ABSTRACT

An Examination of Educators' Perceptions of Their Students' Mental Health Needs and Barriers to Support Services: A Mixed Methods Study

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As national headlines inform us of increasing school violence, adolescent suicide, and other mental health issues, there is an obvious need to offer support to adolescents in their schools. This study was spurred by the researcher's practice as a mental health clinician and school counselor working in a variety of public and private schools over the past 20 years. Through her experiences, the researcher has experienced the frustration of trying to support students in the school setting when teachers frequently do not release students during academic time for this type of support. The dichotomy between teachers' referring students for support and the teacher's hesitation to release a student from class for support begs the questions of what teachers understand about mental health and the reasons behind their decisions for frequently not releasing students to receive support.

This explanatory sequential mixed methods study sought to understand what is the relationship between a teacher's attitude towards mental health services and a teacher's mental health literacy? Additionally, the researcher asked what influences a teacher's decision to release students from academic instruction to access mental health

services, and how do the results of the survey data (quantitative) and the interview data (qualitative) explain teacher decision-making regarding releasing students for mental health services during academic instruction. The researcher used thorough statistical analysis and careful thematic analysis to describe themes discovered from the qualitative interviews.

This study has implications that challenge pre-service education programs, school districts, local, state, and federal governments, and educators to come together to create systemic change to ensure children and adolescents are receiving the support they need. Specifically, this study highlights where future professional development is needed for educators. With an increased understanding of the impact of mental health on academic success, teachers, administrators, and other stakeholders, may see the importance of releasing students from academic class time to receive mental health support. This research links its findings to Bandura's social cognitive theory (1986) and makes suggestions for future research.

*Keywords: M*ental health, support services, professional development, academic success, adolescents, attitudes, literacy, release

An Examination of Educators' Perceptions of Their Students' Mental Health Needs and Barriers to Support Services: A Mixed Methods Study

by

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A Dissertation

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DEDICATION

To my husband: you have been my biggest cheerleader and voice of encouragement on the darkest nights. Thank you for your willingness to travel this journey with me, even though we have no idea where it is headed.

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CHAPTER ONE

Background and Needs Assessment

Introduction

The title of "teacher" is insignificant without a student to teach. Similarly, the title of "student" implies that there is a teacher who is offering instruction and guidance in the learner's education. This symbiotic relationship between teachers and students is often associated with traditional banking systems of education where teachers stand and lecture, filling students' minds with knowledge. Following Bloom's Taxonomy (Pearlman, 2020) students demonstrate mastery and academic success by progressing up Bloom's pyramid. While this style of teaching may assist a child in gaining acceptance into mainstream liberal arts colleges and universities, many educators are shifting their focus towards the whole child, recognizing there is more to life than just academics (Dintersmith, 2018; Pearlman, 2020).

Lancaster County, Pennsylvania is home to 67,968 students in K–12 (National Center for Education Statistics, 2019). Based on national data, an estimated one in five of these students struggles with some type of mental health issue (Center for Disease Control and Prevention, 2020), equating to 13,593 students who could need school counseling support or intervention from an external mental health agency. Most schools in the county have Student Assistance Programs (SAP) in place to help identify students who require more intensive and specific mental health and drug and alcohol support. The county offers a contracted, master's level clinician to work with the public schools to conduct Drug and Alcohol, and Mental Health assessments for students in K–12. In the

2018–19 school year, SAP Consultants conducted 1,180 of these assessments for students in grades five through 12 (Kastner, 2019), meaning there were potentially 12,413 students not assessed or referred for outside support services. These 12,413 potentially unidentified and underserved students in Lancaster County, Pennsylvania is a small sample of potentially unidentified and underserved students living in the United States of America.

To close the gap between identified and unidentified students and to minimize long-lasting negative impacts on our nation, schools must implement mental health initiatives within their buildings. To implement these initiatives, educators and mental health professionals must work together to provide students time during the school day to access these mental health services. This study explored educators' attitudes and perceptions towards mental health and what impact if any, these mindsets have on an educator's decision to release a student from academic instruction to receive support services.

