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Schools as Systems of Care Supporting Mental Wellness in Schools: Teacher Perceptions and Roles

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SCHOOLS AS SYSTEMS OF CARE

SUPPORTING MENTAL WELLNESS IN SCHOOLS:

TEACHER PERCEPTIONS

AND ROLES

A Dissertation

Submitted to the School of Education

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In partial fulfillment of the requirements for

the degree of Doctor of Education

By

Tracy Scanlon Limegrover

December 2016

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Approved April 1, 2016

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ABSTRACT

SCHOOLS AS SYSTEMS OF CARE

SUPPORTING MENTAL WELLNESS IN SCHOOLS:

TEACHER PERCEPTIONS AND ROLES

By

Tracy Scanlon Limegrover

December 2016

Dissertation supervised by Professor Connie M. Moss, Ed. D

Schools lack a response system for effectively supporting student mental health needs and there is a substantial research to practice gap in this area. To better understand how to build capacity for schools, with and through teachers, the purpose of this study was to examine teachers' perceptions of current mental health needs in their schools; their knowledge and competencies about mental health issues as well as perceived competencies and barriers that contribute to burnout. Participants included 20 teachers from two local Pittsburgh area Catholic schools. Teachers reported they believe it is their job to support middle school student mental wellness and confidence in their abilities but that they are lacking the necessary professional development and training and supervision to provide this support.

DEDICATION

This endeavor to grow personally is, as all such matters are, dedicated to my beloved Mum and my son, Gunnar Ryan. Together, they taught me and continue to teach me, everything about being true, being in service to others, and being the best version of myself that is possible.

Veronica June Scanlon, forever my one true thing, raised me up, doing her best to launch a capable, decent human being into the world. She was my beacon, my touchstone, and she was and is the story of my life.

Gunnar Ryan Limegrover, my hijo precioso, continues her work showing me every day what true vulnerability is, that I am blessed beyond words and undeservedly so. He is my reason and the answer to every question.

I simply would not have been able to finish my dissertation without the generosity that my son and husband bestowed. I thank them for understanding that pursuit of this individual dream, one long lived in the hearts of both my mother and me was necessary to the life of my soul.

ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to those most intimately connected to this work, who day to day, week to week, month by month talked me off every ledge, endlessly took my side in the battle between me and 'the work.' I leave Duquesne University not only with my terminal degree, and what's left of my frail sanity, but with real and true friends, my genuine cohort: Dr. Jessica Sapsara, a beautiful spirit who sustained me from day one; Dr. Jennifer Mann, a believer and advocate to the core; Dr. Ahmed Sherrrif, my surprise friend and ever dignified human being; and Dr. Ben Davis, all around good guy and pal who once resorted to singing me a Barry Manilow song to calm my weary mind!

I thank my committee chair, Dr. Connie Moss, a beautiful force of nature. She nurtured me along this journey and held me up. She was my saving grace, and my port in the storm. She is divinely maternal with a wide-open heart and if not for her I would not have made it through!

For technical assistance like no other, laced with love and ever an example of resilience, side by side with me in this quest, with deepest gratitude to my friend Amanda Dukovich. I was blessed with the gift of her kindred friendship when we met in graduate school and I firmly believe that she was absolutely worth the tuition!

Ms. Allison Giannotti, babysitter extraordinaire, girl of my little boy's dreams, academic, and soon to be a doctor herself, whose patience for editing and revising and informing my writing was absolutely vital. No word or deed suffice to express my true gratitude.

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LIST OF ABBREVIATIONS

ACE   Adverse Childhood Experiences

CASSP   Child and Adolescent Service System Principles

CVSD   Chartiers Valley School District

EQ/EI   Emotional Quotient/Emotional Intelligence

IDEA   Individual with Disabilities Act

IEP   Individual Education Plan

IPA   Interpretive Phenomenological Analysis

MH   Mental Health

MLSD   Mount Lebanon School District

SAMSHA   Substance Abuse & Mental Health Administration

SAP   Student Assistance Program

SES   Socio-economic Status

SOC   System of Care

SWB   Social Well-being Theory

WHO   World Health Organization

WRAP   A philosophy of care to build constructive support networks

INSIDE THE MIND OF TEACHERS: DEVELOPING SCHOOLS AS SYSTEMS OF CARE

Adolescence is a critical period for the development of psychological, social, and emotional wellbeing. During adolescence, the brain undergoes significant changes that effect cognitive perception, neuronal processing and emerging behavior patterns that will last into adulthood. Because their brains are still developing, adolescents are particularly vulnerable to influences that affect development strategies, social and emotional learning, and behavioral modeling. Coupled with hormonal changes, they are also more prone to depression and more likely to engage in risky behaviors, even more so than younger children or adults. This study investigates the experiences and perceptions teachers have about current system response and potential alterations that could promote an improved comprehensive and coordinated effort to maintain a system of care within schools that touches all students, particularly middle school students. Building capacity for districts and teachers to have ready access to a method that strengthens social and emotional wellbeing that is adjunctive to academic prowess. Ultimately, the subsumed claim is that a viable response system serves to create opportunities for regular (not just critical response) but on-going maintenance and attention to what serves the mental and behavioral health needs of all students on a day-to-day basis. This system is one that would serve to promote a caring school environment that includes high expectations related to test scores and conduct and citizenship, but also, provides supportive resources for students and teachers (staff) who like all humans, struggle on a daily basis to cope with life's demands.

<center>**The Plight of Adolescents**</center>

According to The National Children in Poverty (NCCP, 2007), approximately 20% of adolescents have a diagnosable mental health disorder. Many of these disorders present during adolescence. Between 20 and 30% have a least one major depressive episode before adulthood with 25% of adolescents experiencing the emergence during adolescence. Between 50% and 75% of adolescents with anxiety, disorders and impulse control disorders (such as conduct disorder or attention-deficit/hyperactivity disorder) develop these during adolescence. The National Association for the Mentally Ill (NAMI) reports that, "Four million children and adolescents in this country struggle with a serious mental disorder that causes significant functional impairments at home, at school, and with peers." Moreover, 21% of American children ages 9 to 17 have a diagnosable disorder that causes at least negligible levels of impairment that infringe on day to (The National Institute of Mental Health, 2013) day functioning. Fifty percent of every lifetime case of mental disability begins by adolescence, or age 14. The NAMI reports goes on to claim that in any given year, only 20% of children with mental illnesses are identified and receive mental health services. (The National Institute of Mental Health, 2013)

The statistics about mental wellness and American adolescents are startling. Prevalence estimates from a recent comprehensive review of the field of child psychiatric epidemiology by Kessler, Amminger, Aguilar-Gaxiola, Alonso & Lee (2007) noted that the number of observations in community surveys of children and adolescents has risen from 10,000 in studies published between 1980 and 1993 to nearly 40,000 from 21 studies published between 1993 and 2002. Kessler, et al. (2007) indicate that about one out of every three to four youth is estimated to meet lifetime criteria for a Diagnostic and Statistical Manual of Mental Disorders (DSM)

<center>3</center>

mental disorder. However, only a small proportion of these youth actually have sufficiently severe distress or impairment to warrant intervention. About one out of every ten youths is estimated to meet the Substance Abuse and Mental Health Services Administration (SAMHSA) criteria for a Serious Emotional Disturbance (SRD), defined as a mental health problem that has a drastic impact on a child's ability to function socially, academically, and emotionally. Additionally, according to SAMSHA, 20% of children and adolescents under the age of 18 have mental health issues or diagnoses and the percentage increases to 25% for children in adverse environments (World Health Organization, 2004). Studies of community samples of children and adolescents claim an average age of onset for major depressive disorder (MDD) and or depressive disorders, not otherwise specified (DD) to be between 11 and 14 years. Additional studies identify age 11 with a correlation to a significant spike in the prevalence of MDD episodes (Merikangas, Nakamura & Kessler, 2009)

Prevalence data from the Oregon Adolescent Depression Project showed that the rates of new onsets of depression increase from 1 % to 2% at age 13 and from 3% to 7% at age 15. The incidence of depression continues to increase throughout early adulthood. (Merikangas, Nakamura, & Kessler, 2009).

"Of the 5% to 9% of children and youth who meet the criteria for severe emotional disorder (SED), only a small percentage are served" (Kauffman, 2005; Walker, 2004). Left untreated and untended, emotional and psychological distress is a horrible disease infecting our society as a whole.

School-based and curriculum-embedded mental health prevention and intervention practices are essential and proven for reducing the incidence of mental health problems that interfere with learning and social development (Dwyer, 2004). Recent research indicates that

schools are the majority provider of mental health support for school-aged children. These data

collected in a study done by School Mental Health Services in the United States, 2002–2003, the

first national survey of mental health services done with a representative sample of the

approximately 83,000 public elementary, middle, and high schools and their respective districts

in the United States (Foster, Rollefson, Doksum, Noonan, Robinson & Teich, 2005). Rones &

Hoagwoods (2000) confirm that the majority of children who acquire any type of mental health

supports do so from within the school system. One only need to refer to recent media accounts

of school shootings, from Franklin Regional to Columbine, and far too many in between, to

realize the devastating effects of emotional distress among children and adolescents. These

critical incidents and reported episodes are symptomatic of a system that often fails to respond

effectively and proactively, and stand as a call to action to address a major gap area that

exacerbates psycho-emotional struggles among many children and adolescents within the school

system.

Surveillance studies of the prevalence of depression and other mental health issues among

adolescents in the United States, including results from the Substance Abuse and Mental Health

Services Administration, 2013 National Survey on Drug (NSDUH, 2014) indicate as of 2007

nearly 4% of children between pre-school and 17 years had received a mental health diagnosis of

some form of depression. According to the Centers for Disease control, the National Co-

morbidity report (Avenevoli, Swedenson, Ping He, Burstein & Reis, 2014) revealed that overall,

11% of adolescents have a mood disorder or form or episode of depressive disorder by 18.

Moreover, the risk for said issues increase with age. This has led the World Health Organization

to claim that the leading cause of disability among our young is depressive disorder (NIMH,

2013). The toll, human and otherwise, is massive. Left untended, social suffering and its fall out,

cost upwards of $100 billion in lost human productivity in the U.S. alone in the early years of the 21st century.

The Marginal Response From PK-12 Schools

Despite these alarming numbers, PK-12 schools have a limited response to the ongoing psychosocial and mental health needs of students on the federal, state and local levels to this looming crisis in America. Given the multitude of responsibilities that schools face, administrators and teachers are limited to targeting problems only related to learning barriers. Additionally, because of funding issues, priority is usually given to those with specialized protection and entitlements given them through the legal requirements that obligate schools, allowing those who go unidentified as "high risk" or disabled to fall through the cracks. Private pay and affordable care act provisions considered, laws along are not sufficient. Insurance options are not a guarantee of access and delivery. Why not utilize the rich and potentially bountiful venue of the schools to intervene? Stigma would be addressed, students would receive quality holistic education, and society itself stands only to gain from children who are healthier, well and productive citizens in a global economy.

The Promise of Early and Ongoing Intervention

Despite an increase in availability of evidence-based protocols and interventions, and the relevant data to support the importance of early and ongoing intervention targeted within the school setting, there is notable lack of widespread or common adoptions of practices that would in fact promote the well-being and mental health of children in school systems. (DuPaul, 2003; Kratcohwill, 2007; Schaughency & Ervin, 2006).

Contemporary theories, including the seminal humanistic and positive psychology theorist's, Seligman (1998), Maslow (1943) and Rogers (1961) support the aforementioned

claims, but go even further to address the gap between diagnosable or 'identified' students and the overall global well-being of the student body at large (Bugental, 1964). Positive Youth Development Theory (PYD), in particular (Benson, Scales, Hamilton & Semsa, 2006) and Humanistic Psychology theory (Maslow, 1966), are centered on a holistic and contextualistic core that understands human development by way of interactions and environment (Hayes, Villatte, Levin & Hildebrandt, 2011). Human conduct and experiences are not singularly a matter to be 'treated' and punishing of misguided or antisocial behaviors within a classroom, but a call to a more social cognitive and humanistic perspective that views human conduct, student behaviors, as a byproduct of the interaction and interplay between environment (school) and tendencies and personality traits. This is the foundation of Albert Bandura's (1986) conception of "reciprocal determination". Bandura theorized that all human thought and action could be modified. Teachers have the ability to improve efficacy and student confidence by supporting and improving their students' mental and emotional states, not just by supporting and improving achievement, test scores and compliance through classroom management techniques (Bandura, 1986).

Frank Pajares (2005) has long argued the presumption that the perceptions that the young hold of their own competencies, their belief about their skill set for handling the challenges that come their way in fact drive the outcomes for either success or failure in every endeavor undertaken. Pajares and Urdan speak to the concept of self-efficacy, and the beliefs manifested from such self-perceptions and how these beliefs inform motivation, a sense of overall well-being and personal accomplishments across the life span. (Pajares, & Urdan, 2005).

Pajares (2005) surmises that schools have the potential to embody a collective vibe of group efficacy to promote a climate in which psychological health can be cultivated. He argues

that teachers, like parents, have a duty and responsibility for mentoring and developing fully functioning youth. Philosopher Nel Noddings (2006) captures the individual elements of these very similar perspectives with her belief in an approach to teaching that centers on the whole student within a system of caring education. She maintains the position that the goal of any educator, teachers and parents alike, should be to bring to fruition a fully efficacious and productive human who is capable of giving and receiving love and care (Noddings, 1992).

Schools are vital venues where the work of fostering and nurturing the pro-social students and psychologically sound behaviors can be cultivated. Pro-social behaviors are tied to higher emotional intelligence (EI) and increased EI to improved student achievement overall (Jennings & Greenberg, 2009). School systems, positive psychological minded teachers and classroom environments can foster character building and set a foundation that embeds concerns for matters of social justice within the lived experiences of a students' life (Yates & Youniss, 1996).

Children have inherent needs. A subject studied intricately and fully by Abraham Maslow (1943). Fulfillment of those needs, varied as they might be, is better acquired with assistance. School systems and teachers can be equipped to support ongoing psych-emotional needs for all students. When they do, it leads to healthy development and a strong baseline from which to launch into adulthood. Conversely, according to Maslow (1943), Rogers (1961), and other humanistic theorist's deficiency needs, unmet needs can handicap and hinder functioning, at home, at school, and at large.

School counseling is not universally mandated for grades Kindergarten through 8[th]grade, as it is in the Commonwealth of Pennsylvania, nor is it mandatory for high school level classes. Further, there are no legal avenues being considered at this time to mandate school counseling (American School Counselor Association, 2015). Credentialed counselors agree that early action,

intervention or diagnosis is paramount. These responders and professionals, like others, including this researcher, are ever aware that we must continue to examine the critical role that psychological support plays in the spectrum of all school-based programs, and in the whole of school life altogether (Greenberg, Domitrovich & Bumbarger, 2001). Too often however, the need for early intervention only becomes salient when critical incidents like that of the Sandy Hook shootings bring it all too poignantly to the forefront.

The prevalence statistics tell the story of gaps, and these gaps can be deadly. In November of 2014, a detailed report of the Sandy Hook incident made clear and precise some of those gaps (Report of The Office of The Child Advocate, November 2014). According to the published report, the Newtown Public Schools provided limited special education services to the shooter (student) during his elementary years, but they were limited and there was no accounting for or communications that addressed his social-emotional deficits. Additionally, the shooter's social-emotional needs spiked just prior to the start of middle school and there were early signs of a predisposition toward violence that appeared to have gone mostly unaddressed by the schools system altogether (Report of The Office of The Child Advocate, November, 2014). Still, very little in the way of standard and comprehensive system responses exist as formalized parts of the curriculum across the American school system. In fact, according to the National Association of Secondary School Principals (NASSP), mental health matters have historically and persistently been stigmatized in our culture. The Principals also claim that psychosocial wellness and health, in schools, is often not assigned a very high priority altogether, with the exception of when a high visibility critical event occurs (National Association of School Psychologists (2011).

Addressing psychosocial and mental health concerns in schools is typically not assigned a high priority, they assert, except when a high-visibility event occurs, and they are in fact often relegated to an ad hoc status or addressed via piecemeal, protocols (NASSP, 2011). The majority of students who drop out of school do so in the 9th and 10th grades, thus making middle school a make or break moment in the academic life. The deficit response model becomes even more pervasive and dangerous in middle school, having even greated impact than during the elementary years. (Child Trends Databank,2015).There are several reasons for this exacerbation in the mental health vulnerabilities during this critical developmental stage; the impact of social media on the day to day life of a student; psycho-sexual struggles that emerge; a move from elementary to middle school and junior high; a conglomeration of conditions that students face and how they perform in middle school also play a vital role in whether or not they will graduate from high school prepared for college and the 21st century workforce. It is a perfect storm that culminates in puberty, the hallmark of adolescent development (middle school age) and it can be a difficult time wrought with stress that can result in greater emotional reactivity (Batada, 2006).

Adolescence is a critical period for social and emotional well-being and growth. Yet, only approximately one quarter of middle school teachers in the U.S. are specifically credentialed to teach in middle school, while the majority of the rest are credentialed for elementary school (United Way, 2008). During this period, the brain undergoes momentous developmental changes, establishing neuronal communication patterns, as well as behavioral patterns pathways and behavior blueprint that will last into adulthood. Because the adolescent brain continues to grow well into the early twenties, this group is both receptive and vulnerable to influence. Coupled with hormonal changes, adolescents are more prone to depression and more likely to engage in risky and thrill-seeking behaviors than either younger children or adults.

These and other factors underline the importance of meeting the mental, social, and emotional health needs of this age group (Schwarz, 2009). Mental health and social and emotional wellbeing – combined with sexual and reproductive health, violence and unintentional injury, substance use, and nutrition and obesity – form part of a complex web of potential challenges to adolescents' healthy emotional and physical development (Schwarz, 2009).

Issues Our Students Seek Help For:

22% Depression-related

3% Eating Disorders

4% Other

8% Alcohol and Drug-related

4% Mood/Bipolar Disorders

27% Anxiety-related

3% Trauma/Abuse/PTSD

14% Personal Concerns

15% Relationship Issues
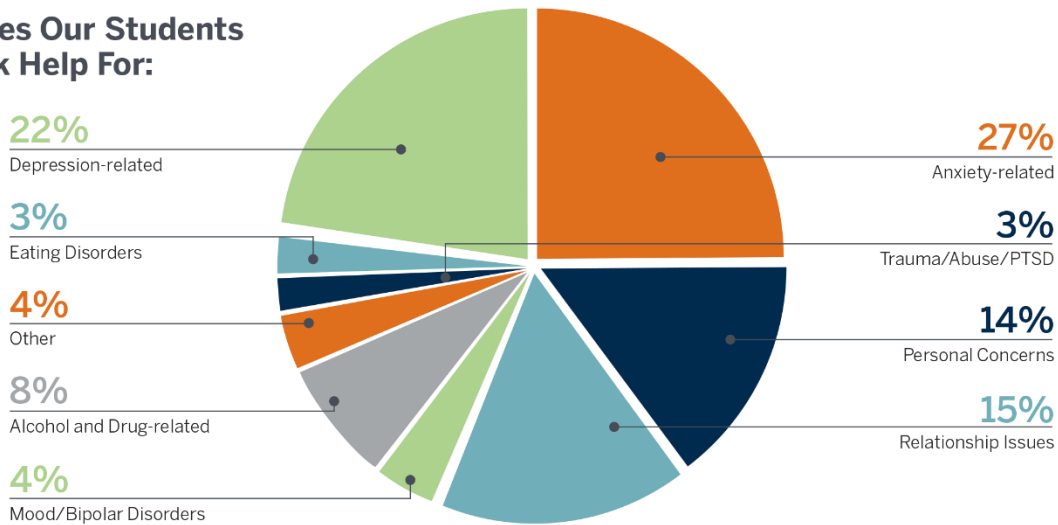
Figure 1.1. Illustrates the percentage breakdown of the specific issues that students seek help for during any given school year.

Figure 1.1 above speaks to the complex web at play during adolescence, for middle-schoolers. Mental wellness is intertwined with their social needs and combined with a spike in sexual exploration and reproductive capacity, nutrition and body image issues related to physiological changes and of course, high risk behaviors that involve substances and drugs. These factors all underlie the great importance of meeting and supporting the psychosocial and emotional hygiene needs of this age group. The bottom line is that any existing or pre-existing mental health needs for children can become increasingly complex and in fact intensify as the transition into middle school, at puberty, begins.

Prevalence and Impact of Poor Mental Wellness in Students

The economic impact of mental disorders is wide-ranging, long lasting and important. Measurable causes of economic burden include health and social service needs, impact on families and care givers (indirect costs) lost employment and lost productivity, crime and public safety, and premature death. Studies from countries with established economies have shown that mental disorders consume more than 20% of all health service costs. Even in countries where the direct treatment costs are, low it is likely that the indirect costs due to "productivity loss" account for a large proportion of the overall costs (World Health Organization, 2001).

Unmanaged stress has a substantial effect on an adolescent's long-term physical and mental well-being and mitigating this stress during this age and stage of development can be critical to the prevention of chronic conditions such as depression. This is paramount public health matter due to its power to derail an adolescent's capacity to handle day-to-day life adjustment demands, yet stressors and subsequent stress of this nature is often demands of daily life, yet it is often unheeded within the school environment. Stress and maladaptive stress response emerge for youths as they transition into adolescence, in part, due to the rapid socioemotional changes that occur. Pervasive stress has a significant impact on the physical and mental well-being of an adolescent. It is often the precursor to mood issues like depression and dysthymia (Chandra & Batada, 2006).

Despite this, according to the National Center for Children in Poverty (NCCP), between 25% and 35% of middle school aged students skip needed care, medical and psychological. In 2007, 3.1 million youth received a form of treatment in a mental health setting; 11.8 percent of youth received said services within their respective academic setting and 2.9 percent in a medical setting. This indicates an access to services though it is obvious that a majority of youth with

mental health concerns do not receive the services they require (National Center for Children in Poverty 2007). According to the NCCP, nearly 80% of those students in need of mental health services did. Schools thusly, stand to eliminate barriers and systemic silos as the natural and perfect place for support to be acquired (Masi & Cooper 2006).

Middle school, the years between 5th grade and seventh grade, during adolescence, has been shown to be a period of time when mental struggles often have first onset (Jorm, Kitchener, Sawyer, Scales & Cvetkovski, 2010). This can be a critical period of psychosocial vulnerability and development. It is well documented that the transition from elementary to middle school is a time when students feel less attached to school and this changing attachment alters perception about inclusion, about the caring adults around them, and a noteworthy drop in connectedness occurs. Connectedness is characteristic of a school culture that support students in growing meaningful relationships, stay engaged and feel that they belong. This feeling of wellbeing is correlated to improved grades and lower dropout rates (Blum & Libbey, 2004; Jackson & Davis, 2000; Klem & Connell, 2004; Mac Iver & Epstein, 1991; McNeely & Falci, 2004). This period presents a crucial and necessary opportunity to re-tether the vulnerable child to the anchoring supports that are conducive to growth, safety and connection (Blum, et al., 2004).

The purpose of education is to educate the mind, body and soul, writes author Sheri Klein. She calls adolescence a time when there is greater risk that a student will fall through the cracks in the current system and ultimately spiral down emotionally and behaviorally. She argues for a more holistic, safe space, within the classroom, inclusive of curriculum-based interventions that allow teens, middle school students to feel connected, to belong and to be validated no matter their emotional state (Klein, 2005).

Because, as Klein acknowledges, not every student has a safe someone to share their inner world with, schools can become that sacred space in which expression and support can be found (2005). She quotes Sontag, from *Regarding the Pain of Others* (2002, pg. 19), "we are spectators of calamities," and exposure to such can cause chaos for the adolescent (Klein, 2005). Alas, contemporary educational strategies, typical go to curriculums go to great lengths to maintain a focusing on the traditional issues, course subjects like reading, writing and arithmetic. She blames *No Child Left Behind* (NCLB) for perpetuating this dilemma with its steadfast overemphasis on grades, tests, and singular academic achievement. (Klein, 2000).

Halpin concurs pointing to Ramon Gallegos-Nava's *Holistic Education: A Pedagogy of Universal Love* (2003) in support of these claims. Gallegos-Nava views a positive and whole education as a spiritual one that provides for a sense of wellbeing inclusive of connections between students and community that go well beyond the customary manner of outmoded schooling towards a complete and whole approach to address every domain of a students' experience (Halpin, 2003).

By failing to address the diverse and complex needs of every student, we are slowly losing our integrity not just as a nation but also as humanity. Proper training of competent teachers who can intervene and transform (Kessler & Halpin, 2003) to grow student wellness and decreasing the ever growing financial burden on governments to address the mental health needs of their citizens is a much preferred methodology (Gallegos-Nava, 2003).

Integrating Mental Health Curricula

While a total change of the current system seems impossible feat, it could begin in fact, with strategic initial improvements. A vital beginning would be integration of curricula and programming that aim at emotional self-management training and growth. This would serve as a

convincing way to intercept some of the stressful responses and minimize how those responses, at-risk behaviors, acting out, and school violence will ultimately manifest within a school building. In studies on behavioral coaching and skills building training for self-management that promotes the learning of emotional competence skills, healthier physiological response patterns emerge and these emergences benefit learning as well as long-term health. In fact, extensive developmental research shows that the mastering ones social-emotional skill set enhances and increases long term positive life outcomes for both the physical and behavioral wellbeing of the adolescent (Clarke, Morreale, Field, Hussein, & Barry).

In a 2015 report out of the Health Promotion Research, National University of Ireland Galway, Clarke, Morreale, Field, Hussein and Barry note substantial international evidence based research that these skills can be enhanced and positive outcomes achieved through the implementation of effective interventions for young people. The researchers searched five academic databases inclusive of searches of in and out of school intervention programs, and public health data sources. They report positive key findings for in-school programs and curricula that address social wellness as having significant impact. Findings from the universal social and emotional skills-based interventions and in-school programming are in line with international research which has documented the substantial positive effect of these programs related to improved self-esteem, enhanced social-emotional wellness and generally improved attitudes about self, other and environ (Durlak, Weare, Nind, Adi, Barry, & Jenkins, 2007). Their reviews identified those schools that focused on promoting and enhancing positive elements of wellbeing, that start earlier in the student life, operating over long timeframes and implemented by trained schoolteachers have the most significant effect. Durlak, Weare, Nind, Adi, Barry, & Jenkins, 2007 note, however, that in spite of the international research that

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promotes this type of approach, very few of the school-based programs that were reviewed used the school as a whole, a system of care approach. These findings confirm that integrating basic training to school personnel, teachers especially, can bring about positive outcomes that would ultimately change the school climate positively.

Because emotional, behavioral, and social difficulties diminish a child's ability to participate in the educational process (Rones & Hoagwood, 2000), schools are incumbent to provide learning by working in partnership with various service providers to offer ongoing academic and behavioral supports to individual students and to the whole school population (Weist &Evans, 2005). Schools willing to provide mental health services and supports see dramatic increases in achievement for all students.

While some may argue that schools are in the business of education, not the business of mental health, that argument is short sighted. Untreated mental illness among students has a significant and harmful impact on schools. Whereas education is certainly the primary mission of schools, there is solid evidence that academic learning is impeded greatly or prohibited entirely when youth suffer from mental health concerns. Evidence clearly demonstrates that addressing children's mental health needs is associated with positive school outcomes. Elias and Greenberg (2006) determined that when students' mental health needs are properly addressed, the likelihood of school success increases. High quality, effective school mental health promotion has been linked to increases in academic achievement and competence; decreases in incidence of problem behaviors; improvements in the relationships that surround each child; and substantive, positive changes in school and classroom climates (Elias &Greenberg, 2006). Payton et al. (2008) agree, finding that when social and emotional

learning is a component of education, students 'standardized test scores—a hallmark of school accountability structures—increase between 11 and 17 points.

Contrastingly, those schools that ignore the mental health needs of students have lower grades across all academic subjects, higher failure rates that increase dropout rates, which are greater than any other disability group and miss reaching an entire population of children whose academic ability is affected by emotional distress (Hoganbruen, Clauss-Ehlers, Nelson, & Faenza, 2003). Recent findings confirm that pro-social children and youth, those who are better equipped for swift and appropriate adjustment, have better relationships within their cohort (Eisenberg et al., 2006). They are also at less risk for use of external locus of control related behaviors (eg. Kokko & Pulkkinen, 2000) and school performance is higher (Caprara, Barbaranelli, Pastorelli, Bandura, & Zimbardo, 2000). Kokko and colleagues also point to pro-social adjustment, equated here with wellbeing, as related to reactions in aggressive behaviors and the resulting negative consequences of such (Kokko, et al. 2006). These researchers and others have found that predictors exist for well-adjusted students and that there is a correlate to academic achievement (Caprara et al., 2000). Cohen, Pickeral, and McCloskey (2009), found that as more schools implement school climate response systems and like improvement strategies, often referred to as 'protective factors' the emotional wellbeing of all students improves and has a direct correlation with academic success. In an Education Week article and commentary from November 2015, entitled Including Teachers in the Student Mental-Health Continuum, Cottle & Green review the most recent National Comorbidity Survey Adolescent Supplement, conducted from 2001 to 2004. As of this time, it is the largest national study of child and adolescent mental disorders, and the striking details it contains speak to a considerable public health issue. According to the study, approximately half the 13- through 18-year-olds studied met benchmarks

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for a MH diagnosis, with only one-third of those students actually received treatment. There are multiple ways to expound on this treatment gap: the collision of budgetary matters, insurance coverage or lack thereof, and stigma, among them. All however, resulting in the same bottom line, schools, teachers, the professional people in the professional setting best poised to intervene, are almost always restricted by.

Most pertinent to this research, the National Comorbidity Survey Adolescent Supplement argues that teachers remain in one of the best positions to attend to youths who will at some point likely exhibit mental distress symptoms and likely do so in the classroom. Other than parents, whose investment and perceptions come from a differing vantage point, teachers are the defacto interveners with the deepest knowledge base about the child or adolescent. Despite their significant burden, the wellbeing of children has at its core the assumption that teachers are a first line of defense and intervention (Cottle& Green, 2014). Cottle and Green (2014) go on to quote University of Pennsylvania President Amy Gutmann who argues that students not only need to be educated, but they also need to be cared for so that they can thrive. She is firm in her assertion that education is a life-or-death enterprise and teachers are where the buck stops (or starts) in this equation. In a series of interviews that Cottle and Green conducted with junior high and high school teachers, the complexity of this issue shown through. "My average student I see for 50 minutes, 55 minutes, and unfortunately based on time and the things that you're trying to get through, I know that there are things that I missed. … I'm sure that there are people who are suffering from some sort of emotional distress or just some general dissonance and, I don't know how to address those. "In another interview a middle school teacher spoke to the all too common challenge of lack of resources and professional support: "We lost our full-time counselor last year, so when I first started at the beginning of the year, we didn't have a counselor." The school

has a new counselor, but the teacher added: "I'm not sure exactly what the procedure is to utilize his services. Or even what days he's exactly in." Still another teacher stated: I just think if teachers knew more about the resources out there that we could use, just to prepare ourselves. … I can go on the Internet" (Cottle & Green, pg. 1).

Teachers are required to obtain specialized and continuing educational training as a part of their general requirements for credentialing, yet no mandated universal training requirements for mental health that go beyond diagnostic criteria and warning signs. Professional development focused on teacher knowledge about child and adolescent emotional intelligence and psychosocial well-being would serve to increase a core knowledge base that could serve to increase the likelihood of appropriate responses. In 2013, President Barack Obama called on American school systems to do just that (Adams, 2013). As part of his call to action, Obama urged us as a culture to do a much better job at recognizing mental distress in our children and moreover, to make access to needed help more readily available (Adams, 2013).Amidst the immergence of school shootings, violence and killing on schools campuses over the last decade, President Barack Obama actually called for such training in 2013 (Adams, 2013).

A number of programs designed to instruct teachers in responding to mental-health and behavioral challenges already exist. The American Psychiatric Foundation's "Typical or Troubled?" program, (American Psychiatric Association Foundation, 2015) for one example, trains school staff members to identify signs of trouble among adolescents. This kind of instruction should be common and widespread as a means of prevention, not intervention or reaction to a crisis. However, the reality is that many schools and communities lack affordable and quality mental-health resources. It is not so simple as to equate this dilemma to a gap or a falling through the cracks matter, but an issue of ignorance and benign neglect. Immanuel Kant

writes: "The human being can only become human through education" (Kant, 1900. pg. 136).

The argument, then, would seem to identify a holistic approach to student wellbeing as an essential ingredient to a proper and whole education.

Clearly, adolescents, middle school age students, children in general, are not impervious or exempt from the adverse effects of stress. Moreover, children who are susceptible to adjustment and psychological struggles represent a significant portion of the contemporary youth culture today. Children with positive outlooks, according to Seligman (American Psychological Association, 2009) are better equipped learners; and schools provide excellent settings in which to hone in on student mental health needs as well as tend to their academic performance (Greenwood, et.al, (2008) with the connection between them being extremely important. Schools cannot be and should not be a part of the problem, but rather a place of safety, inclusion and opportunity.

This alone stands as an argument for sweeping changes in response systems that stem from what the first line responders, teachers, think, feel, know and believe about responding to the mental wellness needs of their students. These systems must promote psychosocial supports, professional training, and school-place interventions that serve as not only deterrents in the short run but as remedy against ineffective coping strategies across a lifetime.

CHAPTER II

LITERATURE REVIEW

Finally, experts and policy makers are beginning to recognize and acknowledge that income and grades are not the singular benchmarks for wellbeing. These quantitative data do not substantiate a median for wellness. Entire cultures, including the culture of schools, are finally redefining and conceptualizing individual and group wellbeing. In general clinical terms, wellbeing is best understood as a dynamic process and phenomenon that can only be considered through a multi-faceted lens that is sometimes subjective and inclusive of objective constructs. It is not an either or proposition nor is it linear and undeviating. Psychology, sociology, and mental health experts have long studied this study frames wellbeing as it. Specifically, paramount is Social Well-being Theory(SWB) born of the Positive Psychology movement which can be traced to Martin E. P. Seligman's 1998 Presidential Address to the American Psychological Association (Seligman, 1999).

