

DIFFERENCES IN SCHOOL DISCIPLINE EFFORTS AND MENTAL HEALTH
SERVICES BY SCHOOL LEVEL: A NATIONAL ANALYSIS

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DEDICATION

The *Webster Dictionary* defines the term dedication as the quality of being dedicated or committed to a task or purpose. With that being said, it is befitting that I dedicate the completion of this dissertation journey to my children Kiara, Gabriel, and Ethan. Although this journey has seemed like an eternity, I hope you see that the pursuit of anything worth having is worth working for. I pray that through my experience you are able to see that anything is possible through hard work and commitment. To my husband, thank you for your unwavering support and always believing in me. Your love, and encouragement has never failed. On those tough days when I felt like quitting, you would quickly remind me that I have come too far to give up. Thank you for all those sleepless nights that you stayed up to proofread many of my writings. I know you did not want to do it, but you did it anyway. You would always say, “When you graduate, half of your diploma is mine!” Well, the time has come, and I officially, unofficially dub the “Mr. Dr. Damion Simon.”

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ABSTRACT

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Purpose

The purpose of this journal-ready dissertation was to determine the degree to which diagnostic assessments and school efforts were provided at different school levels, factors may have limited school personnel in their efforts to provide mental health services to students, and staff was provided training in regard to mental health. In the first journal article, the differences in the availability of diagnostic assessments under the official responsibilities of a licensed mental health professionals by location were examined for the 2015-2016 school year. Additionally, the extent to which diagnostic mental health assessments were provided to evaluate students for mental health disorders and the location in which students were provided diagnostic assessments was addressed for the 2017-2018 school year. In the second journal article, the extent to which differences existed in factors that limit efforts to provide mental health services by school level was investigated. In the third journal article, the degree to which differences were present in staff training and practices was analyzed.

Method

In this dissertation, a causal-comparative research design was used. Archival data were obtained from the School Survey on Crime and Safety for the 2015-2016 and 2017-2018 school years. The focus herein was on the relationships between independent and dependent variables in which the independent variables were not changed or manipulated in any way.

Findings

Inferential statistical analyses were conducted to determine the extent to which differences were present in survey responses by school level. Elementary schools had the highest percentage that did not provide diagnostic assessments to students under the official responsibility of a licensed mental health professional. The top three factors that limited mental health efforts were: (a) inadequate access to mental health professionals; (b) inadequate funding; and (c) potential legal issues. Recognizing signs of students using/abusing alcohol and/or drugs is needed as it was the least likely training to be provided to teachers. Positive Behavioral and Intervention Strategies and Crisis Prevention and Intervention were the top two trainings offered to teachers across all three school levels. Implications for policy and for practice were made along with recommendations for future research.

KEYWORDS: At school; Diagnostic assessments; Elementary school; Mental health professionals; Mental health disorders; Middle school; School based health centers; School survey on crime and safety

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TABLE OF CONTENTS

	Page
DEDICATION	iii
ABSTRACT	iv
ACKNOWLEDGEMENTS	vi
TABLE OF CONTENTS	viii
LIST OF TABLES	x
CHAPTER I: INTRODUCTION/REVIEW OF THE LITERATURE	1
Statement of the Problem	20
Purpose of the Study	21
Significance of the Study	22
Definition of Terms	23
Literature Review Search Procedures	25
Delimitations	25
Limitations	26
Assumptions	27
Procedures	27
Organization of the Study	27
CHAPTER II: DIFFERENCES IN SCHOOL EFFORT TO PROVIDE ASSESSMENTS FOR MENTAL HEALTH DISORDERS BY SCHOOL LEVEL: A NATIONAL ANALYSIS	29
Method	39
Results	43

Discussion	46
Conclusion	50
References.....	51
CHAPTER III: DIFFERENCES IN FACTORS THAT LIMIT SCHOOL	
EFFORTS TO PROVIDE MENTAL HEALTH SERVICES BY SCHOOL	
LEVEL: A NATIONAL ANALYSIS	66
Method	75
Results.....	76
Discussion	83
Conclusion	87
References.....	89
CHAPTER IV: DIFFERENCES IN STAFF TRAINING AND PRACTICES	
BY SCHOOL LEVEL: A NATIONAL ANALYSIS.....	107
Method	117
Results.....	119
Discussion	124
Conclusion	128
References.....	129
CHAPTER V: DISCUSSION.....	147
Conclusion	163
REFERENCES	165
APPENDIX.....	180
VITA.....	181

LIST OF TABLES

Table	Page
2.1 Descriptive Statistics for Frequencies and Percentage of Diagnostic Assessments at School by School-Funded Mental Health Professionals by School Level for the 2015-2016 School Year.....	60
2.2 Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments for Mental Disorders by School Level for the 2017-2018 School Year.....	61
2.3 Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments at School by School-Employed Mental Health Professionals by School Level for the 2015-2016 School Year.....	62
2.4 Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments at School by School-Employed or Contracted Mental Health Professionals by School Level for the 2017-2018 School	63
2.5 Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments Outside of School by School-Funded Mental Health Professionals by School Level for the 2015-2016 School Year	64
2.6 Descriptive Statistics for Frequencies and Percentages of Diagnostic Mental Health Assessments Outside of School by School-Employed or Contracted Mental Health Professionals by School Level for the 2017-2018 School Year	65

3.1 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts limited by Inadequate/Lack of Access to Licensed Mental Health	
Professionals by School Level for the 2015-2016 School Year	93
3.2 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts limited by Inadequate/Lack of Access to Licensed Mental Health	
Professionals by School Level for the 2017-2018 School Year	94
3.3 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by Inadequate Funding by School Level for the 2015-2016	
School Year.....	95
3.4 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by Inadequate Funding by School Level for the 2017-2018	
School Year.....	96
3.5 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by Potential Legal Issues by School Level for the 2015-2016	
School Year	97
3.6 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by Potential Legal Issues by School Level for the 2017-2018	
School Year.....	98
3.7 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by Lack of Parental Support by School Level for the 2015-2016	
School Year	99

3.8 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by Concerns about Reactions from Parents by School Level	
for 2017-2018 School Year.....	100
3.9 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by a Lack of Community Support by School Level for the	
2015-2016 School Year	101
3.10 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by a Lack of Community Support by School Level for the	
2017-2018 School Year	102
3.11 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by a Reluctance to Label Students by School Level for the	
2015-2016 School Year	103
3.12 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by a Reluctance to Label Students by School Level for the	
2017-2018 School Year	104
3.13 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by Payment Policies by School Level for the 2015-2016	
School Year.....	105
3.14 Descriptive Statistics for Frequencies and Percentages of Mental Health	
Efforts Limited by Payment Policies by School Level for the 2017-2018	
School Year.....	106

4.1 Descriptive Statistics for Frequencies and Percentages of Teacher Training Offered for Early Warning Signs for Violent Behavior for the 2015-2016 School Year.....	136
4.2 Descriptive Statistics for Frequencies and Percentages of Teacher Training Offered for Early Warning Signs for Violent Behavior for the 2017-2018 School Year.....	137
4.3 Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered to Recognize Signs of Self-Harm or Suicidal Tendencies by School Level for the 2017-2018 School Year.....	138
4.4 Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Intervention and Referral Strategies for Students Displaying Signs of Mental Health Disorders by School Level for the 2015-2016 School Year	139
4.5 Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Intervention and Referral Strategies for Students Displaying Signs of Mental Health Disorders by School Level for the 2017-2018 School Year.....	140
4.6 Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Recognizing Signs of Students Using/Abusing Alcohol and/or Drugs by School Level for the 2015-2016 School Year.....	141
4.7 Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Recognizing Signs of Students	

Using/Abusing Alcohol and/or Drugs by School Level for the 2017-2018 School Year.....	142
4.8 Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Positive Behavioral Intervention Strategies by School Level for the 2015-2016 School Year.....	143
4.9 Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Positive Behavioral Intervention Strategies by School Level for the 2017-2018 School Year.....	144
4.10 Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Crisis Prevention and Intervention by School Level for the 2015-2016 School Year.....	145
4.11 Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Crisis Prevention and Intervention by School Level for the 2017-2018 School Year	146
5.1 Descriptive Statistics for Summary of Efforts to Provide Assessments for Mental Health Disorders for the 2015-2016 and 2017-2018 School Years	150
5.2 Descriptive Statistics for Summary Factors That Limit School Efforts to Provide Mental Health Services to Students by School Level for the 2015-2016 and 2017-2018 School Years	152
5.3 Descriptive Statistics for Summary Factors That Limit School Efforts to Provide Mental Health Services to Students by School Level for the 2015-2016 and 2017-2018 School Years	154

5.4 Descriptive Statistics for Summary of Staff Training and Practices by School	
Level for the 2015-2016 and 2017-2018 School Years	155
5.5 Descriptive Statistics for Summary of Staff Training and Practices by School	
Level for the 2015-2016 and 2017-2018 School Years	157

CHAPTER I

INTRODUCTION

In the United States, 20-25% of children and teenagers are affected by mental health disorders, with low percentages accessing treatment (Bains & Diallo, 2016; Texas Education Agency, 2020). Untreated mental health issues create a state of public health concern and, if left untreated, could result in adverse economic and health outcomes for communities at large (Bains & Diallo, 2016; Weir, 2020). Many times, school health professionals are the initial contact of students who are experiencing mental health trauma (Bains & Diallo, 2016). Consequently, school medical professionals are essential to maintaining the health and welfare of school-age students. However, educational leaders have a responsibility to understand the influence that mental illness has on academic success and its effect on the school culture. Children and adolescents with mental illnesses are less likely to be academically successful and are less likely to complete high school (Agnafors et al., 2021; Stagman & Cooper, 2010).

Under the Americans with Disabilities Act of 2008, public educators are mandated to provide students with disabilities equitable opportunities to achieve the same successes as their non-disabled peers (ADA National Network, 2021a; Department of Justice, 2010). A disability is defined in this act as “a physical or mental impairment that substantially limits one or more of the major life activities of such individual” (ADA National Network, 2021b; Department of Justice, 2010, p. 192). Thus, students who have a mental illness may be eligible to receive services under this statute. Of note is that in the American with Disabilities Act, a Child Find mandate is present. “Child Find

requires all school districts to identify, locate and evaluate all children with disabilities, regardless of the severity of their disabilities” (Wright & Wright, 2021, p. 1).

Similarly, the Individuals with Disabilities Education Act is a statute that is designed to offer a free adequate public education to qualified children who fulfill eligibility requirements for special education and support services (United States Department of Education, 2020). In school districts across the United States, principals, assistant principals, and other educational leaders are responsible for ensuring that these laws are enforced. As such, it is necessary for educational leaders to ensure that a multi-tiered system is created to identify, evaluate, and assess students with mental disorders. Educational leaders must secure effective services that will help improve not only the emotional health of students but also contribute to an increase in overall academic success. Furthermore, educational leaders need to understand the barriers to accessing mental health services so that mitigation efforts can be solidified. Additionally, administrators and district personnel should ensure that adequate training is provided so that teachers and other personnel are equipped to participate effectively in the multi-tiered system of support. Educational leaders must ensure that interventions are put in place to address the needs of students who are struggling with mental health concerns.

The United States is in the midst of a mental health crisis (American Psychological Association, 2020). A sample of 1,026 teens ages 13-17 was included in a 2020 Harris Poll, and 81% of Generation Z teens ages 13-17 reported changes in schools and pandemic-related school closures as negatively affecting their lives. Additionally, over half agreed that the pandemic creates a feeling of impossibility when it comes to future planning (American Psychological Association, 2020). Included in the report are

specific strategies that educators, parents, policymakers, and parents can use to support individuals who are most affected. Among those strategies are: (a) Ensuring access to mental health services during and after the pandemic, (b) Investing in prevention and treatment, (c) Continue to support and advance telehealth programs, and (d) Increase resources to help support school mental health services. Issues that negatively influence society's mental health are on the rise, and loneliness and anxiety about the future are stressors for teens and young adults who are trying to navigate and understand their place and purpose in the world (American Psychological Association, 2020).

Review of the Literature on Efforts to Provide Assessments and Treatments for Mental Health Disorders by School Level

According to Mental Health America (2018), "63.1% of youth with major depression do not receive any mental health treatment" (p. 1). Mental illness has been related to numerous issues such as poor academic success, weakened relationships with peers, decreased level school in attendance, and an increase in misbehavior (Swick & Powers, 2018; Von der Embse et al., 2017). Unfortunately, adolescents with a mental illness (e.g., emotional disturbance) are often classified as being unruly or exhibiting behavioral difficulties rather than having mental health problems. This misappropriation of terminology prevents students from receiving the help they need. Unaddressed mental health is linked with health, educational, and developmental concerns for youth, including violence, suicidal ideation/suicide, substance abuse, and poor academic performance (Hodges et al., 2021; McLeod et al., 2016; Walker et al., 2010).

Although the K-12 educational system is one of the primary access points for mental health services, school personnel are failing to identify, assess, and provide

treatments and services to those adolescents who need it the most (Bains & Diallo, 2016; Von der Embse et al., 2017). Instead of providing appropriate services and identification systems for students who need mental health services, schools most often refer to strategies and techniques that are reactive in nature. For example, according to the Children and Adults with Attention-Deficit/Hyperactivity Disorder manual (2017), students with mental illnesses are more likely to have a school history of suspension or expulsion. In the context of adolescent mental health and care, under-identification rates, inadequate care coverage, and a subpar standard of service are not unusual (Koning et al., 2019). Educational leaders who are responsible for ensuring that the needs of students are met should consider the interconnectedness of the Response to Intervention process and how this system may affect the identification of students with mental health needs. Incorporating a school based mental health care center is another method in which schools across the United States have sought to bridge the mental health and academic gap. A more cost effective approach, however, may include school based programs.

To provide effective intervention and treatments to students who have mental health conditions, evidenced-based assessments or programs should be included among the resources used. The National Center for Education Statistics reported data from the 2016 and 2018 School Survey on Crime and Safety from approximately 4,800 public schools where principals reported an increase in the number of diagnostic mental health assessments provided (e.g., psychological/psychiatric diagnostics assessments) to evaluate students for mental health disorders at school from 35% in 2016 to 49% in 2018. In regard to providing treatment on campus for students with mental health disorders by a school-employed mental health professional, only a 2% increase occurred from 2016

(35%) to 2018 (37%). Schools in the United States are still growing in the area of providing substantial treatment, diagnostics and assessments for students with mental disorders on campus. However, it is clear that some schools are taking additional measures to ensure that students are assessed and treatment is provided.

To investigate which elements may be connected to the use of evidenced-based assessments, Connors et al. (2015) conducted a study that included 144 school mental health professionals from various states. Researchers established that to increase assessment utilization, measures must be easy to use, provide immediate feedback, and be able to track students' progress and treatment over time. Challenges in administering assessments were attributed to (a) difficulty in contacting the parents, 67%, and (b) parents and students not understanding assessment questions, 70%. Additionally, 29% of clinicians agreed that other barriers to implementation included not having access to the assessments they were most comfortable with, not having access to the assessments they need, and not having enough time during the day. Additional findings were that 80% of clinicians used academic outcome indicators as the most frequently used assessment data. Insufficient access to treatment and intervention for those individuals who have mental health disorders can adversely affect student educational outcome. A solution that may assist in minimizing this concern is the commission of school based health centers.

School-based health centers have been established to meet the needs of those with mental health concerns. For example, Swick and Powers (2018) evaluated a school based support program in which its primary functions were to (a) broaden the capacity of elementary schools in meeting the needs of students who have mental health concerns that adversely affect their academic performance, and (b) strengthen the educational and

behavioral health of children with psychological concerns. The researchers gathered data on 322 students, 80% of whom were Black and at risk of academic failure due to their mental health needs. From the six elementary schools that participated, substantial progress was noted in students' reading and mathematics performance.

Guzman (2011) analyzed whether mental health conditions present in a screening conducted in the first grade were linked to lower academic performance test scores in the fourth grade. Being identified as a student with mental health problems in the first grade on a broad-band teacher, parent, or combined screen was statistically significantly related to standardized achievement test performance three years later. Moreover, mental health was the second most powerful predictor of academic outcome in the study. Students with overall, "mental health risk have lower levels of subsequent academic achievement as measured by standardized academic achievement tests when compared with students who are not at overall mental health risk" (Guzman, 2011, p. 409).

The approach used in this next investigation was similar to the one used by Guzman (2011). To substantiate the claim that mental health and academic performance are closely linked, Murphy (2015) conducted a longitudinal study to determine whether first grade mental well-being predicted future academic performance and whether remission of mental health conditions predicted better academic results. In this study, one of the world's biggest school-based mental health services, called *Habilidades de Vida* or Skills for Life was used. Data were taken from 37,397 Chilean students in first grade in 2009 and third grade in 2011. Academic success was statistically significantly predicted by first grade academic achievement but also by first grade mental health. Additionally established was that mental health assessed near the beginning of Grade 1

independently predicted the percent of school days children would attend in Grade 1 and Grade 3. School mental health indicators could be one of the most crucial variables determining academic achievement in elementary school children, and they may be especially influential in identifying adolescents who may benefit from proactive approaches. School-based preventive programs may favorably influence students' academic and mental health outcomes (Murphy, 2015).

In a recent investigation in Colorado, Westbrook et al. (2020) conducted a longitudinal study about the opening of school based mental health centers in high schools and their influence on graduation rates. They compared high schools without school-based mental health centers with high schools that opened school-based mental health centers between 2000 and 2018. Westbrook (2020) established that high schools that opened a school-based health center had statistically significant higher graduation rates than high schools that did not have a school-based health center.

In a systematic literature review, Larson et al. (2017) determined that extended exposure to severe childhood trauma adversely influenced academic performance when mediated by mental health conditions. In eight out of 10 studies, a high risk of increasing mental health disorders with poor academic performance for adolescents who experienced severe childhood trauma was determined. Students of color who were in poverty and who were subjected to trauma were more likely to develop mental health disorders (e.g., anxiety, depression, conduct disorder, post-traumatic stress disorder, suicidal ideation, attention deficit hyperactivity disorder) and have lower GPAs than their peers who had not experienced trauma or victimization (Larson, 2017, p. 677).

Similar to Larson et al. (2017), Knopf et al. (2016) conducted a systematic literature review of 46 studies. They focused on school-based health centers providing mental health care or a combination of psychiatric and other services. Results were that school-based health centers contributed to a plethora of improved wellness and educational outcomes. Effectiveness was correlated with extended hours and a continuum of services available. Educational gains related with school-based health centers include a decrease in suspension rates, drop-out rates, and grade retention. Moreover, increases in GPAs and grade promotion were noted.

Review of the Literature on Factors Limiting Access to School Based Mental Health Services

According to Lai et al. (2016), “Schools are in a key position to identify mental health problems early and provide appropriate services or links to services” (p. 1). Additionally, school-based mental health centers assist in mitigating barriers that may interfere with accessing mental health services. Moreover, adolescence is an advantageous period of development to address mental disorder concerns as most mental health conditions emerge prior to 20 years of age (Salerno, 2016). If not addressed, adolescents with mental illnesses grow up to be adults with mental illnesses who have difficulties finding and maintaining employment and being productive citizens. Consequently, if the needs of students who have mental health concerns continue to be unmet, society will aid in perpetuating a cycle of mental health neglect that can affect generations to come. Because children, youth, and adolescents spend the majority of their time in K-12 schools, educational leaders need to understand barriers that limit

access to mental health services and be able to seek solutions that will encourage increased utilization.

