel, 2014).

The onset of ODD is typically around preschool age. Dikel (2014) describes ODD as a "pattern of behaviors in which the child or adolescent continually tests limits. The limit testing

may result from not having received clear and consistent behavioral limits from parents or caregivers" (p. 106). Much of the causation from ODD stems from early parenting issues where the child received overly strict discipline or did not receive enough nurturing (Webster-Stratton, Reid, & Hammond, 2004). The ODD behaviors stem from the students' difficulty coping with stressful events and not having the skills to be nonreactive when under pressure. The student may also have another underlying mental health issue. When children feel like they have no control over situations or are degraded by people who are supposed to love them unconditionally, they may act out by engaging in negative behaviors in a misguided attempt to seek attention. These children behave in response to inconsistent, chaotic situations in their environment or harsh and stringent responses from adults. Patterson, Reid, and Dishion, (1992) believe that a child's development is influenced by what they call a coercive process where children learn to withdraw or avoid denigration from their caregivers by acting out in adverse ways. Children behaving this way will incite caregivers who may engage in power struggles or harsh punishment which will, in turn, lead to increased negative behaviors from the children. When a parent interacts detrimentally with their child, they are modeling the bad behavior and reinforcing the child's poor choices when dealing with conflict and stress.

Treatment of a child with ODD is a challenging process. Parents of children diagnosed with ODD require training and modeling of positive parenting by a skilled mental health professional. Webster-Stratton, Reid, and Hammond (2004) view parent training as crucial and believe it will lead to an increase of positive interactions between the parent and child in the home environment. Home life may improve, but it does not always result in improved interactions with adults and peers at school (Taylor & Biglan, 1998). Some parents of children diagnosed with ODD may not want to participate in parent training or do not have access to

parenting resources. Parent training has proven to be the best intervention, yet some parents do not receive training. As a lesser alternative, it is vital for school site staff to provide students with social skills training, support with coping skills, and modeling of positive interactions in individual and small group counseling sessions.

Conduct Disorder

Conduct disorder is one of the hardest mental health disorders to treat. Conduct disorder affects between 1% - 4% of children and adolescents according to a one- year prevalence (Dikel, 2014). Students who have other psychiatric diagnoses such as major depression or bipolar mood disorder are not considered conduct disordered as their adverse behaviors stem from their mental health condition. Dikel writes that to receive a diagnosis of conduct disorder, a child or adolescent needs to demonstrate a chronic pattern of antisocial behavior that goes directly against societal norms for appropriate behavior and infringes on the fundamental rights of others. He lists antisocial behaviors such as physical violence, theft, destruction of property, bullying, threatening, cruelty to people and animals, unwanted sexual advances, and use of weapons. These children will likely disregard any rules that caregivers and authority figures set for them including staying out late at night, running away, and truancy beginning before the age of 13. For a diagnosis of conduct disorder, these negative behaviors would need to significantly impact all areas of life functioning and occur over a period of 12 months or more. When the DSM-5 was revised in 2013, criteria was added that limits appropriate social and emotional skills including lack of remorse, lack of empathy, lack of concern regarding the outcome of adverse home, school, and social situations, and displaying a flat or impaired affect.

Children and adolescents diagnosed with conduct disorder are extremely challenging for school site staff to manage. Unlike ODD where a student may display oppositional behaviors in one setting only, conduct disordered students typically engage in negative behaviors in all environments (Stewart, Klassen, & Hamza, 2016). At school, they may be verbally or physically aggressive to peers, may intimidate others to get what they want, may cheat and lie about school assignments, may destroy property at school, and may have attendance issues related to truancy (Dikel, 2014). These students may have other mental health issues and may engage in impulsive and hyperactive behavior. They may also display inconsistent mood swings and may have good days and bad days at school with no explanation as to why their behavior changes.

Treatment of conduct disorders has the best outcome when it is identified and addressed at a young age. In her research, Webster-Stratton (1993) saw a correlation between low academic achievement and children with a conduct disorder. She lists reading disabilities, language delays and attention problems as common areas where conduct disordered children struggle. Her research found that conduct disordered children who lack reading skills place these children at significant risk for low self-esteem, continuous academic failure, increased negative behaviors, and school dropout. Academic as well as behavior needs to be addressed by school personnel at the first signs of conduct disordered behavior. Mental health professionals describe effective treatment for children and adolescents with conduct disorder, but the method of the right treatment has made slow progress (Winther, Carlsson, & Vance, 2014).

Clinical-Behavioral Spectrum

To guide school staff in decision making and developing interventions, there first needs to be an understanding of how to identify the nature of a student's issues. Staff members may

view the way a student is behaving based on their own experiences and impressions of mental health. They may not be able to identify how severe the student's problems are and to what extent they need support. A meaningful way for teachers to communicate with school site support personnel is for them to have a better understanding of behavioral and clinical disorders. Dikel (2014) has created a conceptual model that can help educators discern the difference between a behavioral disorder and a clinical disorder. He refers to this model as the Clinical – Behavioral Spectrum, which has five categories that fall within a continuum. Dikel (2014) has found that these categories are "useful in identifying the nature of a student's behavioral difficulties, and in identifying interventions that are most likely to be successful" (p.14). The table below shows the five categories on the spectrum.

Table 1

Five categories of the clinical Behavioral Spectrum (Dikel, 2014)

Behavioral
Predominantly Behavioral
Mixed
Predominantly Clinical
Clinical

For general education teachers to understand the difference between what is normal behavior and what is considered a behavioral disorder that reflects a mental health disorder. On one end of Dikel's Clinical-Behavioral Spectrum is the Behavioral category. This category consists of behaviors that are deliberate, willful, and serve a purpose such as eschewing

classwork, attention seeking, or used to attain something they want. This category does not respond well to medication and "talk" therapy as a student who falls into this category is not depressed, anxious, or inattentive. The best type of support for treating students in this category are behavioral interventions, and they need what Dikel refers to as a "narrow path with high walls of contingency" (p. 14).

A researcher created vignette for the purpose of discussion was written as an example of a student who falls in the Behavioral category. John, an eighth-grader who has a history of fighting, lying, and defiance towards adults. John's behavior pattern can be traced back to when he was a small boy. His parents engage in similar behaviors and see nothing wrong with John stealing or fighting. John has been arrested and is court ordered to stay out of trouble. Not wanting to go to juvenile detention, he can abstain from these negative behaviors.

On the opposite end of the spectrum is the Clinical category. Students that fit into the Clinical type do not have a history of adverse behaviors occurring before the presentation of the psychiatric disorder. Students in this category have severe mental health disorders and may present with hallucinations, mania, or extreme depression. Unlike the Behavioral type, the behaviors associated with their mental health diagnosis are not under their control and do not have a function. One can relate this to a person who experiences painful migraine headaches and is prone to lashing out at others when a migraine is happening. Effective treatment for students who fall in the Clinical category includes medication and therapy (Dikel, 2014).

This researcher created vignette for the purpose of discussion is an example of a student who falls under the category of Clinical on the spectrum. Jean is a fifth-grade girl who has been diagnosed with extreme Anxiety and Obsessive-Compulsive disorder (OCD). She cannot cope with any aspect of daily life including attending school, and her rituals, such as checking to see if

the stove is off every half hour for fear of fire, prevents her from leaving the house. Her school performance is minimal as her OCD keeps her focused on her ritualistic routines and leaves little time to complete work. Before the onset of Anxiety and OCD, Jean had good grades and was very social. Jean no longer has friends and is socially isolated. She has not attended school for the past six months. Her anxiety and fears have led to several psychiatric hospitalizations, and her psychiatrist has prescribed medication and cognitive behavioral therapy to try to alleviate her distress.

Though students rarely are found to have the extreme behaviors found with those who fall into the Clinical and Behavioral categories, many students with mental health issues will have a combination of both categories (Dikel, 2014). Children and adolescents who are determined to be on the Predominantly Behavioral category do have a mental health diagnosis, but their behaviors cannot be caused by their disorder. These students may attribute their negative reactions to their mental health conditions as excuses to engage in premeditated, willful behaviors (Joyce & Oakland, 2005).

An example of a student who falls into the Predominantly Behavioral category is included in this researcher created vignette. Jason, a ninth grader, has a history of antisocial behavior and was diagnosed with ADHD when he was seven years old. Jason is sneaky and will do anything he can to get away with whatever he can. His English teacher recently asked him why he punched another student in the stomach, and his reply was he wanted to get revenge on this student for making a rude comment to him the previous day. Jason has been on medication since he was diagnosed with ADHD and it provided an ability to attend to preferred tasks, but it does not seem to help him control his negative behavior. Medication does give him the ability to focus and plan antisocial actions. Jason requires behavioral treatment interventions to treat his

issues, as his mental health diagnosis is not a factor in how he behaves (Dikel, 2014). His teachers are not aware that his actions are not the primary impetus for his behavioral difficulties.

Students who are seen as belonging to the Predominantly Clinical category display some behaviors that are planned and serve a purpose. Nonetheless, a student described as Predominantly Clinical has a mental health disorder that causes the majority of his behavior problems. These students may have exhibited antisocial behaviors before the symptoms of the mental health condition began. They may have been incorrectly diagnosed with anxiety or ADHD as a child. For them to improve behavior, they will need psychological and psychiatric treatment. Without this treatment, the behaviors that are caused by their mental health disorder will not secede.

Illustrating how a student in the Predominantly Clinical category manifests behavior, this researcher created vignette is presented for the purpose of discussion. Carina is a twelfth-grade student whose academic performance has been good. She has recently started to exhibit symptoms related to a diagnosis of bipolar disorder, which include quick transitions between manic impulsive behavior and angry, irritable behavior. Before Carina began exhibiting bipolar symptoms, she had always been high energy and was sometimes defiant towards her mother. She was diagnosed with ADHD when she was eight years old, but the behaviors attributed to the ADHD diagnosis were caused by the impending mental health disorder. Carina has been out of a school for the past two weeks as her medication is being adjusted by her psychiatrist. Her symptoms should improve once the drug begins to work.

Lastly, Dikel (2014) describes the Mixed category on the Clinical-Behavioral spectrum as a psychiatric disorder combined with significant behavioral symptoms which impact a student's ability to be successful in an educational setting. Students who fit into the Mixed category are

often eligible for special education services under the eligibility of Emotional Disturbance and may be placed in self-contained classrooms that cater to students with severe social and emotional issues (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). When younger, these types of students were more than likely viewed as behaviorally challenged but as they get older, signs and symptoms of their emerging mental health conditions emerge (Costello, Mustillo, Erklani, Keeler, & Angold, 2003). Sometimes, their mental health disorders go undiagnosed. For example, a student presenting with symptoms of depression may not get a proper diagnosis when the symptoms of their behavioral disorder are so overt (Desrochers & Houck, 2013). Dikel (2014) writes that these students "pose a challenge for mental health professionals who may tend to focus on the mental health disorders without fully recognizing the impact of behavioral contributors" (p. 18). On the other hand, educators may focus on a student's behaviors more so than their underlying mental health condition as their challenging reactions are hard to ignore. This makes it difficult for educators as they are not trained as clinicians and are often unable to recognize and understand a presentation of mental and behavioral health symptomatology (Lahey, 2016). In order for students to get the best treatment possible, there needs to be a strong partnership between a student's outside mental health providers and his school site staff (Malti & Noam, 2008).

A researcher created vignette explains the psychological profile of a student who presents as fitting into the Mixed category on the Clinical-Behavioral Spectrum. William was diagnosed with ADHD and Autism when he was in elementary school. He has had major difficulty with the transition to middle school, and he is showing signs of oppositional defiance, poor coping skills, and physical aggression over the past three months. It has become impossible to manage his behaviors in the general education setting as William is very disruptive, refuses to complete

work, and elopes whenever he is asked to do non-preferred tasks. He is more anxious and fragile as a sixth grader than he was as a fourth grader. School staff feels the school's larger size, having multiple teachers, and the advent of puberty are all contributing to his increased behaviors. His parents had taken him off of his medication over the summer but are now revisiting the issue as William was recently hospitalized for four days due to threatening self-harm. The school site team needs to collaborate with William's psychiatrist, psychologist and social worker to ensure that everyone is working together to provide the most impactful treatment plan possible for William; both educationally and medically (Malti & Noam, 2008).

Being able to recognize where a student falls on the Clinical-Behavioral Spectrum is extremely important as it is critical for service providers and educators to view the student from the same perspective. A teacher who views a student as more behavioral than clinical will engage the student differently than the private psychologist who treats the student on a weekly basis outside of school hours (Paisley & McMahon, 2001). The difference in treatment approach will lead to an imbalance of interventions that work for the student. Often a parent will see their child as being more clinical than behavioral while the student's teacher may not see the mental health disorder as it is overshadowed by the student's externalizing behaviors (Kazdin, Siegel, & Bass, 1992). If the educational and medical professionals can work together to share insights regarding where they believe the child falls on the spectrum, they can hopefully come to view the child in the same way; thus, using agreed upon interventions that are better suited to the unique needs of the student.

On a school site team, teachers can share their observations of a student's behavior which can help the mental health support staff at the school develop a clearer picture of where the student falls on the spectrum. Working together, school site teams can look at a student's

medical, therapeutic, and educational history to help determine causation for a student's inability to be successful in a general education setting (Lambros et al., 2007).

Students Who Have Not Received Treatment

Adam Lanza was a young man who was severely mentally disturbed (Fox & Levin, 2014). He was responsible for the shooting at Sandy Hook Elementary School in Connecticut. Lanza's parents and educators contributed to his social isolation by accommodating, and not confronting his difficulties engaging with the world. Deferring to those parents can have grave consequences, allowing nascent problems to escalate to serious and sometimes dangerous levels (Metzl & MacLeish, 2015). An analytical report was issued by the task force of the Sandy Hook school shooting. One of the investigators reported that schools often take a hands-off approach to dealing with mentally ill students (Sedensky, 2013). With the Lanza case, the school district left he and his family primarily to their own devices and did not follow up when he stopped attending school (Able Child, 2014). The investigator urged that "even though some of these parents can be very intimidating, schools need to hang tough. If there is a psychologist, a teacher or a social worker who believes this child is headed for deep trouble, they need to hang tough" (Sedensky, 2013, p. 22).

One of Lanza's middle school teachers felt concerned about Lanza's writing and artwork. She reported "I have known 7th-grade boys to talk about things like this, but Lanza's level of violence was disturbing. I remember showing the graphic writings to the principal at the time" (Sedensky, 2013, p. 35). Despite this, the investigation found no documentation that teachers explored the source of the violent content of his writings with Lanza or his parents. There is also

no indication that Mr. or Mrs. Lanza was aware or were reviewing what Lanza was producing for school, or whether they had any concerns about it at all. (Sedensky, 2013)

The role of denial of illness is a relevant theme in the Sandy Hook report. Systems must be ready to respond supportively and appropriately up to and including referral to child protective services when a parent, even with education and resources, appears unwilling or unable to meet the needs of their child (Metzl & MacLeish, 2015).

It is worth noting that teachers may have limited training or expertise to identify or respond to a student who may be progressing academically but who is also exhibiting difficulties in social and emotional development. Teachers may not have a blueprint that tells them how to identify "red flags," when to ask for assessments, or consider further evaluations of children experiencing difficulty with socialization (Wagner et al., 2007). With today's increased focus on academic achievement and concerns over the availability of resources, schools may feel hampered in their efforts to attend to children's overall cognitive and emotional development, despite how necessary this may be for children's ability to learn (Lasky, 2005). Training for teachers, para-educators, and administrators—both regular and special education—is essential (Sedensky, 2013).

The tendency for school personnel or parents to normalize a child's behavior, mainly when the behavior is not disruptive, and the child is not demanding attention in either a positive or negative way, is not unusual (Scheeringa & Zenah, 2001). Children with emerging social phobias, social communication deficits, and sensory processing issues that limit their ability to interact optimally with other people may stay under the radar at school with parents and teachers waiting for a child to mature or emerge from his or her shell (DeSocio & Hootman, 2004). It can be a tremendously challenging or painful event for a parent to state or acknowledge "my child

may be different," or "my child may need help (Scheeringa & Zeanah, 2001)." The need for things to be "normal" is an understandable dynamic and may be a coping strategy for many caregivers, or even teachers, who have numerous responsibilities to grapple with on a daily basis. In contrast, recognition of the underlying problem and acceptance of the need for information and support provides the pathway to better outcomes for children and their families (World Health Organization, 2001).

Adam Lanza presented to school staff with a high functioning form of autism. It is important to note that these children often go undiagnosed if they are not showing behavioral challenges or significant distress. If they are bright, they will do well on structured assessment extent of their problems. School teams do not typically become concerned about social isolation, attributing it to a shy nature (Merz, 2017). Thus, Adam's inability to start a conversation was noted but overlooked, even though it is a reliable indicator of social processing issues. Again, the need for a comprehensive diagnostic evaluation performed by a licensed specialist is evident (Odom, Boyd, Hall, & Hume, 2010). Schools are in a difficult position when confronting these needs. The student is not presenting with marked psychopathology. They are perceived as shy, quirky, or anxious, rather than developmentally disabled. School staff does not possess the training to understand and diagnose the underlying condition fully. Furthermore, as they manage resources, schools may feel constrained to be more conservative with identifying conditions requiring significant special education services (Sedensky, 2013)

Academics

In an era of paramount attention to the academic achievement of our children, school mental health has the advantage of articulating a powerful message linking mental health to

school success (Marques, Pais-Ribeiro, & Lopez, 2011). Mihalas, Morse, Allsopp, and McHatton, (2009) state that academic outcomes for students with mental illness include "failing more courses in school, being retained more frequently, have lower grade point averages, and being less likely to graduate from high school" (p. 109). The argument for integrated approaches to reduce both academic and non-academic barriers to learning supports mounting evidence demonstrating a strong positive association between psychological wellness and academic success (Marques et al., 2011). Research suggests that 46% of the failure to complete secondary school is attributable to psychiatric disorders (Freudenberg & Ruglis, 2007). Thus, it is not difficult to conceive of advocacy and public awareness efforts that highlight the need for attention to school mental health in overall mental health system change (Burns et al., 1995). For the transformation of children's mental health services to expand school mental health, it is necessary to generate understanding and buy-in from educators through the dissemination of clear and compelling messages about the importance of mental health and the negative impact of mental illness on school success (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). To that end, the school mental health field must clearly define specific academic factors—for example, grades, discipline referrals, promotion, dropout, and school connectedness—that are influenced by mental health promotion and intervention. (Stephan, Sugai, Lever, & Connors, 2015).

In the school setting, teachers, in particular, are in a position of authority, responsible for monitoring student behavior, setting classroom rules, reinforcing positive behavior, and imposing disciplinary consequences for inappropriate behavior. For this reason, an understanding of teachers' perceptions is critical in effectively implementing any school-based program that impacts students. (Stauffer, Allen, Heath, Coyne, & Ferrin, 2012). The power of teacher buy-in cannot be underestimated given the strong research base underlying the importance of teachers

supporting interventions that impact students' academic and emotional growth (Biggs, Vernberg, Twemlow, Fonagy, & Dill, 2008).

Literature remains limited in evidence-based academic interventions for students with and at risk for emotional disturbance (Lane, 2007). Of particular importance to this study is discerning practical and evidence-based writing interventions for students with and at risk for mental illness. While several studies have found students who are identified as having mental health concerns are well behind their same-age general education peers in reading, writing, and mathematics (Wagner & Davis, 2006, Benner, Mattison, Nelson, & Ralston, 2009), some studies suggest writing is the most significant academic deficit for these students. For example, Benner et al. (2009) found students with social/emotional issues obtained the lowest mean score on the written language subtests in comparison to the mathematics or reading subtests. Students with and at risk for mental illness struggle with writing considering writing tasks require expressive language skills, which are common deficits among students with mental illness. Despite the apparent need for writing interventions for this population, more attention has been placed on reading interventions (Lane, 2007). Writing is the principal method for demonstrating academic abilities beyond the elementary grades, as well as a tool for effective communication, processing one's feelings, and personal development (Graham and Harris, 2006; Tindal & Crawford, 2002). The National Commission on Writing (2004) found adults without adequate skills in writing faced significant challenges in postsecondary settings, including higher learning and employment. Considering the increased likelihood of adverse academic and employment outcomes of students with social and emotional issues, it is imperative their writing skills are addressed (Mihalas et al., 2009).

One practice shown to be effective for students with disabilities is SRSD, which stands for self-regulated strategy development for writing (Lane, Graham, Harris, & Weisenbach, 2006). The SRSD instructional model is well- suited for students with and at risk for mental illness as it addresses self-regulating behavior, which is a common deficit among students with emotional issues. (Reid, Hagaman, & Graham, 2012). Furthermore, SRSD instruction utilizes self-management strategies, such as self-monitoring and goal setting, which are recognized as effective academic strategies for this population (Carr & Punzo, 1993). Self-regulated strategy development is also taught using explicit instruction, offering a clear sequence set at the pace of the student which has been effective for students with mental illness (Jones Bock & Borders, 2012). Self-regulated strategy development targets cognitive and self-regulation strategies to provide academic support to students' multiple needs and can be applied across a broad range of subjects (Harris, Santangelo, & Graham, 2008). Also, the SRSD model seeks to improve attitudes, beliefs, and motivation related to a targeted area of instruction.

Strategies and Interventions

The real value in understanding risk factors is to do something to reduce them and, if feasible, prevent them from happening. The best approach to helping students is often individualized. Teachers can share their concerns with parents and work together with them to support the student (Rueger et al., 2014). A teacher is not the sole person who can help a struggling student. There needs to be a school team that can meet and discuss ways to support this student (Froese-Germaine & Riel, 2012). The school team may consist of a school psychologist or counselor, a special education teacher, and the school principal. According to Stormont et al. (2011), "teachers should be aware of the resources provided by their school as

well as the evidence-based practices available to support children with behavioral problems" (p. 138). In their research study survey responses, they found that 9 out of 10 teachers had not heard of evidence-based interventions and resources at their school. Often this involves making changes in the learning environment to engage the student in classroom learning and enable success.

Teachers need evidence-based practices to improve student behavior. The lack of specific behavior management strategies and practices in preservice programs affects their ability to maintain a structured environment conclusive to learning (Oliver & Reschly, 2010). There is evidence to support that teachers are unprepared and offer decreased instructional time, feedback, and praise for students with behavior issues (Emmer & Stough, 2001). The lack of preparation leads to an increase over time of these students' ongoing behavior problems (Mrachko, Kostewicz, & Martin, 2017). Partin, Robertson, Maggin, Oliver, & Wehby (2009) found a correlation between students' negative behaviors and teachers who engage in weaker classroom management instead of positive feedback. Sometimes a teacher may chastise a student out of habit even though he is participating in typical behavior. In this environment of negative teacher behavior leading to increased student misbehavior, there needs to be an increase of positive interactions instead of negative ones to 3:1 or 4:1. These positive interactions have been shown to increase a positive classroom environment (Stichter et al., 2009). By creating valid classroom interventions for teachers to manage children with behavior issues, interventions need to include strategies that produce a positive change in teacher behavior (Mrachko et al., 2017).

Students often arrive with splintered skill sets ill-equipped to meet the necessary social, behavioral, and academic demands of school (Sreckovic, Common, Knowles, & Lane, 2014). Given the majority of students with emotional disturbance do not receive special education

supports and are educated in general education classrooms (Lane, 2007), it is essential that the general education community be maximally equipped to meet these students' academic, behavioral, and social needs.

Summary

It is the belief that given the research mentioned in this literature review, that the majority of teachers believe addressing their students' mental health needs is one of the roles they are expected to perform. Some of the best interventions to support students with mental illness occurs during the context of their daily life. It is most effective for the student when the teacher can help the student's brain to change in the context of learning. This can be more powerful that therapeutic interventions because it occurs in a natural setting. What requires further study is in teachers' perceptions of what they know and do not know about student mental health, how much professional development and in what areas of professional development will improve their self-efficacy in instructing and interacting with these types of students. It is also important to assess how much knowledge they acquired in their teacher training programs that they are bringing to their first teaching assignment.

CHAPTER 3: METHODOLOGY

The main purpose of this study was to examine teachers' attitudes, beliefs and knowledge of student mental health as stated in Chapter 1. Upon further exploration of teacher's feelings towards having a student with mental health needs in their classes, the following questions were addressed in this mixed methods research plan:

The following research questions will be addressed in this study:

1. What are teachers' attitudes and beliefs towards students who are exhibiting symptoms of a mental health disorder?
2. What level of training on childhood and adolescent mental health issues was given in teachers' pre-service credential programs?
3. What level of training on childhood and adolescent mental health issues was received at school site professional development?
4. What are teachers perceived roles and responsibilities in the treatment of students with mental health issues?

This mixed methods explanatory sequential design study will address the hypothesis that teachers want to help students with mental health issues in their classrooms, but do not have the training and knowledge to feel competent doing it. Surveys were used to compile data on teachers' attitudes, knowledge and perceived roles when working with students with mental health issues in their classroom.

Setting and Participants

The sample consisted of 186 general and special education middle school teachers from a public school district in Southern California. The district that participated has a population of

approximately 18,370 students and is located in Los Angeles County. The students in the school district come from two suburban cities. These two cities are socioeconomically different with one city having a higher number of families who are considered upper middle class than the other city which has more families considered working class. The district consists of 17 elementary schools, six middle schools, and four high schools. According to 2016-2017 statistics provided by the California Department of Education (CDE), 79.9% the of the students are of Hispanic ethnicity (14,675 students) while 8.7% are comprised of White (1,600), 3.9% of Asian (723), 2.8% of Filipino (523), and 2.6% of African American (479) students. There are 3,256 students classified as English Language Learners, 2,414 students who receive special education services, and 69% of students participate in the Free and Reduced Lunch program. The district has a 94% graduation rate and 96% of teachers are considered highly qualified. The teachers sampled were diverse in their age, experience, race, and gender. The six school administrators gave permission for their teachers to participate in this study.

Sampling Procedures

Convenience sampling was used in this study. An introductory email with a link to a survey was sent to all of the general education teachers at the middle school level of the district involved in the study. The email included a brief introduction of the researcher and an overview of the study. The email also contained a statement regarding confidentiality for all of the participants. Potential participants were told that participation in the study was voluntary.

The sample population used for the qualitative study was represented through a systematic sampling procedure of teachers from one middle school of the six middle schools surveyed. Two professional development sessions were held over a period of two months and

then a post survey was given to the teachers who attended the professional development sessions. There were three open-ended questions on the survey. The information gathered from these questions will be used to determine future need for professional development and training. The reason for collecting both quantitative and qualitative data is to assess if changes occurred after professional development was given to the teachers from one of middle schools surveyed.

Instrumentation

The survey used in this study was developed in consultation with academic peers at Concordia University Irvine and other experts in the mental health and education fields. The survey questions were also based on an extensive review of related survey and literature (Reinke et al, 2011, Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010, Askel- Williams & Lawson, 2013). An initial draft of the survey was emailed to six educators with expertise on the topic for feedback using Survey Monkey. The final items were developed based on literature review and feedback from colleagues. The final survey was created and transferred to Survey Monkey for formatting and distribution. The survey was optional for the participants. The survey included items from two categories: (1) attitudes and beliefs; and (2) demographics. For the majority of the questions, the participant could select any opinion level they may have or type in their response if they had an answer that was not one of the choices provided. There were 24 questions on the survey that were formatted as either multiple choice, true false, or checkmark There were also three open-ended questions that gave participants an opportunity to report their individual opinions. One of the open-ended questions asked the participant to identify the top three mental health concerns they encounter at their school site. Another asked for additional mental health topics for future professional development and training. Given that the survey was optional, the

participant could stop at any time. The complete survey was included at the end of this research study in Appendix A.

The survey was accessible through Survey Monkey, which has developed a reliable and secure data platform. The security embedded in the Survey Monkey program assured security with the infrastructure and practices and reassured that data was appropriately protected. The survey used the response data encryption, rather than only a secure system (SSL), and IP addresses were masked in the settings of the survey. The data was backed up hourly and regularly on the server and could be removed by the researcher to a spreadsheet at any time. The spreadsheet had a timestamp for each respondent. Once the window closed for responses, the online data was destroyed, and only the Excel version of data was used by the researcher for analysis and results. Only the researcher owns the data. Data was only assessed by the researcher and the committee chair. Individual data was not identifiable at the individual or school level, and therefore, repercussions for answers provided were not possible.

Reliability

The most critical concern for reliability is the stability and constancy of the variables. The researcher provided participants multiple choice, checkmark, open-ended, and true/false questions. The assumption that the variable one is measuring is stable or constant is central to the concept of reliability. In principle, a measurement procedure that is stable or constant should produce the same (or nearly the same) results if the same individuals and conditions are used (Statistics LAERD, 2016).

In the fields of education and psychology, the term reliability is operationalized as relative consistency (Weir, 2005). However, not all measurement procedures included in this

study featured the same amount/degree of error (i.e., some measurement procedures were prone to greater error than others—for example, the short-answer questions). A small error was possible during the interpretation of responses. However, the error component within the area was relatively small. Therefore, measurement procedure was reliable. According to Sarantakos (1994), the "definitions of reliability and the types of measurement of the degree of reliability must be considered when the quality of reliability in the two research contents, qualitative and quantitative, is evaluated".

Validity

In research, validation takes the form of triangulation. Triangulation lends credibility to the findings by incorporating multiple sources of data, methods, investigators, or theories (Stemler, 2001). In order to ensure that the research study was considered valid, triangulation of multiple forms of data were used including survey results and interview questions. Prolonged engagement ensures that trust is built with participants. Content validity was established in the first draft of the survey; this draft was reviewed and revised based on feedback from a group of ten teachers, district administrators, and school site administrators. These colleagues were asked to complete the survey and provide feedback about the questions, language, and content of the survey. This researcher used the feedback from these colleagues and edited the survey respectively. Peer review was used to engage the researcher in meaningful analysis asking questions and probing for evidence to support findings. Along those lines, member checking, which entails asking the participants their opinions of the results of the research study to see if they agree or not. Assessing that the methods used measure what they are supposed to measure was another way that validity was checked.

