TEACHERS’ PERSPECTIVES ON EDUCATOR MENTAL HEALTH

COMPETENCIES: A CASE STUDY

A dissertation presented to
The Faculty of the College of Education
Florida Gulf Coast University

In partial fulfillment of the requirement for the degree of
Doctor of Education

By
DIANE KRATT
2016
APPROVAL SHEET

This dissertation is submitted in partial fulfillment of the requirements for the degree of Doctor of Education

____________________________
Diane Kratt

Approved:

____________________________
Tunde Szecsi, Ph.D.
Committee Chair

____________________________
Linda Serro, Ph.D.

____________________________
Carolynne Gischel, Ed.D.

____________________________
Jackie Greene, Ed.D.

Florida Gulf Coast University
Fort Myers, FL

The final copy of this thesis [dissertation] has been examined by the signatories, and we find that both the content and the form meet acceptable presentation standards of scholarly work in the above mentioned discipline.
Acknowledgements

I would like to thank Dr. Tunde Szecsi and my committee members for their mentoring throughout the dissertation process. I also appreciate Florida Gulf Coast University’s College of Education for the opportunity to be a part of its faculty and for its Ed.D. program. Being a part of cohort 3 was terrific and I love the friends I have made. Most of all, I am very thankful for my family and friends who have supported and encouraged me along the way. So many people have helped me reach this pinnacle point in my academic career and I feel grateful for all of them.
Abstract

Given the prevalence and seriousness of children’s mental health disorders, teachers have expanded their role to include identifying students with mental health needs and delivering mental health interventions in the classroom. However, teachers receive little, if any, mental health training. The purpose of this study was to examine teachers’ perspectives regarding the content and implementation of the educator mental health competency framework proposed by Weston, Anderson-Butcher, and Burke (2008). The participants in the case study included 10 general education teachers from three public elementary schools in Southwest Florida. The data were collected through an online questionnaire, focus group interviews, and an individual interview. This study examined the following questions: (1) how the competencies could guide and inform their practice; (2) how the teachers would react if the competencies were adopted; and (3) what suggestions they had for improving the competencies. The data were analyzed using a reiterative process of reading, coding, and reflecting upon emerging themes. The analysis of teachers’ responses indicated the participating teachers needed more knowledge on mental health and larger systems of support to increase their classroom effectiveness. The participants also called attention to the inclusion of personal well-being as one of the competencies. Overall, the teachers supported the adoption of the competencies but had reservations regarding the necessary training and implementation process. Although the participants did not feel knowledgeable enough to provide direct suggestions on revisions to the competencies, they did offer suggestions indirectly. The findings of this study support the use of the mental health curriculum framework in the development of teacher mental health training. By doing so, teachers would be better prepared to address their students’ mental health needs. Several implications for practice are proposed including the addition of mental health curriculum in
teacher preparation programs and the necessity for school administrators to create a school culture and infrastructure to effectively support school mental health.

*Keywords:* school mental health, educator competencies, teacher preparation, professional development, in-service training, expanded school mental health, social emotional development
# Table of Contents

List of Tables ................................................................................................................................................. 8

Chapter 1: Introduction of the Study ................................................................................................................ 9
   Background ...................................................................................................................................................... 9
   Statement of Problem .................................................................................................................................. 11
   Research Questions ..................................................................................................................................... 12
   Definition of Terms ..................................................................................................................................... 12
   Significance of the Study ............................................................................................................................... 13

Chapter 2: Literature Review ........................................................................................................................... 16
   The State of Child and Adolescent Mental Health in the United States ...................................................... 16
   The Impact of Mental Health in the Schools ................................................................................................. 17
   The Role of the Teachers in Social and Emotional Student Development ................................................. 21
   Teachers’ Perspectives on Student Mental Health Needs .............................................................................. 30
   Teachers’ Competency in Mental Health ....................................................................................................... 31

Chapter 3: Research Method ............................................................................................................................ 37
   Introduction ..................................................................................................................................................... 37
   Setting and Participants ................................................................................................................................. 37
   Research Questions .................................................................................................................................... 44
   Qualitative Research Design ....................................................................................................................... 44
   Pilot Test ....................................................................................................................................................... 45
   Data Collection ........................................................................................................................................... 48
   Data Analysis ............................................................................................................................................... 50
## List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enrollment Data</td>
<td>39</td>
</tr>
<tr>
<td>2. Participants’ Background in Mental Health</td>
<td>42</td>
</tr>
<tr>
<td>3. Participants’ Opinions</td>
<td>42</td>
</tr>
<tr>
<td>4. Participants’ Code and Description</td>
<td>43</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION OF THE STUDY

Background

The seriousness of untreated mental health disorders has recently been illustrated in the media by various violent attacks and celebrity deaths. This attention has caused people in communities and schools to look at mental health with a different lens. Although the media gives visibility to these tragedies, the reality is that the United States children’s mental health crisis is largely invisible and silent. It has become clear that the social functioning and emotional health of today’s students are much different than they were in previous generations (Burke & Stephan, 2008). For example, approximately 20% of children and adolescents experience a mental, emotional, or behavioral disorder each year (Adelman & Taylor, 2010). That percentage equates to roughly 10 million K-12 students enrolled in the public schools nationwide (National Center for Education Statistics, 2014). Of those inflicted, only about half of them will receive treatment in a given year (Green et al., 2013).

The state of our children’s mental health greatly impacts schools, both behaviorally and academically. Students with mental health related disorders cannot maximize their potential (Rossen & Cowan, 2014). For example, a significant number of studies have shown that emotional and behavioral challenges interfere with school success (Adelman & Taylor, 2010; O’Connell, Boat, & Warner, 2009; Paternite & Johnson, 2005; Waxman, Weist, & Benson, 1999). Therefore, addressing mental health issues would positively impact the teaching learning cycle and student achievement (Weston et al., 2008). Moreover, schools, as ground zero for the effects of mental health problems, are critical players in providing services (Rossen & Cowan, 2014). Because of the challenges associated with community-based services and the amount of
time that youth spend in school, schools in the United States have been referred to as the “defacto” mental health system for children and adolescents (Burns, Costello, Angold, Tweed, Stangl, & Farmer, 1995). However, schools are usually under-resourced with mental health personnel; therefore, they cannot effectively promote mental health wellness or address emotional and behavioral challenges in students (Weist et al., 2014). 

School mental health (SMH) is broadly defined as any psychosocial intervention or service designed to support learning for students with social, emotional, or behavioral challenges (Franklin, Kim, Ryan, Kelly, & Montgomery, 2012). Although some students receive specific school-based mental health services, mental health can be addressed for all students by offering a full range of programs, strategies, and services from mental health promotion to mental health intervention in a model known as expanded school mental health (ESMH) (Weist & Paternite, 2006). This idea expands the concept of SMH by connecting schools with community services and including all school personnel, such as administrators and teachers (Weist & Christodulu, 2000). Although teachers have always played a critical role in students’ overall academic outcomes, teachers also are instrumental in addressing students’ social-emotional functioning (Johnson, Eva, Johnson & Walker, 2011; Phillippo & Stone, 2013). Disregarding research evidence about the teacher’s role in student social and emotional development, teacher education programs focus on teaching curriculum and instruction with little emphasis on the social-emotional needs of students (Phillippo & Kelly, 2014). This common practice has contributed to teachers feeling unprepared to handle the mental health concerns of their students upon entering the classroom (Hoagwood et al., 2007; Koller & Bertel, 2006; Reinke, Stormont, Puri, &Goel, 2011). When documenting the relevant mental health training in their university preparatory training, both groups of beginning and experienced teachers recognized the importance of
attention to mental health. However, neither group reported adequate training in the implementation of mental health services (Koller, Osterlind, Paris, & Weston, 2004). This study showed that teachers seemed willing to provide mental health interventions, but professional development in mental health to acquire the necessary knowledge and skills for effective implementation was needed.

Statement of Problem

Developing effective and relevant teacher training in mental health is a recent challenge in ESMH. To assess and understand current mental health training, researchers examined educational policies and teaching competencies throughout the United States looking for evidence of mental health curriculum. They found an absence of a comprehensive framework of mental health competencies for teachers in all states. Weston and colleagues (2008) then developed a curriculum framework which has the potential to serve both pre- and in-service teachers. According to Weston and colleagues (2008), these competencies would supplement existing competencies or standards for educators rather than replace them. Along with appropriate teacher dispositions, the proposed framework includes:

1. key policies and laws
2. provision of learning supports
3. collection and use of data
4. communication and building relationships
5. engagement in multiple systems
6. a focus on personal and professional growth and well-being

This framework needs to be field tested to examine teachers’ perspectives on the proposed competencies. Teacher perspectives on the competencies are important so that
Researchers can assess the need for the proposed competencies and to test their relevance. Before the development of teacher training that addresses these competencies, teachers should provide their perspectives and give voice to their opinions in regard to them (Weston et al., 2008).

**Research Questions**

The study aims to examine three questions:

1. What are the participants’ perceptions regarding how mental health competencies can guide and inform their classroom practice?
2. How would the participants react if these competencies were adopted by the state?
3. In what ways would the participants amend, add, or change the proposed mental health competencies?

**Definition of Terms**

Competencies. The knowledge and skills needed by teachers to demonstrate competence in a given area.

Curriculum Framework. A set of learning outcomes that defines the content to be learned.

Crisis Intervention Teams (CIT). A training program to help police officers react appropriately to situations involving mental illness or developmental delays.

De-escalation. To decrease the intensity of a situation that has the potential to result in a crisis.

Emotional Disturbance. Defined by the Individuals with Disabilities Education Act (IDEA) as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance: (a) An inability to learn that cannot be explained by intellectual, sensory, or health factors. (b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. (c) Inappropriate types of behavior or feelings under normal circumstances. (d) A general pervasive mood of
unhappiness or depression. (e) A tendency to develop physical symptoms or fears associated with personal or school problems (Individuals with Disabilities Education Act, 2004).

Expanded school mental health (ESMH). A model of school mental health which goes beyond the typical mental health services offered in schools by their counselors, psychologists, and social workers by linking schools with community services and including all school personnel (Weist & Christodulu, 2000).

Individuals with Disabilities Education Improvement Act (IDEA). U.S. legislation that ensures students with a disability are provided free appropriate public education that is tailored to their individual needs.

Mental health. A person’s condition regarding his/her psychological and emotional well-being. Mental health is not a fixed condition but exists on a continuum.

Multi-tiered System of Support (MTSS). An umbrella framework for integrating academic and behavior instruction and interventions to students in varying intensities (tiers) based upon need.

School mental health (SMH). Any psychosocial interventions or services designed as learning supports for students with social, emotional, learning challenges (Franklin et al., 2012).

Title I school. A school with a large concentration of low-income students that receives supplemental funds to assist in meeting students' educational goals.

Well-being. A person’s condition of happiness, satisfaction, and contentedness.

**Significance of the Study**

Teachers have a major influence on the development of children, including their social and emotional development. Therefore, they also play a critical role in ESMH. Although teachers reported mental health knowledge and skills to be important when working with children, they also acknowledged their lack of training in that area (Koller et al., 2004; Koller & Bertel, 2006;
Before creating effective mental health teacher training, researchers developed a set of educator competencies (Weston et al., 2008) to use as the curriculum framework for such training. These proposed mental health competencies are the only ones in existence (Ball et al., 2016); however, teachers’ perspectives regarding the content and implementation of them have not been examined. Therefore, the findings of this study may be informative for teacher educators as they develop or redesign teacher education programs to meet teachers’ needs for mental health teacher training. In addition, this study is the first research study which aims to examine teachers’ perspectives and ideas in regard to the proposed educator mental health competencies. The findings might contribute to the new knowledge base for researchers and educational experts who develop and refine a framework and competencies in mental health services for teachers. The findings from this study may influence the use of these competencies, along with any revisions to the framework.

Summary

Children’s mental health is a serious problem in schools across the United States. Mental health challenges often become barriers to learning as well as contribute to personal and social problems. Although school personnel include some mental health professionals, student mental health needs still go unmet. To address those unmet needs, teachers are expected to identify students who need professional assistance and deliver mental health interventions in their classrooms. They are willing to play this critical role; however, they lack the knowledge and skills to do so. Moreover, teachers report receiving little to no training in the area of mental health and feel the training would be beneficial to their practice. Researchers developed a comprehensive set of mental health competencies around which curricula for teacher training could be developed and tested. This study explores the teachers’ perspectives of the
competencies in the framework to determine if the developed competencies match teacher expectations. An examination of the related literature will provide the reader with a better understanding of the need for school mental health and a wider perspective of the teacher’s role.
CHAPTER II
LITERATURE REVIEW

This chapter offers a synthesis of current literature as it is related to this study. The literature review is divided into five sections. The first section examines the state of child and adolescent mental health in the United States. The next section reviews the impact of mental health in schools followed by the third section; the role of the teacher in social and emotional student development. The fourth section examines teacher perspectives on student mental health needs, and the chapter concludes with teachers’ competency in mental health.

The State of Child and Adolescent Mental Health in the United States

In regard to mental health, the United States of America’s children and youth are in crisis. Additionally, both the incidence and prevalence of many mental health issues which affect school-age children are increasing (Waller, Bresson, & Waller, 2006). It was reported that between 14-20% of children and adolescents experience a mental, emotional, or behavioral disorder each year (Adelman & Taylor, 2010; National Research Council and Institute of Medicine, 2009; World Health Organization, 2003). However, these percentages did not include students who are undiagnosed but still struggling with a mental health condition. Additionally, the National Institute of Mental Health (2005) reported 50% of all cases of mental health disorders begin by age 14 and 75% by age 24. Furthermore, the long-term consequences of these lifetime cases include some of the most intractable problems like unemployment, incarceration, substance abuse, and poor health (Institute of Medicine, 2006; World Health Organization, 2003). Although mental health disorders have been widely documented, the mental health needs of children and adolescents go largely unmet. For example, for youth ages 8-15 with a diagnosed mental health condition, only about half of them received treatment during the year (Green et al.,
Moreover, due to a variety of factors, the average delay between onset of symptoms and intervention is 8-10 years which further compounds the problems (National Institute of Mental Health, 2005). In addition, mental health disorders are complex, and so are the risk factors associated with developing one. Even for mental health disorders that have a strong genetic component, environmental factors, such as child abuse and poverty, still play a role (Dikel, 2014). Since millions of children and adolescents in the United States experience a mental, emotional or behavioral disorder each year (National Center for Education Statistics, 2014), the impact on student school success is significant (Adelman & Taylor, 2010).

The Impact of Mental Health in Schools

The emotional health of today’s students is much different from previous generations (Burke & Stephan, 2008). Rosen and Cowan (2014) reported that every school has students who are struggling with mental health disorders. The authors further explained that sometimes the problems are temporary and due to an immediate situation in students’ lives whereas, other times, there may be chronic stressors and even clinical mental illnesses with which students are coping on a daily basis. Moreover, students struggling with mental health disorders are unable to thrive academically (Rosen & Cowan, 2014). Studies have reported a high prevalence of emotional and behavioral challenges that interfere with school success (Adelman & Taylor, 2010; O’Connell et al., 2009; Paternite & Johnson, 2005; Waxman et al., 1999; Weist & Evans, 2005). For example, in one study, teachers reported that students’ emotional and behavioral challenges were the biggest obstacles to student achievement and to teachers’ ability to teach (Johnson & Duffet, 2003). Therefore, addressing all needs of the student who has a mental health
disorder would positively impact the teaching learning cycle and student achievement (Weston et al., 2008).

The United States is not alone in the need to address mental health concerns of their students. There is an alarming increase in prevalence rates and an increased need to provide mental health support in Canadian schools (Climie, 2015). Adolescent mental health contributes to the way they view school, and mental health has significant implications on students and schools (Meldrum, Venn, & Kutcher, 2009; Volk, Craig, Boyce, & King, 2006). Specifically, mental health disorders represented the most common disabling condition affecting young people (Meldrum et al., 2009). In addition, researchers in Australia identified 14% of students as having mental health problems (Sawyer et al., 2001). In a study that reviewed mental health services in Australia, Ireland, and the UK, it was reported that access to mental health services was the poorest for children and youth (McGorry, Bates, & Birchwood, 2013). The results of these studies indicated that there is a global need to identify and support students with mental health disorders.

Schools are the most common providers of service to children and youth who have mental health disorders. When more than one in five students at some point experiences a serious mental health disorder (Adelman & Taylor, 2010; Merikangas, Burstein, Swanson, Avenevoli, Cui, & Swendsen, 2010), it equates to over 10 million U.S. students who need professional help in the K-12 public schools nationwide (Rossen & Cowan, 2014; U.S. Department of Health and Human Services, 1999). National policies and briefs, such as the New Freedom Commission on Mental Health report (2003), identified schools as a natural setting and best site to provide mental health treatment and prevention services to youth (Adelman & Taylor, 2010; Cammack, Brandt, Slade, Lever, & Stephan, 2014). Subsequently, schools have taken a greater role in
helping to meet the growing needs of their students and may be regarded as the de facto providers of mental health services for children and youth (Burns et al., 1995; Rones & Hoagwood, 2000; Weissberg, Kupfer, & Seligman, 2003). Due to the large number of students who have mental health disorders, schools have had to adapt and find ways to address the current needs of their student population.