Barriers and challenges regarding why students do not seek out mental health services teeters on a continuum of reasons. Some of these limitations include a lack of awareness on how to obtain assistance, lack of transportation to mental health facilities, inadequate funding, inadequate access to mental health professionals, and stigmatization. To gain a better understanding into these challenges, Ijadi-Maghsoodi et al. (2018) conducted a study on the perspectives of low-income minority groups on assistance searching and challenges to receiving mental health services at school-based health center sites. The study took place in a large urban community and included focus groups consisting of 76 middle and high school students at nine school-based health center sites. Participants reported teachers were the primary source of support regarding mental health issues. Mental health counselors and peers were also mentioned as key supporters. Students identified relationships and trust as essential components in seeking out support for mental health concerns. Obstacles to accessing school-based health centers included: humiliation; apprehension of being judged; confidentiality concerns; a feeling of needing to hold information inside; and lack of awareness. In an effort to mitigate these barriers and enhance mental health involvement, students recommended making school-based health centers more relaxed, increasing understanding of mental health, and improving relationships with schools and school-based health center's staff.

In a similar study, Dunfee (2020) examined literature on the effects of school-based health centers from the viewpoint of various stakeholders. Dunfee (2020) began with a descriptive review regarding the origins of school-based health centers.

Information was presented regarding the demographics of school-based health centers, percentages of centers present at each school level, and the benefits of having school-based health centers located within schools. Revealed in this article were multiple limitations in establishing school-based health centers. These limitations included cost, funding, and economic effects. “The initial cost to design, build, and stock a school-based health center, ranged from \$41,450 to \$378,704, and the annual cost to staff, restock and operate a school-based health centers ranged from \$16, 322 to \$659,684” (Dunfee, 2020, p. 1). It was noted that only 20% of funding came from the school system. Over 51% of funding support of school-based health centers derive from Federally Qualified Health Centers. Additionally, state and local government, insurance companies, private foundations, local business and corporations assist in funding these centers. The cost of building school-based health centers remains an obstacle to their expansion, but inventive partnerships help districts address barriers to funding.

In a similar study, Larson et al. (2017) explored literature on childhood trauma and its effect on student success as it relates to mental illness. They also analyzed the literature to determine the influence school-based health centers that utilized mental health services had on adolescences. Results were: (a) school-based health centers are one possible intervention to support childhood trauma, behavioral health, and academic success; (b) school-based health centers improve accessibility and the use of mental health services; (c) the GPAs of students who utilized school-based health centers improved; and (d) the correlation between trauma and decreased academic success was mediated by mental health illnesses. “The mental health disorders that had the greatest

impact on academic achievement were PTSD, depression, and anxiety” (Larson et al., 2017, pp. 681-682).

Bersamin et al. (2016) conducted an investigation of 948 schools in California to gain an in-depth understanding of the circumstances that necessitates school-based health centers and increase awareness of possible obstacles. Of the 948 schools included in the study, 88 had onsite school-based health centers. Findings from the study were that the majority of school-based health centers were located in cities (65.9%) and suburbs (23.9%). Rural areas and towns accounted for 6.8%. Additionally, schools with school-based health centers had a higher percentage of students of color who were economically disadvantaged as characterized by the number of students who received free and reduced lunch services. Some of the services provided through these centers were mental health services, medical care, family planning clinics, and dental health. Resources, needs, and political philosophy are related to the existence of school-based health centers in California. For example, schools in the district with a higher percentage of registered Republicans were least likely to have a school-based health center. Consequently, it is crucial to consider how geographic contextual factors may influence the development of health services designed to facilitate positive health outcomes. Moreover, for school district leaders who would like to establish school-based health centers, building strong partnerships with local health providers can assist in addressing the unmet needs of students.

In an effort to determine the possible implication of stigmatization on K-12 students who participate in specific mental health services interventions, Gronholm et al. (2018) conducted a systematic literature review. By analyzing eight qualitative studies,

the researchers established the presence of three mega themes that included negative labeling in which students were labeled as being different, strange, weird, crazy, or psycho. Confidentiality concerns were also noted as students felt that they could not trust their interventionist. A fear of others finding out about their mental health concerns caused hesitation when seeking out assistance. Similarly, another stigma-related obstacle was “restricted disclosure” (p. 22) where students believed that there would be adverse consequences if they opened up. To reduce the effects of stigmatization, practitioners need to build relationships and trust. In this study, students reacted favorably when the key substance of interventions stressed connections and applicable strategies to manage the stressors that come with everyday life (Gronholm et al., 2018).

In another investigation, Bowers et al. (2013) surveyed 49 high school students with and without mental health concerns and interviewed 63 professionals who were associated with school based mental health to gain insight on their perception regarding stigma. A larger number of adolescents considered stigma as one of the main barriers to accessing school mental health services. Participants with mental health concerns ranked not knowing where to go to get help as the second most common challenge. However, participants without any mental health related issues recognized pressure from peers and a lack of knowing they have a mental health problem as the second most common factor toward accessing mental health services. Stigma as a barrier becomes detrimental when it inhibits people from pursuing the help they need. Unfortunately, suicide is a common result for those individuals who suffer with a mental illness and who do not seek assistance (Bower et al., 2013).

From 1999 to 2016, the suicide rate increased 25.4% (America's Health Ranking, 2020) in the United States. Suicide is the second leading cause of death among youth and adolescents (Miller, 2019) and many of these individuals suffer from issues that are associated with mental illness or substance abuse. LeCloux et al. (2017) analyzed data from the National Longitudinal Study of Adolescent Health that included a sample of suicidal youth and revealed that school based mental health centers greatly increases the likelihood of adolescents who are susceptible to suicide access mental health services. Other barriers that hinder access to mental health services were an insufficient knowledge of available services, insurance issues, extended waiting lists, financial limitations, transportation concerns, not meeting eligibility criteria, and high levels of staff attrition in mental health agencies.

Additionally, Reinke et al. (2011) conducted a study in which 292 teachers reported reasons why students with mental health needs “fall through the cracks” (p. 8). Participants reported that children's mental health needs were not being met because of insufficient parental support, a lack of staff training/coaching, and a lack of prevention programs. In regard to barriers, the top three factors that limited supporting students with mental health concerns were: (a) an inadequate number of school mental health practitioners, (b) a lack of preparation and training to meet the mental health needs of children, and (c) insufficient funding for school-based mental health.

However, to bridge this gap, parental involvement is paramount. In an exploratory study conducted by Searcey Vulpen et al. (2018), 607 parents and guardians participated in a survey regarding the needs, inadequacies, and limitations of school-based mental health services. Descriptive information was gathered by allowing parents

to choose from a list of behaviors that represented various mental health disorders.

Additionally, parents were given an open format question. Researchers collected data on the following: (a) The role of schools in addressing mental health needs, (b) Perceptions of gaps in services, and (c) Resources for information on mental health concerns and services. Searcey Vulpen et al. (2018) concluded that 63% of respondents indicated that their child experienced anxiety, and 59% suggested that their child was affected by other students who had experienced a personal behavioral health concern. Over 75% of respondents agreed that schools should be involved in addressing student mental health issues as well as taking an active role in connecting families and children to school-based and community-based service providers. In regard to accessing services, over 85% of parents stated that they would contact their child's school counselor, pediatrician, or a community mental health agency if they had concerns regarding their child's mental health.

Review of the Literature on Staff Training and Practices Related to Mental Health Services

A mental health disorder is defined as any health condition that is characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (Padgett et al., 2020). Of importance is that the numbers of students who suffer from mental disorders are increasing. Depression, anxiety, and attention deficit hyperactivity disorder (ADHD) are a few of the most common mental illnesses within the K-12 population. "More U.S. adolescents and young adults in the late 2010s (vs. the mid-2000s) experienced serious psychological distress, major depression, and suicidal thoughts, and more attempted suicide and took their own

lives” (Tweng et al., 2017, p. 1). This pattern may be attributed to a generational trend or shift that has occurred due to a rise in digital communication, an increase usage of the internet, and sleep disturbance (Twenge et al., 2017). The effects of cyberbullying have adversely affected the mental well-being of adolescents (Fahy et al., 2016). Furthermore, mental health problems have been considerably amplified by the effects of a pandemic and social unrest (Substance Abuse and Mental Health Services Administration, May 2020; Wong et al., 2021).

Psychological illnesses are first manifested during the adolescent years. Therefore, teachers, staff, and administrators need to be able to offer first-stage support to students who are having mental health difficulties (Jorm et al., 2010). Although 62% of teachers and staff are being trained in intervention and referral strategies for students displaying signs of mental health disorders (e.g., depression, mood disorders, ADHD) (Padgett et al., 2020), suicide rates are on the rise and the number of students experiencing mental health crises continues to increase.

A little over half of the states have enacted legislation or adopted laws mandating or recommending teacher training and career development in areas such as student psychological health and trauma-informed approaches (Kelley et al., 2020). Texas, the state of interest for this article, requires training includes: “students with mental health conditions or who engage in substance abuse” and “how mental health conditions, including grief and trauma, affect student learning and behavior and how evidence-based, grief-informed, and trauma-informed strategies support the academic success of students affected by grief and trauma” (Texas Public Law, n.d., p.1). Additionally, as of September 2015, the Texas Education Code mandates that anyone pursuing a diploma

that requires a bachelor's degree as one of the basic academic requirements undergo guidance on mental health, drug misuse, and juvenile suicide as part of the preparation needed to earn the certificate (Texas Education Agency, 2020). Yet, many school educators report a lack of preparation and training in the area of mental health literacy (Frauenholtz et al., 2015; Moon et al., 2017; Pierret et al., 2020). This lack of preparation and implementation continues to widen the research to practice gap.

Although mental health training is a requirement for educators in half of the United States, the published research literature about the effectiveness of school based mental health services implemented by school personnel in elementary schools is limited. Sanchez et al. (2018) conducted the first quantitative meta-analysis that included only school professionals (e.g., teachers, counselors, paraprofessionals, or school psychologists). Using a tiered or service level approach, students who received targeted level intervention or selective prevention showed large and high-medium effects which indicated a decline in mental health problems. Mental health universal preventions were indicative of small but significant effects in mitigating mental health concerns. Additionally, school based services that were implemented daily or multiple times per week had a moderate effect size whereas school based services implemented less frequently had a small effect size. When specific school-based psychological methods were assessed, only “contingency management accounted for significant variance in child mental health outcomes (Sanchez et al., 2018, p. 159). Services targeting externalizing problems paired with contingency management had a moderate to large effect whereas services targeting externalizing problems without contingency management had only a small effect in reducing psychological problems.

In a related investigation, Vieira et al. (2014) conducted a study in Brazil about teacher ability to recognize and appropriately refer students with mental health concerns. They focused on analyzing the effectiveness of a psychoeducational strategy to build teacher capability in mental health. The method used to conduct the study included a case control sample and teacher sample. Prior to the training, 32 teachers selected 26 students who they thought exhibited mental health problems. An additional non-selected 26 students acted as the control group. Researchers concluded that teachers were more likely to not identify students who exhibited only internalizing problems (i.e., anxiety, depression) as these students are the least likely to disturb the classroom environment. However, the majority of teachers were able to identify students who displayed externalizing and internalizing difficulties simultaneously. Ninety percent of teachers were able to identify and accurately refer students who displayed a conduct disorder. This high rate of identification is thought to be contributed to its disruptive nature to disrupt the learning environment. The researchers reported that due to the training about 50.0% of teachers learned to make an appropriate referral and accurately recognize the six vignettes or psychological problems (i.e., conduct disorder, mania, depression, hyperactivity, and high risk of psychosis). Moreover, 60% of teachers learned to identify normal adolescence.

Furthermore, Reinke et al. (2011) surveyed 292 early childhood and elementary teachers to ascertain their views of existing mental health issues in their schools and to gather insight on their knowledge and skills as it pertains to supporting students with mental health needs. Teachers reported their top five student mental health concerns in order from most concerning: (a) Behavior problems, (b) Hyperactivity and inattention

problems, (c) Students with significant family stressors, (d) Social skills deficits, and (e) Depression. Twenty-eight percent of teachers believed that they had the knowledge required to meet the mental health needs of their students. In regard to meeting the mental health needs of their students, 30% of teachers agreed that they had the knowledge and skills necessary to address the mental health needs of their students' needs. Additionally, three other areas were identified in which teachers said they needed additional coaching (i.e., techniques for interacting with children who exhibit externalizing behavior disorders, identifying and fully understanding children's mental health challenges, and classroom management and behavioral modification instruction).

In a similar study, Moon et al. (2017) analyzed educators' insight on the present state of mental health in schools. Participants were 786 educators including 127 administrators. Based on the findings, 59% of respondents agreed that they were confident in recognizing signs of student mental health issues. However, almost half disagreed with the assertion that they had acquired sufficient mental health training, and 85% shared a preference for more mental health training. At least 50% of participants identified the following areas for additional training: (a) mental health disorders, (b) behavioral management techniques, (c) social skill training/management, and (d) positive behavioral supports training. Additionally, findings from this research article were congruent with the findings of previous researchers (Frauenholtz et al., 2016; Froese-Germain & Riel, 2012; Reinke et al., 2011) in that numerous educators expressed dissatisfaction with their prior mental health preparation and indicated a desire for additional training.

In a comparable research analysis, Fraunholtz et al. (2016) conducted a focus group of teachers, other school staff members, and community mental health members to investigate teacher and school personnel perceptions of mental health awareness. The group discussed their prior experiences with students experiencing mental health concerns, their training in children's mental health, their perspectives of their current mental health knowledge, and their desire to recognize students experiencing mental health distress and collaborate with local mental health providers. In this study, school personnel reported a lack of proficiency in mental health literacy which hinders their ability to intervene effectively with students in need. This same focus group identified a deficit in recognizing the symptoms of mental health distress. Another gap in mental health knowledge that was identified was the accessibility and availability of local mental health agencies.

In a study conducted in the United Kingdom, Shelemy et al. (2019) addressed the support and trainings teachers needed and wanted regarding mental health. The study consisted of 49 secondary school teachers who participated in a focus group. Respondents indicated a need for training to assess if a student was distressed and whether or not their psychological state or behavior was concerning. Participants desired direction and instruction on how to manage and support a pupil before receiving expert assistance. The teachers emphasized that strategies provided should not be therapeutic in nature. One respondent stated, "I think we have a duty of care, not a duty of cure. Within that duty of care we have a duty, not put out the fire but to educate them first, which is what we're trying to do" (Shelemy et al., 2019, p. 106). Additionally reported was that teachers wanted real-world application, strategies that were practical, and

customizable resources that could easily be adapted into lessons. It was recommended that all trainings should be participatory, foster conversation, and solicit audience input. Participants also shared that the information needed to be delivered by an expert in the field of mental health and evidence-based.

Though apparent that mental health training is needed, educational leaders and teachers must also be trained to be aware of personal biases and cultural differences as it pertains to mental health. According to Cokley et al. (2014), Black adolescents are under identified for mental health related issues. This under identification may be attributed to a lack in training to recognize the link between mental health and socioeconomic level. Because of inadequate economic, family, and psychological supports, those individuals living in poverty are more prone to suffer from mental illness (Wickrama & Vazsonyi, 2011). Children of color are more likely than their White and Asian peers to be economically disadvantaged (Creamer, 2020). This intersectionality of race, culture, and socioeconomic level intertwine in ways that make identifying psychological concerns in children of color more difficult. Trainings in school-based mental health should incorporate understanding the unique stressors of children from diverse backgrounds.

Statement of the Problem

According to the annual State of Mental Health in America report, “19% (47.1 million) of people in the U.S. are living with a mental health condition, a 1.5 million increase over last year’s report” (Mental Health America, 2020, p. 1). In the midst of racial inequality, isolation, lockdown, and COVID-19, the trend reflects that mental illnesses such as isolation and depression are increasing. Moreover, children are showing an increase in suicidal ideations and self-harm. Suicide mitigation measures may have

the greatest influence if they are focused on the care of mental illnesses (Cavanaugh et al., 2003). Based on educational laws and statutes such as the Individuals with Disabilities Act, Americans with Disabilities Act, and Child Find, educational leaders are bound by the law to ensure that students who are suspected to have a physical or mental impairment are identified, evaluated, and provided services. Yet, over 70% of students who have mental illnesses are not receiving the services they need (Bains & Diallo, 2016). When untreated, its effect may have long-term consequences that may not only affect home-life and relationships, but it may also influence academic performance. As mental health continues to worsen, school professionals must prepare to handle the crisis and equip students and parents with the tools they need to be successful. Factors such as inadequate funding, inadequate access to a mental health professional, and a lack of parental support could limit a school's effort to provide necessary and appropriate services.

Purpose of the Study

The purpose of this journal-ready dissertation was to determine the degree to which diagnostic assessments and school efforts were provided at different school levels, factors may have limited school personnel in their efforts to provide mental health services to students, and staff was provided training in regard to mental health. In the first journal article, the differences in the availability of diagnostic assessments under the official responsibilities of a licensed mental health professionals by location were examined for the 2015-2016 school year. Additionally, the extent to which diagnostic mental health assessments were provided to evaluate students for mental health disorders and the location in which students were provided diagnostic assessments was addressed

for the 2017-2018 school year. In the second journal article, the extent to which differences existed in factors that limit efforts to provide mental health services by school level was investigated. In the third journal article, the degree to which differences were present in staff training and practices was analyzed.

Significance of the Study

In the wake of COVID-19, the pandemic has increased the normal day to day stressors of life. Prolonged house confinement, isolation from friends and family, extreme grief, increased internet and social media activity, interfamilial abuse, a prolonged break in school, and now more recently having to attend school with the possibility of being infected has aided in the influx of mental illnesses (Guessoum et al., 2020). Twenty percent of school aged children between the ages of 9-17 have a diagnosable mental health disorder (Bowers et al., 2013; Cefai & Camilleri, 2015; Searcey van Vulpen et al., 2018; The American College of Obstetricians and Gynecologists, 2017, July; Youth.Gov, 2019) and more than 65% percent of adolescents in the juvenile court system have a diagnosable mental health disorder (Youth.Gov, 2019). Yet, approximately 70% do not receive the help they need. These unaddressed mental health conditions may be interpreted to mean that services and support are not sufficient for youth with psychological problems in the United States (Bains & Diallo, 2016).

With suicide being “the second leading cause of death in young people aged 15-24 years” (The American College of Obstetricians and Gynecologists, 2017, July), it is clear that the mental health needs of young people must be aggressively addressed. Moreover, adolescence is an advantageous span of time to address mental disorder

concerns as most mental health conditions emerge prior to 20 years of age (Salerno, 2016). Schools provide a comfortable, familiar, non-stigmatizing support environment for students and school-based programs can reinforce the use of assistance and support. Accordingly, educational leaders need to seek to identify and mitigate factors that may inhibit students from accessing mental health support. Additionally, educational leaders need to advocate for mental health services at all school levels. Legislators and policymakers should consider the effort that the educational system requires to address the needs of students as well as to ensure the physical and social emotional well-being of those students who need it most. This dissertation was conducted to inform current practices and to add to the literature available on this topic. Stakeholders who could benefit from this research include legislators, school administrators, teachers, counselors, nurses, and parents.

Definition of Terms

In this journal-ready dissertation the key terms for the three proposed research investigation are provided for the reader below.

At School/at Your School

At school or at your school is defined as activities happening in school buildings, on school grounds, on school buses, and at places that hold school-sponsored events or activities. Unless otherwise noted, this term refers to normal school hours or to times when school activities/events were in session (Padgett et al., 2020, p. A-3).

Diagnostic Mental Health Assessment or Diagnostic Assessment

A diagnostic mental health assessment is defined as an evaluation conducted by a mental health professional who identifies whether an individual has one or more mental

health diagnoses. A diagnostic mental health assessment is not an educational assessment, which does not focus on clarifying a student's mental health diagnosis (Jackson et al., 2018; Padgett et al., 2020).