Description of the Intervention

The intervention used was included in professional learning sessions presented to teachers from one of the district's middle schools. One professional learning session per month was held over the course of two months. Topics for the presentations were garnered from the results of the pretest survey. One of the items on the survey asked participants to list the top three most observed behaviors/disorders that they see in their classroom. The results from the answers to this item were analyzed and the five child and adolescent mental health disorders seen the most, in order of prevalence, were chosen as potential professional development topics. At the intervention sessions, the participants were given information about various child and adolescent mental health conditions. They were also given strategies on how to support these students in their general and special education classrooms. A PowerPoint slideshow was used to provide visual information to participants. A copy of the presentation was given to every participant so that they could take notes. Handouts were also given to participants that were specific to the topic presented for each session. At the end of each presentation, participants were encouraged to ask questions or make statements. They were also given an anonymous three-question survey to fill out before leaving that asked for any thoughts, feelings, and opinions of the material presented. The presentation is located in Appendix C.

Data Collection

This study employed a quantitative and qualitative methodology of data collection and data analysis. Three major sections of the survey addressed: (a) teachers experience with students who have mental health issues; (b) amount of mental health training teachers have had in their

pre-service credential program at their school sites; and (c) their perceived roles in working with students with mental health disorders.

Questions in the first section of the survey addressed teachers experience with students who have mental health disorders and information on what types of mental health disorder their students have been diagnosed with. A list of possible mental health disorders was given and the teachers were asked to check all that apply. Questions in the second section of the survey addressed the amount of training the teachers have received in their preservice credential program and at their school sites. A standard Likert-type scale, with one designating "none" to five designating "substantial" was used. The third section of questions addressed the perceived roles and responsibilities of teachers' involvement with students who are experiencing mental health problems. A standard Likert-type scale, with one designating "strongly agree" to five designating "strongly disagree" was used.

A demographic section of the survey was used to gather background information on the participants. The questions asked were regarding the grade taught, years of experience teaching, gender, whether they taught special education or general education, and the name of the middle school they worked at out of the six middle schools in the district.

The pretest survey was emailed using Survey Monkey to all of the participants in the sample. The letter and consent are located in Appendix D. Respondents were given two weeks to complete the survey before a reminder email was sent giving the participants one more week to complete the survey. Professional learning sessions were offered to the teachers at one of the middle schools out of the six in the district. A post-test survey using Survey Monkey was given to these specific teachers. Results from the post-test survey were compared to results from the

pre-test survey (entire sample) using the Survey Monkey analyzing tool and IBM's SPSS statistics program.

Once the results were analyzed, the researcher looked to see if change occurred after professional development on childhood and adolescent mental health was given. The information garnered from the three open-ended questions on the survey was helpful in assessing more deeply teachers experience with student mental health in their classroom, level of training received in their credential program, level of training received from their school district, and opinions on the effectiveness of the professional learning sessions. This information was also helpful in planning future professional learning. One hundred and six out of 162 teachers responded to the initial survey emailed giving a return rate of 65.4%.

Data was also collected from results of the posttest survey emailed to just the participants attending the professional learning session on childhood and adolescent mental illness. There was also data collected from three open-ended questions. The posttest survey was given to the middle school teachers who attended the professional learning sessions at the end of the last session. The total return rate for the posttest survey was 100%.

Data Analysis

In this study, quantitative and qualitative data was used to look at changes in teacher attitudes, knowledge, and their perceived role in working with students with mental health issues after professional development was offered.

Data was analyzed using a mixed-methods, sequential explanatory design. This is a type of design that employs the collection of quantitative data which was then analyzed. The quantitative data was then used to create qualitative interview questions which were then coded

and analyzed. Results of these two methods yield potential answers to research questions developed.

The research method was used to collect and categorize the data. The open-ended responses from the survey were analyzed and coded, noting specific themes. The data was collected and then processed in response to the problems posed in Chapter 1 of this dissertation. The surveys were analyzed using Survey Monkey's data analysis tools and IBM's SPSS statistics software program.

After the data was collected from the pretest surveys, quantitative data analysis was employed to find out if the intervention caused a change in the teachers' attitudes, beliefs and knowledge towards students with mental health conditions. Descriptive statistics were utilized including percentages of responses.

The open-ended survey questions were coded using a two-person coding method. This qualitative method employed the researcher and a colleague coding the same questions. This method is useful because it gives more than one opinion of what information was gathered. The main goal, which drove the collection of data and the subsequent data analysis was to develop an understanding of teachers' attitudes, beliefs and knowledge in regard to student mental health. The survey questions were created by this researcher using the four research questions posed at the beginning of this chapter.

Table 2

Survey Questions that Correspond with Research Questions

Survey Question #	Research Questions Addressed	
1	Experience with MH	1

2	Student Identification	1
3	Students with MH Treatment	1

Survey Question #	Research Questions Addressed	Survey Question #
4	Amount of Behavior Training	2 & 3
5	Experience Using Behavior	4
6	Increase in MH	1
7	MH Training Pre-Service	2
8	MH Training School Site	3
9	Knowledge to Meet MH Needs	2 & 3
10	MH Role	4
11	Skills to Meet MH Needs	2 & 3

12	Support from Counselors	4
13	Support from Psychologists	4
14	School Involvement in MH	4
15	Role of Teachers	4
16	Role of Mental Health Staff	4
17	Top Three MH Issues	1
18	Additional MH Training	1, 2, & 3
19	Experience/Learning Format	1, 2, & 3
20	Behavior Training	2 & 3

Plan to Address Ethical Errors

Before the research began, permission was obtained from district administrators to conduct the study. A research study proposal was presented to committee members and approval was granted by the Institutional Review Board (IRB). The participants were informed that the study looked at teachers and their relationships with mentally ill students in their classroom. Consent forms, which stated the overall purpose of the study, were emailed along with the

survey to the participants. They were also informed that their survey answers were kept confidential. Survey questions were created thoughtfully to ensure that they did not have the potential to trigger someone sensitive to the questions. The participants were told that they did not have to complete the survey as it was on a voluntary basis. Due to the nature of this study, potential risks were characterized as minimum to none in that only the perspectives of middle school teachers were analyzed. The data in this study was collected, analyzed, and reported using the appropriate methods. All results were based on the findings of data collected and all positive and negative findings were communicated accordingly. After the study was completed, the researcher reported results to the administration that allowed access to the study as well as the participants.

This study was conducted using this researcher's district of employment. This researcher chose middle school teachers as the middle schools are the schools that this researcher works most closely. Five of the six middle school principals were emailed asking if they wanted to participate in this research project by receiving professional learning on mental health at their school site. The middle school selected to receive the professional learning was selected on a first come, first served basis. One of the six middle schools was not asked to participate in the professional learning sessions as they have a mental health program on campus. It is thought by this researcher that they may be biased in terms of their attitudes, beliefs, and knowledge due to their positive and/or negative experiences with the students from the mental health program who mainstream in their classes. These teachers were asked to participate in the pretest survey. One of the demographic questions on the survey asked the respondent to identify the middle school where they were employed. Analyzing the survey results from this particular school was

important to understanding how exposure with students identified as having mental health issues impacts a teacher's attitudes and beliefs about student mental health.

Summary

This mixed methods explanatory sequential design study addressed the hypothesis that teachers want to help students with mental health issues in their classrooms, but do not have the training and knowledge to feel competent doing it. Research questions were presented at the beginning of the chapter. The school district was selected based on the researcher's employment at this district. Selection of the 162 general education teachers was described. Validity and reliability was discussed. A description of the data collection and data analysis was discussed in this chapter. Results of the analysis are presented in Chapter Four of this dissertation.

CHAPTER 4: RESULTS

Analysis of the Survey

This chapter presents the results of the study in the sequence in which the author introduced the research tools. The pre-intervention survey and the post-intervention survey contain a fixed questionnaire as well as open-ended questions. A pretest survey was designed to give middle school general education teachers the opportunity to share their attitudes, beliefs, and knowledge regarding student mental health. One hundred and sixty two general education middle school teachers were emailed a pretest survey. The teachers were each instructed to complete the 25-question survey within a two-week period of time. Of the 162 teacher who received surveys, 106 were completed and returned. Of the 25 items on the survey there were three questions that contained demographic information. The focus of this study was on items pertaining to teacher reported mental health concerns in their schools, report of knowledge, skills, and training, as well as perceived roles of teachers, school psychologists and counselors.

Pre-Intervention Survey

The pre-intervention survey was designed to give teachers the opportunity to provide insight into their attitudes, beliefs and knowledge regarding student mental health issues. The participants were general education teachers from the six middle schools in the district. The 21 question survey contained three parts: demographic information, questionnaire type items (Likert scale, yes or no, true or false) and open-ended questions. For the demographic questions, the participants were asked information about the grade they taught, years of teaching experience, gender and the name of the middle school where they teach.

Demographic Survey Question 1: “What grade do you teach?” Of the 99 responses to this survey indicated, 58.59% of teachers teach sixth grade, 67.66% of teachers teach seventh grade, and 62.63% of the teachers teach eighth grade. A bar graph of the results is in Figure 4.1.

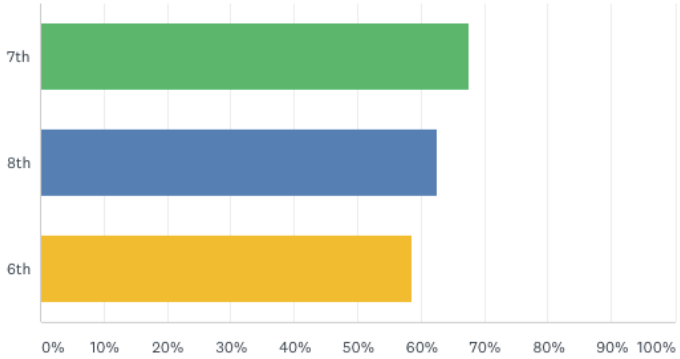


Figure 4.1: Demographic Question 1: This figure illustrates the percentages of teachers teaching sixth, seventh, and eighth grade.

For the question, “How long have you been teaching?”. The survey results indicated that 32.67% of teachers have taught for over 20 years, 22.77% for 16-20 years, 16.83% for 1-5 years, and 13.86% for 11-15 years.

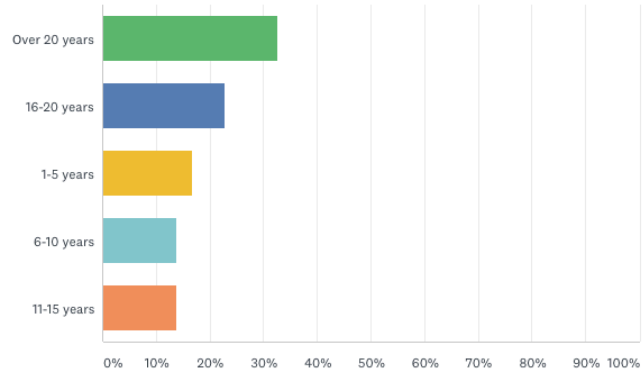


Figure 4.2: Demographic Question 2: This figure illustrates the percentages of teachers who have taught from 1 year to over 20 years.

Demographic Survey Question 3: "What is your gender?" The survey results indicated that 68% of teachers who participated in the survey are female and 32% are male.

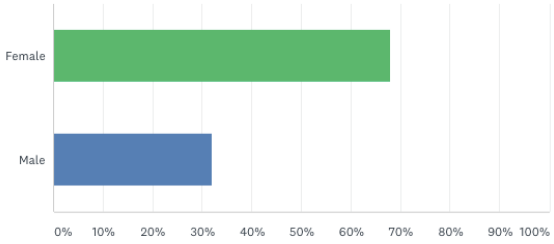


Figure 4.3: Demographic Question 3: This figure illustrates the percentages of teachers who are male or female.

For the last of the demographic questions the middle school teachers were asked in Survey Question 4, "What is the name of your school?"

Table 3

Specified Responses to "What is the name of your school?"

	School Percentage
School A	32%
School B	18%
School C	15%

School D	14%
School E	14%
School F	10%

Reported pre-survey data by either table chart or graph for the next 17 questions is presented with data provided by all the general education middle school teachers

Survey Question 5: “Have you taught a student in the past year with a mental health issue?” Of the 105 responses to this survey, results indicated 90.48% have taught a student with ADHD, 87.62% with social skills problems, 86.67% with disruptive behavior, 76.19% with defiant behavior, 75.24% victim of bullying, 71.43% with aggressive behavior, 70.48% with depression, 69.52% with anxiety, 43.81% engaged in cutting behavior, 20% with bipolar disorder, 17.14% with an eating disorder, 12.38% with post-traumatic stress disorder, and 2.86% answered other.

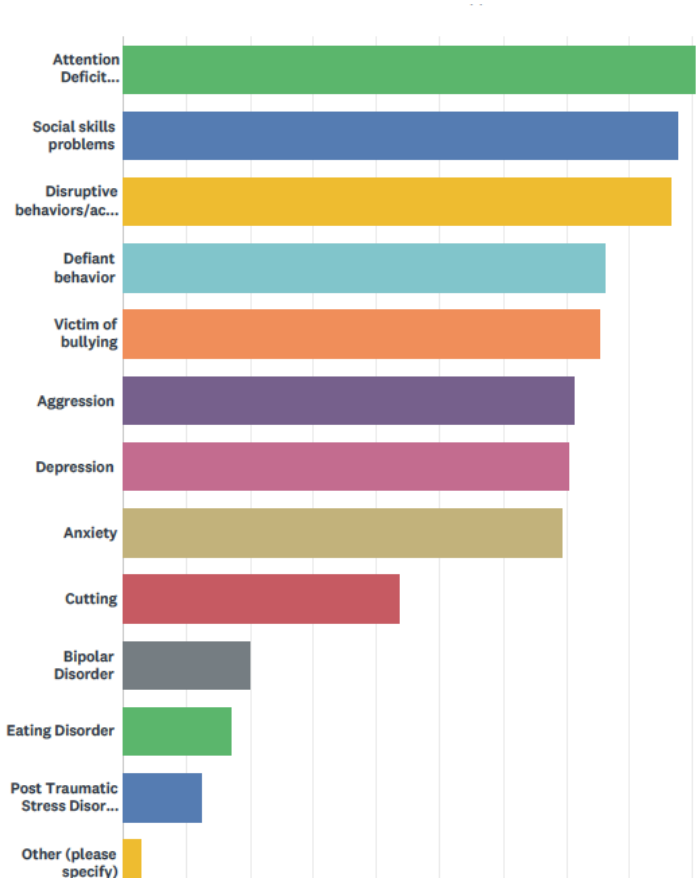


Figure 4.4. Survey response showing the percentages of various mental health disorders that effect students in general education classes.

Table 4

Pre-intervention Open-Ended Teacher Survey: Specified Responses to "Other"

"Have you taught a student in the past year with a mental health problem?"

Other	
T1	"Oppositional Defiant Behavior"
T2	"Autism"
T3	"We don't know

Survey Question 6: "What percentage of your students (rough estimate) have been identified as having a mental illness"? Of the 102 responses to this survey question, results indicated that 52.94% have 0-10% of students, 34.31% have 11-20%, 6.86% have 31-40%, 4.90% have 21-30%, and 0.98% have over 40% of students with a mental illness. A bar graph of the results is in Figure 4.5.

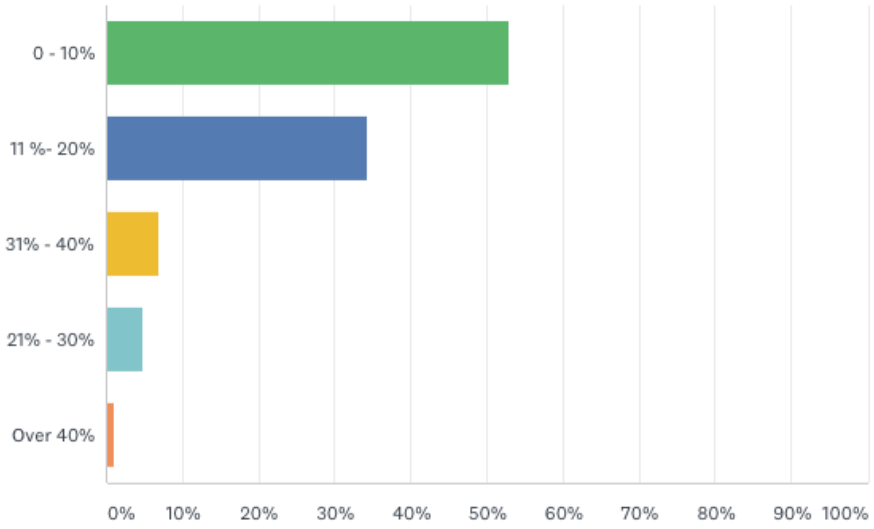


Figure 4.5. Survey response showing the percentages of students with an identified mental illness.

For the question, "What percentage of your students (rough estimate) currently receive mental health services at school"? Of the 101 responses to this survey question, results indicated that 71.29% of 0-10%, 25.74% have 11-20%, 1.98% have 21-30%, 0.99% have 31-40%, and 0.00% have over 40% of students with a mental illness. A bar graph of the results are shown in Figure 4.6.

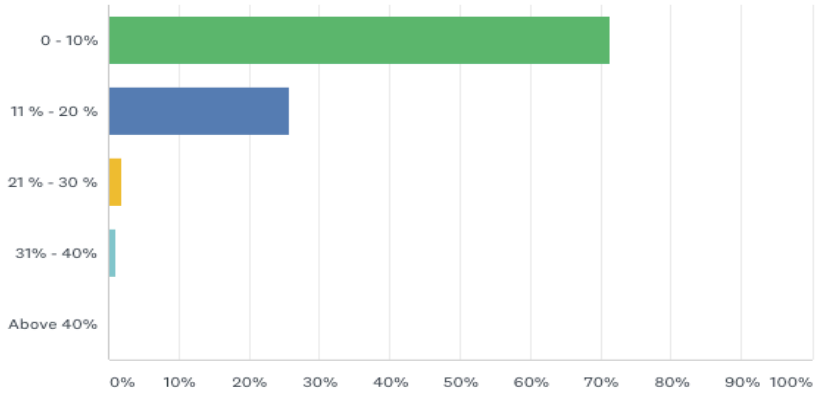


Figure 4.6. This figure illustrates the percentages of students who receive mental health services at school.

For the question, “Rate the amount of training you have had in using behavioral interventions”? Of the 106 responses to this survey question, results indicated that 63.21% have received minimal training, 16.04% received moderate, 15.09% have received no training, and 5.66% have received a substantial amount of training. A bar graph of the results is shown in Figure 4.7.

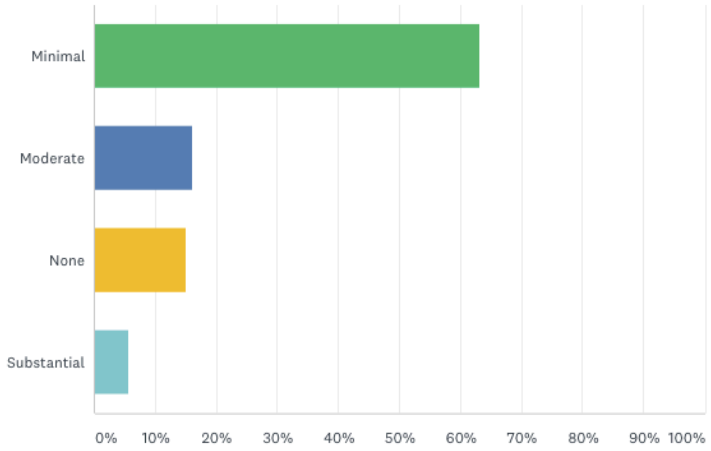


*Figure 4.*7 This figure illustrates the percentage of training teachers have had in using behavioral interventions with students.

Survey Question 9: "Rate the amount of experience you have had in using behavioral interventions with your students"? Of the 106 responses to this survey question, results indicated that 45.28% have minimal experience, 34.91% have moderate experience, 10.38% have substantial experience, and 9.43% have no experience using behavioral interventions with students. A bar graph of the results is shown in Figure 4.8.

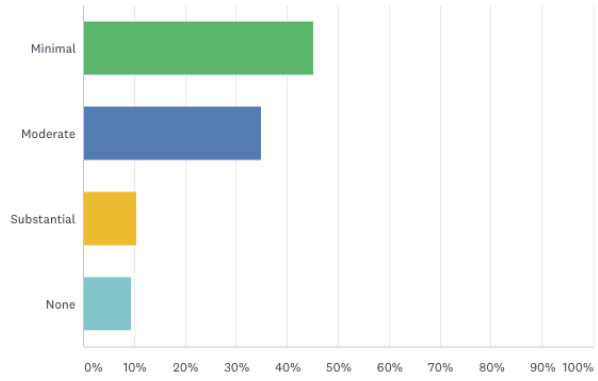


Figure 4.8. This figure illustrates the percentage of experience teachers have had in using behavioral interventions with students.

For the question, "Do you feel that the number of students with mental health problems is increasing?". Of the 106 responses to this survey question indicate 81.13% of teachers replied yes, 16.98% were unsure, and 1.89% replied no. Results to this question are indicative of teachers' perceptions that the number of students with mental health problems is increasing as shown in Figure 4.9

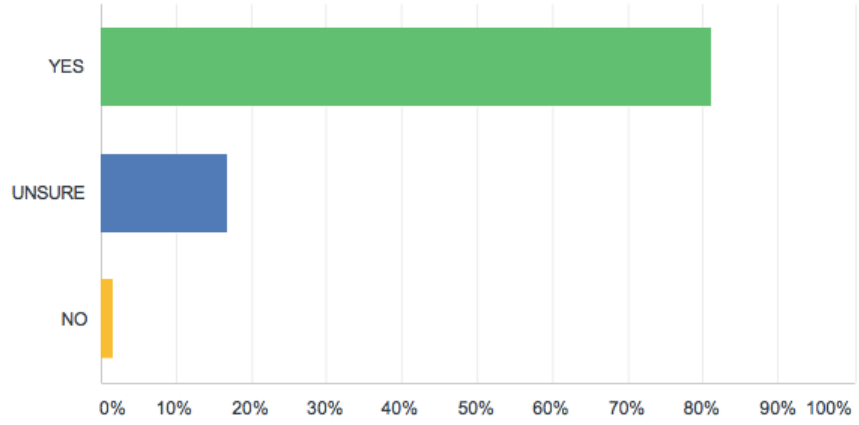


Figure 4.9. This figure illustrates the percentage of teachers who believe that the number of students with mental health problems is increasing.

Survey question 11: "How much training/instruction did you receive on mental health in your pre-service teaching program?". Of the 106 responses to this survey question

indicate, 54.72% of teachers reported minimal training, 41.51% no training, 2.83% substantial training and 0.94% received moderate training on mental health in their pre-service training program. Results of this survey question are indicative of the lack of mental health training teachers receive in the pre-service college programs as shown in Figure 4.10.

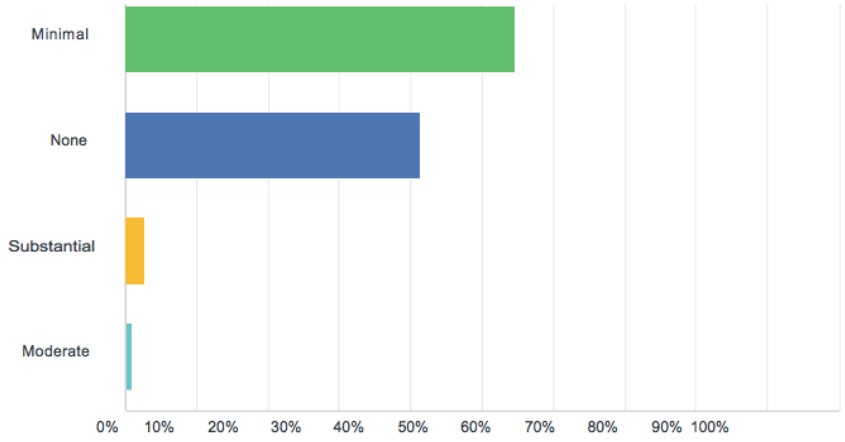


Figure 4.10. This figure illustrates the percentage of training/instruction that teachers reported having received on mental health in their preservice program.

For question 12, “Do you feel there is a need for additional mental health training at your school?”. Of the 104 responses to this survey question, 96.15% replied yes and 3.85% of teachers felt they did not need additional mental health training at their school site. Results from this survey question are indicative of the large majority of general education teachers who feel a need for mental health training as shown in Figure 4.11.

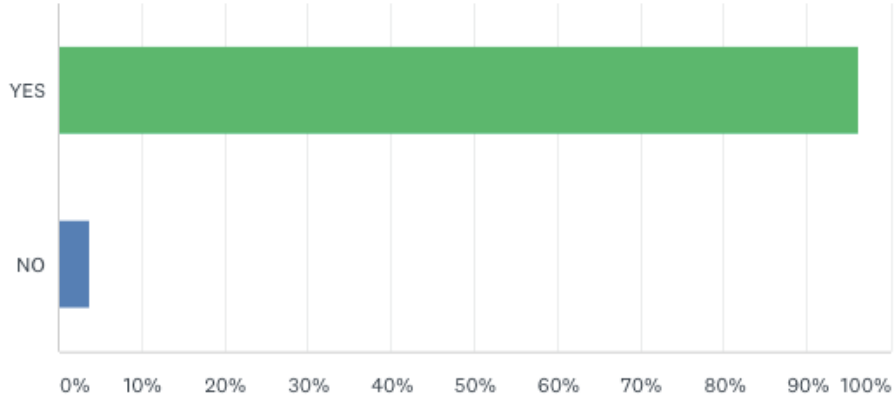
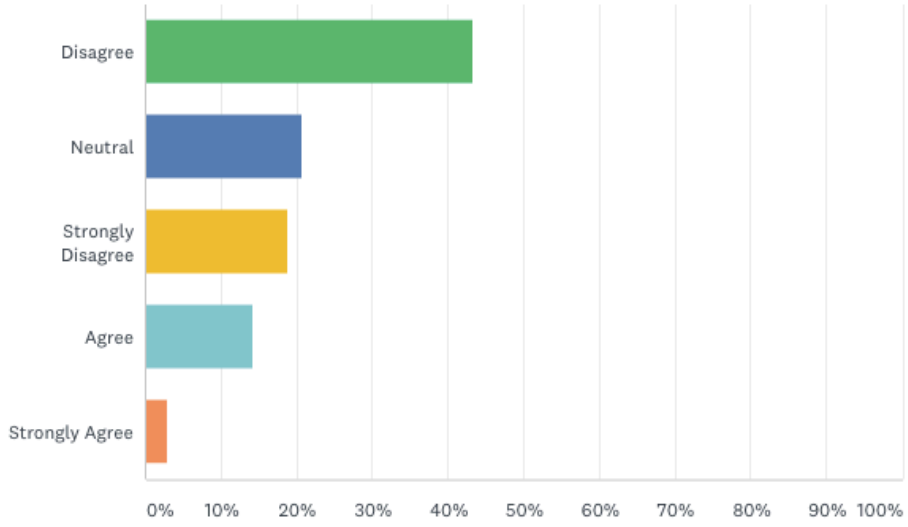


Figure 4.11. This figure illustrates the percentage of teachers who felt there was a need for additional mental health training at their school site.

Survey question 13: “I feel like I have the level of knowledge required to meet the mental health needs of my students?”. Of the 106 responses to this survey question, 43.40% of teachers disagree, 20.75% of teachers were neutral, 18.82% of teachers strongly disagree, 14.15% agree, and 2.83% of teachers strongly agree. Results from this survey question are indicative of a majority of teachers who feel they do not have the background knowledge required to meet the needs of their students with mental health issues as shown in Figure 4.12.



4.12. This figure illustrates the percentage of teachers who felt they have the knowledge required to meet the mental health needs of their students.

For the question, "Addressing mental illness is not considered a role/priority of my school". Of the 104 responses to this survey question, 50.96% of teachers replied false and 49.04% of teachers replied true.

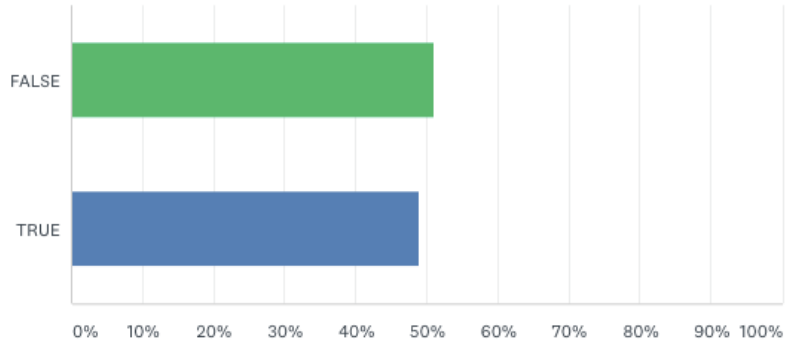


Figure 4.13. This figure illustrates the percentage of teachers who feel addressing mental illness is not considered a role/priority of their school site.

Survey question 15: "I feel I have the skills required to meet the mental health needs of my students". Of the 106 responses to this survey question, 45.28% of teachers disagree,

25.47% of teachers were neutral, 14.15% of teachers agree, 13.21% of teachers strongly disagree, and 1.89% of teachers strongly agreed. Results from this survey question are indicative of a majority of teachers who feel they do not have the skills required to meet the needs of their students with mental health issues as shown in Figure 4.14.