School mental health (SMH) has been in practice for many years. Adelman and Taylor (2010) gave examples of health, social service, counseling and psychological programs provided by the schools since the end of the 19th century. SMH programs offer many services and supports to promote students’ overall well-being and reduce the nonacademic barriers to learning (Weist et al., 2012). These services are typically delivered by SMH professionals including the school counselor, psychologist, nurse and social worker. A meta-analysis review indicated that most SMH early interventions with at-risk high school students were group-based, of short duration and were implemented by SMH professionals (Iachini, Levine-Brown, Ball, Gibson, & Lize, 2015). The authors noted the importance of practicality for school-based mental health services. However, as Weist and colleagues (2014) pointed out, schools are generally under-resourced for addressing emotional and behavioral challenges and the ratios of SMH professionals fail to meet the demand for effective comprehensive services. Furthermore, the SMH professionals are often too busy in roles other than those which actually assist in preventing and addressing emotional and behavioral challenges (Waxman et al., 1999; Weist et al., 2014). Because the schools are under-resourced, expansion in the field of SMH depends upon the involvement of the community and others. In an effort to meet the students’ needs, mental health services and supports in schools have increased through the use of a public health model (Iachini et al., 2015) and through collaboration between community mental health agencies and schools. Because of added
responsibilities and an increased student need, schools became under resourced for effectively addressing student mental health needs. To meet the demand, SMH has expanded into the community and further into the education profession.

The expanded school mental health (ESMH) model not only includes the use of school and community-based mental health professionals, but also the use of educators to address the mental health needs of the students. The ESMH model acknowledges the different roles of mental health professionals and educators in the need for a shared agenda of collaboration to provide students with a full continuum of mental health support in school (Phillippo & Kelly, 2014). An example of a way to accomplish this shared agenda is the creation of the Multi-tiered System of Support (MTSS) which is a framework for educators and support personnel to deliver instructional and behavioral interventions to all students (Paternite & Johnston, 2005). Mental health symptoms exist on a continuum; therefore, MTSS is an effective framework for mental health service delivery to every student (Franklin et al., 2012; Paternite & Johnston, 2005; Rossen & Cowan, 2014; Weist et al., 2014). Another way for educators to address student mental health needs is with interventions through the Individuals with Disabilities Education Improvement Act (IDEA). This United States law introduced comprehensive educational standards and services for meeting the needs of students with disabilities, including those with mental health needs (Rossen & Cowan, 2014). For example, emotional disturbance (ED) is one of the disability categories under IDEA. In the 2011-12 school year, 373,000 students were served in special education under this category, and that number is expected to increase (The National Center for Educational Statistics, 2014). Other health impairment (OHI) is another growing disability category for students living with mental health illnesses such as attention deficit disorder and depression (The National Center for Educational Statistics, 2014). It is
through comprehensive programs like MTSS and IDEA that educators have increasingly become involved in SMH services.

Efforts to meet the mental health needs of students in the United States have made a positive impact on students’ achievement, both academically and emotionally (Adelman & Taylor, 2010; Franklin et al., 2012; Wilson & Lipsey, 2007). Research and practice have laid the foundation and framework for effective mental health services in schools through school support staff and community mental health providers (Payton et al., 2000; Rossen & Cowan, 2014). In addition, ESMH now includes educational professionals such as administrators and classroom teachers (Weist et al., 2014). However, this expansion in SMH poses the question: What is the role of the teacher in regard to children’s mental health and how prepared are teachers for this role?

The Role of the Teacher in Social and Emotional Student Development

Through their day-to-day interactions with students, teachers play a pivotal role, not only in the academic needs, but also in the overall social and emotional development of youth (Anderson-Butcher, 2006; Paternite & Johnston, 2005). For example, a study with a large number of participants reported that the most important factor in student learning is the teacher (Wright, Horn, and Sanders, 1997). Moreover, Anderson-Butcher (2006) stated that few people, other than family, know the students better than educators. She also posited that teachers act as the primary agents of support for their students. Through a teacher’s own actions, and in collaboration with others, it is possible for teachers to promote positive well-being, provide mental health interventions, and increase academic success for our youth (Anderson-Butcher, 2006). Teachers are directly involved in social and emotional student development through the practice of creating the learning environment, establishing teacher-student relationships,
identifying students with mental health needs, providing appropriate interventions, and collaborating with others as necessary.

**Creating a safe and happy learning environment.** Classroom teachers have the opportunity to positively impact students’ lives every day in the classroom. A safe and happy learning environment which includes classroom management practices and positive teacher qualities begins with an effective teacher (Good & Brophy, 2000). Researchers suggested the following components of effective classroom management: establishing clear rules, organizing routines, reinforcing positive behavior, and providing consistent consequences for inappropriate behavior (Anderson-Butcher, 2006; Capizzi, 2009; Good & Brophy, 2000; Simonsen, Fairbanks, Briesch, Myers, & Sugai 2008; Wong & Wong, 2001). For example, a meta-analysis study by Marzano, Marzano, and Pickering (2009) reported on four key components of classroom management: including rules and procedures, disciplinary interventions, mental set, and teacher-student relationships. The authors of that study stated that all four components are necessary to ultimately have a significant impact on students. In addition, it takes a good deal of effort to create a well-managed classroom in which the teacher is responsible for creating it (Levin & Nolan, 2010; Wong & Wong, 2001). Overall, classroom management is an important component of establishing a safe and happy learning environment for students.

Certain personal qualities of a classroom teacher also help to establish an effective classroom environment. For example, teacher qualities such as empathy, trust, and patience for creating a positive classroom environment are linked to fostering psychological resilience in students (Waller et al., 2006). In addition, psychological resilience may help to prevent the development of mental health problems associated with risk factors in their life (Gootman, 1996; Waller et al., 2006). Although teachers have little influence over the risk factors, they can have a
significant influence on factors connected to resilience. For example, Waller et al., (2006) suggested six specific strategies teachers can use to promote psychological resilience. They include: (a) be there, (b) model support of all students, (c) be positive, (d) teach problem solving, (e) encourage self-management, and (f) contrive positive peer interactions. Student well-being is considered an outcome associated with quality education (Myers & Pianta, 2008; Van Petegem, Aelterman, Van Keer, & Rosseel, 2007). As evidenced, both classroom management and teacher qualities play significant roles in creating a positive learning environment conducive to appropriate support for students with mental health needs.

**Teacher-student relationships.** Strong and supportive relationships between teachers and students are fundamental to the healthy development of all students in school (Davis, 2003; Myers & Pianta, 2008). When students first enter school, the teacher serves as the key individual to provide both understanding and support in students’ adaptation to a new social and academic environment (Davis, 2003). In addition, Myers and Pianta’s (2008) study of kindergarten students found that students who had difficulty forming supportive relationships with teachers were at greater risk of school failure. Although the nature of the relationship changes as the students grow and mature, the need for positive teacher-student relationships remained strong (Myers & Pianta, 2008). Supportive teacher-student relationships in middle school helped students maintain interest in both social and academic pursuits which in turn led to better grades and more positive peer relationships (Wentzel, 1998). In addition, relationships with adults in high school settings were among the most important predictors of student success (Myers & Pianta, 2008). Moreover, children who felt a sense of support and belonging from their teacher tended to adopt or internalize the teacher’s goals and values (Stipek and Miles, 2008). The
authors also pointed out those children who have conflict with their teachers are more likely to feel alienated and disengage from sanctioned classroom behavior.

Teacher-student relationships affect student behavior. For example, in a study of 283 students Silver, Measelle, Armstrong, and Essex (2005) found that the quality of teacher-student relationships was important for understanding the development of externalizing behavior problems in the classroom. The results of their study indicated that conflict in the teacher-student relationship during kindergarten contributed to increased rates of student externalizing behavior from kindergarten through third grade. Moreover, decreases in externalizing behaviors were associated with teacher-child closeness (Silver et al., 2005). Similarly, Hamre and Pianta’s (2001) longitudinal analysis suggested that negativity in the teacher-student relationship predicted disciplinary infractions and school suspensions through the eighth grade. Stipek and Miles’s (2008) study also reported teacher-student conflict projected increased aggression and lower engagement from the aggressive students. In addition, teacher-student relationships seem to be a contributing factor in students’ externalized behavior and disciplinary infractions (Hamre & Pianta, 2001; Ladd & Burgess, 2001).

Teacher-student relationships influence student well-being. For example, student perception of interpersonal teacher behavior predicted student well-being (Van Petegem et al., 2007). In that study, teachers who were viewed by their students as dominant-cooperative had a positive influence on student well-being. This type of teacher was described as disciplined, tolerant, enthusiastic, and used a variety of teaching methods. Additionally, Myers and Pianta (2008) reported that a sense of greater connectedness to teachers was associated with lower rates of emotional distress, suicidal ideation, suicidal behavior, violence, substance abuse, and early sexual behavior in high school students. Moreover, teacher-student relationships were an
Teachers’ perspectives mental health competencies which also played a large role in developing professional identities and personal well-being (den Brock, van der Want, Beijaard, & Wubbels, 2013). One of the major sources of both positive and negative teachers’ emotions in the classroom is teacher-student relationships (Hargreaves, 1998; Lewis, 1999). Therefore, teacher-student relationships significantly affect the personal well-being of both the student and the teacher.

Developing positive teacher-student relationships is an important role of the classroom teacher. Pianta (2006) explained that due to the asymmetry in the teacher-student relationship, the teacher holds the primary responsibility to initiate positive interactions and encourage positive relationship development. Teachers have numerous opportunities to establish a rapport with a student. Every time an interaction exists, either intentional or non-intentional, between a teacher and a student, the teacher can use it to increase student success (Scott, Anderson, & Alter, 2012). Establishing positive teacher-student relationships has been shown to impact students’ learning, behavior, and well-being.

**Identification and interventions.** Teachers play an integral role in identifying students who have mental health issues and providing appropriate interventions as needed. Teachers are often the first professional to encounter symptoms of a child or youth in need of mental health services (Paternite & Johnston, 2005). They are central figures in the identification process due to the constant monitoring of their students’ academic, social, and emotional needs (Anderson-Butcher, 2006). Teachers often make student referrals to school-based mental health professionals which can lead to appropriate treatment. However, the referral process can also be problematic and result in under-referral and late referrals (Albers, Glover, & Kratochwill, 2007; Dvorsky, Girio-Herrera, & Owens, 2014). For example, Dvorsky et al., (2014) gave several reasons for challenges regarding teacher referrals. The researchers found that teachers often
identify only high-risk or severe students who are already “failing” in some capacity. Another problem was that the referral process can be biased due to different expectations and thresholds in tolerance across teachers. The third reason for ineffective referrals is the lack of teachers’ knowledge about identification and referral processes for mental health. Given these limitations, some experts have called for systematic school mental health screening to be given as a tier one intervention in MTSS as part of the identification process (Dvorsky et al., 2014). If screening was to be considered, the screening should be psychometrically sound, user friendly, and normed for a diverse population (Dowdy, Kamphaus, Twford, & Dever, 2014). Referrals can also be made during times of crisis when quick and immediate action is required. For instance, Lafee (2013) reported that the teacher was often the first responder to emergency situations and was expected to follow the required protocol for assistance. Unfortunately, a study of crisis intervention training found that few teachers received training as a component of formal coursework. However, when provided with short-term training, measurable improvements were found in teacher behavior and positive student outcomes (Taylor, Hawkins, & Brady, 1991). Similarly, since 1988 Crisis Intervention Teams (CIT) training has been provided for law enforcement officers to deal with emergency situations involving mental health problems with shown positive results (Ralph, 2010).

Using the MTSS framework is an effective way for schools to provide interventions for various stages of mental health need and integrate with the learning environment (Rossen & Cowan, 2014; Weist et al., 2014). MTSS includes whole-school approaches such as Response to Intervention (RTI) and Positive Behavior Intervention Supports (PBIS). There are three tiers of interventions, and teachers are the primary agents for delivering tier one and two MTSS supports.
Tier one of MTSS is considered to be universal and the focus is on wellness promotion and prevention (Rossen and Cowan, 2014; Weist et al., 2014). It is delivered primarily through the classroom teacher. For example, Franklin et al. (2012) analyzed 49 SMH studies and found that teachers were actively involved in 40.8% of mental health interventions evaluated. In addition, teachers were the sole providers of intervention in 18.4% of the studies. Many of the interventions in the studies occurred in the universal tier and included the implementation of a social emotional learning curriculum and the use of positive behavior supports (Franklin et al., 2014). Furthermore, due to their deep involvement with students over long periods of time, teachers can integrate tier one mental health interventions to impact academic performance (Diekstra & Gravesteijn, 2008).

Tier two of MTSS aims to target interventions on specific mental health problems and is addressed through teacher and mental health professional collaboration. Bradshaw, Bottiani, Osher, and Sugai (2014) described tier two which involved approximately 15% of the student population as selective in nature. Additionally, Paternite and Johnston (2005) described tier two strategies as being devised to meet the needs of students “at risk” for serious behavior. Furthermore, Rossen and Cowan (2014) stated that tier two interventions are those which target a specific problem when an identified problem exists for a small group of students. An example of a tier two intervention might be a social skills group or an anger management group. At tier two, collaboration between mental health professionals and teachers is recommended to reinforce interventions in the classroom on a regular basis which ultimately may sustain longer-term effects (Franklin et al., 2012).

Tier three interventions of MTSS typically provide individual mental health services. Approximately 5% of the students receive interventions at tier three which can include indirect
or direct student-level mental health counseling and other therapeutic interventions (Bradshaw et al., 2014; Weist, et al., 2014). Tier three of MTSS aims to meet the specific needs of individual students through more intense services.

Teachers play an important role in ESMH. One aspect of this role is to identify students who need mental health services. Another aspect of the role is to provide mental health interventions. Teachers deliver tiered mental health interventions to their students using the MTSS framework. When teachers identify students with mental health needs and collaboratively work to address those needs through MTSS interventions, they are providing an important service for all students (Rossen & Cowan, 2014; Weist et al., 2014).

**Collaboration.** Teachers serve as a vital link between students with a mental health condition and mental health professionals. To support teachers once student mental health needs are identified, strategic supports and services must be in place within the school system and in the community (Adelman & Taylor, 2010; Anderson-Butcher, 2006). Moreover, collaborative partnerships between teachers and mental health professionals are essential in the promotion of mental health and school success for children and adolescents (Elias, Zins, Gracyzk, & Weissberg, 2003; Paternite & Johnston, 2005). Furthermore, interdisciplinary school-based teams comprised of teachers and SMH professionals have formed to deliver mental health services to students, and collaboration amongst these teams is necessary to accomplish team goals (Markle, Splett, Maras, & Weston, 2014; Nellis, 2012). Additionally, it is important for SMH professionals to treat teachers as valued members of school teams (Paternite & Johnston, 2005). Linking students to mental health professionals and being a part of the collaborative efforts to address student mental health needs seems to be additional roles teachers must play.
Teachers are vitally important in promoting family involvement in regards to mental health. Involving families in youth mental health services is important for achieving positive outcomes (Hoagwood et al., 2010; McDaniel, Schiele, Taylor, Haak, & Weist, 2014). In addition, the National Alliance on Mental Illness (NAMI) recognized the importance of creating an alliance between parents and teachers for early detection and treatment of children and youth with signs of mental illness (Burland, 2003). The organization supports families and teachers with a booklet on mental illnesses and a recommended educational program (Burland, 2003). Some teachers felt uncertain about the ways to include families; however, through foundational courses in family involvement in education, their comfort and competence level grew (McDaniel et al., 2014). Research indicates that family influences the outcome of a student with a mental health disorder; therefore, it is crucial for teachers to engage the family and encourage collaboration.

Teachers, SMH professionals, and families can also collaborate in advocating for funding and policy which will affect children’s mental health. States, counties, and school districts need adequate funding for meeting those needs. For example, schools need funding for additional SMH positions. Rossen and Cowan (2014) posit that until our country takes the role of mental health in learning seriously, school reform efforts will fall short of the goal of having all students thrive in school, at home, and in life.

Once teachers have identified students who need additional mental health support, it is important for them to link those students to the appropriate SMH professional. It is also essential for the teacher to collaborate with the SMH professionals and be considered a vital member of the interdisciplinary team. Teachers must also promote family involvement in the interventions to achieve positive outcomes (Hoagwood et al., 2010; McDaniel et al., 2014). In addition,
beyond the classroom, teachers play a role as citizens in advocating and voting to promote positive policy related to children’s mental health.