Statement of the Problem

School counselors have limited time and attention to focus on the academic, social, and mental health needs of every student in their school. The American School Counselor Association (ASCA) recommends a ratio of 250 students per school counselor with the expectation that a school counselor provides direct services to each of those students at some point throughout the school year (American School Counselor Association, 2020). However, a recent survey completed in a study by ASCA demonstrated that national averages of students to school counselor ratios are well above this recommendation demonstrating a student-to-counselor average of 430:1 (American

School Counselor Association, 2020). The survey shows Arizona has the highest ratio, 905:1 and the Bureau of Indian Education has the lowest ratio, 153:1. Pennsylvania's ratio lands between these two extremes with a ratio of 369 students for every school counselor (American School Counselor Association, 2020). ASCA intends these ratio recommendations for general support for the entire student body.

Approximately 10% of all U.S. students present with symptoms of, or are diagnosed with, a mental health disorder that requires additional support from the school counselor and/or more intensive mental health services from contracted school-based mental health professionals (Centers for Disease Control and Prevention, 2013). Using the aggregated data from ASCA's survey (2020), Pennsylvania counselors average 37 students on their caseload with presenting mental health issues. These students require more frequent contact and intervention with the school counselor compared to their peers. When factoring in the limitations of a seven-hour school day and other responsibilities that fall on the school counselor, the window of opportunity to meet with students is very narrow.

According to information found in the 2019 Pennsylvania Youth Survey, put out by the Pennsylvania Commission on Crime and Delinquency (2019), less than 50% of students needing mental health services have access to any support. The barriers to support service vary from low referrals, limited support staff, limited time, and resistance from educators to releasing students from academic class time. This last barrier is where the focus of this research lies.

This conception of this study came from my practice as a mental health clinician and school counselor working in a variety of public and private schools over the past 20

years. Through my work experiences, I have experienced the frustration of trying to support students in the school setting when teachers frequently do not release students during the academic time for this type of support. While national headlines and local data (Blad & Decker, 2020; Center for Disease Control and Prevention, 2020; Holland et al., 2019; Lancaster, 2019; Mercado et al., 2017) demonstrate a need for more mental health services, some educators still hesitate to release students from class to receive mental health support. So, what are educators' attitudes towards mental health, and what are the reasons behind their decisions for frequently not releasing students to receive support? This study explores both questions to improve students' access to mental health support.

Literature Review

While children's and adolescents' mental health needs increase, researchers are focusing their studies not only on the factors contributing to their mental health needs (Blad & Decker, 2020; Holland et al., 2019; Mercado et al., 2017) but also on how to best support students. Returning to the symbiotic relationship between teachers and students discussed earlier, Reinke et al. (2011) conducted a study on teachers' perceptions of children's mental health issues. The study revealed that 89% of the teachers in the study stated that schools should be involved in the mental health support that students receive. However, Ekornes (2017) found that students' access to services offered within the school competes with academic instruction. The following literature review argues that our nation's youth are experiencing high levels of mental health issues and that schools are the ideal setting to offer support for these issues. This present study further argues that though teachers may vocalize support for mental health interventions in

school, they are lacking in training to help understand the full implications of mental health issues on students' academic achievement.

The literature review that follows demonstrates that an educator's attitudes and perceptions about mental health influence their behaviors which could impact their decision to release a student from academic instruction to receive services. The subsequent line of reasoning unfolds in four main steps. First, the study provides an overview of mental health and some of the issues that are specific to children and adolescents. Second, the reader will gain an understanding of what is the responsibility of schools when it comes to supporting a students' mental health needs. Third, the reader will see an overview of the key support figures that are available to students within the school and the role each plays in assisting the student to access mental health support. Finally, the reader will get a close look at the important role of the educator and see how their daily proximity with their students is ideal for observing and referring a student for mental health support and will also understand the educator's crucial function in a student being able to access mental health support.

Mental Health

Like physical health, mental health is a spectrum that ranges from mental wellness to mental illness. "Mental disorders," "mental problems," "mental conditions," and "mental issues," are terms researchers, clinicians, and the general population, often use interchangeably (National Alliance on Mental Illness, 2020); however, depending on the study or report the different terms may signify specific diagnostic groups. Merriam-Webster (Merriam-Webster, n.d.) defines mental health as "health care dealing with the promotion and improvement of mental health and the treatment of mental illness" and the

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the diagnostic tool utilized by mental health clinicians across the United States(American Psychiatric Association, 2013). The DSM-5 is highly revered to be the most valid and reliable source for psychiatric diagnoses and provides a common language that clinicians, medical professionals, and researchers can use to communicate between fields (Winerman, 2013). Despite the National Institute of Mental Health (NIMH) declaring it no longer utilizes the DSM-5 for research purposes, focusing instead on neuroscience-based sources, this does not impact the DSM-5's standing with clinicians who depend on the criteria outlined to make diagnoses nor the support the DSM-5 receives from NIMH as a suitable diagnostic tool (Winerman, 2013). At present, the DSM-5 contains 20 diagnostic categories with variant diagnoses falling under each (Regier et al., 2013).