Seligman, Ernst, Gilham, Reivich, and Linkins (2009) coined and defined the term positive education as 'education for both traditional skills and for happiness' (p. 293). Peterson (2006) contends that schools are ideal institutions through which to deliver the possibilities for students to be the receive opportunities that can expand their focus beyond only academic achievement toward the advancement of character as well. The literature offers many reasons for adopting this approach. It provides a buffer against youth depression, serves to propel elevated satisfaction with life, while promoting learning, social unity and growing a civic cohesion (Seligman, et al., 2009, Waters, 2011). Positive Education, is education towards both traditional skills and skills for happiness. The process claims a synergy between learning and

position emotion, arguing that the basic skills required for happiness (wellbeing) should be taught in schools (Seligman, Ernst, Gillham, Reivich & Linkins, 2009). The proponents' Seligman (2009) and Duckworth (2005) assert that early self-regulation or self-management of one's mental state and sense of wellbeing may lead to long-term benefits across a lifespan. The researchers claim that self-discipline, student self-regulation, is a better predictor of academic success than is IQ (Duckworth & Seligman, 2005). The benefits of an increased and higher emotional intelligence (EI) and a deeper, better self-awareness outweigh IQ as an affirmative indicator (Waters, 2014). Those positive psychological traits that grow through positive education milieus are linked to improved academic prowess, decreased risk behaviors and overall better physical wellness (Kern, Adler& White, (2015). Given these benefits of positive education, schools need to consider how to best build and support student well-being.

In their official commissioned report to the French government, Stiglitz, Sen, and Fitoussi (2009) noted, 'what we measure affects what we do' (p. 7). But what should be measured? According to Burrus, Betancourt, Holtzman & Minksy (2012), in their article entitled *Emotional Intelligence Relates to Well-being: Evidence From The Situational Judgment Test of Emotional Management*, published in the International Journal of Applied Psychology, there is a notable connection between EI and social well-being and one's ability to self-regulate (emotions) is correlated to an increase in perceived hedonic (perceptions of pleasantness) well-being.

"What you measure affects what you do. If you don't measure the right thing, you don't do the right thing"—the words of Nobel prize-winning economist Joseph Stiglitz (as cited by Goodman, 2009). The question of how wellbeing should be defined and understood still remains largely unresolved, a situation that confounds both interpretation and investigation (Forgeard, 2011). Thomas (2009) also argues that wellbeing is 'intangible' and hard to define and measure.

In other public policy arenas, a common vernacular is used. Descriptors like hardiness, resilience, emotional wellness, mental health, emotional hygiene, psychosocial development, thriving, adaptation and functionality, even happiness, are all words that attempt to cover the comprehensive definition that is wellbeing. As it is relative to this study, some terms will be interchangeable but reminiscent of the overarching theme: strengths based view of mental wellness and health, not mental illness or the associated lingo around psychiatric imbalance or pathology. Nonetheless, for the purposes of this research, the aim is to make 'tangible' the concept of psychosocial wellness, not specific delineations as to definition; a construct more than an exact singular definition, as focal point.

Additionally, evidence for SWB theory, seen prominently in the writing of Martin Seligman (Seligman & Csikszentmihalyi, 2000) refers to how people perceive and experience the quality of their lives and includes both affective (feeling) and thinking (cognitive) reactions. Life satisfaction, wellbeing, as measured by Positive Psychology and SWB theory, is believed to be inherent to positive social relationships, and personal welfare (Kashima, Kokubo, Kashima, Boxall, Yamaguchi & Macrae, 2004). Additionally, SWB aligns with the theory of Emotional Intelligence (EQ) (Citation Needed here for founder of EQ—whose theory is it?) that accounts not only for moods and the fluctuation therein, but also affect sentiments and feelings, as well as ones overarching evaluations (perception) of life satisfaction. Mental well-being, a pivotal but controversial construct viewed from multiple lenses, mental well-being is described as a positive and ongoing state that allows an individual to thrive even in a negative environment. It depends on perception and management of negative emotional responses (Sharma, 2007; 2008). Sharma (citation date) argues that there is pertinent evidence that health and SWB may mutually influence each other, as good health tends to be associated with greater happiness, and numbers

of studies have found that positive emotions and an optimistic outlook have a beneficial influence on health. Sharma, (2011) completed an empirical investigation of the role of emotional intelligence competencies (EQ) and well-being was explored. Sharma integrates relatively easily understood verbiage to outline his concept of mental wellness, emotional intelligence to posit a general terminology that can be investigated. Sharma describes psychosocial well-being as a positive state or condition that can be sustained and that makes it possible to thrive in adversity. To a significant extent, this is a matter of subjective perception that informs behavioral management of negative affective states, where EI (emotional intelligence) is a key factor. (Sharma, 2007; 2008).

A Review of the Literature

Historically research in the domain of mental well-being, when it can be found, has involved two approaches; the hedonic tradition, which accentuates constructs (Dodge, Daly, Huyton, & Sanders, 2012) and the eudemonic tradition (Dodge, Daly, Huyton, & Sanders, 2012) which highlights positive psychological functioning. This study leans towards the later with de-emphasis on diagnosis and a stronger focus on an examination of ordinary people, middle school students, engaged in the process of age, stage and phase development across the lifespan. The study is guided by the following research question: Is what teachers think, feel and know about the response systems for mental health within their schools, interconnected to an overarching worldview of student wellness, as it is understood as a quality of life entitlement? The literature review that follows seeks to support the examination of this guiding question.

Adolescents with low psychological well-being may experience decreased levels of happiness and esteem while also living with high levels of distress. Moreover, write Flouri and Buchmann (2003), those adolescents who have low psychological well-being exhibit high levels

of depression with low self-efficacy. Speaking at the American Psychological Association's annual convention in June 2009, Martin Seligman used Positive Psychology Program and Penn Resiliency Program data to support how teaching resilience, positive emotion, and a sense of purpose in school can in fact protect children, insulating them from depression and increase their perception of satisfaction, which improves their learning power (Seligman 2009).

The Constitution of the World Health Organization (WHO) defines health as "A state of complete physical, mental, and social well-being not merely the absence of disease". It follows that the measurement of health and the effects of health care must include not only an indication of changes in the frequency and severity of diseases but also an estimation of well-being and this can be assessed by measuring the improvement in the quality of life related to (all aspects of) health care. WHO defines quality of life as an individuals' perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, stands and concerns. It is a broad ranging concept affected in a complex way by the person's (student's) physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment (World Health Organization, 2014). Thus, school being the common denominator in this equation. The work of Keyes (2006) and his ongoing study of mental health as more than the absence of pathology, aligns with the WHO premise. Wellbeing is more than happiness. Shah & Marks, in The Wellbeing Manifesto for a Flourishing Society, conclude that feeling satisfied and happy, as a whole, is interconnected to wellbeing and that wellbeing is the precursor to developing a person, fulfillment and being a competent contributor (Shah & Marks, 2004).

In the public health arena, more emphasis and resources have been devoted to screening, diagnosis, and treatment of mental illness than mental health. This too is true within the school

systems where mental health activity is going on regularly. There is a great deal to be done to improve what is taking place however. Resources are attempting to address complex, psychosocial and mental health concerns in highly fragmented, silos, and in marginalized ways. This has in turn resulted in inadequate services and results for all students (Center for Mental Health in Schools at UCLA, 1999).

How Mental Wellness Affects Student Achievement

There are societal issues at stake, not singularly, any one school or student. Thus, the rationale for recognizing that psychosocial and health problems affect learning and performance in profound ways has been acknowledged in contemporary literature. For the most part, Adelman and Taylor (2010) argue that the rationale for strengthening mental health in schools based on both or either of the matters of schools providing good access to students who require mental health support and or schools needing to address psychosocial, mental and physical domains in order to better enable effective academic.

Adolescents, middle school aged students, children in general, are not impervious or exempt from the antagonistic effects of stress. Moreover, children who are susceptible to adjustment and psychological problems represent a major portion of the contemporary youth culture today. Schools, therefore, cannot be, should not be a part of the problem, but rather a place of safety, inclusion and opportunity (Marin & Brown, 2008).

The prevalence of undesirable and anti-social conduct among youth pervades many school environments and alone stands as irrefutable argument for changes in response systems to better promote psycho-social supports, training, and school interventions that serve as not only deterrents in the short run but a rehabilitation of ineffective coping strategies across a life time. (Center for Mental Health in Schools at UCLA, 2015).

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Bolte, Goschke & Kuhl, 2003 urge that well-being be taught in schools for several arguably legitimate and sound reasons. The most pertinent argument to this investigation centers on the belief that there is a sure correlation, a synergy as it is referred to formally, between wellbeing and learning. Contrastingly, he notes, negative mood in the environment produces narrower attention (Bolte, Goschke & Kuhl, 2003). Multiple ways of thinking, multiple intelligences as Howard Gardner (2010) refers to them, have long been touted as vital to all matters of cognition and successful processing; still schools maintain an emphasis on only measureable critical thinking skills. Bolte, Goschke and Kuhl (2003) further assert that the chronic negativity so often felt in the testing environment, facilitates only critical thinking, and none of the other intelligences that a well person utilizes in order to adapt well and successfully (Bolte, Goschke & Kuhl, 2003).

In the late 1990's, a surgeon general's report noted that there are social determinants of mental health just as there are social determinants of general health that support mental health. These include adequate housing, safe neighborhoods, equitable jobs and wages, quality education, and equity in access to quality health care (U.S. Department of Health and Human Services, 1999). Furthermore, the Surgeon General's report associated positive mental health with improved health outcomes and long known research on Adverse Childhood Experiences (ACE) confirms a link, if not a full blown correlation between psycho-social conditions and lifelong physical and mental wellness. (U.S. Department of Health and Human Services, 1999).

These conclusions, born from humanistic psychology (*Boundless Psychology*, 2015) and developmental psychological theory (Aspinwall, & Staudinger, 2003), consistently demonstrate the power and essential need for wellbeing. Based on that set of assumptions as a whole, theorists and clinicians alike, make their case for teaching and tending to student wellbeing

within the schools on the grounds that pro-social, well students have become some due to protective factors and protective factors insulate humans from depression, increase quality of life perception and ultimately act as an aid to better learning and creative thinking. Because in this culture children and youth attend school by legal mandate, these environments provide optimal opportunity to enhance psychosocial well-being on a grand scale (Hofferth & Sandberg, 2001). Children and adolescents spend much of their waking hours within the confines of the school building, upwards of 30 to 35 hours per week in fact, making it is the ideal venue to host ongoing education, support and programming that inform overall wellness.

In his study titled, "Social, Emotional, Ethical, and Academic Education: Creating a Climate for Learning, Participation in Democracy, and Well-being," Jonathan Cohen (2006) argues for educational reform to reframe and prioritize social and emotional learning in addition to academic learning. Cohen notes that many parents and educators see the promotion of wellbeing, alongside character building as a fundamental aspect of educating our children.

Cohen (2006) surveyed the current research in the field of socioemotional and character education with school-based mental health in the United States, concluding that social-emotional skills and resulting knowledge are the bedrock of a quality life. He asserts that a psychosocial, emotional and academic education system is a basic entitlement for all students. He writes, "The American people have expressed their conviction that they primary purpose of public schooling is to prepare children to become effective and responsibility citizens (Rose & Gallup, 2000). Jonathan Cohen (2006) argues passionately and as a matter of social justice, that every child, especially the vulnerable and disenfranchised, have opportunity to hewn social-emotional competencies that will serve them in future endeavors and challenges that life will ultimately bring. These competencies will serve them in multiple life domains-relationships and work. He

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asserts that the United States overemphasizes traditional learning, mathematics and linguistics to such a degree as to be seen as limiting and ill-advised (Cohen, 2006).

Educational Impact of the Lack of Mental Health Supports in Schools

Over 50% of students with a mental health condition age 14 and older who are served by special education services alone, drop out−the highest dropout rate of any disability group. Mood disorders such as depression are the third most common cause of hospitalization in the U.S. for both youth and adults. Suicide is the third leading cause of death for ages 15 to 24 years. More than 90 % of those who die by suicide had one or more mental disorders. Mental illness costs America $193.2 billion per year (National Institutes of Health, 2013).

Moreover, Richardson and Morrisette affirm that it is quite typical that common mental health struggles with issues like mood and anxiety and family dysfunctions are often at the root of poor school performance as well as disciplinary and truancy related matters. (Richardson & Morrisette, 2012).

Dr. Guy Winch has a unique take on the matter of our emotional health and urges us to take it as seriously as we take our physical health. He is a licensed psychologist who works with individuals, couples and families. His well-known TED Talk (Winch, 2013), "Why we all need to practice emotional first aid" has in excess of 2,045,213 views as of this date and is a persuasive accounting for the importance of tending to our emotional and psychosocial needs. It is a helpful way to better understand the terminology utilized in this study. Winch's theory (2014) likens emotional wellness and ongoing hygiene to dental hygiene and personal hygiene in that both of these measures guard against and protect our varying levels of 'health' and that we must work mindfully to sustain them. Psychological wellbeing requires the same monitoring habits.   Dr. Winch believes there is a state of general neglect of our emotional health in the current culture.

With respect to behavioral or mental health education, schools respond with a limited focus on targeted or 'identified' students and subcategories of those 'troubled students' whose conduct serve as barriers to their learning (Rossen & Cowan, 2014). Current school mental health supports and services touch a very small sample of the overall student body, leaving the mass untouched and without a system in which they can access support (Rossen 2014).

Factors Contributing to Teacher Burnout

"Burnout is officially defined and personally experienced as a state of physical, emotional, and mental exhaustion caused by long-term taking part in situations that are emotionally demanding" (Saiiari A., Moslehi M., Valizadeh R. (2011). Westermann uses the term to describe an individual reaction to chronic stress at work (Westermann, Kozak, Harling & Nienhaus, 2012). Maslach, a pioneer in the study of teacher burnout, describe the phenomenon as "a syndrome of physical and emotional exhaustion relating the development of harmful job attitudes, meager professional self-concept, and loss of empathic concern" (Saiiari et al., 2011). These negative and taxing feelings feed an indifferent and cynical attitude that result in a personal sense of lack of accomplishment and efficacy (Maslach, Schaufeli, &Leiter, 2001).

This condition is comprised of emotional depletion, lack or loss of motivation, and is often associated with professions that can generally be categorized as 'helping professions' or social service like professions, including teaching. This requires an extensive amount of emotional and psychological output for middle school teachers especially who are often faced with a learning and achievement slump as well as a lack of specialized training for this age and stage of student(s) (Gootman, 2007). This transitional period is considered a critical stage in a students' academic trajectory and can be especially difficult for middle school students who

struggle to achieve scholastically. As students move from middle school to high school, a vital transformation gets underway.

Emotions can facilitate or impede both child and teacher engagement, commitment, and overall school success. Because relationships and emotional processes affect how and what we learn, teachers must effectively address these aspects of the educational process for the benefit of all students (Zins & Elias, 2006*).* It is a widely held opinion, according to Italian researchers, that adolescents share and show a common set of struggles; malaise and lacking esteem or confidence. A greatest potential protective element against the growth of those struggles; schools as the vital link for promoting and growing mental wellness (Veltro, Ialenti, Iannone, Bonanni & Garcia, 2015).

A 2015 pilot study of high schools mental health programs concludes that the most effective intervention methods result from an embedded part of curricular activity with the aim of promotion of social skills building and efficacy (Jennings & Greenberg, 2009). Teachers as key players in the school milieu are often the first point of contact thus; an improved response system for their access and support for tending to the emotional and psychosocial well-being of *every* member within the system is in order. Reciprocal determination, a term coined by Albert Bandura (1986), is evident in this dynamic; teacher's impact environ: students respond, positively or negatively, and the entire system is affected**.**

Support systems that enable teachers as they support students impel constructive change. Healthy students incite optimistic change in service to the community, the school personnel and the student body as a whole, which in turn serves the society. Burnout and its' ramifications for the field of professional teaching presents a significant crisis. Jointly, these negative experiences and unmet personal and professional needs combined with the expressed deficits and frustrations

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of our teachers demonstrates that current practices are insufficient and in some respects, compound the dilemma.

      Emotional exhaustion. Hakanen and Maslach (2006) describe these phenomena, relative to the teaching profession specifically, and they describe it in terms of high-level exhaustion that precede a state of burnout. It is an intellectual and temporal depletion brought on in part, according to Chang and Davis, (2009) from to day-to-day management of student misbehavior in the classroom. Furthermore, this epidemic of teacher burnout affects worldwide economics. It affects the teacher workforce significantly both externally and internally.

      Milner, Woolfolk and Hoy's (2003) studies of burnout highlight the statistics associated with teacher attrition and teacher shortage, arguing that this untreated or unaddressed crisis in the teacher field is a cause of utter harm to the workforce as a whole and can be measured by way of the numbers of teachers leaving early in their career as well as those numbers that reflect the shortage of professionals who rebuff the field as a professional option altogether-thus a teacher shortage. In the United States, up to 25% of beginning teachers leave the teaching field before their third years, and almost 40% leave the profession within the first 5 years of teaching" (Milner, Woolfolk, & Hoy 2003; National Center for Education Statistics 2004; National Commission on Teaching and America's Future 2003; Smith &Ingersoll, 2004). This emotion laden, labor-intensive work requires more of its professionals than do many other professionals. Moreover, the burned out teacher impacts the individual student, classroom and school building because the higher the burn out the higher the level of withdrawal or disengagement from the student. In other words, the student teacher relationship suffers. If that relationship suffers, the student loses. In addition, if that student is already vulnerable, or emotionally needy, the potential fallout is massive.

Decreased perception of efficacy among burned out teachers. In the contemporary teaching world of the 21st century, educational professionals are called upon to manage the behaviors and emotional needs of all students as they manifest in any given classroom on any given day. Emotionally depleted teachers have lower perception of self-efficacy and both elements place them at risk of negative states of mind that influence the classroom.   "Burnout takes a serious toll on teachers, students, schools, districts, and communities. Burned-out teachers and the learning environments they create can have harmful effects on students, especially those who are at risk of mental health problems" (Jennings & Greenberg, 2009).

In their longitudinal study of teacher burnout and perceived self-efficacy in classroom management, Brouwers anatomic 2000, examined the direction and period of relationships between perceived teacher self-efficacy in classroom management and dimensions of burnout among 243 teachers. Structural equation modeling (SEM) analyses indicated that perceived self-efficacy had a longitudinal effect on depersonalization with a synchronous impact on personal accomplishment. The researchers concluded that perceived self-efficacy, which is impacted by student behaviors in the classroom, must be taken addressed when burnout prevention measures are being created and utilized.

Unmanaged student emotions and psychosocial wellness lends itself to teacher feelings of inadequacy (negative self-efficacy) and reduced personal power, which in turn intensifies depersonalization on part of the teacher(s) (Brouwers &Tomic, 2000) This research correlates strongly with that of Albert Bandura (1997) who is the pioneer of self-efficacy theory and its' correlates and impact. Bandura defines self-efficacy—this kind of personal power—as an individual organism's beliefs about her or his own capabilities and capacities as they relate to the organism's ability to meet the demands of the activity within a given environ. When teachers

believe they no longer have the wherewithal to affect the environment (the student) in a positive way, they disengage, they surrender and the vulnerable student loses even more ground (Bandura, 1997).

Unhealthy professional environments. Schools are environments and there is a cultural ethos that exists within them. Burnout costs school districts billions of dollars annually through absenteeism and disability issues in addition to costly attrition rates. Stressful environments can lead to teacher burnout. Most researchers believe burnout is the result of an interaction between environment (school conditions) and teachers' distinctive trait tendencies in response to stress. It is the responsibility of districts and administrators to mitigate, to the extent possible, stressors in the school environment. Roloff and Brown (2011) point to the results from administration of Miami-Dade County Public Schools' 2009-10 School Climate Survey indicating that the morale of teachers is correlated to leader support, but significant numbers of teachers also report feeling overwhelmed in their day to day job tasks.

This is an especially poignant element as it relates to vulnerable students, those who otherwise, outside of the school system, lack resources for support of their emotional and psychological needs. If teachers are in fact not getting their psychosocial need met, how can they be supportive to the student? Additionally, schools lower in social economic status (SES) are more likely to have insufficient numbers of teachers who have inadequate amounts of ongoing professional development that will aid their efforts to address behaviors and emotional hygiene within a classroom. The job of teachers is one of enormous importance to society. Their expertise must find inclusion with the policy makers and the power brokers.

Teacher unpreparedness. In 2012 Tom Torlakson, State Superintendent of Public Instruction in California, convened a 35-member Student Mental Health Policy Workgroup

(SMHPW) hoping to gain traction for a reform to provide teacher preparation and credentialing in the area of mental health. The all-volunteer workgroup, composed of teachers, counselors and social workers, alongside medical professionals like school nurses and also school administrators, all experts in their own right, are kindred in their views; educators require more instruction in the area of mental health. Torlakson's survey results confirm that teachers themselves do in fact believe and feel that they lack the necessary training (Adams, 2013). Torlakson's workgroup (Adams, 2013) points to a 2011 research study out of the University of Missouri, authored by Reinke, Stormon, Herman, Puri, Rohini and Goel, 2011, that identified a significant research to practice gap in the area of mental health and wellness practices within school systems. The study examined teacher perceptions of current mental health response(s) within the context of their specific school setting. The 292 teacher participants reported on self-beliefs about their role in supporting wellbeing in students, barriers within the system and perceived skill sets and training needs.   The study concluded that teachers perceive themselves as primary points of contact for in-class interventions while deferring to mental health specialists, school psychologists who are perceived as having a more significant responsibility for teaching ongoing psychosocial education and lessons. Notable in this study, teachers remarked on a universal and significant lack of training and education for understanding, supporting and managing the emotional needs of their students, a practice gap of striking significance.

As society takes a sharper and attentive view of mental health issues as a whole, the general population has ample evidence through more and more critical incidents in schools, tragic events like those of Columbine, Newtown, and Taft, push towards a need for a more immediate and specific response from key stakeholders. Policy makers are now demanding that schools provide their students with access to psycho-emotional support. The SMHPW (Adams,

2013) used these public reactions to promote the movement for credentialing and education for all school staff to make them better equipped to identify MH issues but moreover, to take action, to respond in addressing needs. David Kopperud, chair of the SMHPW (Adams, 2013) and a consultant in the State Department of Education calls it a crying need because mental health and wellness needs arise on a daily basis in American schools; teachers face mood and eating disorder issues, as well as a plethora of other student struggles every day, yet specific training for such situations is notably lacking, in both policy and practice. By credentialing and training teachers to help address the ongoing psychosocial needs of their students, basic tenants of the Systems of Care (SOC) theory emerge.

The SOC literature and the lessons learned by the nine federally funded States and tribes and the 18 participating communities of the Children's Bureau's Improving Child Welfare Outcomes Through SOC demonstration initiative contribute to a foundational definition of systems of care in the child welfare context. The definition of SOC's has evolved over the past two decades, based primarily on work in children's mental health.

Hodges, Ferreira, Israel, and Mazza (2007) present a definition that reflects current systems of care components: "A system of care incorporates a broad, flexible array of services and supports for a defined population(s) that is organized into a coordinated network, integrates service planning and service coordination and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, and has supportive management and policy infrastructure." Generally, the definitions serve to point out essential elements such as strengths-based, integrative, and community-oriented.

SOCs are designed to break down silos between providers, organizations and agencies, like schools and community health care providers and the juvenile justice system as well as private practitioners who all have the capacity to touch the very population we are concerned with (Stroul, Blau, & Friedman, 2010). Effective collaboration between silos, build whole systems that are notably more proactive and effective in addressing and accommodating the psych-social needs of all children, across all systems (Stroul, Blau, &Friedman, 2010). In 2013, President Barack Obama, speaking at the National Conference on Mental Health, asked teachers to help identify mental health disorders in students. At the conference, 40 organizations, including the National Education Association and the American Federation of Teachers, pledged to provide some training in recognizing mental health issues to teachers, administrators, staff, students and families.

The Multidimensionality of Mental Health

The World Health Organization (WHO) stresses the positive dimensions of one's mental health by reaffirming their global position that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 2015).

In November 2008, a policy brief "The School Environment and Adolescent Well-being," the argued that because adolescents spend a significant portion of their day to day lives in school or in school-related activities, we must account for school influence above and beyond the academic development of students (Marin& Brown, 2008). The overarching macro view that teachers and schools hold must be far broader than that of testing and formal instruction, and inclusive of the overall wellness of every student-that wellness, physical, mental, and overall social development of an efficacious, competent future adult (Marin& Brown,2008). The policy

brief goes on explaining that a school's impact on all these elements of wellness, can be produced through a variety of activities including formal pedagogy, after-school programs, caretaking activities (e.g., feeding, providing a safe environment) as well as the informal social environment created by students and staff on a daily basis. While most reports focus on a particular aspect of the school environment (e.g., academics, safety, health promotion), this brief looked at schools more comprehensively as an environment affecting multiple aspects of adolescent development. Research has repeatedly demonstrated the interconnectedness of the multiple variables at play; safety and health affecting the academic environment, academics affecting health and social development, and so on. For that reason, any particular aspect of school policy and activities will be better understood through the lens of this much larger holistic context. This is particularly important as school systems have become even more pressured to focus on their main goal of academic development as a result of the federal No Child Left Behind initiative (Klein, 2003). It is also particularly important information for key stakeholders like school principals, district staff, the community of parents and others who are responsible for all aspects of school functioning. It should also be useful to those focusing on a narrower range of school functions (e.g., academics, health and safety, civic development) in order to prompt systemic changes.

Academic success, mostly defined by high test scores, is not just an insufficient assessment of overall wellness, but it does little to inform our understanding about human wellness. According to Seligman (2005), there is a science of positive subjective experience, positive individual traits, and positive institutions. It follows then that schools with adequate mental health support systems may hold promise for improving the quality of life and preventing the pathologies that can manifest when life is stressful or distressing. Yet the focus on pathology

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(Mannarino, Loughran & Hamilton, 2007) dominates so much of the discipline of both psychology and discipline of counseling that therapist results framed by this deficit model is lacking. In a paper presented at the 2007 Association for Counselor Education and Supervision conference, Mannarino, Loughran & Hamilton call for a more culturally focused and sensitive training component that questions the strict adherence to the DSM-IV-TR and subsequent results of its use as unilaterally accepted and unquestioned as reliable because they are believed to be objective. Less tangible and less fact-based indicators like what enables happiness autonomy and self-regulation, optimism, and creativity and how to bring those talents and skills to full fruition in a student, often go unaddressed. Zalaquett, Fuerth, Stein, Ivey & Ivey, (2008) go further calling the need for a more holistic approach to mental wellness as a matter of social justice. Atherton, Graham and Steedman (2011) give a framework for this kind of shift by pointing to a science of positive psychology that emphasizes those mechanisms or environmental factors that build on positive qualities to grow the human mind and spirit rather than a framework built to uncover gaps and point to deficits

The goal of this study is to shine a light beyond the context of scores and rankings and to illuminate the nucleus that affirms that approaches to mental illness should look beyond behaviors defined as diagnosable mental maladaptation, to examine health and welfare conditions that alter one's ability to think, control mood and behavior, and that are often associated with distress or maladaptive functioning.

Diener and Seligman (2012) theorize that the various components of SWB represent distinct constructs that should be understood separately, even though they are closely related. Hence, SWB may be considered an overall construct rather than a singular all-purpose area of model or archetype (Diener& Seligman, 2012). Due to its specific focus on

the subjective characteristics of well-being, Seligman's (2009) definition of Social Well-Being usually excludes the more objective factors or material conditions that are used to gauge overall wellness even though these later factors are influential.

Link Between Adverse Childhood Experiences and Lifelong Vulnerability

There is emerging evidence that positive mental health is associated with improved health outcomes comes from well-substantiated research on Adverse Childhood Experiences (ACE) that confirms a correlation, if not a full blown cause and effect dynamic between psycho-social conditions and lifelong physical and mental healthiness (Centers for Disease Control, 2014).

The seminal study, the ACE Study, conducted from 1995 to 1997, had over 17,000 participants and was the largest study of its kind to study how chronic early life and childhood stress impacts health, wellbeing and quality of life (Centers for Disease Control, 2014). The joint research project involved a collaboration between the Atlanta CDC and San Diego based Kaiser Permanente (Andi & Felitti, 2003).

Researchers define ACE as stressful or traumatic experiences and a range of day to day lived dysfunctions that stem from growing up with substance abuse, mental illness, parental discord, or crime. ACE are strongly related to a wide range of health problems throughout the lifespan. These experiences have been consistently linked to psychiatric difficulties in children and adults. According to Paul Tough (2011), children who live chaotic home lives and who are exposed to chronic stressful events can suffer not only emotionally, but also psychologically and physiologically and often live shorter lives.

Shonkoff (2014) identifies family income and education, neighborhood resources, and other social and economic as factors that affect health at every stage of life—but the effects on young children are particularly dramatic, according to nearly two decades of accumulated

research. The more trauma and stress one experiences as a child, the more likely one is to suffer physically with a multitude of diseases as an adult including chronic depression, addiction to drugs and alcohol, and attempts at suicide. In addition, ACE researchers assert that ACE correlates to a higher likelihood for dropping out of school, being incarcerated, or becoming chronically unemployed (Chapman, Anda, Felitti, Dube, Edwards, & Whitfield, 2004).

Ongoing ACE research by Anda and Bremner (2006) confirms that these kinds of disruptions, especially when they occur in early life development, can impede a child's ability to cope with negative or disruptive emotions and contribute to emotional and cognitive impairment. Over time, and often during middle school years, the adolescent may adopt maladaptive coping strategies in order to manage distress or discomfort. Often, these manifestations show themselves within the confines of the classroom before they become noticeable in other places. Moreover, the impact of these opportunities and obstacles, along with their *health* impacts, accumulate over time and can be transmitted across generations as children grow up and become parents themselves.

In 2014, in an issue brief published by the Robert Wood Johnson Foundation, Braverman, Egerter, Arena & Aslam, address the matter of life cycles and early life experiences as they inform overall health and wellness across a lifespan. Specifically, the researchers focus on social disadvantage(s), which can include chronic stress, absence of cultural capital, and, generally, that socio-economics can very much have a pointed and significant impact on the development of a child. They address what can be done to impact and mitigate this vulnerability and disadvantage and part of the solution involves providing for a safe, nurturing environ in which the young, children and students, can learn to thrive and build capacity for healthy emotional regulation and competence. To that end, the researchers argue that schools are pivotal in this equation.

Schools, they point out, can serve as a point of remedy where social conditions and socioeconomic disadvantages can be mitigated, because here, within the school system, influence can be made on the development of the whole child and that whole child's wellness. Braverman, Egerter, Arena &Aslam, 2014).

Aseltine and Gores' 2007 study on ACE and student wellbeing sampled young adults from urban, socio-economically disadvantaged communities with high rates of adverse childhood experiences. They concluded that the connections between ACE and wellbeing are in fact a matter of public health and that the correlation becomes evident in negative behaviors including mood issues, antisocial conduct and risk for drug used during the transition between adolescence and young adulthood. These findings indicate the critical need for prevention and intervention strategies targeting early adverse experiences and their mental health consequences as early as possible. The researchers argue that many questions much be investigated and answered jointly. A corollary question for middle school and adolescent student's centers on the issue of how activities and events at a given school reverse or increase negative behaviors and outcomes. Are schools funded and evaluated exclusively as institutions for academic learning only or can we utilize these rich and empowering milieus for social and mental reforms as well? (Aseltine &Gore, 2007). If we respond in the affirmative, then a restructuring is essential and must go well beyond the defined roles as they are assumed today.

Altering the Education System

Clearly, there is a long history of posturing and positioning related to the mission and overarching purpose of American schools. The addition of learning about emotional hygiene and psychosocial wellness does not have to negate the traditional mission of educating the child to be academically and scholastically expert -teaching a child to learn and achieve in the sciences

and the arts. In fact, ultimately, learning serves as the catalyst for productive, critical thinking

individuals who will lead healthful and productive lives.

Ones capacity to persevere and other like predictors of what some refer to as 'grit' has

been correlated with positive effects and outcomes for students. Perseverance and grit are the

by-products of enhanced psychosocial supports in the academic setting can provide. These

enhanced supports compliment the preconceived notion of what schools are in fact in the

business of.

In a longitudinal study of 20 schools (Snyder, Flay, Wichinish, Acock, Washburn, Beets,

& Li,2010), conducted from the 2002-2003 through the 2005-2006 school years, researchers

reported findings on the impact from participant schools that utilized the Positive Action Hawaii

intervention. The successful program utilizes scripts that are both easy to comprehend and easy

to teach. The scripted lessons come with predesigned materials to supplement each lesson plan.

Each kit is designed for a specific grade level and provides materials for a classroom of at least

30 students (Flay, Acock, Vuchinich, & Beets, 2006). Each lesson takes 15 minutes to complete

and although individual training is not required, some minimal training is recommended for the

facilitator, and, the kits are designed for every level of stakeholder; teachers, community

members as well as parents. At its core, the philosophy is straightforward and subsumes a basic

theory: do good, feel good. On the other hand, as the creator's state, "Positive Action is based

on the intuitive philosophy that we feel good about ourselves when we do positive actions"

(Flay, et.al, 2006). Figure 2.1 below illustrates the theoretical framework embedded in the

Positive Action Program.

Figure 2.1. The Triadic Circle of Influence (Flay & Beets, 2014. pg. 11).

The Thoughts-Actions-Feelings Circle (TAF) illustrates how this works in life: our thoughts lead to actions and those actions lead to feelings about ourselves which in turn lead to more thoughts. (Flay, et al., 2006). The Program is designed to address whole wellness of each student. Each lesson designed to teach behaviors that support pro-social reactions to both positive and negative dynamics within the classroom (Flay& Slagel, 2006).

According to the What Works Clearinghouse report, revised 2007, Flay and colleagues (2006) claim statistically significant findings to support this kind of intervention to decrease rates of anti-social or negative high risk behaviors for middle school students. Additionally, findings by Flay and Allred (2003) show a positive correlation between the use of the Positive Action Program lessons and a marked decrease in violent behaviors of students who participated in the intervention groups. A summary of the concluding results showed that those schools that utilized the intervention scored almost 10% higher on the TerraNova (2nd ed.); with an 8.8% increase in reading scores, 20.7% better on state content performance test scores for reading overall participant schools showed a 51.4% betterment rate in math, with participant schools

reporting 15% lower rates of absenteeism and less student suspensions (Snyder, Flay, Wichinish, Acock, Washburn, Beets, & Li. 2010). Results of this study underscore the correlation between mental well-being and academic success. Other researchers conclude that the current education system has an urgent need to discover more about the impact of behavior, social skills, and character as they relate to and are intertwined with scholastic (Eccles, 2004; Meece, Anderman, & Anderman, 2006).

Yet in the wake of the No Child Left Behind Act, teachers and schools have had a heightened focus on the instruction of core guidelines to enhance academic scores (Hamilton, 2007). Thus, instruction around psychosocial wellness and providing support for the character and pro-social elements has been relegated to a position of lesser importance.

Mental health concerns grow in prevalence as children transition into adolescence and can contribute to conduct and actions that negatively affect student achievement (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). In a 2005 study published in the School Journal of Health, Fleming, Haggerty, Catalano, Harachi, Mazza and Gruman looked examined whether or not social and behavioral traits addressed via school interventions could inform or predict test scores and student grades. Strong support for the Flemings presumed claims were indicated. The study results point to improved levels of school connectedness and better social-emotional intelligence are correlated to higher testing scores and overall higher grades. On the contrary, negative behaviors, those understood as being non-pro-social in nature, were correlated to lower grades and test scores. These findings give strong support for Fleming's claims that early and strong strengths based social-emotional interventions that support good problem solving and decision-making skills can positively combat declines in student achievement in measureable

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ways like better grades and higher test scores (Fleming, Haggerty, Catalano, Harachi, Mazza & Gruman, 2005).