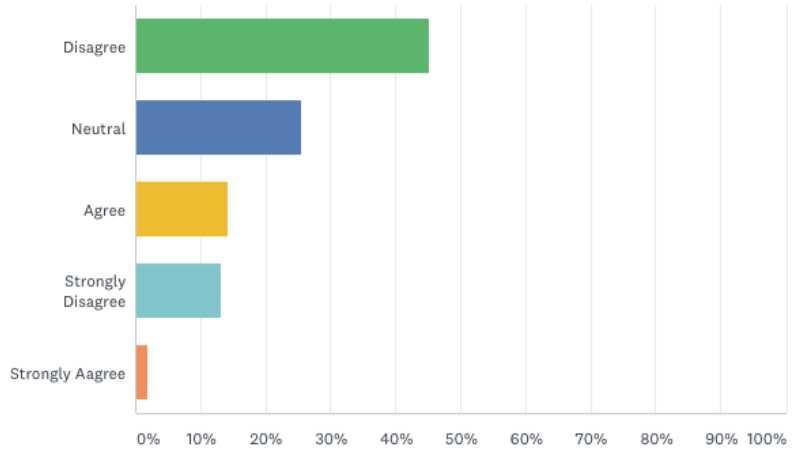


Figure 4.14. This figure illustrates the percentage of teachers who feel they have the skills required to meet the mental health needs of their students.

Survey question 16: "Do you feel supported by the counselor(s) at your school?" 42.45% of teachers agree, 35.85% of teachers strongly agree, 17.92% were neutral, 1.89% disagree, and 1.89% strongly disagreed. The answers to this question are indicative of almost half of the teachers surveyed feel supported by the counselors at their school as shown in Figure 4.15.

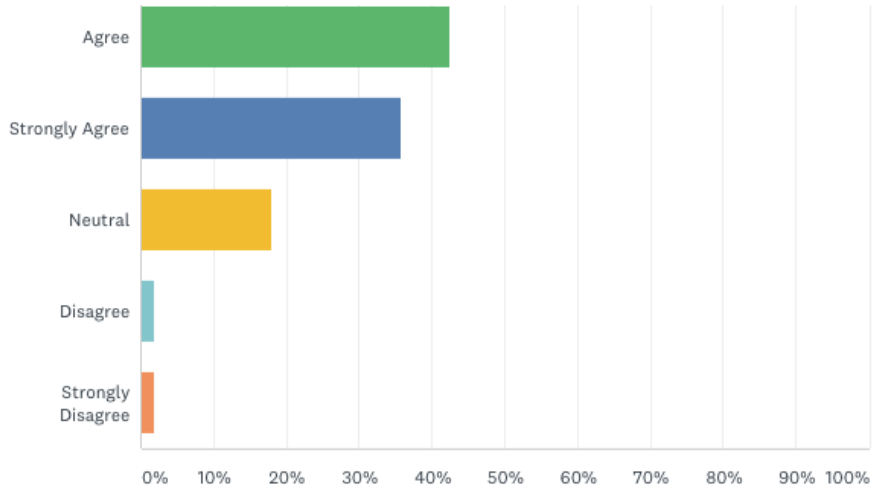


Figure 4.15. This figure illustrates the percentage of teachers who feel supported by the counselor(s) at their school.

For question 17, "Do you feel supported by the school psychologist at your school?" 34.91% of teachers agree, 32.08% of teachers were neutral, 23.58% strongly agree, 7.55% disagree, and 1.89% strongly disagree. Results are shown in Figure 4.16.

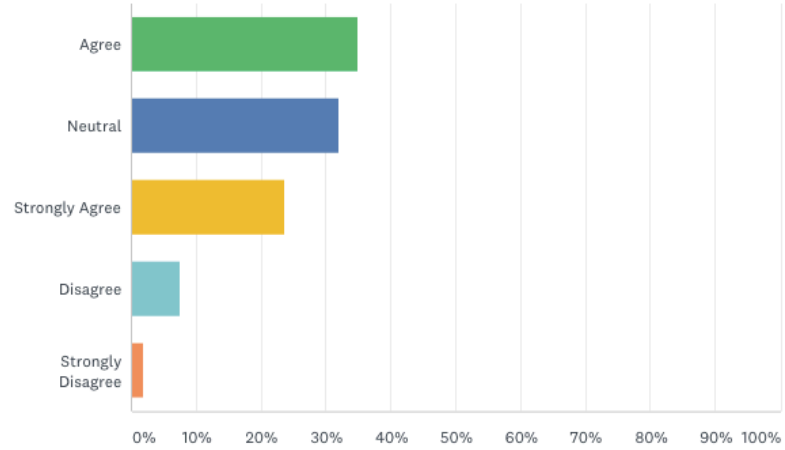


Figure 4.16. This figure illustrates the percentage of teachers who feel supported by the school psychologist at their school.

Survey question 18: "I feel that schools should be involved in addressing the mental health issues of students?" Fifth percent of teachers agree, 41.51% of teachers strongly agree,

5.66% were neutral, 1.89% disagree, and 0.94% strongly disagree. Results are indicative of the belief shared by one half of the teachers that their school should be involved in addressing student mental health needs as shown in Figure 4.17.

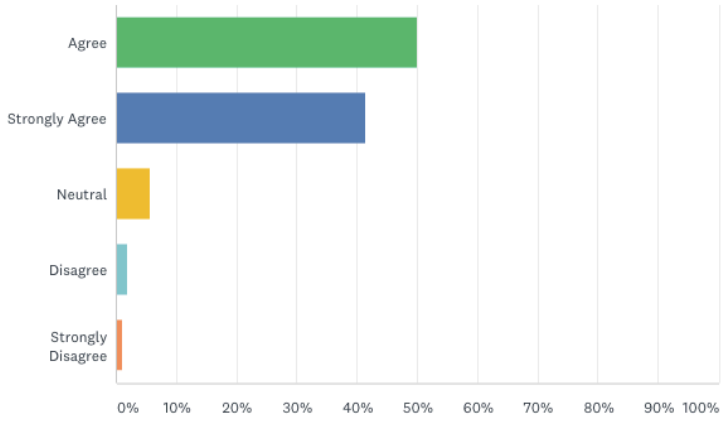


Figure 4.17. This figure illustrates the percentage of teachers who feel that schools should be involved in addressing the mental health issues of students.

Survey question 19 inquired, "What is the role of teachers related to mental health in your school. Check all that apply?" There were 82.35% of teachers who felt that teachers should implement classroom behavioral observations, 62.75% felt teachers should monitor student progress, 47.06% felt teachers should refer children and families to school-based mental health services, 40.20% felt teachers should teach social/emotional lessons, 18.63% felt teachers should screen for mental health problems, and 14.71% believed that referring children and families to outside mental health services is the role of the teacher.

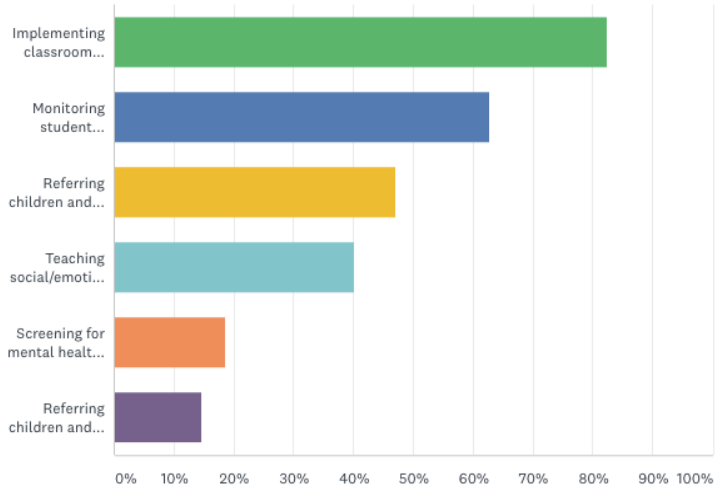


Figure 4.18. This figure illustrates the percentage of teachers who feel there are certain roles teachers should play related to mental health issues at their school.

For question 20, "What is the role of counselors/psychologists related to mental health in your school? Check all that apply". Eighty four percent of teachers felt that teachers should refer children and families to school-based mental health services, 81% should monitor student progress, 78% feel referring children and families to outside mental health services 69% screening for mental health problems, 57% teaching social/emotional lessons, and 42% feel counselors and psychologists should implement behavioral interventions in the classroom.

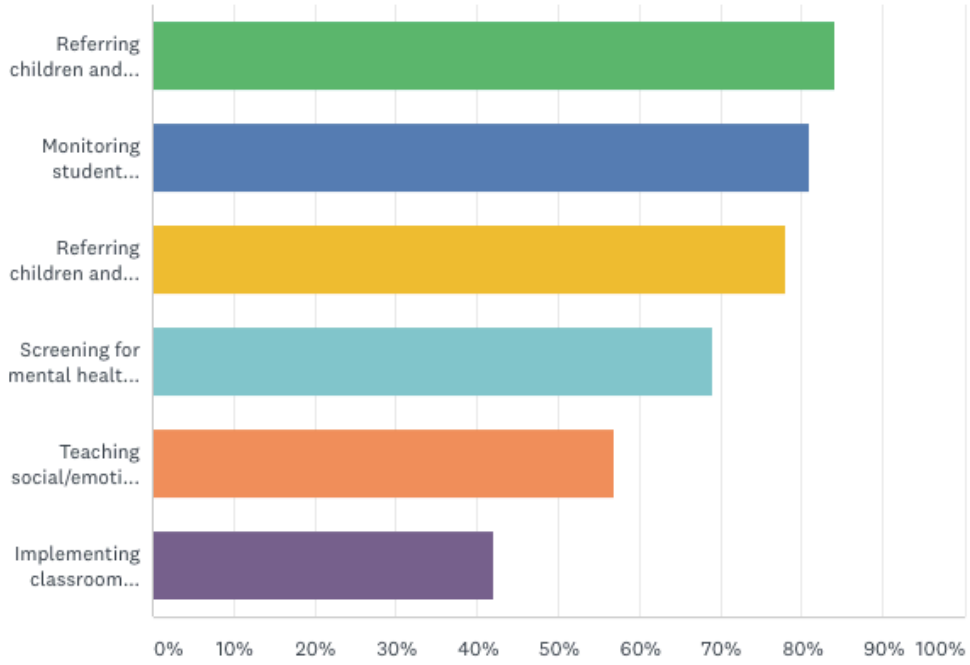


Figure 4.19. This figure illustrates the percentage of teachers who describe the role they feel counselors and psychologists should perform related to mental health issues at their school.

Survey question 21: "From which experience have you learned the most about mental health issues?" Results indicated 25.24% of teachers responded none of the choices listed, 22.33% reported through independent study/research, 14.56% replied other, 13.59% from professional development, 12.62% from graduate coursework, and 11.65% from undergraduate coursework.

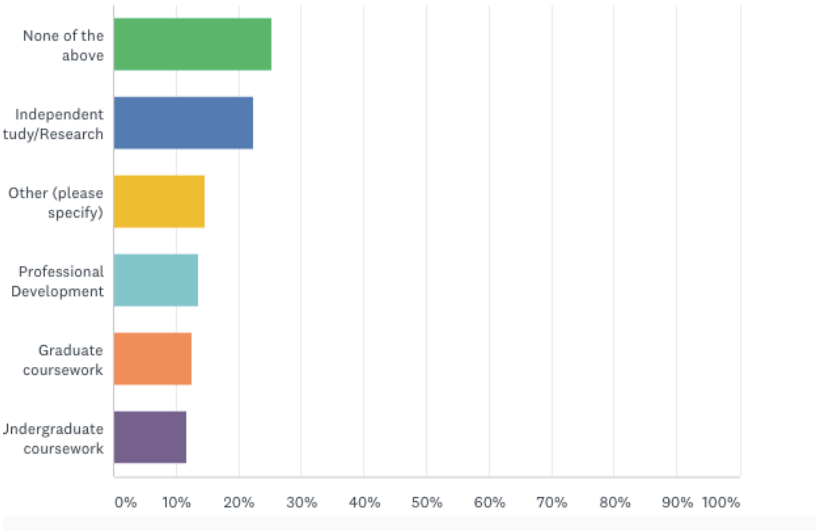


Figure 4.20. This figure illustrates which experiences teachers have learned the most about mental health issues.

There were several open-ended survey questions. For the question 22, "What are the top three mental health issues you face at your school", the top three answers were ADHD, Depression, and Anxiety. These three disorders were seen in students across the district the most frequently.

Table 5

What are the top three mental health issues you face at your school site?

	Responses
T1	"ADHD"
T2	"Depression"
T3	"Anxiety"
T4	"Disruptive Behavior"
T5	"Victim of Bullying"

T6	“Defiance”
T7	“Aggression”
T8	“Social Skills Issues”
T9	“Anger Control”
T10	“Cutting”
T11	“Trauma”
T12	“Acting Out”
T13	“Autism”
T14	“Stress”
T15	“Motivation”

In another open-ended question 23, “Which mental health issues and/or disorders would you like additional training?”, teachers were instructed to list topics on student mental health that they would like to receive more training. Teachers were instructed that they could check all of the disorders that apply. The three disorders that were listed the most by general education middle school teachers were ADHD, Depression, and Anxiety. Results are shown in Table 6.

Table 6

"*Which mental health issues and/or disorders would you like additional training?"*

Responses	
T1	"Depression"
T2	"All of Them"
T3	"Disruptive Behavior"
T4	"ADHD"
T5	"Anxiety"
T6	"Defiance"
T7	"Cutting"
T8	"Behavioral Interventions"
T9	"Bipolar Disorder"
T10	"Social Skills Problems"
T11	"Trauma, especially as it relates to adolescent males"
T12	"Victim of Bullying"
T13	"Autism but that isn't a mental health disorder"
T14	"Psychosis"

Table 6 (continued)

"*Which mental health issues and/or disorders would you like additional training?"*

	Responses
T15	"Ways to approach the disengaged attitude of students with depression"
T16	"Anger Management"
T17	"Obsessive Compulsive Disorder"
T18	"Defiance to start but training all throughout the year"
T19	"More open discussion with counselors who have info about students who are at risk"
T20	"Borderline Personality Disorder"

An open-ended question on the survey asked, "Besides independent research, college coursework, and professional development, from which experience have you learned the most about mental health issues?" The majority of teachers reported that they have learned more from personal experience and on the job training.

Table 7

"*Besides Independent Research, college coursework, and professional development, from which experience have you learned the most about mental health issues?"*

	Responses
T1	"Personal experience with students"
T2	"On the job training and personal experience"
T3	"I was an RSP and SPED instructional aide for a number of years in another school district"
T4	"Colleagues"
T5	"Previous career as a behavior consultant"
T6	"From teaching students with mental health issues"
T7	"I worked at a daycare for special needs"
T8	"Personal experience"
T9	"I worked in a mental hospital for four years"
T10	"Teaching credential classes"

From the survey, teachers were asked "What type of behavior intervention training have you had?" Results varied from having learned during graduate school coursework to having no previous behavior intervention training.

Table 8

Teachers respond to "What type of behavior intervention training have you had?"

	Responses
T1	"I have received training through my graduate program at Chapman and some in-service training with Special Education"
T2	"Restorative Justice"
T3	"None that I recall"
T4	"PBIS"
T5	"I don't think that I have had any"
T6	"From ASSIST team and the Diagnostic Center"
T7	"A lot"
T8	"PD-Tier Levels"
T9	"How to safely restrain an aggressive student"
T10	"Simple staff meetings that superficially address the issue"
T11	"ABA"
T12	"Minimal"
T13	"Bullying"
T14	"MTSS behavior training with Clay Cook and Capturing Kids Hearts"
T15	"CKH"
T16	"Nonverbal"
T17	"Very little. How to read/implement behavior plans"
T18	"Principal Wednesday in-service"
T19	"Body Language"
T20	"One Hour PD"

Pre-intervention Survey Results from School A

The following pre-survey results are from the data collected from School A. School A was the only school out of the six middle schools in the district that received the professional learning sessions. 33 general education teachers at School A completed the survey.

School A Demographic Survey Question 1: "What grade do you teach?" Of the 29 responses to this survey indicated, 51.72% of teachers teach sixth grade, 62.07% teach seventh grade, and 65.52% teach eighth grade. A bar graph of the results is in Figure 4.21.

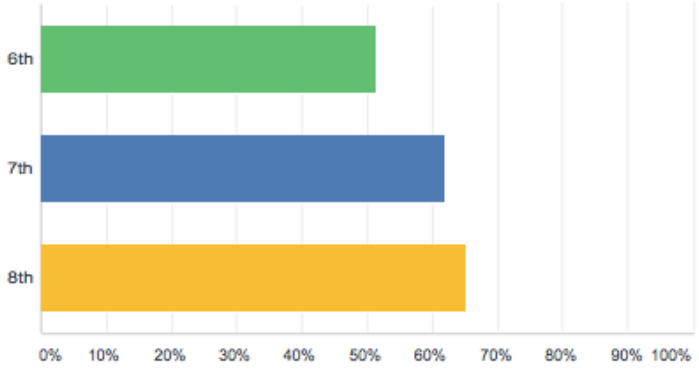


Figure 4.21. This figure illustrates the grades that School A teachers teach.

School A Demographic Survey Question 2: "How long have you been teaching?" The survey results indicated that 41.94% of teachers have taught for 16-20 years, 25.81% for over 20 years, 12.90% for both 6-10 years and 11-15 years, and 6.45% for 1-5 years.

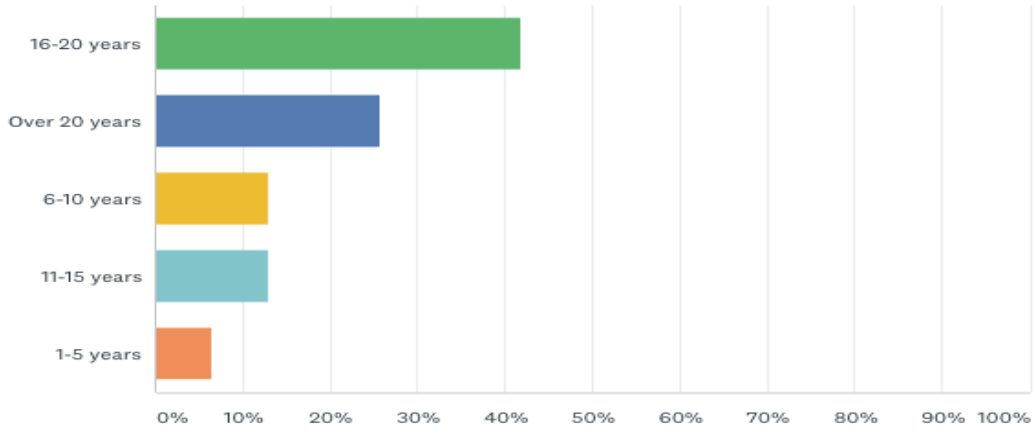


Figure 4.22. This figure illustrates the amount of years teachers who completed the survey have been teaching.

School A Demographic Survey Question 3: "What is your gender?" The survey results indicated that 54.84% of School A teachers are female and 45.16% are male.

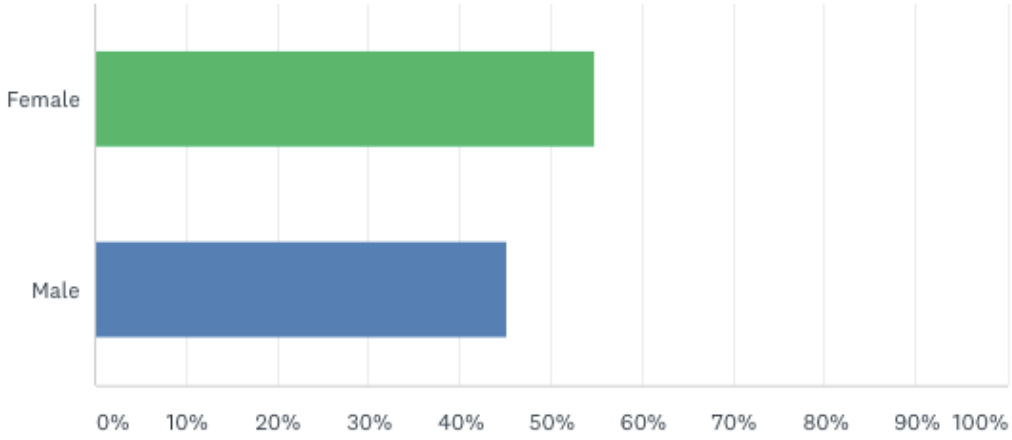


Figure 4.23. This figure illustrates the gender of the teachers who completed the survey.

For the question, "Have you taught a student in the past year with a mental health issue?" Of the 33 responses to this survey, results indicated 90.91% have taught a student with ADHD, 90.91% with disruptive behavior, 87.88% with social skills problems, 81.82% with aggression, 81.82% with defiant behavior, 75.76% victim of bullying, 72.73% with

depression, 69.70% with anxiety, 42.42% engaged in cutting behavior, 30.30% with bipolar disorder, 24.24% with an eating disorder, 12.12% with post-traumatic stress disorder, and 3.03% answered other.

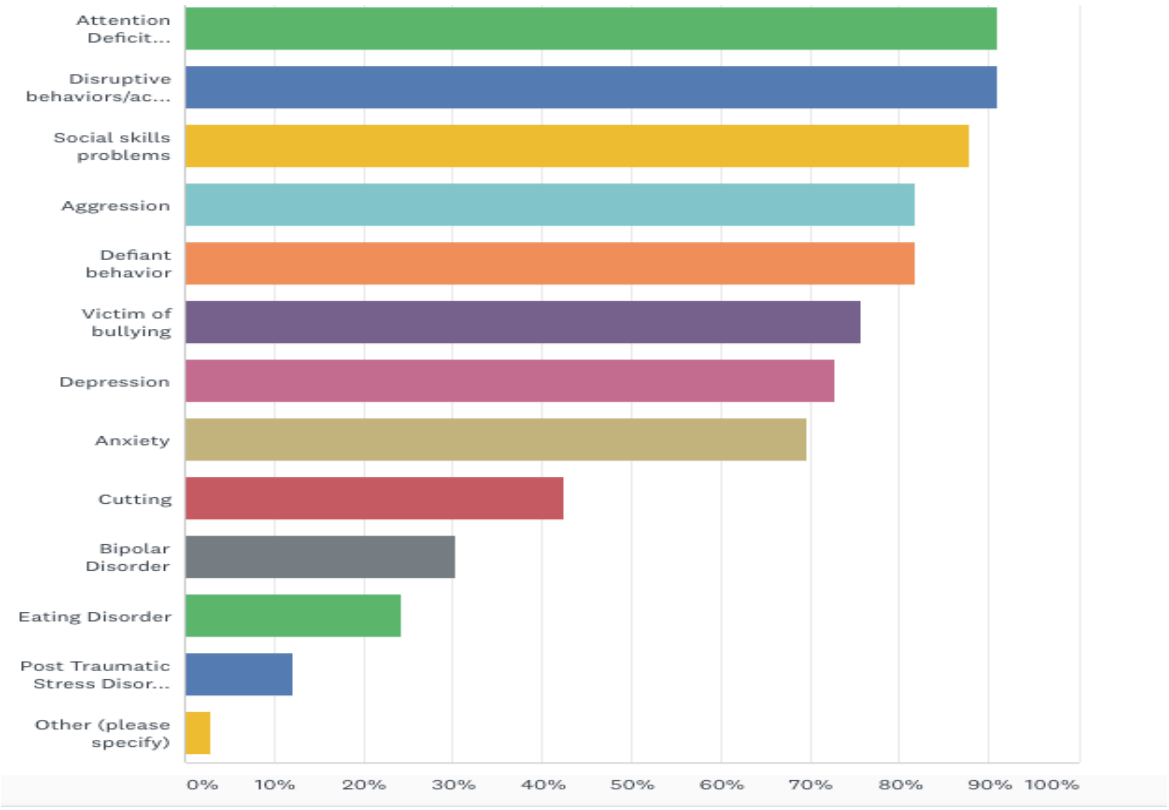


Figure 4.24. This figure illustrates the percentages of student mental health disorders in general education classes.

Table 9

Pre-intervention Open-Ended Teacher Survey: Specified Responses to "Other"

"Have you taught a student in the past year with a mental health problem?"

	Other Responses
T1	"Working with students with all types of disabilities"

For the question, “What percentage of your students (rough estimate) have been identified as having a mental illness”? Of the 32 responses to this survey question, results indicated that 46.88% have 11-20% of students, 37.50% have 0-10% of students, 6.25% have 21.30% of students, 6.25% have 31-40% of students, and 3.13% have over 40% of students with an identified mental illness.

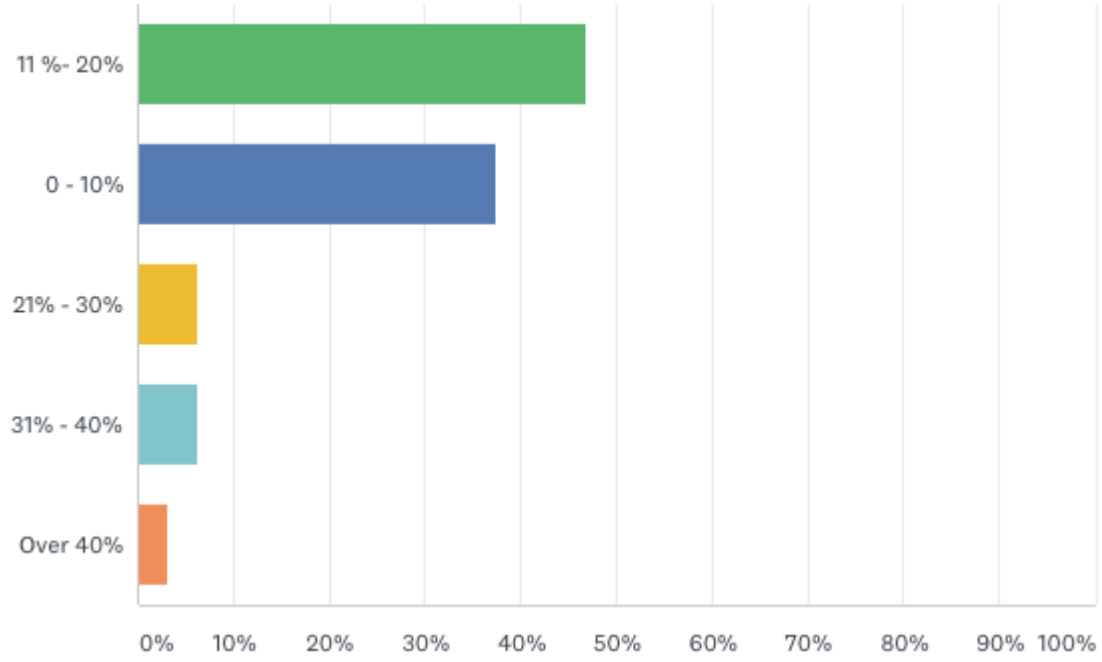


Figure 4.25. This figure illustrates the percentages of students with an identified mental illness in School A’s general education classes.

For the question, “What percentage of your students (rough estimate) currently receive mental health services at school”? Of the 32 responses to this survey question, results indicated that 59.38% of 0-10% of students, 37.50% have 11-20% of students, 3.13% have 21-30% of students, 0% have 31-40% of students, and 0% have over 40% of students who receive mental health services at school.

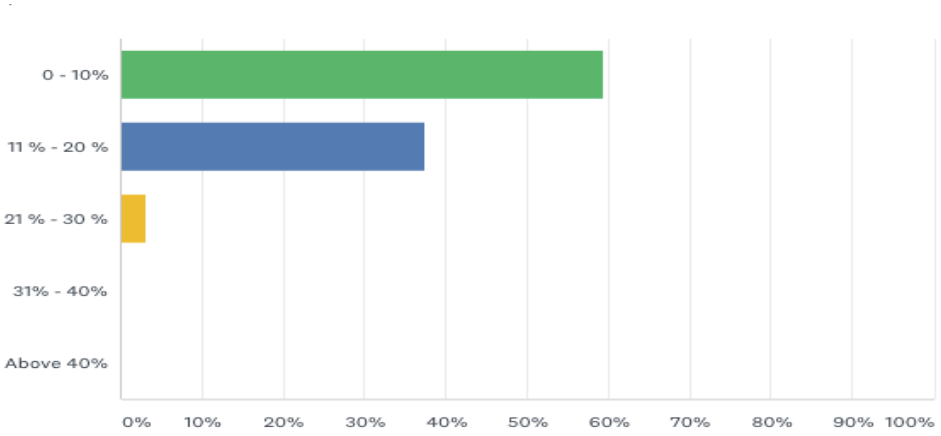


Figure 4.26 This figure illustrates the percentages of students who receive mental health services at school.

For the question, "Rate the amount of training you have had in using behavioral interventions"? Of the 33 responses to this survey question, results indicated that 51.52% have received minimal training, 21.21% received no training, 18.18% received moderate training, and 9.09% received a substantial amount of training.

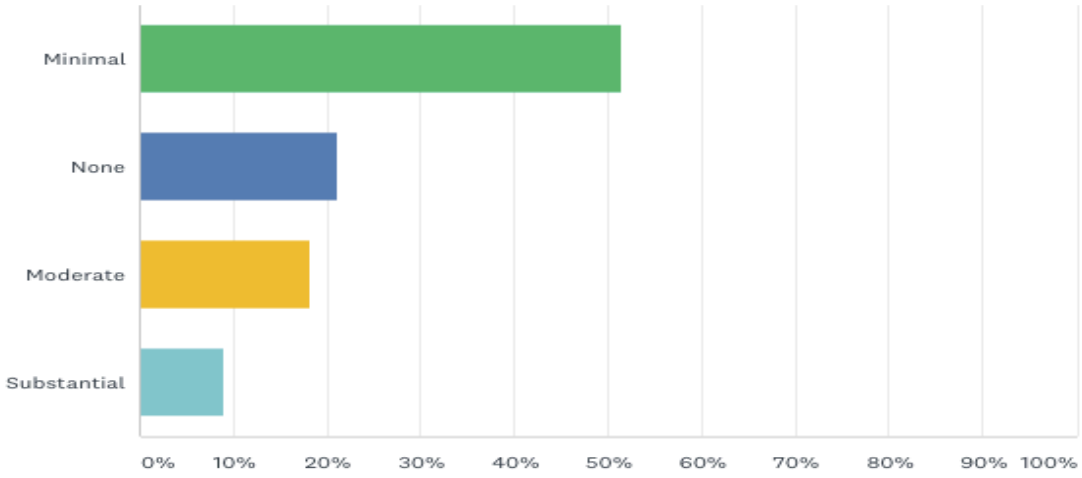


Figure 4.27 This figure illustrates the percentage of training teachers have had in using behavioral interventions with students.