**Teacher Perspectives on Student Mental Health Needs**

Teachers’ involvement in mental health issues has initiated new research about their perceptions of children’s mental health. An increasing body of research is developing in this area with a couple of consistent findings. Specifically, one finding was the need for effective teacher training to garner more knowledge regarding mental health (Bishop, Giles, & Bryant, 2005; Franklin et al., 2012; Graham, Phelps, Maddison, & Fitzgerald, 2011; Williams, Horvath, Wei, Van Dorn, & Jonson-Reid, 2007). For example, a study in the United States involved a needs-assessment survey given to 119 elementary school teachers regarding student mental health problems. Teachers reported that they lacked knowledge and training which lessened their ability to solve mental health problems (Walter, Gouze, & Lim, 2006). Similarly, a study based on 32 interviews with teachers in England documented the need for teacher training to recognize and address mental health problems (Rothi, Leavey, & Best, 2008). Moreover, a study in Canada suggested the need for a sustained, research-based focus on effective ways to promote mental health literacy among teachers. The vast majority of Canadian teachers perceived mental health issues as pressing concerns in their schools (Whitley, Smith, & Vaillancourt, 2012).

Another reemerging research finding indicated that due to the lack of time, teachers felt overwhelmed with taking on the role of a mental health provider (Bishop et al., 2005; Graham et al., 2011; Williams et al., 2007). For instance, a Norwegian study involving K-12 teachers showed that teachers often see and identify a mental health problem but do not have time to fully engage and give the student special attention amidst all the day to day responsibilities (Ekornes, 2016). Furthermore, when teachers encounter a student mental health issue, they are often
uncomfortable in this yet-undefined role. For example, in a comprehensive study in Australia, Graham and colleagues (2011) found that teachers were most comfortable dealing with familiar family situations such as divorce and moving as they related to mental health. Moreover, the majority of teachers in this study identified mental health education as “very” or “extremely” important (89%) and 70% felt willing to be involved in mental health education programs outside of the usual classroom processes. Additionally, because of the lack of available resources, many of the teachers felt a sense of isolation when dealing with problems arising from children with mental health conditions (Graham et al., 2011). Phillippo and Kelly (2014) also found high school teachers who experienced little collaboration with SMH professionals. Their study led to a conclusion that the teachers were an underused resource for mental health services: therefore, changes to the structure and practice were necessary to expand the schools’ mental health supports.

All these studies indicated that teachers recognized the importance and need for knowledge on mental health. However, teachers had little knowledge in regard to mental health: therefore, quality training was needed. In addition, teachers felt they did not have time to take on a more assertive role in mental health because of the myriad of responsibilities. To some extent, teachers also perceived their role isolated and disconnected from SMH professionals when dealing with students who have mental health problems.

**Teachers’ Competency in Mental Health**

Teachers have reported feeling incompetent and ill prepared to take on a more active role in school mental health. One contributing factor is lack of formal education on mental health for pre-service teachers (Phillippo & Kelly, 2014; Walter et al., 2006). To compound the problem, there is little in-service training available to teachers for addressing mental health concerns in the
classroom (Koller et al., 2004). When teachers enter the classroom untrained to deal with students with mental health problems they often become frustrated, disappointed, and discouraged (Koller et al., 2004).

Although teacher preparation programs are not entirely responsible for the problem of unprepared teachers for mental health services, Weston et al., (2008) suggested that better preparation of teachers in promoting healthy social-emotional development and providing effective learning supports would help initiate an important systemic change in our schools. Weston and colleagues (2008) also stated the importance in understanding that children’s social-emotional development is as critical to their long-term success as to their academic development. Social-emotional dysfunction is a barrier to academic achievement that requires school-based intervention and support (Adelman & Taylor, 2010; O’Connell et al., 2009; Paternite & Johnson, 2005; Waxman et al., 1999; Weist & Evans, 2005). For example, general education teachers are held accountable for attaining learning objectives, but many students may not come to school ready and able to learn. The lack of teacher preparation for this complex problem presents an authentic breakdown in the schooling system (Weston et al., 2008).

As evidenced earlier, schools have implemented various mental health supports trying to meet the needs of their students. For example, there are existing school-based programs which focus on social skills, bullying prevention, character education initiatives, and even suicide prevention (Weston et al., 2008). However, Adelman and Taylor (2000) found these programs to be fragmented and marginalized, often disconnected from the academic mission of the school. Although policies and practices to advance mental health promotion exist, such as the President’s New Freedom Commission (2003), those policies have not yet led to comprehensive services
ready for school implementation nor had an impact on teacher preparation (Burke & Stephan, 2008; Weston et al., 2008).

In a seminal study, Weston and colleagues (2008) investigated the competencies and standards in regard to mental health language for each state in the U.S. They found a range of mental health language examples; some very broad statements. For example, Ohio had broad-based standards for creating safe and healthy learning environments (Weston et al., 2008). Other states had specific statements such as New Jersey’s educator requirement of 2 hours of suicide prevention instruction (Weston et al., 2008). However, not a single state had a comprehensive framework for mental health competencies or standards targeting teacher dispositions, knowledge, and skills. With Mental Health and Education Integration Consortium (MHEDIC), Weston and colleagues (2008) created and proposed an integrated, comprehensive mental health competencies curriculum framework consisting of 34 specific dispositions and six major domains of knowledge and skills that are recommended for inclusion in pre-service and in-service professional preparation programs (Weston et al., 2008). The proposed six targeted competence domains are as follows:

1. The teacher demonstrates understanding and application of key policies and laws that foster delivery of effective and ethical learning supports in schools.

2. The teacher demonstrates knowledge and skills related to the provision of learning supports that promote academic achievement, healthy development, and overall school success.

3. The teacher demonstrates knowledge and skills in the collection and use of data measuring student behaviors, affect, and attitudes, as they relate to academic, social, and emotional needs and outcomes.
4. The teacher possesses and demonstrates the skills to communicate effectively and build relationships with others.

5. The teacher engages multiple systems and people in practices that maximize students’ academic achievement, healthy development, and overall school success.

6. The teacher demonstrates knowledge and skills that facilitate personal and professional growth, development, and overall well-being.

According to this framework, beginning teachers would be expected to have an awareness of and basic skills in all of the competencies as they entered the field. Beginning teachers would also be required to be committed to developing their proficiency levels with more experience. On the other hand, advanced practitioners would be expected to demonstrate more ability to apply the knowledge and skills to meet the criteria of a highly effective teacher (Weston et al., 2008). Although the authors expected this argument to create controversy within both the teacher education and teaching professions, they perceived mental health teacher practices as critical for fostering school and life success (Weston et al., 2008). To date, it is the only comprehensive framework available for mental health teacher preparation or professional development (Ball et al., 2016). However, in a recent comprehensive study (Ball et al., 2016), state standards from 48 states and national Interstate Teacher Assessment and Support Consortium (InTASC) standards were examined for evidence of the SMH competencies identified by Weston et al. (2008). The results showed an increase from 2008 in the use of SMH competency language in the standards. Moreover, all the professional state standard documents examined contained standards that aligned with at least one of the six SMH competency domains. In addition, there was content from all SMH competency domains in the InTASC standards. Overall, these standards documents reflect the increasing importance of teachers’
involvement in SMH. However, gaps existed, variability among the states was present, and the focus for most of the competencies was on academic domains rather than social and emotional domains (Ball et al., 2016).

Summary

There is a significant amount of research in regard to child and adolescent mental health, as well as school mental health. It is an alarming fact that 14-20% of children and adolescents experience a mental, emotional, or behavioral disorder each year (Adelman & Taylor, 2010; National Research Council and Institute of Medicine, 2009; World Health Organization, 2003). It may be more alarming to know that only about half of these children and adolescents received treatment for their disorder during the year (Green et al., 2013; Paternite & Johnston, 2005; Rones & Hoagwood, 2000). Unfortunately, many studies have shown that emotional and behavioral challenges interfere with school success (Adelman & Taylor, 2010; O’Connell et al., 2009; Paternite & Johnson, 2005; Waxman et al., 1999; Weist & Evans, 2005). To mitigate this problem, schools have taken on more responsibility in meeting the mental health needs of their students.

Many schools have implemented procedures to identify students who may need mental health services as well as programs to provide those needed services. Teachers play an integral role in both of these aspects. The MTSS framework effectively delivers universal and specific mental health supports to students (Franklin et al., 2012; Paternite & Johnston, 2005; Rossen & Cowan, 2014; Weist et al., 2014). Through the use of tiered interventions and constant monitoring, teachers can identify students who need more support (Anderson-Butcher, 2006). In addition, students who are eligible for exceptional student education (ESE) services receive an Individualized Education Plan (IEP) through IDEA. For the emotionally disturbance category of
IDEA, it was reported that there were 373,000 students receiving ESE services (The National Center for Educational Statistics, 2014).

Besides being a part of these formalized programs, teachers play other important roles. Research shows the significance of classroom management (Anderson-Butcher, 2006; Capizzi, 2009; Good & Brophy, 2000; Simonsen et al., 2008; Wong & Wong, 2001), teacher-student relationships (Davis, 2003; Myers & Pianta, 2008; Stipek & Miles, 2008), and collaborative partnerships between teachers and mental health professionals (Elias et al., 2003; Paternite & Johnston, 2005). However, a teacher’s role in SMH is relatively new and research in this area is still in its infancy. Most studies in this area included teachers’ perspectives on the mental health needs of students and the extent of teacher preparation for this role. In addition, teachers recognized a great need in their students but at the same time were ill prepared to meet the need (Bishop et al., 2005; Franklin et al., 2012; Graham et al., 2011; Williams et al., 2007).

In a seminal study, researchers investigated the educator competencies and standards nationwide only to discover that not a single state had a comprehensive framework for mental health competencies or any standards targeting mental health dispositions, knowledge or skills for teachers (Weston et al., 2008). As a result, the researchers developed a comprehensive framework of mental health competencies for educators to address the need in teacher preparation. In communicating with the study’s first author, I was informed that the competencies had not yet been field tested to examine teachers’ perspectives on them. This lack of research on the teachers’ perspectives represented a gap in literature, and by using the six proposed competencies, this study aims to fill that gap. The purpose of this study was to examine teachers’ perspectives of the content and implementation of the proposed competencies in order to include the teacher voice in this research.
CHAPTER III

RESEARCH METHOD

Introduction

The aim of this study was to examine the participating teachers’ perspectives regarding the content and implementation of the proposed mental health competency framework. The six targeted competence domains are:

1. key policies and laws
2. provision of learning supports
3. collection and use of data
4. communication and building relationships
5. engagement in multiple systems
6. a focus on personal and professional growth and well-being (Weston et al., 2008).

This study used a qualitative research method. Patton (2002) suggested qualitative methods facilitate an in-depth study of issues. This case study, using focus group interviews as the primary data source, investigated teachers’ opinions and ideas related to the issue of applying the proposed educator mental health competencies in their practice. The chapter begins by examining the setting and participants of the study. The research design is then outlined with a description of the pilot test. Data collection and analysis are next followed by the various ethical and bias explanations.

Setting and Participants

Three elementary schools from a large school district in South Florida was the setting for this study. Mental health contextual factors for the state and county contribute to an understanding of the setting. Florida is ranked 49th in state funding for mental health (National
Alliance on Mental Illness, 2015). However, the need for mental health services for children is still present. According to the Kids Count Data Center, 637,000 children were reported to have one or more emotional, behavioral, or developmental conditions in the 2011-12 school year (Kids Count Data Center, 2013). To help bridge the gap between need and state funding, some counties have created local Children’s Services Councils through county referendums and millage tax rates up to five percent (Dobson, 2015). Eight Florida counties established these councils, and two other counties have created similar councils through the use of private funding. A Children’s Services Council or anything similar is absent from Lee County, Florida. A recent article in the Fort Myers News-Press stated that SalusCare is the largest provider of mental health services in Lee County and the surrounding region. Additional beds have recently been added at SalusCare to the involuntary examination facility where children are brought during a mental health crisis; Florida’s Baker Act. The increase of beds is in response to an increasing number of pediatric admissions in recent years, many coming from local schools (Gluck, 2016).

Geographically, Lee County covers a large land area and includes cities such as Fort Myers, Cape Coral, and Lehigh Acres. The district includes a total of 121 schools and an enrollment of over 91,000 students. Of the total population, 11,700 are students who receive exceptional student education (ESE) services. There is a culturally and linguistically diverse student population in the district as well with students from over 159 countries being represented and 124 languages spoken (The School District of Lee County, 2016). The school district is divided into three geographic zones: west, east and south. The School district uses a school choice model for student assignment which means that upon initial enrollment, parents rank the schools in their geographical zone according to their placement preference. Then, using a
computer program, the district makes the official placement into one of the schools in a specific zone (The School District of Lee County, 2016).

Three elementary schools representing each zone of the school district were selected to recruit participants for the study. The following criteria drove the selection of the three schools:

1. one school per geographical zone.
2. member of the Professional Development Schools (PDS) initiative.
3. Title I school designation.

With those three criteria I narrowed down the choices and I contacted administrators with whom I had an established relationship to invite the school to participate. Based on the school enrollment data for April-May 2015, the selected three schools show some similarities and differences in their enrollment data (The School District of Lee County, 2015). The east zone school had the highest total enrollment (n=1027), while the south zone school had the highest minority enrollment percentage (n= 469) (77.08%). All of the schools had at least 75% of their students who qualify for free and reduced lunch. Table 1 provides each school’s total enrollment and the percentages for minority and free and reduced lunch student enrollment.

Table 1

<table>
<thead>
<tr>
<th>School Zone</th>
<th>Minority Enrollment</th>
<th>Free and Reduced Lunch</th>
<th>Total Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>west</td>
<td>48.05%</td>
<td>78%</td>
<td>633</td>
</tr>
<tr>
<td>south</td>
<td>77.08%</td>
<td>84%</td>
<td>609</td>
</tr>
<tr>
<td>east</td>
<td>69.69%</td>
<td>75%</td>
<td>1027</td>
</tr>
</tbody>
</table>
To recruit teachers from the school, I used email to contact the school administration with a letter about my study and asked for permission to recruit participants from their school. After receiving the principal’s approval, I used an email recruitment letter for general education teachers asking them to volunteer as participants in the study. I targeted general education teachers in grades K-5th. As part of purposeful sampling, I recruited general education, elementary level school teachers for several reasons. These include:

- elementary education is the beginning of a student’s mandated educational career
- students most often begin their educational career in a general education setting, as opposed to a special education setting
- inclusion is an educational practice in this school district, and
- this school district has more elementary schools in the district than any other school level.

I intended to have three to five general education teachers from each school. If more than five teachers from a school had volunteered for the study, purposeful sampling would have been used to select the participants. However, only three to five teachers volunteered and participated from each school for a total of 11 participants. Anonymous information from the online questionnaire is used to describe the participants below and in Tables 2 and 3.

All 11 original participants (100%) in the study were females and general education teachers. In the west zone school, there were five teachers who began the study, but only four completed it. In the south and east zone schools, each school had three teacher participants. The grade levels represented by all the participants ranged from kindergarten (n=4) through fifth (n=1). There were two second grade teachers, one third grade teacher, and three fourth grade teachers. Only first grade had no teacher representatives. Five (45.45%) of the teachers had five or less years of teaching experience, while three (27.27%) teachers’ experience was in the range
of 5-10 years, and the other three (27.27%) had over 10 years of teaching experience. A Master’s degree was the highest earned degree; three (27.27%) participants held a Master’s degree and eight had a Bachelor’s degree. In terms of receiving mental health training during their undergraduate course work, 100% of the teachers responded that they had no training. One teacher stated she did receive some mental health training after earning her Bachelor’s degree as part of a graduate course. All the others responded that they have never received mental health training as part of their professional development.