Just as the cause of mental health issues and disorders is widespread from life events to chemical imbalances, so is the impact of different mental health issues and disorders among individuals. In the case of trauma, for example, two individuals can go through the same traumatic event, such as an explosion or shooting, but one may experience minimal symptoms of stress and or anxiety while the second individual may meet the criteria for a diagnosis of Post-Traumatic Stress Disorder (PTSD). The outcome, diagnosis, and type of treatment, if any, that an individual need is determined by the level of impact and interference with daily functioning.

An estimated 47.6 million adults aged 18 or older in the United States struggle with some form of mental health challenge (Substance Abuse and Mental Health Services Administration, 2019) though findings from the 2018 National Survey on Drug Use and Health (further referred to as the NSDUH) indicate that 11.2 million of these adults, or

44.4 %, did not receive any form of mental health service (Substance Abuse and Mental Health Services Administration, 2019). The report of lack of services is an increase from the data collected over the ten years before 2018. The NSDUH data cites reasons individuals did not receive services varied from lack of knowledge of services to access to services, though lack of insurance and finances were major factors reported. Understanding adults struggle with access to care for mental health treatment, the next sections explore mental health issues as they directly impact children and adolescents.

Child and Adolescent Mental Health Issues

Children are not exempt from mental health issues. According to data aggregated from the 2018–2019 National Survey of Children's Health (The Child & Adolescent Health Measurement Initiative, 2019), 16.5% or 7.7 million children aged 0–17 have at least one mental health disorder and 46.8 % of those did not receive any type of services. Of those adolescents, aged 12 to 17, who did receive services, 14.2 % (3.4 million adolescents) received services in an education setting (Substance Abuse and Mental Health Services Administration, 2019). Figure 1.1 shows the sources of mental health treatment in the past year for adolescents between the ages of 12 to 24. My research focused on these mentioned school-based services, along with the large percentage of children and adolescents who are falling through the gap by not receiving any services.

Untreated mental health issues have led to a crisis of sorts for the United States. In a study done by (Twenge et al., 2019), mood disorders and suicide-related outcomes for adolescents aged 12 to 17 increased by 52% over a twelve-year range from 2005–2017. An interesting observation from the study inferred that this increase in mood disorders among younger survey participants correlated with the emergence of the internet and

smartphones. Twenge et al. (2019) went on to report that adolescents' increase in the use of the internet and smartphones has a direct correlation with a decrease in social contact as well as a decrease in sleep. both of which are factors that can contribute to mood disturbances such as depression.

Source	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19
Specialty Mental Health Setting	11.8+	12.4+	13.4+	13.4+	13.0+	12.4+	12.7+	12.0+	12.1+	12.6+	12.7+	13.6+	13.7+	13.3+	14.7+	14.8+	16.0	16.7
Education Setting	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12.1+	12.4+	11.9+	12.9+	13.0+	13.2+	13.2+	13.1+	13.3+	14.2+	15.4
General Medical Setting	2.7+	2.9+	3.4	3.2	2.8+	2.8+	2.9+	2.5+	2.5+	2.5+	2.5+	2.8+	2.9+	2.7+	2.9+	3.3	3.1+	3.7
Child Welfare Setting	0.6+	0.7+	0.6+	0.6	0.5	0.5	0.5	0.4	0.4	0.6	0.4	0.4	0.4	0.3	0.4	0.4	0.4	0.4
Juvenile Justice Setting	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.4+	0.3+	0.4+	0.3+	0.2	0.3	0.2	0.2	0.2	0.2	0.2

N/A = not available.

+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

Figure 1.1. Sources of mental health services among youths aged 12 to 17: 2002-2019.

Note*:* Reprinted with permission from the National Survey on Drug Use and Health by the Substance Abuse and Mental Health Services Administration, 2019, p. 57.