Elementary School

An elementary school will be defined as the grade level for a school that has students enrolled within Grade Pre-K through Grade 3 and a highest grade level that is within Grade 1 and Grade 8 (Padgett et al., 2020).

Mental Health Disorders

All diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (Jackson et al., 2018, p. A-3; Padgett et al., 2020, p. A-3).

Mental Health Professional

Mental health professionals are individuals who are licensed to provide mental health services (e.g., psychiatrists, psychologists, psychiatric/mental health nurse practitioners, psychiatric/mental health nurses, clinical social workers, and professional counselors (Padgett et al., 2020).

Middle School

A middle school will be defined as the grade level for a school that has students enrolled within Grade 4 through Grade 9 (Padgett et al., 2020).

School Based Health Centers

School based health centers offer a wide-range of care to children and adolescents. The centers serve as bridges to primary care, public health, and education to

ensure quality health outcomes for students (Census Report of School-Based Health Centers 2011).

School Survey on Crime and Safety

According to the National Center for Education Statistics (2018), the School Survey on Crime and Safety is the primary source of crime and safety data that were collected at different school-levels for the U.S. Department of Education. The document contains estimated data regarding school discipline, crime, disorder, policies, and programs cross-sectional surveys from public elementary and secondary schools.

Literature Review Search Procedures

For this journal-ready dissertation, the literature regarding mental health as it relates to assessments and treatments, factors that limit school efforts, and staff training, and practices was examined. The following phrases were used in the search for relevant literature: school level, elementary school, middle school, high school, school based mental health, barriers, challenges, assessment, academic achievement, prevention, intervention, and teacher training. The searches were conducted through the EBSCO Host database for academic journals. Relevant articles were reviewed that pertained to school level and mental health.

Delimitations

In this journal-ready dissertation, the three studies that were conducted were delimited to public elementary, middle, and high schools. These three school designations were selected because they are the most common types of school levels. Specifically examined in this journal-ready dissertation was the degree to which differences were present in mental health efforts as a function of traditionally configured

school levels. Data were delimited to public schools in the United States. This delimitation included only mental health data for Pre-K-12 schools. Additionally, only two school years of data (i.e., 2015-2016 and 2017-2018) were analyzed. As such, the extent to which results might be generalizable over time is limited. The final delimitation is in relation to the definition of diagnostic mental health assessment which was defined by the School Survey on Crime and Safety and excludes any evaluations conducted by educational diagnosticians.

Limitations

In this journal-ready dissertation, the relationship of school level with mental health efforts was addressed. As a result, key limitations were present for the study. In this investigation quantitative data from the School Survey on Crime and Safety for the 2015-2016 and 2017-2018 school years only in the United States will be analyzed herein. Therefore, the extent to which the results are generalizable beyond the participants of the School Survey on Crime and Safety for public schools whose data were examined in this study is unknown. The data are accessible for the aforementioned school years only as the other five years did not include a section on school mental health services and it was not administered every year. Additionally, other variables cannot be eliminated as factors that contribute to mental health disorders. Another limitation is with the use of a causal-comparative research design that is common when archival data are analyzed. As such, cause and effect relationships cannot be determined. Additional variables other than school level may be contributing factors to any differences obtained in mental health efforts. Another restriction is that responses are reported from only public-school

principals at each school level. Although data were collected by the National Center for Education Statistics, the possibility exists that inaccurate reporting may occur.

Assumptions

The assumption made in this journal-ready dissertation was that crime and safety data acquired from the School Survey on Crime and Safety for both years were accurately reported. Assumed was that school principals accurately reported data that were collected by the National Center for Education Statistics for diagnostic assessments and treatments, staff trainings and practices, and factors that limit mental health efforts. Any errors in such reporting could result in inaccurate data and inaccurate findings.

Procedures

Following the approval of this journal-ready dissertation from the doctoral dissertation committee, an application was submitted to the Sam Houston State University Institutional Review Board to perform the study. Upon approval from the Institutional Review Board, data from the School Survey on Crime and Safety (SSOCS) were downloaded and analyzed. The data that were collected and analyzed were from the 2015-2016 and 2017-2018 school years.

Organization of the Study

In this journal-ready dissertation, three manuscripts were generated. In the first article, the availability of diagnostic assessments under the official responsibilities of a licensed mental health professionals by location were examined for the 2015-2016 school year. Additionally, the extent to which diagnostic mental health assessments were provided to evaluate students for mental health disorders and the location in which students were provided diagnostic assessments were analyzed for the 2017-2018 school

year. In the second article, the extent to which differences existed in factors that limit efforts to provide mental health services by school level for the 2015-2016 and 2017-2018 school years were investigated. In the third article, the degree to which differences were present in staff training and practices by school level for the 2015-2016 and 2017-2018 school years were addressed.

This journal-ready dissertation is composed of five chapters. Chapter I contains the background of the study, statement of the problem, purpose of the study, significance of the study, theoretical framework, definition of terms, delimitations, limitations, and assumptions of the three research investigations. In Chapter II, the framework for the first article concerned the availability by location of mental health services to students under the official responsibilities of a licensed mental health professionals and whether diagnostic mental health assessments were provided to evaluate students for mental health disorders and the location in which students were provided diagnostic assessments. In Chapter III, the second article was about factors that limited efforts to provide mental health services by school level. In Chapter IV, research questions involved the extent to which differences were present in staff training and practices by school level. Lastly, Chapter V contains the results of all three articles that were conducted.

CHAPTER II

DIFFERENCES IN SCHOOL EFFORTS TO PROVIDE ASSESSMENTS FOR MENTAL HEALTH DISORDERS BY SCHOOL LEVEL: A NATIONAL ANALYSIS

This dissertation follows the style and format of *Research in the Schools (RITS)*.

Abstract

The degree to which diagnostic assessments were available to students under the official responsibilities of a licensed mental health professional by school level was addressed in this study using data from the National School Survey on Crime and Safety for the 2015-2016. For the 2017-2018 school year, the extent to which schools provided diagnostic mental health assessments to evaluate students for mental health disorders by school level was also examined. Nearly 75% of elementary schools did not provide diagnostic assessments at school by school-funded mental health professionals compared to 60% of elementary schools that did not provide diagnostic assessments outside of school by a school-funded mental health professional. Implications for policy and practice were discussed, as well as recommendations for further study.

Keywords: At school; Diagnostic assessments; Mental health professionals; Mental health disorders; School based health centers; School survey on crime and safety

DIFFERENCES IN SCHOOL EFFORTS TO PROVIDE ASSESSMENTS FOR MENTAL HEALTH DISORDERS BY SCHOOL LEVEL: A NATIONAL ANALYSIS

According to Mental Health America (2018), “63.1% of youth with major depression do not receive any mental health treatment” (p. 1). Mental illness has been related to numerous issues such as poor academic success, weakened relationships with peers, decreased level in attendance, and an increase in misbehavior (Swick & Powers, 2018; Von der Embse et al., 2017). Unfortunately, adolescents with a mental illness (e.g., emotional disturbance) are often classified as being unruly or exhibiting behavioral difficulties rather than having mental health problems. This misappropriation of terminology prevents students from receiving the help they need. Unaddressed mental health is linked with health, educational, and developmental concerns for youth, including violence, suicidal ideation/suicide, substance abuse, and poor academic performance (Hodges et al., 2021; McLeod et al., 2016; Walker et al., 2010).

Although the K-12 educational system is one of the primary access points for mental health services, school personnel are failing to identify, assess, and provide treatments and services to those adolescents who need it the most (Bains & Diallo, 2016; Von der Embse et al., 2017). Instead of providing appropriate services and identification systems for students who need mental health services, schools most often refer to strategies and techniques that are reactive in nature. For example, according to the Children and Adults with Attention-Deficit/Hyperactivity Disorder manual (2017), students with mental illnesses are more likely to have a school history of suspension or expulsion. In the context of adolescent mental health and care, under-identification rates, inadequate care coverage, and a subpar standard of service are not unusual (Koning et al.,

2019). Educational leaders who are responsible for ensuring that the needs of students are met, should consider the interconnectedness of the Response to Intervention process and how this system may affect the identification of students with mental health needs. Incorporating a school based mental health care center is another method in which schools across the United States have sought to bridge the mental health and academic gap. A more cost effective approach, however, may include school based programs.

To provide students who have mental health conditions with effective interventions, evidenced-based assessments or programs should be included among the resources used. The National Center for Education Statistics reported data from the 2016 and 2018 School Survey on Crime and Safety from approximately 4,800 public schools where principals documented an increase in the number of diagnostic mental health assessments provided (e.g., psychological/psychiatric diagnostics assessments) to evaluate students for mental health disorders at school from 35% in 2016 to 49% in 2018. In regard to providing treatment on campus for students with mental health disorders by a school-employed mental health professional, a paltry increase of only 2% was established from 2016 (35%) to 2018 (37%). Schools in the United States are still improving in the area of providing substantial treatment, diagnostics, and assessments for students with mental disorders on campus. However, it is clear that some schools are taking additional measures to ensure that students are assessed and treatment is provided.

To investigate which elements may be connected to the use of evidenced-based assessments, Connors et al. (2015) conducted a study that included 144 school mental health professionals from various states. They determined that to increase assessment utilization, measures must be easy to use, provide immediate feedback, and be able to

track students' progress and treatment over time. Challenges in administering assessments were attributed to (a) difficulty in contacting the parents, 67%, and (b) parents and students not understanding assessment questions, 70%. Additionally, 29% of clinicians agreed that other barriers to implementation included not having access to the assessments they were most comfortable with, not having access to the assessments they need, and not having enough time during the school day to assess. Additional findings were that 80% of clinicians used academic outcome indicators as the most frequently used assessment data. Insufficient access to treatment and intervention for individuals who have mental health disorders can adversely affect student educational outcomes. A solution that may assist in minimizing this concern is the commission of school based health centers.

School-based health centers have been established to meet the needs of individuals with mental health concerns. For example, Swick and Powers (2018) evaluated a school based support program in which its primary functions were to (a) broaden the capacity of elementary schools in meeting the needs of students who have mental health concerns that adversely affect their academic performance, and (b) strengthen the educational and behavioral health of children with psychological concerns. They gathered data on 322 students, 80% of whom were Black and at risk of academic failure due to their mental health needs. From the six elementary schools that participated, substantial progress was noted in students' reading and mathematics performance.

In another investigation, Guzman (2011) analyzed whether mental health conditions present in a screening conducted in the first grade were linked to lower

academic performance test scores in the fourth grade. Being identified as a student with mental health problems in the first grade was statistically significantly related to standardized achievement test performance three years later. Of note was that, mental health was the second most powerful predictor of academic outcome in the study. Students with overall, “mental health risk have lower levels of subsequent academic achievement as measured by standardized academic achievement tests when compared with students who are not at overall mental health risk” (Guzman, 2011, p. 409).

The approach used in this next investigation was similar to the one used by Guzman (2011). To investigate the assertion that mental health and academic performance are closely linked, Murphy (2015) conducted a longitudinal study to determine whether first grade mental well-being predicted future academic performance and whether remission of mental health conditions predicted better academic results. In this study, one of the world's biggest school-based mental health services, called *Habilidades de Vida* or Skills for Life was used. Data were taken from 37,397 Chilean students in first grade in 2009 and third grade in 2011. Academic success was statistically significantly predicted by first grade academic achievement but also by first grade mental health. Additionally established was that mental health assessed near the beginning of Grade 1 independently predicted the percent of school days children would attend in Grades 1 and 3. School mental health indicators could be one of the most crucial variables determining academic achievement in elementary school children, and they may be especially influential in identifying adolescents who may benefit from proactive approaches. School-based preventive programs may favorably influence students' academic and mental health outcomes (Murphy, 2015).

In a recent investigation in Colorado, Westbrook et al. (2020) conducted a longitudinal study about the opening of school based mental health centers in high schools and their influence on graduation rates. They compared high schools without school-based health centers to high schools that opened school-based mental health centers between 2000 and 2018. Westbrook et al. (2020) established that high schools that opened a school-based health center had statistically significant higher graduation rates than high schools that did not have a school-based health center.

In a systematic literature review, Larson et al. (2017) determined that extended exposure to severe childhood trauma adversely influences academic performance when mediated by mental health conditions. In 8 out of 10 studies, a high risk of increasing mental health disorders with poor academic performance for adolescents who experienced severe childhood trauma was determined. Students of color who were in poverty and who were subjected to trauma were more likely to develop mental health disorders (e.g., anxiety, depression, conduct disorder, post-traumatic stress disorder, suicidal ideation, attention deficit hyperactivity disorder) and have lower GPAs than their peers who had not experienced trauma or victimization (Larson, 2017, p. 677).

Similar to Larson et al. (2017), Knopf et al. (2016) conducted a systematic literature review of 46 studies. They focused on school-based health centers providing mental health care or a combination of psychiatric and other services. Results were that school-based health centers contributed to a plethora of improved wellness and educational outcomes. Effectiveness was correlated with extended hours and a continuum of services available. Educational gains related with school-based health

centers include a decrease in suspension rates, drop-out rates, and grade retention.

Moreover, increases in GPAs and grade promotion were noted.

Statement of the Problem

Adolescents who experience a mental health crisis are more likely to have lower educational attainment than adolescents who do not experience a mental health crisis (Murphy, 2015). Researchers (Guzman et al., 2011; Larson et al., 2017; Merikangas et al., 2010; Murphy et al., 2015) have conducted studies to substantiate the claim of strong relationships between children and adolescents' mental health and academic success. Unmet or untreated mental health needs can lead to poor educational outcomes, such as poor grades, an increase in suspensions, a decline in attendance, grade retention, delays in reading, and an increase in school dropouts (Murphy, 2015). As such, educational leaders must investigate measures that will mitigate the mental health and achievement gap. By establishing a multi-tiered system of support, educational leaders, teachers, and staff may be able to meet the needs of students who are experiencing a mental health crisis. Moreover, as educational leaders make a concerted effort to understand the dynamics between educational outcomes and mental health, they will inherently contribute to an improved climate and culture where the needs of the whole child are being addressed.

Purpose of the Study

The first purpose of this study was to determine the extent to which differences existed for diagnostic assessments services available to students at school by school-funded mental health professional for the 2015-2016 school year. The second purpose of this study was to examine the degree to which differences were present in the frequency

of schools to provide diagnostic mental health assessments to evaluate students for mental health disorders by school level (i.e., elementary, middle, and high school) for the 2017-2018 school year. The third purpose was to ascertain the degree to which differences were present in whether diagnostic assessments were available at school by school-employed mental health professionals for the 2015-2016 school year. The fourth purpose of the study was to determine the extent to which differences existed in diagnostic mental health assessment services provided to students at school by a school-employed or contracted mental health professional by school level for the 2017-2018 school year. The fifth purpose was to examine the degree to which difference were present in the frequency of schools to in providing students diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year. The sixth purpose was to ascertain the degree to which differences were present in whether diagnostic mental health assessment services provided to students outside of school, by a school-employed or contracted mental health professional for the 2017-2018 school year.

Significance of the Study

As reported by the National Alliance on Mental Illness (2021), 16.6% of adolescents will experience a mental health crisis. Accordingly, the state of an individual's mental health may alter at any point in time depending on environmental influences, biological factors, and other external/internal factors (National Alliance on Mental Illness, 2021). Educational leaders and educators need to be aware of students' mental status and to be on alert if they begin to observe a sudden drop in grades, attendance, or behavioral changes. According to Substance Abuse and Mental Health

Services Administration (n.d.), mental health functions on a continuum. For example, just as physical health, can range from well to ill, so can mental health.

Educational leaders, teachers, and staff, as well as other school stakeholders, assume the responsibility of knowing and understanding the unique needs of their students. Moreover, data are used to gain a complete understanding of the students they serve. For example, educators look at demographics, socioeconomic status, ethnicity/race, at risk status, language, and other variables when determining how to meet the individualized needs of students. Unfortunately, the mental health status of students is rarely considered when making these decisions (Substance Abuse and Mental Health Services Administration, p. 1). One of the most effective measures in identifying students' areas of strengths and weaknesses is through a process referred to as Response to Intervention. Although predominantly used as an academic framework to assist students who are at risk and struggling with academic performance (Franklin et al., 2017) this tiered system of intervention has the potential to aid in the identification of students with mental health concerns.

The reauthorization of the Individuals with Disabilities Education Act instituted a new system for determining an impairment, termed Responsiveness to Intervention (United States Department of Education, n.d.). When deciding if a child has a particular learning disorder, a local educational agency can implement a process of review and monitoring to determine the child's response to evidence based intervention over time. By implementing a similar system for identifying children with mental health needs, educators will play a proactive role in closing the achievement and mental health divide. One of the main functions of educators is to ensure that students are learning at high

levels. If student psychological needs are not fulfilled, academic performance may suffer. Academic success is a by-product of mental health (McGrath, 2010).

Research Questions

In this study, the following research questions were addressed: (a) What is the difference in diagnostic assessments at school by school-funded mental health professionals for the 2015-2016 school year?; (b) What is the differences in diagnostic assessment for mental disorders for the 2017-2018 school year?; (c) What is the difference in diagnostic assessments at school by school-employed mental health professionals for the 2015-2016 school year?; (d) What is the differences in diagnostic assessments at school by school-employed or contracted mental health professionals for the 2017-2018 school year?; (e) What is the difference in diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year?; (f) What is the difference in diagnostic assessments outside of school by school-employed or contracted mental health professionals for the 2017-2018 school year.

These six research questions were analyzed separately. The 2015-2016 questions on the School Survey on Crime and Safety regarding diagnostic assessments and mental health were slightly altered during the 2017-2018 school year.

Method

Research Design

A non-experimental, causal comparative research design was present herein. Archival data from the 2015-2016 and 2017-2018 National School Safety Datasets were retrieved and examined in this section. Due to the pre-existing data, neither the independent variables of school level (i.e., elementary, middle, and high schools) nor the

dependent variables of mental health could be manipulated or modified. Dependent variables were responses to six questions regarding (a) What is the difference in diagnostic assessments at school by school-funded mental health professionals for the 2015-2016 school year?; (b) What is the differences in diagnostic assessment for mental disorders for the 2017-2018 school year?; (c) What is the difference in diagnostic assessments at school by school-employed mental health professionals for the 2015-2016 school year?; (d)What is the differences in diagnostic assessments at school by school-employed or contracted mental health professionals for the 2017-2018 school year?; (e) What is the difference in diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year?; (f) What is the difference in diagnostic assessments outside of school by school-employed or contracted mental health professionals for the 2017-2018 school year. These six research questions were analyzed separately.

Participants and Instrumentation

Data analyzed in this article were obtained from the 2015-2016 and 2017-2018 School Survey on Crime and Safety (SSOCS), a nationally representative survey of K–12 public schools in the United States. This survey, managed by the National Center for Education Statistics, is the main source of statistics on crime and safety in schools located in the United States. Participants in this investigation were public school principals or person with the most expertise of school crime and safety. Respondents were asked to report on a range of safety and crime related questions including school mental health services, staff training and practices, parent and community involvement at school,

disciplinary actions and other factors related to school crime and safety (Jackson et al., 2018; Padgett et al., 2020).