To understand the participants’ background knowledge about mental health issues, several questions were asked. For the question regarding the school district’s mental health services to students, eight (72.73%) responded that they did not know whether or not the district provided those services and one teacher said the district did not provide mental health services. Only two (18.18%) thought that the district offered mental health services. Regarding their knowledge about district contacts for help with mental health, seven (63.64%) said they did not know. Four (36.36%) responded positively; they knew who to contact but the positions named were inconsistent with one another. All eleven teachers (100%) responded with “no” to the question regarding whom to contact in the community for mental health assistance. In addition, prior to this study, none of the teachers were familiar with the proposed mental health competencies. However, on a scale from one (not at all) to five (very), seven (63.64%) teachers indicated having mental health competencies would be very important for the teaching profession by rating it a five. Again, seven (63.64%) teachers responded that it is very important for educators to be aware and knowledgeable about mental health.
Table 2

Participants’ Background in Mental Health

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>I Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Training in Undergraduate Program</td>
<td>0% (n=0)</td>
<td>100% (n=11)</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td>Mental Health Training Since Bachelor’s</td>
<td>9.09% (n=1)</td>
<td>90.91% (n=10)</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td>School District Provide Mental Health Services</td>
<td>18.18% (n=2)</td>
<td>9.09% (n=1)</td>
<td>72.73% (n=8)</td>
</tr>
<tr>
<td>Knows Who to Contact in District</td>
<td>36.36% (n=4)</td>
<td>63.64% (n=7)</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td>Knows Who to Contact in Community</td>
<td>9.09% (n=1)</td>
<td>90.91% (n=10)</td>
<td>0% (n=0)</td>
</tr>
</tbody>
</table>

Table 3

Participants’ Opinions

<table>
<thead>
<tr>
<th>Question</th>
<th>1 Not at All</th>
<th>2 Very Little</th>
<th>3 Neutral</th>
<th>4 Somewhat</th>
<th>5 Very</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarity of Proposed Competencies</td>
<td>81.82% (n=9)</td>
<td>18.18% (n=2)</td>
<td>0% (n=0)</td>
<td>0% (n=0)</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td>Importance of Having Educator Mental Health Competencies</td>
<td>0% (n=0)</td>
<td>9.09% (n=1)</td>
<td>9.09% (n=1)</td>
<td>18.18% (n=2)</td>
<td>63.64% (n=7)</td>
</tr>
<tr>
<td>Importance of Educators Being Knowledgeable on Mental Health</td>
<td>0% (n=0)</td>
<td>9.09% (n=1)</td>
<td>9.09% (n=1)</td>
<td>18.18% (n=2)</td>
<td>63.64% (n=7)</td>
</tr>
</tbody>
</table>
As stated above, although 11 participants completed the online questionnaire, only 10 teachers participated in the focus group and follow-up interviews. For those participants, I collected specific demographic data and created a coding system. I numbered each of the participants in numerical order 1 through 10 to maintain anonymity. For reporting purposes, I coded each teacher by school and number for identification. The codes were the following: TW1 was a teacher from the west zone school with a participant number 1. This coding was consistently used in the chapters. Table 4 shows the code for the 10 teachers who participated in the focus group interviews along with specific demographic information.

Table 4

Participants’ Code and Description

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Race</th>
<th>Degree</th>
<th>Yrs of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>TW1</td>
<td>25</td>
<td>White</td>
<td>Bachelor</td>
<td>1</td>
</tr>
<tr>
<td>TW2</td>
<td>43</td>
<td>White</td>
<td>Bachelor</td>
<td>10</td>
</tr>
<tr>
<td>TW3</td>
<td>36</td>
<td>White</td>
<td>Bachelor</td>
<td>13</td>
</tr>
<tr>
<td>TW4</td>
<td>33</td>
<td>White</td>
<td>Master</td>
<td>10</td>
</tr>
<tr>
<td>TS5</td>
<td>28</td>
<td>Hispanic</td>
<td>Master</td>
<td>4</td>
</tr>
<tr>
<td>TS6</td>
<td>37</td>
<td>Black</td>
<td>Bachelor</td>
<td>10</td>
</tr>
<tr>
<td>TS7</td>
<td>40</td>
<td>White</td>
<td>Bachelor</td>
<td>1</td>
</tr>
<tr>
<td>TE8</td>
<td>28</td>
<td>Black</td>
<td>Bachelor</td>
<td>4</td>
</tr>
<tr>
<td>TE9</td>
<td>39</td>
<td>White</td>
<td>Bachelor</td>
<td>16</td>
</tr>
<tr>
<td>TE10</td>
<td>28</td>
<td>White</td>
<td>Bachelor</td>
<td>4</td>
</tr>
</tbody>
</table>
Research Questions

The study will examine the following research questions:

1. What are the participants’ perceptions regarding how mental health competencies can guide and inform their classroom practice?
2. How would the participants react if these competencies were adopted by the state?
3. In what ways would the participants amend, add, or change the proposed mental health competencies?

Qualitative Research Design

Qualitative research is used when a problem or issue needs to be explored (Creswell, 2013). In this study, I examined the participating teachers’ perspectives on the content and implementation of the proposed mental health competencies. I was interested in their opinions about the need for the competencies and the possible implications of the application of these competencies. I also wanted to know if participants were currently practicing any of the competencies. By speaking directly with teachers and allowing them to tell their stories, others can gain a detailed understanding of the problem or issue on hand (Creswell, 2013). In this study, it is the issue of examining educator mental health competencies. According to Denzin and Lincoln (2005), qualitative researchers study things in their natural settings, attempting to make sense of, or interpret them. This qualitative study also aimed to empower individual teachers in the use of their voice to influence future decisions regarding mental health competencies. In addition, qualitative research validates the use of individual voices which have the ability to transform the world (Creswell, 2013).

Epistemology is the explanation of how we acquire knowledge. As the researcher, this concept was embedded in my theoretical perspective and methodology (Crotty, 2004). This study
was based on the belief that in order to understand the world around us, one must interact with others and inquire about their views. In addition, my interpretive framework was grounded in social constructivism where researchers primarily rely on the participants’ views (Denzin & Lincoln, 2005) and disability theory where researchers consider a disability to be a difference rather than an impairment (Mertens, 2003).

For this study, I examined a case involving teachers at different schools. Case study research identifies a case which can be defined or bound by certain parameters, such as a specific time and place (Creswell, 2013). Stake (1995) described two intents of a case study: (a) intrinsic case, meaning it is a unique or unusual case; (b) instrumental case, meaning it seeks to understand a specific issue or problem. No matter which intent exists, Creswell (2013) stated that a good qualitative case study provides an in-depth understanding of the case where assertions are formed by the researcher about the overall meaning derived from the case and are reported at the end of a study.

This study was an instrumental case study used to gain insight on mental health competencies. The case was bound by several factors including that all participants are general education teachers working in an elementary school setting within the same school district. For this study, one case was formed using teachers at three elementary schools within the same school district. In this way, focus group interviews were conducted to explore and examine the proposed educator mental health competencies.

**Pilot Test**

Prior to conducting the actual study, I used a pilot test. Yin (2009) recommends a pilot test to refine the data collection plan and develop relevant questions. Pilot cases are often selected on the basis of convenience, access and geography (Creswell, 2013). For my pilot test, I
used a group of five elementary teachers from a school where I previously worked. I was able to pilot each phase of data collection for the study as described below.

A case study does not require a survey which would provide information from a sample or an entire population (Creswell, 2012). However, I did want to collect some demographic information from my participants as well as capture their attitudes, opinions, and background knowledge before the study. I first created a questionnaire to collect demographic and background information on each of the participants (Appendix A). The questionnaire collected information, such as the teacher’s grade level and number of years of experience as an elementary teacher. I developed additional questions based upon the focus of this study to provide a rich description of the participants’ background. An example question is, “Does the school district provide mental health services?” and the response choice was “yes”, “no”, or “I don’t know”. In addition, teachers were asked to answer questions using a Likert scale where answers based on their own experience and opinion ranged from 1, indicating not at all, to 5, indicating very. Some sample questions were “How familiar are you with the six proposed mental health competencies?” and “How important is it for educators to be aware of and knowledgeable about mental health?”

I converted the Word document to Checkbox so the questionnaire could be easily accessed using an online link. A link to the questionnaire was sent via email to each participant in the pilot study. Using their responses, I verified the validity of the questionnaire and I was able to determine that the linked worked properly. Some revisions were made prior to using it in my actual study. One example of an important revision was to add a question to indicate at which school they worked. Other minor revisions included changing some wording, such as adding the word undergraduate to the question asking, “Was mental health training part of your
undergraduate teacher preparation curriculum?” For the pilot test, I also determined the amount of time to complete the questionnaire. With this estimated time, I provided accurate information to my participants.

To test the next phase of my study, I also pilot tested the focus group protocol (Appendix B) with the same group of teachers. I developed interview questions to ensure the same questions would be asked at each focus group interview. Knowing I had a limited amount of time for a group interview, I carefully decided on 10 opinion and values questions all related to the research questions (Patton, 2002). The first six questions most directly related to the research questions just in case we ran out of time for all ten questions. Examples of the questions included, “In what ways do you find the proposed competencies relevant?” and “How would the proposed competencies alter your current teaching practice?” As a first step of the focus group pilot test, I emailed the teachers an article (Weston et al., 2008) on the mental health competencies. Also, I included a few options for dates and times to set up a mutually agreed upon focus group interview. I emailed a meeting reminder two days prior to our session. At our focus group interview, I first orally read through the competencies to the participants as a review. Then the interview began and I recorded our conversation. I started with the first question and proceeded in order while still including some follow-up questions and prompts for elaboration. In this way, I was able to gage how well the questions targeted the information. I also tested the order of the questions and decided about any revisions. Minor revisions were made to the focus group interview protocol after this pilot test was conducted. For example, one revision was to use the word relevant instead of important in three separate questions. Another revision was to change the wording in question number five so it asked about reacting to mental health competencies rather than supporting. In this way, the question was not leading the respondents; a teachers’
reaction could be either positive or negative. I timed the session and used the information to plan future focus group interviews for my study.

The last phase of data collection to pilot test was the follow up individual interview question (Appendix C). Three days after the pilot focus group interview, I contacted each participant with one final follow up question. I asked if she had any additional thoughts or considerations regarding mental health or the competencies since our focus group interview. In this way, I intended to collect any further relevant data which did not emerge in our group session. No revisions were needed on this final follow up interview question.

Data Collection

In the three schools, I used the same data collection process, which employed three data sources for triangulation. First, I obtained proper consent from each participant in the study by having them sign the approved consent form. Next, I sent each participant a link to an electronic questionnaire, and I asked them to complete it individually within a week’s time. Specific information concerning the questionnaire and its content was discussed earlier in this chapter. The questionnaire instrument can be found in Appendix A. The data from the questionnaire served as the first set of data. After the participant submitted the questionnaire, I emailed the participant with the article titled “Developing a Comprehensive Curriculum Framework for Teacher Preparation in Expanded School Mental Health” (Weston et al., 2008) for her to read prior to the focus group interview. Participants had a minimum of two weeks’ time to read the article. The purpose of requesting them to read the article was to allow them to acquire knowledge of the proposed mental health competencies before the focus group interview.

The second source of data was the focus group interviews regarding the mental health competencies. Patton (2002) defined a focus group as a small group of people with similar
backgrounds who participate in an interview on a specific topic for one to two hours. As I pointed out, the participants in this study had similar backgrounds. Out of the variations of qualitative interviewing, I used a combination of the interview guide and the standardized open-ended approaches. According to Patton (2002), this combination standardizes some specific questions that must be asked while still allowing for some topics to be explored at the interviewer’s discretion. This flexibility allowed me to probe for elaboration in responses for greater depth or new ideas. Overall, the focus group interviews gave the participants the opportunity to respond in their own words and express their own personal perspectives (Patton, 2002).

The focus group interview at each school was approximately 60-90 minutes. These sessions were audio recorded, and then transcribed for analysis purposes. The unique feature of the focus group interview was that the participants heard each other’s responses and were able to make additional comments beyond their own original responses (Patton, 2002). However, the participants were not expected to agree or disagree with one another because the goal was to collect data in a social context where people considered their own views in the context of the views of others (Patton, 2002). Two days prior to our focus group setting, I sent an email reminder to the participants. In the reminder, I suggested they bring a hardcopy of the competency article (Weston et al., 2008) which I asked them to read earlier. At the beginning of our session, I read through the competencies to help the recollection of the competencies. In each focus group session, I asked all of the participants 10 major questions. These questions are included in the official protocol (Appendix B):

1. In what ways do you find the proposed competencies relevant?
2. How are the proposed competencies different and/or the same from your current teaching practice?
3. Which competency did you find to be the most relevant? Why?
4. Which competency did you find to be the least relevant? Why?
5. How would you react if these competencies were adopted by the state?
6. How would you amend, add, or change these proposed competencies?
7. In your opinion, what is the most useful time to be exposed to these competencies (pre-service or in-service)?
8. What roles do teachers play in regard to children’s mental health in the classroom?
9. What do you wish you knew about mental health?
10. If you have had any experiences in the classroom regarding mental health, please describe them.

As a follow up to the focus group session, I asked each participant one question individually to establish the third set of data (Appendix C). Approximately three days after our focus group interview, I contacted each participant and asked for any other information they would care to contribute to the study. With this step, I provided the opportunity for each participant to reflect on the focus group experience, and add any additional thoughts or considerations concerning the competencies which had not emerged in the focus group interview. Each conversation was short, approximately 30 seconds to 2 minutes in length. I took notes on each conversation.

**Data Analysis**

I used the data analysis spiral to make meaning of the information (Creswell, 2013). This is a reiterative process of moving in an analytical circle through (a) data management; (b)
I initially read through all three data sets for each school to receive an overall feel for the responses. I then reread the focus group transcriptions multiple times, first making notes in the margins and then using coding techniques. I first color-coded the data using the three research questions. Then, for each question, I color-coded the data again by subject similarity forming them into particular categories (Charmaz, 1983). From the coding, I recognized emerging themes related to the research questions. As part of data analysis process, I triangulated the data by rereading, and coding where appropriate, the questionnaire responses and final interview question notes. I took time to think and reflect while analyzing which brought clarity to me. By using the three data sources described above, the essence of the participants’ thoughts, opinions, and experiences related to the proposed mental health competencies emerged. Through this reiterative process of reading, coding for themes, and reflection, I interpreted meaning and provided statement results for the research questions in this study.

Confidentiality

Confidentiality was maintained in this study in several ways. First, the online questionnaire was submitted anonymously, only providing the zone of their school at which the participant worked. Another use of confidentiality was during the focus group interview. I audio recorded the interviews, and then transcribed it. To assist with that process, each participant had the choice of using their real name or a pseudonym of their choice for identification on the recording. At no time did I share my data with anyone. Lastly, I kept all data secure while I conducted the study and it will be safely kept for the three-year time period required by IRB.
Ethical Considerations

A good study is ethical (Creswell, 2013). Besides obtaining permission and support from institutional review boards, I ensured ethical practices were used in a variety of ways. Participants volunteered for the study after being informed there will be no obligation to participate and signed the approved consent form. The information in the study was reported honestly and participants had the opportunity to read and verify all of the written material.

Trustworthiness, Credibility, and Internal Integrity in Case Study Research

I used three techniques to maintain trustworthiness and credibility of this study. The first of which is the triangulation of data sources. As reported earlier, I used questionnaire data, focus group interviews, and notes as three sources of data. Cross-referencing of the data can be performed when a variety of sources are used, thus leading to a stronger research study (Patton, 2002). I also asked for member checking by inviting each participant to read through the data analysis chapter. In this way, participants were able to check and be sure their words, thoughts, and meanings are accurately depicted in the study. Lastly, I had an outside reader who verified the analysis and thematic representations independently from my committee. The use of these three methods strengthened the credibility and trustworthiness of the study.

Janesick (2000) encouraged qualitative researchers to use alternative ways to think about internal validity and the unique challenges of case study work. The researcher needs to consider that “validity in qualitative research has to do with description and explanation and whether or not the explanation fits the description” (p. 393). I maintained validity using appropriate explanations fitting the descriptions given by the participants. However, there is more than one way to describe and explain information. Therefore, in this research, I do not claim that mine is the only “correct” way.
Potential Research Bias

The researcher is part of the inquiry process and through my own lens the study is conducted. I selected the field of study and the specific topic based upon my own personal and professional interests. I developed an interest in the field of children’s mental health and expanded school mental health when my son received a mental health diagnosis. I wanted to learn all that I could about his needs, and was dismayed at how little I actually understood. In addition, as a classroom teacher, I also realized how my lack of knowledge might impact my ability to address student needs as well. Since becoming a faculty member in the College of Education, I have worked to impart some of this new found knowledge to pre-service teachers in the courses I teach and by organizing an annual conference focused on children’s mental health.

As a doctoral student, I have participated in the Mental Health Education Integration Consortium (MHEDIC) meetings. This is where I learned of the development of the mental health competency framework, and met two of the authors. Karen Weston, first author, approved of my research study as a follow up to their work.

I was able to maintain objectivity through the use of several practices. First, a qualitative research design supports understanding which supports objectivity (Creswell, 2013; Janesick, 2011). The purpose of this study is to understand teachers’ perspectives. Since I was not trying to control the study with predetermined answers, objectivity was maintained. The use of focus groups is also a method of keeping objectivity. Instead of using individual stories, the multiplicity of ideas and experiences from a group unfold to create something new and avoid a predetermined meaning (Kamberelis & Dimetriadis, 2011). Throughout the study I kept a journal of notes, ideas, and questions pertaining to the study which kept me focused on the purpose. Janesick (2011) also stated that researcher journals help refine the understanding of the
researcher role. Journaling is an effective aid in the examination of personal assumptions and goals which might impact data analysis and interpretation (Meloy, 2001). In addition, I also used an outside reader who not only verified the analysis of the data but who also acted as a sounding board when I needed to talk through phases of the study. An ongoing dialogue with an outside reader, or a critical friend, builds researcher authenticity and supports objectivity (Creswell, 2013; Denzin & Lincoln, 2005).