Survey question 8 asked, “Rate the amount of experience you have had in using behavioral interventions with your students”? Of the 33 responses to this survey question, results indicated that 39.39% have minimal experience, 36.36% have moderate experience, 12.12% have no experience, and 12.12% have substantial experience using behavioral interventions with students.

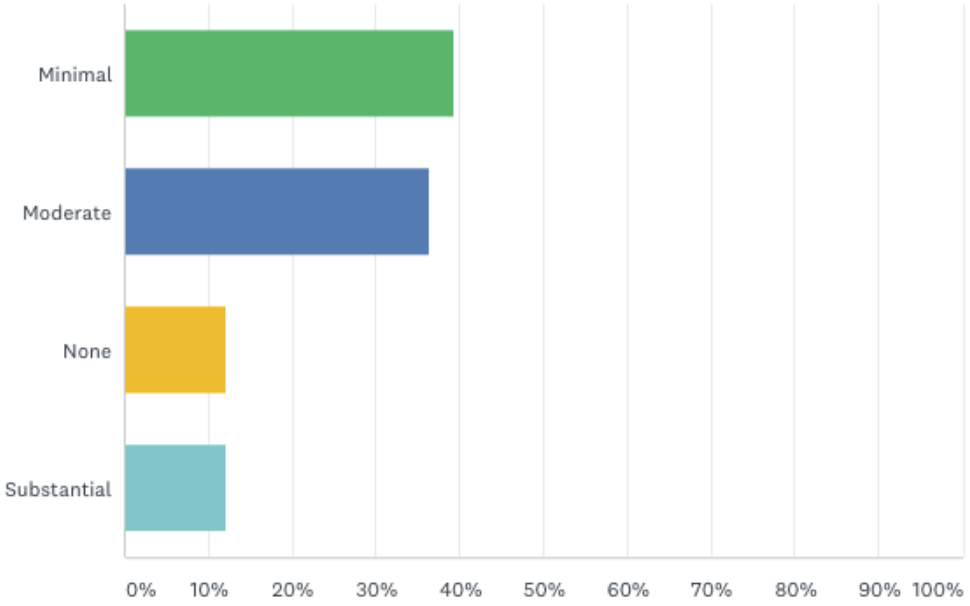


Figure 4.28. This figure illustrates the amount of experience School A teachers have with using behavioral interventions with their students.

For the question, “Do you feel that the number of students with mental health problems is increasing?” Of the 33 responses to this survey question indicate, 87.88% of teachers replied yes, 12.12% were unsure, and 0% replied no.

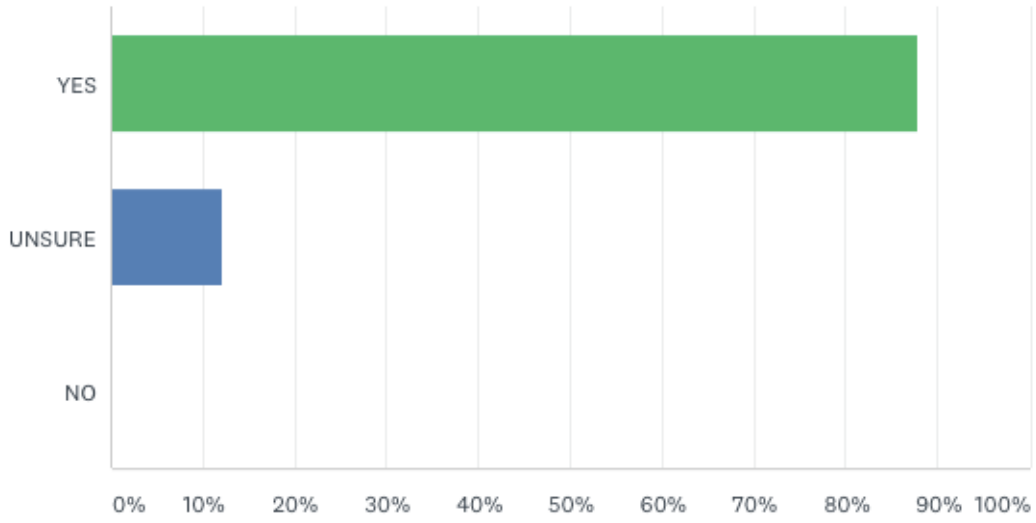


Figure 4.29. This figure illustrates the percentage of School A teachers who believe that the number of students with mental health problems is increasing.

For the question, “How much training/instruction did you receive on mental health in your pre-service teaching program?”. Of the 33 responses to this survey question indicate, 51.52% of teachers reported no training, 39.39% reported minimal training, 6.06% reported substantial training and 3.03% received moderate training on mental health in their pre-service training program. The results indicate that the majority of general education teachers at School A have not received any training in the area of child and adolescent mental illness.

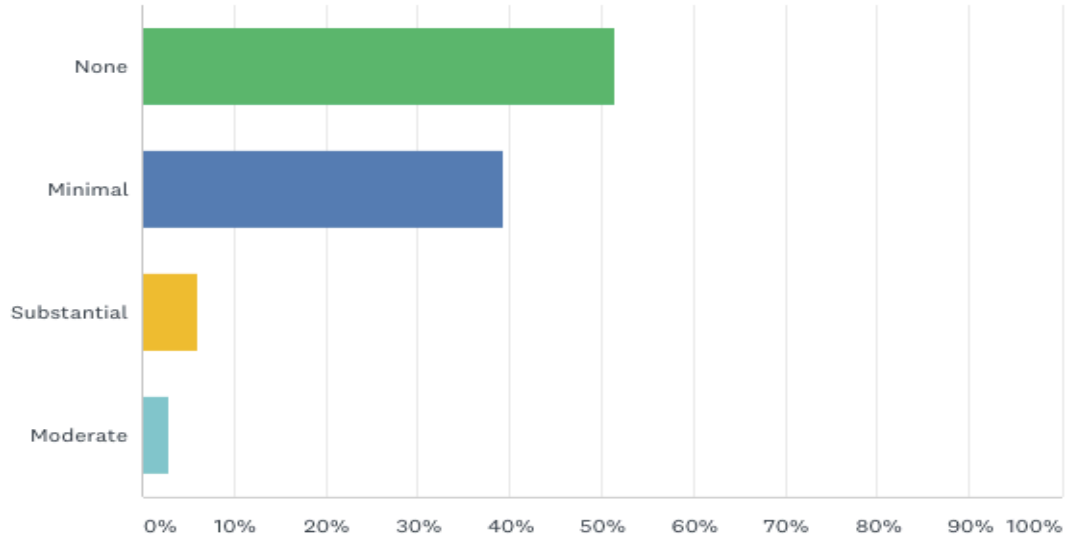


Figure 4.30. This figure illustrates the percentage of School A teachers who received training/instruction on mental health in their pre-service teaching programs.

All of the School A participants responded to the question, "Do you feel there is a need for additional mental health training at your school?" Of the 33 responses to this survey question, 96.97% replied yes and 3.03% of teachers felt they did not need additional mental health training at their school site. The results indicated that all but one respondent felt they need more training at their school site.

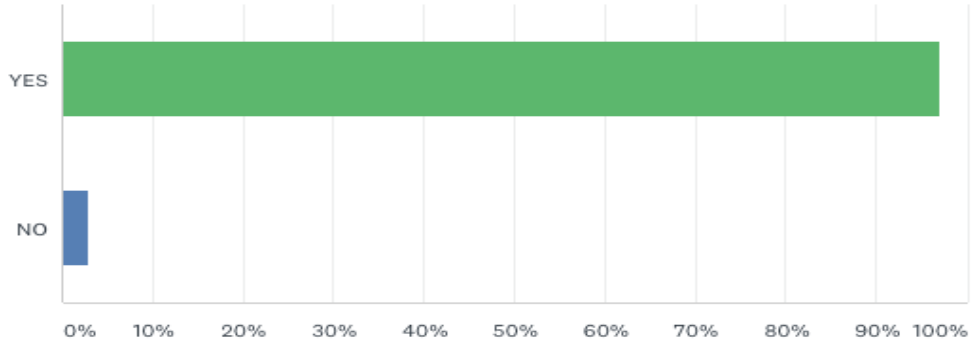


Figure 4.31. This figure illustrates the percentage of School A teachers who feel that there is a need for additional mental health training at their school site.

Survey question 12 asked, "I feel like I have the level of knowledge required to meet the mental health needs of my students?" Of the 33 responses to this survey question, 45.45% of School A teachers disagree, 24.24% of teachers strongly disagreed, 18.18% of teachers were neutral, 9.09% agree, and 3.03% of teachers strongly agree. There were 23 participants who disagreed or strongly disagreed with this survey question indicating teachers at School A do not feel they have enough understanding of student mental health disorders to support their students.

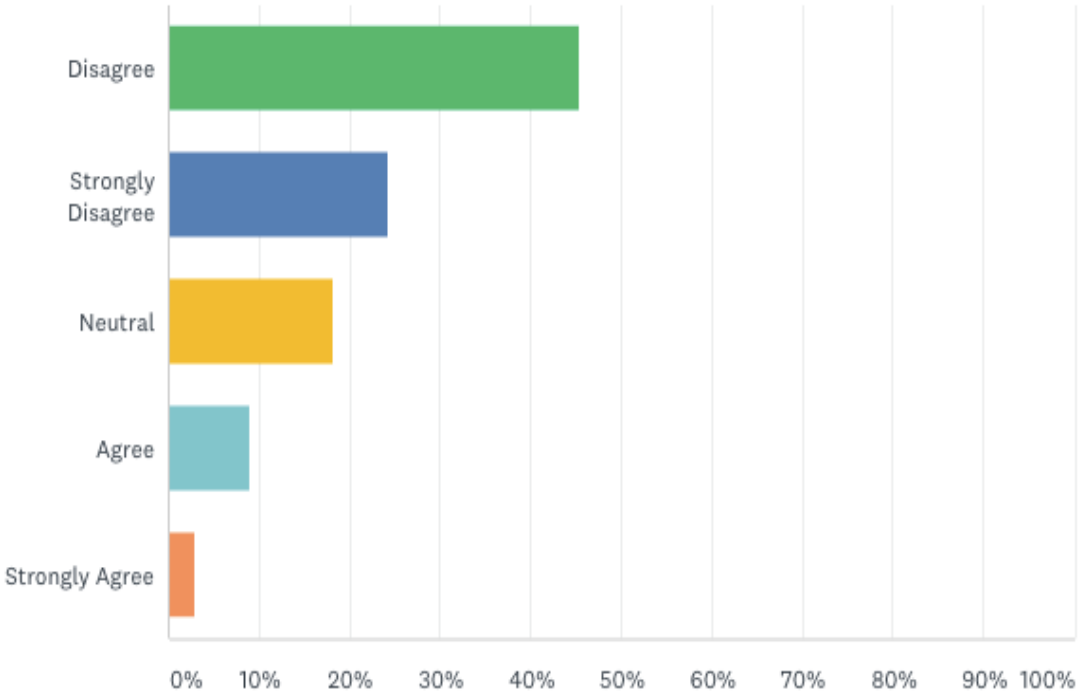


Figure 4.32. This figure illustrates the percentage of teachers who felt they had the knowledge required to meet the mental health needs of their students.

For the question, “Addressing mental illness is not considered a role/priority of my school” 51.52% of School A teachers replied true and 48.48% of teachers replied false.

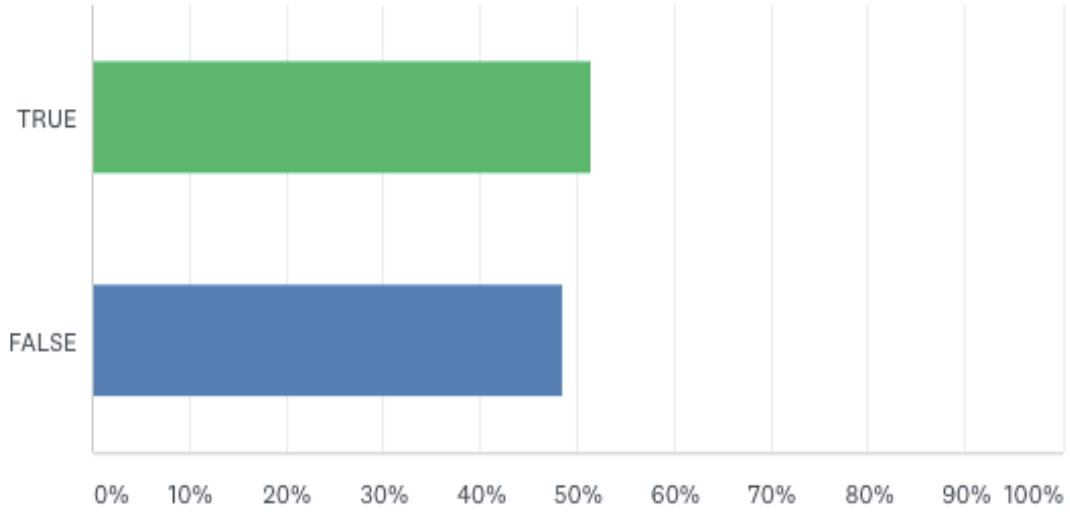


Figure 4.33. This figure illustrates the percentage of teachers who feel addressing mental illness is not considered a role/priority of their school site.

Survey question 14 asked, “I feel I have the skills required to meet the mental health needs of my students”. Of the 33 responses to this survey question, 45.45% of teachers disagree, 24.24% of teachers were neutral, 18.18% of teachers strongly disagree, 12.12% of teachers agree, and 0.0% of teachers strongly agreed. Like the survey question about having the knowledge to support their students, the majority of teachers also felt they did not possess the skills required to meet the needs of their students with mental illness.

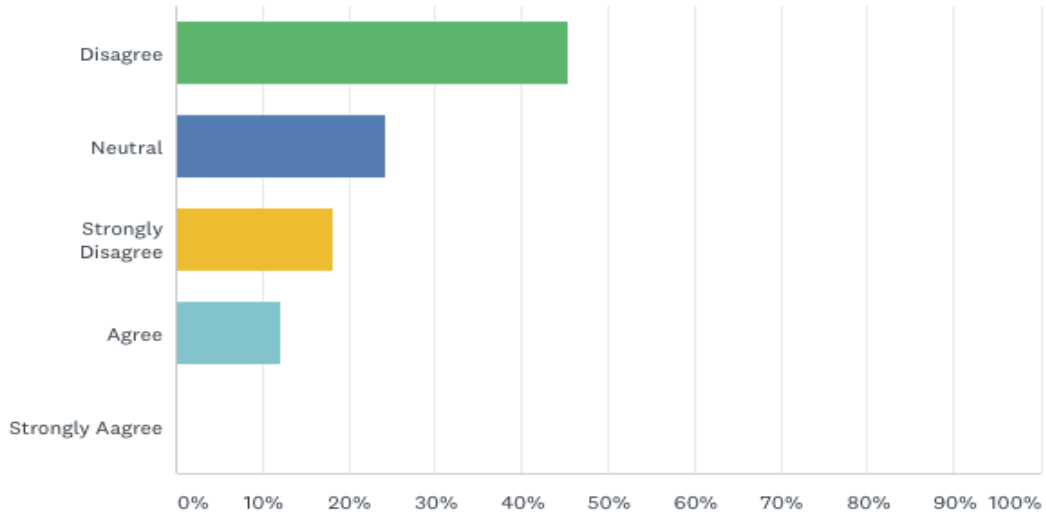


Figure 4.34. This figure illustrates the percentage of School A teachers who feel they have the skills required to meet the mental health needs of their students.

Survey question 15: "Do you feel supported by the counselor(s) at your school?"

53.13% of teachers strongly agree, 34.38% of teachers agree, 12.50% were neutral, 0.0% disagree, and 0.0% strongly disagree.

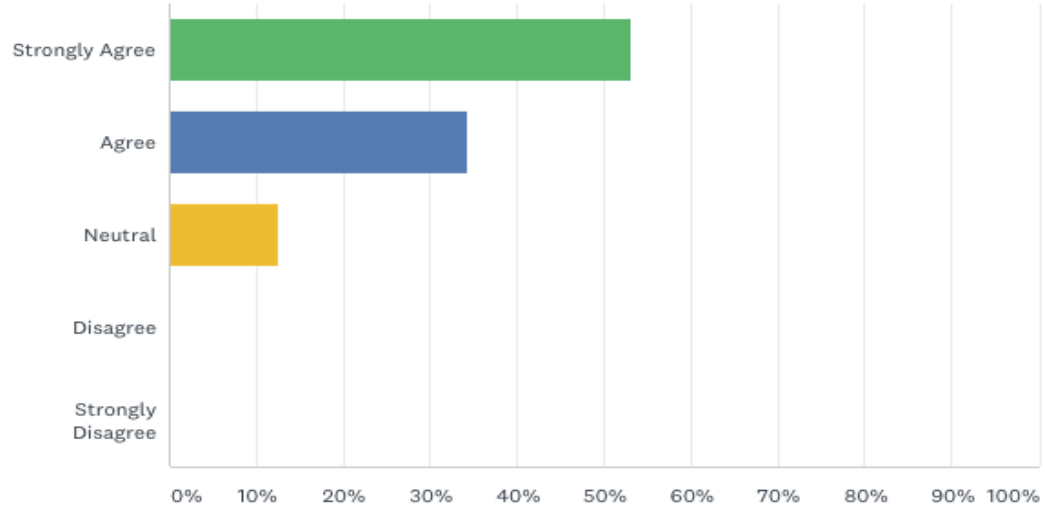


Figure 4.35. This figure illustrates the percentage of School A teachers who feel supported by the counselor(s) at their school.

Survey question 18: "Do you feel supported by the school psychologist at your school?" The results indicated 36.36% of School A teachers strongly agree, 30.30% of teachers agree, 30.30% are neutral, 3.03% disagree, and 0% strongly disagree.

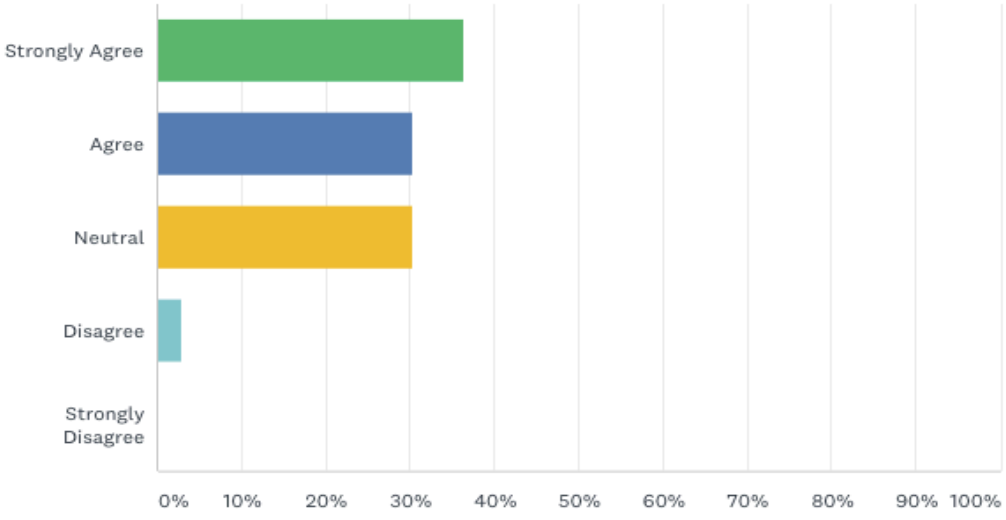


Figure 4.36. This figure illustrates the percentage of School A teachers who feel supported by the school psychologist at their school.

For the survey question, "I feel that schools should be involved in addressing the mental health issues of students?" Of the 33 teachers who responded, 48.48% of teachers

agree, 36.36% of teachers strongly agree, 15.15% were neutral, 0.0% disagree, and 0.0% strongly disagree.

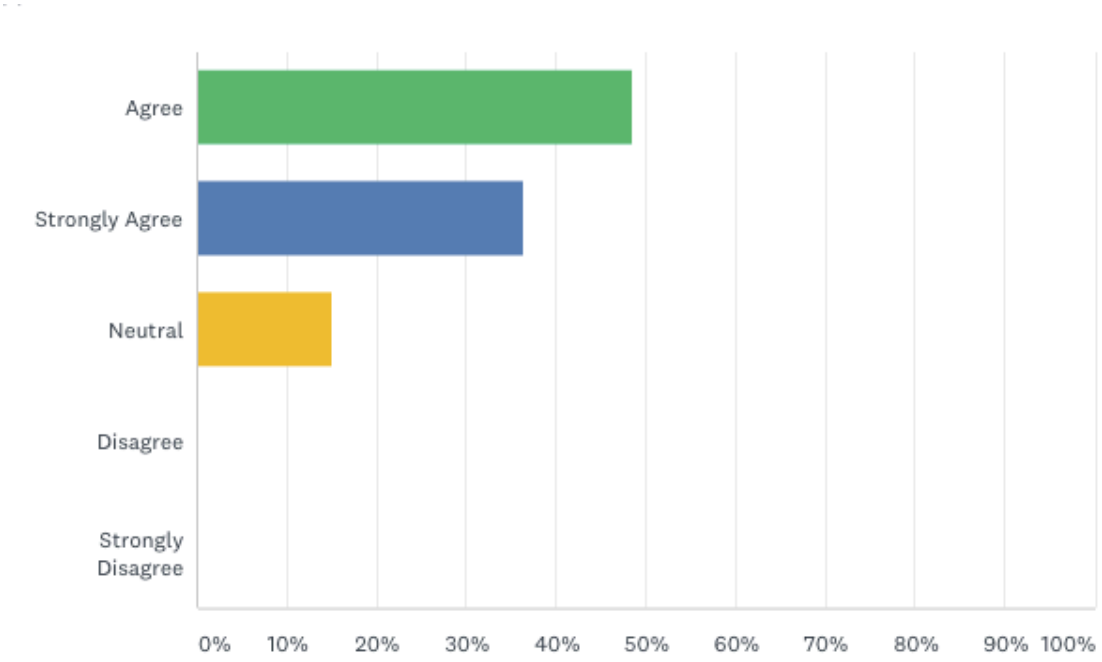


Figure 4.37. This figure illustrates the percentage of teachers who feel that schools should be involved in addressing the mental health issues of students.

For the question, "What is the role of teachers related to mental health in your school. Check all that apply?" Thirty-one School A teachers replied to this survey. 77.42% of teachers felt that teachers should implement classroom behavioral observations, 67.74% monitoring student progress, 58.06% referring children and families to school-based mental health services, 45.16% teaching social/emotional lessons, 25.81% believe referring children and families to outside mental health services, and 16.13% feel screening for mental health problems is the role of the teacher.

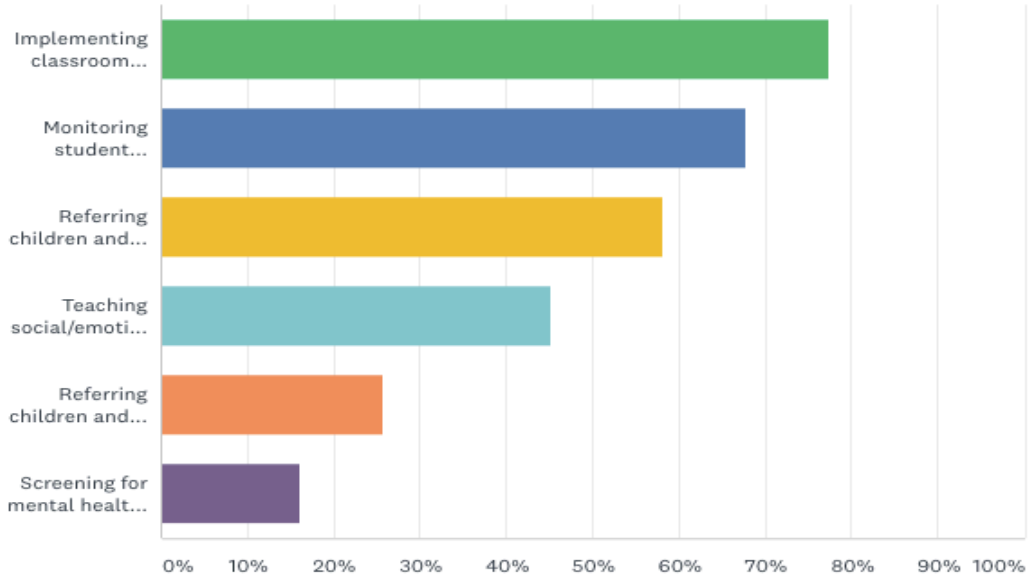


Figure 4.38. This figure illustrates the percentage of teachers who feel there are certain roles teachers should play related to mental health issues at their school.

Survey question 19: "What is the role of counselors/psychologists related to mental health in your school. Check all that apply?" Of the 33 respondents, 87.50% of teachers feel that counselors/school psychologists should refer children and families to school-based mental health services, 84.83% feel counselors/school psychologists should refer children and families to outside mental health services, 68.75% feel counselors/school psychologists should screen students for mental health problems, 68.75% should monitor student progress, 59.38% feel counselors/school psychologists should teach social/emotional lessons, and 40.63% feel counselors/school psychologists should implement behavioral interventions in the classroom.

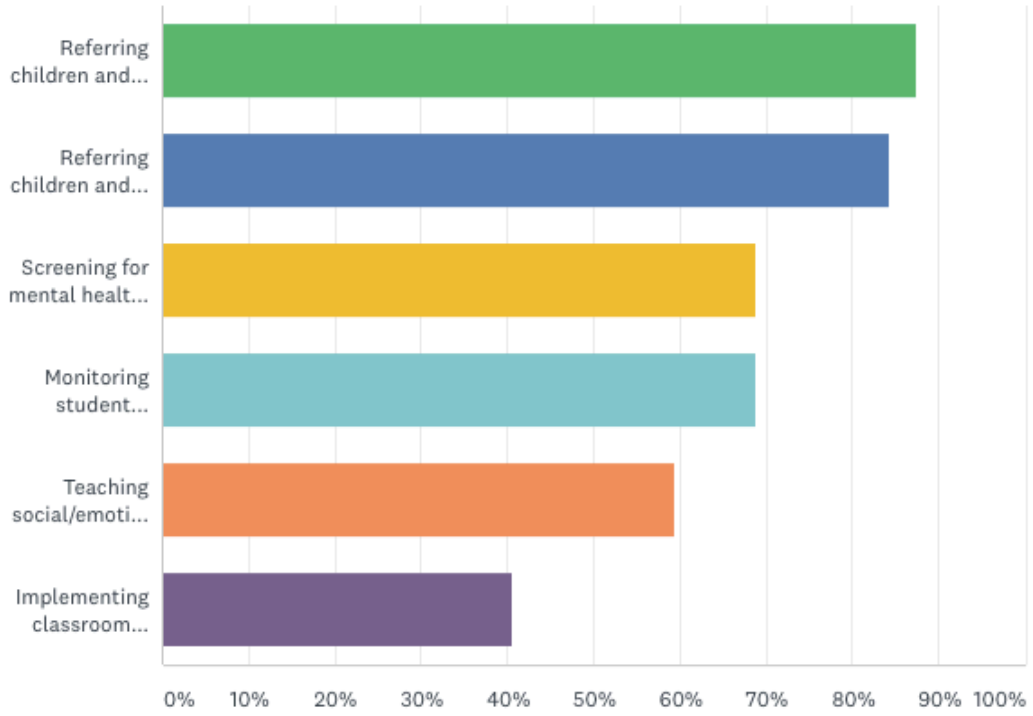


Figure 4.39. This figure illustrates the percentage of teachers who feel there are certain roles counselors/school psychologists should play related to mental health issues at their school.

Survey question 20: "From which experience have you learned the most about mental health issues?" Of the 31 respondents, 35.48% of teachers responded none of the choices listed, 19.35% reported other, 16.13% from professional development opportunities, 12.90% from undergraduate coursework, 9.68% from independent study/research, and 6.45% from graduate coursework.

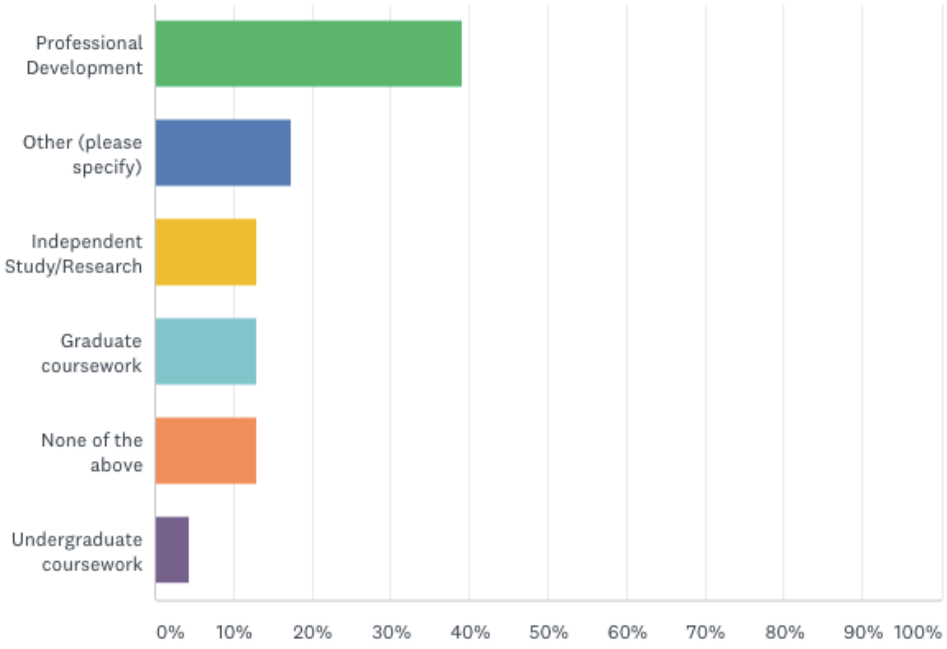


Figure 4.40. This figure illustrates from which experiences teachers have learned the most about mental health issues.