Research has also demonstrated that there is a societal benefit to investing in the positive mental health of students. A study by the Teacher's College at Columbia University (2005) estimated that the United States loses $192 billion (1.6% of the gross national product) in combined income and tax revenue with each cohort of students who fail to complete high school (Fleming et al., 2005). It is well established that students who are struggling emotionally and behaviorally are more likely to drop out of the school.

One in five children and adolescents will face a significant mental health condition during their school years. This, according to General David Satcher in a seminal, first ever Surgeon General's report on mental health, released in December of 1999 (Satcher, 1999). The release, promoting mental health in middle level and high schools, addressed, in part, why the barriers that prevent some pockets of school students from open access to support is such a threat to safe and nurturing schools across the country. Schools, students and families situated in poverty or sub-standard school systems are even more at risk from the limited capacity that their schools have. The ongoing disinvestment of funding for such supports and the stigma that surrounds mental health struggles altogether only worsen an already growing hindrance to student success (Satcher, 1999).

The Importance of Preparing Teachers to Identify Early Indicators of Distress

Often the first line of defense for students, teachers must be prepared and develop the skill set to not only identify early indicators of distress deepen their understanding of the age appropriate developmental states of their students, but they also must be equipped with mechanisms through which to acquire a set of aids that answer the presenting dilemma.

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Teachers themselves seek more support, a dynamic often evident in the professional practice of this researcher.

In 2014, Cottle and Green spoke to this very issue in an article entitled *Including Teachers in the Student Mental Health Continuum,* published in Education Week. They argue that there ought to be a system where teachers can call upon someone, a counselor or a principal, on behalf of the student(s) so that an appropriate and fruitful action can be taken. Teachers often remark, during their private therapy sessions, that it seems obvious to them that this kind of care should be available on the school campus and recognize that mechanisms serve their community, themselves and their students (Cottle & Green, 2014).

In a study by Yale University researchers (Ginicola & Finn-Stevenson, 2003), teachers, parents and community members were surveyed about this matter. The researchers concluded that that mental health and wellness is a vital matter of concern in schools today. From their data they assert that there mental health issues are of prevalence; school professionals, teachers and other personnel feel underequipped to manage and address these issues and current response mechanism need revised and changed as the majority of students exhibit signs for need of a considerable nature (Ginicola & Finn-Stevenson, 2003).

While some may continue to argue that schools are not in the business of providing social services, a team of community mental health professionals integrated into school services is crucial for early intervention, prevention and identification of adolescent mental health conditions. "Even for professionals who work with adolescents and practically have seen it all, the number of youths with mental health challenges is simply staggering. One-half of all lifetime diagnosable mental health conditions begin by the age of 14" (Kessler, Berglund, & Demler, 2012, pg. 24l).Moreover, Wu, Hoven, Bird, Moore, Cohen and Alegria (2006) note, "the

presence of mental illness in children and adolescents, if not properly diagnosed and treated, increases the likelihood of significant health issues for them as adults and greatly limits their ability to become productive members of society" (pg. 1081).The research of Wu, Hoven, Bird, Moore, Cohen, & Alegria (2006) confirms that for the adolescent population, first signs of emotional distress often emerge within the school environment.

The Foundation for Positive Education

"Use your signature strengths and virtues in the service of something much larger than you are." ~ *Martin Seligman (2002, p. 263)*

Seligman (2004) defines positive education as the conglomeration of both traditional skill sets and overall happiness. He argues repeatedly in his writings that academics are not enough, nor do they stand alone as any real measurement of a whole human animal. Seligman, Steen, Park and Peterson, 2005, write, "The high prevalence worldwide of depression among young people, the small rise in life satisfaction, and the synergy between learning and positive emotion all argue that the skills for happiness should be taught in school. There is substantial evidence from well-controlled studies that skills that increase resilience, positive emotion, engagement and meaning can be taught to schoolchildren. We speculate that positive education will form the basis of a 'new prosperity', a politics that values both wealth *and* well-being" (Seligman et al., 2009, pg. 294).

Seligman and other researchers (Seligman, Steen, Park & Peterson, 2005) studied schools in Australia to find the answers to how happiness and wellbeing can be defined as well as how schools, alongside parents, can 'teach' wellbeing to all students. In a rather famous oft-quoted speech, he asked teachers to describe in two words or less, what schools teach? The overwhelming responses included achievement, cognitive skills, reading and literacy, math and

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science, conformity and discipline–in short a measureable and finite set of accomplishment skills. Schoolchildren, according to the teachers surveyed in this study, have an almost singular focus on traditional formal achievement and parents and society buy into that model as well. Seligman (2008) defends his position noting that he is in fact a proponent of success, literacy, and accomplishment, but he imagines schools as a place without need for compromising what we typically account for when we measure 'achievement' while still being the place where we also teach skills for well-being. It is in fact, not an either or matter.

Should well-being be taught in schools? This is the question that researchers posed to the Australian audience, an audience in a place, like every wealthy nation in the world, including the United States, in the throes of a depression epidemic. Depression is about ten times more common now than it was just 50 years ago. Today, that epidemic is prevalent among young people, adolescents, with an average age of onset of first episode at age 15 (Seligman, 2008). Seligman is famous for his firmly held belief that happiness can in fact be taught. He refers to a new prosperity, a movement of sorts that combines well-being with wealth. His position, that one must begin this type of learning early, in the critical and formative years, is based on his unwavering idea that the mechanism for this adaptation is kindled by positive education (Seligman, 2008, pg. 14). Below, a visual illustration, a cognitive map, to further explain his theory.
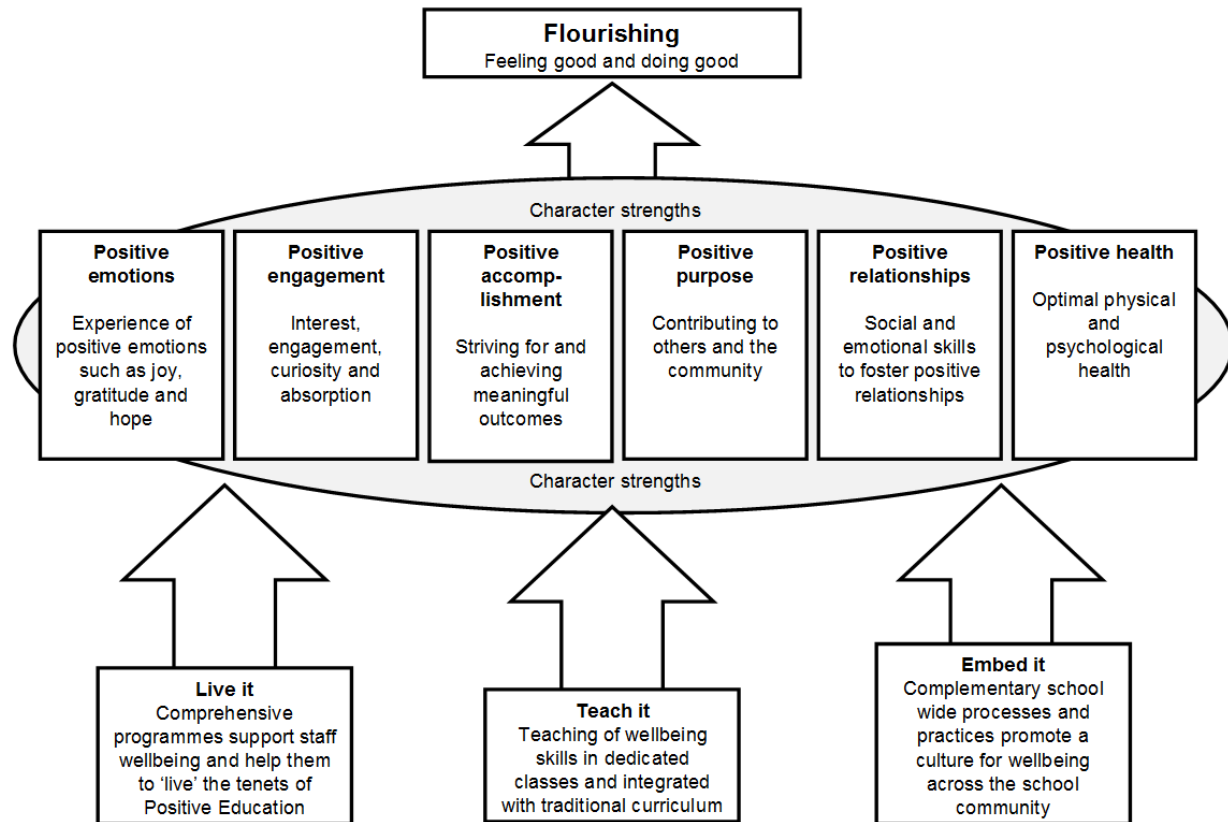
Figure 3.1. Illustrates the Geelong Grammar School (GGS) Applied Model for Positive Education (Williams, 2011).

A Positive Education theory must be embedded into the real lived experience of the student, within the classroom, no matter the subject matter and a teacher must be an authentic model who also abides by the same codes as entire schools aims at becoming a practice community where positive education can thrive and become implicit to all other goals within the setting (Seligman, 2008).

The teaching of the subject of wellbeing involves both the implicit and explicit learning for the student. In other words, there are timetables and scripts and lessons that are facilitated and can be known and understood overtly (Brunwasser, Gillham, & Kim, 2009). Also, the ongoing underlying the implicit lesson of living daily experiences that lend themselves to a

lifelong value system that is strengths-based, impacting the individual, the group, and the socio-culture system at large (Seligman et al., 2009).

Mental Health Systems as a Matter of Social Justice and Equity

"Poverty is pain; it feels like a disease. It attacks a person not only materially but also morally. It eats away at one's dignity and drives one into total despair" (A woman, Republic of Moldova, WHO | World Health Organization, 2001). "One of the most consistently replicated findings in the social sciences has been the negative relationship of socioeconomic status (SES) with mental illness: The lower the SES of an individual is, the higher is his or her risk of mental illness" (Hudson, 2005. Pg 3). Socioeconomic factors, especially poverty, influence mental health in powerful and complex ways. They are highly correlated with an increase in the prevalence of serious disorders such as schizophrenia, major depression, antisocial personality disorders and substance use. Most of these disorders are about twice as common (or more commonly diagnosed) among the poorest sections of society as in the richer ones (Murali & Oyebode, 2004).

Additionally, lack of access to education can be risk factors for mental disorders and can worsen existing mental problems. These findings are consistent in countries across income levels. They illustrate the broader concept of poverty, which includes not only economic deprivation but also the associated lack of opportunities for accessing information and services. Schools remain the one constant and consistent venue in which poorer students and their families can gain entry into the system that can support ongoing mental wellness (Ritsher, Warner, Johnson & Dohrenwend, 2001). Poorer people, even among those in the wealthy land of America, are exposed to greater levels (quality and quantity) of environmental and psychological adversity, which produces high levels of stress and psychological distress (Haushofer & Fehr, 2014).

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As noted earlier, this aligns with ACE theory and its' aftermath. These students can have major difficulties accessing information and mental health services in the private sector. In all events, socioeconomic factors and mental health are inextricably linked. The treatment gap for most mental disorders is large but for the poorer segments of populations, students in particular, it seems at time unbridgeable. Mental vulnerability can result in substantial societal burdens, present and future loss of productivity and added costs for support, not to mention the loss of contribution to our society in general (Stagman &Cooper, 2010).

National policies are needed that reduce poverty with a focus on stabilizing and improving income, strengthening education, and meeting basic human needs such as housing and employment. With the health of a nation increasingly being seen as a critical component of development, psychosocial wellness as a public health concern must be acknowledged as a priority for overall social development. Social development, alongside academic success, goes hand in hand. On the other side, policy makers and some school systems and parents take the position that schools should maintain a hands-off approach to all matters of social service (Kessler, Berglund, Demler, Jin, Merikangas& Walters, 2005). This is however, counterintuitive to the basic universal standard of having at least an identified professional counselor or social worker embedded within school districts, if not in every building. Unfortunately, this line of defense is underwhelming in contrast to the depth of the issues, especially when these professionals are often inundated with the demand for supports and even more often relegated to the position of service coordinators, crisis responders or testers.

The Manifestation of Negative Mental Health in Adolescents

Crisis, emergency, catastrophe tragedy – all common language frequently heard at schools today. Far too many institutions, as the media attends to quite vigorously, continue to

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have major crises. It can happen anywhere and at any time. Schools differ in the specifics as to their crisis response systems, if they exist at all. They also differ in the amount of support they provide in establishing response protocols, staff training, as well as district level staffing patterns for these responses. As a course of justice, as a basic human entitlement every school requires facets to prevent, intervene and support ongoing psychological wellbeing among the student body. Howard Adelman (2015) has studied this niche area of practice for many years. He warns against inaction, too little effort as he has referred to it. He is strenuous in his accounting that we cannot risk the perils of the aftermath of school systems that fail to acknowledge the interconnectivity of schooling, home performance and lifelong psychosocial and achievement problems.

According to Eric Rossen and Catherine Cowan, (2013) in addition to crisis management plans and procedures, all schools must acknowledge and account for the students who are struggling mental health dilemmas. These very students, all students in fact, who struggle psycho-socially do not thrive, and rarely meet their learning and achievement potential. Rossen goes on to argue that emotional wellness; emotional intelligence quotient is a prerequisite to academic achievement and success. Mental and psychological wellness is part and parcel in this equation; it is not a luxury or add-on.

The most common mental health issues in youth that can emerge in adolescence are anxiety, depression, eating disorders and substance abuse and over two thirds of all interventions for MH related reasons (for students) stem from their home school (Rossen & Cowan, 2014).

Rossen, director of professional development for the National Association of School Psychologists urges that children, students, need educated around mental wellness. The former school psychologist goes on to espouse the basic premise that students, who feel safe, are well and

stable emotionally, are more successful in the classroom (Rossen & Cohen, 2014). Furthermore, according to Rossen and Cohen (2014) U.S. schools have profound and far-reaching needs. One in five students experience a serious mental health episode or incident (Merikangas et al., 2010) and that statistic is not inclusive of the average student who struggles but does not meet criteria for an official diagnosis. Ultimately, nearly 10 million students will need professional supportive services for psychosocial reasons during the first twelve years of school (National Center for Education Statistics, 2014). The common emotional struggles ultimately reflect mood problems that manifest in behavioral actions, negatively alter a student's ability to meet the cognitive landmarks that make for good grades. Inter-relational struggles also quite often result (Rossen & Cohen, 2015).

In a Dec. 2014/Jan. 2015 article published in Phi Beta Kappan, researcher's points to an inadequate system of care for serving the needs of these students. They name a lack of mental health providers as well as inaccessible services among the problem. Additionally, stigma is identified as a significant impediment to getting necessary help (Knopf, Park, & Mulye, 2008).

The multitude of disorders that might exist and then manifest regularly within the school milieu include the above mentioned but also, attention deficit hyperactive disorders, various types of anxiety and conduct related disorders, and bipolar disorder, a form of clinical depression. Approximately one in five children has a mental health problem, and one half of all lifetime cases of mental health disorders begin by the age of 14 (Stagman & Cooper, 2010). Moreover, according to SAMSHA, traumatic or stressful events encountered during formative years, childhood and adolescence, often increase the likelihood of developing poor functionality or disorders later in life (SAMHSA, 2012). These may include victimization, grief and loss, divorce or separation, violence, child abuse or neglect, substance abuse, natural

disasters, school crises, military deployments, familial mental illness and poverty (AAP, 2009; National Association of Chronic Disease Directors [NACDD], n.d.; SAMHSA, 2012).

The National Association of School Nurses (2011) reports that physical conditions among children and youth are on the assent, among the chronic diseases, obesity, diabetes and asthma. Students with vulnerable physical health issues have increased risk for mental health disorders and risk-taking behaviors (NACDD, n.d.). According to the NACDD (n.d.), the 1998 *Adverse Childhood Experiences* (ACE) study by Felitti and Anda identified the relationship between adverse childhood experiences and the development of emotional and physical illness in adults with increased mortality rates. The ACE study highlights the need to manage all manors of 'disease' with a holistic approach that includes physical and behavioral health strategies (NACDD, n.d.). The issue of ACE is addressed throughout this study.

Inefficacy of Current Treatment Systems

Medical and psychological conditions, or the fallout from them, increases, as does the use of psychotropic drug interventions in children, with two-thirds of the prescriptions written for stimulants and antidepressants (Center for Health and Health Care in Schools, 2012).   In 2013 the National Association of School Nurses (NASN), made public in their position statement that mental wellbeing of school students is as vital as is physical wellbeing (NASN, 2013). Additionally, the NASN, important partners in the system that is school, believe that professional nurses situated within school systems are uniquely qualified to support, identify, and intervene when student mental health issues arise. The NASN equates mental health with a state of social wellness inclusive of an individual student's abilities to realize their own competencies and to navigate life stresses (NASN, 2013). Also supporting the view of the NASN, the American Academy of Pediatrics (AAP, 2009) addresses imbalances between physical and psychosocial

wellness as pertinent to overall healthy development across a lifespan (American Academy of Pediatrics, 2004). Moreover, SAMSHA (SAMSHA 2012) reports that 5% to 9% of school-aged children between 9 and 17 experience a significant emotional upset each year and these disturbances impact functioning within the school, the home and the community (SAMSHA, 2012).

The evidence is mounting. If children will continue to use school as a means of ingress for accessing much needed support and service, building a system of care, a school response system in service to these children is a matter of effective school practice sustained by decades of research and real lived experiences that have built a solid foundation and argument to this end. Providing these kinds of supports engages families, promotes appropriate use of resources, augments school safety, and helps to facilitate positive outcomes in the area of attendance while also promoting positive dialogue that can eliminate stigma. Being an adolescent has inherent challenges. For those who also struggle psychologically, to whatever degree and for however long, it is clear that they stand to benefit from a response system that serves them and serves them well. SAMSHA confirms that schools are indeed the most efficient venues from which to deliver supportive services for students. Their studies show that students who participate in compressive and collaborative school-based mental health programs have notably less disciplinary issues, better mental health, and, perform better in school (SAMHSA, 2012).

Reprioritizing Mental Health

Approximately, around the 1920's, the dominant perspective held that human conduct and behavior was to be explained and understood mostly by individual variables, primarily innate personality traits and characteristics (Schultz & Schultz, 2004). A deterministic point of view that framed biology as destiny. When behaviorism found favor shortly thereafter, the

pendulum swung towards the competing view held that DNA is in fact less important, whereas human animals were seen as products of their unique environments. The nature nurture controversy repeated (Rutherford, 2003). Today, the contemporary perspective is much more eclectic and dynamic. Today, most theorists and experts would agree that human functioning could only be understood in context and the transactions that occur between the person and the environment, and the outcome of that transaction (Yang &Lu, 2007).

In their 2009 journal article, Dialogues in Clinical Neuroscience, Merikangas, Nakamura and Kessler, recount the epidemiology of the marginalization of mental wellness from conventional conversations in and out of schools and how it has contributed to pervasive stigmatization (Merikangas Nakamure & Kessler, 2009). It has also meant that the overarching matter of human mental health has received low priority in most public health agendas with consequences on budget, policy planning and service development, and schools are no exception (Weir, 2012). Among all the mental and neurological disorders and diagnosis, depression accounts for the largest proportion of the burden on today's tween and adolescent middle school-aged student. Almost everywhere, the prevalence of depression is twice as high among girls and women as among boys and men (Belfer, 2008). Four other mental disorders figure in the top 10 causes of disability in the world, namely alcohol abuse, bipolar disorder, schizophrenia and obsessive compulsive disorder (an anxiety disorder) (Cassells, 2011).

In most countries in the world, inclusive of the United States, the development of mental health services for children has lagged behind those for adults. This vulnerable population is more exposed to the psychological consequences of poverty, loss of parents, and a plethora of life adjustment related distress issues and yet notably they are most often precisely the least or less served (WHO| World Health Organization, 2001). That same year, ambassadors and world

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leaders from across the globe gathered to address the worldwide mental health crisis. They agreed that with a universal education system in place, are an obvious and most viable venue for (mental) health delivery for students. Primary service delivery professionals then, need to be based in schools and must be equipped with skills to identify and manage emotional and behavioral matters for children and adolescents (WHO| World Health Organization, 2004).

Establishing School-Based Mental Health Supports. The shift required for moving a system toward a more comprehensive organism that integrates organizational, programmatic and restructuring of both technicalities and mindset can be daunting. Within any such settings key stakeholders, leaders, consumers and in this instance, teachers, must commit and put that commitment into action. This particular process, answering what teachers ask for almost every day, help in helping their students, comes through and by a readiness, a call to duty and a definitive plan. Proponents believe this design for learning to be basic, obvious, yet the implication of inaction continues to be ignored (Adelman & Taylor, 1999). The actions, the plans and the steps must be transparent and evident in policies that will ultimately hold accountable practitioners. Adelman goes on to argue for a shift in roles, as well as a shift in priorities for school systems if there is a true desire to become responsive and useful in the matters of mental wellness for students (Adelman, 1999).

Coordinating mental health services for children is a challenge for both families and service providers due to fragmented and silos of services. Families experience barriers in the context of the private insurance and or public health arena:

- Lack of health coverage for mental health services;
- Long waits and potentially long drives to see one of the limited number of child treatment providers

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- Lack of communication about the child's mental health treatment between the primary care physician and behavioral/mental health providers;

- Varied and complex eligibility criteria for public programs.

Many children and youth are underserved, particularly members of racial/ethnic minority groups. Studies indicate that quality of service is often poor and the cost very high. While some mental health prevention and treatment programs have been demonstrated to be effective, evidence-based practices have not been widely adopted (McMorrow, 2010).

Current Adaptations. Changes are taking place in the children's mental health system in an effort to make it more responsive to families and reduce the fragmentation of services. These changes are built on a set of defined principles and incorporate new types of services and they are often labeled System of Care Initiatives (SOCI). Over the last several decades, parents, among other key stakeholders, have created a movement to bring mental health resources for children into a more functional "system of care" founded upon Child and Adolescent Service System Values (CASSP) (Lourie, 1994; Stroul & Friedman, 1996).

The Substance Abuse and Mental Health Services Administration (SAMHSA) has provided funds to various states to support systems of care. CASSP principles and practices are entirely consistent with those of medical homes and family centered care in the primary care arena. Many states have implemented a formal system of care or are adapting service systems to better reflect these principles. Similar to Title V, the goal of a comprehensive, family-centered, community-based, coordinated system of care subsumes principles that include the following: child-centered: meet the individual needs of the child; family-driven: recognize the family is the primary support system for the child and the family is a full partner in service planning; community-based: whenever possible, delivered in the home and within school buildings and

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obtained from community resources (Meyer, Lakeisha, Anderson, & McQueen, 2013). An integrated service delivery model, with care coordination and seamless service delivery, includes the voices of parents, student, teachers, and other community members. These services are deemed clinically appropriate, age fitting, and are least restrictive, taking place in natural settings like the home and the school (Stroul, Blau & Friedman, 2010).

Systems of care have developed wraparound services, which are individualized community-based services that are easily embedded within schools.   In their joint 2010 study, McMorrow and Howell reviewed the contemporary and current literature on the child mental health service system for the potential feasibility of producing a comprehensive statewide response system. The resulting findings of these researchers' review identified wraparound services as highly effective in supporting the psychosocial wellness for children and for their emotional, behavioral and mental health needs. Moreover, the study indicated that most children make marked improvements when wrap services are initiated as a means of care versus traditional institutional care (McMorrow & Howell, 2010). The development of these types of system responses and mechanisms are in fact growing in popularity. According to a 2007 Kellogg Foundation survey, two-thirds of voters support such funding and action, with over 80 percent of parents supporting mental health care delivery within schools (Chamberlin, 2009).

Teachers too have weighed in with their support as well as their ideas for how best to play a positive role in delivering this kind of supportive service delivery. In her 2014 survey of teacher perceptions and responses to mental health issues, Eminely Soberanis noted the following trends in her data analysis: Nearly half of the teacher respondents answered an open-ended question about their perception of the need as well as recommendations about solutions, with several themes identified in the analysis:

1. Having a social worker or mental health professional on the school site and being available full-time.

2. Provide training and professional development on child mental health.

3. Consultation with a mental health professional to discuss interventions and best practices.

4. Providing counseling services to students.

5. Provide advice and guidance to teachers.

6. Meet with parents to discuss their child's mental wellness. (Soberanis, 2014, pg. 2).

Another study of teachers' mental health literacy and capacity towards student mental health, done in Ontario, Canada, examined teacher experiences and the relationship to burnout for teachers. Daniszewski, the primary investigator writes, "Teachers often spend precious time on discipline, safety and classroom management for students with emotional and behavioral concerns, thus limiting learning opportunities for the entire class (Daniszewski, 2013).

Daniszewski asked teachers to "think of a recent time when they had a student with a significant emotional or behavioral problem and to "check all that apply" from a list of actions they took in dealing with this situation" (Daniszewski, 2013, pg.33). Of the Thirteen Action Institutional Practices from which teachers chose, Daniszewski found that teachers most frequently (more than 70% of the time) chose to change their own actions in order to better serve the child combined with listening to the child's perspective on the situation in order to offer emotional support. The next most frequent action was discussing the child's actions with an administrator, social worker, counselor or school psychologist. The next most frequent action, the one that nearly half of the teachers reported taking, was to contact the parents to learn more about the home environment and the student's needs in order create a collaborative, proactive plan. Teachers were less likely (less than 20% of the time) to attend workshops,

consult online resources, use "restorative practices" customized to student's behavior, or contacting specialized services. The least number of teachers (less than 6%) reported that they did nothing and the issue stopped (Daniszewski, 2013, pgs. 33-35).

Ultimately, there is no all-encompassing panacea that will instantly or automatically result in a 'cure' for eradicating mental illness, how it impacts teaching professionals and the overarching problem of schools lacking an effective response system to support the mental health needs for all students. It is apparent however, that teachers, de-facto interveners, are fast to attest to the why behind the very fact that mental health services are the fastest-growing component of all in-school health care programming, and that the number of school-based therapeutic centers and staffing has more than doubled in the last decade, further encourages the position that we must continue an in-depth self-conscious investigation about intervention and treatments for the an obvious issue (Chamberlin, 2009).

We must continue to reflect and review in search of systemic mechanisms that work, and that can in fact be imported and revised to support and make better what schools are and not doing now, and to inform designs to be utilized moving forward. Therefore, this study presents a call to action framed as a resounding plea for better school connectedness, the formation of learning communities, and a shift towards a response fosters programs and systems that combine the collective community of teachers and leaders with the shared mission of growing psychologically healthy students (McNeely & Blum, 2002). This study begins that process begins with preliminary focused investigation of what teachers think, feel, know and believe about the mental health responses within their schools in hopes that these impressions and perceptions advance the search for systemic changes for all students, for the sake of all of the elements of middle school student psychosocial well-being.

CHAPTER III

STUDY

      This study is guided by the primary research question: *What do teachers think, feel, know, and believe about the mental health response systems in their schools?* The core claim inherent to this pilot study is that schools fail to effectively respond to the psychosocial wellness of every student. As such it intentionally promotes focused inquiry into the perceptions of professionals in the classroom regarding their experience with serving students; and, how teachers experience the current response system, or lack thereof. Additionally, the study seeks to deepen understanding of the ways in which teachers and students can interact to positively affect the ongoing emotional hygiene needs of all middle school students. It is hoped that the pilot study will inform future investigations and designs for actions and learning that promote continuous improvement for every stakeholder involved; students, teachers, schools and communities.

Research Methods

      This study employed a qualitative research theory known as phenomenology, an inductive, descriptive research approach developed from phenomenological philosophy aimed at describing an experience as it is actually lived by the person or persons involved (Campbell, 2011). To gain information related to teachers' experiences, perception data was collected through a survey focused the meaning teachers make about students' mental health, as well as the response systems implemented within their home school. These types of data are well suited to describing people (teachers) knowledge, attitudes, beliefs, and perceived competencies (Campbell 2011). For the purposes of this study, perception data collection was vital to

illuminating teacher beliefs about the effectiveness of programs or interventions or the lack of those mechanisms.

Procedure Overview

A survey was administered to a selected sample from a specific population identified by the researcher. The term 'survey' is commonly applied to the research, methodology designed to compile data from a specific population, or a sample of said population, and typically utilizes a questionnaire or interview(s) (Robson, 1993). Surveys are used to obtain data from individuals about themselves, their environments or about other contexts of their experiences. Sample surveys are vital for collecting and analyzing information from selected individuals. They are widely accepted as a key tool for conducting and applying basic research methodology (Rossi, Wright, and Anderson, 1983). The general population is familiar with the use of surveys to assess issues or trends (Leary, 1995). Such sample surveys are comprised of standardized methodologies designed to gather information by systematically making inquiry into identified population samples.

For these reasons, the researcher designed a preliminary questionnaire to pilot the assessment of the perceptions of selected schoolteachers from two schools regarding what they think, know, feel and believe about the mental health response system(s) within their individual schools.

Sample

Study sites. Historically, elementary schools attempt to meet mental and psychosocial needs of students while serving their middle school students in rudimentary and less than efficient and productive ways. Specific to this research, a purposefully narrowed lens was

utilized to study two private institutions. School A is located in Scott Township and School B in nearby Mt. Lebanon.

Mt. Lebanon is a suburb of Pittsburgh, Pennsylvania, 7 miles (11 km) south of the city's downtown metro area. This suburb houses the School District (MLSD)—well known locally and nationally as a top-tiered school district. The district has seven public elementary schools in addition to School A, which is among the private schools in the area. The public schools: Foster Elementary School, Hoover Elementary School, Howe Elementary School, Jefferson Elementary School, Lincoln Elementary School, Markham Elementary School, and Washington Elementary School, two middle schools (Jefferson Middle School and Andrew W. Mellon Middle School), and one high school (Mt. Lebanon High School). There are two small borders with Pittsburgh neighborhoods to the northeast (Brookline) and north (Banksville). The entire western border is with Scott Township. School B, has a student body of 340 individuals. School A outsources its mental health services through the Allegheny Intermediate Unit, and pays a private school psychologist as a part-time school employee. The psychologist is on site at regularly scheduled intervals, but not on a full-time basis. School A, however, does maintain a full-time guidance counselor but in accordance with the basic tenants of 'school guidance-counseling' proper, this professional position is not on site to guide or direct the mental health aspects of curriculum or ancillary psychosocial needs.

School A, in neighboring Scott Township of Pittsburgh, Pennsylvania, is a part of the Chartier's Valley School District (CVSD), a suburban borough school district that serves an area southwest of Pittsburgh, including the Boroughs of Bridgeville, Heidelberg, Collier Township, and Scott Township in Allegheny County, Pennsylvania. The district was formed in 1956. CVSD encompasses approximately 18 square miles. In school year 2007-08, the District provided basic

educational services to 3,471 pupils through the employment of 264 teachers, 255 full-time and part-time support personnel, and 22 administrators. Chartier's Valley received more than $9.1 million in state funding in school year 2007-08. CVSD operates one high school, one middle school, one intermediate school and one primary school. The district borders eight other school districts: Montour S.D., Mt. Lebanon S.D., Keystone Oaks S.D., Upper St. Clair S.D., South Fayette S.D., West Allegheny S.D., Carlynton S.D. and Pittsburgh S.D.

Approximately three miles from School A, School B, has a student body of 315 individuals. Moreover, these students have access to psychosocial and mental health services and supports are acquired through a part-time school psychologist, and via in-school Student Assistance Program (SAP) teams. The Commonwealth of Pennsylvania's (SAP) is administered by the PA Department of Education's Division of School Options and Safety, a collaboration between the PA Department of Health's Bureau of Drug and Alcohol Programs, as well as the PA Department of Public Welfare's Office of Mental Health and Substance Abuse Services (Meggie, Edwards, & Gwozdz, 2006). Fertman, Fichter, Schlesinger and Tarasevich (2001) explain that SAP Programs are designed to assist school personnel in identifying issues including alcohol, tobacco, other drugs, and mental health issues that pose a barrier to a student's success. The primary goal of SAP according to Meggie, Edwards and Gwozdz (2006), is to help students overcome these barriers in order that they may achieve, remain in school, and advance. The student assistance team members, however, do not diagnose, treat or refer to treatment, but rather refer or outsource for a screening or an assessment for treatment. Again, a demonstration of a lack of a systematic response incorporating an explicitly identified protocol or person(s) identified in the role of responder or liaison to a mental health response system in-house. SAP teams are often only called upon for crisis response and triage. They do not exist to function as

on-going support for 'unidentified' students nor do they function to promote ongoing psychosocial support to middle school students (Meggie, Edwards & Gwozdz, 2006).

Participant sample. Teachers were recruited from both schools from all 5th, 6th, and 7th grade classes. The researcher intentionally chose this particular context for reasons related to the researcher's own work and life experiences. Specifically, the researcher attended Catholic schools from first through twelfth grade; attended Catholic undergraduate and graduate programs and finally pursued the terminal doctoral level credential at a Catholic institution. Therefore, this study is an intentional piece of research to serve as inquiry within schools similar to those that match the assumptions and narrative of the researcher, providing a familiar lens through which to view the nuances in the teachers' responses and assign meaning to the predispositions and the cultural underbelly of Catholic schools.

A convenience sample group of fifth, sixth, and 7th grade teachers were recruited from two schools. Anonymous teacher surveys were presented electronically (22 questions in total) to all middle school teachers in two (2) Diocese of Pittsburgh elementary schools, known in this study as School A and School B.

In all, 20 teachers completed the survey and comprise the participant sample for this study. Eleven participants were from School A and nine participants were from School B.

Design

With the approval of school administrators at both sites (see Appendix A); the respective principals executed the recruitment process. The recruitment mechanism, electronic school mail, included a flyer that was distributed to each potential respondent (Appendix B). Individuals were invited to participate and provided informed consent notifying them that their participation

was at their own volition without reward or risk (Appendix C). The surveys were anonymous and required no identifying information for participation.

Instrumentation

The instrument (Appendix A) created for this study is a teacher perception survey. A 22 item Likert-scaled instrument takes approximately 10 minutes to complete. The survey was distributed online and administered from within the school's electronic mail system. The 22 items are relatable to multiple theme areas that allow analyses and categorization into perception sub-groups.

The goal of this particular teacher survey was to discover teacher perceptions about their abilities to note indicators, respond appropriately to mental health needs of their middle school students, and learn if the response systems (if any) in their schools allow for appropriate interventions and reactions. The survey attempts to discover and uncover the individual and uniquely personal lived experiences of the study participants and to examine how those participants make sense of their personal and collective worlds as professional instructors who have or lack access to a response system that can be utilized to serve the emotional needs of their students.