Knowledge has the ability to inform practice, which is one purpose of research (Patton, 2002). Qualitative research is often conducted in the field to gain a deeper understanding of an issue and can use interviews as a data source. This case study has sought teachers’ perspectives about the proposed mental health competencies from teachers in the field through a questionnaire and interviews.
CHAPTER IV

RESULTS

The purpose of the study was to examine the participating teachers’ perspectives on the content and implementation of proposed mental health competencies. I used three research questions to guide the study and collected data from 10 participants at three elementary schools. At each school, the participants first completed an online questionnaire which provided demographic and background information. The next step was for the participants at each school to participate in a focus group interview with a ten-question protocol. As a final step of data collection, I conducted individual follow-up phone interviews with all participants. All of the data were analyzed using a reiterative process of reading, coding, writing, and reflecting. This chapter will report the results for each research question:

1. What are the participants’ perceptions regarding how mental health competencies can guide and inform their classroom practice?

2. How would the participants react if these competencies were adopted by the state?

3. In what ways would the participants amend, add, or change the proposed mental health competencies?

Competencies Guide and Inform Participants’ Practice

According to the participants of this study, teachers who demonstrate knowledge and skills in the six targeted competencies (Weston et al., 2008) would be better equipped for the classroom. The examination of the participants’ responses regarding the first research question: “What are the participants’ perceptions regarding how mental health competencies can guide and inform their classroom practice?” resulted in three major themes. The participating teachers felt that educators, in general, need to be more knowledgeable in the area of mental health for
today’s classrooms. They also reported on the need for support systems to assist in meeting the needs of their students with mental health challenges. Finally, the participants saw a great need to include a competency on personal well-being for the educators as well as for the students.

**Educators need knowledge on mental health.** All participants perceived knowledge on mental health as the foundation to guide and inform their classroom practice for their current student population. In examining the competencies, the participating teachers recognized their lack of knowledge and perceived the competencies as an opportunity to acquire new knowledge and skills regarding mental health. They believed this knowledge ultimately would improve their teaching practice and their credibility. The participants also felt that the manner in which they would learn about the proposed competencies was important, and had suggestions for mental health professional development.

Most participants acknowledged their current lack of general knowledge about mental health including signs, symptoms, strategies, interventions, and resources. For example, TW2 said, “I would love to understand more about how their [students’] little minds work so I can figure out if he is being defiant or if he is overly stressed about something else in his life that I could help him with and also avoid the frustration of his defiance.” She then stated that to be further trained and educated on mental health would only be considered a benefit. As an example, TE10 stated, “Teaching would be different with these competencies because I would be more knowledgeable and I would have had training and have resources to use.” Also, TE8 said, “I feel like there’s so much you need to know, especially when you’re interacting with kids. I didn’t get a lot of background on mental health when I was in school.” In all three schools, the competencies and our focus group interview generated a rich discussion about teaching. For
example, many teachers indicated that new knowledge built upon existing knowledge can lead to more effective teaching practices.

The participating teachers thought that competency two, which is developing knowledge and skills regarding learning supports, would help to guide and inform their teaching practice. TE8 stated, “If we’re not knowledgeable about the things we need to do in order to make our students successful, it’s going to be difficult to accomplish it”, and her colleague, TE9 agreed. Similarly, TW2 thought competency two was important for all teachers because “In teaching the whole child, his/her social emotional well-being and their academic success go hand in hand. You need to teach the whole child.” TW4 made a similar connection, and pointed out that having a better understanding of the child’s mental health would help her “know how to go about it with their learning.” All four teachers from the west zone school agreed that promoting student success should be the main focus for teachers who are knowledgeable about mental health. The teachers at the south zone school were also interested in acquiring more knowledge to support learning for children who have mental health problems. TS6 made the comment that “Teachers don’t always know what to do”, but she added that being more competent in mental health would allow her to deeply explore the issues with the student and family. Gaining more knowledge on learning supports for children with mental health conditions was considered as a way for a teacher to be more effective in the classroom.

The participating teachers were most interested in learning new information regarding children’s mental health to apply directly to their classroom management and instruction. TW4 noted that she did not know any early warning signs, though they would be helpful for her to know as a teacher. Also, TE10 said she would like more information on all topics including disorder descriptions, techniques for working with students who have specific diagnoses, plans
of action, interventions, and support. In addition, TE8 and TE9 both wanted practical information that they can use with their students, especially for behavior management. In regard to behavior management, training to prevent a crisis situation with an emotionally unstable child (de-escalation) was an immediate need of the teachers in the south zone school. For example, TS5 asked for effective strategies to use for students who are unable to control their outbursts. TS7 agreed and stated she needed to know how to diffuse or de-escalate the outbursts. The three teachers (TS5, TS6, and TS7) alluded that these de-escalation strategies would serve many teachers well. New practical knowledge on mental health was welcomed by the participating teachers to guide and inform their teaching practice.

The teachers from the south zone school considered the addition of the mental health knowledge and skills competencies not only as a way to improve their teaching practice but also as an opportunity to take on a new and more credible role in addressing children’s mental health. “It [mental health knowledge and skills] would definitely change our role as a teacher” (TS6). With training, these teachers felt they would be seen as credible and competent team members. They expressed how helpful it would be if parents and other professionals considered them to be informed, credible and an integral part of the solution for students and families. TS6 said that teachers currently have to express their thoughts about mental health very carefully. Because teachers have not been professionally trained in this area, they might make incorrect statements regarding a child’s mental health. She also said it is not part of their current job to address mental health issues, for the same reason. The same group of teachers also expressed that the parents are often reluctant to share information on their child’s mental health, rather they remain uninvolved in any kind of treatment plans with outside agencies. If mental health services became part of their responsibility these teachers assumed it would change the role of a teacher. Ultimately, they
would be able to “really get deep” (TS6) into the issues. TS5 believed that this new transparency about the child’s mental health would enable teachers to address mental health problems directly. By having the knowledge and skills to make a real difference in their students’ lives, teachers will effectively collaborate with parents and mental health providers. For example, TS6 commented, “I think it would change our whole classroom dynamics because then we’ll know exactly what we need to do, what we can do to help our kids, what we can do to help their families, and all of that”. In addition, TS7 perceived this new role as being important because, “when a teacher is too afraid to voice his/her concern, the problem can increase and the chances of the student receiving any help can decrease.” Based upon the teachers’ interviews, the teachers seemed to believe that acquiring new knowledge on mental health would enable teachers to play an extended and more credible role in helping students.

In order to become more knowledgeable on mental health, the teachers all agreed that effective on-going professional development would be needed. TE8 summarized it this way, “We need the training to know what we need to do so that we’re not wasting time trying to figure it out on our own, then we can implement whatever strategy will work best.” In accordance with her view, other participants agreed teachers need good quality and effective training. TS6 said that training should include the use of real life examples to demonstrate the application of the information. The teachers in both the west and south zone schools emphasized the importance of having qualified and experienced trainers. TW2 said that the person who delivers the content should have some experience in children’s mental health and in education. For example, the teachers in the west zone school suggested a peer as a trainer who is relatable to give them information in a simple and straightforward manner. Though the trainer might be from their own school, they also pointed out the value of bringing in a credible person from an outside agency.
Although they wanted quality professional development in mental health, none of the participating teachers were interested in just being asked to do “one more thing (TW2).” They stated firmly that they would only “buy into” (TS6) the idea of mental health competencies if they received appropriate and effective training to ensure the competencies could be used to improve their instruction and classroom management. The participants recognized their own lack of knowledge and training in mental health. At the same time, they believed that acquiring knowledge and skills in the area of mental health through quality professional development would indeed guide and inform their teaching practice in a positive manner.

**Educators want large and effective support systems.** All teacher participants expressed their need and desire for comprehensive and more effective support systems when working with students who have mental health challenges. Participating teachers wanted more support from the school faculty, parents, and community because this well-coordinated support can offer greater assistance to individual students.

In the mental health curriculum framework, competency number five stated that teachers should engage in multiple systems of support. However, the responses from the questionnaire completed prior to the focus group interview indicated that none of the participants knew anyone in the community to whom they can refer families for assistance. Although, some of the participants named the school guidance counselor or school psychologist to contact for mental health assistance in their school, all the participants said the people in those positions are usually unavailable for individual mental health concerns. Participating teachers at all three schools would like larger support systems; therefore, they supported the adoption of these competencies which ultimately could initiate/generate a comprehensive support system.
Participants perceived multiple support systems as a valuable way to both guide and inform a teachers’ practice when working with students who have mental health conditions. An extensive discussion regarding the fifth competency on multiple systems was geared toward support within their own school. Having additional support personnel would assist classroom teachers. TE10 said that if other people around the school were sharing the mental health responsibility, her job would be easier. At the time of the interview, TS6 recognized the guidance counselor as the only source of help in her school. However, she also said that the guidance counselor is often unavailable and has 600 other students to work with. Teachers (TE9, TW1, TW2, TS7) agreed that the counselors should play a larger role in children’s mental health. However, three of the participants (TS5, TW3, TE8) recognized that counselors are currently tasked to perform other duties. As an example, TW1 stated the guidance counselor in her school is really good at talking with people but “she’s wearing so many hats right now that she doesn’t have a chance to do it.” TE10 was also concerned about the lack of a guidance class and individual meetings for students. When asked about other support staff, e.g. the school psychologist and social worker, most of the teachers said they were not used to working with them. Moreover, some teachers (TW1, TS7, TE8) acknowledged that they were unaware of those individual people at their schools. The teachers at the west zone school said the school psychologist primarily evaluates children, especially for gifted eligibility. On the other hand, the teachers at the south zone school mentioned the assistant principal as a potential person, because she is responsible for disciplinary actions. TS7 also suggested the intervention specialist at her school might be helpful; however later she admitted that she did not really know what that position title meant. The teachers from the east zone school said that no one at their school understood mental health. While discussing other support staff, TE8 offered a new idea. She
suggested that a mental health specialist be assigned to every school. This new position could be a specially trained teacher who could be in charge of helping others in the school building by providing resources, suggestions, strategies, and even assistance when speaking to family members. Not limited to only their school, TE10 also thought the communication between schools in the same district regarding a specific student and mental health concerns should be consistently followed through. Clearly, all participants believed that a larger support network in and among the schools would be beneficial to teachers and their students.

Besides support personnel in the schools, the participants also saw the inclusion of parent support as an important factor in effectively meeting the needs of the students. TW1 suggested that the adoption of the mental health educator competencies would create more parent involvement and help to establish better relationships with parents. All teachers at the south zone school were optimistic about the adoption of the competencies that would lead to transparent and open discussions with the parents about the child’s mental health. As TS5 noted, if the teachers were more knowledgeable and skilled in the area of mental health, parents would consider teachers to be credible on mental health, and partners in the solution. TS6 had an idea; teachers and parents would collaborate as a support system. Specifically, her proposal included a written or verbal report from the parent to the teacher on the background or history of each student. She suggested, “If we just had good background knowledge of where these kids have been and what has been going on in their life, it would really open our eyes to what we can do to help” (TS6). TS5 noted that the adoption of teacher mental health competencies which included multiple support systems might lead to parent classes or training: “So maybe if parents went through some kind of mental health training on what supports are available it could help even more.” All
participants agreed that positive collaboration with the parents would lead to more effective support.

A third area of focus for competency five related to community support and resources in mental health to guide and inform teachers’ instruction. Some participating teachers thought that instead of solely relying on the school, using more community resources could expedite the process of students receiving the help they need. The participating teachers spoke about the existence of MTSS in their school; a process for providing students’ the help they needed to succeed. However, the teachers also stated MTSS is a lengthy, complex, and often uncertain process because teachers are asked to observe, watch, collect data, and fill out a lot of paperwork for students going through an MTSS process (TS6). Also, TW4 found that most MTSS referrals focused on academics first. Then, if there was a behavioral concern, teachers would start a new process for another behavioral MTSS process. To mitigate these problems, a teacher (TS7) at the south zone school suggested a database of community resources be made available to all district employees upon the adoption of the mental health competencies. She said this database would be helpful in reducing the amount of time it often takes for a student to receive help inside the school. “I think that it would get them access to the help they need quicker and I think that’s probably most important for these kids” (TS7). Her colleague, TS6, completely agreed with her. In addition, communication among and between a multi-system team of people working with a student was also discussed among several teachers. TS7 hoped that all organizations would share files with the teachers given the new role teachers would play as knowledgeable and credible key stakeholders. All three teachers at the south zone school had examples of students who were seeing a doctor, a private counselor, and/or being involuntarily committed to a crisis unit for psychiatric reasons, and afterwards no information was shared with teachers. Teachers stated that
in those situations, “We need to know what has happened” (TS6), and “Getting all the information would help us teach differently” (TS7). An additional aspect of community resources is creating connections between families and agencies for meeting children’s needs. TW2 said that, “If I’ve learned anything, it’s I can’t do it all by myself. I need to connect this family with this resource for these reasons.” She mentioned that the problem is not always in connecting with mental health providers but other organizations like churches, food banks, and shelters. “You have to know how to meet all those needs (TW2).” However, she was disappointed that she was not familiar enough with the community to make all the needed connections. She had no idea where to refer people for help; though she hoped that the adoption of these competencies would lead to larger support systems including all of the stakeholders. In addition, all the participants perceived community services as a vital piece to be included in multiple systems of support.

**Educators support personal well-being.** Most of the participants supported personal well-being, competency number six (Weston et al., 2008), as an important way to improve their teaching practice. TS5 noted that it is important for a teacher to be at his/her emotional best because the students notice when their teacher is burned out and stressed. She also added that students’ response to teacher stress could range from empathy to negative reactions which could cause chaos and loss of control. The high rate of teacher turnover nationwide might be connected to a lack of understanding of competency six, which outlines the need for teachers to demonstrate overall personal and professional well-being (TS5). During the focus group with the teachers at the west zone school, competency six was at first not mentioned as an important competency. When I brought it to the teachers’ attention, TW1 first said that “In a teacher’s world, you would put them [children] before yourself.” As the discussion unfolded, TW2 said,
“Maybe six [competency] is higher than we really want to think it is because if it were higher maybe we could all last longer [as teachers].” In addition, the four teacher participants from the south zone school wanted to create awareness of the people with whom they work and who experience life challenges by showing empathy and support for them. The teachers at the east zone school related competency six with how others expressed their appreciation of them. Furthermore, TE8 gave examples such as community organizations that support their school and provide treats like deli sandwiches for the teachers on occasion. Similarly, TE9 thought it was a good idea to include competency six because the teacher’s mental well-being is important. The teachers from the east zone school also discussed the idea of having someone at the school with whom teachers can talk about their own mental health issues. She also stated, “This is what I love about this [competency framework], they [researchers] not only put in competencies for kids but for teachers’ needs too.” Teachers’ personal well-being grew in importance throughout each focus group interview, and was ultimately perceived as a necessary component in becoming an effective teacher.

Some teachers also thought personal well-being should be taught to students. The west zone school is a Leader in Me school in that they use the content from The 7 Habits of Happy Kids (Covey, 2008) to build leadership skills in the students. TW3 recognized that personal well-being could be presented to students through the Leader in Me curriculum. She said, “The Leader in Me does focus on making yourself into a better person, a leader.” One of the habits, referred to as Sharpening the Saw, could be used to help students become more aware of their own traits and empower students to improve themselves. Using this habit, students learn how to achieve a balance in their life with important habits like eating and sleeping. The west zone teachers wanted to add content on balancing emotions to the existing curriculum. Further, TS5
brought up the same program and made a similar connection during the interview. Personal well-being was not only thought to be an important idea for teachers, but an important skill for the students as well.

In summary, through focus group interviews, the teacher participants shared their perceptions on how mental health competencies can guide and inform their classroom practice. They expressed their thoughts with three major themes: participating teachers needed knowledge on mental health to support the students, large and effective support systems including other school personnel, families, and community agencies and lastly, support for personal well-being both for teachers and students.

Participants’ Reaction to Mandated Competencies

The second research question examined “How the participants would react if the competencies were adopted by the state?” Overall, they supported the adoption of the mental health competencies because of the great need for mental health services which exists. However, they also expressed apprehension and reasons for their reservations. Two major themes emerged from the participants. The first theme was the support for the adoption of the mental health competencies. The second theme was the participants’ concerns regarding the implementation of the competencies.