Table 10

Pre-intervention Open-Ended Teacher Survey: Specified Responses to "Other" (School A)

"From which experiences have you learned the most about mental health issues?"

	Responses
T1	"Previous career-behavior consultant"
T2	"From teaching students with mental health issues"
T3	"On the job"
T4	"Worked at a daycare for special needs children"
T5	"Colleagues"
T6	"Personal experience"

Table 11

What are the top three mental health issues you face at your school site?

	Responses
T1	"ADHD"
T2	"Depression"
T3	"Anxiety"
T4	"Aggression"
T5	"Disruptive Behavior"
T6	"Defiance"
T7	"Social Skills Issues"
T8	"Victim of Bullying"

T9	“Cutting”
T10	“Anger Control”
T11	“Acting Out”
T12	“Motivation”
T13	“Abuse”
T14	“Emotional Disturbance”
T15	“Lethargy”
T16	“Social/emotional problems related to social media”

Table 12

Which mental health issues and/or disorders would you like additional training?

Responses	
T1	“Depression”
T2	“Aggression”
T3	“Anxiety”
T4	“All of the above”
T5	“Disruptive Behavior”
T6	“Defiance”
T7	“Cutting”
T8	“Eating Disorders”
T9	“Suicide”
T10	“ADHD”
T11	“Bullying”
T12	“Post-Traumatic Stress Disorder”
T13	“Motivation”
T14	“5150 Training”
T15	“Behavior Interventions”
T16	How to deescalate behavior”

Table 13

What type of behavior training have you had?

	Responses
T1	“None”
T2	“PBIS”
T3	“Behavior Management”
T4	“CPI”
T5	“Applied Behavior Analysis”
T6	“Social Skills”
T7	“Aggression”
T8	“Minimal”
T9	“Depression”
T10	“One day workshop”
T11	“MTSS”

Post-Intervention Survey Results:

The following post-survey results are from the data collected from School A. School A was the only school out of the six middle schools in the district that received the professional learning sessions. Teachers at School A completed this post-survey at the end of their last training session.

School A Post-Survey Demographic Question 1: "What grade do you teach"? Of the 19 teachers who answered this survey questions, 68.42% teach 7th grade, 52.63% teach 6th grade, and 52.63% teach 8th grade.

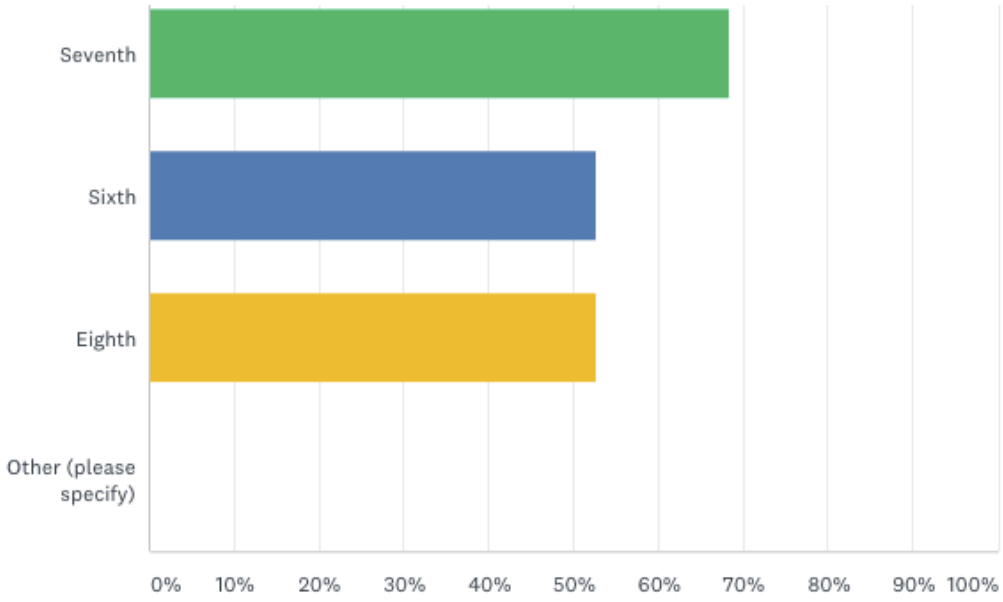


Figure 4.41 This figure illustrates the grade level that the School A teachers teach.

School A Post-Survey Demographic Question 2: "How long have you been teaching"? Of the 19 teachers who responded to this question, 33.33% have taught from 16-20 years, 22.22% over 20 years, 16.67% for 6-10 years, 16.67% 1-5 years, and 11.11% have taught for 11-15 years.

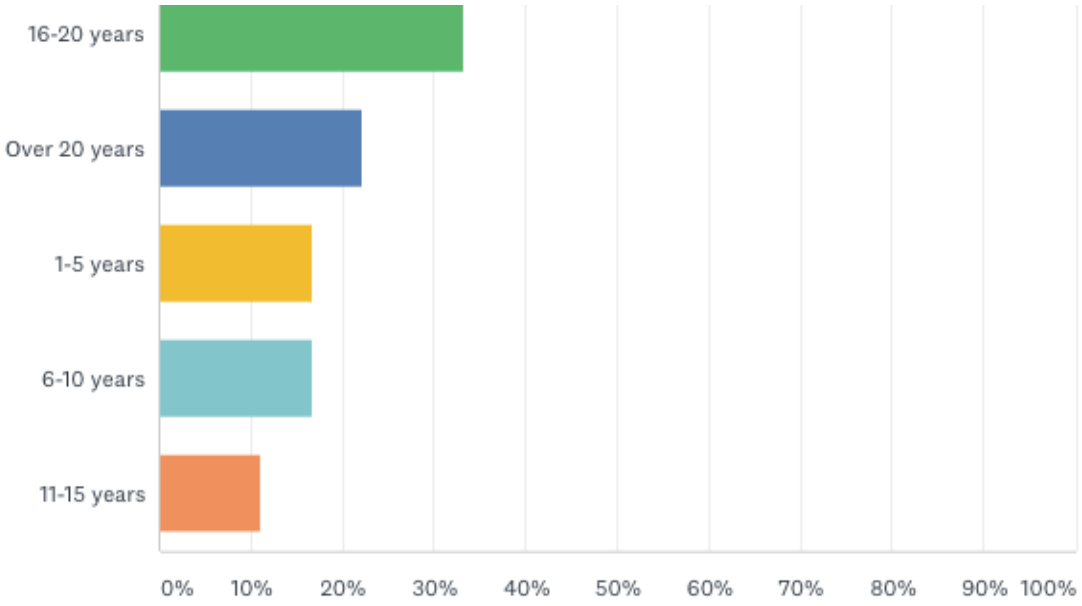


Figure 4.42. This figure illustrates the number of years School A teachers have been teaching.

School A Post-Survey Demographic Question 3: "What is your gender?" Of the 20 teachers who responded to this question, 65% are female and 35% are male.

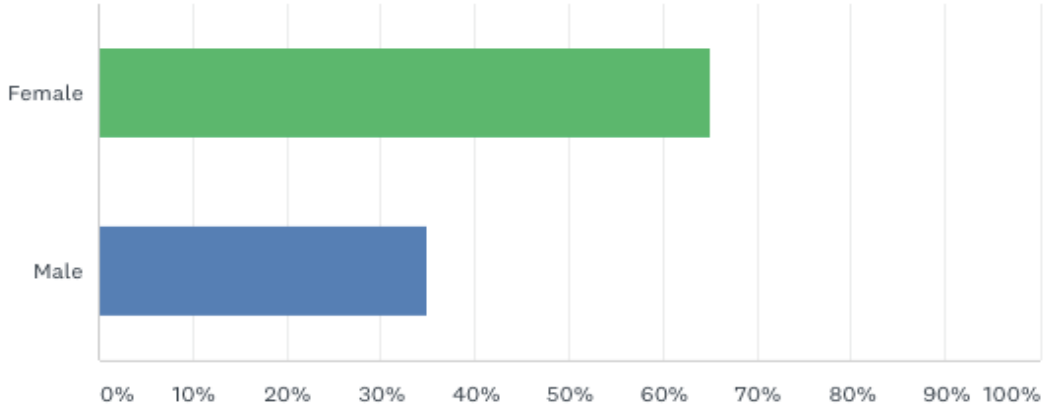


Figure 4.43. This figure illustrates the gender of the School A participants.

Post-Survey Question 4: "Has your level of knowledge regarding student mental health increased after attending the two mental health training sessions"? Of the 25 teachers who responded, 56% feel that the trainings slightly increased their level of knowledge, 28%

feel that the trainings strongly increased their level of knowledge, and 16% feel that their level of knowledge pertaining to student mental health is unchanged.

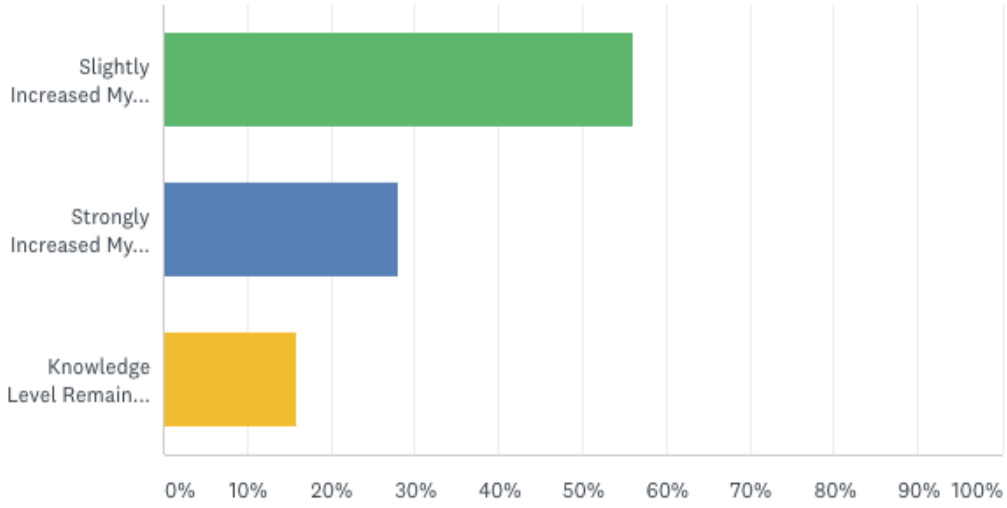


Figure 4.44. This figure illustrates teachers' level of knowledge of student mental health increased after attending the training sessions.

Post-Survey Question 5: "Have your level of skills regarding student mental health increased after attending these two mental health training sessions"? Of the 25 teachers who responded, 72% feel that the trainings slightly increased their skill level, 24% feel their skill level remained the same, and 4.00% feel that the trainings strongly increased their skill level.

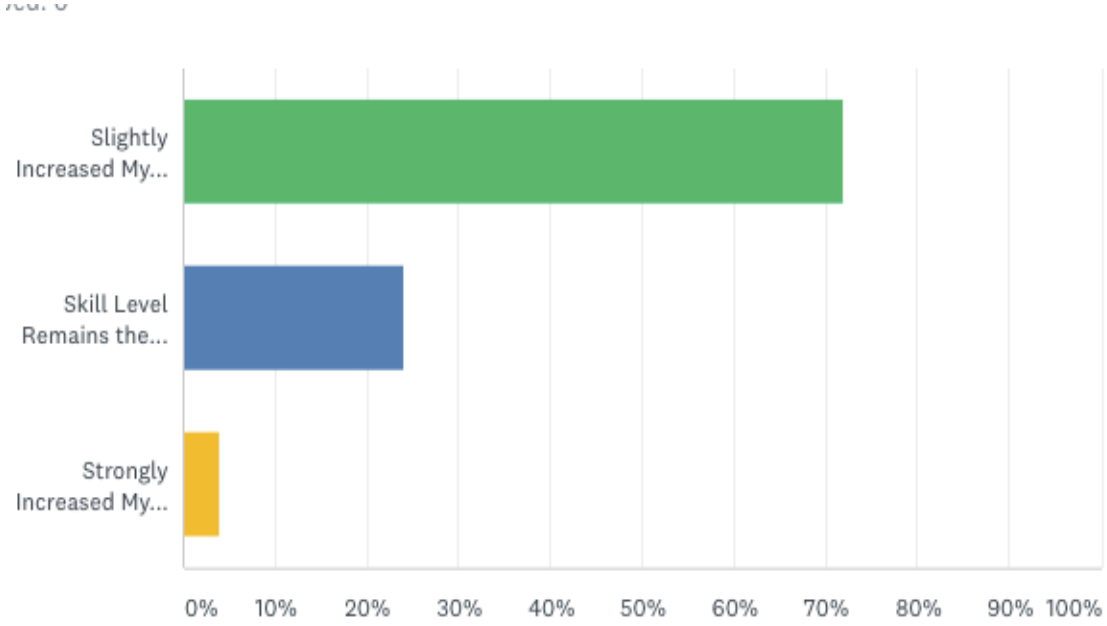


Figure 4.45. This figure illustrates how teachers feel their skill level has increased after attending training.

Post-Survey Question 6: “Has your attitude towards students with mental health issues changed since attending these trainings?”. Of the 25 teachers who answered this survey question, 60% reported they feel more accepting of having students in their class with mental health problems than they did before the training. 32% feel their attitude has remained the same after the training. Eight percent replied that they feel less accepting of having students with mental health problems than they did before the training.

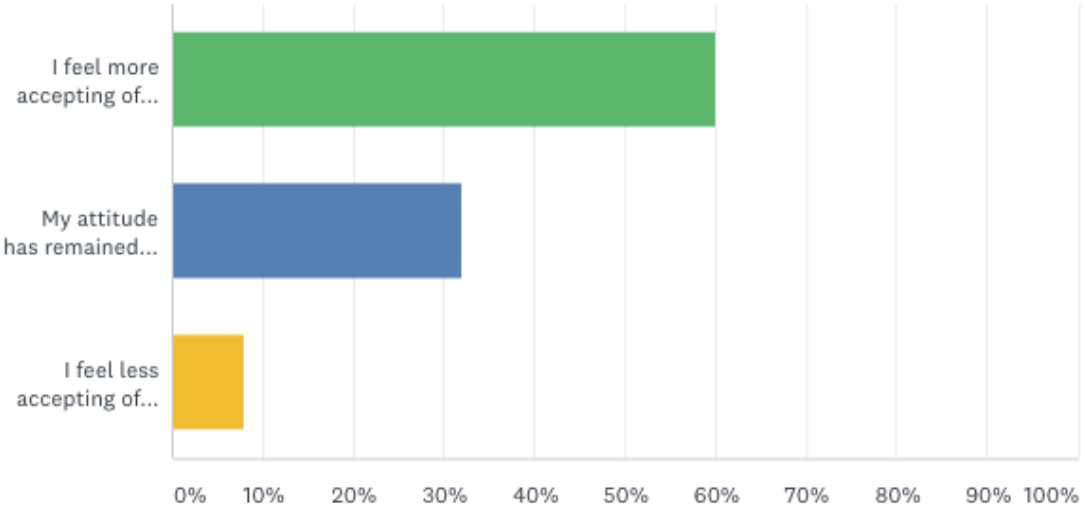


Figure 4.46. This figure illustrates teachers perceived attitude change since attending the training.

Post-Survey Question 7: "Addressing mental illness is not considered a role/priority of my school. Of the 25 respondents, 28% answered true and 72% answered false.

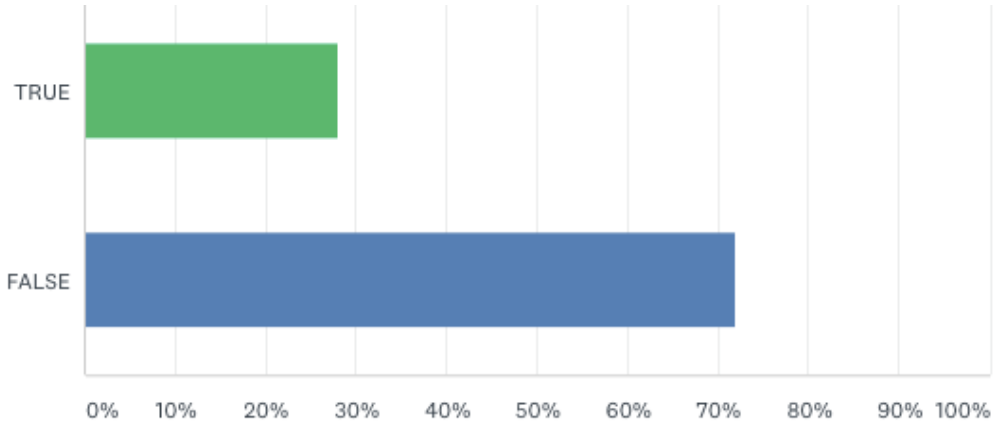


Figure 4.47. This figure illustrates teachers' beliefs as to how much the school site members should take a role/priority regarding addressing mental illness.

Post-Survey Question 8: "I feel that schools should be involved in addressing the mental health issues of students". Of the 25 respondents, 64% strongly agree and 36% agree

that schools should be involved in addressing the mental health issues of students. There was a 0.0% response for the choices strongly disagree, neutral, and disagree.

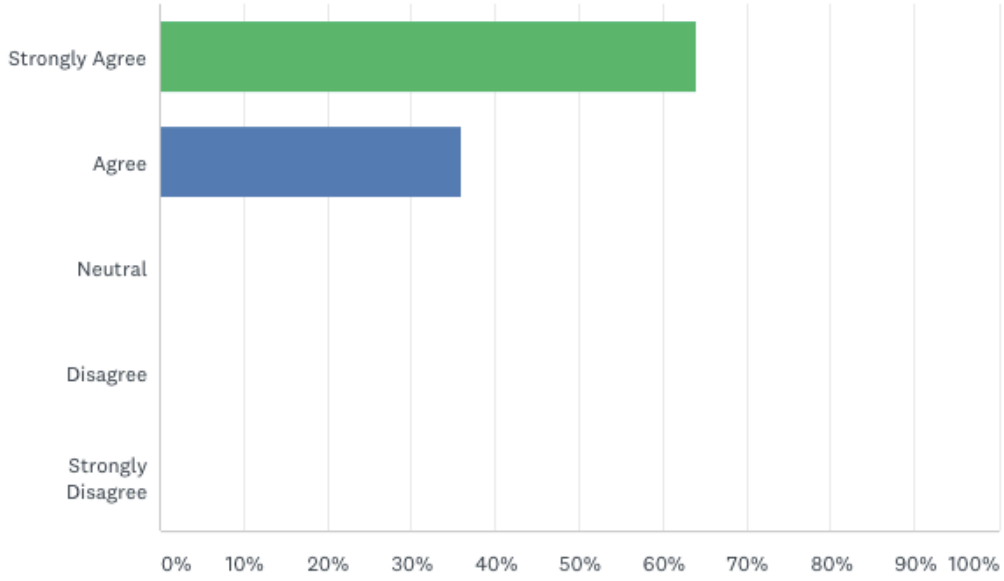


Figure 4.48. Question 8 illustrates teachers' feelings towards their schools' level of involvement in addressing the mental health needs of the students.

Post-Survey Question 9: "What is the role of teachers related to mental health in your school? Check all that apply". Of the 25 respondents, 84% feel implementing classroom behavioral interventions is a teachers' role, 60% feel that monitoring student progress is the role of the teacher, 56% fee; referring children and families to school-based mental health services is the role of the teacher, 28% feel teaching social/emotional lessons is the role of the teacher, 20% feel that screening for mental health problems is the role of the teacher, and 4% feel referring children and families to outside mental health services is part of a teachers' role.

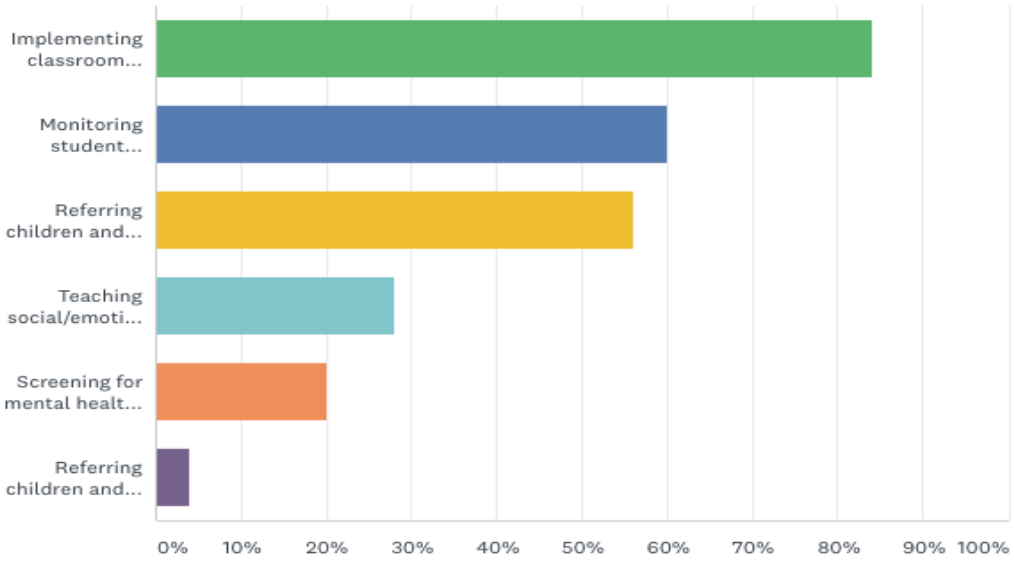


Figure 4.49. This Figure illustrates teachers' perceived role related to mental health in the school.

Post-Survey Question 10: "Do you feel child and adolescent mental health training is helpful to you as a teacher?" Of the 25 teachers who responded, 96% replied yes and 4% replied no.

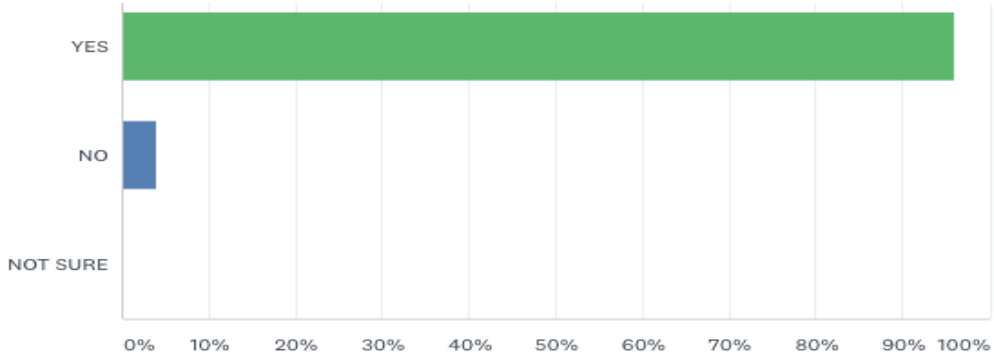


Figure 4.50. Question 10 illustrates how teachers feel about how helpful child and adolescent mental health training is to them.

Post-Survey Question 11: "From which experience have you learned the most about mental health issues?" Of the 23 teachers who responded to this question, 39.13% reported professional development, 17.39% replied other, 13.04% replied independent study/research,

13.04% choose graduate coursework, 13.04% replied none of the above, and 4.35% found that they learned the most about mental health issues from undergraduate coursework.

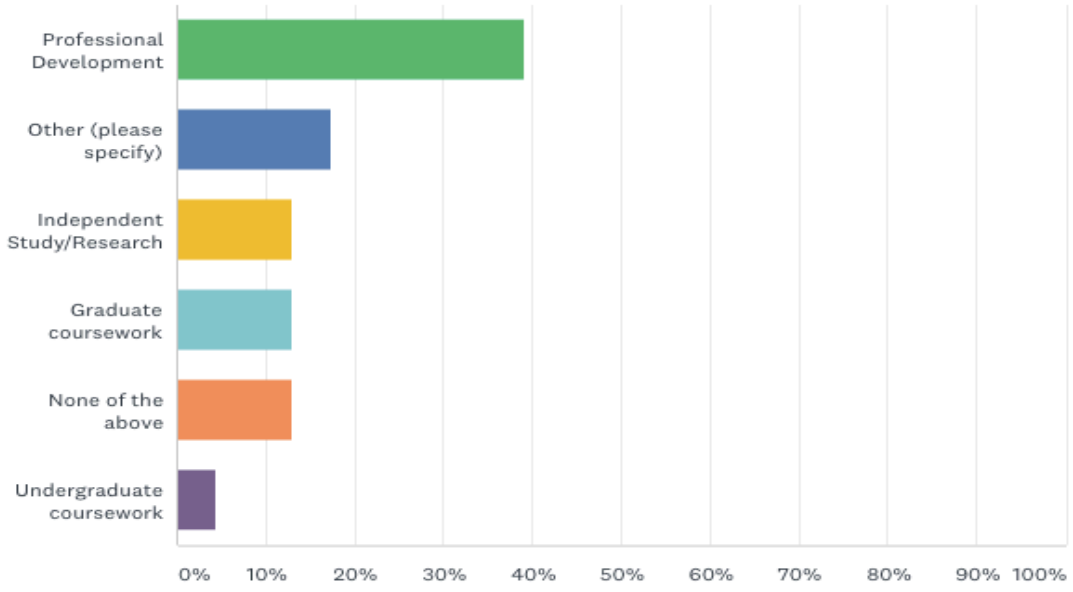


Figure 4.51. Question 11 illustrates the experiences where teachers learned the most about mental health issues.

Table 14

Post-intervention Open-Ended School A Teacher Survey: Specific Responses to "Other"?

	Responses
T1	"Previous Career – I had some ABA training"
T2	"Worked at a daycare that facilitated mentally ill kids"
T3	"Classroom experience"
T4	"Personal experience"

Post-Survey Question 12: "Would you like to receive more training on student mental health?" Of the 25 respondents, 68% replied yes, 28% were not sure, and 4% would not like to receive more training on mental health.

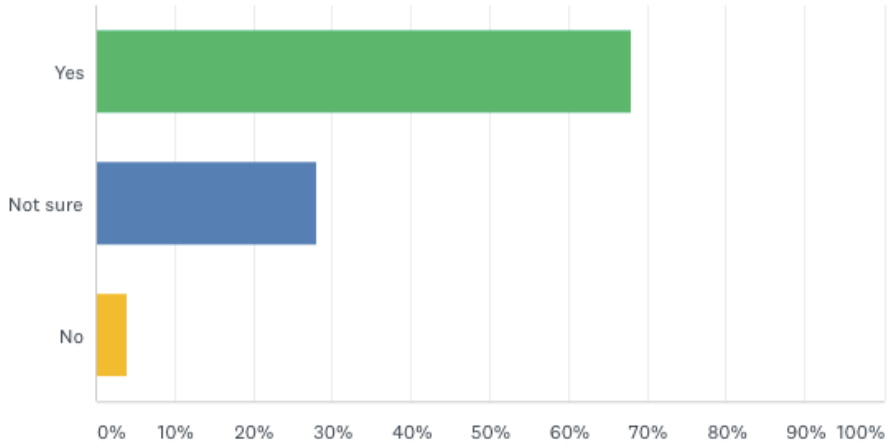


Figure 4.52. Question 12 illustrates the percentage of teachers who would like to receive additional training on student mental health.

Post-Survey Question 13: "If so, do you feel additional training would be helpful in the following areas: Check all that apply". Twenty-three teachers responded to this question with 65.22% wanting additional training on depression, 65.22% chose Oppositional Defiant Disorder, 60.87% chose ADHD, 56.52% want additional training on Conduct Disorder, 52.17% chose anxiety, 39.13% chose Bipolar Disorder, 26.09% wanted additional training on Disruptive Mood Dysregulation Disorder, 26.09% reported wanting to learn more about Post Traumatic Stress Disorder, and there were no answers recorded on the question about not needing any additional training in the areas mentioned above.

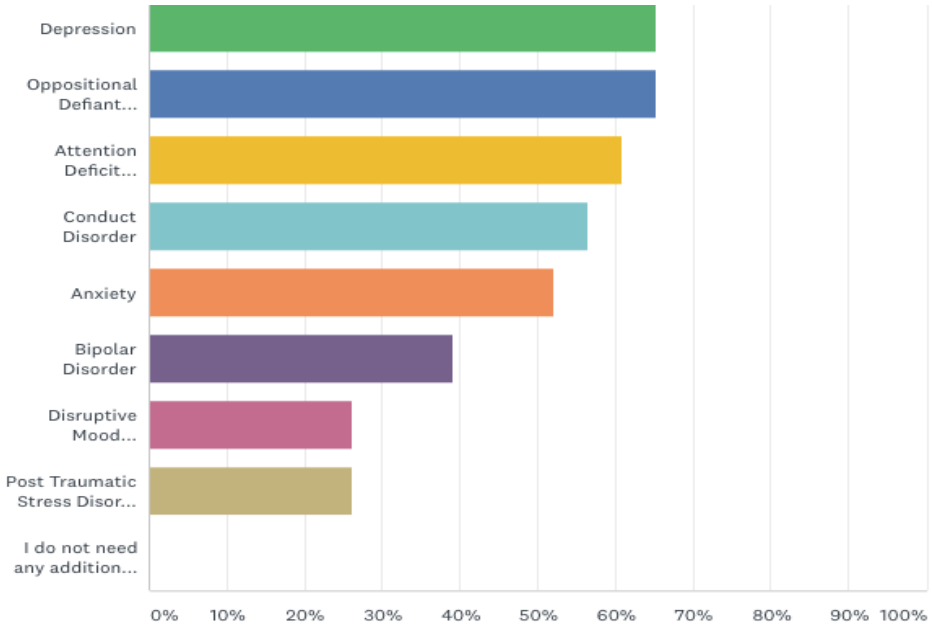


Figure 4.53. Question 13 illustrates areas School A teachers would like more training.