For the context of this research, the term school level refers to the traditional elementary, middle, and high school levels. The SSOCS was conducted seven times. However, the National Center for Education Statistics only recently added a section on school mental health services in the following two school years: 2015-2016 and 2017-2018. Prior to these years, this survey only addressed one of two or both of the following questions regarding mental health: (a) How many mental health agencies were involved in school's efforts to promote safe, disciplined, and drug-free schools?; and (b) How many paid counselors or mental health professional were employed at schools? (Chaney, 2015; Izrael, 2006; Ruddy, 2009, 2010; United States Department of Education, National Center for Education Statistics, 2003). Definitions pertaining to the survey's data on school mental health services were added to the SSOCS by The National Center for Education Statistics during the 2015-2016 school year.

In 2015-2016 the formal definitions for (a) diagnostic assessment, (b) mental health disorder, and (c) mental health professionals were added to the survey in accordance with the addition of a new section on school mental health services. However, in 2017-2018 the term "Diagnostic assessment" was changed to "Diagnostic mental health assessment," and its definition was modified to assist participants in differentiating diagnostic evaluations for mental health disorders from assessments that may be used to indicate other health or academic concerns. The term mental health professional was also revised. A revision to the definition added clarification to emphasize that mental health providers must be licensed (Padgett et al., 2020).

Diagnostic mental health assessment is defined as an evaluation conducted by a mental health professional that identifies whether an individual has one or more mental health diagnoses. This is in contrast to an educational assessment, which does not focus on clarifying a student's mental health diagnosis. (Padgett et al., 2020, p. A-3)

Archival data were collected from the 2015-2016 and 2017-2018 National School Safety Datasets and converted to Statistical Package for Social Sciences (SPSS) data. Survey questions were recoded using a codebook: (a) What is the differences in diagnostic assessments services available to students at school by school-funded mental health professional for the 2015-2016 school year, (b) What is the differences in the frequency of schools to provide diagnostic mental health assessments (e.g., psychological/psychiatric diagnostics assessments) to evaluate students for mental health disorders by school level (i.e., elementary, middle, and high school) for the 2017-2018 school year, (c) What is the differences in diagnostic assessments available at school by school-employed mental health professionals for the 2015-2016 school year, (d) What is the differences in diagnostic mental health assessment services provided to students at school by a school-employed or contracted mental health professional by school level for the 2017-2018 school year, (e) What is the differences in the availability of diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year, and (f) What is the differences in diagnostic mental health assessment services provided to students outside of school, by a school-employed or contracted mental health professional for the 2017-2018 school year.

Results

To determine the degree to which the differences were present in the frequency of schools in providing diagnostic mental health assessments to evaluate students for mental health disorders by school level for the 2015-2016 school year, Pearson chi-square procedures were conducted. The statistical procedure was viewed as the optimal statistical procedure to use because frequency data were present for school level and for the six dependent variables: (a) diagnostic assessments services available to students at school by school-funded mental health professional for the 2015-2016 school year, (b) diagnostic mental health assessments to evaluate students for mental health disorders by school level (i.e., elementary, middle, and high school) for the 2017-2018 school year, (c) availability of diagnostic assessments at school by school-employed mental health professionals for the 2015-2016 school year, (d) diagnostic mental health assessment services provided to students at school by a school-employed or contracted mental health professional by school level for the 2017-2018 school year, (e) availability of diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year, and (f) diagnostic mental health assessment services provided to students outside of school, by a school-employed or contracted mental health professional for the 2017-2018 school year. Because these variables were categorical, chi-squares are the statistical procedure of choice (Slate & Rojas-LeBouef, 2011). With the large sample size, the available sample size per cell was more than five. Therefore, the underlying assumptions of the Pearson chi-square statistic were met.

At School by School-Funded Mental Health Professionals

Concerning the first research question for the 2015-2016 school year, the result was statistically significant, $\chi^2(2) = 26.74$ $p < .001$. The effect size for this finding was small, a Cramer's V of .12 (Cohen, 1988). As delineated in Table 2.1, nearly three-fourths of elementary schools did not provide diagnostic assessments at school by school-funded mental health professionals. In comparison, slightly over three-fifths of middle schools and high schools did not provide such services.

 Insert Table 2.1 about here

Diagnostic Mental Health Assessments for Mental Disorders

Regarding diagnostic mental health assessments for mental disorders for the 2017-2018 school year, a statistically significant difference was revealed, $\chi^2(2) = 32.08$, $p < .001$, small effect size, Cramer's V of .11 (Cohen, 1998). Half of elementary schools did not provide diagnostic mental health assessments for mental disorders. In contrast, over two-fifths of middle schools and less than two-fifths of high schools did not provide such services. Table 2.2 contains the descriptive statistics for these analyses.

 Insert Table 2.2 about here

At School by School-Employed Mental Health Professionals

With respect to diagnostic assessment at school by school-employed mental health professionals for the 2015-2016 school year, a statistically significant difference

was yielded, $\chi^2(2) = 26.02, p < .001$, small effect size, Cramer's V of .11 (Cohen, 1988).

As revealed in Table 2.3, almost three-fifths of elementary schools did not provide diagnostic assessments at school by school-employed mental health professionals, compared to more than half of middle schools, and less than half of high schools that did not provide such assessments.

 Insert Table 2.3 about here

At School by School-Employed or Contracted Mental Health Professionals

Concerning the 2017-2018 school year, a statistically significant difference was not present by school level, $\chi^2(2) = 2.35, p = .31$. Elementary schools provided the fewest diagnostic mental health assessment at school by school-employed or contracted mental health professional, followed by middle schools and then high schools. Table 2.4 contains the descriptive statistics for this school year.

 Insert Table 2.4 about here

Outside of School by School-Funded Mental Health Professionals

Regarding diagnostic assessment outside of school by school-funded mental health professionals for the 2015-2016 school year, a statistically significant difference was revealed, $\chi^2(2) = 21.52, p < .001$, small effect size, Cramer's V of .10 (Cohen, 1988). As revealed in Table 2.5, three-fifths of elementary schools did not provide diagnostic

assessments outside of school by a school-funded mental health professional compared to a little over half of middle schools and less than half of high schools.

 Insert Table 2.5 about here

Outside of School by School-Employed or Contracted Mental Health Professionals

For the 2017-2018 school year, the result approached, but did not reach, the conventional level of statistical significance, $\chi^2(2) = 5.03, p = .08$. Although nearly one-third of all school levels did not provide mental health assessments outside of school by school-employed or contracted mental health personnel, elementary schools were more likely not to provide these services followed by high schools and then middle schools.

Delineated in Table 2.6 are the descriptive statistics for this analysis.

 Insert Table 2.6 about here

Discussion

Data regarding the frequency of schools in providing diagnostic assessments at school by school-funded mental health professionals by school level were obtained and analyzed from the national SSOCS for the 2015-2016 school year. Inferential statistical analyses revealed that diagnostic assessments at school by school-funded mental health professionals were statistically significantly different by school. Elementary schools had the highest percentage that did not provide diagnostic assessments to students under the official responsibility of a licensed mental health professional. Nearly 10% fewer middle

and high schools did not provide such services. This occurrence could be due to all school levels having school-employed educational assessment diagnosticians to perform these assessments.

During the 2017-2018 school year, providing diagnostic mental health assessments to evaluate students for mental health disorders was also statistically significant by school level. Nearly half of elementary schools provided diagnostic mental health assessments to evaluate mental health disorders. In contrast, more than half of middle and high schools provided such services.

Diagnostic assessments at school by school-employed mental health professionals were statistically significantly different by school level in the 2015-2016 school year. Almost three-fifths of elementary schools did not provide diagnostic assessments at school by school-employed mental health professionals, compared to more than half of middle schools and less than half of high schools that did not provide such assessments. Regarding diagnostic mental health assessment at school by school-employed or contracted mental health professionals, a statistically significant difference was not present for the 2017-2018 school year. Elementary schools provided the fewest diagnostic mental health assessments at school by school-employed or contracted mental health professional, followed by middle schools and then high schools.

Regarding diagnostic assessments outside of school by school-funded mental health professionals for the 2015-2016 school year, a statistically significant difference was revealed. Diagnostic assessments were available to slightly over half of high school students outside of school by a mental health professional. Less than half of middle and elementary schools ensured that this mental health service was available to students. In

the 2017-2018 school year, diagnostic mental health assessments outside of school by school-employed or contracted mental health professionals was not statistically significant by school level. Over two-thirds of elementary, middle, and high schools provided students diagnostic assessments outside of school by school-employed or contracted professionals.

Implications for Policy and for Practice

Based on the results of this study, several implications can be made for policy. Policymakers should rethink the role of mental health experts at each school level and explore reforming how licensed professional counselors are employed on and off campuses. In this study, mental health professionals are professionals who are licensed (e.g., psychiatrists, psychologists, psychiatric/mental health nurse practitioners, psychiatric/mental health nurses, clinical social workers, and professional counselors). Currently on the elementary level, counselors, whether licensed or not, are used as guidance counselors. At the secondary level, a major responsibility includes creating and assisting students with scheduling and graduation. By restructuring how licensed counselors are used on campus, more students may have more access to diagnostic assessments. Second, schools and universities should include an introductory course identifying the interconnectedness between various mental health professions and the educational setting and how these professions can contribute to providing mental health services/diagnostic assessments in K-12 schools. Third, policymakers should implement awareness campaigns each school year regarding mental health awareness and assessments.

Implications for practice include awareness efforts provided at all school levels and implementation of the Response to Intervention framework for mental health. Similar to the Response to Intervention framework that is used for academics, Tier I would consist of prevention and awareness. Tier II would include a screening for students who display certain behaviors such as suicide, drug abuse, cutting, and depression or students who have been identified to be in crisis. Lastly, Tier III would address the needs of students who need intensive support such as counseling, psychological evaluation, and other clinical care. School campus principals and/or administrators should gather input from teachers, counselors, and other mental health professionals regarding how this system could be implemented efficiently and effectively at each school level.

Recommendations for Future Research

Based upon the results discussed in this article, additional recommendations for future research can be made. First, researchers are encouraged to replicate this study using more current data. Second, researchers should consider a study on contracted mental health professionals and how they support schools to bridge the mental health gap in the area of diagnostic assessments. Moreover, researchers should analyze the differences in factors that limit school efforts to provide mental health services by school level. A final recommendation for future researchers would be to analyze differences in staff training and practices by school level as this investigation could provide insight regarding mental health and training in the educational arena.

Conclusion

Through inferential statistical analyses of national survey data, statistically significant differences were present for all research questions except for the two questions regarding diagnostic assessment at school and outside of school by school-employed or contracted mental health professionals. For the 2015-2016 school year, students at all school levels were less likely to receive diagnostic assessments at school by school-funded mental health professionals. During the 2017-2018 school year, students at all school levels were more likely to be provided diagnostic mental health assessments for mental disorders. Readers should note, however, that a substantial percentage of students was present who are not being provided this service. School leaders and administrators should strongly consider implementing the Response to Intervention framework for mental health. This system could aid in identifying students who are at risk for mental health disorders and provide next steps for teachers and parents.

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Table 2.1

Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments at School by School-Funded Mental Health Professionals by School Level for the 2015-2016 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 132) 25.6%	(<i>n</i> = 384) 74.4%
Middle	(<i>n</i> = 265) 36.9%	(<i>n</i> = 454) 63.1%
High	(<i>n</i> = 302) 39.0%	(<i>n</i> = 472) 61.0%

Note. The *n* represents the number of schools.

Table 2.2

Descriptive Statistics for Frequencies and Percentages of Diagnostic Mental Health

Assessment for Mental Disorders by School Level for the 2017-2018 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 330) 49.2%	(<i>n</i> = 341) 50.8%
Middle	(<i>n</i> = 548) 56.2%	(<i>n</i> = 427) 43.8%
High	(<i>n</i> = 629) 63.1%	(<i>n</i> = 368) 36.9%

Note. The *n* represents the number of schools.

Table 2.3

Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments at School by School-Employed Mental Health Professionals by School Level for the 2015-2016 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 216) 41.9%	(<i>n</i> = 300) 58.1%
Middle	(<i>n</i> = 335) 46.6%	(<i>n</i> = 384) 53.4%
High	(<i>n</i> = 431) 55.7%	(<i>n</i> = 343) 44.3%

Note. The *n* represents the number of schools.

Table 2.4

Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments at School by School-Employed or Contracted Mental Health Professionals by School Level for the 2017-2018 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 282) 85.5%	(<i>n</i> = 48) 14.5%
Middle	(<i>n</i> = 481) 87.8%	(<i>n</i> = 67) 12.2%
High	(<i>n</i> = 559) 88.9%	(<i>n</i> = 70) 11.1%

Table 2.5

Descriptive Statistics for Frequencies and Percentages of Diagnostic Assessments

Outside of School by School-Funded Mental Health Professionals by School Level for the 2015-2016 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 207) 40.1%	(<i>n</i> = 309) 59.9%
Middle	(<i>n</i> = 338) 47.0%	(<i>n</i> = 381) 53.0%
High	(<i>n</i> = 412) 53.2%	(<i>n</i> = 362) 42.8%

Note. The *n* represents the number of schools.

Table 2.6

Descriptive Statistics for Frequencies and Percentages of Diagnostic Mental Health Assessments Outside of School by School-Employed or Contracted Mental Health Professionals by School Level for the 2017-2018 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 204) 61.8%	(<i>n</i> = 126) 38.2%
Middle	(<i>n</i> = 378) 69.0%	(<i>n</i> = 170) 31.0%
High	(<i>n</i> = 425) 67.6%	(<i>n</i> = 204) 32.4%

Note. The *n* represents the number of schools.

CHAPTER III

DIFFERENCES IN FACTORS THAT LIMIT SCHOOL EFFORTS TO PROVIDE MENTAL HEALTH SERVICES BY SCHOOL LEVEL: A NATIONAL ANALYSIS

This dissertation follows the style and format of *Research in the Schools (RITS)*.

Abstract

The degree to which factors limited school efforts to provide mental health services was addressed in this study using data from the National School Survey on Crime and Safety for the 2015-2016 and 2017-2018 school years. Inferential statistical procedures revealed the presence of statistically significant differences in a lack of access to mental health professionals and a lack of community support for both school years. Elementary schools had a higher percentage of effort limited in a major way by a lack of access to mental health professionals and community support than did middle or high schools. Additionally, elementary schools had the highest percentage limited in a major way for: lack of parental support, concerns about reactions from parents, reluctance to label students, and payment policies. Implications for policy and practice were discussed, as well as recommendations for further study.

Keywords: Elementary school; Mental health professionals; Mental health disorders; Middle school; School based health centers; School survey on crime and safety

DIFFERENCES IN FACTORS THAT LIMIT SCHOOL EFFORTS TO PROVIDE MENTAL HEALTH SERVICES BY SCHOOL LEVEL: A NATIONAL ANALYSIS

According to Lai et al. (2016), “Schools are in a key position to identify mental health problems early and provide appropriate services or links to services” (p. 1). Additionally, school-based mental health centers assist in mitigating barriers that may interfere with accessing mental health services. Moreover, adolescence is an advantageous period of development to address mental disorder concerns as most mental health conditions emerge prior to 20 years of age (Salerno, 2016). If not addressed, adolescents with mental illnesses grow up to be adults with mental illnesses who have difficulties finding and maintaining employment and being productive citizens. Consequently, if the needs of students who have mental health concerns continue to be unmet, society will aid in perpetuating a cycle of mental health neglect that can affect generations to come. Because children, youth, and adolescents spend the majority of their time in K-12 schools, educational leaders need to understand barriers that limit access to mental health services and to be able to seek out solutions that will encourage increased utilization.

Barriers and challenges regarding why students do not seek out mental health services teeters on a continuum of reasons. Some of these limitations include a lack of awareness on how to obtain assistance, lack of transportation to mental health facilities, inadequate funding, inadequate access to mental health professionals, and stigmatization. To gain a better understanding into these challenges, Ijadi-Maghsoodi et al. (2018) conducted a study on the perspectives of low-income minority groups on assistance searching and challenges to receiving mental health services at school-based health center

sites. The study took place in a large urban community and included focus groups consisting of 76 middle and high school students at nine school-based health center sites. Participants reported teachers were the primary source of support regarding mental health issues. Mental health counselors and peers were also mentioned as key supporters. Students identified relationships and trust as essential components in seeking out support for mental health concerns. Obstacles to accessing school-based health centers included: humiliation; apprehension of being judged; confidentiality concerns; a feeling of needing to hold information inside; and lack of awareness. In an effort to mitigate these barriers and enhance mental health involvement, students recommended making school-based health centers more relaxed, increasing understanding of mental health, and improving relationships with schools and school-based health center's staff.

In a similar study, Dunfee (2020) examined literature on the effects of school-based health centers from the viewpoint of various stakeholders. Dunfee (2020) began with a descriptive review regarding the origins of school-based health centers. Information was presented regarding the demographics of school-based health centers, percentages of centers present at each school level, and the benefits of having school-based health centers located within schools. Revealed in this article were multiple limitations in establishing school-based health centers. These limitations included cost, funding, and economic effects. "The initial cost to design, build, and stock a school-based health center, ranged from \$41,450 to \$378,704, and the annual cost to staff, restock and operate a school-based health centers ranged from \$16, 322 to \$659,684" (Dunfee, 2020, p. 1). It was noted that only 20% of funding came from the school system. Over 51% of funding support of school-based health centers derive from

Federally Qualified Health Centers. Additionally, state and local government, insurance companies, private foundations, local business, and corporations assist in funding these centers. The cost of building school-based health centers remain an obstacle to their expansion, but inventive partnerships help districts address barriers to funding.

In a similar study, Larson et al. (2017) explored literature on childhood trauma and its effect on student success as it relates to mental illness. They also analyzed the literature to determine the influence school-based health centers that utilized mental health services had on adolescences. Results were: (a) school-based health centers are one possible intervention to support childhood trauma, behavioral health, and academic success; (b) school-based health centers improve accessibility and the use of mental health services; (c) the GPAs of students who utilized school-based health centers improved; and (d) the correlation between trauma and decreased academic success was mediated by mental health illnesses. “The mental health disorders that had the greatest impact on academic achievement were PTSD, depression, and anxiety” (Larson et al., 2017, pp. 681-682).

Bersamin et al. (2016) conducted an investigation of 948 schools in California to gain an in-depth understanding of the circumstances that necessitate school-based health centers and increase awareness of possible obstacles. Of the 948 schools included in the study, 88 had onsite school-based health centers. Findings from the study were that the majority of school-based health centers were located in cities (65.9%) and suburbs (23.9%). Rural areas and towns accounted for 6.8%. Additionally, schools with school-based health centers had a higher percentage of students of color who were economically disadvantaged as characterized by the number of students who received free and reduced

lunch services. Some of the services provided through these centers were mental health services, medical care, family planning clinics, and dental health. Resources, needs, and political philosophy are related to the existence of school-based health centers in California. For example, schools in the district with a higher percentage of registered Republicans were least likely to have a school-based health center. Consequently, it is crucial to consider how geographic contextual factors may influence the development of health services designed to facilitate positive health outcomes. Moreover, for school district leaders who would like to establish school-based health centers, building strong partnerships with local health providers can assist in addressing the unmet needs of students.

In an effort to determine the possible implication of stigmatization on K-12 students who participate in specific mental health services interventions, Gronholm et al. (2018) conducted a systematic literature review. By analyzing eight qualitative studies, the researchers established the presence of three mega themes that included negative labeling in which students were labeled as being different, strange, weird, crazy, or psycho. Confidentiality concerns were also noted as students felt that they could not trust their interventionist. A fear of others finding out about their mental health concerns caused hesitation when seeking out assistance. Similarly, another stigma-related obstacle was “restricted disclosure” (p. 22) where students believed that there would be adverse consequences if they opened up. To reduce the effects of stigmatization, practitioners need to build relationships and trust. In this study, students reacted favorably when the key substance of interventions stressed connections and applicable strategies to manage the stressors that come with everyday life (Gronholm et al., 2018).