Support for the adoption of the mental health competencies. All teacher participants agreed that mental health care is relevant in today’s society and needed in the schools; therefore, they expressed their support related to the adoption of the proposed mental health competencies. Teachers believed that by adding the knowledge and skills associated with mental health to their preparation and training, they could become more effective classroom teachers. For example, TW2 shared a scenario illustrating her need for knowledge and skills on mental health. A year
before she witnessed extreme bullying among the middle school students. Because of the bullying, she often worried about students who were bullied might attempt suicide. One day, a student inflicted self-harm by cutting herself in the girl’s bathroom. The teacher acknowledged her ability to handle this kind of situation was limited to her own common sense and interpretation of best practices for these situations. She admitted that she could have done more for the students if she had known how to help. Ultimately, if TW2 had been able to address and solve the problem of bullying, more learning could have taken place. Other stories were also shared in the focus group interviews about specific students with mental health concerns. From all these stories, lack of knowledge, effective strategies, and resources emerged as common threads, which ultimately led to the conclusion that these competencies were essential for teachers.

The participating teachers wished they already knew the information found in the mental health competencies. The teachers at the east zone school said they support the mental health competencies whether or not they ever are adopted. For example, TE8 wished there was someone currently available to teach them the knowledge and skills included in the mental health competencies so she could include them in her practice now. The three participants at the south zone school saw the competencies as being helpful to a teacher. One stated that, “We don’t always know what to do. We try to find the quick solution without really fully understanding what these principles are all about (TS6).” Another teacher (TS7) eagerly pointed out that teachers actually want to help their students; therefore, possessing the knowledge and skills associated with the mental health competencies would assist them in becoming better teachers. TS5 responded to her with, “I think it [the competencies] would make teaching easier.” Overall, the participating teachers supported the adoption of the mental health competencies. Several of
the teacher participants stated in their final individual interview that they were grateful to have participated in this study because it provided an opportunity for them to think about the complexity of mental health challenges and to share their ideas.

**Concerns with the implementation of adopted mental health competencies.** Although there was extensive support for the mental health competencies, reluctance was also present due to teachers being overburdened and concerned about the implementation process. When asked how they would react to the adoption of these competencies, immediate reaction of the four teachers in the west zone school indicated a feeling of already being overwhelmed with school-related responsibilities. In addition, the possibility of having to be responsible for one more thing was just too much. TW2 responded, “Honestly, in all honesty, it [adoption of new competencies] would feel heavy because it would feel like there is already so much on my plate. It would be difficult to wrap my mind around such an enormous pile of information as well.” Similarly, the teachers at the east zone school also discussed feeling overburdened. Learning new strategies and changing classroom practices would require a time investment for teachers, which would be challenging. For example, TE9 spoke about the extra time needed to teach students additional social skills and new procedures for handling specific situations. TE8 mentioned that certain students or cases could be complex and require a lot of time and resources. Although more communication with other professionals might increase effectiveness; still, it would also be time intensive. TE10 added that collecting data or record keeping for mental health issues would also require additional teacher time. In a climate of overburdened teachers, the time to accomplish these new tasks seemed to cause concern regarding the adoption of these competencies.

In addition to feeling overburdened, the most reluctance to the adoption of the competencies emerged from the concerns regarding the implementation process. Many
participating teachers were skeptical about an effective implementation of the competencies due to past experiences with other district or school initiatives. According to TE10, at the beginning of each school year a new idea or program is presented with excitement along with expectation of teachers’ commitment to these new projects. However, then very little additional training or support is provided, and gradually the new program dwindles away until it is non-existent. The following school year the cycle starts again with a new and different initiative. The other two participants from the east zone school nodded in agreement, as TE10 vocalized her concern. Lack of follow through and support for past implementation processes caused the participating teachers to share their concern regarding the implementation of these mental health competencies if they were adopted statewide.

The quality and quantity of the necessary training needed to fully implement the mental health competencies was a concern as well. All of the teachers discussed the need for quality training. The participants in both the west and south zone schools discussed how a credible presenter would be vitally important. As for quantity, all of the participants described re-occurring sessions which would be a “thread which runs through the year like a small nugget of information here and there (TW2).” One reason they were adamant about the training was the lack of effective trainings in the past. TW5 mentioned that her school implemented a social emotional curriculum for students the past year, without teacher professional development in this area. Therefore, the curriculum had fallen to the side and was ineffective. The notion of effective training was emphasized through similar stories regarding teachers being continually asked to learn and utilize new programs without adequate training for successful implementation.

Implementation of the competencies that also requires additional personnel for support was another area of concern. All 10 participants agreed that mental health support staff would be
needed to share the responsibility of mental health care to decrease the teacher’s responsibility. TE8 said that the teacher competencies would only work “if we had procedures set in place, if we had training set in place, and if we had people that we could identify who could help us if we didn’t understand something or if we had mental health questions.” The teachers at the west zone school discussed the implementation factors. For example, TW1 stated that she would need someone to whom she could turn for support when having problems regarding the mental health of a student. In addition, TW2 suggested a document showing a teacher’s role along with all the other personnel’s responsibilities, and the connection between roles and resources available. Furthermore, there were discussions about the roles of the school counselor, psychologist, social worker, nurse, administration, parents, and even community members at each focus group interview. Participants suggested that a strong infrastructure of support at both the district and school level would be important to have in place for implementing the educator competencies. Furthermore, one teacher believed the support had to start with the superintendent of schools. She stated, “I think our district has to be convinced that the problem is big enough for them to invest a lot of money and time into school-based mental health (TE8).” Unfortunately, the teacher participants were not confident about the reality of a strong infrastructure because it would take knowledge, time and money. However, TE8 optimistically stated, “It depends on the leader of the school. If the leader is passionate about mental health and makes sure the teachers are knowledgeable and it is being implemented in the classroom, I think it will happen because that’s the atmosphere of the school.” She also added that the reverse is also true. At that point the competencies become just another task for teachers to do. Given the current practices in the district, receiving additional support staff seemed unlikely which caused feelings of reservations in all participants about the adoption of the proposed educator mental health competencies.
Undoubtedly, the participating teachers showed support for the adoption of the proposed competency framework on mental health. However, the teachers also raised legitimate concerns regarding the implementation of the mental health competencies. Due to past experiences, they were hesitant about receiving appropriate training and other support personnel, though they acknowledged the need. It was these concerns which gave trepidation to their overall support of the mental health competencies.

**Participants’ Recommendations about the Competencies**

This study not only investigated the participating teachers’ perceptions on the mental health competencies (Weston et al., 2008), but also examined teachers’ recommendations regarding these competencies. The participants agreed that the competencies were well developed. However, they did not feel knowledgeable enough on the topic of mental health to provide comprehensive recommendations. For example, TW3 stated, “I thought they [competencies] were pretty thorough”, and it was a thought echoed by many of the participants without changes to recommend. In addition, TE8 noted, “I don’t feel like I know enough about mental health to say that I would change anything.” Her colleagues at the other schools agreed, and expressed similar comments. Another example illustrating the lack of mental health knowledge is “I feel like I don’t know anything about these policies and laws” (TS5) with which TS6 agreed. It was implied that teachers are not knowledgeable enough on the topic of mental health to determine whether or not these competencies should be changed. The questionnaire results support their responses about lack of mental health knowledge because all of the participating teachers except for one responded as having no training about mental health in their teacher preparation program. Although participants failed to give direct recommendations about the competencies, they implied suggestions in their comments throughout the focus group.
interviews. The participants’ indirect comments regarding suggestions for the mental health competencies are organized according to the three major themes which emerged. The participants suggested (1) additions to include in the competency framework, (2) small adjustments to the competencies, and (3) major changes to the entire format.

**Additions to the competency framework.** The participating teachers indicated two different additions to the current educator mental health competencies, (1) a mandatory college course and (2) the inclusion of other school mental health professionals. All 10 focus group participants agreed that students in the teacher preparation program would benefit from some instruction on mental health. The participants at the west zone school suggested an additional course be included in teacher preparation programs. For example, TW1 found it beneficial to include a mandatory behavioral health course in teacher preparation programs. According to her, due to the different focus of a behavioral health course, this training would be in addition to the already existing classroom management course. TW2 considered it as a way to learn more about behavioral health problems rather than avoiding the problem. Furthermore, TW4 perceived the course as a way to learn more foundational information and receive instruction on practical applications for handling behavioral health situations in a classroom.

The mental health competencies are written for educators. Although the participants recognized the need for teachers to become better informed, they also thought that other personnel in the school are needed in a similar capacity to effectively meet the mental health demands of the student population. The teachers wanted to have the competencies that address and include all the other school-based personnel. For example, TE10 recalled a time working with a challenging student when she felt like, “it was just on me”, and there was not a positive resolution for the specific situation. She said that the competencies should include other school
personnel so everyone has a shared sense of responsibility. Several other teachers made similar comments throughout the focus group interviews (TE9, TW1, TS7). However, TE8 thought teachers should be accountable for the knowledge and skills associated with the competencies regardless of other school-based support personnel. The participants supported the educator’s role in mental health; however, they recommended other professional roles be added to the competencies as well.

**Adjustments to the competency framework.** The participants suggested a reduction of content in two of the proposed competencies. Overall, their opinion was that laws and policies, along with data collection, were not the primary focus of a classroom teacher; therefore, the knowledge and skills associated with legal requirements could be reduced. On the other hand, the most important competencies should remain as they were formulated, specifically the ones associated to working with people; numbers two [learning supports], four [communication skills and relationship building], five [multiple systems], and six [personal and professional development and well-being]. The participating teachers wanted to adjust the first competency which is on key policies and laws that foster the delivery of effective and ethical learning supports and the third one about collecting and use of data. “Competencies one and three are lower on our list”, stated TW1. The first competency which targets laws and policies received a lot of attention. The teachers perceived the laws and policies as being handled by lawyers and the administration rather than by teachers. Their experience has been that district personnel and administrators give teachers the information they need to know for district compliance. For example, TS7 described it as a “trickle down” effect. Teachers primarily work with students and parents who are unfamiliar with the laws anyway (TS6). In addition, TE8 said that though it is good to know the laws, the practice in the classroom is more important. She stated, “It is the
teacher’s practice that will make the most difference in the life of a child.” Although laws and policies were perceived as important in education, these teachers suggested less content for competency one because laws and policies would primarily fall under the role of an administrator, rather than a teacher.

The participants thought the content in the third competency on collection and use of data measuring student behaviors, affect, and attitudes should also be reduced. Although data collection and data driven decisions have become a necessary component of the educational process, most teachers failed to recognize these as important; rather they perceived them as merely another job requirement. For example, TW1 stated that data collection is “not a top priority” and focusing on the student is more important than focusing on the data. She also stated that collecting data on social emotional behavior might be difficult. However, one of the teachers disagreed with all the others. TE8 noted, “I think it is necessary because if you don’t have that data, you really don’t know if what you are doing is effective or not.” The other two teachers in the east zone school acknowledged her point, but with some reservation. Overall, the majority of the participating teachers suggested reducing the amount of required content related to competencies one [key policies and laws] and three [data collection] because of the perceived lack of relevance of them to teaching and classrooms.

Major changes related to the competency format. The participating teachers would change the format of the proposed mental health competencies in two ways: using simple language and providing practical strategies. Although all teachers thought that the proposed competencies were well developed, the teachers from the south zone school stated that the competencies were written at a high level of language complexity. TS7 noted that “the easier it is for people to understand on all different IQ levels, the easier it will be to get the buy-in that you
need to help the kids.” Her colleagues agreed and suggested to keep the competencies simple and to illustrate with examples. TS6 stated that the list of skills and knowledge provided in the appendix of the Weston et al. (2008) article is “a lot for a teacher, especially when it is on top of everything else they are asked to do.” Besides using simple and clear language, the teachers also asked for practical solutions for mental health challenges.

Participants suggested explicit instruction on practical strategies rather than a curriculum framework. Regarding the competencies which require that teachers identify, describe, and implement behavior management strategies, the teacher participants wanted to know specific strategies for solving the problems they are currently facing. For example, TS5 asked for “some effective strategies” during our conversation. The teachers at the east zone school wished for a specific set of guidelines regarding behavior and consequences. In addition, TE10 strongly recommended having a resource guide listing consequences for every behavior. Administrators and teachers would be expected to consistently follow the listed consequences district wide. In support of the idea, TE9 added, “We need strategies to be able to pull out of our bag.”

Furthermore, TE10 also wanted explicit instruction regarding the effectiveness of commonly used consequences for working with students who have mental health challenges, for example sending a student to the office, having a student change his/her color, or writing a note home. Another request was for direction on how to avoid triggers and effectively de-escalate students in crisis or in the throes of an outburst. For example, TS5 taught 5th grade and TS7 taught kindergarten, yet both of these teachers were concerned about out of control student behavior and the lack of effective strategies to address them. In addition, TS5 would like a strategy that everyone could learn and implement to de-escalate student behavior as needed. The teachers from the east zone school had similar concerns and suggestions when discussing their behavior
concerns. Specifically, TW4 wanted more information on atypical behavior and on common symptoms. TW2 thought a simple checklist could help with identifying signs and symptoms. She described how a teacher could simply look up the symptoms which would correspond to a diagnosis, and then would be given interventions or strategies to follow for effective results. Then, to understand the support system needed, she suggested a kind of map connecting all the pieces. It would show the various roles associated with meeting mental health needs and where the teacher fits into the picture. The same map would explain the responsibility of everyone included and list how to contact the person in each role. Even though these teachers did not see the laws associated with mental health as being relevant to their practice, TS5 would like the laws presented in a simple resource like a flowchart. She suggested a tool which can be used as needed to quickly ascertain the needed information. An easily accessible electronic repository of up-to-date information pertaining to laws and policies was another idea presented by TS7. The participants were interested in the acquiring knowledge and skills associated with mental health; however, they suggested changing the competencies to practical strategies written in simple, clear language. Even though the participating teachers did not feel confident to provide recommendations for improving the mental health competencies, they shared their concerns, ideas and suggestions throughout the focus group interviews.

In summary, the teachers would like a behavioral health course required in undergraduate teacher preparation programs as an addition to the competency framework. They also suggested more educational personnel be included in the competencies for a whole school support system. The teachers acknowledged the importance of all six of the competencies; however, they would decrease the content regarding laws, policies, and data collection. In addition, some suggestions included a change to the entire format of the competency framework. The participating teachers
suggested the competencies be written using simple language and supply practical classroom strategies. Overall, teachers seemed to want a competency document that is easy to understand and implement to address mental health challenges in classrooms.
CHAPTER V

DISCUSSION

School mental health (SMH) is often overlooked, yet it is an extremely relevant issue for today’s teachers. Research indicates that approximately 20% of all children and adolescents have a mental health-related issue that would benefit from professional care (Adelman & Taylor, 2010). In many cases, schools have become the main source of care for students struggling with a mental health disorder (Cammack et al., 2014). The SMH programs have been providing some services and support to students for years, but schools are often under-resourced and unable to meet the level of need which exists (Weist et al., 2014). However, teachers can significantly impact the development and well-being of students, and the role of the teacher often extends beyond typical expectations (Meldrum et al., 2009). Therefore, it is important to consider a teacher’s role in the expanded version of school mental health. Teachers reported a considerable need for mental health support in school; however, they also recognized their own lack of knowledge and ill-preparedness to take on a role in mental health (Walter et al., 2006). Therefore, there is a critical need for teacher training in terms of preparing teachers with the knowledge and skills required to recognize signs and intervene appropriately in situations where mental health may be a concern (Meldrum et al., 2009). To address the limited, and often fragmented, mental health standards for teachers across the United States, a comprehensive framework of mental health competencies for teachers has been developed and proposed by Weston and colleagues (2008). Prior to this study, there has been an absence in regards to the teachers’ perspectives and opinions on the competencies.
The purpose of this case study was to examine the teachers’ perspectives regarding the content and implementation of the proposed mental health competency framework. Specifically, the research questions were:

1. What are the participants’ perceptions regarding how mental health competencies can guide and inform their classroom practice?
2. How would the participants react if these competencies were adopted by the state?
3. In what ways would the participants amend, add, or change the proposed mental health competencies?

Discussion of Findings

**Competencies guide and inform participants’ practice.** Results from the focus group interviews indicated that the participating teachers believed the educator mental health competencies would guide and inform their practice. Three themes emerged from the discussions on this topic: the need for more knowledge on mental health, the importance of effective support systems, and the consideration for personal well-being to maximize their effectiveness in the classroom.