The prompts focused on perceptions about preparedness, experiences with the 'response system' as it stands, and how that system is/isn't being experienced in the specific context of each school independently. The questions purposefully align with the principles of Gestalt psychology theory, (Perls, 1968) which assert that human perceptual organization is key to understanding whole context, whole experiences, the sum total of isolated events or stimuli; a constant relationship, if you will (Perls, 1968). To explain the combinations of these isolated sensations (and their images), this theory is particularly important when evaluating real time

teacher experiences that later result in their response of lack of response. The objective of

Gestalt is to discern the elements of one's experiences and align them with the corresponding or

triggering stimuli and to then describe those associations (Perls, 1968). Introspection and self-

conscious and purposeful analytic deciphering is key. The implication of the gestalt stance is

that once the facts are known, the mental operations ensue and one creates a structure or form.

These mental products, if you will, shape beliefs and perception but are not in fact irrefutable

truths about the actual environment. Such relations are mental products, ways we make sense of

the world; they are not given as facts about the environment (Woldt & Toman, 2005). As the

teacher participants reflected about their understanding, encounters and events related to

attention to mental health issues among middle school students within the specific context of the

school in which they teach, key themes were identified. These themes feed potential theory and

action steps for system restructuring ideas and lessons learned from the study can serve to launch

potential improvements to the networks and involved systems for the maximum possible

generative impact to the systems as possible.

To maintain confidentiality all documents and survey items were maintained in a

confidential locked office space in a locked cabinet.

Procedure

After three individual face-to-face meetings between the researcher and both principals,

administrators at both school sites agreed to participate in the research. The first step in the

process involved a review, by the principals, of the survey in hard copy format (Appendix A).

Then, the respective principals executed the recruitment process. The recruitment mechanism,

electronic school mail, included a recruitment flyer (Appendix B) that was distributed to each

potential respondent prior to initiation of the survey link. An Anonymous teacher survey

(Appendix A) was presented electronically (22 items in total) to all middle school teachers in two (2) Diocese of Pittsburgh elementary schools, in total 21 teacher participants were invited to respond. All potential respondents were provided with the opportunity to participate in the survey at their own volition without reward or negative consequences either way. The informed consent (Appendix C) was displayed prior to the start of the survey, above the start button.

The completed surveys were anonymous and required no identifying information for participation. Because the teachers reported all responses through Survey Monkey, this reporting process negated any outside program automatically noting identifying personal information about the respondent, and therefore maintained confidentiality.

Participants from the two groups were informed that survey was open and available via email and prompted to log onto Survey Monkey to fill out the survey. Participants were told that their completed surveys served as their informed consent.

Participants were given a 60-day window during which to respond to the survey. While the intent was to permit teachers to log on and participate at their convenience, this extended period may have led to decreased participation over the 60-day time span. Teacher respondents were required to complete the entire survey in order for their responses to be included in the study. All survey information was kept electronically only and on the Survey Monkey site.

History

With limited knowledge of the respondents, the research could not reflect on prior struggles or difficulties or other factors that may lend to a certain perception or belief set that might contribute to feelings of negativity or positivity for the school system. While academic achievement and overall psychosocial wellness may be correlated, there are individual student variables that could not be accounted for in this specific study. Finally, the experiment did not

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account for any historical interactions that teacher may have had with student body members. These previous experiences could influence teachers' perceptions either positively or negatively depending on preceding shared experiences.

Lack of Controls on Outside Factors

The inability for this study to control for all outside factors that may affect a teacher's opinion or perception may have led to misunderstood data analysis. Additionally, the inability to know whether teachers responded honestly without fear of retribution or lack of confidence about confidentiality is also a variable that might ultimately skew results. In much the same way we must remain cautious as to not assert findings onto a larger population after a study on a convenience sample group. Only through repetition can future research and post study designs for actions detect themes and trends that hold the possibility of leading to better confirmed conclusions that can generalized.

CHAPTER IV

ANALYSIS & RESULTS

Discussion

The core research question, what do teachers think, feel, know and believe about the

mental health response system(s) in their school, was investigated through an online, electronic

survey using a four-point Likert scale. The intention was to learn more about the perceptions of

teachers related to their experiences as daily eyewitnesses to student/pupil psychosocial health

and wellness. In addition, the survey examined their perceptions about their ability or inability

to act and address those wellbeing needs when necessary. The purpose was to provide initial

evidence to support future investigations into whether or not schools embed a knowable,

effective, systemic response process focused on the ongoing psychosocial development and

overall wellness of their student body. To learn more about the quality of any systems currently

in place, the survey also gathered information about teacher training and ongoing education

issues, teacher perceptions about the level of duty that they have or do not have respective to

addressing mental health from inside the classroom rather than through other types of

outsourcing or shifting of responsibilities.

Analysis of Teacher Perceptions

Data. The survey was open for a 60-day period. After the allotted timeframe, all

respondents had completed the survey and the online survey was closed. All completed surveys

(n= 20) were analyzed. All data were subject to qualitative analysis to determine patterns of

attitude toward and/or responses to mental health wellness and response systems. The results

were hand tallied and the responses for each category and prompt response were counted. Porter

(2004) supports this method as manageable and appropriate for surveying smaller audiences with a limited number of questions. The survey used in this study was a web survey allowing for each response and respondent reply to be captured automatically (Porter, 2004).

The responses were then coded into themes to further investigate the implications and the teachers' perceptions and how those implications might inform efforts to improve mental health response systems in both schools by examining what teachers think, feel, know and believe about the response systems (or lack thereof) in their respective schools.

Results from the perception survey were subjected to frequency counts. Those counts were then collected and organized into a graph(s) for group analysis and individual comparative analysis for each school and for teachers within those schools.

The data were organized into themes that align with the survey prompts. These areas included:

1. Perception of the existence of and access to a response system (MH services)
2. Implementation of services (teacher engagement or inaction)
3. Self-perception of efficacy/confidence
4. Self-perception of knowledge and skill related to MH issues and service

Intended outcomes. his study sought to identify areas for improvement of a student's and a teacher's abilities to access a knowable, useable and effective system of care, within their individual school milieu to increase overall student wellness and ultimately to raise the potential for greater academic achievement. In order to accomplish this the improvement effort centered on learning about how to best increase teacher efficacy as well as improve access to interventions and universal policies and programs to support student adjustment and positive behavioral health. These identified outcomes can later be more fully developed through

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networked improvement communities to effect policy change and to promote schools and personnel as systems of care for every student.

Results

Individual school-by-school comparisons as well as group results are illustrated by survey prompt into numbers of respondents, specific responses, percentages and notable findings as the data represent.

School to school comparison and group data. Individual school responses per survey, as well as group responses were analyzed to identify a baseline representation of the implications and how those implications might inform further research for the development of an improved mental health response system in both schools. This comparison takes into account what teachers think, feel, know and believe about the response systems (or lack thereof) in their respective schools.

Results from the perception survey were subject to frequency counts. Those counts were then collected and organized into individual and group graphs for analysis. Using frequency counts to tally both individual school responses and group responses, themes were analyzed for notable similarities and variances. What follows are the results of the survey, illustrated as graphs that display responses by school, followed by illustrations of whole group responses. It is important to note that some of the respondents chose not to answer specific promptss. That limitation is reflected in the discussion of the findings following each graph.

	Srongly Agree	Agree	Disagree	Strongly Disagree
School A	0	4	3	2
School B	1	5	3	0

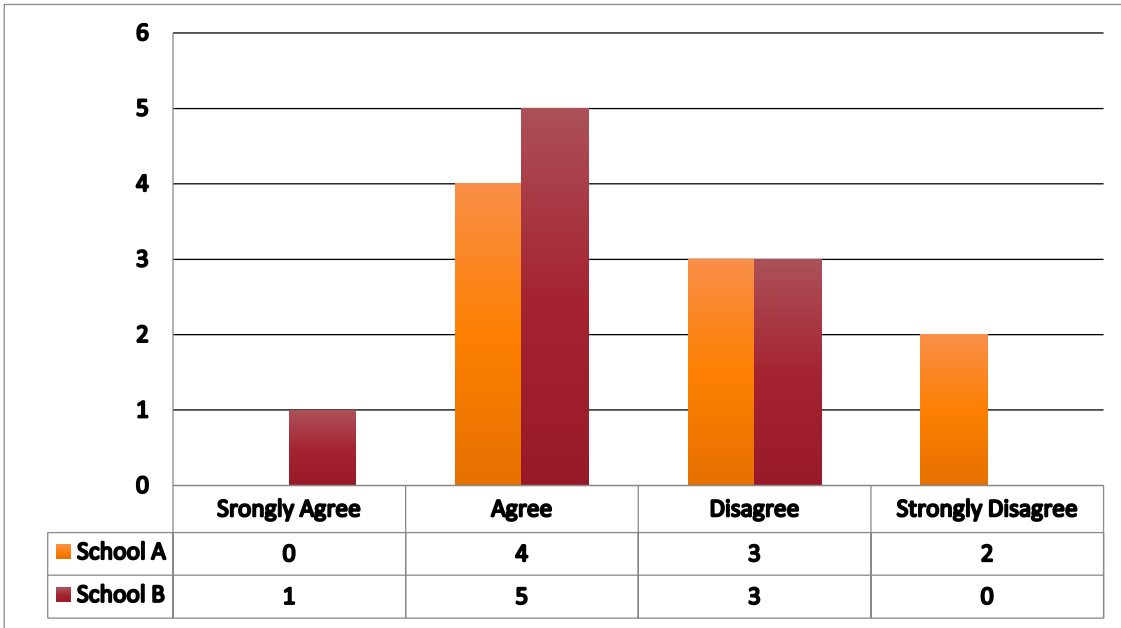**Figure 4.1**. A comparison of responses by school to the prompt: All students are able to access appropriate mental and behavioral healthcare support.

There is a high level of agreement between the two schools. School A respondents, nine in total, are almost divided between agree and disagree/strongly disagree while School B respondents, also nine in total, have a majority, six respondents, who agree/strongly agree.

	Total
■ Data Sum of Strongly Agree.	1
■ Data Sum of Agree.	9
■ Data Sum of Disagree.	6
■ Data Sum of Strongly Disagree.	2
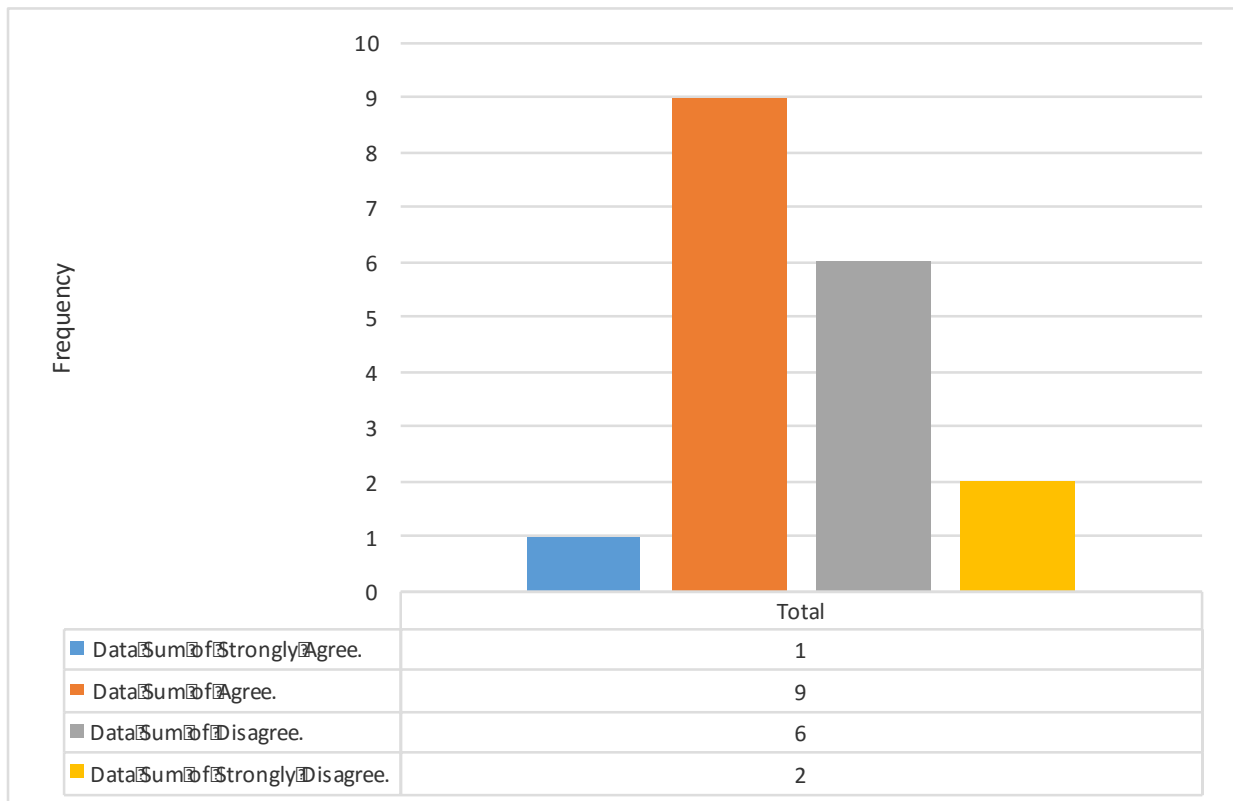
Figure 4.2. Group responses to the prompt: All students are able to access appropriate mental and behavioral healthcare support.

Eighteen of 20 teachers responded to the prompt and indicated strong agreement that students do in fact have 'access' to appropriate mental health care. The responses, however, do not shed light on what 'appropriate' might mean to any given teacher respondent. Nor do the data allow us to surmise whether or not the access implies in school access.

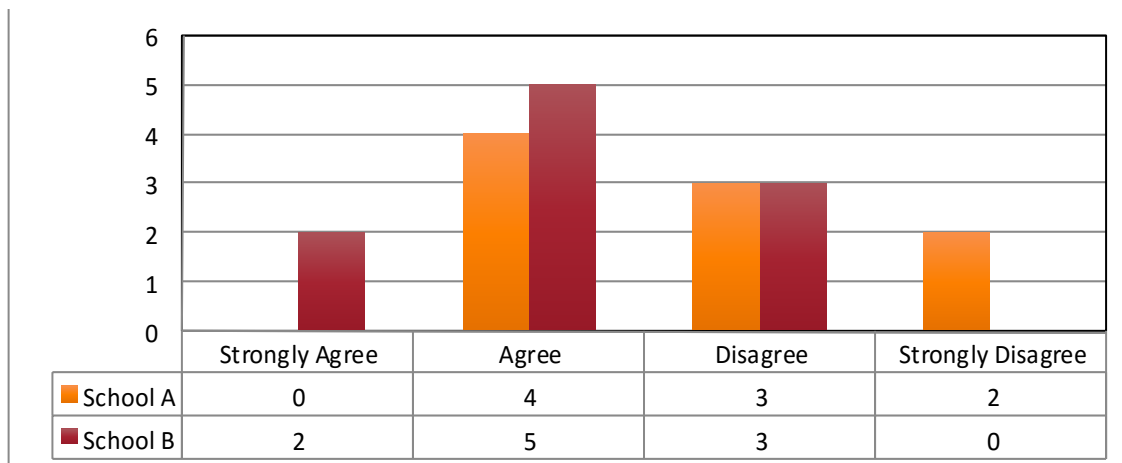|	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	0	4	3	2
School B	2	5	3	0

Figure 4.3. A school-by-school comparison to the prompt: Teachers are able to access appropriate mental and behavioral healthcare support for students.

This prompt, like its predecessor, is centered on access to a system of care. Unlike prompt one, the second prompt seeks to gather input from the teacher respondents as to their perceived ability to garner access to supports on behalf of the student. Nine respondents from School A and 10 from School B responded. Of these responses the more teachers agreed or strongly agreed that they wer able to access supports on the part of their students. Interestingly, almost identical numbers of teachers responded in a similar fashion to the previous that focused on the teachers' access to the system.

This is expected and is congruent rather than indicative of a gap. If in fact teachers perceive students to have access to services, it subsumes that they themselves, the teachers, have equal or similar access to a known mechanism for support(s).

This unperceived gap between theory and practice, is seen repeatedly in the literature and noted in chapter two is specifically addressed in prevalence statistics that tell the story of gaps. For example, a detailed report of the Sandy Hook incident made clear and precise some of those gaps (Report of The Office of the Child Advocate, November 2014). According to the published report, the Newtown Public Schools provided only limited special education services to the

shooter (student) during his elementary years. In addition to being limited, there was no accounting for or communication about any attempts that addressed his social-emotional deficits. These middle-schooler records indicated that the shooter's social-emotional needs spiked at the start of middle school with behavioral consequences that appeared to have gone mostly unaddressed by the schools system altogether (Report of The Office of The Child Advocate, November 2014). Moreover, the report goes on to support further action and more research into causes and roadblocks, and ultimately, the generative impacts of such deficits in the current system.

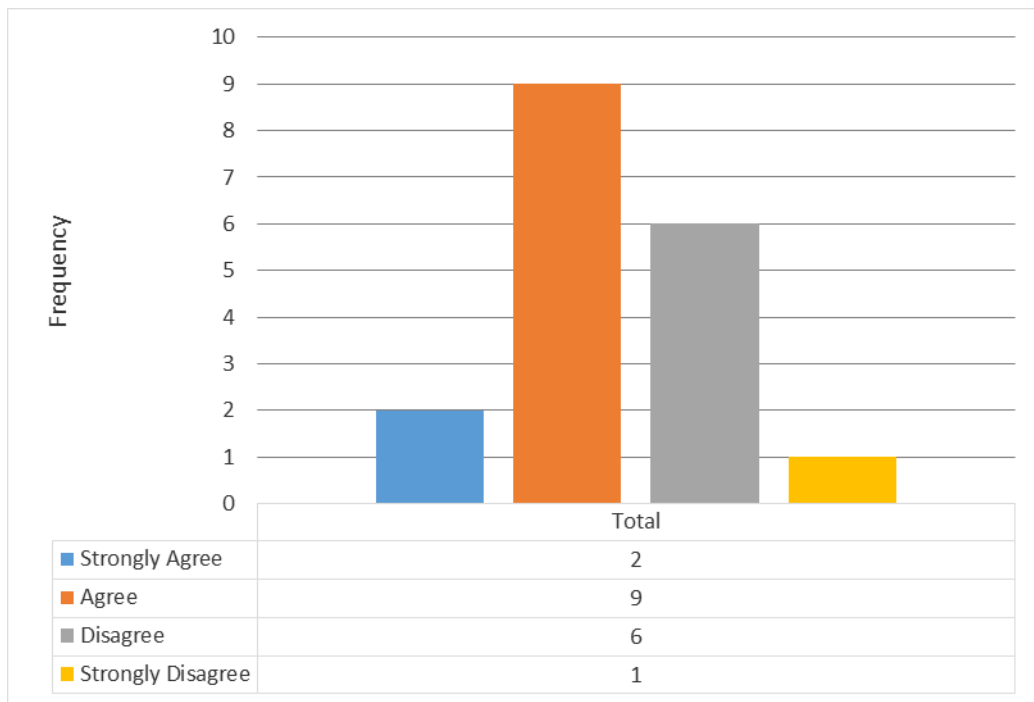|	Total
■ Strongly Agree	2
■ Agree	9
■ Disagree	6
■ Strongly Disagree	1

Figure 4.4. Group response to the prompt: Teachers are able to access appropriate mental and behavioral healthcare support for students.

Of the 18 respondents, a majority, 11, strongly agree or agree versus seven responses that disagree or strongly disagree.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	0	4	3	1
School B	2	5	3	0

Figure 4.5. School-by-school comparison to the prompt: Middle schools programs and curriculum are implemented to address needs and strengthen the psychosocial assets for students, families, schools and communities.

Twenty respondents opted to reply to this prompt. The eight respondents from School A were evenly split as to agreeing or disagreeing. Respondents from School B showed a slightly higher number of responses (7) that agreed or strongly agreed as opposed to the 3 responses that disagreed. This response pattern for School B is similar to School B's responses among the first three survey prompts.

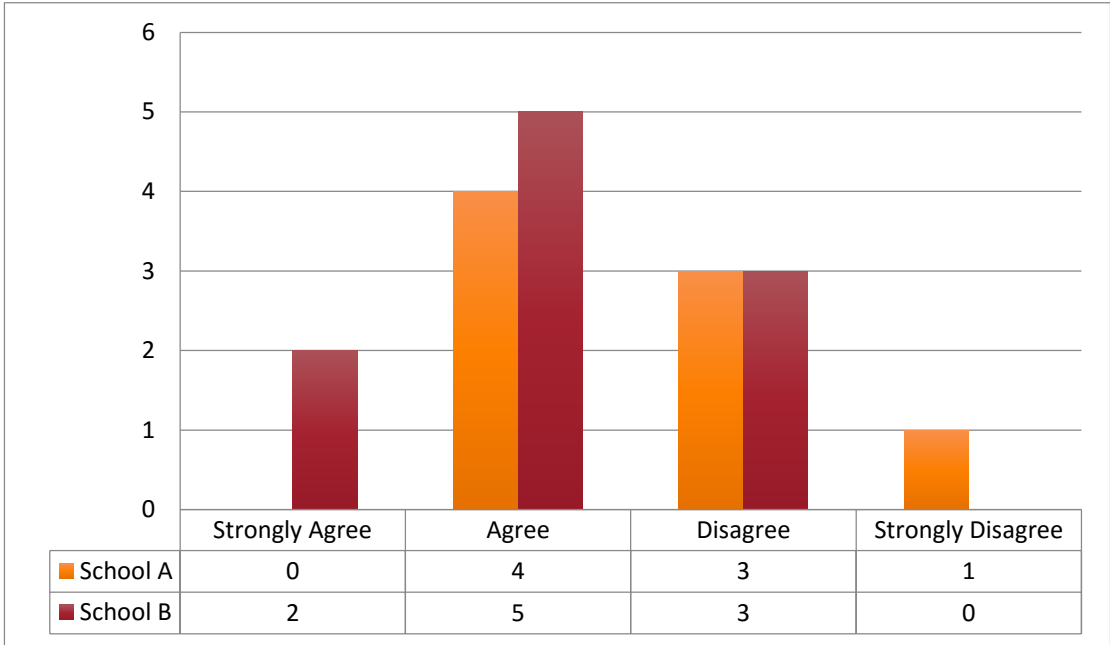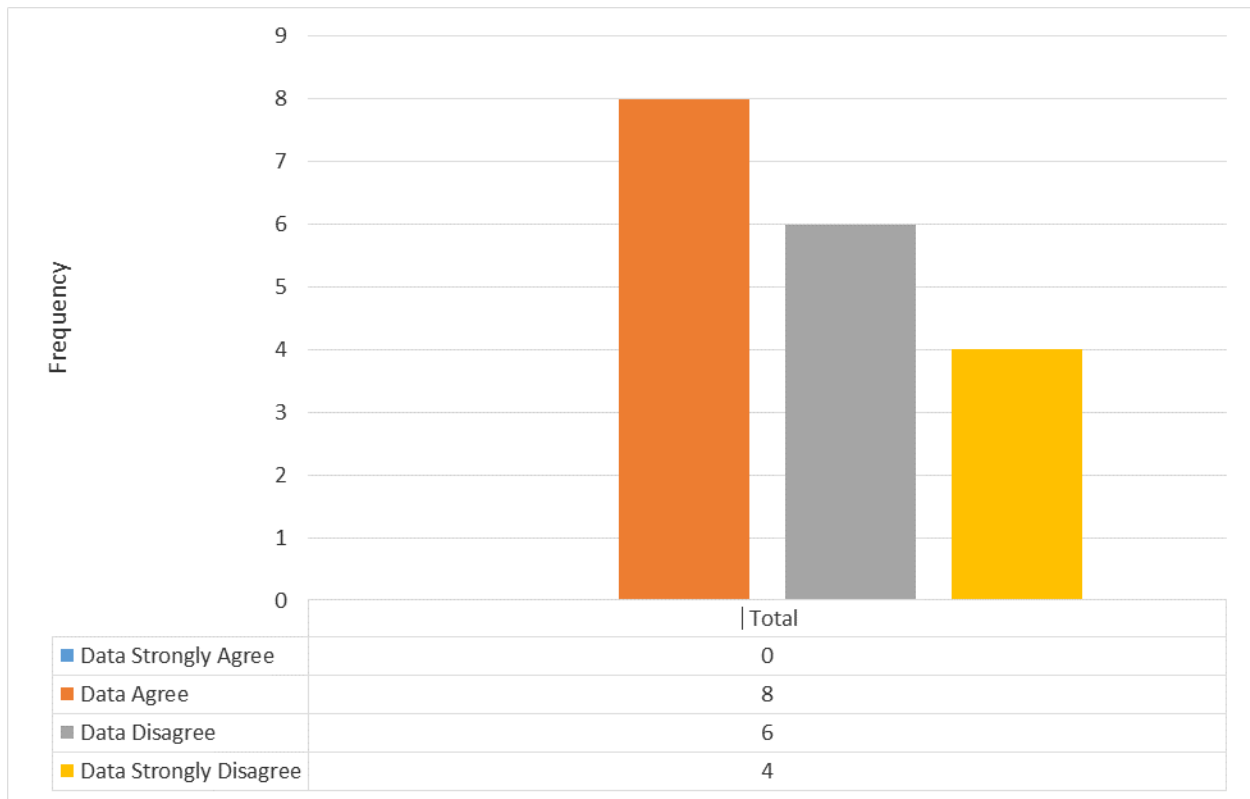|	Total
■ Data Strongly Agree	0
■ Data Agree	8
■ Data Disagree	6
■ Data Strongly Disagree	4

Figure 4.6. Overall survey responses to the prompt: Middle schools programs and curriculum are implemented to address needs and strengthen the psychosocial assets for students, families, schools and communities.

Note that none of the 18 respondents to this survey prompt chose the *Strongly Agree* response. Moreover, of the respondents who answered, nearly one-third felt strongly that the programs and curriculum do not serve to strengthen psychosocial skills for students, families, schools and the community. Their perceptions align with the literature that indicates, mental health programming and or responses are not embedded elements found easily in the overall curriculum(s), which supports the notion that this matter of student wellbeing, overall emotional and psychosocial wellness, as noted in the literature review, remains a matter of debate. A conceptualization of wellbeing tends towards the philosophical with little agreement in current literature as to objective constructs (Haybron 2008). More contemporary discourse about the matter are moving toward generating research and policy about wellbeing, but the literature

remains contradictory because of the complexities of human wellbeing and what it is contrived of. (Stratham & Chase, 2010; McNaught, 2011; Seligman, 2011; Dodge et al., 2012). Therefore, school systems, then, do not seem to view these human variables as appropriates matters for ongoing proactive practice but rather view them as a reactive response to situational variables and crises.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	0	2	7	0
School B	2	4	3	0

Figure 4.7. Individual school responses to the prompt: There is a known, effective, accessible response system in place in my school that addresses the ongoing mental wellness and behavioral health needs for every student.

This prompt in particular sits at the core of the claims set forth in this study: schools fail to respond effectively to the psychosocial wellbeing of all students; and, there is a lack of a system of care or a response system that is not only known, but effective and accessible. All 20 respondents replied to this prompt. Seven of the 20 possible respondents from School A disagreed with only two respondents from School A noting their agreement. Respondents from School B were slightly higher in terms of agreement with six of the nine respondents indicating

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strong agreement or agreement. Again, note that only School B teachers responded in the

strongly agree category. What is notable in this graph is the sharp distinction between the two

schools. Responders from School A were mostly negative, with seven of the nine respondents

disagreeing with the prompt. In School B, however, six of the nine responders either agreed or

strongly agreed with the prompt. The schools, therefore, delivered almost exact opposite views

regarding this prompt.

	Strongly Agree	Agree	Disagree	Strongly Disagree
■ Series1	2	6	10	0

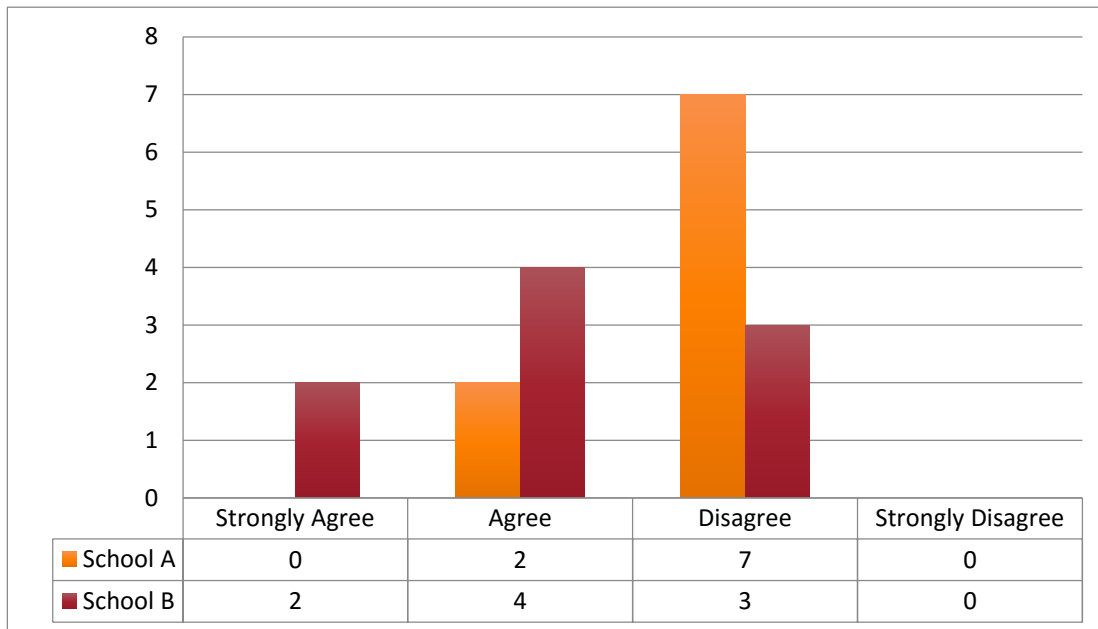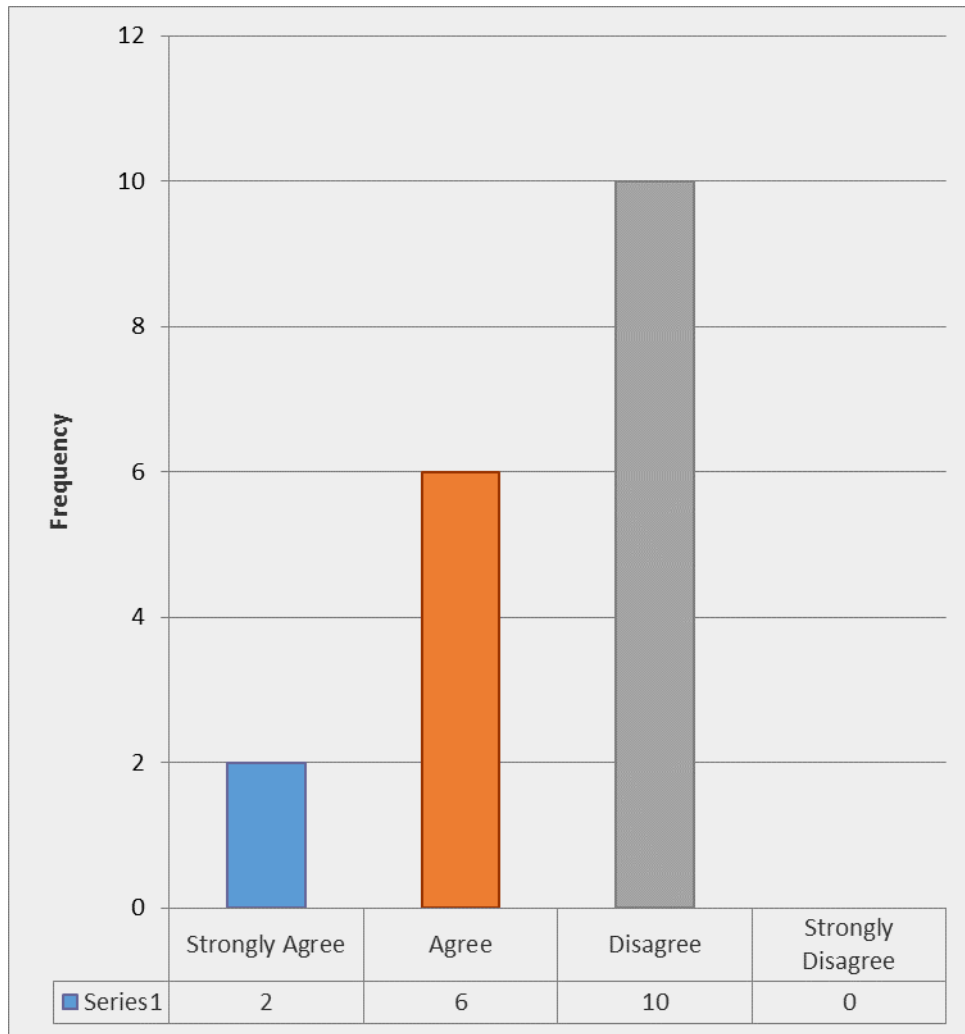**Figure 4.8.** Group response to the prompt: There is a known, effective, accessible response system in place in my school that addresses the ongoing mental wellness and behavioral health needs for every student.