In another investigation, Bowers et al. (2013) surveyed 49 high school students with and without mental health concerns and interviewed 63 professionals who were associated with school based mental health to gain insight on their perception regarding stigma. A larger number of adolescents considered stigma as one of the main barriers to accessing school mental health services. Participants with mental health concerns ranked not knowing where to go to get help as the second most common challenge. However, participants without any mental health related issues recognized pressure from peers and a lack of knowing they have a mental health problem as the second most common factor toward accessing mental health services. Stigma as a barrier becomes detrimental when it inhibits people from pursuing the help they need. Unfortunately, suicide is a common result for those individuals who suffer with a mental illness and who do not seek assistance (Bower et al., 2013).

From 1999 to 2016, the suicide rate increased 25.4% (America's Health Ranking, 2020) in the United States. Suicide is the second leading cause of death among youth and adolescents (Miller, 2019) and many of these individuals suffer from issues that are associated with mental illness or substance abuse. LeCloux et al. (2017) analyzed data from the National Longitudinal Study of Adolescent Health that included a sample of suicidal youth. Revealed in their investigation was that school based mental health centers greatly increases the likelihood of adolescents who are susceptible to suicide access mental health services. Other barriers that hinder access to mental health services were an insufficient knowledge of available services, insurance issues, extended waiting lists, financial limitations, transportation concerns, not meeting eligibility criteria, and high levels of staff attrition in mental health agencies.

Additionally, Reinke et al. (2011) conducted a study in which 292 teachers reported reasons why students with mental health needs “fall through the cracks” (p. 8). Participants reported that children’s mental health needs were not being met because of insufficient parental support, a lack of staff training/coaching, and a lack of prevention programs. In regard to barriers, the top three factors that limited supporting students with mental health concerns were: (a) an inadequate number of school mental health practitioners, (b) a lack of preparation and training to meet the mental health needs of children, and (c) insufficient funding for school-based mental health.

However, to bridge this gap, parental involvement is paramount. In an exploratory study conducted by Searcey Vulpen et al. (2018), 607 parents and guardians participated in a survey regarding the needs, inadequacies, and limitations of school-based mental health services. Descriptive information was gathered by allowing parents to choose from a list of behaviors that represented various mental health disorders. Additionally, parents were given an open format question. Researchers collected data on the following: (a) The role of schools in addressing mental health needs, (b) Perceptions of gaps in services, and (c) Resources for information on mental health concerns and services. Searcey Vulpen et al. (2018) concluded that 63% of respondents indicated that their child experienced anxiety and 59% suggested that their child was affected by other students who had experienced a personal behavioral health concern. Over 75% of respondents agreed that schools should be involved in addressing student mental health issues as well as taking an active role in connecting families and children to school-based and community-based service providers. In regard to accessing services, over 85% of parents stated that they would contact their child’s school counselor, pediatrician, or a

community mental health agency if they had concerns regarding their child's mental health.

Research Questions

The following overarching research question were addressed in this investigation: During the 2015-2016 and 2017-2018 school years, what is the difference in the frequency of factors that limits mental health efforts by school level (i.e., elementary, middle, and high school)? regarding The following sub-questions were addressed: (a) What are the differences between efforts limited by inadequate/lack of access to licensed mental health professionals by school level?; (b) What are the differences in efforts limited by inadequate funds by school level?; (c) What are the differences between efforts limited by potential legal issues for school or district (e.g., malpractice, insufficient supervision, confidentiality?; (d) What are the differences between efforts limited by lack of parental support?; (e) What are the differences between efforts limited by concerns about reactions from parents by school level?; (f) What are the differences between efforts limited by a lack of community support for providing mental health services to students in your school?; (g) What are the differences between efforts limited by a reluctance to label students with mental health disorders to avoid stigmatizing the child by school level?; and (h) What are the differences between efforts limited by written or unwritten policies regarding the school's requirement to pay for the diagnostic mental health assessment or treatment of students? Six of these eight research questions were answered separately for the elementary, middle, and high school level and were analyzed for two school years (i.e., 2015-2016, and 2017-2018). Data for the research question "What are the differences between efforts limited by parental support by school

level?” was only available for the 2015-2016 school year only. Similar data were available for only the 2017-2018 school year for the research question, “What are the differences between efforts limited by concerns about reactions from parents by school level?”

Method

Research Design

In this multiyear analysis, a causal-comparative research design was present because of the use of pre-existing data. Already existing survey data for the 2015-2016 and 2017-2018 school years were obtained and analyzed to address the research questions previously delineated. In this type of study, the independent and dependent variables cannot be adjusted or controlled. Moreover, any extraneous variables that might be present are unknown. Accordingly, Johnson and Christensen (2017) cautioned against making cause-and-effect determinations from causal-comparative research investigations. In this investigation, the independent variable was school level: elementary schools, middle schools, and high schools. The dependent variables were responses of educational leaders to questions regarding the factors that limit school efforts to provide mental health services.

Participants and Instrumentation

Participants in this study were principals or a designee considered an expert on campus safety who participated in a safety survey that questioned schools in regard to school mental health services along with other safety and security data from public schools. The School Survey on Crime and Safety gathers data from educational leaders from primary and secondary public schools as mandated by the federal government. The

survey questions focused on various school-related safety and security issues that may aid school administrators in adopting effective safety measures, preventing or reducing safety concerns, and identifying gaps or areas of needs that will ensure the safety and well-being of students and staff. Participants completed the survey by answering the questions with either: limits in major way, limits in minor way, or does not limit. In this investigation, the term school level refers to the conventional elementary, middle, and high school grades. The data analyzed herein were from the survey administrations in the 2015-2016 and 2017-2018 school years.

The School Survey on Crime and Safety was conducted seven times. The National Center for Education Statistics, however, only recently added a section on school mental health services in the following two school years: 2015-2016 and 2017-2018. Prior to these years, addressed in this survey was one of two or both of the following questions regarding mental health: (a) How many mental health agencies were involved in school's efforts to promote safe, disciplined, and drug-free schools?; and (b) How many paid counselors or mental health professionals were employed at schools? Definitions pertaining to the survey's data on school mental health services were added to the School Survey on Crime and Safety by the National Center for Education Statistics in the 2015-2016 school year.

Results

To determine the degree to which the differences were present in the frequency of factors that limited mental health efforts by school level (i.e., elementary, middle, and high school) for the 2015-2016 school year, Pearson chi-square procedures were conducted. The statistical procedure was viewed as the optimal statistical procedure to

use because frequency data were present for school level and for the eight dependent variables. Because these variables were categorical in nature, chi-squares are the statistical procedure of choice (Slate & Rojas-LeBouef, 2011). Because the available sample size per cell was more than five, the underlying assumptions of the Pearson chi-square statistic were met.

Inadequate/Lack of Access to Mental Health Professionals

With respect to mental health efforts limited by inadequate/lack of access to mental health professionals for the 2015-2016 school year, a statistically significant difference was yielded, $\chi^2(4) = 18.31, p = .001$, a below small effect size, Cramer's V of .07 (Cohen, 1988). As revealed in Table 3.1, one-third of elementary schools' efforts to provide mental health services were limited by inadequate/lack of access to licensed mental health professionals in a major way in comparison to slightly over one-fourth of middle schools. Less than one-fourth of high schools were limited by inadequate access to licensed mental health professional in a major way.

 Insert Table 3.1 about here

For the 2017-2018 school year, the result was statistically significant, $\chi^2(4) = 14.83, p = .005$, Cramer's V of .05, a below small effect size (Cohen, 1988). Delineated in Table 3.2 are the descriptive statistics for efforts limited by inadequate/lack of access to mental health professionals. Slightly over two-fifths of elementary schools' effort were limited by inadequate/lack of access to mental health professionals in a major way. In comparison, slightly over one-third of middle schools, and one-third of high schools

were limited in providing mental health services by inadequate access to mental health professionals in a major way.

Insert Table 3.2 about here

Inadequate Funding

Concerning mental health efforts limited by inadequate funding for the 2015-2016 school year, a statistically significant difference was not yielded, $\chi^2(4) = 6.50, p = .16$. Though not statistically significant, nearly half of elementary schools were limited to providing mental health services due to inadequate funding in a major way in comparison to slightly over-two fifths of middle and high schools. Table 3.3 contains the descriptive statistics for this analysis.

Insert Table 3.3 about here

Regarding inadequate funding to provide mental health services to students for the 2017-2018 school year, a statistically significant difference was not yielded, $\chi^2(4) = 3.19, p = .53$. Similar percentages of elementary, middle, and high schools, over 50%, were limited in providing mental health services to students by inadequate funding in a major way. Table 3.4 contains the descriptive statistics for this analysis.

Insert Table 3.4 about here

Potential Legal Issues

For the third research question concerning potential legal issues as a factor in providing mental health services to students for the 2015-2016 school year, the result was not statistically significant, $\chi^2(4) = 5.45, p = .24$. Potential legal issues did not limit nearly three-fifths of elementary, middle, and high schools' effort to provide mental health services to students. Revealed in Table 3.5 are the descriptive statistics for this research question.

Insert Table 3.5 about here

Concerning potential legal issues as a factor in providing mental health services to students for the 2017-2018 school year, the result approached, but did not reach, the conventional level of statistical significance, $\chi^2(4) = 7.80, p = .10$. Potential legal issues did not limit over half of elementary, middle, and high schools. Delineated in Table 3.6 are the descriptive statistics for potential legal issues that limit schools' efforts to provide mental health services to students.

Insert Table 3.6 about here

Lack of Parental Support

Regarding mental health efforts limited by lack of parental support for the 2015-2016 school year, the result was statistically significant, $\chi^2(4) = 22.62, p < .001$. The effect size for this finding, Cramer's V of .08, was a below small effect size (Cohen, 1988). Half of middle and high schools were limited in a minor way by lack of parental support compared to slightly over two-fifths of elementary schools. Table 3.7 contains the descriptive statistics for this analysis.

Insert Table 3.7 about here

Concerns About Reactions From Parents

With respect to efforts limited by concerns about reactions from parents for the 2017-2018 school year, the result was statistically significant, $\chi^2(4) = 17.81, p = .001$, Cramer's V of .058, a below small effect size (Cohen, 1988). Almost 30% of elementary schools and 30% of high schools were limited in a minor way by concerns about reactions from parents compared to 35% of middle schools. Delineated in Table 3.8 are the descriptive statistics for this analysis.

Insert Table 3.8 about here

Lack of Community Support

Concerning efforts limited by a lack of community support for providing mental health services to students for the 2015-2016 school year, the result was statistically

significant, $\chi^2(4) = 13.94$, $p = .007$, Cramer's V of .06, a below small effect size (Cohen, 1988). Elementary and middle schools had almost twice the percentage of high schools that were limited in a major way by a lack of community supports. Table 3.9 contains the descriptive statistics for this analysis.

 Insert Table 3.9 about here

Regarding efforts limited by a lack of community support for providing mental health services to students for the 2017-2018 school year, the result was statistically significant, $\chi^2(4) = 19.22$, $p = .001$, Cramer's V of .06, a below small effect size (Cohen, 1988). Elementary schools had a higher percentage of efforts limited in a major way by a lack of community support than did middle or high schools. Delineated in Table 3.10 are the descriptive statistics for this analysis.

 Insert Table 3.10 about here

Reluctance to Label Students

With respect to efforts limited by a reluctance to label students with mental health disorders to avoid stigmatizing the child for the 2015-2016 school year, the result was statistically significant, $\chi^2(4) = 24.27$, $p < .001$, Cramer's V of .08, a below small effect size (Cohen, 1988). As revealed in Table 3.11, elementary schools had the highest percentage of efforts limited in a major way by a reluctance to label students with mental

health disorders to avoid stigmatizing the child compared to high school. Middle schools had the second highest percentage followed by high schools.

Insert Table 3.11 about here

Concerning efforts limited by a reluctance to label students with mental health disorders to avoid stigmatizing the child for the 2017-2018 school year, the result approached, but did not reach, the conventional level of statistical significance, $\chi^2(4) = 7.95, p = .09$. Though not statistically significant, elementary schools and middle schools had similar percentages of effort limited in a major way by a reluctance to label students with mental health disorders to avoid stigmatizing children in comparison to high schools which had a lower percentage. Revealed in Table 3.12 are the descriptive statistics for this analysis.

Insert Table 3.12 about here

Payment Policies

Regarding mental health efforts limited by payment policies for the 2015-2016 school year, the result was not statistically significant, $\chi^2(4) = 7.38, p = .12$. Payment policies did not limit three-fifths of elementary and high schools from providing mental health services to students. Additionally, payment policies did not limit nearly three-fifths of middle schools' mental health efforts. Table 3.13 contains the descriptive statistics for this analysis.

Insert Table 3.13 about here

With respect to mental health efforts limited by payment policies for the 2017-2018 school year, the result was statistically significant, $\chi^2(4) = 14.06$, $p = .007$, Cramer's V of .05, a below small effect size (Cohen, 1988). High schools had the highest percentage of efforts that did not limit mental health services to students compared to middle and elementary schools. Delineated in Table 3.14 are the descriptive statistics for this analysis.

Insert Table 3.14 about here

Discussion

Data regarding the frequency of mental health efforts limited by inadequate access to professionals by school level were obtained and analyzed from the national School Survey on Crime and Safety for two years. Inferential statistical analyses revealed efforts limited by inadequate access to professionals were statistically significantly different by school level. During the 2015-2016 school year, elementary schools had nearly the same percentage of efforts that were limited in a major and minor way by inadequate access to professionals. Additionally, nearly the same percentage of elementary schools were not limited at all. Furthermore, all school levels had higher percentages that were not limited by inadequate access to professionals. Contrasting results, however, were present in the 2017-2018 school year. High schools had the same

percentage of efforts limited by inadequate access to professionals in all categories. Furthermore, all school levels had higher percentages limited in a major way by inadequate access to professionals.

Regarding efforts limited by inadequate funds, results were not statistically significant for the 2015-2016 school year. Almost 50% of elementary schools were limited by inadequate funding. Similar findings were present for this survey question in middle and high schools. Concerning efforts limited by inadequate funds for the 2017-2018 school year, results were not statistically significant. Again, similar findings were present for this survey question across all three school levels.

Concerning efforts limited by potential legal issues, results were not statistically significant for the 2015-2016 school year. More than half of all three school levels were not limited by potential legal issues. Similarly for the 2017-2018 school year, statistically significant differences were not revealed. The percentages, however, slightly decreased across all school levels for efforts not limited by potential legal issues. In comparison to the previous year, a 5 to 6% increase was observed in percentages in efforts limited in a major way by potential legal issues.

Efforts limited by a lack of parent support were statistically significant for the 2015-2016 school year. Elementary schools had a higher percentage of efforts limited by a lack of parental support in a major way. Middle schools provided the second most efforts limited by a lack of parental support in a major way, and high schools provided the least. During the 2017-2018 school year, efforts limited by concerns about reactions from parents were statistically significant. Although the percentages were low across all school levels, elementary schools had the highest percentage of efforts limited in a major

way by concerns about reactions from parents. Middle and high schools had the same percentage of efforts limited in a major way.

With respect to the investigation about efforts limited by a lack of community support, results were statistically significant for the 2015-2016 and 2018-2018 school year. Over half of all three school levels were not limited by a lack of community support for both school years. High schools declined by 10% compared to elementary by 5% and middle school by 3%. A decline was also observed in efforts limited in a major way with a change of 2-3% points across all levels.

Efforts limited by reluctance to label students to avoid stigmatization for the 2015-2016 school year were statistically significant by school level. However, statistically significant differences were not yielded for the 2017-2018 school year. From the 2015-2016 school year to the 2017-2018 school year, efforts limited in a minor way by a reluctance to label students declined across all three school levels. Additionally, efforts limited in a major way remained somewhat the same across the elementary and middle school level for both school years. Furthermore, from the 2015-2016 school year to the 2017-2018 school year, an increase was present in all school levels that were not limited by a reluctance to label students.

Statistically significant differences for efforts limited by payment policies were not present for the 2015-2016 school year. From the 2015-2016 school year to the 2017-2018 school year, a slight decline was observed in efforts limited in a major way for payment policies for all three school levels. For the 2017-2018 school year, findings were not statistically significantly different by school level.

Implications for Policy and Practice

Several policy implications may be made based on the findings of this study. To begin, legislators should develop annual awareness campaigns to promote understanding of mental health, knowledge of available treatment, and how to seek assistance. Second, federal and state regulatory agencies should reexamine the licensing requirements of school counselors. All school counselors should be required to be licensed after a certain number of years in education. Finally, federally funded mental health care agencies/organizations should be required to develop partnerships and support local public school districts to meet the mental health needs of students who have been identified with mental health concerns.

Concerning implications for practice, school leaders should implement teacher initiatives at each school level as teachers are a primary support for mental health issues. School districts should consider reimaging the role of the counselor on the secondary level. Districts could pay for counselors to be licensed and allow them to function in a dual capacity when needed or eventually fade out the time consuming responsibility of (scheduling) and reassign roles. Parent initiatives/classes should also be offered at the district and campus level to engage and educate parents in community mental health activities. Additionally, schools should take an active role in connecting families and children to school-based and community-based service providers. To address funding concerns, schools should build strong partnerships with local health providers. These partnerships may be able to assist in addressing funding issues and the unmet needs of students.

Recommendations for Future Research

Several recommendations for further inquiry may be made based on the findings of this nationwide investigation. Researchers are encouraged to consider conducting a mixed method study or qualitative analysis regarding students' perceptions on mental health barriers and its impact on services received by school level. Exploring students' perspective on this issue may offer insights on how to overcome limitations associated with providing mental health services to students. In this investigation, potential legal issues were one of the factors that limited schools' mental health efforts in a major way, as such, a more in-depth investigation of legal concerns and mental health in K-12 schools will add to the existing body of literature. Additionally, a further investigation regarding the differences in a lack of parental support and concerns about reactions from parents is also recommended. Although parental support and concerns about reactions from parents were only analyzed for one school year, a study concerning these factors over multiple school years would contribute to the material already available.

Conclusion

Through inferential statistical analyses of national survey data, statistically significant differences were present for the majority of the research questions with the exception of questions regarding mental health efforts limited by inadequate funding and potential legal issues for the 2015-2016 and 2017-2018 school years, and payment policies for the 2015-2016 school year. The following factors: (a) inadequate access to mental health professionals; (b) inadequate funding; and (c) potential legal issues, revealed an increase from the 2015-2016 school year to the 2017-2018 school year in the percentages of all school levels that were limited in a major way by mental health efforts.

A decline occurred from the 2015-2016 school year to the 2017-2018 school year in percentages at all school levels that were not limited in any way by these same mental health efforts. As such, school leaders are encouraged to analyze the components of a school based health center and consider how to employ some if not all of these components into an already established school system.

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Table 3.1

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Inadequate/ Lack of Access to Licensed Mental Health Professionals by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 171) 33.1%	(<i>n</i> = 169) 32.8%	(<i>n</i> = 176) 34.1%
Middle	(<i>n</i> = 198) 27.5%	(<i>n</i> = 244) 33.9%	(<i>n</i> = 277) 38.5%
High	(<i>n</i> = 175) 22.6%	(<i>n</i> = 275) 35.5%	(<i>n</i> = 324) 41.9%

Note. The *n* represents the number of schools.