Post-Survey Question 14: "Would you like to receive additional behavior intervention training?" Of the 25 teachers who responded, 72% stated yes, 24% stated not sure, and 4.00% stated that they would not like to receive additional behavior intervention training.

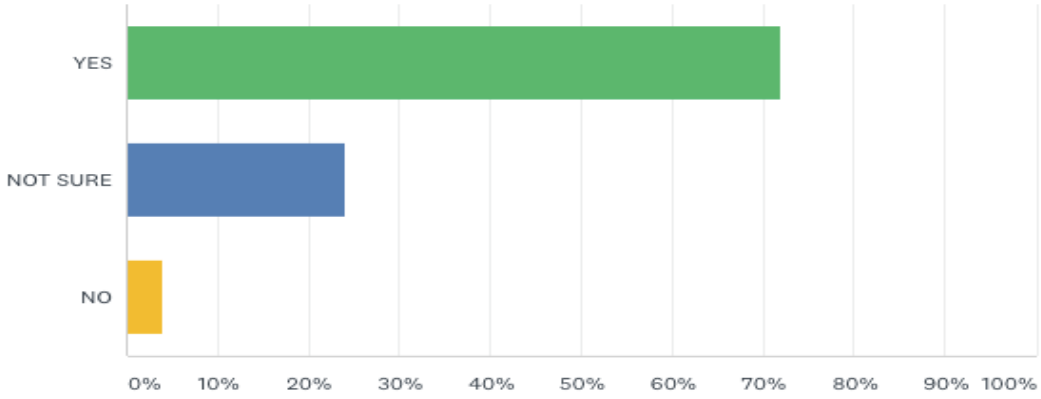


Figure 4.54. This figure illustrates School A teachers' interest having additional behavior intervention training.

Post-Survey Question 15: "Are there any other areas or issues related to student mental health that you would like to receive more training on?"

Table 15

Post-intervention Open-Ended question: "Areas teachers would like more training in?"

	Responses
T1	"Specific strategies to use"
T2	"ADHD"
T3	"None"

Post-Survey Question 16: "Is there anything else you would like to request or comment on in the area of student mental health?"

Table 16

Post-intervention Open-Ended Question: Anything else to request or comment?

	Responses
T1	"Scenarios and discussions"
T2	"Our school does consider mental illness in children their
T3	role/priority but not enough"

Summary

This chapter provided qualitative and quantitative results of this research study including pre-intervention survey questions for middle school teachers from the six middle schools in the district and one from just School A. School A was the only middle school that received the professional learning sessions. There was also a post-intervention survey completed by the School A teachers after the training was completed. In the next chapter, the data will be discussed, a summary of the findings will be provided, implications for application and practice will be suggested, recommendations for future research will be offered, and conclusions will be presented for this research study.

CHAPTER 5: DISCUSSION AND IMPLICATIONS

In Chapter 4, the results and analysis of quantitative and qualitative data were presented. Chapter 5 provides a summary of the study, implications for practice, recommendations for further research, conclusions, and a summary. The purpose of Chapter 5 is to provide a more detailed understanding of general education teachers' attitudes, beliefs, and values regarding student mental health.

Summary of the Study

This mixed methods explanatory sequential design study explored the hypothesis that teachers want to help students with mental health issues in their classrooms, but do not have the training and knowledge to feel competent doing it. Surveys were used to compile data on teachers' attitudes, knowledge and perceived roles when working with students with mental health issues in their classroom.

The purpose of this research study is to gain a better understanding of how general education teachers feel about having students with mental health disorders in their classrooms. The researcher also wanted to know how much preparation these teachers received during their teacher training programs and how confident they feel to identify and support these students in the general education environment. This study examined teachers' self-efficacy and their willingness to change their beliefs and attitudes after completing professional development sessions in the area of student mental health.

The sample consisted of 186 general education middle school teachers from a public school district in Southern California. Convenience sampling was used in this study. The sample population used for the qualitative study was represented through a systematic sampling

procedure of teachers from one middle school of the six middle schools. There were three open-ended questions on the survey. The information gathered from these questions will be used to determine future need for professional development and training. The reason for collecting both quantitative and qualitative data is to assess if changes occurred after professional development was given to the teachers from one of middle schools surveyed.

The sample population used for the qualitative study was represented through a systematic sampling procedure of teachers from one middle school of the six middle schools surveyed. Two professional development sessions were held over a period of two months and then a post survey was given to the teachers who attended the professional development sessions.

The researcher used several qualitative and quantitative tools to explore the impact that professional development can have on participants' feelings and beliefs about children who have mental health disorders. The research methods included a pre-intervention survey (Raposa, 2017), two sessions of professional learning on the topic of students and mental health, and a post-intervention teacher survey (Raposa, 2017). The study addressed three research questions:

1. What are teachers' attitudes and beliefs towards students in their classroom who are exhibiting symptoms of a mental health disorder?
2. What level of training on childhood and adolescent mental health issues was provided in teachers' credential programs and job site professional development?
3. What do teachers perceive their roles to be in the treatment of students with mental health issues?

Discussion of Findings

The tools used to measure the research outcomes are presented here in a sequence based on their order of introduction. A discussion of the findings from the pre-and-post surveys and open-ended questions can be found in the following sections. There are three research questions which are the foundation of this study.

Research Question One: "What are general education teachers' attitudes and beliefs towards students in their classroom who are exhibiting symptoms of a mental health disorder?" The researcher analyzed data from the fixed and open-ended items on the pre and post-surveys. Along with the data and discussion during the instructional learning sessions, it is believed that general education teachers became more understanding and empathetic towards their students who were struggling with symptoms of their mental illness after they attended the two instructional learning sessions.

Research Question Two: "What level of training on child and adolescent mental health issues was provided in teachers' credential programs and job site professional development?" This research question can be answered by the data from the pre and post survey with results indicting that the majority of general education teachers surveyed have had little or no training in either their pre-service credential program or from professional development opportunities once they were employed. With evidence supported by the review of literature discussed in Chapter 3, the mental health needs of children and adolescents are increasing and becoming more complex. Based on survey results, teachers who participated in the study have expressed a need for more training so that they can better support the needs of their students with mental illness.

Research Question Three: "What do teachers perceive their roles to be in the treatment plan of students with mental health issues?" As with research questions one and two, research question three is answered by the data collected from the fixed and open-ended survey items. Teachers are more receptive to implementing classroom behavioral interventions and monitoring student progress. They believe screening for mental health issues and referring students and families to outside mental health services should be the role of the school counselor and the school psychologist. The data also supported the belief that teaching social/emotional lessons and referring children and families to school-based mental health services can be shared with the school site mental health staff.

Pre-Intervention Teacher Survey

The survey provided information about the teachers' feelings and beliefs as well as their prior knowledge in the area of child and adolescent mental illness.

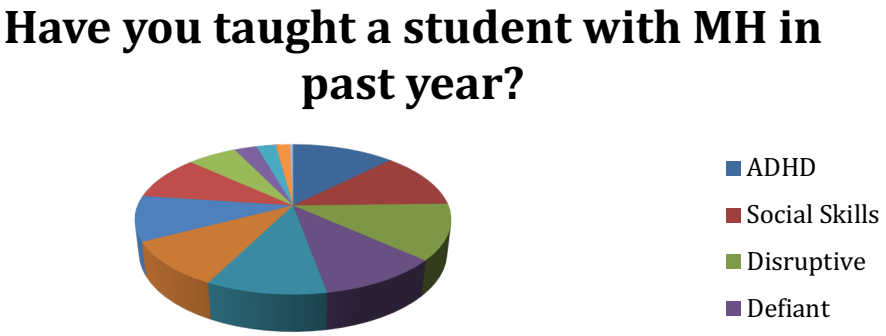


Figure 4.55. This figure illustrates the areas of mental health in students taught.

The Pre-Intervention Survey compared to the Post-Intervention School A Survey, highlighted important findings that support the claim of mental health training as a positive intervention as seen in the comparison lines of Figure 4.56 through Figure 4.63.

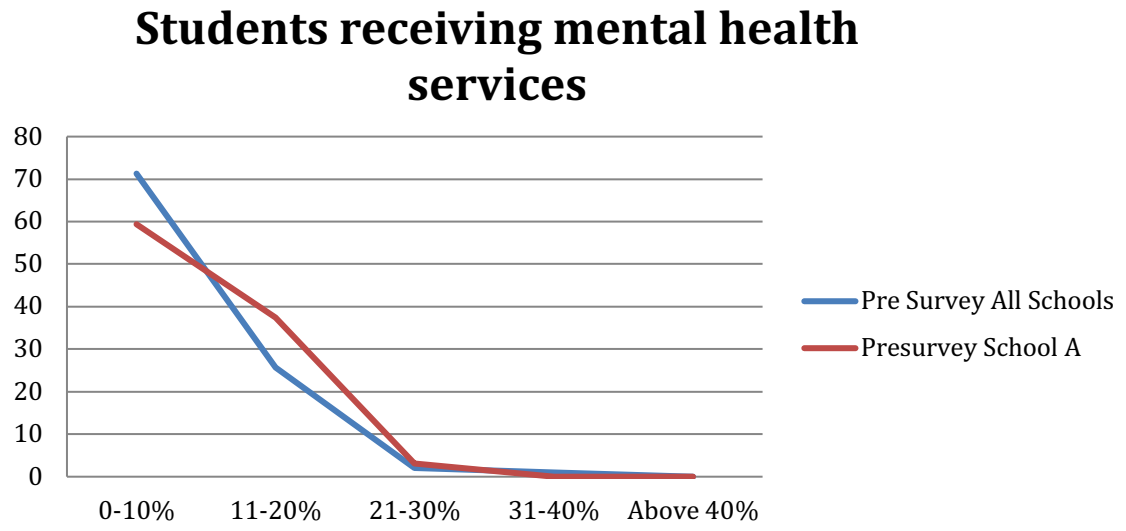


Figure 4.56. This figure compares students with mental health services.

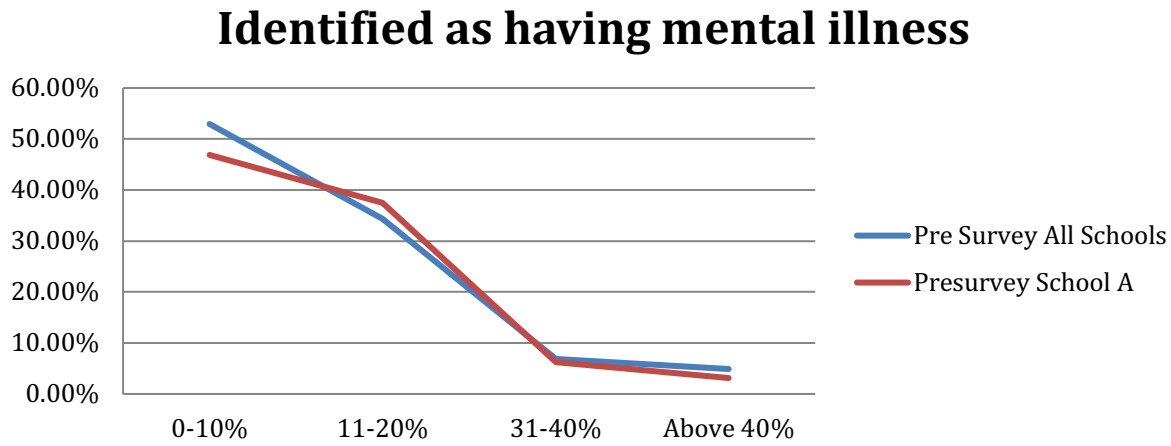


Figure 4.57. This figure compares students with specific mental illness.

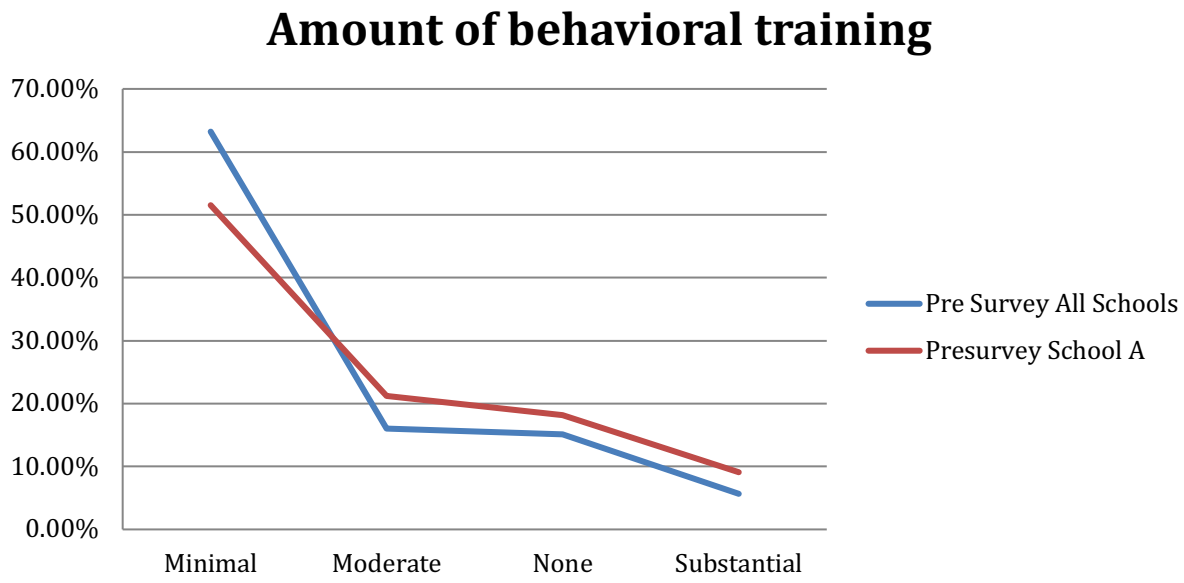


Figure 4.58. This figure compares amount of behavioral training received by teachers.

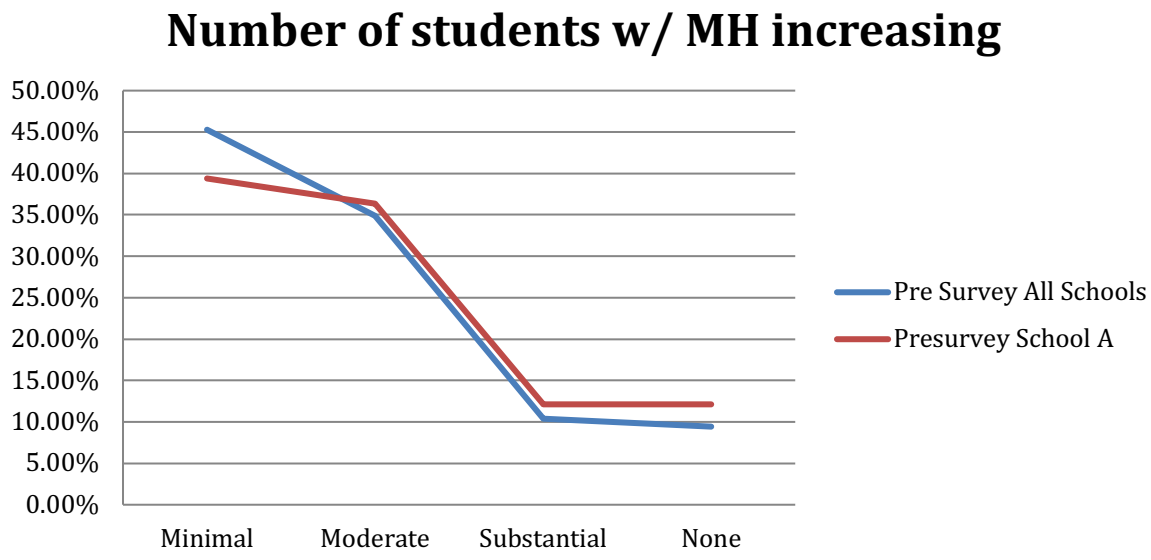


Figure 4.59. This figure compares number of students with increasing mental health issues.

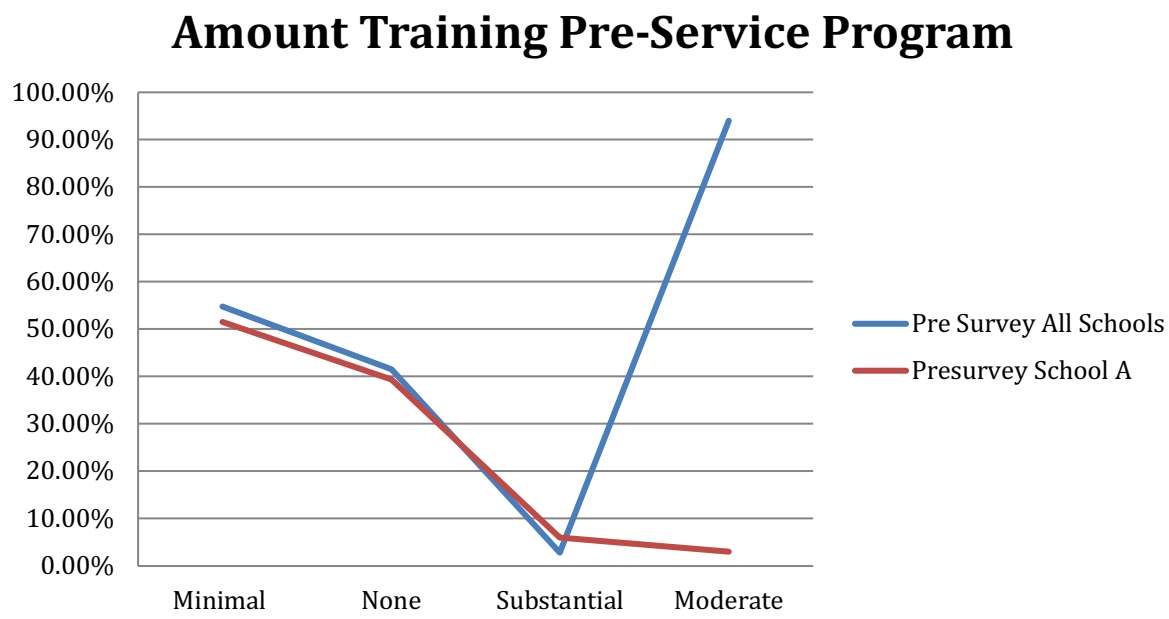


Figure 4.60. This figure compares number of students with increasing mental health issues.

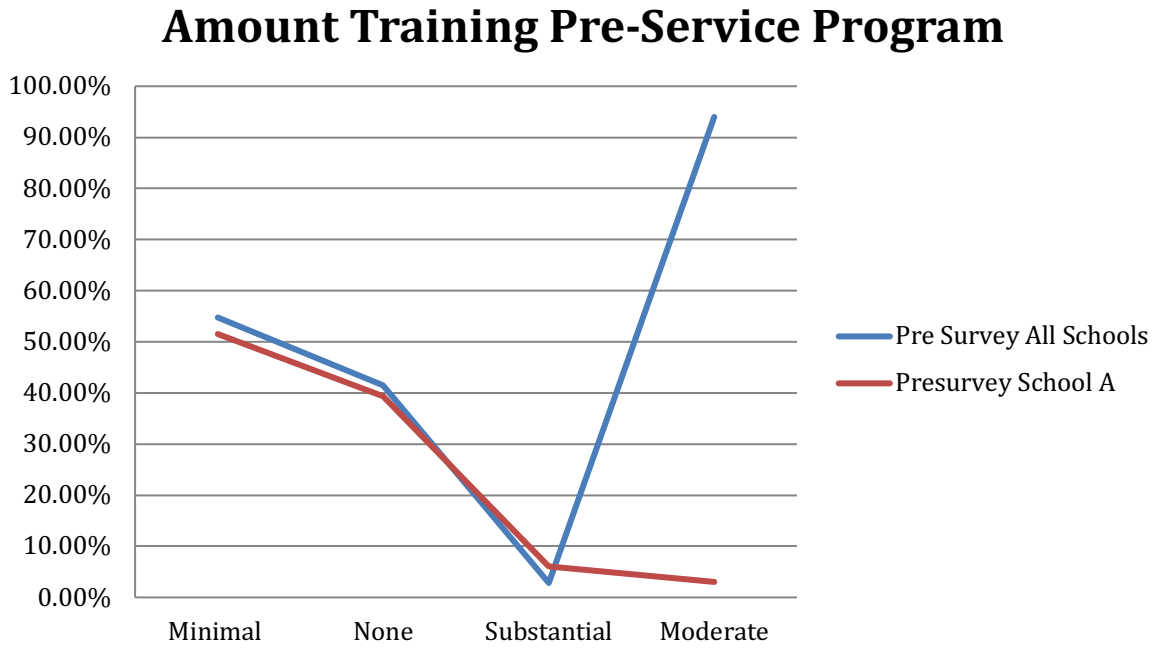


Figure 4.61. This figure compares amount of training received in pre-service programs.

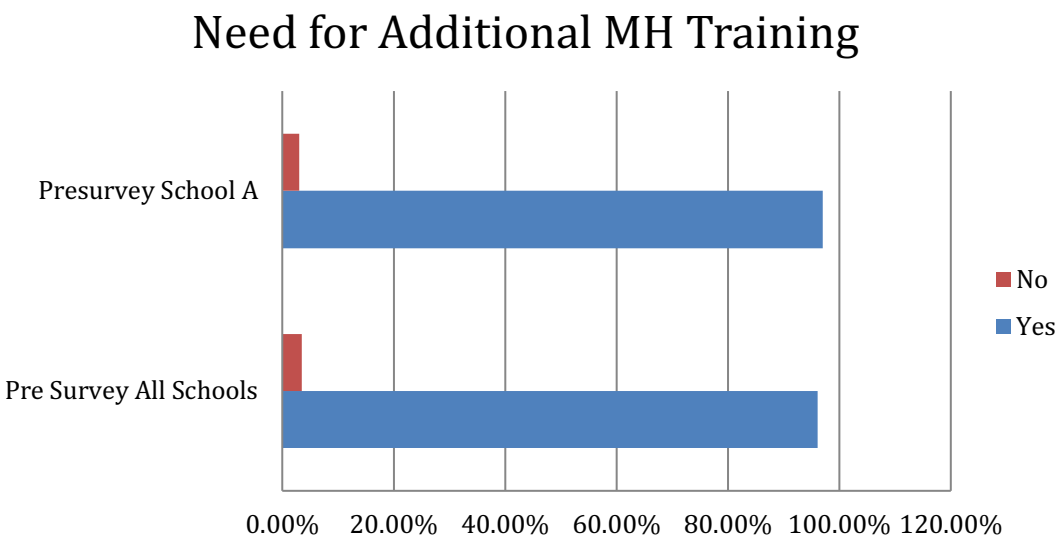


Figure 4.62. This figure compares amount of training needed or desired by teachers

Post-Intervention Survey

This post-survey provided information on whether teachers knowledge, skills, and attitudes changed after participating in the professional learning sessions. The results give a better understanding of teachers' desire to receive additional training in the area of student mental health as well as helped to define teachers' perceptions about roles and priorities of school site staff when addressing the needs of students who are facing challenges caused by their mental illness.

The questions regarding a change in perceived knowledge and skills regarding student mental health resulted in positive data. There was a significant increase in teachers' level of knowledge and skills in the area of student mental health. The results from Post-Survey Question four (Figure 4.41) which asks if the teachers' level of knowledge increased after the two instructional learning sessions suggests that more than half (56%) of the teachers felt they were slightly more knowledgeable about the topic of child and adolescent mental health than they were when they took the pre-survey. 28% of the teachers felt that the trainings strongly increased their level of knowledge and a small percentage (16%) felt that their knowledge level remained the same.

The results from Post-Survey Question five (Figure 4.42) which asks if the teachers' level of skills increased after the two instructional learning sessions suggests that almost three fourths (72%) of the teachers surveyed reported that their skill level had slightly increased while 24% of teachers felt their skill level remained the same. A very small number of teachers (4%) felt that there was a strong increase in skill level after attending the sessions.

The last question (Figure 4.43) that addressed perceived change in teacher attitude toward students with mental health issues resulted in 60% of teachers surveyed reported that they feel

more accepting of having students in their class with mental health problems than they did before the training. There were approximately a third of the teachers who felt the same about having students in their classes that have mental health issues. Only 8% of teachers felt less accepting of having these students in their classes than they did before the sessions.

When addressing roles and priorities of school administrators and staff in the support of student mental health problems, there was a difference between the results of the School A pre-survey (Figure 4.34) and the results of School A post-survey (Figure 4.43). For the pre-survey 51% of teachers felt that addressing mental health is not considered a role/priority of their school which post-survey results have only 28% of teachers responding this way. That is a 23-percentage point discrepancy between the pre and post-survey.

For the question "I feel that schools should be involved in addressing the mental health issues of students", there was a 28-percentage point increase in the number of teachers who strongly agreed to this statement (36%) in the pre-survey versus 64% of teachers who strongly agreed after attending the instructional learning sessions.

In the area of perceived roles of teachers related to mental health concerns at School A, the results were similar for the pre and post-tests. Teachers who took the pre-survey felt that the role of a teacher is to implement classroom behavioral interventions (77%) and monitor student progress (67%) while similar results were found in the post-survey results (84% and 60% respectively). Screening for mental health problems (16%) in the pre-survey and 20% in the post-survey was viewed by teachers as a role of their job they do not feel they should do.

When analyzing teachers' attitudes and feelings towards mental health instructional learning sessions, the participants were asked if they felt child and adolescent mental health training is helpful to them as educators. 96% of teachers replied yes (Figure 4.46). This supports

a strong need that administrators from School A need to provide continued mental health training to their teachers.

In looking at teachers responsive to having more training on student mental health (Figure 4.48), 68% of teachers responded yes, 28% responded they were not sure, and 4% responded they would not like more training. Though 96% of these teachers surveyed reported that they feel mental health training is helpful to them as educators, only 68% wanted to attend additional training.

As for additional mental health training that they would like to receive, teachers reported in the post-survey their top five topics in order of preference from most to least as depression, aggression, anxiety, all disorders, and defiance/disruptive behavior.

Delimitations and Limitations

While the findings from this survey can provide additional research to the field of child and adolescent mental health, it is essential to note that this research study has expected delimitations and limitations.

One of the primary delimitations is that the researcher has worked with the staff of School A for almost two years. Having this prior working relationship with them may have affected their responses to the survey questions in a more advantageous way; either consciously or unconsciously. These feelings may have caused some of the participants to rate the effects of the instructional learning sessions as more impactful that they would have if the researcher was a stranger.

A secondary delimitation is that the participants were only middle school general education teachers. Elementary and high school teachers did not participate in the survey as

mental health issues of secondary school students can be vastly different than ones of younger students. Because of their experience with these various mental health issues, teachers in elementary and middle school may view children with mental illness differently than high school teachers.

There are three main limitations found in this research study. One of limitations has to do with the fact that the sample is limited to just teachers from the state of California. Another factor to consider is that the majority of these teachers attended pre-service teaching programs within California and quite possibly in Southern California colleges and universities.

A second limitation is that results may be skewed due to self-selection bias, meaning that teachers who chose to participate may have held differing beliefs than those who decided not to complete the survey. It may be that teachers who did not participate may have attitudes, beliefs and prior experiences that were not appropriately defined. For example, educators who chose not to take the survey on student mental health may not feel that this issue is important to them or that there are feelings of uneasiness when it comes to anything to do with mental illness. It is possible that participants and nonparticipants were emotionally triggered by the survey questions due to their own negative or even traumatic experiences in the past involving depression, anxiety, or other mental disorders.

Lastly, participants only completed the survey. The qualitative data that was collected was from short, open-ended questions with responses that were written down. Adding personal interviews to the study in addition to the survey may have garnered more in-depth conversation about the topic and also the researcher would have the ability to gauge body language, response length, and interaction to another person rather than just the paper and pencil survey. Teachers

were able to volunteer to participate in the survey but the teachers from School A were required to attend the two instructional learning sessions.

Implications for Practice

The number of children and adolescents with mental health disorders is increasing exponentially. The findings of this study have protracted implications for researchers interested in general education teachers' feelings, attitudes, and beliefs regarding students in their class who are struggling with mental health issues. As the research suggests, teachers want to support these students but have not been given the tools to do so. Related implications for practice include the seriousness of the need for increased professional development in the area of child and adolescent mental health. Teachers are not equipped nor have they been trained to understand the complexity of mental health issues their students face. Results of the pre-survey completed by 106 general education middle school teachers in a district support the fact that there needs to be a more comprehensive district wide approach to supporting teachers who are ill equipped to handle the severity and number of students enrolled in public schools. Additional implications for practice include: (a) professional learning sessions in the areas identified by teachers as proposed professional development, (b) increased resources and support to ensure these students are safe and are receiving academic and social/emotional services, and (c) working with preservice teaching programs to bring awareness for the need for student mental health to be included in the program's curriculum.

Further Application for Research

The research study to provide training to teachers in mental health issues and strategies can be placed in a wider spectrum such as district or regional trainings. The current research in mental health was limited to specified audiences who sought the information because it was either necessary for certification or highly recommended.

The findings of this study support the intervention of mental health training to take place regardless of necessity. It would be prudent to also train families and stakeholders in education of the strategies that are shared among teachers. Too often, a gap in communication between home and school can have a detrimental effect on students. If information used in the training of this study were shared in such as way to improve communication, there could be additional benefits for those who work in the field of both general and special education.

Conclusion

In conjunction with current scholarly research, this research study affirms that teachers have not received adequate training in mental health and behavioral interventions. They confirmed that the lack of training and understanding about mental illness in the children they spend a lot of time with.