As Figure 4.8 shows, slightly more (10 of the 18 responses) disagreed with the prompt. Eight of

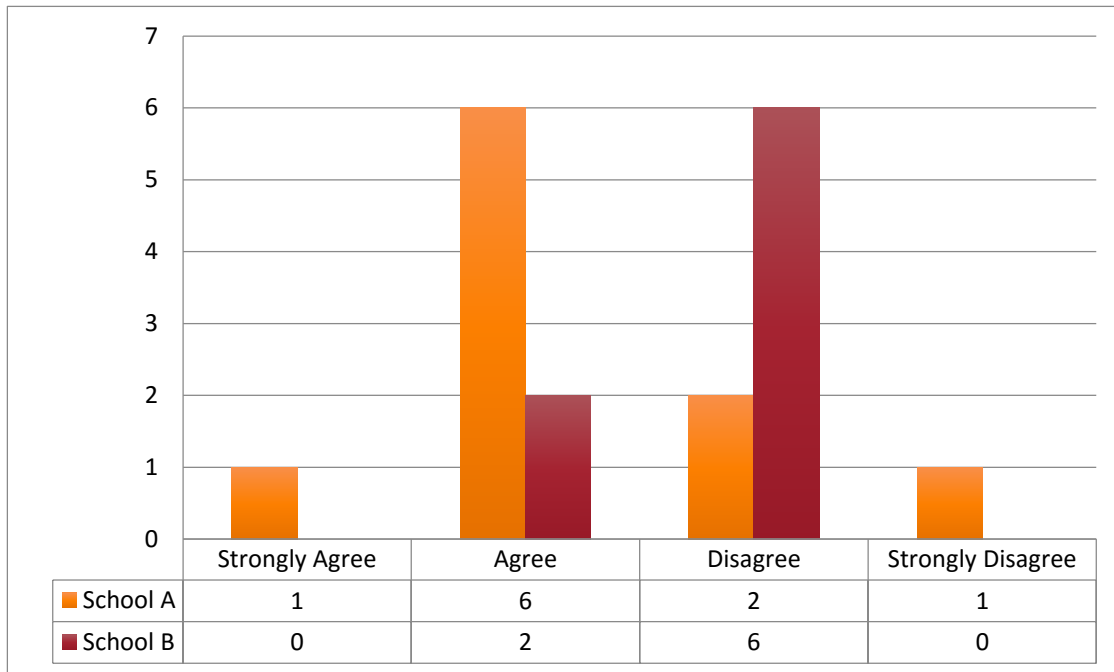the 18 responses agreed or strongly agreed.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	1	6	2	1
School B	0	2	6	0

Figure 4.9. School-to-school comparison to the prompt: Middle school students in my school
have access to mental wellness and behavioral health support only if they have a diagnosis and
educational entitlements (IE: IEP, 504).

Of the 18 responses, note that the graph illustrate nearly duplicate number of responses

mirrored between the Strongly Agree/ Agree and the Disagree/Strongly Disagree categories.

School A has a majority of seven respondents who agreed or strongly agreed that entitled or

eligible, identified students--students with IEP's or 504's and the like—have access to needed

supports. In School B a majority, 6 of the 8 responders, disagree. What is notable in this graph

is that School A, whose responders rarely choose the strongly agree category, emerges with one

response in that category to this prompt. It might be that the responses to this prompt reveal at

the very least that School A, although lacking a known and effective, accessible response system,

does have a required mechanism in place to serve those who are required to be served by law or mandate. It might also support a basic assumptions of this study, which subsumes that without an effective response system in place, schools do two things: 1). they respond only when required; and, 2). many students fall through the cracks resulting in a 'system' that is reactive and crisis oriented.
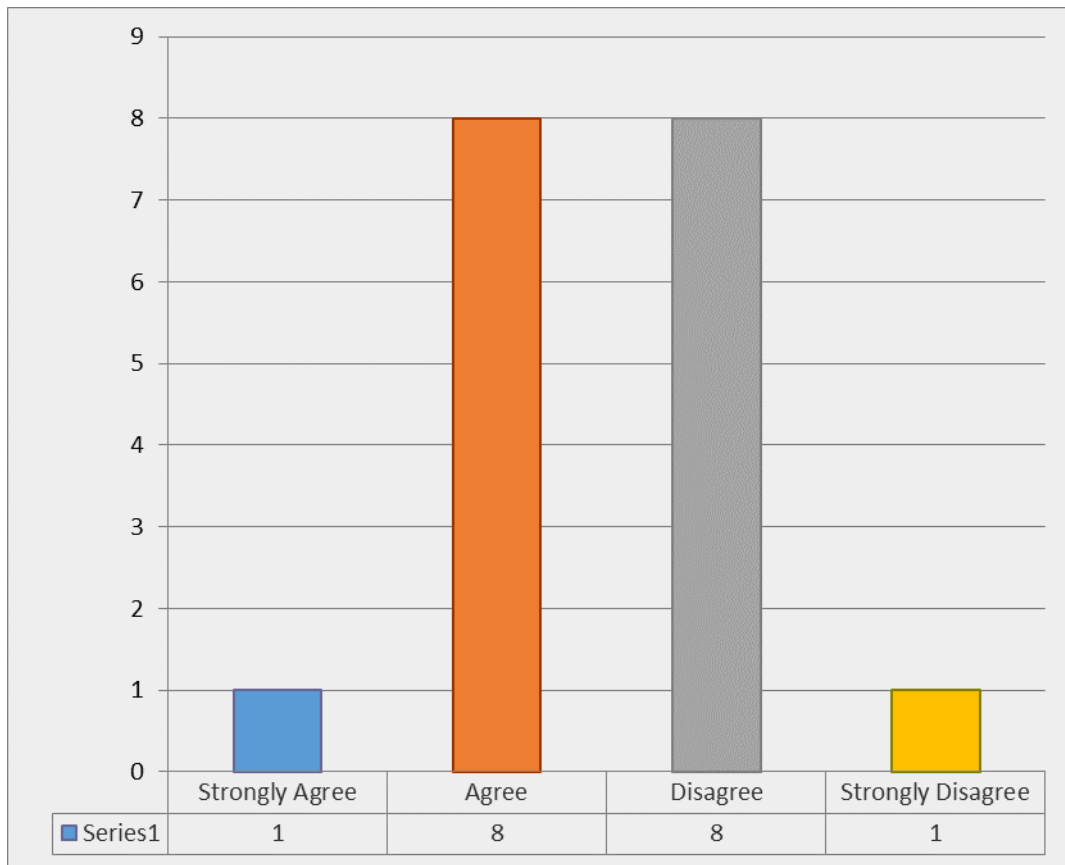
Figure 4.10. Group response to prompt: Middle school students in my school have access to mental wellness and behavioral health support only if they have a diagnosis and educational entitlements (IE: IEP, 504).

There are important elements to illustrated in the responses to this survey prompt.

Eighteen respondents answered this prompt with exactly half of the respondents strongly agreeing or agreeing and half of them disagreeing or strongly disagreeing.
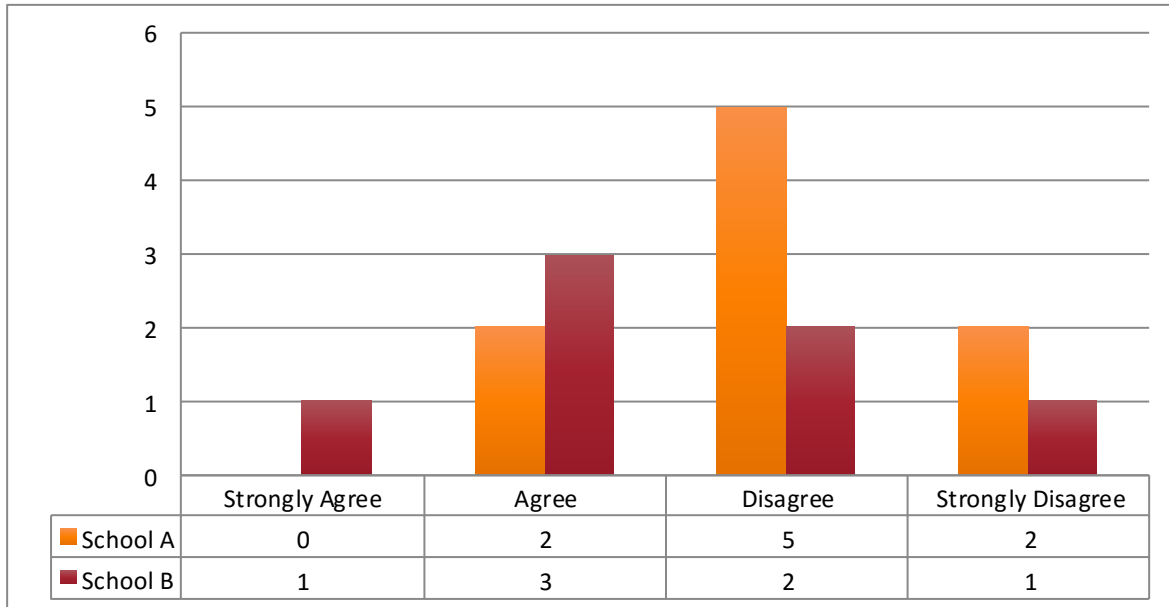
	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	0	2	5	2
School B	1	3	2	1

Figure 4.11. Individual School responses to the prompt: When indicated, you feel able to provide case management assistance to students and families to assist them in obtaining enrollment to mental health services for which they are eligible.

This prompt was designed to garner the perceptions of teachers regarding the levels of engagements in psychosocial matters and MH support for students. In Figure 4.11, a majority of seven respondents from School A disagree or strongly disagree that they are able to provide ancillary supportive services, case management, referrals, and the like on behalf of their eligible students.

There is a congruent response with that displayed in Figure 4.11. Again, responses from School B indicated that 4 teachers agree or strongly agree and three teachers disagree or strongly disagree that they assist with assessment of general risk factors among their middle school students. One could infer from this subset of responses that more teachers, especially those from School A are either not engaged or they are excluded from such processes. There was slightly more agreement School B respondents.

The literature supports this result. As noted earlier, Kessler, et al., assert that social development, adjunctive with academic achievement, are aligned. However, often, according to Kessler, Berglund, Demler, Jin, Merikangas & Walters, (2005) policy makers and school systems as well as parents take the position that schools, thus, teachers, should maintain a hands-off approach to all matters of social service.
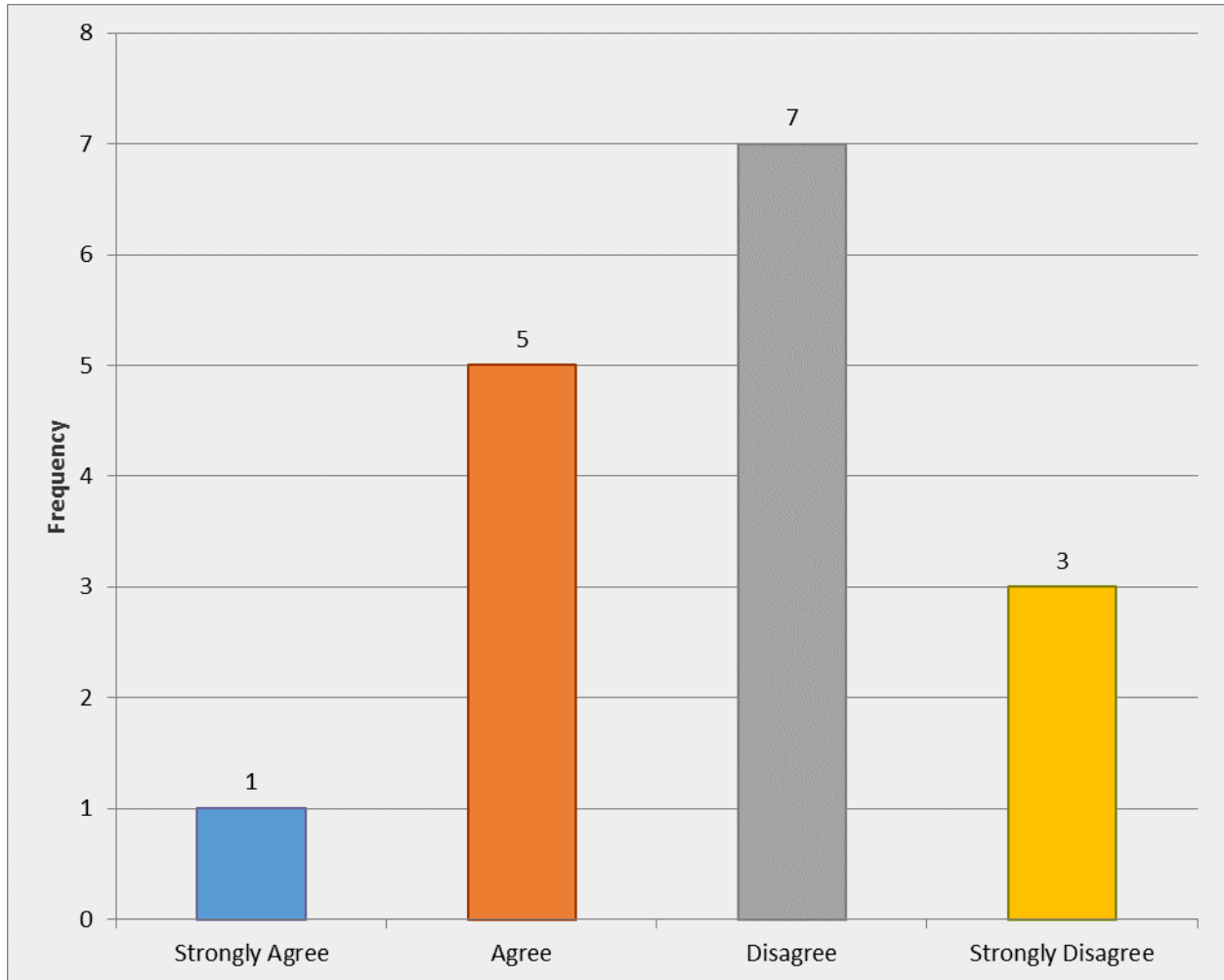
Figure 4.12. Group responses to the prompt*: When indicated, you feel able to provide case management assistance to students and families to assist them in obtaining enrollment to mental health services for which they are eligible.

Of the 16 respondents to this prompt, a majority of 10 disagreed or strongly disagree while six strongly agreed or agreed.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	0	4	2	0
School B	1	2	5	2
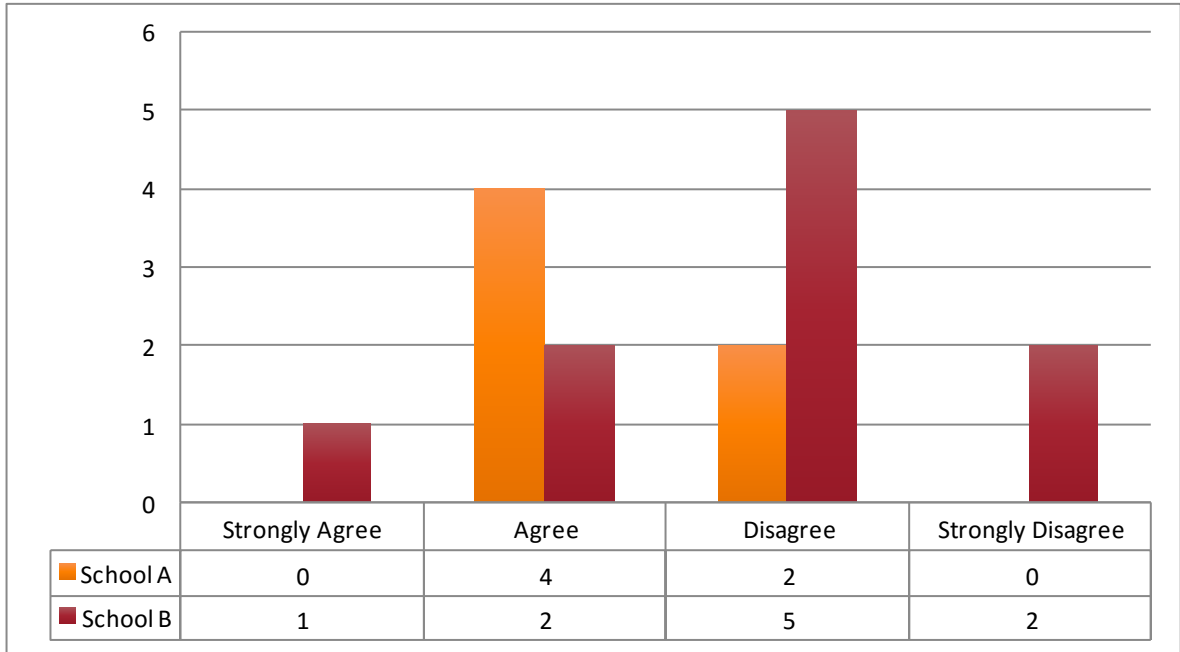
Figure 4.13. Comparison of school responses to the prompt: You are engaged in activities that may bring resources or support into the school mental health program(s)

Figures 4.14. Total group responses to the survey prompt: You are engaged in activities that may bring resources or support into the school mental health program(s). **Figures 4.13** and **4.14** organize the comparison data as well as the total group responses to the survey prompt: You are engaged in activities that may bring resources or support into the school mental health program(s).

Both Figure 4.13 and Figure 4.14 illustrate that although being on the forefront and having daily interactions with students, teachers are often rendered incapable or ineffective to act w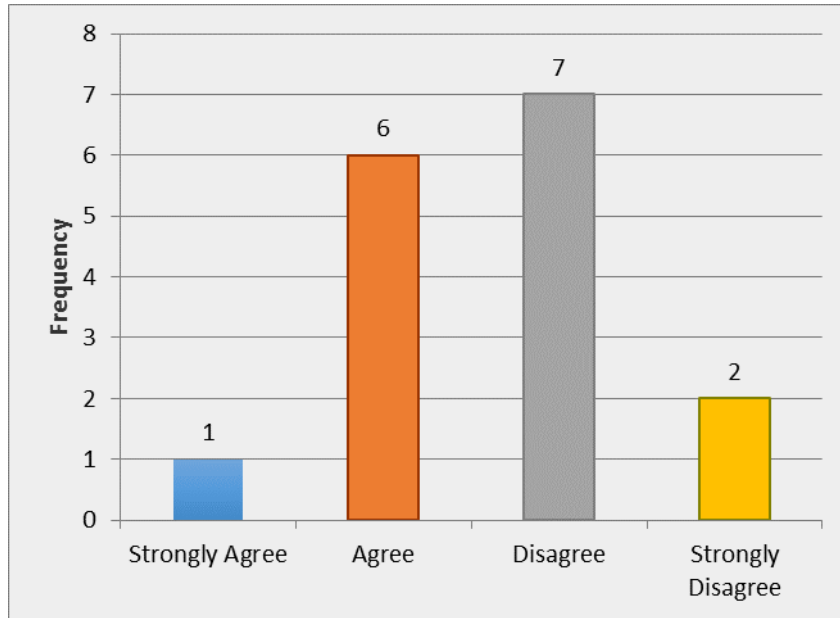hen they note student need. Of the 16 total responses to this prompt, nine of the teachers indicated that they disagreed or strongly disagreed with the prompt. Slightly less of the responders, seven of the possible 16 indicated agreement or strong agreement.

According to current literature, fewer and fewer schools have specific funds and identified personnel to provide service coordination and case management services. Some responses, thus, could indicate in the affirmative that these two schools either have those personnel or that they in fact do not engage in such matters as a rule. Either way, the claims remain viable; a school as a system of care-SOC (Stroul, Blau, & Friedman 2010) is designed to create a community-based network for improving systems responses and is one that is embedded, without silos, as a seamless response across domains. If these two schools have only identified

personnel or are disengaged in student psychosocial wellbeing, there cannot be an effective response system.

What is notable in the responses to this prompt, is that seven of the ten respondents from School B have disagreed or strongly disagreed. Five of the 16 respondents, 1/3 of the teachers and all from School B. The responses could indicate that these two schools either have those personnel or that they in fact do not engage in such matters as a rule. Either way, the claims remain viable; a system of care is one that is embedded, without silos, as a seamless response across domains. If these two schools have only identified personnel or are disengaged in student psychosocial wellbeing, there cannot be an effective response system. Knopf, Park & Mulye speak to this very issue, as noted in chapter two, in their December 2014/January 2015 article published in Phi Beta Kappan. The researchers point to an inadequate system of care for serving the needs of these students. They name a lack of mental identified mental health professionals as well as inaccessible services among school students as problematic for access and positive outcomes (Knopf, Park & Mulye, 2008).

As a group, a majority of the convenience sample respondents, nine of 16, agree that they have or do assist at some level with assessments as they relate to ongoing day-to-day life adjustment related risk factors such as exposure to crime, substance abuse matters, violence, etc.). Moreover, of the 16 total respondents for survey prompt seven, almost half, attest to disagreement as to their engagement in activities that might bring, grow, or develop a system, or mechanism in service to a response system that would enhance MH support to students. The unknown factor inherent to this question is whether teachers perceive themselves as unable or uninvited to be able to engage in such matters.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	0	3	3	2
School B	2	6	0	0

Figure 4.15. Individual school responses to the prompt: You have assisted with assessments on common risk and stress factors faced by the middle school students in your classroom (IE: exposure to crime, violence, substance abuse).

This prompt gathered perceptions about teacher participation in assessments for common risk factors that influence their middle school students. The majority of School A respondents, five out of eight disagree and strongly disagree, while the all of School B, eight, strongly agree and agree.
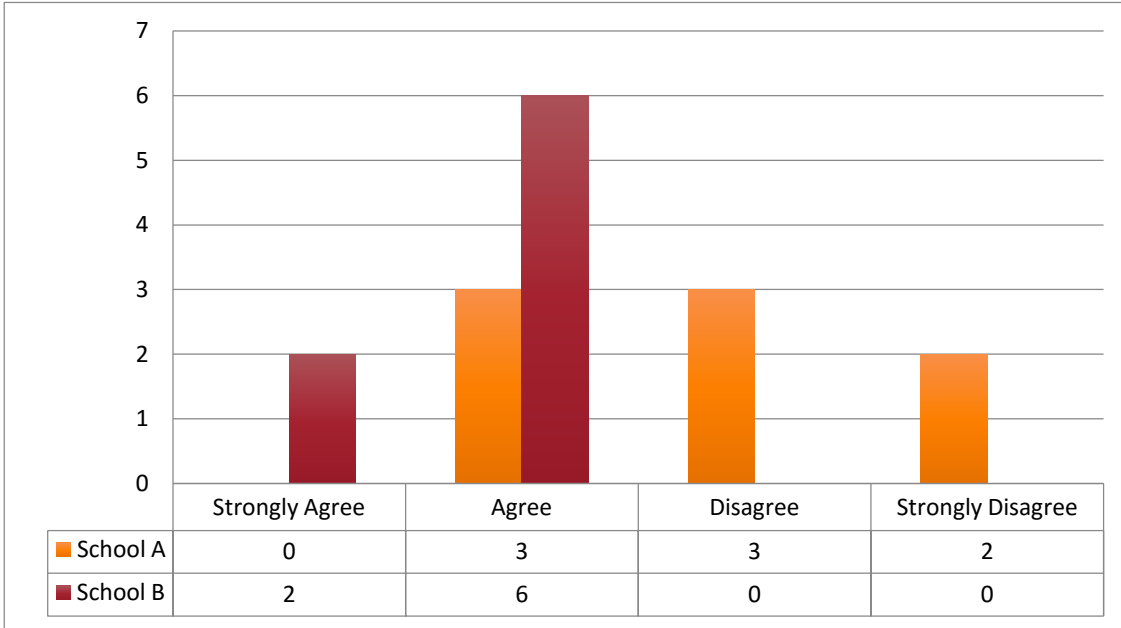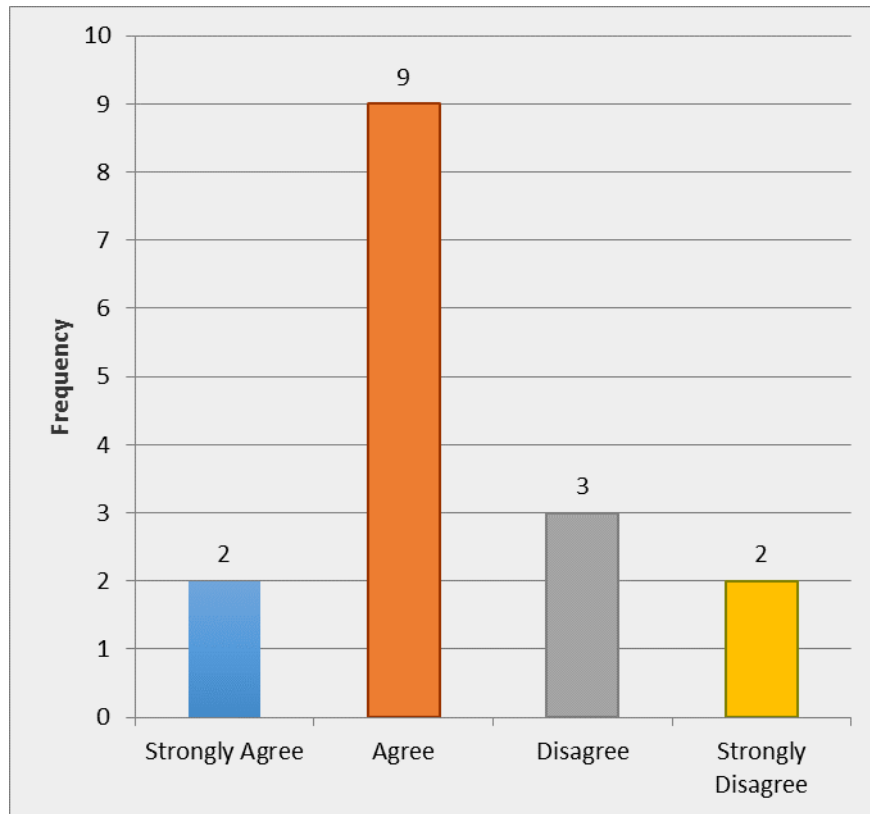
Figure 4.16. Group responses to the prompt: You have assisted with assessments on common risk and stress factors faced by the middles school students in your classroom (IE: exposure to crime, violence, substance abuse).

A majority of the respondents, 11 of 16, agree or strongly agree. Group responses indicate then that if in fact teachers truly do perceive themselves as partly responsible for supporting the mental wellness and emotional functioning of their students, then the responses in figure 4.7 are concerning and worth further inquiry.

Teachers appear to agree to involvement, as strongly supported by Figure 4.16, but they do not affirm this when responding to prompts concerning their active participation in a system response, as indicated by earlier figures. The graph illustrates that School B is largely in disagreement with five of the 14 respondents, 1/3 of the teachers who responded disagreeing. All of those negative responses were from School B. This gap between theory and practice, as

seen over and over again the literature bares out the claims of Pajares & Urdan (2015, pg. 27). Pajares and Urdan speak to the concept of self-efficacy, and the beliefs manifested from such self-perceptions and how these beliefs inform motivation, a sense of overall well-being and personal accomplishments across the life span (Pajares, & Urdan, 2005). Pajares (2005) goes on to assert that schools have the potential to embody a collective vibe of group efficacy which helps promote a climate in which psychological wellness is cultivated.

In the contemporary literature that addresses the theory to the practice gap, over the last decades, at the Center for School Mental Health out of UCLA, Center for Mental Health in Schools (2008), the central focus of their work has been the transformation of schools to support students and teachers to thrive. Specifically, they promote reform, in both policy and practice, from the current system into a universal unified and comprehensive system. Similar to Systems of Care (SOC) initiatives, and the Positive Psychology Movement, the Center asserts that these systemic changes are a matter of equity and social justice-they are in promoting whole child development.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	1	4	3	1
School B	2	4	1	0

Figure 4.17. School-by-school comparison to the prompt: You feel confident in your professional abilities to identify common risk and stress factors faced by the middle school students in your classroom.

Teachers are often the first line of defense with students when factors arise that impact student wellness in a negative way. A teacher's lack of perceived efficacy could easily explain inaction or failures within the system. School A and School B respondents' are nearly equally matched in responses in agree and strongly disagree categories. This, when considered with the prompt that follows it on the survey, sheds light on the whether confidence or high efficacy exists. One could argue that participation and activity in the student MH arena would indicate higher teacher self efficacy and confidence.
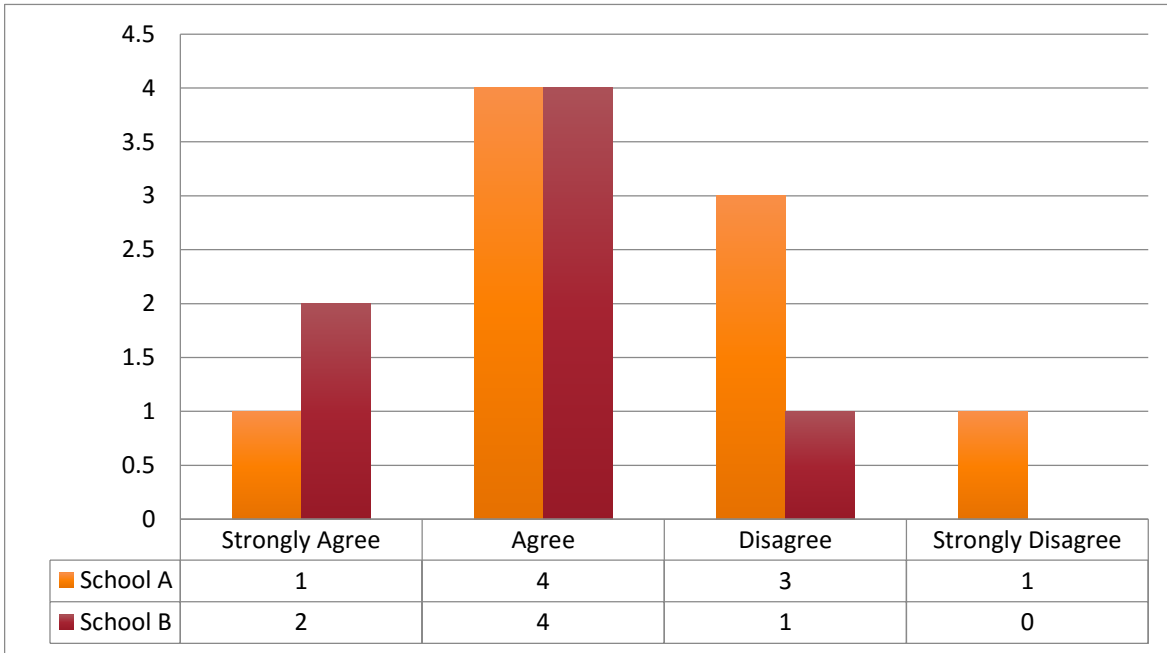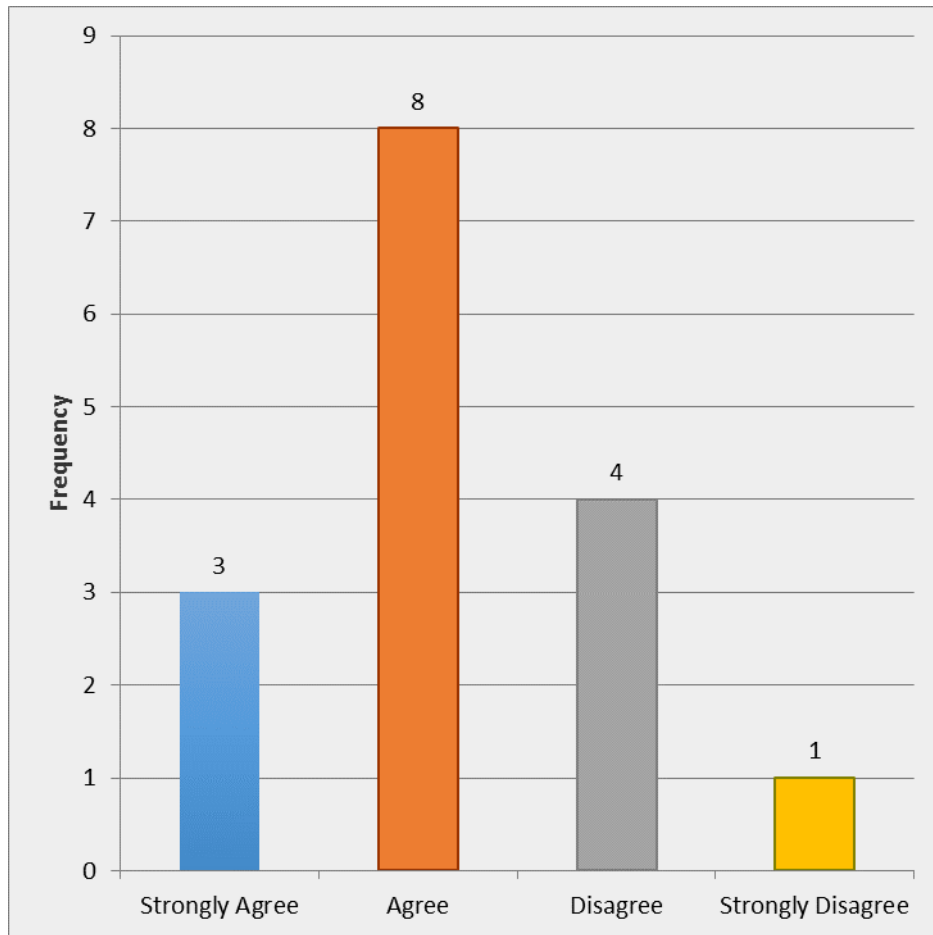
Figure 4.18. Group responses to the prompt: You feel confident in your professional abilities to identify common risk and stress factors faced by the middle school students in your classroom.

Figure 4.18 illustrates that as a group, a majority of teachers are in agreement as to their perceived individual confidence in their ability to identify the above mentioned risk factors. This specific result supports claims from Pajares & Urdan (2015) that the concept of self-efficacy, and the beliefs manifested from such self-perceptions inform motivation, a sense of overall well-being and personal accomplishments across the life span. Pajares (2005) goes on to assert that schools have the potential to embody a collective vibe of group efficacy which helps promote a climate in which psychological wellness is cultivated.

	Strongly Agree	Agree	Disagree	Strongly Disagree
■ School A	1	3	1	2
■ School B	1	7	1	0

Figure 4.19. School-by-school responses to the prompt: You have participated in meetings with students, parents, and other school staff to ask them about their behavioral and mental health needs and to ask them for their recommendations for actions by school staff.

This figure highlights the perceptions that the responding teachers hold about their level of involvement (activity) with not only students, but also families and other school staff as it relates to a continuum of care. Sixteen of the 20 teachers who engaged in this survey opted to respond to this prompt. Of 16 responses, nine responders from from School B agreed or strongly agreed their active participation in such matters. Of the seven teachers who responded from School A, four strongly agreed or agreed and three disagreed or strongly disagreed. Again, it would appear that School B respondents confirm a mechanism or mechanisms in place or utilized to address emotional wellness, while School A is somewhat split in their response but has 4 teachers indicating a deficit in this area..

The prompt in and of itself fails to specify the kinds of meetings, formal, informal or other, that are held and why.