As mental health issues rise among children and adolescents, schools cannot avoid the negative impacts associated with untreated mental health concerns as students spend most of their waking hours in the school setting (Elias et al., 1997; Erasmus, 2019; Gur et al., 2012; Langley et al., 2010; Payton et al., 2000). The severity of impact that schools face varies depending on many factors, including school climate, student demographics, and what resources are available to students for support (Elias et al., 1997; Zimmerman et al., 2013). Much of the school violence that is reported is often caused by and impacts a students' mental health.

Headlines in newspapers and media programs abound with stories of violence in our nation's schools. In 2020, there were ten school shootings in the United States (Blad & Decker, 2020). This number is relatively low when compared to the 49 shootings that occurred between the years 2018 and 2019 collectively (Blad & Decker, 2020). The drastic decrease is something worthy to celebrate though it is worth considering that one plausible reason for the decrease in school shootings is the global pandemic of COVID-19 that forced schools across the United States to shut down and operate virtually between March 16, 2020, to the fall of 2021. Consequently, the ten reported shootings are a high number of incidents when considering this fact.

Another pandemic of sorts plaguing our nations' schools is bullying. According to the National Center for Educational Statistics, 20% of students between the ages of 12 and 18 report being bullied (Seldin & Yanez, 2019). Bullying occurs when there is an imbalance in power and the repeated behaviors are not consensual between the parties involved. Bullying can be physical, verbal and social, or emotional and can have lasting effects on all involved (McGrath & Noble, 2010; U.S. Department of Health and Human Services, 2020). Individuals who have experienced bullying witnessed bullying, and those who have bullied others are more prone to health issues, a decline in academic performance and attendance, and an increase in mental health concerns like anxiety and depression (McGrath & Noble, 2010; U.S. Department of Health and Human Services, 2020). These behaviors are often associated with feelings of isolation and lack of connection which can turn some individuals towards aggressive behaviors and harm to others, like fighting, while others turn those feelings towards acts of self-harm.

Though the idea of school shootings and bullying is enough to draw concern for our students, self-inflicted harm among adolescents is another phenomenon that cannot go unnoticed. According to a study put out by the Journal of the American Medical Association, 43,138 adolescents received treatment for self-inflicted injuries between 2001 and 2015 (Mercado et al., 2017). Non-suicidal self-injury (NSSI) is defined as "the direct, deliberate destruction of one's own body tissue in the absence of suicidal intent" (Nock & Favazza, 2009, p. 9). The severity of the harm inflicted upon an individual varies but is often used as a coping skill to manage other mental health issues such as anxiety, depression, body dysmorphia, and others (Lewis & Heath, 2013; Nock & Favazza, 2009). NSSI, though sometimes connected to the risk of suicide, is a separate and distinct behavior and mindset when compared to someone who struggles with suicidal ideations. Where suicidal ideations demonstrate a desire to end one's life, NSSI is not associated with any intention of dying. NSSI does not discriminate between genders and is often maintained a secret by the individual. However, if an individual presents with NSSI behaviors, a suicide assessment is warranted (Lewis & Heath, 2013).

The Center for Disease and Control (Center for Disease & Control and Prevention, 2018) listed suicide as the second leading cause of death for adolescents, resulting in over 4,000 lives lost each year. Nationally this number equates to the loss of a small town and can seem difficult to grasp. While untreated and undiagnosed mental health issues are factors, (Dintersmith, 2018) argues that some students' mental health issues (i.e. anxiety, depression, and self-esteem issues) stem from the fact that many schools focus on academic success and begin pushing students toward college as early as kindergarten with no room built in to pause and ask for what are schools preparing kids.

Dintersmith speaks to the dangers of academic pressure in his account of a community that noticed spikes in student suicides when schools released test scores and acceptance letters (2018).

Lancaster County, Pennsylvania is not exempt from these sad statistics as they reported 40 suicides between January and August 2020. This statistic is higher than in 2019, which had only 36 deaths by suicide between January and August of 2019 and 52 suicides for the entire year (Lancaster, 2019) and I responded to three deaths of students who completed suicide between November 2018 to May 2019. These are three deaths too many.