Summary

Chapter 5 discussed the findings, implications for practice, recommendations for further research, and conclusion. This study sought to analyze the attitudes, beliefs, and knowledge of general education teachers that teach students who are experiencing mental health problems. The results of the study provided data that support the hypothesis that teachers want to support

students and understand more about mental illness but they do not have the skills, knowledge or training required to meet the complex needs of their students' secondary teachers? Implications for practice were also discussed for the findings in relation to the research that contained the theoretical foundation for the study. Recommendations for further research were provided by the researcher with the suggestions that the current study widen its 162 sample population to veteran secondary teachers, athletic secondary management, new secondary administrators, and induction mentors. Further research was also suggested to take place at different sites to include public charter and private schools. Finally, the conclusion to the current study was discussed.

REFERENCES

Able Child (2014). Child advocate report claims Adam Lanza untreated. Retrieved from http://ablechild.org

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC:

Edition. Arlington, VA, American Psychiatric Association, 2013.

Anderson-Butcher, D. (2006). The role of the educator in early identification, referral, and linkage. In R. Waller (Editor), *Fostering child and adolescent mental health in the classroom*, (pp. 257-274). Thousand Oaks: SAGE Publications.

Appleton, K., & Kindt, I. (2002). Beginning elementary teachers' development as teachers of science. *Journal of Science Teacher Education*, *13*(1), 43-61.

Askell-Williams, H., & Lawson, M. J. (2013). Teachers' knowledge and confidence for promoting positive mental health in primary school communities. *Asia-Pacific Journal of Teacher Education*, *41*(2), 126-143.

Association for Children's Mental Health. (2004). Evidence-based practice beliefs, definition, and suggestions for families. Okemos, MI.

Avery, L. M., & Meyer, D. Z. (2012). Teaching science as science is practiced: Opportunities and limits for enhancing preservice elementary teachers' self-efficacy for science and science teaching. *School Science and Mathematics*, *112*(7), 395-409.

Ball, A. (2011). Educator readiness to adopt expanded school mental health: Findings and implications for cross-systems approaches. *Advances in School Mental Health Promotion*, *4*(2), 39-50.

Ball, A., & Anderson-Butcher, D. (2014). Understanding teachers' perceptions of student

support systems in relation to teachers' stress. *Children & Schools*, *36*(4), 221-229.

Barkley, R.A. & Peters, H. (2012). The earliest reference to ADHD in the medical literature? Melchior Adam Weikard's description in 1775 of "attention deficit". *Journal of Attention Disorders*, *16*(8), 623-630.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191.

Bandura, A. (1997). Editorial. *American Journal of Health Promotion*, *12*(1), 8-10.

Bartlett, L. D., Weisenstein, G. R., & Etscheidt, S. L. (2002). *Successful inclusion for educational leaders*. Upper Saddle River, New Jersey: Prentice Hall.

Benner, G. J., Mattison, R. E., Nelson, J. R., & Ralston, N. C. (2009). Types of language disorders in students classified as ED: Prevalence and association with learning disabilities and psychopathology. *Education and Treatment of Children*, *32*(4), 631-653.

Best, R. (2005). Deliberate self-harm in adolescence: A challenge for schools. *British Journal of Guidance and Counseling, 34*(2). 77-101.

Biggs, B.K., Vernberg, E., Twemlow, S., Fonagy, P. & Dill, E. (2008). Teacher adherence and its relation to teacher attitudes and student outcomes in an elementary school-based violence prevention program. *School Psychologist Revie*w, 37(4), 533-549.

Billings, A. G., & Moos, R. H. (1983). Comparisons of children of depressed and non-depressed parents: A social-environmental perspective. *Journal of Abnormal Child Psychology*, *11*(4), 463-485.

Birmaher, B. (2013). Bipolar disorder in children and adolescents. *Child and Adolescent Mental Health*, *18*(3).

Birmaher, B., & Brent, D. (2007). Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(11), 1503-1526.

Blader, J. C., & Carlson, G. A. (2007). Increased rates of bipolar disorder diagnoses among US child, adolescent, and adult inpatients, 1996–2004. *Biological Psychiatry*, *62*(2), 107-114.

Boling, E. (2007). "Yeah but I still don't want to deal with it". Changes in a teacher candidate's conceptions of inclusion". *Teaching Education.* Vol. *18*(3). 217-231.

Bruns, E. J., Walrath, C., Glass-Siegel, M., & Weist, M. D. (2004). School-based mental health services in Baltimore: Association with school climate and special education referrals. *Behavior Modification*, *28*(4), 491-512.

Bucalos, A. B.& Lingo, A. S. (2005). What kind of "managers" do adolescents really need? Helping middle and secondary teachers manage classrooms effectively. *Beyond Behavior, 1*(2),9-14.

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health affairs*, *14*(3), 147-159.

Buss, R. R. (2010). Efficacy for teaching elementary science and mathematics compared to other content. *School Science and Mathematics*, *110*(6), 290-297.

California Department of Education (2017). CALPADS Primary disability category codes. Retrieved from https://www.cde.ca.gov.

Carr, S. C., & Punzo, R. P. (1993). The effects of self-monitoring of academic accuracy and productivity on the performance of students with behavioral disorders. *Behavioral*

Disorders, *18*(4), 241-250.

Carswell, S. B., Hanlon, T. E., O'Grady, K. E., Watts, A. M., & Pothong, P. (2009). A preventive intervention program for urban African American youth attending an alternative education program: Background, implementation, and feasibility. *Education & Treatment of Children*, *32*(3), 445.

Castens, A. R., & Overbey, G. A. (2009). ADHD, boredom, sleep disturbance, self-esteem, and academic achievement in college students. *Psi Chi Journal of Undergraduate Research*, *14*(2).

Cauley, K. M., & Jovanovich, D. (2006). Developing an effective transition program for students entering middle school or high school. *The Clearing House: A Journal of Educational Strategies, Issues and Ideas*, *80*(1), 15-25.

Center for Disease Control (2011). Mental health surveillance among children—United States, 2005-2011. 6*2*(02); 1-35. Retrieved from the Centers for Disease Control and Prevention: https://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid=su6202al

Chavira, D., Garland, A., Yeh, M., McCabe, K. & Hough, R. (2009). Child anxiety disorders in public systems of care: Comorbidity and service utilization. *The Journal of Behavioral Health Services and Research. 36*(4). 492-504.

Chen, C., Greenberger, E., Farruggia, S., Bush, K., & Dong, Q. I. (2003). Beyond parents and peers: The role of important non-parental adults (VIPs) in adolescent development in China and the United States. *Psychology in the Schools*, *40*(1), 35-50.

Colarossi, L.G., & Eccles, J.S. (2003). Differential effects of support providers on adolescents' mental health. *Social Work Research 27*(1), 19-30.

Collie, R. J., Shapka, J. D., & Perry, N. E. (2012). School climate and social–emotional learning: Predicting teacher stress, job satisfaction, and teaching efficacy. *Journal of Educational Psychology*, *104*(4), 1189.

Conners-Burrow, N. A., Johnson, B., & Whiteside-Mansell, L. (2009). Maternal substance abuse and children's exposure to violence. *Journal of Pediatric Nursing*, *24*(5), 360-368.

Cook, M. N. (2005). The disruptive or ADHD child: What to do when kids won't sit still and be quiet. *Focus on Exceptional Children*, *37*(7), 1.

Cortiella, C., & Horowitz, S. H. (2014). The state of learning disabilities: Facts, trends and emerging issues. *New York: National Center for Learning Disabilities*, 2-45.

Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of General Psychiatry*, *60*(8), 837-844.

Coyle, J. T., Pine, D. S., Charney, D. S., Lewis, L., Nemeroff, C. B., Carlson, G. A. & Hellander, M. (2003). Depression and bipolar support alliance consensus statement on the unmet needs in diagnosis and treatment of mood disorders in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *42*(12), 1494-1503.

Crespi, G. S. (1990). Efficiency rejected: Evaluating undue hardship claims under the Americans with Disabilities Act. *Tulsa LJ*, *26*, 1. Retrieved from https://digitalcommons.law.utulsa.edu

Crundwell, R. A., & Killu, K. (2010). Responding to a student's depression. *Educational Leadership*, *68*(2), 46-51.

Daniel, L., Gupta, S. and Sagar, R. (2013). Effect of educational model on knowledge of primary school teachers regarding early symptoms of childhood psychiatric disorders. *Indian*

Journal of Psychological Medicine. 35(4). 368-372.

Darling-Hammond, L. (2006). Constructing 21st century teacher education. *Journal of Teacher Education. 57*(3), 300-314.

DeSocio, J., & Hootman, J. (2004). Children's mental health and school success. *The Journal of School Nursing*, *20*(4), 189-196.

Desrochers, J.E. & Houck, G.M. (2013). Depression in children and adolescents: Guidelines for school practice. Silver Spring: MD National Association for School Psychologists.

Dikel, W. (2014). The Teacher's Guide to Student Mental Health. Sage. Thousand Oaks, CA.

Dix, K. L., Slee, P. T., Lawson, M. J., & Keeves, J. P. (2012). Implementation quality of whole-school mental health promotion and students' academic performance. *Child and Adolescent Mental Health*, *17*(1), 45-51.

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). Enhancing students' social and emotional development promotes success in school: Results of a meta-analysis. *Child Development*, *82*(1), 405-32.

Eisenberg, D. & Scheinder, H. (2007) Perceptions of academic skills of children diagnosed with ADHD, *Journal of Attention Disorders, 10* (4), 390–397.

Elia, J. (2017). Depressive disorders in children and adolescents. Merck Manual. Retrieved from: http://www.merckmanuals.com

Emmer, E. T., & Stough, L. M. (2001). Classroom management: A critical part of educational psychology, with implications for teacher education. *Educational Psychologist*, *36*(2), 103-112.

Franklin, C. G., Kim, J. S., Ryan, T. N., Kelly, M. S., & Montgomery, K. L. (2012). Teacher involvement in school mental health interventions: A systematic review. *Children and Youth Services Review*, *34*(5), 973-982.

Freudenberg, N., & Ruglis, J. (2007). Peer reviewed: Reframing school dropout as a public health issue. *Preventing Chronic Disease*, *4*(4).

Friedman, M. J. (2015). *Posttraumatic and acute stress disorders*. Springer International Publishing. doi: 10.1007/978-3-319-15066-6

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

Gottfredson, G. D., Gottfredson, D. C., Payne, A. A., & Gottfredson, N. C. (2005). School climate predictors of school disorder: Results from a national study of delinquency prevention in schools. *Journal of Research in Crime and Delinquency*, *42*(4), 412-444.

Graham, S., & Harris, K. R. (2006). Preventing writing difficulties: Providing additional handwriting and spelling instruction to at-risk children in first grade. *Teaching Exceptional Children*, *38*(5), 64-66.

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

Hannon, C., Wood, C., & Bazalgette, L. (2010). *In loco parentis*. London, UK: Magdalene.

Harris, K. R., Santangelo, T., & Graham, S. (2008). Self-regulated strategy development in writing: Going beyond NLEs to a more balanced approach. *Instructional Science*, *36*(5-6), 395.

Headley, C. & Campbell, M. (2011). Teachers' recognition and referral of anxiety disorders in primary school children. *Australian Journal of Educational and Developmental Psychology* Vol 11. 78-90.

Huefner, D. S. (2000). The risks and opportunities of the IEP requirements under IDEA'97. *The Journal of Special Education*, *33*(4), 195-204.

Idol, L. (2006). Toward inclusion of special education students in general education: A program evaluation of eight schools. *Remedial and Special Education*, *27*(2), 77-94.

Individuals with Disabilities Education Improvement Act of 2004, Pub. L. No. 108–446. Washington, DC: U.S. Department of Education.

Jennings, P. A., & Greenberg, M. T. (2009). The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. *Review of Educational Research*, *79*(1), 491-525.

Jensen, E. (2009). How poverty affects behavior and academic performance. *Teaching with poverty in mind: What being poor does to kids' brains and what schools can do about it*, 13-45.

Jones Bock, S., & Borders, C. (2012). Chapter 4 Effective Practices/Interventions for Students with Emotional and Behavioral Disorders. In *Behavioral Disorders: Practice Concerns and Students with EBD* (pp. 61-82). Emerald Group Publishing Limited.

Jorm, A. F., Kitchener, B. A., Sawyer, M. G., Scales, H., & Cvetkovski, S. (2010). Mental health first aid training for high school teachers: A cluster randomized trial. *BMC Psychiatry*, *10*(1), 51.

Joyce, D., & Oakland, T. (2005). Temperament differences among children with conduct disorder and oppositional defiant disorder. *The California School Psychologist*, *10*(1), 125-136.

Kapalka, G. (2005). Avoiding repetitions reduces ADHD children's management problems in the classroom. *Emotional & Behavioral Difficulties*, *10* (4), 269–279.

Kazdin, A. E., Siegel, T. C., & Bass, D. (1992). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting and Clinical Psychology*, *60*(5), 733.

Kearney, C. A. (2003). Bridging the gap among professionals who address youths with school absenteeism: Overview and suggestions for consensus. *Professional Psychology: Research and Practice*, *34*(1), 57.

Kearney, C. A., & Bensaheb, A. (2006). School absenteeism and school refusal behavior: A review and suggestions for school-based health professionals. *Journal of School Health*, *76*(1), 3-7.

Kearney, C. A. (2008). School absenteeism and school refusal behavior in youth: A contemporary review. *Clinical Psychology Review*, *28*(3), 451-471.

Kearney, C., Chapman, G., & Cook, L. (2005). School refusal behavior in young children. *International Journal of Behavioral and Consultation Therapy*, *1*(3). 216-222.

Kendall, L. (2010) 'Now he has a label, we can cope!' Parent perceptions of attention deficit hyperactivity disorder.' *Meeting the Needs of Students with Diverse Backgrounds* London: Continuum International Publishing Group.

Kendall, L. (2016). 'The teacher said I'm thick!' Experiences of children with Attention Deficit Hyperactivity Disorder within a school setting. *Support for Learning*, *31*(2), 122-137.

Kidger, J., Araya, R., Donovan, J., & Gunnell, D. (2012). The effect of the school environment on the emotional health of adolescents: a systematic review. *Pediatrics*. doi: 10.1542/peds.2011-2248.

Killoran, I. (2004). Understanding the child with sensory integration dysfunction. *Focus on Inclusive Education Quarterly. 2*(1). 3-7.

Killoran, I., Woronko, D., & Zaretsky, H. (2014). Exploring preservice teachers' attitudes towards inclusion*. International Journal of Inclusive Education*. *18*(4). 427-442.

Lafee, S. (2013). The school's role in students' mental health. *School Administrator*, *7*(70). 24-30.

Lahey, J. (2016). Retrieved from https://www.theatlantic.com/education/archive/2016/10/the-failing-first-line-of-defense/504485/

Lambros, K., Culver, S., Angulo, A., & Hosmer, P. (2007). Mental health intervention teams: A collaborative model to promote positive behavioral support for youth with emotional or behavioral disorders. *The California School Psychologist*, *12*, 59-71.

Lane, C. (2017). Retrieved from: www.psyweb.com/mdisord/jsp/moood.jsp

Lane, K. L. (2007). Identifying and supporting students at risk for emotional and behavioral disorders within multi-level models: Data driven approaches to conducting secondary interventions with an academic emphasis. *Education and Treatment of Children*, *30*(4), 135-164.

Lane, K. L., Graham, S., Harris, K. R., & Weisenbach, J. L. (2006). Teaching writing strategies to young students struggling with writing and at risk for behavioral disorders: Self-regulated strategy development. *Teaching Exceptional Children*, *39*(1), 60-64.

Lasky, S. (2005). A sociocultural approach to understanding teacher identity, agency and

professional vulnerability in a context of secondary school reform. *Teaching and Teacher Education*, *21*(8), 899-916.

Laver-Bradbury, C. (2012) Reducing the social and emotional impact of ADHD. *British Journal of School Nursing*, *7*(5).

Lee, J.Y. (2014). Predictors of teachers' intention to refer students with ADHD to mental health professionals: Comparison of U.S. and South Korea. *School Psychology Quarterly, 29*, 385–394.

Leibenluft, E., Charney, D. S., Towbin, K. E., Bhangoo, R. K., & Pine, D. S. (2003). Defining clinical phenotypes of juvenile mania. *American Journal of Psychiatry*, *160*(3), 430-437.

Leverich, G. S., Post, R. M., Keck, P. E., Altshuler, L. L., Frye, M. A., Kupka, R. W., & Denicoff, K. (2007). The poor prognosis of childhood-onset bipolar disorder. *The Journal of Pediatrics*, *150*(5), 485-490.

Li, C. E., DiGiuseppe, R., & Froh, J. (2006). The roles of sex, gender, and coping in adolescent depression. *Adolescence*, *41*(163), 409.

Liang, L. L., & Richardson, G. M. (2009). Enhancing prospective teachers' science teaching efficacy beliefs through scaffolded, student-directed inquiry. *Journal of Elementary Science Education*, *21*(1), 51-66.

Malti, T., & Noam, G. (2008). The hidden crisis in mental health and education: The gap between student needs and existing supports. *New Directions for Youth Development*. *120*(Winter). 13-24.

Marlowe, M., Maycock, G. A., Palmer, L. F., & Morrison, W. F. (1997). Utilizing literary texts in teacher education to promote positive attitudes toward children with emotional and behavioral disorders. *Behavioral Disorders*, *22*(3), 152-159.

Marques, S. C., Pais-Ribeiro, J. L., & Lopez, S. J. (2011). The role of positive psychology constructs in predicting mental health and academic achievement in children and adolescents: A two-year longitudinal study. *Journal of Happiness Studies*, *12*(6), 1049-1062.

Martin, E. W., Martin, R., & Terman, D. L. (1996). The legislative and litigation history of special education. *The Future of Children*, 25-39.

Mazzer, K. R., & Rickwood, D. J. (2015). Teachers' role breadth and perceived efficacy in supporting student mental health. *Advances in School Mental Health Promotion*, *8*(1), 29-41.

McAllister, D. J., Kamdar, D., Morrison, E. W., & Turban, D. B. (2007). Disentangling role perceptions: How perceived role breadth, discretion, instrumentality, and efficacy relate to helping and taking charge. *Journal of Applied Psychology*, *92*(5), 1200.

McCray, E., & McHatton, P. (2011). "Less afraid to have them in my classroom": Understanding pre-service general educators' perceptions about inclusion. *Teacher Education Quarterly, 38*(4), 135-155.

McShane, G., Walter, G., & Rey, J. M. (2001). Characteristics of adolescents with school refusal. *Australian and New Zealand Journal of Psychiatry*, *35*(6), 822-826.

Merz, S. (2017). Who in your class needs help? *Mental Health in Schools*. *75*(4). 12-17.

Metzl, J. M., & MacLeish, K. T. (2015). Mental illness, mass shootings, and the politics of American firearms. *Journal Information*, *105*(2).

Mihalas, S., Morse, W., Allsopp, D., & McHatton, P.A. (2009). Cultivating caring relationships between teachers and secondary students with emotional and behavioral disorders: Implications for research and practice. *Remedial and Special Education*, *30*(2), 108-125.

Milsom, A. S. (2002). Students with disabilities: School counselor involvement and preparation. *Professional School Counseling*, *5*(5), 331-339.

Minnesota Governor's Council on Developmental Disabilities (2007). Retrieved from: http://mn.gov/mnddc/

Moor, S., Ann, M., Hester, M., Elisabeth, W. J., Robert, E., Robert, W., & Caroline, B. (2007). Improving the recognition of depression in adolescence: Can we teach the teachers? *Journal of Adolescence*, *30*(1), 81-95.

Mrachko, A. A., Kostewicz, D. E., & Martin, W. P. (2017). Increasing positive and decreasing negative teacher responses to student behavior through training and feedback. *Behavior Analysis: Research and Practice*, *17*(3), 250.

Mufson, L., Dorta, K. P., Moreau, D., & Weissman, M. M. (2011). *Interpersonal psychotherapy for depressed adolescents*. Guilford Press.

Muris, P., Meesters, C., van Melick, M., & Zwambag, L. (2001). Self-reported attachment style, attachment quality, and symptoms of anxiety and depression in young adolescents. *Personality and Individual Differences*, *30*(5), 809-818.

Mychailyszyn, M., Beidas, R., Bnejamin, C., Edmunds, J., Podell, J., Cohen, J., & Kendall, P. (2011). Assessing and treating child anxiety in schools. *Psychology in the Schools. 48*(3), 223-230.

National Center for Children in Poverty (2014). Retrieved from: http://www.nccp.org/topics/mentalhealth.html

National Commission on Writing (2004). Writing: A ticket to work...or a ticket out: A survey of business leaders. Retrieved from http://www.writingcommission.org/prod_downloads/ writingcom/writing-ticket-to-work.pdf

National Institute of Mental Health (2015), Retrieved from www.nimh.nih.gov/statistics/prevalence/majordepression.

Nelson, E.C., Grant, J.D., Bucholz, K.K., Glowinski, A., Madden, P.A., Reich, W., et al (2000). Social phobia in a population-based female adolescent twin sample: Co-morbidity and associated suicide-related symptoms. *Psychological Medicine 30*(4), 797-804.

Nutter, D.A., & Pataki, C. (2017). Pediatric generalized anxiety disorder. Retrieved from: https://emedicine.medscape.com

Odom, S. L., Boyd, B. A., Hall, L. J., & Hume, K. (2010). Evaluation of comprehensive treatment models for individuals with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, *40*(4), 425-436.

O'Donnell, M. L., Alkemade, N., Nickerson, A., Creamer, M., McFarlane, A. C., Silove, D., & Forbes, D. (2014). Impact of the diagnostic changes to post-traumatic stress disorder for DSM-5 and the proposed changes to ICD-11. *The British Journal of Psychiatry*, *205*(3), 230-235.

Ogletree Jr, C. J. (2005). All deliberate speed: Reflections on the first half-century of Brown vs. Board of Education. *Mont. L. Rev.*, *66*, 283.

Oliver, R. M., & Reschly, D. J. (2010). Special education teacher preparation in classroom management: Implications for students with emotional and behavioral disorders. *Behavioral Disorders*, 188-199.

Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*(6), 731-738.

Paisley, P. O., & McMahon, G. (2001). School counseling for the 21st century: Challenges and opportunities. *Professional School Counseling*, *5*(2), 106-116.

Partin, T. C. M., Robertson, R. E., Maggin, D. M., Oliver, R. M., & Wehby, J. H. (2009). Using teacher praise and opportunities to respond to promote appropriate student behavior. *Preventing School Failure: Alternative Education for Children and Youth*, *54*(3), 172-178.

Patterson, G., Reid, J., & Dishion, T. (1992). *Antisocial boys: A social interactional approach* (Vol 4). Eugene, OR: Castalia.

Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., & Parks, S. E. (2013). Mental health surveillance among children—United States, 2005–2011. *MMWR Surveill Summ*, *62*(Suppl 2), 1-35.

Petersen, J. E., & Treagust, D. F. (2014). School and university partnerships: The role of teacher education institutions and primary schools in the development of preservice teachers' science teaching efficacy. *Australian Journal of Teacher Education*, *39*(9), 10.

Planty, M., Hussar, W. J., & Snyder, T. D. (2009). *Condition of education 2009*. Government Printing Office.

Reid, R., Hagaman, J. L., & Graham, S. (2014). Using self-regulated strategy development for written expression with students with attention deficit hyperactivity disorder. *Learning Disabilities--A Contemporary Journal*, *12*(1).

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

Reis, C., & Cornell, D. (2008). An evaluation of suicide gatekeeper training for school counselors and teachers. *Professional School Counseling*, *11*(6), 386-394.

Renard, L. (2003). Setting new teachers up for failure... or success. *Educational Leadership*, *60*(8), 62-64.

Reynolds, M. C. (1989). An historical perspective: The delivery of special education to mildly disabled and at-risk students. *Remedial and Special Education*, *10*(6), 7-11.

Roberson, S. (2011). Defying the default culture and creating a culture of possibility. *Education. 131*(4). 885-904.

Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review*, *3*(4), 223-241.

Rueger, S. Y., Katz, R. L., Risser, H. J., & Lovejoy, M. C. (2011). Relations between parental affect and parenting behaviors: A meta-analytic review. *Parenting: Science and Practice*, *11*(1), 1-33.

Rueger, S., Chen, P., Jenkins, L., & Choe, H. (2014). Effects of perceived support from mothers, fathers, and teachers on depressive symptoms during the transition to middle school. *Journal of Youth and Adolescence. 43*(4). 655-670.

Sarantakos, S. (1994). *Social Research*. London: Sage

Scanlon, D., & Baker, D. (2012). An accommodations model for the secondary inclusive classroom. *Learning Disability Quarterly*, *35*(4), 212-224.

Scheeringa, M. S., & Zeanah, C. H. (2001). A relational perspective on PTSD in early childhood. *Journal of Traumatic Stress*, *14*(4), 799-815.

Sedensky III, S. J. (2013). Report of the state's attorney for the judicial district of Danbury on the shootings at Sandy Hook Elementary School and 36 Yogananda Street, Newtown, Connecticut on December 14, 2012.

Sherman, J., Rasmussen, C., & Baydala, L. (2008). The impact of teacher factors on achievement and behavioral outcomes of children with Attention Deficit/Hyperactivity Disorder (ADHD): A review of the literature. *Educational Research*, *50*(4), 347-360.

Shippen, M., Crites, S., Houchins, S., Ramsey, M., & Simon, M. (2005). Preservice teachers' perceptions of including students with disabilities. *Teacher Education and Special Education. 28*(2). 92-99.

Slee, R. (2006). Inclusive education: Is this horse a Trojan? *Exceptionality Education Canada 16*(2-3). 223—42.

Soles, T., Bloom, E. L., Heath, N. L., & Karagiannakis, A. (2008). An exploration of teachers' current perceptions of children with emotional and behavioral difficulties. *Emotional and Behavioral Difficulties*, *13*(4), 275-290.

Solter, A. (1998). Why do children misbehave. Retrieved from www.awareparenting.com/misbehavior.pdf

South Whittier School District (2005). School District Board Policies. Retrieved from http://www.gamutonline.net/district/swhit/DisplayPolicy/373823/9

Sreckovic, MA, Common, EA, Knowles, MM, & Lane, KL. 2014. A review of self-regulated strategy development for writing for students with EBD. *Behavioral Disorders*, *39*(2). 56-77.

Statistics, L. (2013). Independent t-test using SPSS. *Retrieved July 25*, 2016.

Stauffer, S. Heath, M. Coyne, S. & Ferrin, S. (2012). High school teachers' perceptions of cyberbullying prevention and intervention strategies. *Psychology in the Schools 49*(4). 353-367.

Stemler, S. (2001). An overview of content analysis. *Practical Assessment, Research & Evaluation*, *7*(17), 137-146.

Stephan, S. H., Sugai, G., Lever, N., & Connors, E. (2015). Strategies for integrating mental health into schools via a multi-tiered system of support. *Child and Adolescent Psychiatric Clinics*, *24*(2), 211-231.

Stephan, S. H., Weist, M., Kataoka, S., Adelsheim, S., & Mills, C. (2007). Transformation of children's mental health services: The role of school mental health. *Psychiatric Services*, *58*(10), 1330-1338.

Stewart, S., Klasson, J., & Hamza, C. (2016). Emerging mental health diagnoses and school disruption: An examination among clinically referred children and youth. *Exceptionality Education International 26*(2), 5-20.

Stichter, J. P., Lewis, T. J., Whittaker, T. A., Richter, M., Johnson, N. W., & Trussell, R. P. (2009). Assessing teacher use of opportunities to respond and effective classroom management strategies: Comparisons among high-and low-risk elementary schools. *Journal of Positive Behavior Interventions*, *11*(2), 68-81.

Stormont, M., & Reinke, W. M. (2014). Providing performance feedback for teachers to increase treatment fidelity. *Intervention in School and Clinic*, *49*(4), 219-224.

Stormont, M., Reinke, W., & Herman, K. (2011). Teachers' knowledge of evidence-based interventions and available school resources for children with emotional and behavioral problems. *Journal of Behavioral Education*, *20*(2), 138.

Strøm, I. F., Schultz, J., Wentzel-Larsen, T., & Dyb, G. (2016). School performance after experiencing trauma: A longitudinal study of school functioning in survivors of the Utøya shootings in 2011. *European Journal of Psychotraumatology*, *7*

Summey, H. K., & Strahan, D. B. (1997). An exploratory study of mainstreamed seventh graders' perceptions of an inclusive approach to instruction. *Remedial and Special Education*, *18*(1), 36-45.

Taylor, L., & Adelman, H. S. (2004). Advancing mental health in schools: Guiding frameworks and strategic approaches. *Advances in School-Based Mental Health Interventions: Best Practices and Program Models*, *2*-1.

Taylor, T.K. & Biglan, A. (1998). Behavioral family interventions for improving child-rearing: A review for clinicians and policy makers. *Clinical Child and Family Psychology Review, 1,* 41-60.

Testa, M., Miller, B. A., Downs, W. R., & Panek, D. (1992). The moderating impact of social support following childhood sexual abuse. *Violence and Victims*, *7*(2), 173.

Thomason, M. E., Marusak, H. A., Tocco, M. A., Vila, A. M., McGarragle, O., & Rosenberg, D. R. (2015). Altered amygdala connectivity in urban youth exposed to trauma. *Social Cognitive and Affective Neuroscience*, *10*(11), 1460-1468.

Tindal, G. & Crawford, L. (2002). Teaching writing to students with behavior disorders: Metaphor and medium. *Interventions for Children with or at-risk for Emotional and Behavioral Disorders*, 104-124.

Tomb, M. & Hunter, L. (2004). Prevention of anxiety in children and adolescents in a school setting: The role of school-based practitioners. *Children and Schools* *26*(2). 87-101.

Tosun, T. (2000). The beliefs of preservice elementary teachers toward science and science teaching. *School Science and Mathematics*, *100*(7), 374-379.

Travell, C., & Visser, J. (2006). 'ADHD does bad stuff to you': Young people's and parents' experiences and perceptions of Attention Deficit Hyperactivity Disorder (ADHD). *Emotional and Behavioural Difficulties*, *11*(3), 205-216.