**Educators need knowledge on mental health.** The findings of the study indicated that the participants had limited knowledge about mental health. However, as a classroom teacher, they clearly recognized a need for this knowledge. These findings are similar to those found in other research studies (Graham et al., 2011; Rothi et al., 2008; Walter et al., 2006; Williams et al., 2007). For example, many of the teachers expressed urgency and frustration in their need to receive more training in mental health (Graham et al., 2011). Similarly, Walter et al., (2006) found that most teachers who had taught students with mental health problems reported limited mental health knowledge. They also lacked confidence about their ability to manage mental
health problems in the classroom. In this study, the participating teachers perceived the greatest need for knowledge in two areas: learning supports and behavior management. Acquiring knowledge about learning supports for children who have mental health disorders was perceived as being very important. The idea of supporting children in their learning is consistent with how teachers define their role as educators (Franklin et al., 2012). In addition, Ball and colleagues (2016) reported that 43 out of 48 state standards documents also included some language regarding academic, social emotional, and behavior learning supports indicating that learning supports was considered an important competency in effective teaching. Additionally, knowledge on behavior management, especially to avoid a crisis, was the other important need expressed by the participants of this study. Similar findings can also be found in other studies. For example, two thirds of the teachers reported disruptive behavior in the classroom and on the playground as the greatest mental health problem facing their school (Walter et al., 2006). Furthermore, disruptive behavior is especially troublesome because of the horrific and violent acts carried out across the country and shown on mass media. Since the shootings at Sandy Hook, the recognition for the need of mental health services in the schools has increased considerably (Cowan & Vaillancourt, 2013). Moreover, there are techniques for de-escalating students who are exhibiting out of control behavior which are essential for school staff; however, the school staff’s verbal and physical actions can worsen student behavior when they are not properly trained in effective crisis intervention techniques (Couvillon, Peterson, Ryan, Scheuermann, & Stegall, 2010). The participating teachers in this study all agreed that more knowledge on behavior management skills, including de-escalation techniques would be helpful in managing student behavior.
The participants also believed that parents and other mental health professionals would perceive them as credible and reputable team members if teachers were knowledgeable about mental health. This finding relates to their professional identity which is formed through a process involving many knowledge sources (Beijaard, Meijer, & Verloop, 2004). Thus, acquiring knowledge on mental health would further develop their professional identity. The finding also resonates with the findings related to the lack of collaboration between school mental health professionals and teachers in Phillippo and Kelly’s study (2014). The participants in that study reported similar situations in their schools as what this study found. For example, teachers had one role and the mental health professionals had another; often, they failed to work collaboratively (Phillippo & Kelly, 2014). Some of the participating teachers in this current study suggested that mental health professionals may consider them to be credible and collaboration could increase if teachers were more knowledgeable about mental health. Furthermore, Hatch, White, and Faigenbaum (2005) posited that teacher leadership should include expertise, credibility, and influence on others. With expertise on mental health and skills to influence outcomes, teachers may gain credibility which supports the claim made by some of the participants in the current study.

The participating teachers realized that mental health training would be needed to acquire the knowledge and skills, but they were only willing to participate in relevant, effective, and ongoing training. This response can be directly linked to adult learning theory (Knowles, 1984) which provided four basic principles recommended for adult learning:

1. Adults need to be involved in the planning and evaluation of their instruction.
2. Experience provides the basis for the learning activities.
3. The subject matter must have immediate relevance and impact to their personal or professional life.

4. Adult learning is problem-centered rather than content-oriented.

The need for mental health knowledge was strongly supported throughout all of the focus group interviews. The teachers expressed care for their students and wanted to develop the necessary knowledge and skills to meet their students’ needs.

**Educators want large and effective support systems.** The findings in this study indicated that teachers want multiple support systems which include the school faculty, parents, and the community when working with students who have mental health challenges. The responses on the questionnaire showed that the participating teachers felt unsupported and were unfamiliar with appropriate people and/or organizations for support. All of the teachers believed that a comprehensive support system would help to increase their effectiveness in the classroom.

Although most of the teachers could name school mental health professionals such as the psychologist, school counselor, and social worker, they also acknowledged that these professionals were often unavailable as mental health support due to their other job responsibilities and the large number of students who needed assistance. Weist et al., (2014) found a similar situation; schools were under-resourced for addressing student emotional/behavioral challenges. Furthermore, mental health professionals were often too busy with tasks unrelated to those which actually assisted the students with emotional/behavioral challenges (Weist et al., 2014). For example, school psychologists were only used as psychological testing evaluators, school counselors were responsible for coordinating state testing mandates and for academic advising, and school social workers were inundated with administrative duties and were crisis responders (Weist et al., 2014). Instead of just wishing the
school mental health professionals would be used more effectively, one of the participants in this study suggested a new position at the school: a mental health specialist. This proposal is similarly addressed with a leadership position regarding learning supports in school (Adelman and Taylor, 2010). The authors proposed two personnel: one school administrator lead and one staff (teacher) lead who would take on the major daily functions in addressing mental health as a barrier to learning in three ways: enhancing interventions, broadening school-community linkages and partnerships, and capacity building. Examples of the staff lead’s job duties included, but are not limited to: organize and coach the Learning Supports Resource Team, provide advocacy for the component at the school in the community, and provide rapid problem solving (Adelman & Taylor, 2010). School-based mental health professionals who are able to directly assist students and teachers in addressing mental health problems are a critical part of a necessary support system.

The participating teachers also believed that the adoption of the educator mental health competencies would assist in strengthening the support of the parent/guardians. Teachers assumed if they had more knowledge about mental health, parents would be more transparent and willing to provide more information about the whole child. With this information, they could collaboratively resolve problems. Teachers have been found to play a critical role in promoting family involvement (McDaniel et al., 2014). Ultimately, accessing the appropriate assessment and treatment for the child is the main goal and involving families in mental health services is important for positive outcomes (Hoagwood et al., 2010; McDaniel et al., 2014). Moreover, the participating teachers felt that more personal background information and family history on each child would help them to meet student needs and increase learning. In addition, teachers’ use of culturally responsive practices for more effective learning is essential. For instance, a teacher
decided to move into the neighborhood where most of her students lived in order to have a shared lived experience and to gain understanding about the cultural context (Coffey & Farinde-Wu, 2016). Therefore, the teacher was then able to develop better relationships with her students and provide more relevant instruction. Bartolome (1994) also believed in the power of human experiences. She stated that teaching methods were not the most important factor in learning, but rather the degree in which a teacher values the students’ culture, life experiences, and background knowledge. In order to understand the whole child in the process of learning and to learn about all factors influencing the child, teachers are expected to work closely with parents. Another method of learning more information about students is the use of a universal screening instrument. Two self-report instruments were used with over 2,000 students at two high schools to assess for behavioral and emotional risks (Dowdy et al., 2015). They found that screening could be used to prevent and promote mental health issues rather than just react to them. Overall, results showed that the school teams in the study were grateful for the additional information increased actions as a result of the screening (Dowdy et al., 2015).

Mental health education and training for parents was an additional suggestion by a teacher participant in this study. She was optimistic that educator competencies could also lead to increased opportunities for parents to gain awareness, such as educational classes and/or training. Mental health knowledge and skills for parents can help children in both home and school environments. As an example, the National Alliance on Mental Illness (NAMI) used a signature peer-led program called Basics to educate and train a group of parents. Results of the study showed significant improvements in parental functioning and familial processes (Brister et al., 2012). Improvement in families is a positive outcome for all stakeholders.
The findings of the current study indicated that the community was the third area to include in a comprehensive support system. At the time of the study none of the participating teachers knew a contact person for mental health support or resources in the community, but they were interested in learning about agencies to make referrals. They suggested that students with mental health issues would be able to receive more appropriate help at a much faster rate, if teachers could make referrals to community agencies. Anderson-Butcher (2006) supported the idea that teachers can serve as an important link between students with a mental health condition and the professional help. She also stated that mental health professionals are better trained to handle the mental health issues. With the professionals who meet the mental health needs of the students, teachers would likely be able to focus on teaching and learning in the classrooms. Moreover, once a student’s needs are identified, strategic supports and services must be in place within the school system and in the community (Adelman & Taylor, 2010). Ultimately, collaboration between school personnel and community mental health professionals is a significant component of ESMH (Weist et al., 2012).

**Educators support personal well-being.** Findings in the current study show teachers’ support the inclusion of competency six, personal well-being. At first, the participating teachers’ focus was only on the students’ mental health but as the conversations developed, everyone recognized the importance of their own well-being. The teachers discussed the stress in this profession, even without considering the mental health of their students. When that added responsibility of mental health services was factored in, considerably more worry and pressure surfaced. Similarly, Greenglass and Burke (2003) found that in looking at occupational stress in teachers, the most frequently mentioned stressor is students’ emotional and behavioral problems.
In addition, Ekornes (2016) suggested that teacher stress, in regard to mental health, is mainly the result of a mismatch between perceived demands and the perceived ability to cope with them.

To assist teachers in reducing stress and maintaining a positive sense of well-being, the teachers endorsed particular practices; for example, having a person at the school available for teachers to speak with about their personal concerns, receiving recognition and appreciation from others, and supporting colleagues who are going through challenging times. Kyriacou (2001) found a similar coping strategy among the teachers: discuss problems and express feelings to others. However, many other strategies in Kyriacou’s study (2001) such as relaxing after work, taking action to deal with problems, and recognizing your own limitations were not mentioned by the participating teachers in the current study. In the interviews in the current study the focus was on the importance of teacher well-being as part of the mental health competencies rather than on coping strategies.

In addition, the participating teachers also recognized the power of teaching students to care for their own well-being. Although one of the schools used a program for student leadership with a module on personal well-being, this opportunity is often unavailable. However, MTSS is a widely used framework in which the first tier promotes mental wellness and utilizes prevention techniques for all students (Franklin et al., 2012; Paternite & Johnston, 2005; Rossen & Cowan, 2014; Weist et al., 2014). Moreover, student well-being is considered an outcome associated with quality education (Myers & Pianta, 2008; Van Petegem et al., 2007) and across all areas of life. Clearly, personal well-being for teachers and students emerged as a critical need.

**Participants’ reaction to mandated competencies.** Due to the considerable need witnessed by the participating teachers, they fully supported the adoption of the mental health competencies for educators. Along with their support; however, they expressed apprehension and
concern in regard to the implementation of the competencies. The support and concern emerged as the two themes for the second research question: “How would you react if these competencies were adopted by the state?”

**Support for the adoption of the mental health competencies.** The findings in this study indicated full support for the educator mental health competencies based upon the present need for them. All participants acknowledged the lack of training they received and felt ill-prepared in regard to mental health. Therefore, they were eager to learn the important information outlined in the proposed competency framework to increase their effectiveness. Statistics support the need described by the participating teachers. For example, there is a 20% prevalence rate for mental health disorders in children and adolescents (Adelman & Taylor, 2010; National Research Council and Institute of Medicine, 2009; World Health Organization, 2003) which means over 10 million students need professional help in the K-12 public schools nationwide (Rossen & Cowan, 2014; U.S. Department of Health and Human Services, 1999). Furthermore, Rosen and Cowan (2014) reported that students living with mental health challenges are unable to thrive academically. In support, other studies have found that a high prevalence of emotional and behavioral challenges interfere with school success (Adelman & Taylor, 2010; O’Connell et al., 2009; Paternite & Johnson, 2005; Waxman et al., 1999). Moreover, teachers are expected to be responsive to a wide range of student needs and circumstances in order to facilitate positive learning gains for all students. Just as the participants in the current study have stated, other studies have also found little teacher education training to adequately prepare them to work with students with mental health disorders (Phillippo & Kelly, 2014; Walter et al., 2006). As an example, teachers cited lack of information and training as one of the most important barriers to successfully working with mental health problems in their school (Walter et al., 2006). That
study also found few teachers had received any training about child and adolescent emotional or behavioral problems because mental health training was not routinely required in teacher preparation programs, nor was it required for teacher certification. Studies conducted in the UK (Rothi et al., 2008) and in Australia (Graham et al., 2014) had similar findings. Teachers support the adoption of the proposed mental health competencies because they see the need for knowledge and skills to support interventions.

**Concerns with the implementation of the adopted mental health competencies.** Along with the participating teachers’ support for the competencies were the concerns for implementing them. One area of concern in this study was the participants’ feeling of being overburdened with their current responsibilities. Trying to find a way to add one more item to their overflowing list of responsibilities was difficult. Based on their previous experiences, another area of concern was the implementation of something new. The participating teachers lacked confidence in the school and district leaders in terms of supporting a comprehensive implementation process. This study found that teachers were concerned about the lack of follow through and support and with the possibility of poor quality and irrelevant, one-time training.

Similarly, Han and Weiss (2005) directly associated several of the same factors with the sustainability of teacher-implemented school-based mental health programs. Implementation of school-based mental health programs is complex, and many factors contribute to the effectiveness and sustainability of them. In accordance with the findings of the current study, Han and Weiss (2005) first addressed factors of the broader school system e.g., alignment of institutional policy, the program’s objectives, and allocation of resources. Next, they provided six factors of the teacher and school which either facilitate or impede teachers’ efforts and motivation to implement a program: (a) support of the program from the school principal, (b)
teachers’ self-efficacy beliefs, (c) professional burnout, (d) teachers’ beliefs about the acceptability of the program, (e) the compatibility of the program with their own beliefs about student behavior, and (f) the anticipated effectiveness of the program. Finally, two program-specific factors were reviewed: teacher training and performance feedback. Concerns from the teacher participants of this study can be found at all levels of the factors by Han and Weiss (2005). For example, teachers were concerned about district and principal support, the time involved, additional resources needed, and the quality on-going training.

**Participants’ recommendations about the competencies.** The participants’ direct response to the request for recommendations was that they were not knowledgeable enough to provide insightful input. Lack of knowledge was a reoccurring theme almost for all research questions. The participating teachers reported an absence of training in mental health on the questionnaire, which supports their response. However, the teachers provided indirect suggestions and recommendations which resulted in three distinct themes: additions, adjustments, and major changes to the competency framework.

**Additions to the competency framework.** Findings in this study indicated two possible additions to the mental health competencies. One addition the participating teachers suggested was a mandatory class in all teacher preparation programs on behavioral health. Although it can be difficult to add courses to a state-approved teacher preparation program, it is also an optimal time to inform large numbers of future educators with information related to the mental health of their students. Teacher preparation programs have the potential to be influential in shaping the beliefs and practices of their students (Darling-Hammond, 2000; Hong & Lin, 2010). For example, Darling-Hammond (2000) stated that those who have had more preparation for teaching are more confident and successful than those who have had little or none. Preparing
future teachers to prevent, identify, and intervene with children who have mental health difficulties may add to their confidence and success with students. Currently, researchers in Canada are working to create an online national mental health literacy curriculum education resource for pre-service teachers (Teen Mental Health, 2016). At this time, studies and literature providing more information about the curriculum is unavailable. The idea of providing a mental health literacy course supports the suggestion of additional coursework in mental health as part of a teacher preparation program.

The other addition to the competencies was to include school mental health professionals in the competencies rather than having it geared only toward teachers. This finding supports the results associated with the need for systems of support. The teacher participants felt that the school-based mental health support positions are imperative in working with students who have mental health problems. In hopes of increasing collaboration among all school faculty members, including these other roles would make the framework more comprehensive. Collaboration among teachers and school-based mental health professionals is a reoccurring theme in the current study, and supported in other studies as well (Adelman & Taylor, 2010; Weist et al., 2014). However, one example of an innovative approach for expanding the role of the school psychologist and increasing collaboration was to include support for early career teachers with preventing and managing classroom behavior concerns (Shernoff et al., 2016). In this study, the school psychologist modeled and co-taught specific strategies for behavior management which had been introduced earlier during seminars and in their Professional Learning Communities. The early career teachers showed an increase in classroom management effectiveness, and the students also exhibited appropriate classroom behavior. Those results were promising for schools. The participating teachers in the current study suggested the need for intentional
collaboration among the people who hold various positions within their school. Therefore, they recognized a need to include competencies for multiple roles for a more comprehensive and effective framework.

_Adjustments to the competency framework._ Although the teachers thought of themselves as ill-equipped to debate the content of the competencies, the findings indicated two areas of content for adjustment. They suggested that both, competency one, related to law and policies, and competency three, related to data collection, could be reduced based upon their perceived relevance to their daily duties. The participating teachers commented that those two competencies were towards the bottom of their list of responsibilities because their focus is on the students and the promotion of learning. Therefore, they concluded that the content in those two competencies should be reduced.

There is research to support the teachers’ beliefs and perceived role of a classroom teacher. For example, researchers found that teacher-student relationships were an important source of teachers’ emotions which also play a large role in developing professional identities and personal well-being (den Brock et al., 2013). Furthermore, the teacher-student relationship was one of the main sources of teachers’ emotions in the classroom (Hargreaves, 1998; Lewis, 1999). Sockett (2008) embraced the nurturer-professional as one of the four models of moral and epistemological purposes in teacher education. The model focused on the development of the individual and primarily on relationships with children. This child-centered model is an example of how human beings care and are cared for. These humanistic perspectives offer some support for the findings in this study which suggest a greater importance on individuals than on duties involving laws, policies, and data. However, state standards documents and InTASC standards show substantial evidence of language from both competency domains (Ball et al., 2016). Over
60% of the states had some language reflecting key polices and laws, though Florida was not one of them. The InTASC standards included all of the language from the key laws and policies domain. In regard to the collection and use of data domain, every state (100%) had at least some language reflective of collection and use of data. However, only a small number (20%) included language similar to what is in the mental health domain, specifically to identify and explain the early warning signs and symptoms of mental health problems. The InTASC standards included some, but not all of the competency language for collection and use of data. While the participants of this study suggested a reduction of content regarding key laws, policies, and data, educational policy has increased those expectations for our nations’ teachers.