Table 3.2

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Inadequate/ Lack of Access to Licensed Mental Health Professionals by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 281) 41.9%	(<i>n</i> = 194) 28.9%	(<i>n</i> = 196) 29.2%
Middle	(<i>n</i> = 369) 37.8%	(<i>n</i> = 327) 33.5%	(<i>n</i> = 279) 28.6%
High	(<i>n</i> = 333) 33.4%	(<i>n</i> = 335) 33.6%	(<i>n</i> = 329) 33.0%

Note. The *n* represents the number of schools.

Table 3.3

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Inadequate Funding by School Level for the 2015-2016 Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 250) 48.4%	(<i>n</i> = 139) 26.9%	(<i>n</i> = 127) 24.6%
Middle	(<i>n</i> = 313) 43.5%	(<i>n</i> = 208) 28.9%	(<i>n</i> = 198) 27.5%
High	(<i>n</i> = 320) 41.3%	(<i>n</i> = 233) 30.1%	(<i>n</i> = 221) 28.6%

Note. The *n* represents the number of schools.

Table 3.4

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Inadequate Funding by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 355) 52.9%	(<i>n</i> = 166) 24.7%	(<i>n</i> = 150) 22.4%
Middle	(<i>n</i> = 491) 50.4%	(<i>n</i> = 251) 25.7%	(<i>n</i> = 233) 23.9%
High	(<i>n</i> = 485) 48.6%	(<i>n</i> = 274) 27.5%	(<i>n</i> = 238) 23.9%

Note. The *n* represents the number of schools.

Table 3.5

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Potential Legal Issues by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 69) 13.4%	(<i>n</i> = 140) 27.1%	(<i>n</i> = 307) 59.5%
Middle	(<i>n</i> = 82) 11.4%	(<i>n</i> = 235) 32.7%	(<i>n</i> = 402) 55.9%
High	(<i>n</i> = 89) 11.5%	(<i>n</i> = 226) 29.2%	(<i>n</i> = 459) 59.3%

Note. The *n* represents the number of schools.

Table 3.6

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Potential Legal Issues by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 133) 19.8%	(<i>n</i> = 179) 26.7%	(<i>n</i> = 359) 53.5%
Middle	(<i>n</i> = 177) 18.2%	(<i>n</i> = 307) 31.5%	(<i>n</i> = 491) 50.4%
High	(<i>n</i> = 161) 16.1%	(<i>n</i> = 295) 29.6%	(<i>n</i> = 541) 54.3%

Note. The *n* represents the number of schools.

Table 3.7

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Lack of Parental Support by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 145) 28.1%	(<i>n</i> = 226) 43.8%	(<i>n</i> = 145) 28.1%
Middle	(<i>n</i> = 151) 21.0%	(<i>n</i> = 356) 49.5%	(<i>n</i> = 212) 29.5%
High	(<i>n</i> = 133) 17.2%	(<i>n</i> = 389) 50.3%	(<i>n</i> = 252) 32.6%

Note. The *n* represents the number of schools.

Table 3.8

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Concerns about Reactions from Parents by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 77) 11.5%	(<i>n</i> = 195) 29.1%	(<i>n</i> = 399) 59.5%
Middle	(<i>n</i> = 73) 7.5%	(<i>n</i> = 345) 35.4%	(<i>n</i> = 557) 57.1%
High	(<i>n</i> = 75) 7.5%	(<i>n</i> = 301) 30.2%	(<i>n</i> = 621) 62.3%

Note. The *n* represents the number of schools.

Table 3.9

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by a Lack of Community Support by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 73) 14.1%	(<i>n</i> = 163) 31.6%	(<i>n</i> = 280) 54.3%
Middle	(<i>n</i> = 83) 11.5%	(<i>n</i> = 234) 32.5%	(<i>n</i> = 402) 55.9%
High	(<i>n</i> = 60) 7.8%	(<i>n</i> = 261) 33.7%	(<i>n</i> = 453) 58.5%

Note. The *n* represents the number of schools.

Table 3.10

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by a Lack of Community Support by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 88) 13.1%	(<i>n</i> = 179) 26.7%	(<i>n</i> = 404) 60.2%
Middle	(<i>n</i> = 88) 9.0%	(<i>n</i> = 288) 29.5%	(<i>n</i> = 599) 61.4%
High	(<i>n</i> = 87) 8.7%	(<i>n</i> = 238) 23.9%	(<i>n</i> = 672) 67.4%

Note. The *n* represents the number of schools.

Table 3.11

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by a Reluctance to Label Students by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 61) 11.8%	(<i>n</i> = 185) 35.9%	(<i>n</i> = 270) 52.3%
Middle	(<i>n</i> = 70) 9.7%	(<i>n</i> = 227) 31.6%	(<i>n</i> = 422) 58.7%
High	(<i>n</i> = 40) 5.2%	(<i>n</i> = 258) 33.3%	(<i>n</i> = 476) 61.5%

Note. The *n* represents the number of schools.

Table 3.12

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by a Reluctance to Label Students by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 71) 10.6%	(<i>n</i> = 202) 30.1%	(<i>n</i> = 398) 59.3%
Middle	(<i>n</i> = 101) 10.4%	(<i>n</i> = 281) 28.8%	(<i>n</i> = 593) 60.8%
High	(<i>n</i> = 80) 8.0%	(<i>n</i> = 268) 26.9%	(<i>n</i> = 649) 65.1%

Note. The *n* represents the number of schools.

Table 3.13

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Payment Policies by School Level for the 2015-2016 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 80) 15.5%	(<i>n</i> = 129) 25.0%	(<i>n</i> = 307) 59.5%
Middle	(<i>n</i> = 108) 15.0%	(<i>n</i> = 198) 27.5%	(<i>n</i> = 413) 57.4%
High	(<i>n</i> = 87) 11.2%	(<i>n</i> = 216) 27.9%	(<i>n</i> = 471) 60.9%

Note. The *n* represents the number of schools.

Table 3.14

Descriptive Statistics for Frequencies and Percentages of Mental Health Efforts Limited by Payment Policies by School Level for the 2017-2018 School Year

School Level	Major	Minor	Did Not Limit
Elementary	(<i>n</i> = 71) 10.6%	(<i>n</i> = 202) 30.1%	(<i>n</i> = 398) 59.3%
Middle	(<i>n</i> = 101) 10.4%	(<i>n</i> = 281) 28.8%	(<i>n</i> = 593) 60.8%
High	(<i>n</i> = 80) 8.0%	(<i>n</i> = 268) 26.9%	(<i>n</i> = 649) 65.1%

Note. The *n* represents the number of schools.

CHAPTER IV

DIFFERENCES IN STAFF TRAINING AND PRACTICES BY SCHOOL LEVEL: A NATIONAL ANALYSIS

This dissertation follows the style and format of *Research in the Schools (RITS)*.

Abstract

The degree to which differences were present in staff training and practices by school level were addressed in this study using data from the national School Survey on Crime and Safety for the 2015-2016 and the 2017-2018 school years. Inferential statistical procedures revealed the presence of statistically significant differences in trainings offered to teachers to recognize early warning signs for violence, signs of self-harm and suicidal tendencies, student alcohol/drug abuse and positive behavioral intervention strategies. Elementary schools offered the lowest percentages of training provided to teachers in almost all areas examined, with the exception of positive behavioral and intervention strategies. Trainings provided to teachers increased at nearly all school levels from the 2015-2016 school year to the 2017-2018 school year.

Keywords: Elementary school; Mental health professionals; Mental health disorders; Middle school; School based health centers; School survey on crime and safety

DIFFERENCES IN STAFF TRAINING AND PRACTICES BY SCHOOL LEVEL: A NATIONAL ANALYSIS

A mental health disorder is defined as any health condition that is characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (Padgett et al., 2020). Of importance is that the numbers of students who suffer from mental disorders are increasing. Depression, anxiety, and attention deficit hyperactivity disorder (ADHD) are a few of the most common mental illnesses within the K-12 population. “More U.S. adolescents and young adults in the late 2010s (vs. the mid-2000s) experienced serious psychological distress, major depression, and suicidal thoughts, and more attempted suicide and took their own lives” (Tweng et al., 2017, p. 1). This pattern may be attributed to a generational trend or shift that has occurred due to a rise in digital communication, an increase usage of the internet, and sleep disturbance (Twenge et al., 2017). The effects of cyberbullying have adversely affected the mental well-being of adolescents (Fahy et al., 2016). Furthermore, mental health problems have been considerably amplified by the effects of a pandemic and social unrest (Substance Abuse and Mental Health Services Administration, May 2020; Wong et al., 2021).

Psychological illnesses are first manifested during the adolescent years. Therefore, teachers, staff, and administrators need to be able to offer first-stage support to students who are having mental health difficulties (Jorm et al., 2010). Although 62% of teachers and staff are being trained in intervention and referral strategies for students displaying signs of mental health disorders (e.g., depression, mood disorders, ADHD)

(Padgett et al., 2020), suicide rates are on the rise and the number of students experiencing mental health crises continues to increase.

A little over half of the states have enacted legislation or adopted laws mandating or recommending teacher training and career development in areas such as student psychological health and trauma-informed approaches (Kelley et al., 2020). Texas, the state of interest for this article, requires training that includes: “students with mental health conditions or who engage in substance abuse” and “how mental health conditions, including grief and trauma, affect student learning and behavior and how evidence-based, grief-informed, and trauma-informed strategies support the academic success of students affected by grief and trauma” (Texas Public Law, n.d., p. 1). Additionally, as of September 2015, the Texas Education Code mandates that anyone pursuing a diploma that requires a bachelor's degree as one of the basic academic requirements undergo guidance on mental health, drug misuse, and juvenile suicide as part of the preparation needed to earn the certificate (Texas Education Agency, 2020). Yet, many school educators report a lack of preparation and training in the area of mental health literacy (Frauenholtz et al., 2015; Moon et al., 2017; Pierret et al., 2020). This lack of preparation and implementation continues to widen the research to practice gap.

Although mental health training is a requirement for educators in half of the United States, the published research literature about the effectiveness of school based mental health services implemented by school personnel in elementary is limited. Sanchez et al. (2018) conducted the first quantitative meta-analysis that included only school professionals (e.g., teachers, counselors, paraprofessionals, or school psychologists). Using a tiered or service level approach, students who received targeted

level intervention or selective prevention showed large and high-medium effects which indicated a decline in mental health problems. Mental health universal preventions were indicative of small but significant effects in mitigating mental health concerns.

Additionally, school based services that were implemented daily or multiple times per week had a moderate effect size whereas school based services implemented less frequently had a small effect size. When specific school-based psychological methods were assessed, only “contingency management accounted for significant variance in child mental health outcomes (Sanchez et al., 2018, p. 159). Services targeting externalizing problems paired with contingency management had a moderate to large effect whereas services targeting externalizing problems without contingency management had only a small effect in reducing psychological problems.

In a related investigation, Vieira et al. (2014) conducted a study in Brazil about teacher ability to recognize and appropriately refer students with mental health concerns. They focused on analyzing the effectiveness of a psychoeducational strategy to build teacher capability in mental health. The method used to conduct the study included a case control sample and teacher sample. Prior to the training, 32 teachers selected 26 students who they thought exhibited mental health problems. An additional non-selected 26 students acted as the control group. Researchers concluded that teachers were more likely to not identify students who exhibited only internalizing problems (i.e., anxiety, depression) as these students are the least likely to disturb the classroom environment. However, the majority of teachers were able to identify students who displayed externalizing and internalizing difficulties simultaneously. Ninety percent of teachers were able to identify and accurately refer students who displayed a conduct disorder.

This high rate of identification is thought to be contributed to its disruptive nature to disrupt the learning environment. The researchers reported that due to the training about 50.0% of teachers learned to make an appropriate referral and accurately recognize the six vignettes or psychological problems (i.e., conduct disorder, mania, depression, hyperactivity, and high risk of psychosis). Moreover, 60% of teachers learned to identify normal adolescence.

Furthermore, Reinke et al. (2011) surveyed 292 early childhood and elementary teachers to ascertain their views of existing mental health issues in their schools and to gather insight on their knowledge and skills as it pertains to supporting students with mental health needs. Teachers reported their top five student mental health concerns in order from most concerning: (a) Behavior problems, (b) Hyperactivity and inattention problems, (c) Students with significant family stressors, (d) Social skills deficits, and (e) Depression. Twenty-eight percent of teachers believed that they had the knowledge required to meet the mental health needs of their students. In regard to meeting the mental health needs of their students, 30% of teachers agreed that they had the knowledge and skills necessary to address the mental health needs of their students' needs. Additionally, three other areas were identified in which teachers said they needed additional coaching (i.e., techniques for interacting with children who exhibit externalizing behavior disorders, identifying and fully understanding children's mental health challenges, and classroom management and behavioral modification instruction).

In a similar study, Moon et al. (2017) analyzed educators' insight on the present state of mental health in schools. Participants were 786 educators including 127 administrators. Based on the findings, 59% of respondents agreed that they were

confident in recognizing signs of student mental health issues. However, almost half disagreed with the assertion that they had acquired sufficient mental health training, and 85% shared a preference for more mental health training. At least 50% of participants identified the following areas for additional training: (a) mental health disorders, (b) behavioral management techniques, (c) social skill training/management, and (d) positive behavioral supports training. Additionally, findings from this research article were congruent with the findings of previous researchers (Frauenholtz et al., 2016; Froese-Germain & Riel, 2012; Reinke et al., 2011) that numerous educators expressed dissatisfaction with their prior mental health preparation and indicated a desire for additional training.

In a comparable research analysis, Frauenholtz et al. (2016) conducted a focus group of teachers, other school staff members, and community mental health members to investigate teacher and school personnel perceptions of mental health awareness. The group discussed their prior experiences with students experiencing mental health concerns, their training in children's mental health, their perspectives of their current mental health knowledge, and their desire to recognize students experiencing mental health distress and collaborate with local mental health providers. In this study, school personnel reported a lack of proficiency in mental health literacy which hinders their ability to intervene effectively with students in need. This same focus group identified a deficit in recognizing the symptoms of mental health distress. Another gap in mental health knowledge that was identified was the accessibility and availability of local mental health agencies.

In a study conducted in the United Kingdom, Shelemy et al. (2019) addressed the support and trainings teachers needed and wanted regarding mental health. The study consisted of 49 secondary school teachers who participated in a focus group. Respondents indicated a need for training to assess if a student was distressed and whether or not their psychological state or behavior was concerning. Participants desired direction and instruction on how to manage and support a pupil before receiving expert assistance. The teachers emphasized that strategies provided should not be therapeutic in nature. One respondent stated, “I think we have a duty of care, not a duty of cure. Within that duty of care we have a duty, not put out the fire but to educate them first, which is what we’re trying to do” (Shelemy et al., 2019, p. 106). Additionally reported was that teachers wanted real-world application, strategies that were practical, and customizable resources that could easily be adapted into lessons. It was recommended that all trainings should be participatory, foster conversation, and solicit audience input. Participants also shared that the information needed to be delivered by an expert in the field of mental health and evidence-based.

Though apparent that mental health training is needed, educational leaders and teachers must also be trained to be aware of personal biases and cultural differences as it pertains to mental health. According to Cokley et al. (2014), Black adolescents are under identified for mental health related issues. This under identification may be attributed to a lack in training to recognize the link between mental health and socioeconomic level. Because of inadequate economic, family, and psychological supports, those individuals living in poverty are more prone to suffer from mental illness (Wickrama & Vazsonyi, 2011). Children of color are more likely than their White and Asian peers to be

economically disadvantaged (Creamer, 2020). This intersectionality of race, culture, and socioeconomic status intertwine in ways that make identifying psychological concerns in children of color more difficult. Trainings in school based mental health should incorporate understanding the unique stressors of children from diverse backgrounds.

Statement of the Problem

Expectations for teachers to be responsible for detecting and directing students who are experiencing mental health challenges to appropriate assistance (Department of Health and Department of Education, 2017) are increasing. More than half of teachers and staff are being trained in intervention and referral strategies for students displaying signs of mental health disorders (Survey on Crime and Safety, 2018), yet over half of youth with psychological concern do not receive any mental health treatment (Bains & Diallo, 2016; Mental Health America, 2018). Although some states require educators to participate in mental health training on an annual basis, many teachers feel ill-prepared in supporting students with psychological concerns. Mental illness is not a localized problem nor is its effects centralized. Therefore, educators must be able to identify and provide support to students who may be at risk of experiencing a mental health episode. According to Family Guidance Center (2014), 20% of children have an undiagnosed mental illness. Having an undiagnosed mental illness, can have detrimental outcomes for students (e.g., decreased academic performance, increase referrals and behavior concerns). Therefore, teachers need to be trained effectively in identifying and supporting students with mental health concerns.

Significance of the Study

Educational leaders and educators are in a unique position to help children and teens overcome issues associated with psychological illnesses. Mental disorders such as depression, anxiety and suicide are treatable diagnoses. Students should not have to suffer in silence and wait for solutions to help rectify their problems. Suicide attempt among children is often associated with impulsivity, feelings of depression, anger, and issues with attention attempted by adolescents are spontaneous. Legitimate concerns exist that the latest Covid-19 pandemic could have long-term detrimental effects on the mental health of adolescents (Gunnell et al., 2020; Pierret et al., 2020). Educational leaders and educators need to be confident in their knowledge and understanding in how to recognize signs and symptoms of students who may be experiencing a mental health crisis.

Research Questions

The following overarching research question was addressed in this investigation: What is the difference in the frequency of staff trainings and practices that were offered school-wide related to mental health by school level (i.e., elementary, middle, and high school)? Specific subquestions under this overarching research question were: (a) What is the difference in staff trainings that are offered to recognize early warning signs for students who are likely to exhibit violent behaviors by school level?; (b) What is the difference in staff trainings and practices that are offered to recognize signs of self-harm or suicidal tendencies?; (c) What is the difference in staff trainings and practices that are offered for intervention and referral strategies for students displaying signs of mental health disorders (e.g., depression, mood disorders, ADHD) by school level?; (d) What is the difference in staff training offered for recognizing signs of students using/abusing

alcohol and/or drugs?; (e) What is the difference in staff training offered for positive behavioral intervention strategies?; and (f) What are the differences in staff trainings that are offered for crisis prevention and intervention by school level? During this investigation, five of six research questions were repeated for two years of data: 2015-2016 and 2017-2018 school year. The research question regarding suicide and self-harm was analyzed for the 2017-2018 school year only as this question was in the 2015-2016 data set.

Method

Research Design

Present in this empirical inquiry was a non-experimental, causal comparative research approach (Creswell & Creswell 2018; Johnson & Christensen, 2017). As such, the focus of this study was on the relationship between independent and dependent variables in which the independent variable was not changed or manipulated in any way. Dependent variables were principals' responses to the following question: What is the difference in the frequency of staff trainings and practices that are offered school-wide related to mental health? Additional dependent variables were the following six subquestions: (a) frequency in staff trainings that are offered to recognize early warning signs for students who are likely to exhibit violent behaviors; (b) frequency in staff trainings and practices that are offered to recognize signs of self-harm or suicidal tendencies; (c) frequency in staff trainings and practices that are offered for intervention and referral strategies for students displaying signs of mental health disorders; (d) frequency in staff training offered for recognizing signs of students using/abusing alcohol and/or drugs; (e) frequency in staff training offered for positive behavioral intervention

strategies; and (f) frequency in staff trainings that are offered for crisis prevention and intervention. The independent variable was school level (i.e., elementary, middle, and high schools). Archival data from the National School Safety Datasets from 2015-2016 and 2017-2018 were examined.