Trudgen, M., & Lawn, S. (2011). What is the threshold of teachers' recognition and report of concerns about anxiety and depression in students? An exploratory study with teachers of adolescents in regional Australia. *Australian Journal of Guidance and Counselling*, *21*(2), 126-141.

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

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

Turnbull III, H. R. (2005). Individuals with Disabilities Education Act reauthorization: Accountability and personal responsibility. *Remedial and Special Education*, *26*(6), 320-326.

Upthegrove, R., Chard, C., Jones, L., Gordon-Smith, K., Forty, L., Jones, I., & Craddock, N. (2015). Adverse childhood events and psychosis in bipolar affective disorder. *The British Journal of Psychiatry*, *206*(3), 191-197.

Wagner, M., & Davis, M. (2006). How are we preparing students with emotional disturbances for the transition to young adulthood? Findings from the National Longitudinal Transition Study—2. *Journal of Emotional and Behavioral Disorders*, *14*(2), 86-98.

Wagner, M., Kutash, K., Duchnowski, A. J., Epstein, M. H., & Sumi, W. C. (2005). The children and youth we serve: A national picture of the characteristics of students with emotional disturbances receiving special education. *Journal of Emotional and Behavioral Disorders*, *13*(2), 79-96.

Walker, H. M. (2004). Commentary: Use of evidence-based interventions in schools: Where we've been, where we are, and where we need to go. *School Psychology Review*, *33*(3), 398-408.

Wasburn-Moses, L. (2005). How to keep your special education teachers. *Principal Leadership*, *5*(5), 35-38.

Wastell, C. A., & Shaw, T. A. (1999). Trainee teachers' opinions about suicide. British problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology*, *65*(1), 93.

Webster-Stratton, C. (1993). Strategies for helping early school-aged children with oppositional defiant disorder and conduct disorders: The impact of home-school partnerships. *School Psychology Review*, *22*(3), 437-457.

Webster-Stratton, C., Reid, M. J., & Hammond, M. (2004). Treating children with early-onset conduct problems: Intervention outcomes for parent, child, and teacher training. *Journal of Clinical Child and Adolescent Psychology*, *33*(1), 105-124.

Weir, J. P. (2005). Quantifying test-retest reliability using the intraclass correlation coefficient and the SEM. *Journal of Strength and Conditioning Research*, *19*(1), 231.

Weist, M. D., & Evans, S. W. (2005). Expanded school mental health: Challenges and opportunities in an emerging field. *Journal of Youth and Adolescence*, *34*(1), 3-6.

Williams, B., Boyle, K., White, J. & Sinko, A. (2010). Children's mental health: Promotion and support: Strategies for educators. National Association of School Psychologists. Helping children at home and school III.

Winther, J., Carlsson, A., & Vance, A. (2014). A pilot study of a school-based prevention and early intervention program to reduce oppositional defiant disorder/conduct disorder. *Early Intervention in Psychiatry*, *8*(2), 181-189.

World Health Organization. (2001). *The World Health Report 2001: Mental health: New understanding, new hope*. World Health Organization.

World Health Organization. (2004). Preventions of mental disorders: Effective interventions and policy options. Summary Report. Geneva: Author.

Wozniak, J., Biederman, J., Kiely, K., Ablon, J. S., Faraone, S. V., Mundy, E., & Mennin, D. (1995). Mania-like symptoms suggestive of childhood-onset bipolar disorder in clinically referred children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *34*(7), 867-876.

Wyman, P. A., Inman, J., Brown, C. H., Cross, W., Schmeelk-Cone, K., & Pena, J. B. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology, 76*, 104–115.

Yell, M. L., Rogers, D., & Rogers, E. L. (1998). The legal history of special education: What a long, strange trip it's been! *Remedial and Special Education*, *19*(4), 219-228.

Yell, M. L., Shriner, J. G., & Katsiyannis, A. (2006). Individuals with Disabilities Education Improvement Act of 2004 and IDEA regulations of 2006: Implications for educators, administrators, and teacher trainers. *Focus on Exceptional Children*, *39*(1), 1.

Yost, D. S. (2006). Reflection and self-efficacy: Enhancing the retention of qualified teachers from a teacher education perspective. *Teacher Education Quarterly*, *33*(4), 59-76.

Zald, D. H. (2003). The human amygdala and the emotional evaluation of sensory stimuli. *Brain Research Reviews*, *41*(1), 88-123.

Zirkel, P. A. (2012). Section 504 for Special Education Leaders: Persisting and Emerging Issues. *Journal of Special Education Leadership*, *25*(2).

Zirkel, P. A., & Weathers, J. M. (2015). Section 504-only students: National incidence data. *Journal of Disability Policy Studies*, *26*(3), 184-193.

APPENDICES

APPENDIX A

CONCORDIA UNIVERSITY IRVINE

Dear Teachers,

You are invited to participate in a research study titled "A Mixed Methods Study of General Education Teachers' Attitudes, Beliefs, and Knowledge Regarding Student Mental Health". This study is being conducted by researcher Beth Raposa, an SLMUSD Program Specialist who is an Educational Leadership doctoral candidate at Concordia University, Irvine. The purpose of this study is to examine teachers experience with students' who have mental health issues, to ascertain how much training teachers have received in both their professional careers and in their preservice credential programs, and to assess the level of support teachers felt they need knowing they may have as a teacher of a student with a mental health disorder.

Participation in this research study is voluntary. You can choose not to participate in answering the survey. You are being asked to take part in this research study because you are a teacher in a middle school in the Norwalk La Mirada Unified School District. Your insight can provide valuable data that helps this research study address the topic of student mental health. The survey will take five to ten minutes to complete.

The contents of the completed surveys will be kept strictly confidential, and you will remain anonymous with no links to you in any way. There will be no identifying information collected about you at any point during the study. The paper version of the post-survey will be destroyed after the data is collected. Only Beth Raposa will have access to the data.

There are no risks associated with this research study. While you may not experience any direct benefits from participation, information collected in this research study may benefit you and others in the future by helping understand teacher attitudes, knowledge, beliefs, and training experience in the area of student mental health. This information will support future professional development opportunities and may influence the decision to provide additional support for teachers who have mentally ill children in their class.

If you have any questions regarding the surveys and presentations or this research in general, please contact the principal researcher, Beth Raposa, at 310-467-5681 or via email at beth.raposa@coyote.csi.edu.

Beth Raposa, M.A., C.A.G.S.

TEACHERS AND THEIR STUDENTS WITH MENTAL HEALTH ISSUES

Attitudes and Beliefs

1

1. Have you taught a student in the past year with a mental health issue. Check all that apply

- [ ] Aggression
- [ ] Depression
- [ ] Attention Deficit Hyperactivity Disorder (ADHD)
- [ ] Social skills problems
- [ ] Disruptive behaviors/acting out
- [ ] Anxiety
- [ ] Bipolar Disorder
- [ ] Defiant behavior
- [ ] Post Traumatic Stress Disorder (PTSD)
- [ ] Victim of bullying
- [ ] Cutting
- [ ] Eating Disorder
- [ ] Other (please specify)

2. What percentage (rough estimate) of your students have been IDENTIFIED as having a mental illness?

- ( ) 0 - 10%
- ( ) 11 %- 20%
- ( ) 21% - 30%
- ( ) 31% - 40%
- ( ) Over 40%

3. What percentage of your students (rough estimate) currently RECEIVE mental health services at school

- ( ) 0 - 10%
- ( ) 11 % - 20 %
- ( ) 21 % - 30 %
- ( ) 31% - 40%
- ( ) Above 40%

4. Rate the amount of TRAINING you have had in using behavioral interventions

- ○ None
- ○ Minimal
- ○ Moderate
- ○ Substantial

5. Rate the amount of EXPERIENCE you have had in using behavioral interventions with your students

- ○ None
- ○ Minimal
- ○ Moderate
- ○ Substantial

6. Do you feel that the number of students with mental health problems is increasing

- ☐ YES
- ☐ NO
- ☐ UNSURE

7. How much training/instruction did you receive on mental health in your pre-service teaching program?

- ○ None
- ○ Minimal
- ○ Moderate
- ○ Substantial

8. Do you feel there is a need for additional mental health training at your school?

- ☐ YES
- ☐ NO

9. I feel like I have the level of KNOWLEDGE required to meet the mental health needs of my students?

- ○ Strongly Agree
- ○ Agree
- ○ Neutral
- ○ Disagree
- ○ Strongly Disagree

10. Addressing mental illness is not considered a role/priority of my school

- TRUE
- FALSE

11. I feel like I have the SKILLS required to meet the mental health needs of my students?

- Strongly Aagree
- Agree
- Neutral
- Disagree
- Strongly Disagree

12. Do you feel supported by the counselor(s) at your school?

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

13. Do you feel supported by the school psychologist at your school?

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

14. I feel that schools should be involved in addressing the mental health issues of students

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

15. What is the role of teachers related to mental health in your school ? Check all that apply.

- [ ] Screening for mental health problems
- [ ] Implementing classroom behavioral interventions
- [ ] Teaching social/emotional lessons
- [ ] Monitoring student progress
- [ ] Referring children and families to school-based mental health services
- [ ] Referring children and families to outside mental health services

16. What is the role of counselors/psychologists related to mental health in your school? Check all that apply.

- [ ] Screening for mental health problems
- [ ] Implementing classroom behavioral interventions
- [ ] Teaching social/emotional lessons
- [ ] Monitoring student progress
- [ ] Referring children and families to school-based mental health services
- [ ] Referring children and families to outside mental health services

17. What are the top three mental health issues you face at your school site?

18. Which mental health issues and/or disorders would you like additional training?

19. From which experience have you learned the most about mental health issues?

- ( ) Professional Development
- ( ) Independent Study/Research
- ( ) Undergraduate coursework
- ( ) Graduate coursework
- ( ) None of the above
- ( ) Other (please specify)

20. What type of behavior intervention training have you had?

21. Do you teach general education or special education

- [ ] General Education
- [ ] Special Education

22. What grade do you teach? Check all that apply

- [ ] 6th
- [ ] 7th
- [ ] 8th

23. What is your gender?

- ( ) Female
- ( ) Male

24. How long have you been teaching?

- ( ) 1-5 years
- ( ) 6-10 years
- ( ) 11-15 years
- ( ) 16-20 years
- ( ) Over 20 years

25. What is the name of your school

- [ ] Benton
- [ ] Corvallis
- [ ] Hutchinson
- [ ] Los Alisos
- [ ] Los Coyotes
- [ ] Waite

APPENDIX B

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Beth Raposa** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 07/06/2016.

Certification Number: 2091111.

APPENDIX C

MENTAL HEALTH DISORDERS: SUPPORT FOR GENERAL EDUCATION TEACHERS

Beth Raposa M.A., C.A.G.S.
Lori Brummel M.A., BCBA, LEP
02/07/2018

THE IMPACT

Functional Impairments

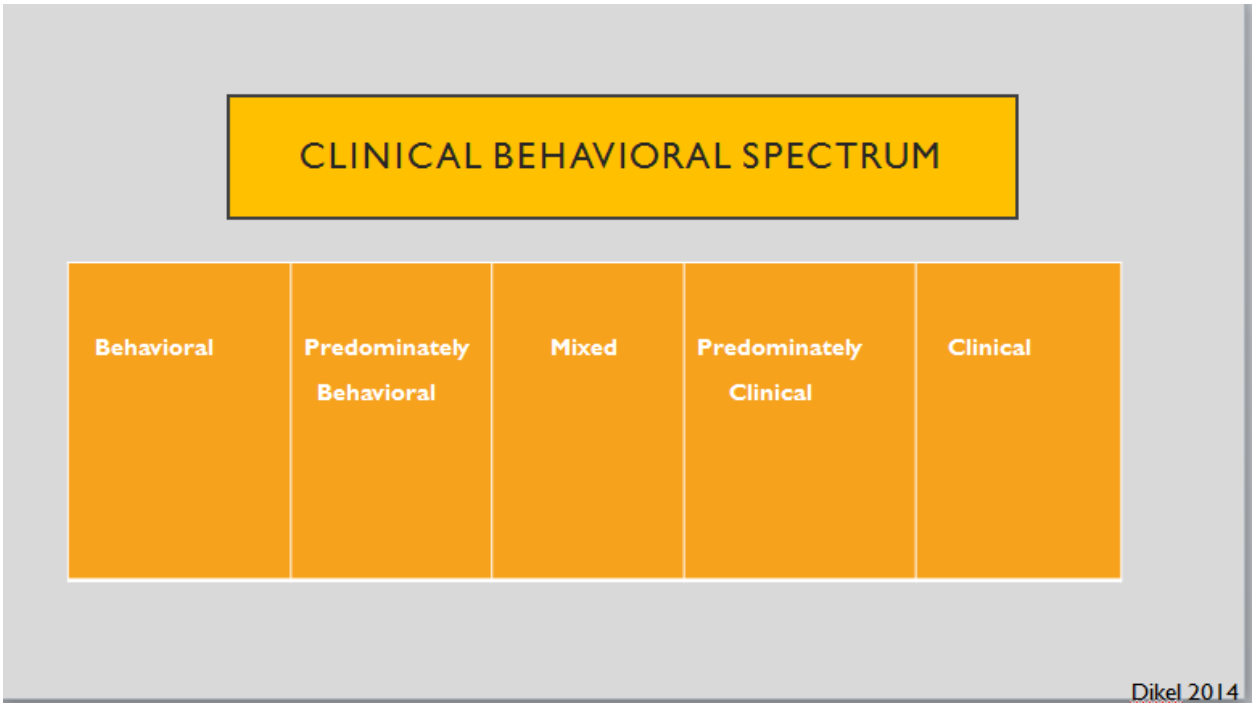
- Mood
- Thinking
- Behavior

WHAT FUNCTIONAL FACTORS IMPEDE

- Attending
- Engaging
- Following directions
- Concentration
- Staying in a work area
- Communication
- Handling time pressures
- Multi-tasking
- Memory
- Impulsivity
- Planning and Organizing
- Accommodating Change
- Social Interaction
- Handling Feedback

THINKING VS. REALITY

- HE WOULDN'T BE LIKE THAT IF HE JUST TRIED MORE
- HE KNOWS EXACTLY WHAT HE IS DOING AND HE DOES IT TO ANNOY ME
- THE RIGHT MEDICATIONS WOULD FIX THIS
- SHE WOULDN'T BE THIS WAY IF IT WEREN'T FOR HER PARENTS
- BUT HE HAS SO MUCH POTENTIAL. HIS IQ IS AVERAGE! HE SHOULD BE ABLE TO DEAL WITH GRADE LEVEL WORK



BEHAVIORAL

- Learned behaviors
- This individual needs behavioral interventions.
- Medication will not help.
- Needs a behavioral plan - "a narrow path with high walls".

BEHAVIORAL: CASE EXAMPLE

- Alan is a 17 year old student who has a long history of delinquent behaviors dating back to age 9. He has no evidence of any psychiatric illness, and all of his behaviors are planned and volitional.
- Alan grew up in a home where he was exposed to antisocial behaviors of both parents and two older siblings. He was finally placed in foster care at the age of 16, and has been receiving structure, nurturance, consistency and stability since then.
- Also, Alan would not benefit from insight oriented psychotherapeutic approaches. Alan needs "a narrow path with high walls"-clear behavioral consequences, and a behavior plan that will hopefully extinguish his antisocial behaviors, and replace them with pro-social behaviors.

CLINICAL

- No history of behavioral problems prior to the onset of the mental health disorder
- Symptoms include hallucinations, delusions, and/or agitation and manic behavior
- Symptoms are severe and not under the student's control
- There is no function of the behavior

CLINICAL: CASE EXAMPLE

- John, a 16 year old student who has childhood schizophrenia, with no
- history of antisocial behavior prior to the onset of his illness three years
- ago. Behavioral interventions for John would be ineffective in addressing
- the underlying cause of his difficulties. A behavioral model of intervention
- would be inappropriate. John needs a clinical model of intervention.

PREDOMINATELY BEHAVIORAL

- Child or adolescent who has a mental health disorder, but whose
- behavior problems are due to volitional planning
- not significantly related to the mental health disorder
- Example:
- An antisocial child/adolescent who also has ADHD.
- Medication will help him plan his crimes better
- Requires behavioral interventions
- Medication can help only if there are also behavioral interventions

PREDOMINATELY BEHAVIORAL: CASE EXAMPLE

- Jared is a 9 year old boy who has been stealing, lying, cruel to animals,
- setting fires, skipping school and aggressively bullying other children.
- He has recently been diagnosed with ADHD
- His antisocial behaviors are planned and are not related to the impulsivity of ADHD.
- Medication for ADHD is likely to "help him plan his crimes better".
- Although Jared has a mental health disorder, the predominate intervention for addressing his behavior problems will need to be behavioral

MIXED

- Students have both major psychiatric disorders and significant behavioral difficulties
- Often not able to be successful in general education classrooms
- Their mental health disorders often go undiagnosed or untreated
- Often receive special education services under the eligibility of ED
- This category is the most challenging for educators
- Poor outcomes: education, employment, rates of arrest

MIXED: CASE EXAMPLE

- Karen is a 16 year old who has spent most of her life in a home with catastrophic stresses. She has fetal alcohol and drug spectrum disorder, ADHD, Post Traumatic Stress Disorder secondary to being molested at age 10, and clinical depression.
- Karen also has a long history of antisocial behaviors, dating back to kindergarten. She has assaulted teachers and other students, shoplifted from stores and vandalized the neighborhood. She is noted to be able to charm others, and to be able to be in control of her behaviors to suit her desires.
- Karen is a very high risk individual, including dropping out of school. She has a mixture of severe mental illness and of severe antisocial behaviors. Some of her behavior problems stem from her psychiatric disorders, whereas others have clear environmental antecedents. Effective interventions will require equally intensive therapeutic and behavioral approaches.

PREDOMINATELY CLINICAL

- Child or adolescent whose problems are mainly due to a psychiatric disorder
- There may be power struggles or other behavioral problems
- These are minor compared to the psychiatric disorder
- Behavioral interventions will only work if there is treatment for the unerlying psychiatric disorder

PREDOMINATELY CLINICAL: CASE EXAMPLE

- Susan is a 16 year old student who has a history of oppositional and defiant behaviors since early childhood. She grew up in a home where she received inconsistent parenting, and subsequently tested limits in all settings, including school. She has a family history of Bipolar Mood Disorder, and began to develop symptoms of this disorder at age 15.
- Within the last six months, she has been agitated, hyperactive, irritable, engaging in risky behaviors, and demonstrating severe mood swings. Her baseline of mild to moderat e oppositional behaviors remain, but are overshadowed by her new behavioral difficulties.
- Susan will require behavioral interventions, but, since her severe behaviors directly stem from her psychiatric disorder, the predominate intervention needs to be clinical. Otherwise, she is unlikely to improve.

REMEMBER

- The Clinical Behavioral Spectrum isn't a diagnostic tool. It is a "hypothesis generator" that raises awareness that clinical and behavioral issues are often not "either-or" but "both-and
- It can be the basis of discussion when educational plans or treatment plans are not working well. It can defuse highly charged emotional discussions regarding a student's behavior
- Parents who say, "My child has a psychiatric disorder and therefore should have no consequences for his/her behavior"
- Or, a teacher tells parents, "I know that he can pay attention when he wants to-I don't believe that he has any disorder, just an attitude problem".

ANXIETY

- Most common psychiatric disorder in children and adolescents
- Between 10% to 20% of youths
- Normal human emotion but can become disabling
- Interferes with ability to function effectively in social situations
- Interferes with the normal developmental process
- Some children with significant behaviors have underlying anxiety

TYPES OF ANXIETY DISORDERS

- Generalized Anxiety: anxiety symptoms that occur in multiple situations with worrying as the prominent feature
- Social Anxiety: intense fear in social situations (age of onset 10-13 years)
- Specific Phobias: persistent fears of situations or objects that student wants to avoid
- Separation Anxiety: excessive fear and anxiety when one is separated from those to whom student is attached
- Obsessive-Compulsive Disorder: disabled by obsessions (persistent thoughts, images, impulses) and compulsions (actions or mental activities that are repetitive)
- Post Traumatic Stress Disorder: caused by experiencing a traumatic event

ANXIETY IN THE CLASSROOM

- Generalized Anxiety Disorder — student appears tense, unable to relax; may ask excessive questions about the assignment; displays nervous habits (i.e. biting nails, cracking knuckles); may express constant worries ranging from personal safety to fears of failure; classroom performance may suffer.

- Social Anxiety Disorder — student will tend to avoid situations in which they are exposed to unfamiliar people, due to fears of embarrassment; this may be particularly heightened on the first day of school, field trips or on the playground; it is manifested in avoidant behavior and can result in the refusal to go to school, which is a major cause of mental health problems leading to missed days of school.

ANXIETY IN THE CLASSROOM (CONT.)

- Phobias — persistent fears of situations or objects that are avoided; if exposure is unavoidable the student will experience significant distress; it can interfere both with social and occupational activities; some phobias include arachnophobia, claustrophobia, agoraphobia, etc. Some phobias are due to a traumatic experience and some are hard-wired instinctual responses.

- Separation Anxiety – student may refuse to go to school; appear anxious upon arrival at school; cling to caregiver; verbalize fears of something happening to caregiver when they are apart

- Panic Disorder – a student experiencing a panic attack may have a sudden urge to leave the classroom; if remaining in class anxiety may cause significant distraction; may appear shaken or disoriented; may sit on the end of a row so they can exit quickly; may also develop school refusal.

ANXIETY IN THE CLASSROOM (CONT.)

- Obsessive compulsive disorder (OCD) – can be completely hidden or may manifest as compulsions (i.e. touching light switches when entering classroom); can also manifest as avoiding to shake hands due to fear of contamination or excessive hand washing; they may also engage in skin picking or hair pulling; a hidden compulsion which may affect school work is the student that fells compelled to count the ceiling tiles.

- Post-traumatic stress disorder (PTSD) – student may appear overly quiet, withdrawn, and not engaged in classroom activities; younger children may repeat the themes of the trauma in play activities, drawings or conversation

MOOD DISORDERS

- Depression: sad or irritable mood, inability to experience pleasure from activities usually found to be enjoyable, often comorbid with other mental health disorders such as anxiety, substance abuse, conduct disorder, ADHD
- Bipolar Disorder: significant instability of mood (mania and depression), much more severe than typical ups and downs of life
- Disruptive Mood Dysregulation Disorder: chronic irritability and severe, recurrent temper outbursts that are grossly out of proportion to the situation, low frustration tolerance, difficulty interacting with peers, adults, and family members, verbal rages and/or physical aggression towards people or property

MOOD DISORDERS IN THE CLASSROOM

- Depression – (may be very obvious or completely hidden)
- internalizers may appear sad, withdrawn, low energy;
- externalizers may appear more irritable, having angry outbursts, oppositional behaviors and even aggression;
- depression causes difficulties with concentration as students with depression often have poor sleep and appetite abnormalities; they also have a lack of interest in previously enjoyed activities; low self-esteem and can have thoughts of death or plans to attempt suicide.
- Bipolar mood disorder — students will demonstrate mood swings; may experience highs and lows simultaneously; may become agitated or very irritable; may appear exhilarated one minute then depressed the next; symptoms of mania may appear as making grandiose statements about his/her immense abilities; they may present with excessive talking, interrupting others or speaking at a rapid rate. They may act impulsively and sexually provocatively. Symptoms may overlap with ADHD and have high comorbidity with substance use.

MOOD DISORDERS IN THE CLASSROOM (CONT)

- Disruptive mood dysregulation disorder (DMDD) – (ages 7-18) chronic irritability and severe, recurrent temper outbursts (grossly disproportionate to situation); observed as significant outbursts in the classroom, playground or in the lunchroom; includes physical aggression toward people and property; observed >3 times per week; students have great difficulty with relationships with peers/adults; because its due to mood dysregulation tends to not respond to typical behavioral interventions

ATTENTION DEFICIT HYPERACTIVITY DISORDER

- Symptoms of inattention, hyperactivity, and impulsivity or a combination of these symptoms
- 11% of children diagnosed in the U.S. (41% increase over past decade)
- 1 in 10 high school boys prescribed ADHD medication

Centers for Disease Control (2013)

ATTENTION DEFICIT HYPERACTIVITY DISORDER IN THE CLASSROOM

- ADHD – hyperactive – may become impatient, frustrated and disruptive; combined – symptoms are most pronounced when they are required to sit for long periods of time focused on a specific task; they have difficulty remaining seated, will fidget, appear unfocused, and may be disruptive. Students may rush through work, may not attend to details, appear to not be listening, have difficulty with organizational skills, may be task avoidant or oppositional.
- Inattentive – these students tend to be easy to miss; poor study skills, not disruptive, disorganized, inattentive, may be seen as lazy, achieve significantly below potential

OPPOSITIONAL DEFIANT DISORDER

- Pattern of angry or irritable mood
- Continually test the limits
- Argumentative or defiant behavior
- Vindictiveness
- Behaviors lasting at least 6 months
- 3% of population
- Behaviors tend to appear in preschool
- Not having recevied clear and consistent limits from parents or authority figures
- Child's maladaptive response to life stressors

CONDUCT DISORDER

- Persistent and repetitive pattern of behavior that violates societal norms or the basic rights of others
- Physical aggression
- Destruction of property
- Theft and deceit
- Serious violation of rules
- Bullying
- Cruelty to people and animals

BEHAVIOR DISORDERS IN THE CLASSROOM

- Oppositional defiance disorder (ODD) — defy authority, refuse to comply with rules and requests; may be argumentative; easily annoyed, angry, annoying, spiteful, blaming or vindictive
- Conduct Disorder – students demonstrate a repetitive and persistent pattern of behavior problems displayed in multiple settings; may be aggressive; cheat or lie; destroy property; steal; truancy; may have been incarcerated in the juvenile justice system.

PSYCHOTIC DISORDERS IN THE CLASSROOM

- Psychotic disorders — (schizophrenia)
- Disorganized\
- Socially withdrawn
- Poor hygiene
- Possible bizarre behaviors
- May be actively hallucinating and
- May demonstrate paranoia

HELP !!!!!!

- Difficult
- Frustrating
- Exhausting
- Annoying
- Disrupting

HEADWINDS

- Come from hostile, abusive, fearful, dangerous homes
- Poverty
- Learning Disabilities
- Foster Care
- PTSD and Trauma


HOW THEY REALLY FEEL
• Rather be bad than sick
• Behaviors are communication
• Push away adults who care for them
• Low self-worth and self-esteem
• Afraid to try for fear of failure
• Need for attention

HANDICAP OR DISABILITY

- Disability: a condition that limits a person's movements, senses, or activities
- Ex: blind person has no ability to see
- Handicap: the degree to which one's disabilities limit one's ability to function in the world
- Ex. Helen Keller
- Goal of educational intervention:
- maximize their abilities to succeed in school
- eliminate or limit their handicaps as much as possible

STRATEGIES FOR EDUCATORS

- Primary goal :
- Earn trust
- Provide safe environment

IDEAL CLASSROOM ENVIRONMENT

- stable
- predictable
- consistent
- nuturing

BUILDING RELATIONSHIPS

Emotionally Supportive
Welcoming
Sense of Humor
Acceptance
Thoughtful Feedback

TRIGGERS

- LEARNING HOW TO MANAGE CONFLICT
- OVER-USE OF DRAMATIC REACTIVE STRATEGIES BEING ASKED TO WORK WHEN YOU CAN'T/AREN'T ABLE
- BEING TREATED LIKE YOU ARE CRAZY
- GETTING DISCIPLINED FOR YOUR DISABILITY
- NEVER

STRATEGIES

- Shaping behaviors
- Encourage self-control
- Reward positive social interactions
- Help with student's response to stress
- Attainable goal setting
- Meet them where they are
- Reconsider homework
- Ignore negative behaviors

STRATEGIES

- Testing limits
- Don't engage in power struggles: they already feel powerless
- Don't threaten or demand compliance
- Empower : offer choices
- Try not to take it personally
- Use humor
- Choice of methods to demonstrate their grasp of concepts
- Let them help with consequences
- Overcorrection
- Teach self-monitoring and self-reflection

REFERENCES

- Dikel, W. (2014). *The Teacher's Guide to Student Mental Health.* Norton & Company, New York, NY
- Centers for Disease Control (2013).

APPENDIX D

Dear Teachers,

You are invited to participate in a research study titled "A Mixed Methods Study of General Education Teachers' Attitudes, Beliefs, and Knowledge Regarding Student Mental Health". This study is being conducted by researcher Beth Raposa, an NLMUSD Program Specialist who is an Educational Leadership doctoral candidate at Concordia University, Irvine. The purpose of this study is to examine teachers experience with students' who have mental health issues, to ascertain how much training teachers have received in both their professional careers and in their preservice credential programs, and to assess the level of support teachers fell they need knowing they may have as a teacher of a student with a mental health disorder.

Participation in this research study is voluntary. You can choose not to participate in answering the survey. You are being asked to take part in this research study because you are a teacher in a middle school in the Norwalk La Mirada Unified School District. Your insight can provide valuable data that helps this research study address the topic of student mental health. The survey will take five to ten minutes to complete.

The contents of the completed surveys will be kept strictly confidential, and you will remain anonymous with no links to you in any way. There will be no identifying information collected about you at any point during the study. The paper version of the post-survey will be destroyed after the data is collected. Only Beth Raposa will have access to the data.

There are no risks associated with this research study. While you may not experience any direct benefits from participation, information collected in this research study may benefit you and others in the future by helping understand teaches attitudes, knowledge, beliefs, and training experience in the area of student mental health. This information will support future professional development opportunities and may influence the decision to provide additional support for teachers who have mentally ill children in their class.

If you have any questions regarding the surveys and presentations or this research in general, please contact the principal researcher, Beth Raposa, at 310-467-5601 or via email at beth.raposa@eagles.cui.edu.

Beth Raposa, M.A., C.A.G.S.