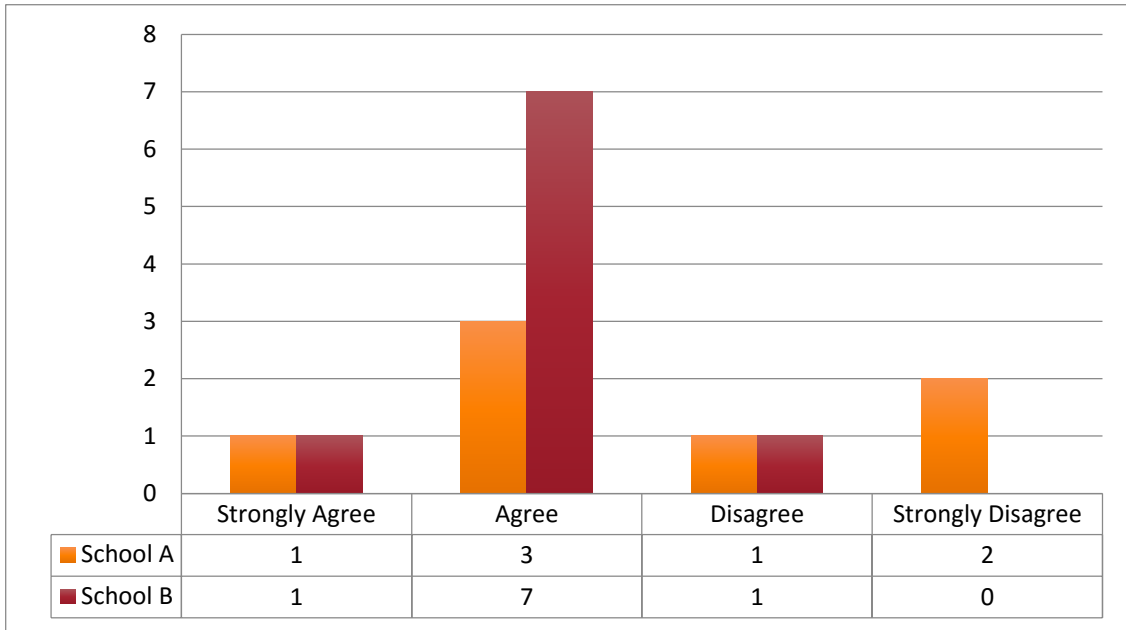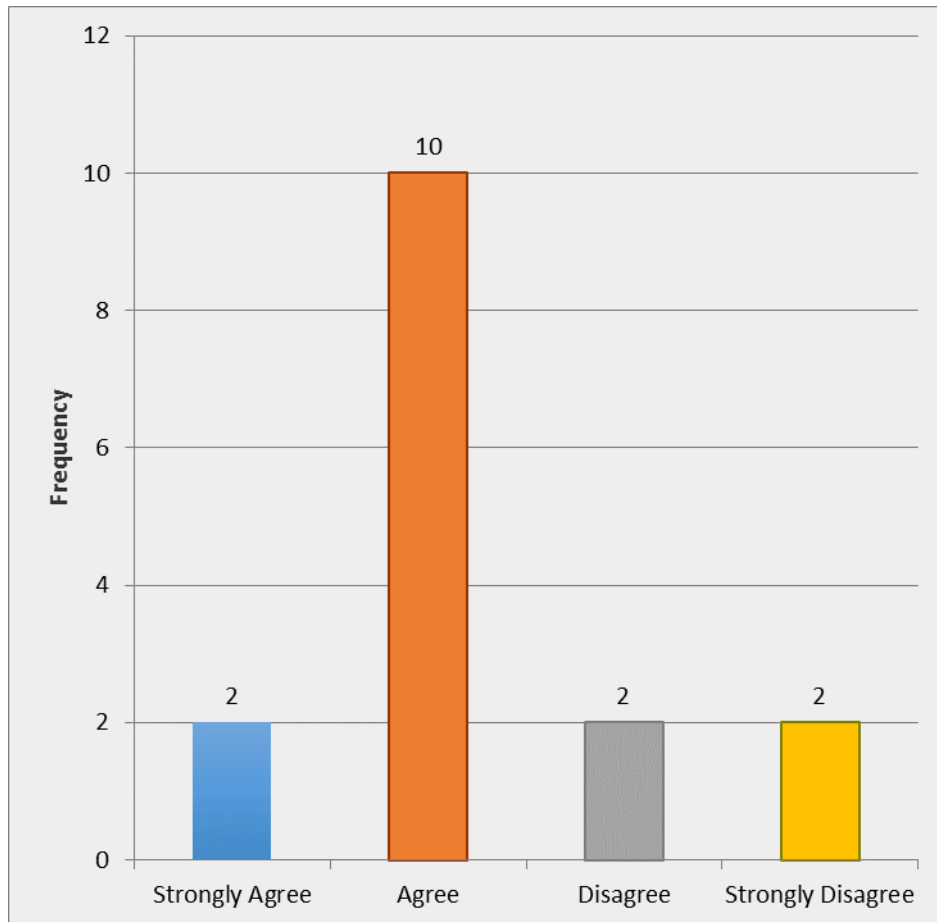**Figure 4.20.** Group responses to the prompt: You have participated in meetings with students, parents, and other school staff to ask them about their behavioral and mental health needs and to ask them for their recommendations for actions by school staff.

Sixteen teachers opted to respond with an overwhelming majority of the respondents

confirmed strong agreement or agreement in this area.

	Strongly Agree	Agree	Disagree	Strongly Disagree
Schhol A	0	3	3	1
School B	2	4	1	0

Figure 4.21. School-by-school comparison to the prompt: Services are in place, within your school, to help students contend with common risk and stress factors and to support mental health and wellness.

This prompt highlights a key factor related to the claims in this study. Interestingly, only 14 of the 20 teachers opted to respond to the prompt. School B again, indicated higher agreement with this premise with six of its total of 5 respondents indicating that they agreed or strongly agreed. The seven School A respondents were nearly evenly split. Three of the seven agreed and 4 of the seven disagreed or strongly disagreed that there services are in place in their school.

As supported in the literature, embedded systemic interventions and supports for students within the school setting show positive outcomes. In a 2005 study published in the School Journal of Health, researchers concluded that in-school interventions could positively impact or predict test scores and student grades. The study results point to school connectedness and higher social-emotional intelligence correlated to higher testing scores and overall higher grades (Fleming, Haggerty, Catalano, Harachi, Mazza & Gruman, 2005).

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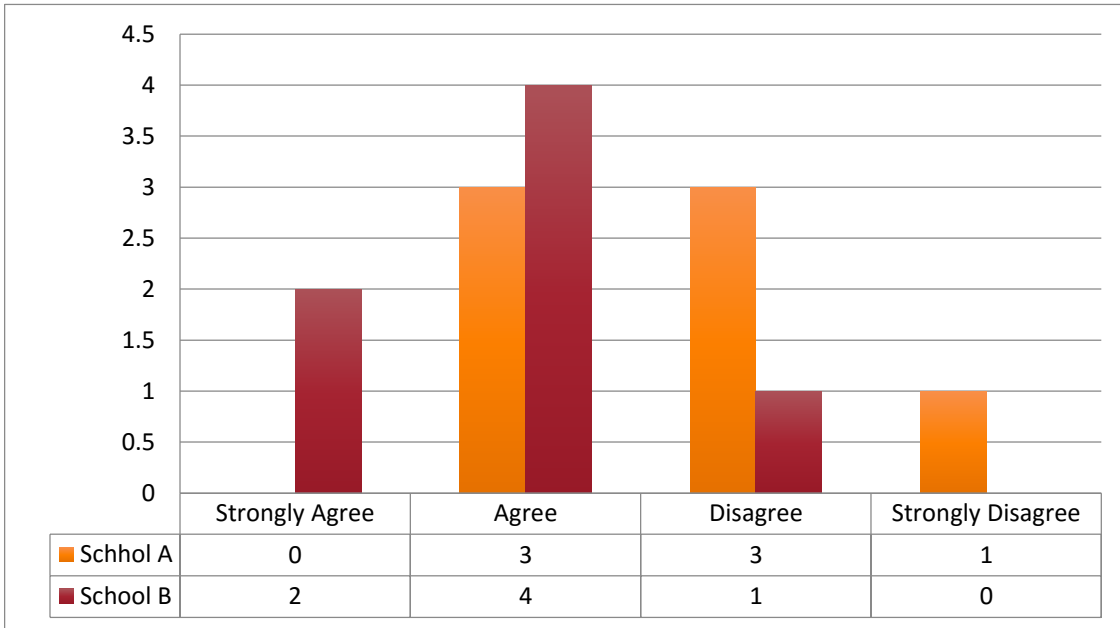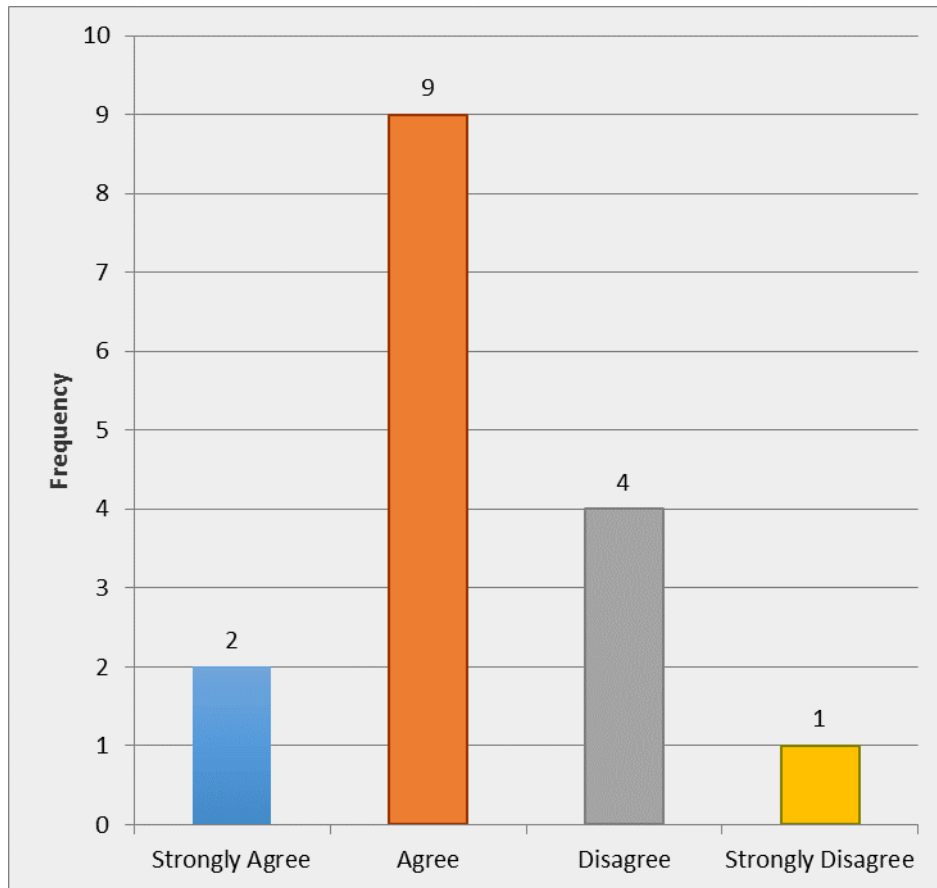**Figure 4.22.** Group response to the prompt: Services are in place, within your school, to help students contend with common risk and stress factors and to support mental health and wellness.

More of the respondents, 11 of the 16 responses, either strongly agree or agree with this

prompt. Only five of the 16 respondents disagreed or strongly disagreed.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	0	2	7	2
School B	0	2	3	0

Figure 4.23. School-by-school comparison to the prompt: You receive ongoing training and supervision on effective identification and treatment protocols that promote effective responses for clinical decision-making for all middle school students.

A comparison of the by School responses as well as the overall group responses (see Figure 4.24 below) show potential areas for future designs for actions. Sixteen of 20 teachers responded that they disagree or strongly disagree. In School A's 11 total responses, 9 of the teachers, a strong majority, disagreed or strongly disagreed. School B, had only five respondents and they were nearly evenly split with two agreeing and three disagreeing.

These data seem to suggest that teachers perceive themselves as undertrained or lacking ongoing training and supervision to not only effectively identify but also to enact treatment that would promote good clinical decision making for the middle school students in their schools. However, the very same teachers disagree that they have the training and ongoing education as well as the supervision needed in order to do exactly what they believe they should do support the wellbeing and mental wellness of every student. Durlak, Weare, Nind, Adi, Barry, & Jenkins (2007) note, however, that in spite of the international research, that promotes this type of

holistic approach; very few of the school-based programs that were reviewed used the school as

a whole, a system of care approach. Moreover, the researchers confirm that integrating basic

training to school personnel, teachers especially, bring about positive outcomes that ultimately
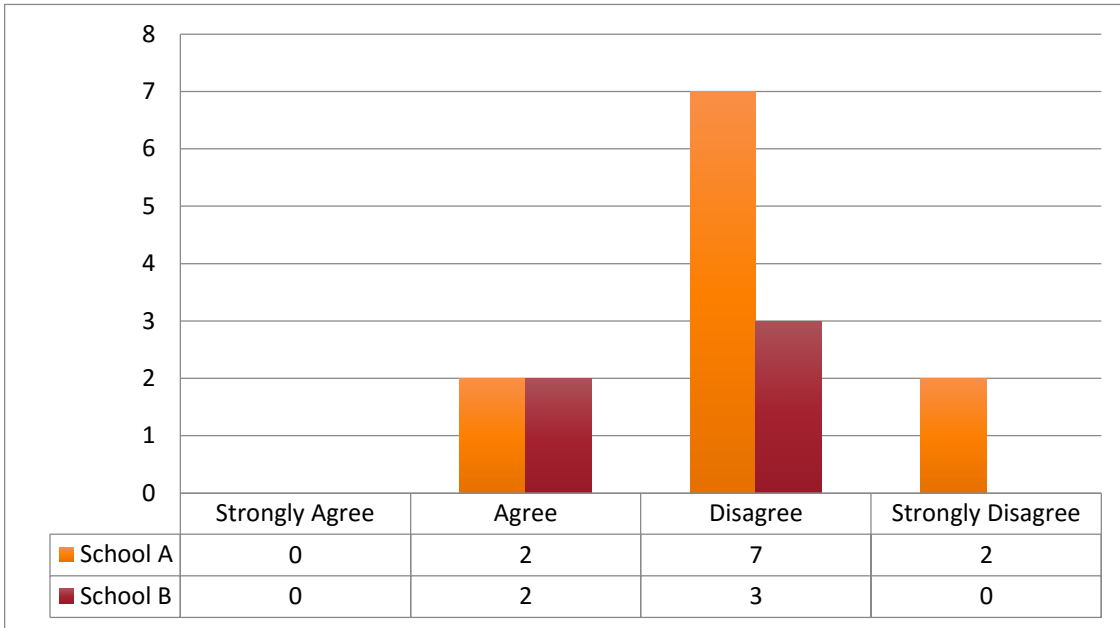
change the school climate positively.
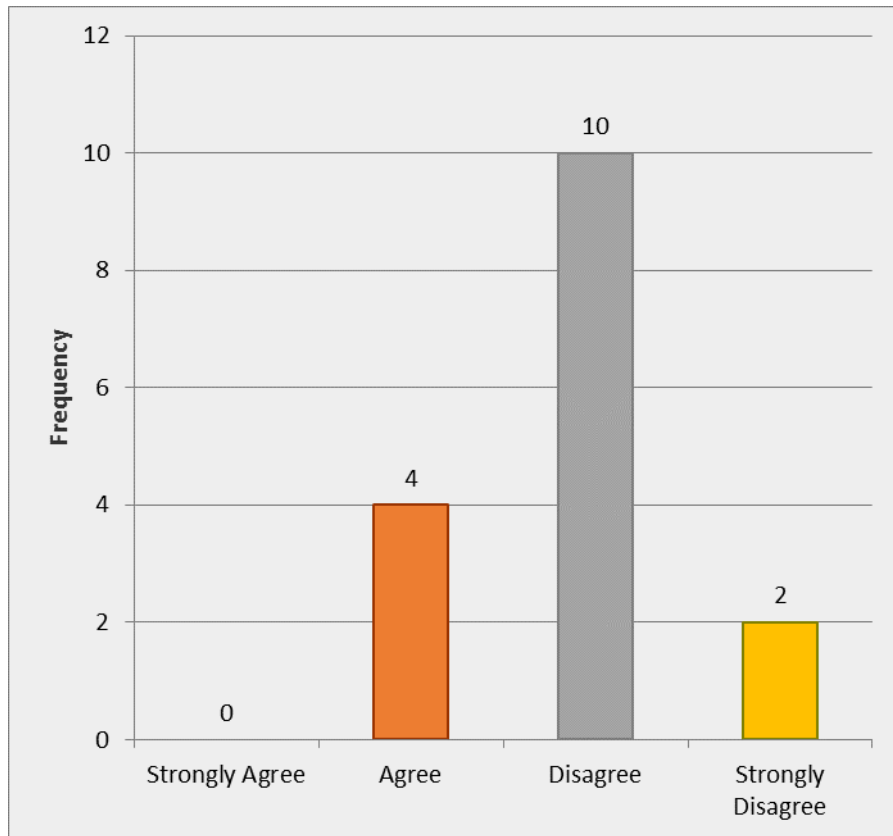
Figure 4.24. Group response to the prompt: You receive ongoing training and supervision on
effective identification and treatment protocols that promote effective responses for clinical
decision-making for all middle school students.

Of the 16 responses from both schools, an overwhelming majority of teachers, 12 of the

16 responses, disagreed and strongly disagreed that they receive adequate and ongoing training

that supports their ability to address the psychosocial wellness of their students. Note that

despite the data represented in the Figure 4.25 below that addresses teacher willingness to

support and their belief about duty to support the overall wellness of their students, the same

group clearly notes that they do not feel adequately equipped or supported. This seems to be the case in spite of the results indicating that teachers are overwhelmingly of the belief that they owe a duty to the overall wellness of their students.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	7	4	0	0
School B	3	2	0	0
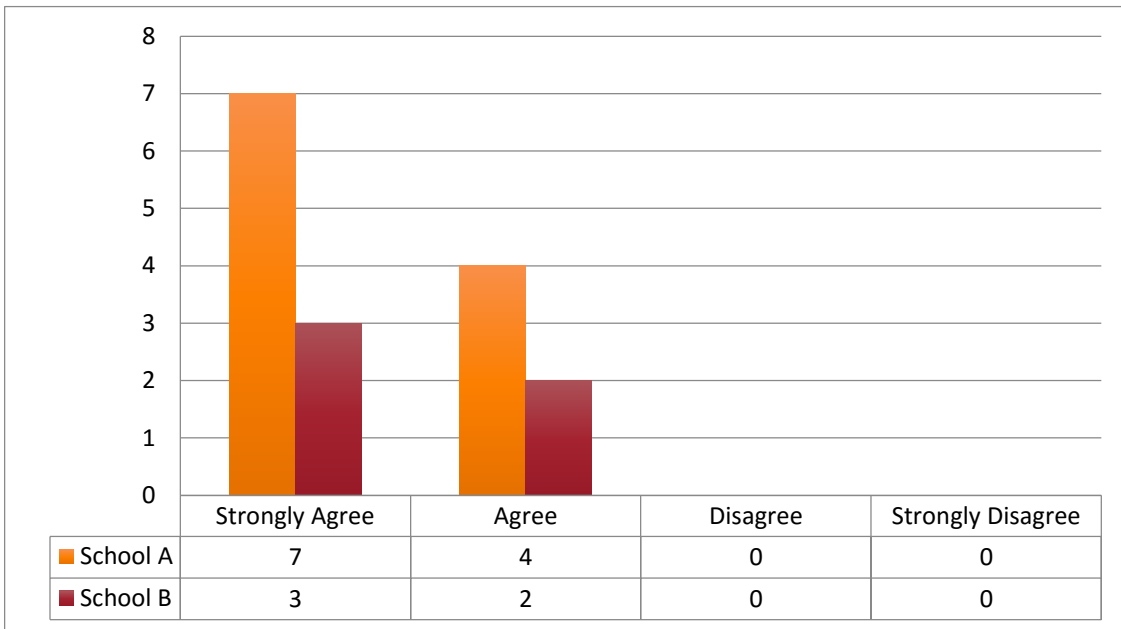
Figure 4.25. School-to-school comparison to the prompt: You believe it is your job to support the mental health and wellness of the students in your classroom.

This prompt is vital, as it affects any future designs for actions. Sixteen of 20 teachers responded to the prompt. Of the 16 responses, 11 responses were from School A and noted either strong agreement or agreement. None of the responses from School A indicated disagreement. Only four teachers from School B chose to respond to this prompt. Of those four respondents all of them answered strongly agree or agree with no disagreement.
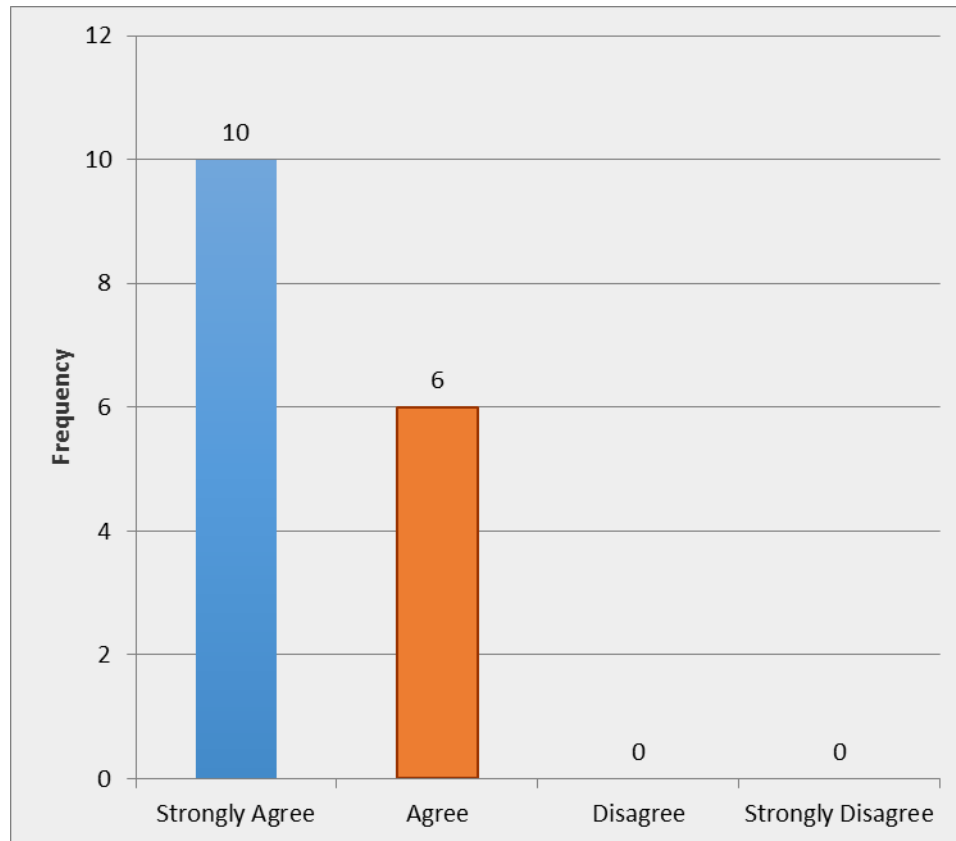
Figure 4.26. Group response to the prompt: You believe it is your job to support the mental health and wellness of the students in your classroom.

As dicussed above, all 16 respondents,either strongly agreed or agreed with this prompt.

Clearly, those who chose to respond see the mental health and wellness of the students in their

care as part of their duties and responsibilities as teachers.

	Zero	One	Two	Three	Four	Five	Six+
School A	5	2	2	1	1	1	1
School B	2	1	0	0	0	0	0

Figure 4.27. School-by-school responses to the prompt: Number of times referred a student to a mental health professional in the last 90 days.

The responses to the prompt displayed in Figure 4.27 represent the only responses to a survey prompt that asked the teachers to supply information. This prompt asked teachers to identify the number of times that they have made a referral for a student over the 90-day period preceding their responses to the survey.

As shown in Figure 4.27, School A responders indicate a significantly higher number of referrals than School B even though five responders from School A reported no referrals. School A teachers reported making over 24 referrals in the 90 day period. Comparatively, School B responses display only one referral over the 90 day period.

It could be inferred that School B teachers, again, answer in such a manner as to imply that they lack a system or mechanism for responding to the overall well-being of every student in middle school. Conversely, School A respondents display a consistent response theme that could be interpreted as that school having a better or different response system in place.

The interesting dilemma inherent to this prompt centers on the unknown factors that would better inform this research. Who did teachers refer the student to? If the referral was made to someone in school it would imply a system in place. Why did did the teacher refer? Why so few referrals overall from School B? Does School B see mental health as less of an issue or does it go unexamined? Future research, beyond this study, would require follow up questions to the original prompt(s) as well as interviews with specific respondents in order to gain more insight into rationales and perceptions.

What's more, the responses to the prompt do not indicate why or why not referrals are made in each school and by which teacher. For the teachers who did make referrals, the prompt does not indicate to whom the referrals were made. These data might inform the existence or nonexistence of a response system within the school(s).
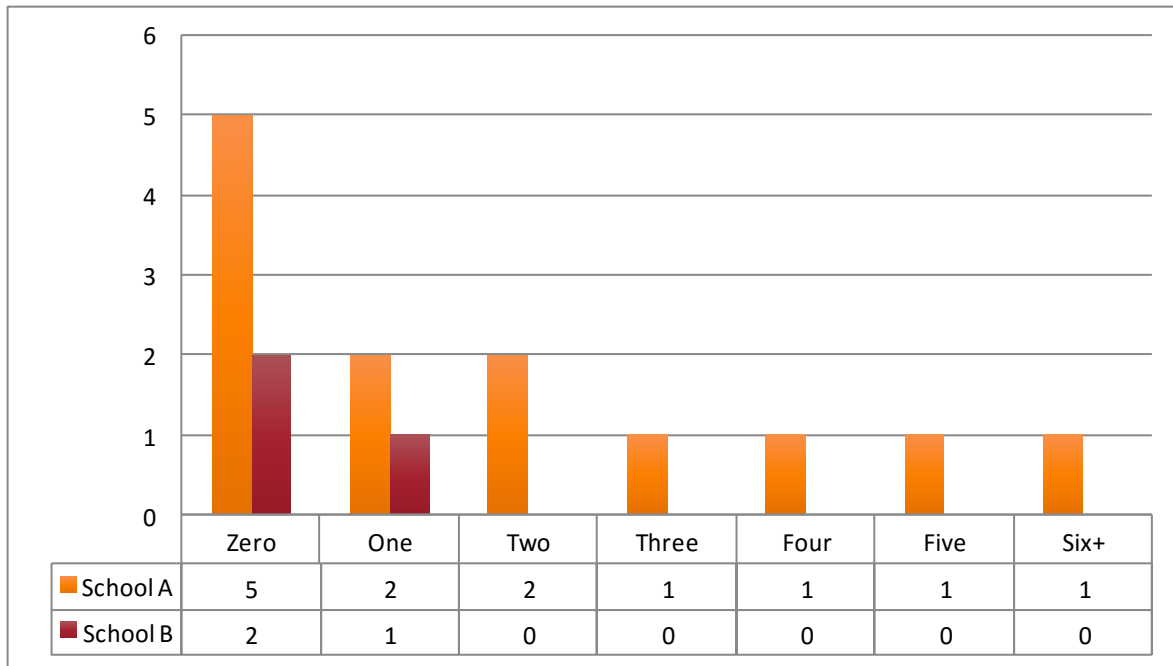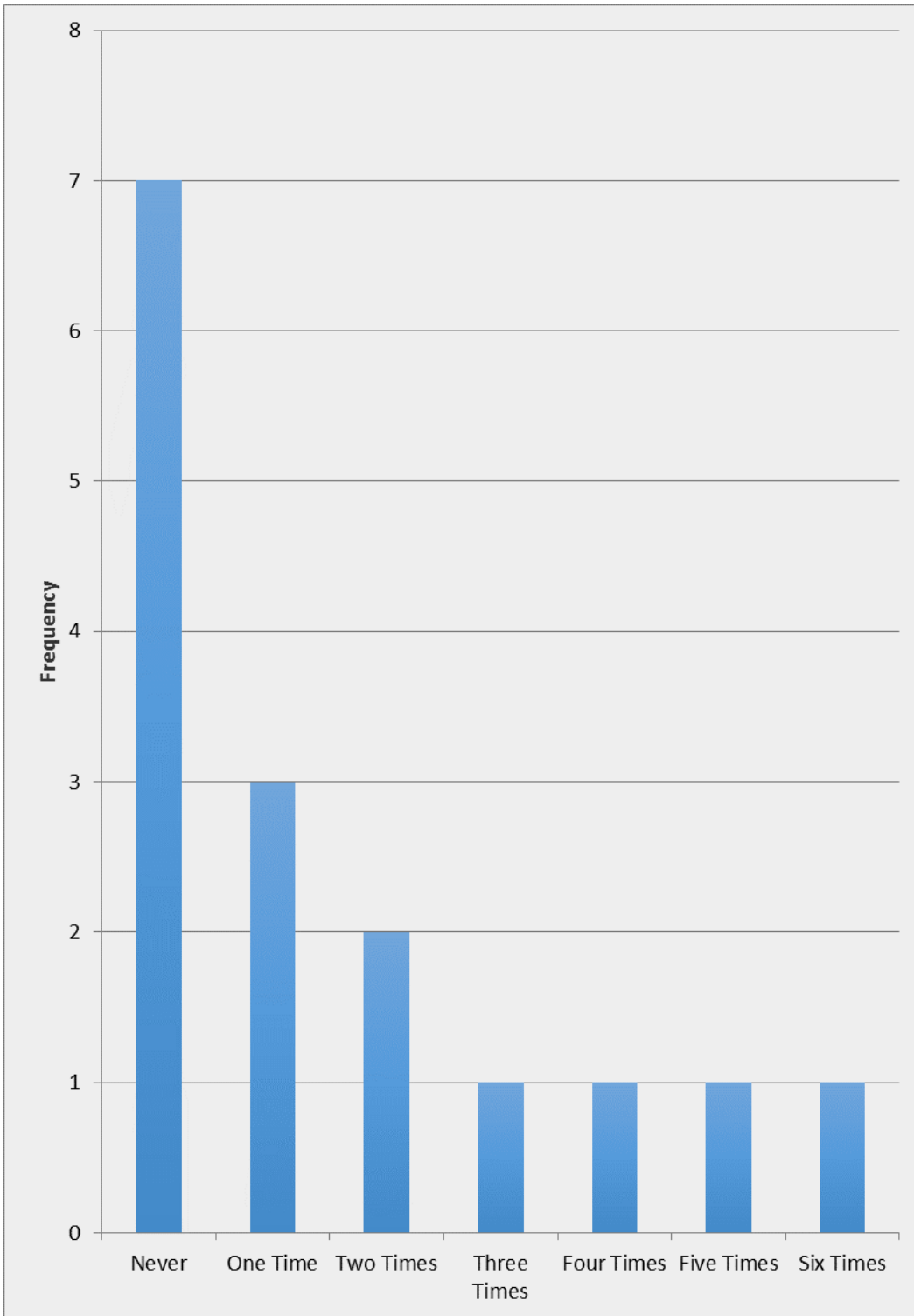
Figure 4.28. Group response to the prompt: Number of times referred a student to a mental health professional in the last 90 days.

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	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	0	1	5	3
School B	2	3	1	0
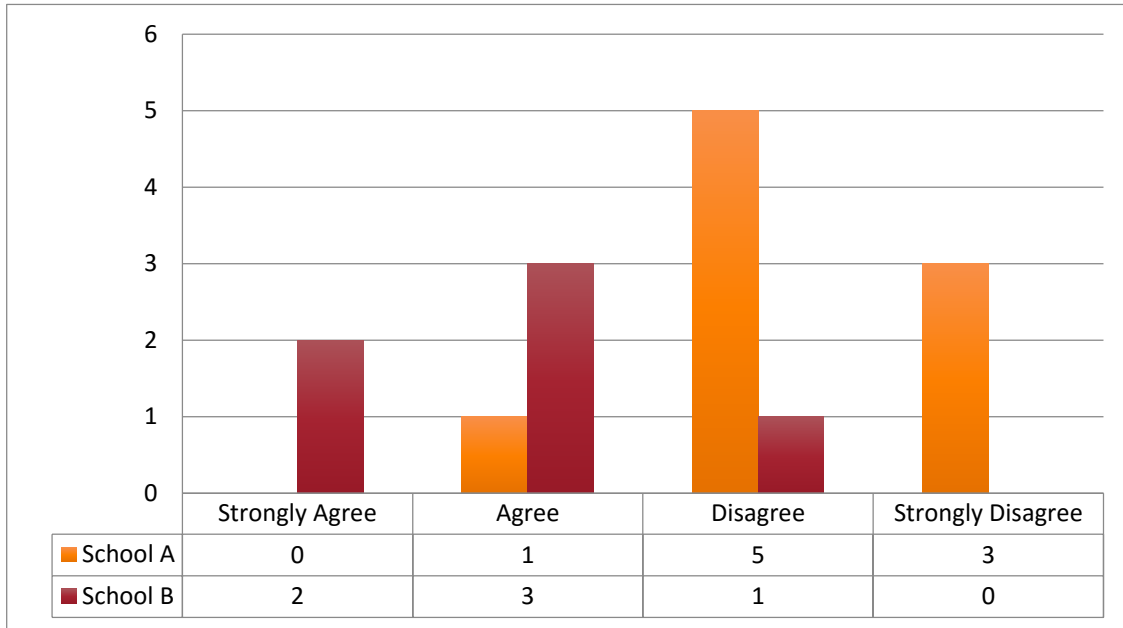
Figure 4.29. School to school comparison to the prompt: There is ready access to mental health services for *all* (diagnosed or undiagnosed, identified of unidentified as having MH issues) middles schools students within your school.
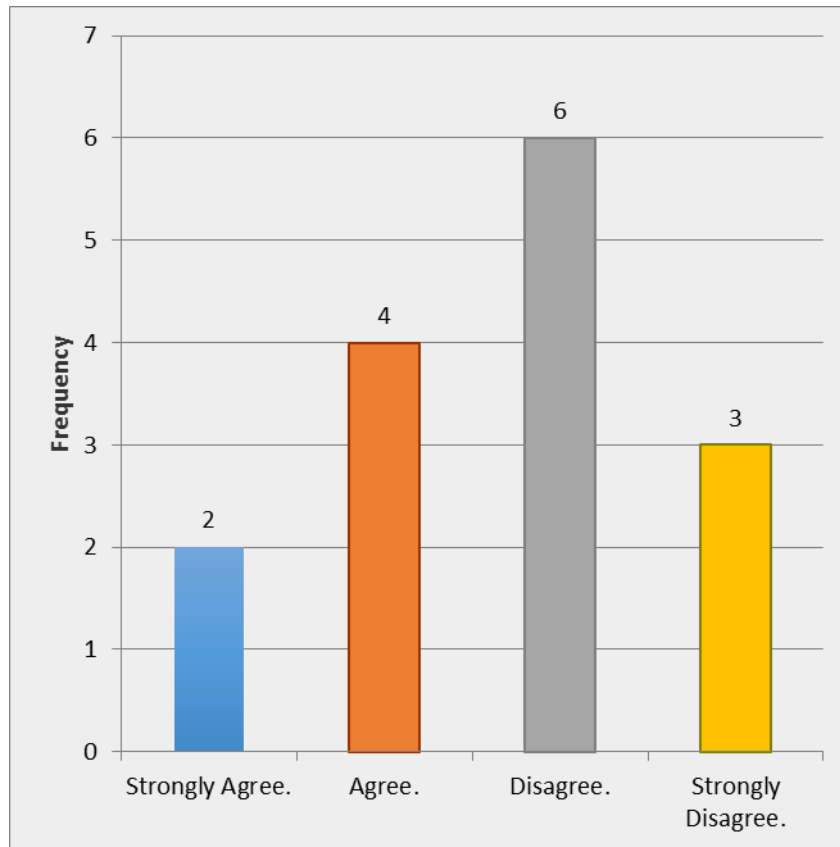
Figure 4.30. Group response to the prompt: There is ready access to mental health services for *all* (diagnosed or undiagnosed, identified of unidentified as having MH issues) middles schools students within your school.