**Major changes related to the competency format.** Participating teachers were interested in two major changes to the competencies: use of simple language and applicable strategies. They recommended the use of simple language that all teachers can understand. The teachers felt that the competencies were written at a high level of complexity which made it difficult and time consuming to read and understand. They suggested rewriting them at a lower level using simple and clear language. The other major change was to turn the competencies into a guidebook of practical strategies they could use to solve problems they were currently facing in the classroom.

The mental health competencies opened their eyes to new information which they appreciated, but ultimately they wanted strategies that they could immediately apply.

These recommended changes can be viewed as an example of the academic-teacher divide which Gore and Gitlin (2004) described in their study. Tension has existed between the education academics who produce research knowledge and the teachers who produce experiential knowledge, which is generally less valued. Gore and Gitlin (2004) surveyed and interviewed 147 practicing teachers and found the teachers wanted academic research to inform
their actual practices. In this study, this is similar to the teacher participants who said they wanted actual strategies to use immediately. Gore and Gitlin’s (2004) findings also showed that the teachers wanted the research to be relevant, certain, and simple. Because academics write for other academics, the writing style failed to fulfill the desires of the practitioners. Therefore, teachers did not value the research and chose to rely more on trusted colleagues with experience (Dore and Gitlin, 2004). Those findings support an academic-teacher divide which may be the reason for recommending the use of clear, simple written language as well as applicable strategies in the form of a handbook rather than the curriculum framework written as a publication by educational academics.

**Implications for Practice**

The findings in this study offer numerous implications for practice. An overall increase in mental health awareness is needed. Then, schools need to make the necessary changes to support ESMH. More implications for practice focus on the teacher. These include developing pre- and in-service mental health training using the proposed competencies as a curriculum framework, creating quality training programs with much consideration on the implementation process, and prioritizing personal well-being for all educators. Lastly, researchers conducting studies in ESMH should work diligently to bridge the gap between academic educators and teachers.

Although awareness of mental health disorders has increased over the years, there is still more work to do, especially in regard to children’s mental health. Teachers who are on the frontline are acutely aware that children are struggling with mental health challenges. Lack of funding, legislation, policies, services, and programs to address the severity of this problem indicate a lack of understanding in the general public. In order to thoroughly and effectively address the mental health needs of children, researchers, educators and politicians must
acknowledge the problem and recognize the significant impact mental health disorders has on all facets of our society. However, it is also important for people to envision a better tomorrow by seeing how a change in beliefs can lead to change in actions. One opportunity to increase mental health awareness is to organize and hold a community event such as a children’s mental health conference. Bringing all stakeholders together for presentations, resources, and networking can increase awareness and encourage dialog and collaboration amongst attendees. Ultimately, comprehensive society changes will drive and support many essential changes needed in schools and communities.

School districts and individual schools should embrace the SMH model and implement the necessary changes needed to support it. Schools play a significant role in addressing children’s mental health and serve as a natural setting for services and support. Educational leaders, at both the district and school level, need to become informed about SMH in order to provide positive leadership, appropriate policies, ample funding, and the necessary resources for implementing mental health initiatives and programs. Organizational changes such as the number of mental health professionals assigned to a school and the way they are utilized needs serious consideration. The knowledge and skills those professionals possess can benefit the students, parents, and teachers in a much more significant way when innovative ideas and practices are considered. School districts and schools need to create a caring culture and build capacity in the area of mental health. This capacity building includes creating large support networks, enhancing the well-being of all stakeholders, and providing ongoing training to all school personnel. Creating a school environment conducive to supporting the inclusion of mental health is a critical prerequisite to the implementation of any mental health service or program.
An additional way to encourage and support collaboration among school personnel is to create a table documenting each professional’s competencies and indicate where they complement, hinder, and overlap with each other. The teachers in this study thought it would be more effective to show other roles in the proposed mental health competencies. They may not have considered that the school mental health professionals already have some similar competencies and that the educator mental health competencies are the only ones which are new. However, looking at all of the competencies together may help in understanding each role and planning for collaboration.

Although district and school level factors are important, the education and training of teachers is the key component of the ESMH model. Teachers have typically been responsible for supporting the social and emotional development of students and for using effective behavior management strategies. However, teachers are now also expected to implement academic and behavioral tiered interventions, identify emotional and behavioral problems that warrant referral for clinical assessment, and act as first responders in crisis situations. Therefore, teacher preparation programs need to prepare teacher candidates to be effective in those roles. A current initiative is the development of an online course in mental health literacy for all pre-service teachers across the country of Canada (Teen Mental Health, 2016). Dr. Kutcher plans to field test the course this spring and before publishing results. Training future teachers in mental health is critical, but adding a course to a program of study is often difficult to accomplish and sometimes unnecessary. Instead, mental health curriculum could be developed using the proposed framework (Weston et al., 2008) and then systematically integrated into already existing courses within a program. Pre-service teacher training would enable future teachers to develop a foundation of knowledge upon which new skills can be built.
Teachers care about their students and want to have the knowledge and skills needed to work with students who have mental health challenges, but they need effective, relevant, ongoing training and support which meets their needs. Mental health teacher training is a new initiative but Australia and Canada have already begun to field test different approaches. One approach to teacher training was conducted in Australia where a training course called Mental Health First Aid was developed (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010). The course teaches the adult general public how to apply a mental health action plan with another adult. Another course called Youth Mental Health First Aid was later developed for the use with children. According to the study, researchers modified the youth course to train a group of teachers. The teachers received two days of training, seven hours each day. The results of the training showed an increase in teachers’ knowledge, a change in beliefs about treatment, reduced some stigma, and increased confidence in providing help to students and colleagues. The original courses which are available throughout the United States could serve as an initial training for all adult stakeholders. Another example of mental health teacher training was developed by Dr. Stan Kutcher in collaboration with the Canadian Mental Health Association (Whitley et al., 2012). They first developed a mental health curriculum for high school students and then trained teachers for using it with their students. Although the teachers perceived the students as the intended audience, their own knowledge and attitudes improved significantly after taking part in the training (Whitley et al., 2012). Another possible outcome in using student curriculum is that awareness among the youth will increase thus decreasing the stigma in the future with adults. This could be easily replicated using existing curriculum developed by various organizations in the United States. However, the content of the curriculum would not cover all the necessary content needed by teachers and the training would most likely occur just once.
Optimally, mental health teacher training curriculum should be developed from the proposed educator competencies curriculum framework. The teacher participants of this study acknowledged how little they knew about mental health. Research supports this finding with educators from all over the world. Therefore, if educators attempt to develop mental health training opportunities for teachers, they will not be familiar enough with the content to know what to include. Although the competencies were written by academic educators for publication in a scholarly journal, the content is purposeful, relevant, and research-based. In addition, some SMH language from the proposed competencies can be found throughout the state standards documents and InTASC national standards (Ball et al., 2016). Therefore, a precedent for including the mental health competencies as effective teaching practice has already been set. Curriculum and Instruction specialists should work with mental health professionals and use the competency framework in the development of practical material for teachers. In addition, once educators are trained and are more knowledgeable, they can use the competencies as criteria from which to assess ready-made programs, texts, or online resources prior to their engagement.

Mental health professional development needs to be of high quality to ensure teacher acceptance, engagement, and implementation of it. Adult learning theory (Knowles, 1984) is one factor to consider when developing a program. Adult learners need to be able to bring their own experiences into the learning environment and find ways to solve relevant problems. They also enjoy taking part in the planning of instruction and expect the training to have an immediate impact in their professional life. As the participants in this study expressed, the training should be led by individuals with credibility in both, education and mental health fields. It should include not only meaningful content but also opportunities for teachers to discuss real-life situations for input on practical strategies and ways to resolve them. Mental health training
should provide opportunities for people with lived experiences to share their perspectives as well. Overall, the training should be presented in a meaningful and ongoing manner for best results.

It is necessary to consider many important factors when implementing new school mental health programs. In this study, concerns regarding negligent or insufficient implementation practices emerged which have the potential to diminish a program’s effectiveness. Therefore, examining the important factors provided to us by Han and Weiss (2005) prior to implementing a training or program is advised. There are broad contextual factors to first consider. Those include the political and legislative landscape which helps determine state policies and funding, district policies and priorities which define the way schools are run, and evaluation and promotion strategies for principals and teachers which communicate values and expectations. Han and Weiss (2005) also included school and teacher-specific factors to consider. These include administrative support, teachers’ intrinsic motivation, teacher burnout, and teachers’ perceptions and beliefs about the new program. Finally, there are two program-specific factors to also consider. The amount and quality of teacher training are major factors in determining the success of a program as well as receiving performance feedback provided through oral comments, written notes, or graphs. Teachers act as central change agents so educational leaders should pay attention to their concerns and suggestions. Being intentional and thorough with an implementation process is necessary to achieving effective and sustained positive results for school-based mental health programs.

Including teachers’ professional and personal well-being as part of the competency framework is necessary and should be reinforced in all pre-and in-service mental health training. The participating teachers in this study came to realize the significance of their well-being
through the focus group interview. Once the subject surfaced, many concerns were expressed. Teachers’ well-being is foundational to all that is expected of them. When their well-being is compromised, so are students’ academic gains, behavioral actions, and social emotional development. In addition, when teachers leave the field due to professional stress and burnout, it impacts the educational profession. Although Ball and colleagues (2016) found that current state standards documents and InTASC national standards show an absence of the teacher well-being competency, educational leaders should recognize the importance of it and be intentional in including well-being as a major priority.

Bridging the gap between the academic educators and teachers is an important factor in addressing such a critical problem like the children’s mental health crisis. ESMH researchers should consider writing material specifically for teachers and purposely publish their articles in teacher-friendly journals that are easily accessible. There is a large audience of teachers looking for information, strategies, and support in regard to mental health. Targeting that audience may make the most difference for children, schools, and ultimately society.

Limitations

Although my study accomplished the purpose, there are some limitations. The researcher is dependent on the participants for data. While the participants are not considered limitations, some aspects regarding the use of people might be thought of as limitations. Examples of this limitation include the experiences of the participants, how well they read and understood the article, their motivation for joining the study, and their candor when answering the questions. These obstacles are beyond the researcher’s control but should be noted as possible limitations in the study. It should also be noted that I have no knowledge that my participants were anything but honest.
Focus groups do have some limitations. According to Patton (2002), the number of questions which can be asked and the time allotted for responses has to be limited. Another limitation may exist when those in the minority perspective choose to remain quiet. When participants in the group have established prior relationships with one another, it makes for a more complex group dynamic. The inability to assure confidentiality exists with focus groups and can be considered a limitation as well.

Besides the general limitations of using focus groups, the use of only one school district might be considered a limitation. However, it was my intent to use participants from one school district to capture the perspectives of a select group of elementary teachers. I will not make generalizations from this study.

**Recommendations for Future Research**

The possibilities for future research in this new field of ESMH are vast and several areas of research emerged in this study. Because teachers’ perspectives are an important consideration when developing and using educator competencies, it would be beneficial to conduct a similar study with a larger sample of participants so the results could be generalized. Examining administrators’ perspectives on educator mental health competencies would also be interesting since it is the administrators who make many of the decisions and who set the stage for the implementation of ESMH. The use of the competencies as a curriculum framework for creating teacher preparation content and professional development training is another area that should be investigated and studied. As the competencies are used in the field, revisions and updates may be warranted. It is also important to continue to examine the level of collaboration among teachers and school mental health professionals. Since collaboration is a key component of effective SMH practices, studying the practice of it in the school setting can assist in increasing the level of
collaboration that exists and the quality of it too. Examining the competencies and standards associated with each role to determine where they complement, hinder, and overlap with one another may also assist schools when planning for purposeful collaboration. Additionally, another critical area for future research is teacher de-escalation and crisis intervention training. Disruptive behavior remains of great concern to teachers, and they asked for strategies to de-escalate behavior and prevent crises. There is limited research on de-escalation strategies for teachers available. Research on the need for, and use of, teacher de-escalation and crisis prevention programs is an important and imminent topic to explore. Finally, future research to examine the views and perspectives of children and young adults who have a mental health disorder could further explain the role of teachers and schools in supporting or hindering their emotional well-being. First-hand information and descriptions can reduce the possibility of speculation and misunderstanding. As the body of expanded school mental health research grows, new initiatives and interventions can be implemented in the hopes of reducing barriers to learning and improving student well-being.

Conclusions

Millions of U.S. students come to school each day struggling with a mental health disorder. Many of these students do not receive any professional services or treatment, other than what they receive at school. Although schools may have some mental health professionals on staff, teachers are the people who work closely with the students on a daily basis. Teachers have said they are unprepared to work with students who have emotional or behavioral problems, and they witness the various ways in which mental health disorders impede student learning and personal well-being. In addition, teachers want to help their students, and they support the addition of new educator mental health competencies. Therefore, teachers need training and
support to increase their competency level for working with students who have mental health disorders.

This study has shown that teachers’ perceived the proposed educator mental health competency curriculum framework (Weston et al., 2008) useful and effective for developing teacher preparation and teacher professional development training. It is imperative that teachers are given appropriate knowledge and skills to address mental health needs and these competencies provide the framework to do that. Keeping that in mind, all training needs to be of high quality and delivered appropriately. Furthermore, the implementation of any school mental health program needs to be carefully considered and done with integrity. In addition, competency number six on personal well-being is of utmost importance. As found in this study, educational leaders and teachers must recognize the importance of their own well-being and take necessary action to maintain a balanced and positive state of mind so that they are able to assist the students in developing their own positive well-being.

If the need for ESMH practices goes unmet, children will continue to suffer emotionally, and barriers to learning will remain unsurpassed obstacles. This scenario can lead to other school problems including discipline issues, poor attendance rates, higher dropout rates, and lower test performance scores. In addition, the same scenario can ultimately contribute to large-scale societal problems such as substance abuse, large disability rates, overcrowded prisons, homelessness, and suicide. For these reasons, it is imperative for research on ESMH practices to facilitate the necessary changes in our schools and be easily accessible to school practitioners.
References


Kids Count Data Center (2013). *Children who have one or more emotional, behavioral, or developmental disorders*. Retrieved from: http://datacenter.kidscount.org/data/tables/6031-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=11&loct=2#detailed/2/11/false/1021,18/any/12694,12695


Appendix A

Participant Questionnaire

1. Which school do you represent? West zone, South Zone, East Zone

2. Are you a general education elementary teacher? Yes/no

3. What is the grade level you currently teach? Kg, 1st, 2nd, 3rd, 4th, 5th

4. How many years of teaching experience do you have as a general education elementary teacher?

5. What is the highest degree you have earned? Bachelor, Master, Specialist, Doctorate

6. Was mental health training part of your undergraduate teacher prep curriculum? Yes/no
   If yes, please describe ____________.

7. Since receiving your Bachelor’s degree, have you received any training regarding mental health? Yes/no
   If yes, please describe ________________.

8. Does the school district provide mental health services to students? Yes/no/I don’t know

9. If you had a question regarding mental health for a student, do you know who in your school district to contact in your school district for assistance? Yes/no
   If yes, who or what department?

10. If you had a question regarding mental health for a student, do you know who to contact in your community for assistance? Yes/no
    If yes, who or what organization?

Using the Scale: 1 not at all and 5 very

11. How familiar are you with the six proposed mental health competencies for educators?

12. How important is it to have educator mental health competencies?
13. How important is it for educators to be aware and knowledgeable about mental health?

14. In your own words, describe what challenges you the most as a general education elementary teacher in regards to mental health.
Appendix B

Focus Group Interview Protocol

Research Questions: What are the participants’ perceptions regarding how mental health competencies can guide and inform their classroom practice? How would the participants react if these competencies were adopted by the state? In what ways would the participants amend, add, or change the proposed mental health competencies?


1. In what ways do you find the proposed competencies relevant?
2. How are the proposed competencies different and/or the same from your current teaching practice?
3. Which competency did you find to be the most relevant? Why?
4. Which competency did you find to be the least relevant? Why?
   (If any competency doesn’t get mentioned, bring it up as a follow up question)
5. How would you react if these competencies were adopted by the state?
6. How would you amend, add, or change these proposed competencies?
7. In your opinion, what is the most useful time to be exposed to these competencies (pre-service or in-service)?
8. What roles do teachers play in regards to children’s mental health in the classroom?
9. What do you wish you knew about mental health?
10. If you have had any experiences in the classroom regarding mental health, please describe them.
Appendix C

Individual Interview Question

As a follow up to the initial focus group interview:

Is there any new information or additional comments you wish to contribute at this time?