Participants and Instrumentation

Participants in this study were principals or a designee considered an expert on campus safety who participated in a safety survey that questioned schools in regard to school mental health services along with other safety and security data from public schools. The School Survey on Crime and Safety gathers data from educational leaders from primary and secondary public schools as mandated by the federal government. The survey questions focused on various school-related safety and security issues that may aid school administrators in adopting effective safety measures, preventing or reducing safety concerns, and identifying gaps or areas of needs that will ensure the safety and well-being of students and staff. Participants completed the survey by answering the questions with yes or no. In this investigation, the term school level refers to the conventional elementary, middle, and high school grades. The data analyzed herein were from the survey administrations in the 2015-2016 and 2017-2018 school years.

The School Survey on Crime and Safety was conducted seven times. The National Center for Education Statistics added a section on school mental health services in the 2015-2016 and 2017-2018 school years. Prior to these years, this survey only addressed one of two or both of the following questions regarding mental health: (a) How many mental health agencies were involved in school's efforts to promote safe, disciplined, and drug-free schools?; and (b) How many paid counselors or mental health

professional were employed at schools? (Chaney, 2015; Izrael, 2006; Ruddy, 2009; Ruddy, 2010; United States Department of Education, National Center for Education Statistics, 2003). Definitions pertaining to the survey's data on school mental health services were added to the School Survey on Crime and Safety by the National Center for Education Statistics in the 2015-2016 school year.

Results

To determine the degree to which differences were present in the frequency of staff training and practices concerning mental health efforts by school level for the 2015-2016 and 2017-2018 school year, Pearson chi-square procedures were conducted. The statistical procedure was viewed as the optimal statistical procedure to use because frequency data were present for school level and for the six dependent variables. All underlying assumptions of the Pearson chi-square procedure were determined to have been met (Slate & Rojas-LeBouef, 2011).

Early Warning Signs for Violent Behavior

With respect to teacher training that were offered for early warning signs for violent behaviors for the 2015-2016 school year, the result approached, but did not reach, the conventional level of statistical significance, $\chi^2(2) = 5.40, p = .07$. As revealed in Table 4.1, less than half of elementary and middle schools offered staff training for early warning signs for violent behavior. In comparison, slightly half of high schools offered this training.

Insert Table 4.1 about here

Regarding the 2017-2018 school year, the result was statistically significant, $\chi^2(2) = 12.81, p = .002$, Cramer's V of .07, a below small effect size (Cohen, 1988). Teacher training was offered at half of all three school levels. High schools had the highest percentage of staff who were offered training for early warning signs for violent behavior. Delineated in Table 4.2 are the descriptive statistics for this analysis.

Insert Table 4.2 about here

Signs of Self-Harm or Suicidal Tendencies

Concerning teacher training offered to recognize signs of self-harm or suicidal tendencies for the 2017-2018 school year, a statistically significant difference was yielded, $\chi^2(2) = 40.74, p < .001$, Cramer's V of .12, a small effect size (Cohen, 1988). Slightly over three-fourths of middle and high schools offered teachers training to recognize signs of self-harm or suicidal tendencies. Elementary schools had the lowest percentage offering this training. Table 4.3 contains the descriptive statistics for this analysis.

Insert Table 4.3 about here

Intervention and Referral Strategies

During the 2015-2016 school year, the result approached, but did not reach, the conventional level of statistical significance, $\chi^2(2) = 5.08, p = .08$. Though not statistically significant, high schools had the highest percentage that offered teachers training in intervention and referral strategies compared to middle and elementary schools. Delineated in Table 4.4 are the descriptive statistics for this analysis.

 Insert Table 4.4 about here

With respect to interventions and referral strategies for the 2017-2018 school year, the result was not statistically significant, $\chi^2(2) = 4.39, p = .11$. As revealed in Table 4.5, slightly over three-fifths of middle and high schools offered teachers training in intervention and referral strategies. Slightly less than three-fifths of elementary school offered this same training to teachers and staff.

 Insert Table 4.5 about here

Student Alcohol and Drug Abuse

Regarding training offered to teachers to recognize the signs of alcohol and drug abuse for the 2015-2016 school year, a statistically significant difference was revealed, $\chi^2(2) = 105.64, p < .001$, Cramer's V of .23, a small effect size (Cohen, 1988). At the elementary school level, slightly over three-fourths of teacher were not offered training to recognize signs of alcohol and drug abuse. In comparison, a little over three-fifths of

middle schools and slightly less than half of high schools did not offer this training to teachers. Table 4.6 contains the descriptive statistics for this analysis.

Insert Table 4.6 about here

Concerning the 2017-2018 school year, a statistically significant difference was yielded, $\chi^2(2) = 91.18, p < .001$, Cramer's V of .19, a small effect size (Cohen, 1988). As delineated in Table 4.7, slightly over two-thirds of elementary schools did not offer teachers training to recognize the signs of students using alcohol and drugs. In comparison nearly three-fifths of middle schools and over two-fifths of high schools did not offer teachers training in this same area.

Insert Table 4.7 about here

Positive Behavioral Intervention

During the 2015-2016 school year, the result was statistically significant, $\chi^2(2) = 84.23, p < .001$, Cramer's V of .21, a small effect size (Cohen, 1988). Revealed in Table 4.8 are the descriptive statistics for teacher trainings and practices that were offered for positive behavioral interventions. Over 85% of elementary and high schools offered training to teachers for positive behavioral interventions compared to only 70% of high schools. Furthermore, high schools had the highest percentages that did not offer training in positive behavior interventions whereas elementary and middle schools had the lowest percentages for not offering this training.

Insert Table 4.8 about here

For the 2017-2018 school year, a statistically significant difference was revealed, $\chi^2(2) = 44.10, p < .001$, Cramer's V of .13, a small effect size (Cohen, 1988). Elementary schools offered nearly 90% of positive behavioral intervention training to teachers compared to less than 10% of middle schools. Slightly over 75% of high schools offered teachers training for positive behavior and interventions. Additionally, high schools had the highest percentages that did not provide positive behavior intervention trainings. Middle schools had the second highest percentage that did not offer this training, followed by elementary schools with the lowest percentage. Table 4.9 contains the descriptive statistics for this analysis.

Insert Table 4.9 about here

Crisis Prevention and Intervention

With respect to crisis prevention and intervention for the 2015-2016 school year, a statistically significant difference was not revealed, $\chi^2(2) = 1.64, p = .44$. All school levels had similar results for teacher training that were offered for crisis prevention and intervention. Table 4.10 contains the descriptive statistics for this analysis.

Insert Table 4.10 about here

During the 2017-2018 school year, the results were not statistically significant, $\chi^2(2) = 0.34, p = .85$. Elementary and high schools had the same percentages that offered teachers training for crisis prevention and intervention. Although close to the other school levels, middle schools had the lowest percentage that offered teachers training for crisis prevention and intervention. Revealed in Table 4.11 are the descriptive statistics for this analysis.

Insert Table 4.11 about here

Discussion

Data regarding efforts limited by staff training and practices by school level were obtained and analyzed from the national SSOCs for the 2015-2016 and 2017-2018 school year. Inferential statistical analyses revealed that staff training offered to recognize early warning signs of violent behaviors for the 2015-2016 school year, was not statistically significant. Elementary schools had the highest percentage that did not offer this training to teachers. For the 2017-2018 school year, the results were statistically significant. Middle schools had the highest percentage for not offering this training followed by elementary schools and then high schools.

Regarding staff training and practices to recognize signs of self-harm and suicidal tendencies for the 2017-2018 school year, the results were statistically significant by

school level. Elementary schools were more likely not to provide training to recognize signs of self-harm and suicidal tendencies than middle or high schools. Over 75% of middle and high schools provided this training to teachers and staff.

Teacher trainings offered for intervention and referral strategies for students displaying signs of mental disorders were not statistically significantly different by school level for both school years. An increase in the percentages of trainings offered to teachers was noted from the 2015-2016 school year to the 2017-2018 school year in all three school levels. Elementary and middle schools increased by 8% compared to high school with an increase of 7%. Moreover, a decrease in the percentages of trainings not offered to teachers declined from the 2015-2016 school year to the 2017-2018 school year in all three school levels. Middle and high schools had the same percentages that did not provide teachers with this training.

Teacher trainings offered to recognize signs of students using alcohol or drugs were not statistically significantly different by school level for the 2015-2016 and 2017-2018 school year. Elementary schools were the least likely to offer this training to teachers. Only half of high schools provided this training. For the 2017-2018 school year, all three school levels had an increase in the percentage of teacher trainings offered to recognize signs of students using alcohol or drugs. Even so, elementary and middle schools continued to offer less than half of this training to teachers.

During the 2015-2016 and 2017-2018 school year, positive behavioral and intervention strategies were statistically significant by school level. In comparison to all of the trainings investigated in this study, elementary schools had the highest percentages that offered this training to teachers. This occurrence could be due to the various

components that are included in the PBIS framework such as classroom management, rules, and policies. Students are taught social structures and school wide systems so that schools can function more effectively and efficiently. Positive Behavior Intervention Strategy was also the least likely training not to be offered at elementary and middle schools in both school years.

Teacher trainings offered for crisis prevention and intervention were not statistically significantly different by school level in the 2015-2016 and 2017-2018 school year. For the 2017-2018 school year, elementary and high schools had similar percentages for offering crisis prevention and intervention training to teachers. Similar percentages were also noted for these same two school levels not offering this training to teachers.

Implications for Policy and Practice

Based on the results of this study, several implications can be made for policy. First, policymakers should require follow-up trainings throughout the year regarding mental health efforts. All states should enact legislation or adopt laws mandating or recommending teacher training and career development in areas such as student psychological health. Additionally, students pursuing a 4-year degree at any college or university should be required to take an introductory course in mental health literacy.

With respect to implications for practice, school districts are encouraged to implement school-wide initiatives that promote mental health awareness. School leaders should ensure that trainings are participatory, foster conversation, and solicit audience input instead of the customary web-based format. Training should also be delivered by an expert in the field of mental health and evidence based. It is recommended for school

leaders and administrators to create open forums where teachers are provided opportunities to collaborate with local mental health professionals to formulate solutions to mitigate the mental health gap. Central office administrators and leaders should also consider a course in mental health literacy at the secondary school level and at the end of Grade 5 for elementary schools.

Recommendations for Future Research

In this nationwide study, staff trainings and practices offered in regard to mental health disorders were examined. As such, a number of recommendations for research can be made. First, in lieu of current societal events such as Covid-19 and social injustice being on the rise, researchers are encouraged to replicate this investigation utilizing more current data as training efforts in mental health are increasing. A second recommendation for future study is for researchers to examine the components behind the Positive Behavior Intervention Strategy training model to determine why almost 90% of teachers are being offered this training. Understanding why this training is offered to teachers at a higher percentage than any other training examined in this article could provide valuable information regarding the implementation of future trainings offered to teachers in the area of mental health. Third, researchers are encouraged to extend this study into specific states, rather than a large national study. Finally, although economic status was not investigated in the article, researchers should also examine the link between mental health and socioeconomic level. Because of inadequate economic, family, and psychological supports, those individuals living in poverty are more prone to suffer from mental illness (Wickrama & Vazsonyi, 2011).

Conclusion

Through inferential statistical analyses of national survey data, statistically significant differences were present for four of the six research questions examined. However, a statistically significant difference was not present for early warning signs of violence for the 2015-2016 school year. Furthermore, during both school years, intervention referral strategies and crisis prevention and intervention did differ by school level. With the exception of high schools in the 2015-2016 school year, positive behavioral intervention strategies had the highest percentage of teachers receiving training across all three school levels for both school years. The majority of trainings analyzed in this study increased across all school levels from the 2015-2016 school year to the 2017-2018 school year.

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Table 4.1

Descriptive Statistics for Frequencies and Percentages of Teacher Training Offered for Early Warning Signs for Violent Behavior for the 2015-2016 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 239) 46.3%	(<i>n</i> = 277) 53.7%
Middle	(<i>n</i> = 351) 48.8%	(<i>n</i> = 368) 51.2%
High	(<i>n</i> = 408) 52.7%	(<i>n</i> = 366) 47.3%

Note. The *n* represents the number of schools.

Table 4.2

Descriptive Statistics for Frequencies and Percentages of Teacher Training Offered for Early Warning Signs for Violent Behavior for the 2017-2018 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 350) 52.2%	(<i>n</i> = 321) 47.8%
Middle	(<i>n</i> = 488) 50.1%	(<i>n</i> = 487) 49.9%
High	(<i>n</i> = 577) 57.9%	(<i>n</i> = 420) 42.1%

Note. The *n* represents the number of schools.

Table 4.3

Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered to Recognize Signs of Self-Harm or Suicidal Tendencies by School Level for the 2017-2018 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 426) 63.5%	(<i>n</i> = 245) 36.5%
Middle	(<i>n</i> = 729) 74.8%	(<i>n</i> = 246) 25.2%
High	(<i>n</i> = 769) 77.1%	(<i>n</i> = 228) 22.9%

Note. The *n* represents the number of schools.

Table 4.4

Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Intervention and Referral Strategies for Students Displaying Signs of Mental Health Disorders by School Level for the 2015-2016 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 266) 51.6%	(<i>n</i> = 250) 48.4%
Middle	(<i>n</i> = 402) 55.9%	(<i>n</i> = 317) 44.1%
High	(<i>n</i> = 448) 57.9%	(<i>n</i> = 326) 42.1%

Note. The *n* represents the number of schools.

Table 4.5

Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Intervention and Referral Strategies for Students Displaying Signs of Mental Health Disorders by School Level for the 2017-2018 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 397) 59.2%	(<i>n</i> = 274) 40.8%
Middle	(<i>n</i> = 617) 63.3%	(<i>n</i> = 358) 36.7%
High	(<i>n</i> = 638) 64.0%	(<i>n</i> = 359) 36.0%

Note. The *n* represents the number of schools.

Table 4.6

Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Recognizing Signs of Students Using/Abusing Alcohol and/or Drugs by School Level for the 2015-2016 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 116) 22.5%	(<i>n</i> = 400) 77.5%
Middle	(<i>n</i> = 273) 38.0%	(<i>n</i> = 446) 62.0%
High	(<i>n</i> = 394) 50.9%	(<i>n</i> = 380) 49.1%

Note. The *n* represents the number of schools.

Table 4.7

Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Recognizing Signs of Students Using/Abusing Alcohol and/or Drugs by School Level for the 2017-2018 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 211) 31.4%	(<i>n</i> = 460) 68.6%
Middle	(<i>n</i> = 415) 42.6%	(<i>n</i> = 560) 57.4%
High	(<i>n</i> = 547) 54.9%	(<i>n</i> = 450) 45.1%

Note. The *n* represents the number of schools.

Table 4.8

Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Positive Behavioral Intervention Strategies by School Level for the 2015-2016 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 452) 87.6%	(<i>n</i> = 64) 12.4%
Middle	(<i>n</i> = 619) 86.1%	(<i>n</i> = 100) 13.9%
High	(<i>n</i> = 542) 70.0%	(<i>n</i> = 232) 30.0%

Note. The *n* represents the number of schools.

Table 4.9

Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Positive Behavioral Intervention Strategies by School Level for the 2017-2018 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 600) 89.4%	(<i>n</i> = 71) 10.6%
Middle	(<i>n</i> = 816) 83.7%	(<i>n</i> = 159) 16.3%
High	(<i>n</i> = 768) 77.0%	(<i>n</i> = 229) 23.0%

Note. The *n* represents the number of schools.

Table 4.10

Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Crisis Prevention and Intervention by School Level for the 2015-2016 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 370) 71.7%	(<i>n</i> = 146) 28.3%
Middle	(<i>n</i> = 538) 74.8%	(<i>n</i> = 181) 25.2%
High	(<i>n</i> = 563) 72.7%	(<i>n</i> = 211) 27.3%

Note. The *n* represents the number of schools.

Table 4.11

Descriptive Statistics for Frequencies and Percentages of Teacher Trainings and Practices Offered for Crisis Prevention and Intervention by School Level for the 2017-2018 School Year

School Level	Yes	No
Elementary	(<i>n</i> = 497) 74.1%	(<i>n</i> = 174) 25.9%
Middle	(<i>n</i> = 720) 73.8%	(<i>n</i> = 255) 26.2%
High	(<i>n</i> = 747) 74.9%	(<i>n</i> = 250) 25.1%

Note. The *n* represents the number of schools.

CHAPTER V

DISCUSSION

The purpose of this journal-ready dissertation was to determine the degree to which school level (i.e., elementary, middle, and high) was related to mental health efforts. In the first journal article, the extent to which school level was related to effort to provide diagnostic assessments for mental health disorders were examined. In the second study, the extent to which school level was related to factors that limit school efforts to provide mental health services to students was ascertained. In the third investigation, the relationship between school level and staff training and practices was examined. In each of the three studies, two years of national archival data were examined. In this chapter, results across the three empirical studies will be summarized. Implications from these three studies for policy and for practice will be provided, along with recommendations for future research. A summary will conclude this chapter.

Summary of Article One Results

In the first article, school effort to provide diagnostic assessments for mental health disorders by school level were examined. Archival data for the 2015-2016 and 2017-2018 school years were analyzed from the School Survey on Crime and Safety. The questions on the School Survey on Crime and Safety regarding diagnostic assessment changed slightly from the 2015-2016 school year to the 2017-2018 school year. As such, the dependent variables in this article were examined for either the 2015-2016 school year or for the 2017-2018 school year, but not for both school years.

Diagnostic assessments at school by school-funded mental health professionals were statistically significantly different by school level for the 2015-2016 school year.

Elementary schools had the highest percentage that did not provide diagnostic assessments to students under the official responsibility of a licensed mental health professional. Nearly 10% fewer middle and high schools did not provide such services nearly three-fourths of elementary schools did not provide diagnostic assessments at school by school-funded mental health professionals. In comparison, slightly over three-fifths of middle schools and high schools did not provide such services.

Regarding diagnostic mental health assessments for mental disorders for the 2017-2018 school year, a statistically significant difference was present. Half of elementary schools did not provide diagnostic mental health assessments for mental disorders. In contrast, over two-fifths of middle schools and less than two-fifths of high schools did not provide such services. Almost half of elementary schools provided diagnostic mental health assessments to evaluate mental health disorders. In contrast, more than half of middle and high schools provided such services.

Concerning diagnostic assessment at school by school-employed mental health professionals for the 2015-2016 school year, a statistically significant difference was present. Almost three-fifths of elementary schools did not provide diagnostic assessments at school by school-employed mental health professionals, compared to more than half of middle schools, and less than half of high schools that did not provide such assessments. With respect to at school by school-employed or contracted mental health professionals for the 2017-2018 school year, a statistically significant difference was not present. Elementary schools provided the fewest diagnostic mental health assessments at school by school-employed or contracted mental health professional, followed by middle schools and then high schools. Over 85% of all school levels

provided this service. Regarding diagnostic assessment outside of school by school-funded mental health professionals for the 2015-2016 school year, a statistically significant difference was present. Three-fifth of elementary schools did not provide diagnostic assessments outside of school by a school-funded mental health professional compared to a little over half of middle schools and less than half of middle schools. Concerning outside of school by school-employed or contracted mental health professionals, a statistically significantly difference was not present for the 2017-2018 school year. Although nearly one-third of all school levels did not provide mental health assessments outside of school by school-employed or contracted mental health personnel, elementary schools were more likely not to provide these services followed by high schools and then middle schools. Table 5.1 contains a summary of these results.