In Figures 4.29 and 4.30 teachers are asked to respond about individual access to resources specific to the full continuum across middle school students in their milieu. The prompt attempts to distinguish between emotional support and wellness support access for all students versus specific identified, entitled students (note that entitled refers to legal entitlements as identified by NCLB, IDEA and district/state mandate). This prompt is similar to the responses displayed in Figure 4.

Even if a teacher or group of teachers in this survey believe that a system does in fact exist, the research maintains the argument that a system that only serves identified or mandated students, is not an effective system. Rather, it is flawed in multiple ways: lack of access,

reactivity vs. proactivity, and lacking in service to overall EQ and human well-being, in other words, a crisis protocol, not an embedded system of care, in service only to deficits rather than one that promotes and builds on strength for overall success across a lifespan.

There are notable levels of disagreement among the 15 respondents to this prompt. Five of the 15, one-third from School A in disagreement or strong disagreement. This could imply that there is either no ready access or no ready access unless the child is already identified, labeled or diagnosed.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	1	3	2	1
School B	1	5	1	0
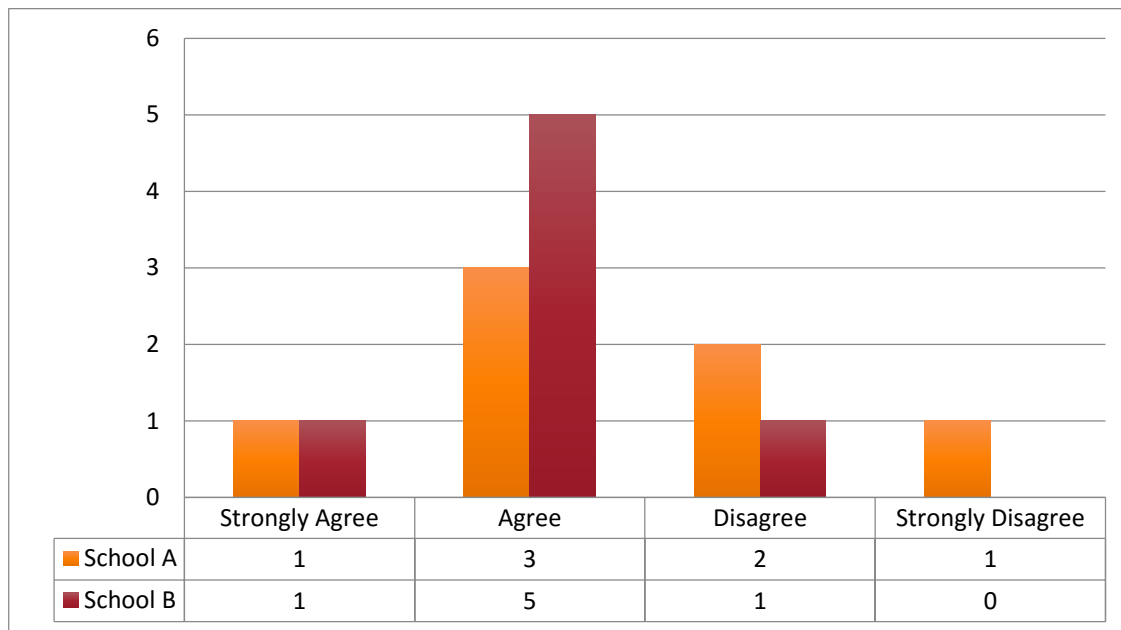
Figure 4.31. School-by-school comparison to the prompt: Knowledge of resources and personnel who conduct screening and follow-up assessments to assist in the identification and appropriate diagnosis of mental health problems for the middle school student in your school.

Figure 4.31 illustrates the extent to which the respondents perceive that they have knowledge about navigation of the system. Only 14 of 20 teachers who completed the survey chose to respond to this prompt. Responses were evenly split with seven responders from each school. Of the responses, those from School A leaned slightly toward agreeing with four of the seven responders indicating either agree or strongly agree. In School B, nearly all of the

responders, 6 of the 7, rated their knowledge as high. Again, there was far less agreement in

School A, which is congruent with other survey responses from School A.
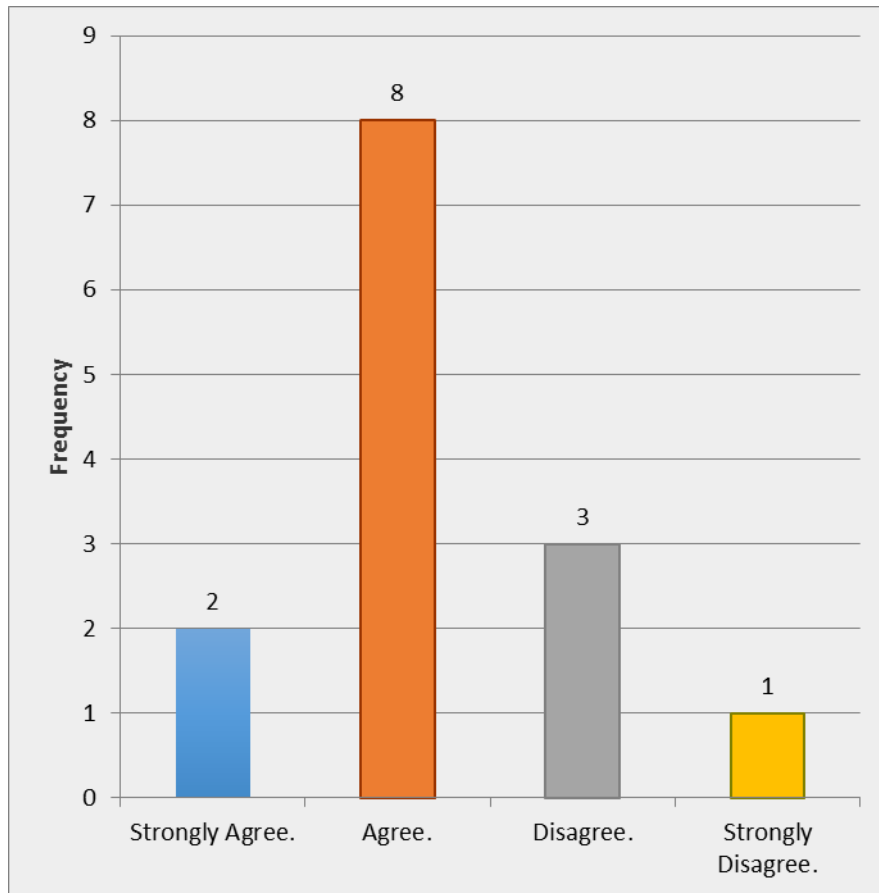
Figure 4.32. Group results for the prompt: Knowledge of resources and personnel who conduct screening and follow-up assessments to assist in the identification and appropriate diagnosis of mental health problems for the middle school student in your school.

Of the 14 respondents, the majority across both school, 10 teachers, agreed or strongly

agreed that they have knowledge of resources and of the personnel who conduct formal

screenings and or assessments.

	Strongly Disagree	Agree	Disagree	Strongly Disagree
School A	0	3	5	1
School B	0	6	1	0
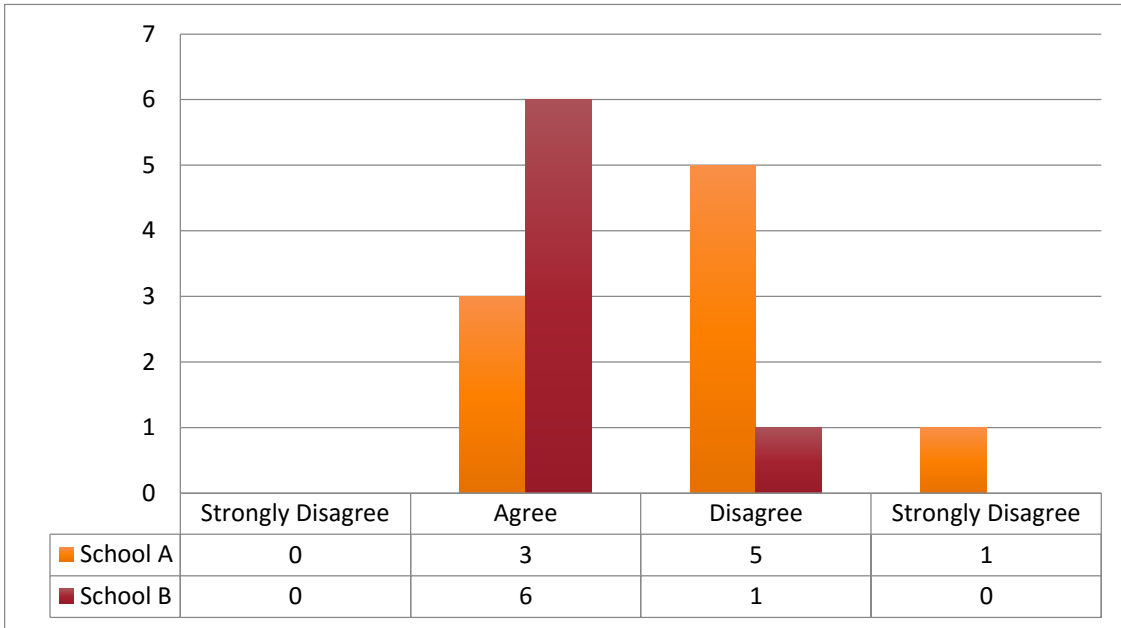
Figure 4.33. School-by-school responses to the survey prompt: You continually assess whether ongoing services provided to students are appropriate and helping to address presenting problems that you identify in your classroom.

This particular prompt is focused on uncovering teacher perceptions of themselves as real time and consistent eyewitnesses to the dynamic and changing emotional support needs of the students in their charge. It is focused especially on how this eyewitnessing pertains to life adjustment needs and life stressors that manifest in the classroom (not pathos and disease)

Again, as Figure 4.33 illustrates, School B responses indicate a higher level of confidence or efficacy with six of their seven total responses agreeing with the prompt. Interestingly, the figure shows an almost reverse mirror image between the schools. Of School A's nine responders, only three agree and six of School A responders indicate that they disagreed or strongly disagreed.
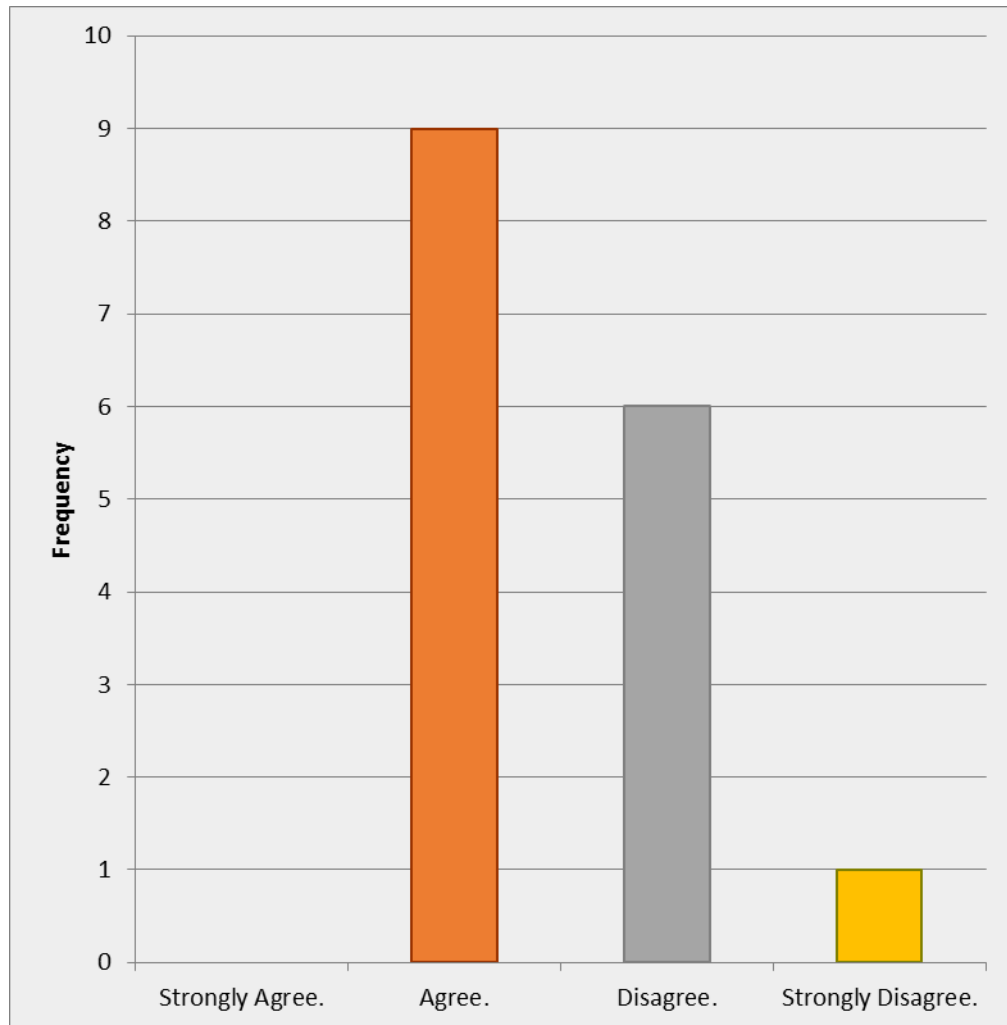
Figure 4.34. Group response to the survey prompt: You continually assess whether ongoing services provided to students are appropriate and helping to address presenting problems that you identify in your classroom.

As previously noted, the responses indicated more than half of the teachers, nine out of

the sixteen agreed with the prompt. Seven of the 16 teachers who responded either disagreed or

strongly disagreed with the prompt.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	0	2	3	4
School B	1	5	1	0
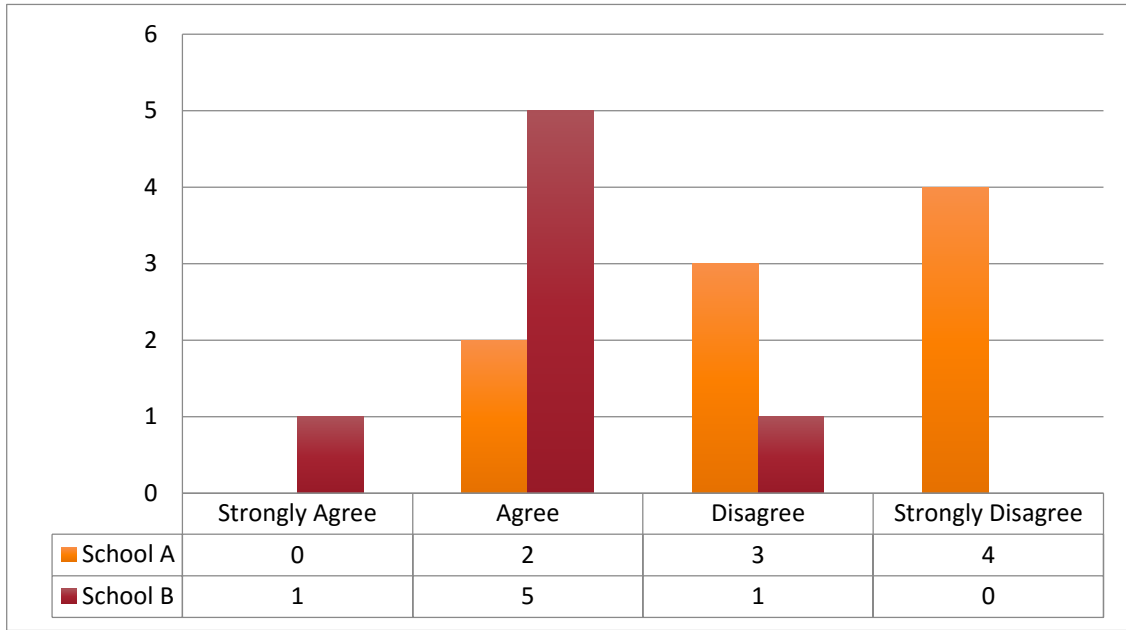
Figure 4.35. School-by-school response to the prompt: You believe there is a clear and effective system in place to assist and support the ongoing mental health and wellness of all students within your school and not just the emergency response system involving critical incidents and crisis.

Sixteen teachers chose to respond to this prompt; nine from School A and eight from School B. In School A, a majority of the responders, seven of the nine, either disagreed or strongly disagreed that there is a clear system in place in their school. In School B, the opposite occurred. A majority of School B responders, six of the seven either agreed or strongly agreed. Again, a potential theme emerges.

The responses could indicated that School A responses indicate a need for a system to be put into place in their school; while School B responses seem to indicate that some sort of response system already exists in their school.
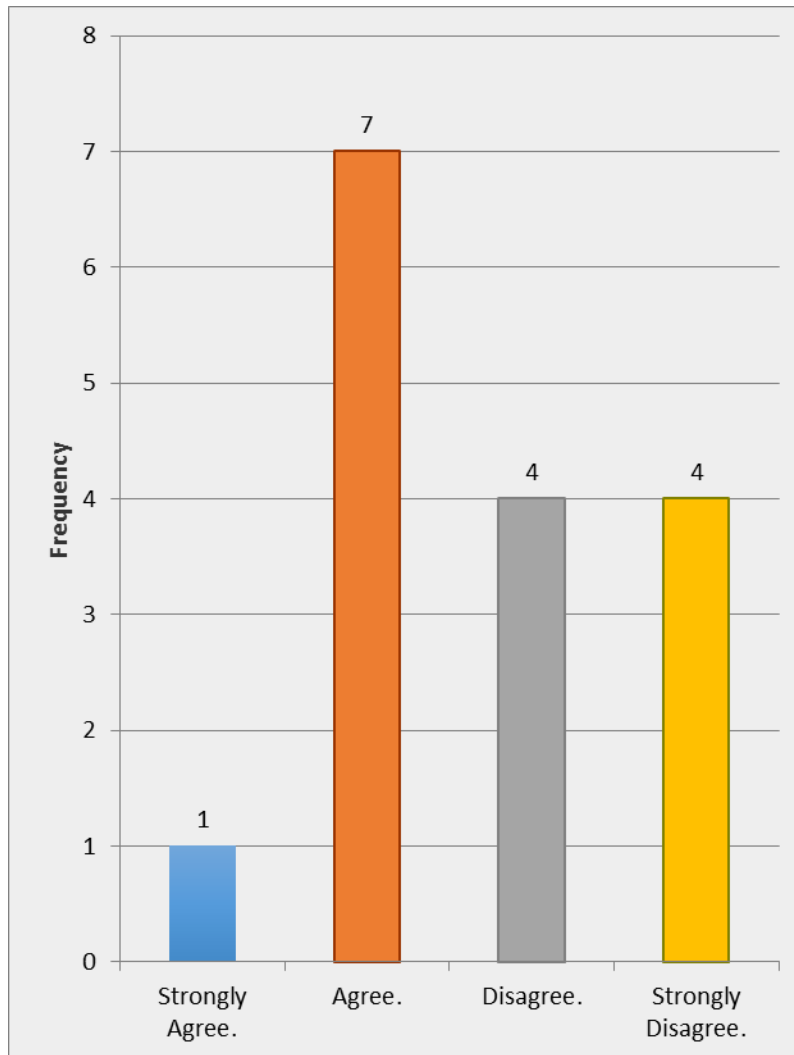
Figure 4.35. Group response to the survey prompt: You believe there is a clear and effective system in place to assist and support the ongoing mental health and wellness of all students within your school and not just the emergency response system involving critical incidents and crisis.

As Figure 4.35 shows, the total responses from both schools areequally divided with 8 who strongly agree and agree and 8 who disagree or strongly disagree.

	Strongly Agree	Agree	Disagree	Strongly Disagree
■ School A	0	1	6	1
■ School B	2	4	2	0
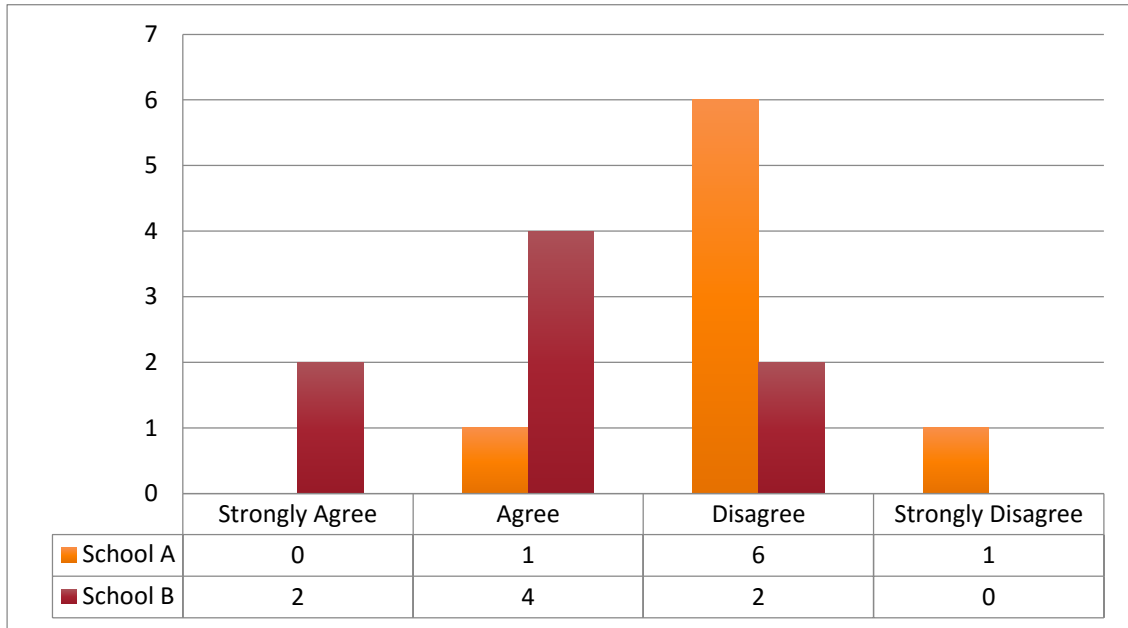
Figure 4.36. School-by-school responses to the prompt: Your school uses preventive, evidence-based practices and programs to consistently intervene in child and adolescent mental health development and growth.

The prompt illustrated in Figure 4.36 probes for the presence of interventions and modalities rather than whether a system for interventions exists. If responses were congruent with the subsumed claims, one would expect a higher response of responses that disagree and strongly disagree. This would indicate that no real, true, effective or reliable system exists.

Sixteen teachers chose to respond to this prompt. Eight were from School A and 8 were from School B. In School A only one out of the eight School A responders agreed with the prompt. The other seven responders either disagreed or strongly disagreed. Conversely, in School B, six of the eight responders from that school indicated agreement or strong agreement with only two responders from School B disagreeing with the prompt.
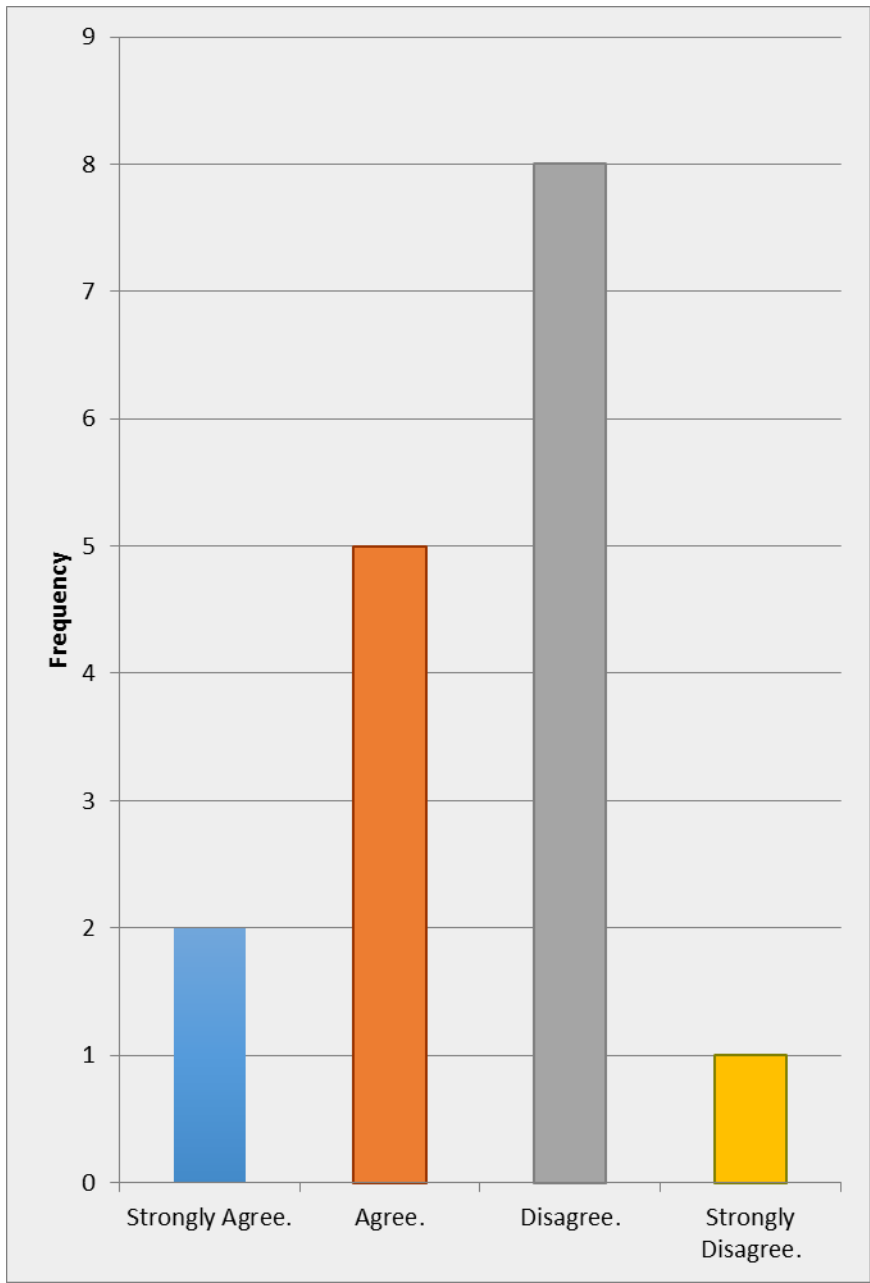
Figure 4.37. Group response to the survey prompt: Your school uses preventive, evidence-based practices and programs to consistently intervene in child and adolescent mental health development and growth.

Nine of the respondents strongly disagreed or disagreed while seven strongly agreed or agreed. More than 50% answered disagree and strongly disagree, lending supporting evidence to

the researcher's claim(s) that schools fail to support the mental wellness of all students. Conversely, strong agreement or agreement would imply a systemic response or intact system.

The researcher's assumptions as well as the reviewed literature, specifically, a 2011 study out of the University of Missouri, authored by Reinke, Stormon, Herman, Puri, Rohini and Goel (2011), support that a significant research to practice gap in the area of mental health and wellness practices exists within school systems. The study by Reinke, et.al (2011) examined the perceptions of 292 teachers related to current mental health response(s) within the context of their specific school setting. The participants reported on self-beliefs about their role in supporting wellbeing in students, barriers within the system and perceived skill sets and training needs. The study concluded that teachers perceive themselves as primary points of contact for in-class interventions while deferring to mental health specialists, school psychologists who are perceived as having a more significant responsibility for teaching ongoing psychosocial education and lessons. Notably, teachers remarked on a universal and significant lack of training and education for understanding, supporting and managing the emotional needs of their students, a practice gap of striking significance.

Clearly, Figures 4.36 and 4.37 indicate a lack of a universal policy or uniformity, even among the two schools studied, that for better or for worse, reside within a 3-mile radius.

	Strongly Agree	Agree	Disagree	Strongly Disagree
■ School A	4	6	0	0
■ School B	2	4	0	0
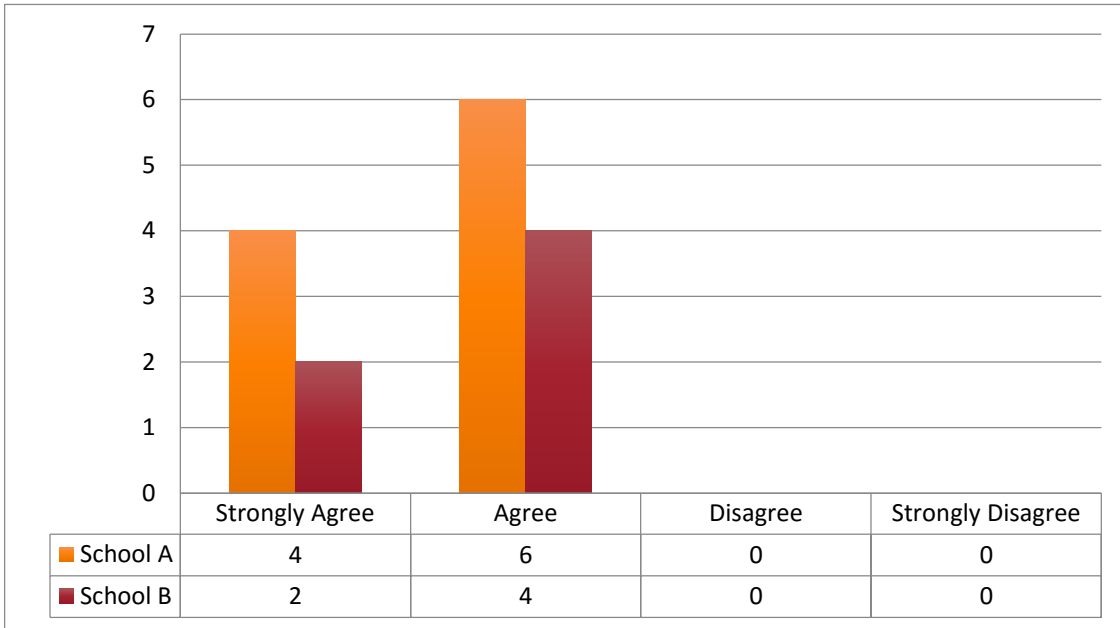
Figure 4.38. School-by-school response to the prompt: You believe it is within your job duties as the/a teacher to identify, support, and take action around to support the mental health and wellness issues.

Sixteen teachers chose to respond to this survey prompt. In School A, a total of 10 teachers responded with all of them agreeing or strongly agreeing that it was their duty to take action to support mental health. Likewise, the six School B respondents also indicted that they all strongly agreed or agreed with the prompt. Clearly, whether of not a system exists, teachers hold the belief that it is part of their job to support and take action regarding student mental health and wellness issues.
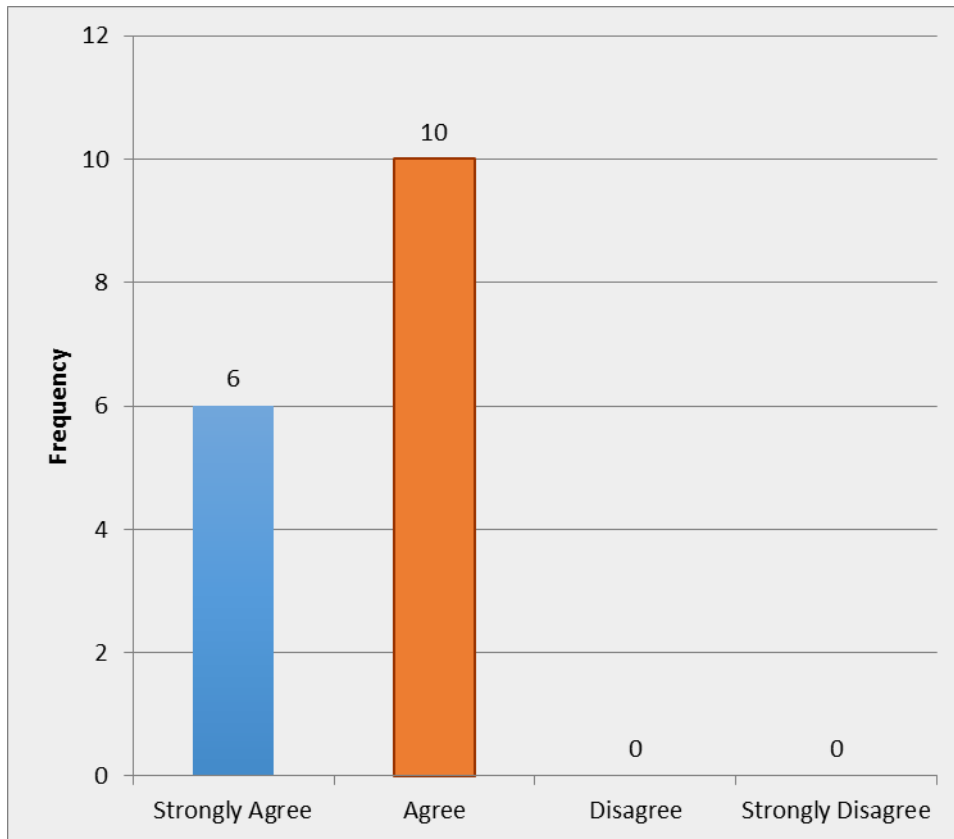
Figure 4.39. Group response to the suvery prompt: You believe it is within your job duties as the/a teacher to identify, support, and take action around to support the mental health and wellness issues.

As both Figures 4.38 and 4.39 indicate, and in correspondence with the literature,

teachers are, for the most part, "do whatever it takes" people. As Harrison and Killion (2007)

reported that teachers assume a varied and multi-faceted role in support of students. Whether

roles are assigned or assumed, teachers have the ability to build capacity and building capacity

goes well beyond curriculum instruction only. The prompt posed to the teachers: You believe it

is within your job duties as the/a teacher to identify, support, and take action around student

mental health and wellness, sheds light on these reported statements. Overwhelmingly, this

group of teachers from both schools shows themselves to be willing to take on informal duties or

roles to act for their students going beyond what is prescribed within a specific job description.

To that matter, the prompt illustrated in Figures 4.38 and 4.39, provide important information in light of the assumed narrative of this research. The teachers were asked to think about their personal beliefs and their individual convictions that student wellbeing and mental wellness a matter of their duties as they understand and interpret those duties.

The above figures illustrate their overwhelmingly positive responses. Many times, teachers have reported to this clinician that during the course of their normal working life, day-to-day with their students, they are called upon to address psychosocial issues and at times, the need to address the students' overall wellness does impact the teacher's ability to fully deliver on matters of curriculum and teaching driven as increasing test scores. This presents a significant dilemma as addressed by Seligman (2005) who asserts that academic success is predominantly defined by high test scores, and it is an insufficient measurement of overall wellness.

According to Seligman (2005), there is a science of positive subjective experience, positive individual traits, and positive institutions. It follows then that schools with adequate mental health support systems may hold promise for improving the quality of life and preventing the pathologies that can manifest when life is stressful or distressing. Yet the focus on pathology (Mannarino, Loughran & Hamilton, 2007) dominates so much of the discipline of both psychology and discipline of counseling that therapist results framed by this deficit model is lacking.

	Strongly Agree	Agree	Disagree	Strongly Disagree
School A	7	1	0	0
School B	6	1	0	0
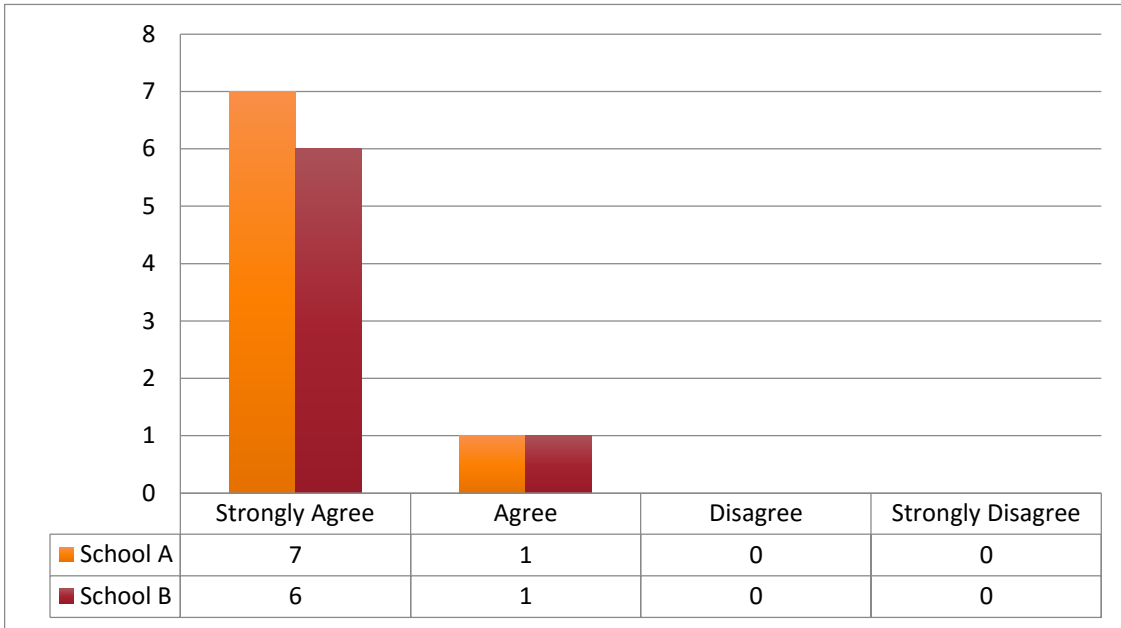
Figure 4.40. School by school response to the prompt: You believe that psychocsocial wellness is correlated to academic achievement.

Of the 15 teachers who opted to respond to this prompt, 100% agreed strongly or agreed..

Their resounding affirmation indicates that they believe academic success, often measured only

by high test scores, is absolutely correlated to wellness. An argument could be made that these

educators know and operate under the assumption that a well student, an emotionally adept

middle school student, is in fact more likely to be an academic success, and, conversely, an

unwell student, a more vulnerable or lesser achiever.

The respondents' perceptions are supported in the literature. In the *International Journal

of Wellbeing*, Norrish, Williams, O'Connor & Robinson (2013) attest that Positive Education

gains momentum with ongoing and increasing recognition of the role that schools play in

growing wellbeing, and the correlations between academic achievement and wellbeing.
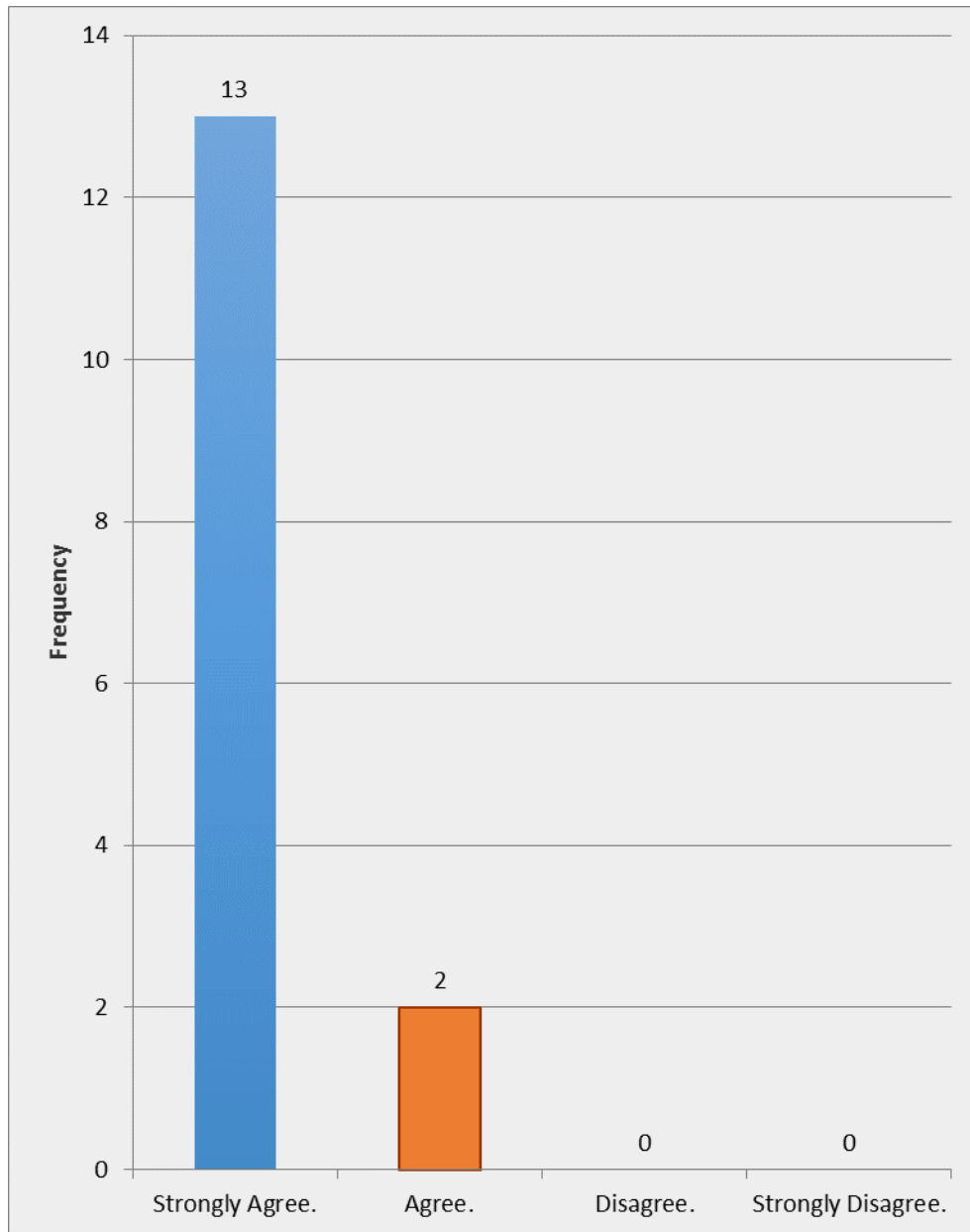
Figure 4.41. Group response to the suvery prompt: You believe that psychocsocial wellness is corredlated to academic achievement.

Fifteen of the 20 possible participants chose to respond to this prompt. Of the 15 teachers,

13 strongly agreed and two agreed. None of the teachers who responded disagreed with the

prompt.

	Strongly Agree	Agree	Disagree	Strongl Disagree
School A	5	5	1	0
School B	1	2	1	1
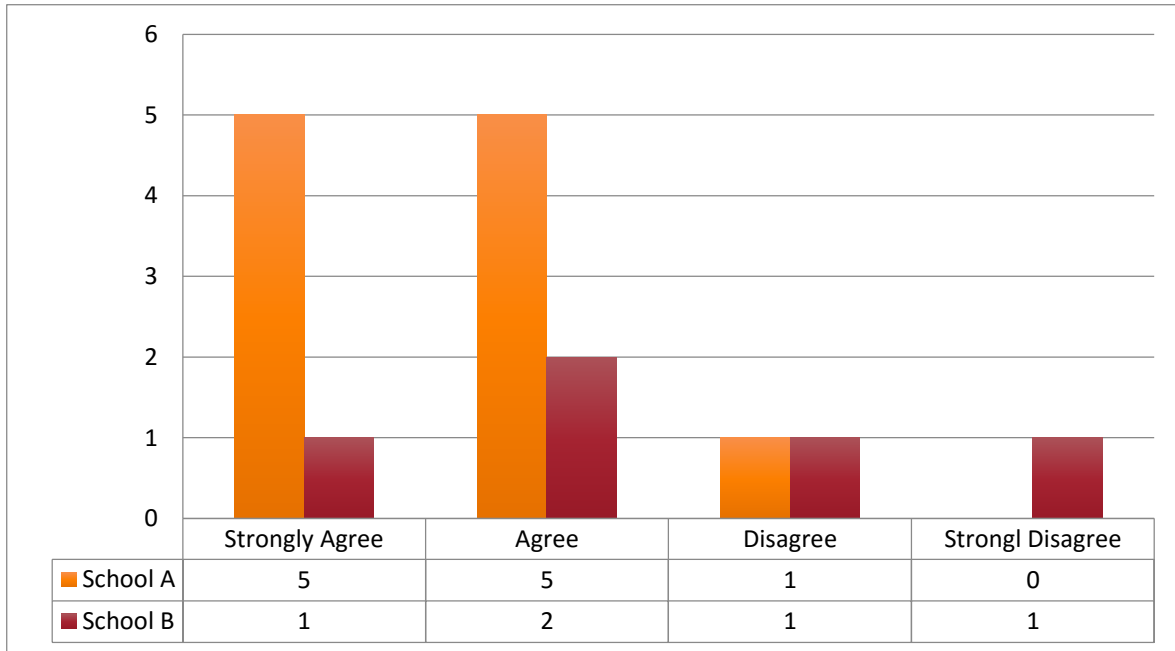
Figure 4.42. School by school comparison to the prompt: You believe that your school needs to put a response system into place to address the ongoing mental health and wellness needs for every student as a matter of ongoing support and education.

Figure 4.42 displays the reponses by school to the last prompt on the survey. Of the 16 teachers who chose to respond to the prompt, a majority, 11, are from School A, while only five teachers from School B responded. Notably, the comparison displayed in Figure 4.42 shows that the only teacher who strongly disagreed with the prompt was a teacher from School B. This is congruent. Only a teacher from a school where respondents have repeatedly indicated that they perceive their school to have mechanisms for managing and addressing student mental wellness, School B, could logically disagree strongly to the prompt of whether or not their school is in need of a response system based on their perception that a system or mechanism already exists.

When comparing the responses by school, likewise, with a similar theoretical premise, it is School A that has the more noteworthy number of agreement (strongly agree/agree) that their school does in fact have a significant need for a system.
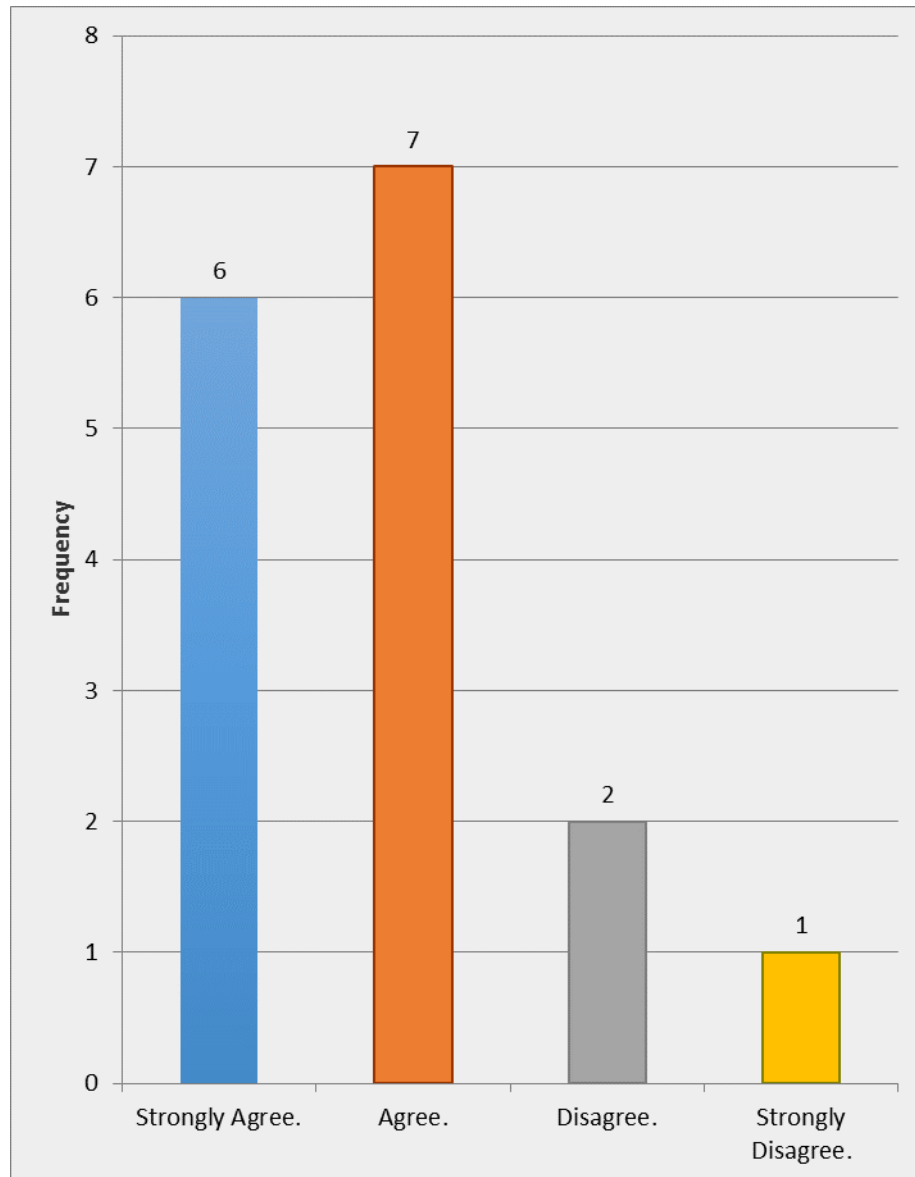
Figure 4.43. Group response to the prompt: You believe that your school needs to put a response system into place to address the ongoing mental health and wellness needs for every student as a matter of ongoing support and education.

Overall, thirteen of the respondents, an overwhleming majority, strongly agree or agree

that their school needs to a put a response system into place to support the ongoing psychosocial

wellness of their middle school student body. This finding alone warrants support for the

subsumed claim of this and other calls to action such as that of the Mental Health Commission of

Canada report expressing an urgent need to act to address children and student mental wellness.

In their national commission report, Kirby & Keon (2006) stated that the most effective mechanism with which to provide and give access to mental wellness services is to provide them within the school setting. This report lends support to the embedded claim of this study, that schools lack an effective, known, easily accessed system to respond to the day-to-day psychosocial wellbeing of middle school students.

Conclusions

Ultimately, the perceived deficits or contributions of this study to generate positive impacts on school systems to more effectively grow whole and well children represents the first steps in what should be a longer research agenda. In the end, the students, teachers and families stand to gain from embedding positive psychology elements into a school system of care to serve the psychosocial wellbeing of every student. As a society and culture, if, and as we endeavor to foster the wellness of our students, we must look for changes and system shifts beyond what we have done and even beyond what we might be doing successfully right now.

A strong, integrated and comprehensive networked community of improvement, encompassing every layer and measure of stakeholder, must be a part of, if not the driving force behind the changes that will bring forth American schools into an era of recognition that psychosocially ept children are significantly acculturated in the classroom. Schools then, are the ideal place for providing multi-faceted levels of care to support the growth of students to enable them to grow as whole adults and contributing members of our society.

As demonstrated through the 2009 Alliance for Catholic Education's Mental Health and Wellness Survey out of Notre Dame, that surveyed some 400 principals across 12 different dioceses, we must do more to illuminate common and universal strategies and practices in service to the emotional hygiene and wellness of students (Frabutt, Clark & Speach (2010). In

their study, the researchers identified three patterns via the surveyed principals' (n=244) responses about the provision of services to support student mental health in their schools and districts. Three relatively common shared practices or beliefs for needed practices emerged: collaboration & communications, action plans/planning and professional assistance were identified as the basic tenants of successful response systems (Frabutt, et. al., 2010).

For School A and School B, two private Catholic institutions in neighboring districts of the same Diocese, shared practices seem nonexistent. Both schools effectively responded in such a way as to display that discrepancies and sporadic responses exist, but not for all students and not across life domains of the middle school students. There is evidence within the survey data that point to a high likelihood that schools in the current system as we know it, are without a universal or well understood knowable response system. The survey results reflected teachers' attitudes about students with mental wellness issues and struggles, and did indicate an overall level of positivity. One such indicator being that the majority of teachers in the study have referred a student to mental health services. Yet more is needed in regard to this finding since the data did not reveal causation or referral reasons.

Largely, teacher responses indicated a significant perception and belief about a duty to help aid or tend to the psychosocial wellness and wellbeing of every student. Respondents identified a willingness to participate actively in mental health related student matters. And, a majority of the teachers indicated a level of confidence in the area of identification of risk and need. Conversely, a similar majority reported that they were under-trained or under-educated about student emotional hygiene. Moreover, the responses strongly indicated a lack of supervisory support as a factor in their efficacy.

Though the findings speak affirmatively to the core assumptions that drove the research in this study, the amount of data are not sufficient for drawing definitive conclusions about school response systems. The claims and perceptions must be investigated further, including follow-up questions and interviews. Larger studies are necessary in order to definitively account for the underlying claim: schools fail to effectively respond to the mental health needs of all students.

The data do point to areas for impending research and designs for action, and those areas include enhanced or increased teacher training, specifically in the area of psychosocial wellness; what a school system can do to embed a more whole system of care of behavioral health that effectively serves all students, rather than only the at risk or diagnosed; and the potential negative impact of lending disproportionate weight to tests scores and traditional curriculum instruction rather than a positive education that embodies every possible facet for holistic education and the growing of well students who will development into emotionally intelligent and contributing members of society.

Lastly, and most notably, the results of the two-school sample utilized for this preliminary first phase study of systemic response to the psychosocial wellbeing of middle school students, revealed a discrepancy between teacher perceptions in School A and School B. The teacher responses make evident and clear that even among two similarly a very similar group of professional middle school teachers as drastically different reports situated institutions, in neighboring communities, with profoundly similar mandate and mission, the response systems, or lack thereof.

Summary Discussion

With the exception of the responses displayed in Figure 4.5 to the prompt: Middle school students in my school have access to mental wellness and behavioral health support only if they have a diagnosis and educational entitlements, School A reported no responses in the strongly agree category to any other survey prompt. The responses in Figure 4.5 display the only time that teachers from School A indicated strong agreement. School B, on the other hand repeatedly indicated responses that strongly agreed with the prompts throughout the survey. One could argue that this factor might infer that School B teachers are indicating that some sort of response system already exists in their school, while School A teacher responses might indicate a need for a system.

This is important for many reasons: both schools are parochial schools within the Diocese of Pittsburgh with shared or like missions and value statements. What's more their demographics are similar across the categories of socioeconomics of the communities to the geographical locales and the student and teacher census. These facts alone beg the obvious question: Why would two such similarly situated schools vary so greatly in their accounting of the supports for student mental wellness? Why the gaps and differences in teacher responses?

Figure 4.8 also displays a split decision of agreement and disagreement in regard to the matter of *all students* having access. This finding also points to important considerations. First, the prompt was designed to not only discover open access to the system, if a system does in fact exist, but also, and as importantly, if an existing system is known and accessible, is it known and available to students even if they have not been previously 'identified' or otherwise labeled as entitled (IEP, 504, etc.). The responses to this prompt beg multiple follow up questions in order to deconstruct nuances that would inform the above distinctions.

Figures 4.19 and 4.20 as well as Figures 4.37 and 4.38, address teacher willingness to engage in or participate in meetings and other activities to support and or initiate services or support for their students. Specifically Figures 4.37 and 4.38 focus on teacher perceptions as to their beliefs about whether or not psychosocial wellbeing and MH support are in fact part of their responsibilities. Teachers indicated strong agreement to participating in meetings, which implies that teachers are involved in service planning or referral but the responses are troubling since there is very low agreement around actual delivery of services. Responses from School A seem to indicate that the teachers in that school believe that it is in fact a part of their job to support the mental health and wellness of the students in their classroom. In other survey promptss, however, that also address willingness and engagement by teachers, there is great variance and little congruence across both schools.

Figure 4.24 displays responses that indicate minimal agreement that teachers perceive that they receive adequate ongoing training and supervision to increase their skill set for identifying and supporting student wellness. Additionally, the responses to this prompt also highlights *that not one teacher from either school* indicated a strong agreement. In fact, the higher rating and the most frequent responses in both schools is that the teachers disagree about receiving adequate supervision and training to respond well to the psychosocial needs of middle school students. This set of responses could indicate that although a willingness to help exists on the teachers' part, teachers lack the confidence and self-efficacy to put that willingness into practice. In other words, these teachers report that they have the will but lack the skill necessary to best serve their students.

Figure 4.26 displays evidence that every teacher who chose to respond to the illustrated prompt study believes it to be their duty to support students beyond academics and curriculum

instruction. The teachers unanimously support the idea of responding and intervening with the

psychosocial wellness of their students.

In both schools, as illustrated in Figure 4.43 of the group analysis, teachers respond

affirmatively and by majority that they have responsibilities for student mental wellness and

social well-being. There are also congruent data across both schools that show that although

teachers perceive MH support to be part of their job duties there is a gap in training and

supervision to support teachers in ongoing education for such matters.

<div align="center">**Limitations**</div>

There were several limitations to this study, including limited survey category choices,

sample size, length of study, and assumed concerns over confidentiality.

The survey permitted respondents to skip a response without indicating why. And since

the responses were anonymous there was no way to indicate which teacher skipped which

category. Additionally, the survey did not provide a choice of response that would allow

respondents to indicate applicability or non-applicabity to specific prompts. Therefore, it is not

clear why some respondents skipped certain prompts. And, respondents were not provided a

way of making additional or explanatory comments that might have provided important context

for their response choices or lack of choices.

When you couple the random and unreliable nature of the responses (not all teachers

responded to every prompt and the data were not cleaned for this factor, with the small sample

size of 21 participants, several problems arise in interpreting the data. The problem with small

sample size is always a problem of statistical precision or reliability but in this case that

statistical precision is compounded by an unreliable data set resulting in very low statistical

power even with simple frequency counts (Button, et al., 2013). Although, reliability may not

always depend directly upon the measurement unit, the population value, or the shape of the population distribution, it always depends upon the sample size and the fidelity of the sample to indicate total responses per respondent (Cohen, 1988). Thus, the relationship between precision and sample size is direct too. Although this study did not use statistical analysis beyond frequency counts, it still bears noting that as sample size increases and the reliability of the responses increases due to a cleansed data set, the results increase in precision or reliability (Brown, 2007). Conversely, as sample size decreases, the results decrease in precision even with the most precise data set.

The other adverse effect of small sample size is the low positive predictive value (Button, et al., 2013). This study, however, is not particularly interested in the predictive value of the data apart from better understanding of teachers' perceptions in these two private schools.

Another limitation of the study involves the anonymity of the respondents. Privacy is an inherent and instrumental aspect of research ethics (Drew, Hardman, & Hosp, 2008; Scott, 2005). Anonymity is an important aspect of privacy. In this study, respondents expressed negative criticism regarding accessibility of resources. Their assurances of anonymity might not have been enough to encourage the respondents to disclose all negative perceptions they had about the topic, therefore the respondents may have chosen to disclose only information that was perceived as politically correct enough or expressed only general negative impacts even though the respondents were assured their comments were anonymous. Fox and Schwarz (2002) noted that assurances for confidentiality from researchers might not be believable by certain respondents for a variety of reasons.

Perceived confidentiality of the information disclosed may also adversely influence the quality and quantity of data (Wolf, Zandecki & Lo, 2004). Despite adequate coding performed in

this study (Easter, Davis, & Henderson, 2004), such as the use of "School A" and "School B" to code the identity of responders, perceived confidentiality may be still ineffectively secured as far as the respondents were concerned. This respondent reaction cannot be fully controlled by the researcher in this study even though the researcher took precautions to protect the confidentiality of the information obtained from the respondents.

Because the study was limited to a period during a single academic semester, it did not produce suffient evidence that teacher perceptions as understood from these survey responses are universal or common. In fact, the overall nature of this study does not warrant generalization of the responses in any way.

Future Considerations

Next steps in furthering this design for action would do well to make comparisons of teacher responses based on teaching experience, as well as their overall personal perceptions of mental health and what they consider supportive. Additionally, a deeper investigation of the thematic analysis of teachers' written comments about improving the system for supporting student mental health would grow the data and be highly informing. Parents too, as well as other stakeholders could provide a fuller investigation as well. What follows are the next logical steps as informed by this study:

The first logical next step would be to expand the research. This preliminary study has yielded information regarding how to improve the survey promptss, produce a clean data set, and provide ways to teachers to expand their responses. There are many ways to expand the research in addition including using follow-up interviews, requiring principals to respond to the same survey prompts and asking responders to provide examples or explanations for their response

choices. And finally, the study should be expanded to include a larger number of schools and teachers within each school.

Second, the additional studies should be done that compare of Catholic school systems with public school systems. We need to learn if the responses in this survey are typical of Catholic schools or simply indicative of what is happening in a specific Catholic school. The same can be said of surveying only public schools to uncover any strengths or weaknesses that seem to be inherent to public schools because of budgets, mandates, and staffing policies.

A comparative analysis of elementary school teacher perceptions and high school teacher perceptions would also further inform our understanding and support our actions. Do elementary teachers, who spend more time with their students more often observe and report mental health issues? Conversely, do high school teachers who operate in a system where they spend one or less class periods each day with a group of students, report less mental health issues because of their lack of familiarity with the behavior patterns of their students. What's more, do the sheer numbers of students in a high school teacher's average case load prevent that teacher from noticing the nuances of behavior that might inform the need to report mental health issues?

Inclusion of additional stakeholders, including parents and other family members would be another important way to expand the research. If systems are in place, then we would assume that all school staff—administrators, teachers, aids, counselors, athletic coaches, custodians, cafeteria workers, bus drivers, etc.—and parents and community members see the school as a place that supports mental health and also provides a place to seek help should student mental health issues present themselves.

Future studies could survey school mental health professionals to compare and contrast their perception of the systems in place in their schools versus the perceptions of the teachers within that system. Would there be differences of access, knowledge and confidence based on the specific training and experiences of these mental health professionals?

Finally, future researchers should consider study designs that make use of follow-up interviews and additional survey categories. There is a great deal to be learned and the prompts in this survey only scratched the surface of those understandings.

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APPENDIX A: SURVEY INSTRUMENT

Teacher Mental Health Assessment Questionnaire
Teacher Survey

Please answer each item that follows based on your current practice and impressions related to your current school placement and position.

* 1. All students are able to access appropriate mental and behavioral health care support.

Strongly Agree.	Agree.	Disagree.	Strongly Disagree.
◯	◯	◯	◯

* 2. Teachers are able to access appropriate mental and behavioral health care support for students.

Strongly Agree.	Agree.	Disagree.	Strongly Disagree.
◯	◯	◯	◯

* 3. Middle school programs and curriculum are implemented to address needs and strengthen the psychosocial assets for students, families, schools, and communities.

Strongly Agree.	Agree.	Disagree.	Strongly Disagree.
◯	◯	◯	◯

* 4. There is a known, effective, and accessible response system in place in my school that addresses the ongoing mental wellness and behavioral health needs for every student.

Strongly Agree	Agree.	Disagree.	Strongly Disagree.
◯	◯	◯	◯

* 5. Middle school students in my school have access to mental wellness and behavioral health support only if they have a diagnosis and educational entitlements (IE: IEP, 504).

Strongly Agree.	Agree.	Disagree.	Strongly Disagree.
◯	◯	◯	◯

Teacher Survey

* 6. Please select the option that best reflects your opinion for each of the following statements.

	Strongly Agree.	Agree.	Disagree.	Strongly Disagree.

When indicated, you feel able to provide case management assistance to students and families to assist them in

obtaining enrollment to mental health services for which they are eligible.

     ○   ○   ○   ○

You are engaged in activities that may bring resources or support into the school mental health program(s).

     ○   ○   ○   ○

You have assisted with assessments on common risk and stress factors faced by the middle school students in

your classroom. (e.g., exposure to crime, violence, substance abuse).

     ○   ○   ○   ○

You feel confident in your professional abilities to identify common risk and stress factors faced by the

middle school students in your classroom

     ○   ○   ○   ○

You have participated in meetings with students, parents, and other school staff to ask them about their

behavioral & mental health needs and to ask them for their recommendations for actions by school staff.

     ○   ○   ○   ○

Services are in place, within your school, to help students contend with common risk and stress factors and to

support mental health and wellness.

     ○   ○   ○   ○

| Strongly Agree. | Agree. | Disagree. | Strongly Disagree. |

You receive ongoing training and supervision on effective identification and treatment protocols that promote

effective responses for clinical decision-aking for all middle school students.

    ○   ○   ○   ○

You believe it is your job to support the mental health and wellness of the students in your classroom.

○   ○   ○   ○

7. Please indicate the number of times within the last 90 days that you have referred a student to a

mental health professional within your school, your district, or to a community service provider. If you

have not referred a student to a mental health professional, please enter zero.

[   ]

* 8. Please select the option that best reflects your opinion for each of the following statements.

	Strongly Agree.	Agree.	Disagree.	Strongly Disagree.

There is ready access to mental health services for **all** (diagnosed or - undiagnosed identified or unidentified as having MH issues) middle school

students within your school.

	Strongly Agree.	Agree.	Disagree.	Strongly Disagree.
	○	○	○	○

Knowledge of resources and personnel who conduct screening and follow-up assessments to assist in the

identification and appropriate diagnosis of mental health problems for the middle school students in your

school.

		Agree.	Disagree.	Strongly Disagree.
	○	○	○	○
	.			

You continually assess whether ongoing services provided to students are appropriate and helping to address

presenting problems that you

identify in your classroom.

	○	○	○	○

You believe there is a clear and effective system in place to assist and support the ongoing mental health and

wellness of all students within your school and not just the emergency response system involving critical

incidents or crisis.

	○	○	○	○

Your school uses preventative, evidence based practices and programs to consistently intervene in child and

adolescent mental health

development and growth.

	○	○	○	○

You believe it is within your job duties as the/a teacher to identify, support and take action around student

mental health and wellness issues.

	○	○	○	○

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You believe that psychosocial
wellness is correlated to academic
achievement.

      ○   ○   ○   ○

You believe that your school needs to put a response system into place to address the ongoing mental health

and wellness needs for every student as a matter of ongoing support and education.

     ○   ○   ○   ○

RECRUITMENT FLYER
TEACHER PERCEPTION SURVEY
DUQUESNE UNIVERSITY, SUMMER 2015

Tracy Scanlon Limegrover, a graduate student at Duquesne University is conducting a research study to evaluate teacher knowledge, perception and opinion of mental health support systems within school(s) specifically related to middle school students (grades, 5th, 6th, 7th grades). You are being asked to complete this survey because you are a teacher with responsibility for students in those grades. Participation is voluntary. The survey will take approximately 20 minutes or less to complete.

This study involves no foreseeable serious risks. You are being asked to answer all questions; however, if there are any items that make you uncomfortable or that you would prefer to skip, please leave the answer blank. Your responses are anonymous.

If you have any questions or concerns, feel free to contact Tracy or her faculty advisor:

Tracy Scanlon Limegrover   **Dr. Rick McCown**

scanlont@duq.edu   **mccown@duq.edu**

If you have questions about your rights as a research participant, you may contact the Duquesne University Institutional Review Board (IRB), which is concerned with the protection of volunteers in research projects. Understand that should you have any further questions about participation in this study, you may call Dr. Rick McCown, the Advisor, and Dr. Linda Goodfellow, Chair of the Duquesne University Institutional Review Board 412-396-6326). If

you would prefer not to participate, please do not fill out a survey. If you consent to participate, please complete the survey.

DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Schools as mental health systems of care.

INVESTIGATOR: Tracy Scanlon Limegrover, NCC, LPC, CT

                                            scanlont@duq.edu

ADVISOR: (if applicable :)   Dr. Rick McCown

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the

                                            requirements for the (doctoral or masters) degree in

                                            Professional Leadership Education Doctorate at Duquesne

                                            University.

PURPOSE: You are being asked to participate in a research project that

                                            seeks to investigate your experiences, as a middle school

                                            teacher, with mental health systems/responses within your

                                            specific context. You will be asked to complete a brief

                                            electronic or hard copy survey of no more than 10

                                            questions. The survey process should require no more than

                                            15 to 30 minutes of your time. In addition, you will be

asked to allow me to interview you if the researcher finds it

pertinent and the interviews will be taped and transcribed.

Follow up interviews will be limited to 20 minutes.

These are the only requests that will be made of you.

RISKS AND BENEFITS: There are no risks greater than those encountered in

everyday life. Your participation stands to benefit students

and other teachers.

COMPENSATION: There is to be no compensation for participation.

Participation in the project will require no monetary cost to

you. An envelope is provided for return of your response

to the investigator.

CONFIDENTIALITY: Your name will never appear on any survey or research

instruments. No identity will be made in the data analysis.

All written materials and consent forms will be stored in a

locked file in the researcher's home. Your response(s) will

only appear in statistical data summaries. All materials will

be destroyed at the completion of the research.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study.

You are free to withdraw your consent to participate at any

time.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied

to you, at no cost, upon request.

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VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. Rick McCown, the Advisor, and Dr. Linda Goodfellow, Chair of the Duquesne University Institutional Review Board (412-396-6326).

_____   _____

Participant's Signature   Date

Tracy Scanlon Limegrover

_____   _____

Researcher's Signature   Date   April 28, 2015