Table 5.1

Descriptive Statistics for Summary of Efforts to Provide Assessments for Mental Health Disorders for the 2015-2016 and 2017-2018 School Years

Diagnostic Assessments	Outcome	Effect Size
At school/School-funded		
2015-2016	Significant	Small
Mental Health Assessment for Disorders		
2017-2018	Significant	Small
At School/School-employed Professionals		
2015-2016	Significant	Small
At School/School-employed or Contracted Professionals		
2017-2018	Not Significant	NA
Outside School/School-funded		
2015-2016	Significant	Small
Outside of School/Employed or Contracted Professionals		
2017-2018	Significant	Small

Summary of Article Two Results

In the second article, the extent to which school level was related to factors that limit school efforts to provide mental health services to students was addressed. Archival data for the 2015-2016 and 2017-2018 school years were analyzed from the School Survey on Crime and Safety. In regard to inadequate access to mental health professionals, statistically significant differences were present for both school years. Elementary schools were more likely to be limited in a major way by a lack of access to mental health professionals than were middle and high schools. Moreover, high schools

had the highest percentages for not being limited by inadequate access to mental health professionals in both school years.

Concerning lack of funding for both school years, statistically significant differences were not present. Elementary schools had the highest percentage for being limited in a major way for both school years followed by middle schools and then high schools. High schools had the highest percentage for not being limited by lack of funding. The number of schools limited in a major way increased from the 2015-2016 school year to the 2017-2018 school year across all school levels.

Regarding potential legal issues for both school years, statistically significant differences were not present. However, during the 2015-2016 school year, elementary and high schools had nearly the same percentages for not being limited by potential legal issues. During this same school year, middle and high school had the same percentages for being limited in a major way. For the 2017-2018 school year, efforts limited in a major way were similar across all three school levels.

Efforts limited by a lack of parental support were analyzed for one school year only and revealed the presence of a statistically significant difference. Half of middle and high schools were limited in a minor way by lack of parental support compared to slightly over two-fifths of elementary schools. Elementary schools had the highest percentages for efforts limited in a major way by a lack of parental support. Table 5.2 contains a summary of these results.

Table 5.2

Descriptive Statistics for Summary Factors That Limit School Efforts to Provide Mental Health Services to Students by School Level for the 2015-2016 and 2017-2018 School Years

Limited Efforts by School Year	Outcome	Effect Size
Lack of Access to Mental Health Professionals		
2015-2016	Significant	Below Small
2017-2018	Significant	Below Small
Inadequate Funding		
2015-2016	Not Significant	NA
2017-2018	Not Significant	NA
Potential Legal Issues		
2015-2016	Not Significant	NA
2017-2018	Not Significant	NA
Lack of Parental Support		
2015-2016	Significant	Below Small

For the 2017-2018 school year, concerns about reactions from parent resulted in a statistically significantly difference. Data for this variable were available for one school year only. Almost 30% of elementary schools and 30% of high schools were limited in a minor way by concerns about reactions from parents compared to 35% of middle schools. Middle and high schools had the same percentages for mental health efforts limited in a

major way due to concerns about reactions from parents, whereas elementary schools had the highest percentage that were limited in a major way.

With respect to efforts limited by a lack of community support, a statistically significant difference was present in both school years. Mental health efforts limited in a major way slightly declined from the 2015-2016 school year to the 2017-2018 school year for elementary and middle schools compared to high schools that had a slight increase in this area. For the 2017-2018 school year, all three school levels increased in the percentages of mental health efforts that were not limited by a lack of community support.

Regarding a reluctance to label students, a statistically significant difference was present for one school year, but not both. Elementary and middle schools had nearly the same percentages for mental health efforts limited in a major way for the 2017-2018 school year. Furthermore, all three school levels increased in efforts that were not limited by a reluctance to label students. From the 2015-2016 school year to the 2017-2018 school year, elementary schools slightly declined in efforts limited in a major way; however, the opposite occurred for middle and high schools as an increase in efforts limited in a major way was noted.

Concerning payment policies, a statistically significant difference was present for the 2017-2018 school year, but not the 2015-2016 school year. During the 2015-2016 school year, payment policies did not limit three-fifths of elementary and high schools from providing mental health services to students. For the 2017-2018 school year, high schools had the highest percentage of efforts that did not limit mental health services to students compared to middle and elementary schools. Additionally, middle and high

schools increased in efforts limited in a major way by payment policies compared to elementary schools that remained the same. Table 5.3 contains a summary of these results.

Table 5.3

Descriptive Statistics for Summary Factors That Limit School Efforts to Provide Mental Health Services to Students by School Level for the 2015-2016 and 2017-2018 School Years

Limited Efforts by School Year	Outcome	Effect Size
Reactions from Parents		
2017-2018	Significant	Below Small
Lack of Community Support		
2015-2016	Significant	Below Small
2017-2018	Significant	Below Small
Reluctance to Label Students		
2015-2016	Significant	Below Small
2017-2018	Not Significant	NA
Payment Policies		
2015-2016	Not Significant	NA
2017-2018	Significant	Below Small

Summary of Article Three

In the third article, the relationship between staff training and practices concerning mental health efforts by school level was investigated. For the 2017-2018

school year only, a statistically significant difference was present for recognizing early warning signs of violence. In regard to recognizing signs for self-harm and suicidal tendencies, a statistically significant difference was present for the 2017-2018 school year. Middle school and high schools offered 75% of teachers this training compared to 64% in elementary schools. Additionally, data were only available for this training for one school year. Concerning intervention and referral strategies, a statistically significant difference was not present for both school years. However, over 70% of schools across all school levels for both school years offered this training to teachers. Table 5.4 contains a summary of these results.

Table 5.4

Descriptive Statistics for Summary of Staff Training and Practices by School Level for the 2015-2016 and 2017-2018 School Years

Staff Training and Practices	Outcome	Effect Size
Early Warning Signs of Violent Behavior		
2015-2016	Not Significant	NA
2017-2018	Significant	Below Small
Self-Harm/Suicidal Tendencies		
2017-2018	Significant	Small
Intervention/Referral Strategies		
2015-2016	Not Significant	NA
2017-2018	Not Significant	NA

Regarding recognizing signs of alcohol and drug abuse, statistically significant differences were present for both school years. In comparison to all other trainings, recognizing signs of alcohol and drug abuse as the most least likely to be provided to teachers. Slightly over a third of elementary schools and slightly over two-fifths of middle schools provided this training to teachers compared to a little over half of high schools.

Concerning positive behavioral intervention strategies, a statistically significant difference was present in both school years. This training had the highest percentages of teachers receiving training across all three school levels. Although the majority of trainings offered to teachers in this study increased across all school levels from the 2015-2016 school year to the 2017-2018 school year, middle schools had a slight decline of three percentage points in its PBIS trainings for teachers from the previous year. With the exception of high schools, elementary and middle schools offered over 83% of teachers this training.

With respect to crisis prevention and intervention strategies, statistically significant differences were not present in either school year. Crisis prevention and intervention was the second highest training that teachers received, at 75% in the 2017-2018 school year. These percentages were similar across both school years and for all school levels. When comparing all trainings across school levels and school years, with the exception of positive behavioral intervention strategies and crisis prevention and interventions, teachers were more likely to be offered trainings in high schools than in elementary or middle schools. Delineated in Tables 5.4 and 5.5 are summaries of these results.

Table 5.5

Descriptive Statistics for Summary of Staff Training and Practices by School Level for the 2015-2016 and 2017-2018 School Years

Staff Training and Practices	Outcome	Effect Size
Alcohol and Drug Abuse		
2015-2016	Significant	Small
2017-2018	Significant	Small
Positive Behavioral Intervention		
2015-2016	Significant	Small
2017-2018	Significant	Small
Crisis Prevention/Intervention		
2015-2016	Not Significant	NA
2017-2018	Not Significant	NA

Connections to Literature

According to Bains and Diallo (2016) and Von der Embse et al. (2017), the K-12 educational system is one of the primary access points for mental health services. Yet, school personnel are failing to identify, assess, and provide treatments and services to those adolescents who need it the most. Clearly established in this journal-ready dissertation is that mental health services are available at all three school levels. However, half of elementary schools did not provide diagnostic mental health assessments for mental disorders. In contrast, over two-fifths of middle schools and less than two-fifths of high schools did not provide such services. Diagnostic assessments

were utilized at all three school levels; however, a substantial percentage of students did not receive any services.

In the second article regarding factors that limit school efforts to provide mental health support, clearly established in this study was evidence that elementary schools had the highest percentage of effort limited in a major way across all school years and school levels. Inadequate access to professionals and inadequate funding were the top two factors that limited school efforts to provide mental health services. These data are aligned with findings reported by Reinke et al. (2011) concerning reasons why students with mental health needs were not being met. In regard to barriers, the top three factors that limited supporting students with mental health concerns were: (a) an inadequate number of school mental health practitioners, (b) a lack of preparation and training to meet the mental health needs of children, and (c) insufficient funding for school-based mental health. The results in this study are commensurate with the research literature that more mental health professionals and adequate funding are necessary if schools are expected to mitigate the learning and academic gap that will lead to high student achievement.

Finally, clearly established in the third article concerning staff trainings in this nationwide study were findings about various training provided to staff regarding mental health at the elementary, middle, and high school level. Although almost 50% of all school levels during both school years provided teacher trainings, elementary schools had the lowest percentages for providing training to teachers in all areas, with the exception of Positive Behavioral and Intervention strategies, which had in over 85% of elementary and middle schools offering this training to staff. This occurrence could be due to the

fact that Positive Behavior and Intervention Strategies offer real-world applications and practical strategies that may be applied easily and effectively in the classroom environment. Shelemy et al. (2019) conducted a study in which secondary teachers indicated that they wanted trainings that included real-world application, strategies that were practical, and customizable resources that could easily be adapted into lessons. Furthermore, Moon et al. (2017) analyzed educators' perspective on the current state of mental health in schools and noted that at least 50% of participants wanted additional training in the areas of: (a) mental health disorders, (b) behavioral management techniques, (c) social skill training/management, and (d) positive behavioral supports training. In this study, during the 2017-2018 school year, training to recognize mental health disorders increased between 7-9% from the previous year. Moreover, trainings on positive behavior and intervention strategies and crisis and prevention strategies continued to be the top trainings offered across school level.

Implications for Policy and for Practice

Based on the results of this study, several implications can be made for policy. First, policymakers should implement awareness campaigns each school year regarding mental health awareness and assessments. knowledge of available treatment, and how to seek assistance. Second, lawmakers are encouraged to reform how licensed professional counselors are employed on and off campuses. Moreover, all school counselors should be required to be licensed after a certain number of years in education. By restructuring how licensed counselors are used on campus, more students may have more access to diagnostic assessments. Law makers are encouraged to consider innovative modes of mental health delivery and assessment such as Telemedicine. This mode of service may

be a cost-effective alternative to meeting the mental health needs of K-12 students, especially students whose families are in poverty. Third, federally funded mental health care agencies/organizations are encouraged to develop partnerships and support local public school districts to meet the mental health needs of students who have been identified with mental health concerns. Fourth, policymakers should require follow-up trainings throughout the year regarding mental health efforts. All states should enact legislation or adopt laws mandating or recommending teacher training and career development in areas such as student psychological health.

Regarding implications for practice, students pursuing a 4-year degree should be required to take an introductory course in mental health literacy. Similarly, school boards are recommended to add a mental health literacy course at the secondary school level and at the end of Grade 5. Second, postsecondary settings are encouraged to add a specialization in mental health to their non-licensed counseling degree plan. In turn, school districts could then employ these specialized non-licensed counselors at the school level to work specifically with students who may be at risk of or are experiencing a mental health crisis. Furthermore, the non-licensed mental health counselor would work in conjunction with licensed mental health professionals within and outside the school community to provide students the service they need. Their responsibilities may include facilitating the response to intervention process for students who may be at risk for mental health concerns. These professionals would ensure that the process is implemented with fidelity.

A third implication for practice involves school districts creating and developing a universal screening system to identify students who may be at risk for developing mental

health concerns. However, instead of a campus wide initiative, school districts are encouraged to pilot the system with a small group of students instead of the entire school body. This process allows administrators the opportunity to determine areas that need adjustment or realignment, and it would provide school leaders valuable data and feedback for implementing an effective school wide approach. To assist in the development of a universal mental health screening, school leaders are recommended to refer to the 2019 Substance Abuse and Mental Health Services Administration Manual titled Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools (Substance Abuse and Mental Health Services, 2019). This document provides valuable guidance to school districts on how to design incrementally an effective screening assessment.

A fourth recommendation for practice is for school districts to create mental health intervention teams. Cy-Fair Independent School District provides an excellent model for a mental health intervention team. This single team serves the entire district and is comprised of “four Licensed Professional Counselors, two Licensed Psychologists, and two Mental Health Police Officers (Cypress Fairbanks Independent School District, 2022, p. 1).” The purpose of the mental health intervention team is to develop a more proactive, targeted, and safe approach to dealing with mental health issues in the district. Moreover, this team of professionals could also provide staff the trainings they need to recognize and identify students who may need mental health support.

Concerning practices for staff trainings, school leaders are encouraged to implement teacher initiatives at each school level as teachers are a primary support for

mental health issues. Parent partnerships/classes should also be offered at the district and campus level to engage and educate parents in community mental health activities.

School leaders should ensure trainings are participatory, foster conversation, and solicit audience input instead of the customary web-based format. Training should also be delivered by an expert in the field of mental health and evidence based. Also recommended is for school leaders and administrators to create open forums where teachers are provided opportunities to collaborate with local mental health professionals to formulate solutions to mitigate the mental health gap.

Recommendation for Future Research

The results of the three articles in this journal-ready dissertation add to the research literature that is available for the national SSOC on mental health efforts. Several recommendations for future research can be generated from the results of the three articles discussed previously. First, researchers should replicate this study using current data and to determine whether trends might be present in the factors that were analyzed in the investigation. Second, researchers are also encouraged to utilize the School Survey on Crime and Safety to examine whether treatment differences might be present by school level. A third recommendation is to conduct a study on the differences between supports provided to schools by educational diagnosticians compared to a licensed mental health professional to meet the mental health needs of students. Currently, in K-12 education, educational diagnosticians are responsible for assessing students who may have disabilities; however, limitations exist regarding mental health assessments.

A fourth recommendation is to conduct a qualitative study on the perspective of the contracted mental health professionals regarding the challenges, barriers, and benefits of working in K-12 education and their impact on student achievement. A fifth recommendation for future researchers would be to take a more in-depth analysis into tele health and how it may be used in the educational setting to meet the needs of K-12 students who may experience a mental health crisis. Another recommendation would be for researchers to examine the effectiveness of teacher trainings regarding mental health. A seventh recommendation for further study entails a qualitative study on how personal biases and cultural differences may affect recognizing students with mental health concerns. Lastly, researchers of the SSOCS are encouraged to develop a more detailed questionnaire that moves beyond a “yes or no” response. Furthermore, terms such as effort limited in a “major way or minor way” should be clearly defined as this may alleviate any ambiguity in participants responses.

Conclusion

The purpose of this journal-ready dissertation was to determine the effect of school level on mental health efforts. Elementary schools had the highest percentage for not providing diagnostic assessments for 5 out of 6 independent variables analyzed. Conversely, high schools had the highest percentage for providing these services across school level and school year. The top three factors that limited mental health efforts were: (a) inadequate access to mental health professionals; (b) inadequate funding; and (c) potential legal issues. A decline occurred from the 2015-2016 school year to the 2017-2018 school year in percentages at all school levels that were not limited in any way by these same mental health efforts. Regarding differences in staff training and

practices, trainings such as Positive Behavioral and Intervention Strategies and Crisis Prevention and Intervention were the top two trainings offered to teachers across all three school levels. Elementary schools were the most likely not to provide teacher trainings. Trainings continued to increase from the 2015-2016 school year to the 2017-2018 school year.

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[disorders-among-youth](https://youth.gov/youth-topics/prevalence-mental-health-disorders-among-youth)

APPENDIX



Date: Oct 26, 2021 8:11:22 PM CDT

TO: Chastity Harper Simon John Slate

FROM: SHSU IRB

PROJECT TITLE: Differences in School Discipline Efforts and Mental Health Services by School Level: A National Analysis

PROTOCOL #: IRB-2021-329

SUBMISSION TYPE: Initial

ACTION: Exempt

DECISION DATE: October 26, 2021

EXEMPT REVIEW CATEGORY: Category 4. Secondary research for which consent is not required: Secondary research uses of identifiable private information or identifiable biospecimens, if at least one of the following criteria is met:

- (i) The identifiable private information or identifiable biospecimens are publicly available;
- (ii) Information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects;
- (iii) The research involves only information collection and analysis involving the investigator's use of identifiable health information when that use is regulated under 45 CFR parts 160 and 164, subparts A and E, for the purposes of "health care operations" or "research" as those terms are defined at 45 CFR 164.501 or for "public health activities and purposes" as described under 45 CFR 164.512(b); or
- (iv) The research is conducted by, or on behalf of, a Federal department or agency using government-generated or government-collected information obtained for nonresearch activities, if the research generates identifiable private information that is or will be maintained on information technology that is subject to and in compliance with section 208(b) of the E-Government Act of 2002, 44 U.S.C. 3501 note, if all of the identifiable private information collected, used, or generated as part of the activity will be maintained in systems of records subject to the Privacy Act of 1974, 5 U.S.C. 552a, and, if applicable, the information used in the research was collected subject to the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 et seq.

OPPORTUNITY TO PROVIDE FEEDBACK: To access the survey, click [here](#). It only takes 10 minutes of your time and is voluntary. The results will be used internally to make improvements to the IRB application and/or process. Thank you for your time.

Greetings,

Thank you for your submission of Initial Review materials for this project. The Sam Houston State University (SHSU) IRB has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations.

We will retain a copy of this correspondence within our records.

*** What should investigators do when considering changes to an exempt study that could make it nonexempt?**

It is the PI's responsibility to consult with the IRB whenever questions arise about whether planned changes to an exempt study might make that study nonexempt human subjects research.

In this case, please make available sufficient information to the IRB so it can make a correct determination.

If you have any questions, please contact the IRB Office at 936-294-4875 or irb@shsu.edu. Please include your project title and protocol number in all correspondence with this committee.

Sincerely,

Chase Young, Ph.D.

Chair, IRB

Hannah R. Gerber, Ph.D.

Co-Chair, IRB

VITA

Chastity Simon

EDUCATIONAL HISTORY

Doctorate of Education – Educational Leadership, May 2022
Sam Houston State University, Huntsville, TX Dissertation:
 Differences in School Discipline Efforts and Mental Health Services by School Level: A
 National Analysis

Master of Education, Educational Leadership
University of Saint Thomas, Houston, TX

Bachelor of Arts
University of Louisiana at Monroe, Monroe, LA

PROFESSIONAL EXPERIENCE

Assistant Principal, Klein ISD, Oct. 2019-Present
 Assistant Principal, Spring ISD, August 2013-Oct. 2019
 English as a Second Language Coordinator- Spring ISD, Aug. 2011-July .2013
 Teacher – English Language Arts, Spring ISD, August 2004-July 2011

RECOGNITIONS

Recipient of the Governor’s Educators Excellence Grant
 Teacher of the Year, Clark Elementary, Spring ISD, 2009-2010
 Selected to participate on the 2013-2014 Teacher Leadership Institute
 Klein Coalition Member, Klein ISD Jan 2019-Current

SCHOLARLY RESEARCH ACTIVITY/PUBLICATIONS

Simon, C. H., & Slate, J. R. (2019). Differences in principal experience at low-
 performing and high-performing elementary schools: A national analysis.
*Exemplars of Conducting Archival Data Analyses: A Collection of K-12 and
 Higher Education Studies.*

STATE/NATIONAL PRESENTATIONS

Simon, C. H. (2019, September). *Differences in principal experience at low-performing
 and high-performing elementary schools: A national analysis.* Paper presented at
 the annual conference of Texas Council of Professors of Educational
 Administration (TCPEA), Dallas, TX