Mental Health Impact on Students' Lives and Academics

Mental stressors and mental disorders impact a child's or adolescent's ability to function in daily activities, though the level of impact is determined by the severity and type of mental health issue and the support systems students have in place. Earlier in this literature review, I described mental health as existing on a spectrum ranging from mental illness to mental wellness. Similarly, mental health disorders also fall on a spectrum. Anxiety, for example, can present as mere symptoms of nervousness such as the feeling of butterflies in the stomach or sweaty palms or as an anxiety disorder that may include severe and debilitating panic attacks among other symptoms. The anxious child may have difficulty separating from a parent or may worry excessively about a test, whereas the child with an anxiety disorder may not feel comfortable participating in social activities or may not feel safe in situations outside of their comfort zone. Some symptoms associated with anxiety disorder mimic medical issues, such as migraines, stomach aches

and nausea, heart palpitations, and others. These symptoms, just like those from other mental health issues and disorders, can permeate into all aspects of a child's life.

A child or teen struggling with mental health issues may not find respite during the hours of the school day. Mental health issues, including family stressors that can cause mental duress, coupled with the pressure to perform in the school setting can exacerbate pre-existing conditions or create heightened levels of stress that may present like anxiety, depression, or behavior issues. A child's social and emotional needs, if left addressed, can have serious implications for their academic success (Elias et al., 1997; Gur et al., 2012; Loades & Mastroyannopoulou, 2010; Maslow, 1943; Rothi & Leavey, 2006) including low to failing grades, gaps in knowledge and disciplinary issues. Repie (2005) goes a step further and asserts that children who do not receive much-needed mental health support are at risk of having ongoing issues throughout adulthood that can impact their way of life and future generations.

The theory of the Hierarchy of Needs (Maslow, 1943) supports the argument that a student's mental health is correlated with academic struggles, behavior concerns, and social conflict and barriers (Elias et al., 1997; Gur et al., 2012; Loades & Mastroyannopoulou, 2010; Maslow, 1943; Rothi & Leavey, 2006). Maslow (1943) believed that there are five basic goals or needs, that each human possesses: (a) physiological, (b) safety, (c) love, (d) esteem, and (e) self-actualization (p. 394). Maslow (1943) believed these needs, or components, to be interdependent upon one another, as such someone cannot attend to safety needs if basic physiological needs are not first. Applying Maslow's (1943) theory to my career's work, students are unable to attend to higher-order skills required for learning, such as critical thinking, problem-solving, and

mathematical calculations, without their lower-order, or basic needs, being satisfied. If support services and other interventions can meet some of these basic needs, then the student can engage more of themselves in the learning process. This concept resonates with Lerner's theory of developmental contextualism (2002) which focuses on the reciprocal relationship that exists between an individual and all other organisms and events in his or her life. Lerner argues that development and change do not occur independently, but in synchronous with other systems, so if one-part changes, then it is within reason those other systems also show improvement (2002). Connecting to Maslow, if the student's mental health receives support and shows improvement, then it is with good cause that the student's academics also improve (Baskin et al., 2010; Lerner, 2002; Maslow, 1943).

Many researchers support the movement away from the traditional banking system of teaching and instead encourage educators to engage the student in taking ownership of their learning while strengthening collaborative, creative, and critical thinking skills (Blythe, 1998; National Academies of Sciences, Engineering, and Medicine, 2018; Perkins, 2014). Implementation of these practices requires a shift in mindset where the focus moves from performance and instead emphasizes the process. In his book, *What Schools Could Be*, Dintersmith (2018) takes a serious look at the impact of students' mental health and well-being on academic performance. The literature review asserts that schools should focus more on developing human potential rather than ranking it which may require changing the structure of schools and how they operate (Dintersmith, 2018; Blythe, 1998; Perkins, 2014). By keeping the focus of education on performance, not only are schools doing a disservice to our student's level of

understanding, but schools are also creating environments that are potentially detrimental to a student's mental health.

Response to Students' Mental Health

The previous sections have demonstrated that our nations' youth are struggling with mental health issues. Recognizing students' struggles, agencies and schools have developed programs to support students' mental health. The following sections highlight the different systems and individuals available for supporting a student's social, emotional, and overall mental health needs. Specifically, families, community agencies, and schools.

Families. Parents and guardians may seem the best suited to get their child the mental health help that is needed. However, many barriers impede a parent's ability to help their child. First, most parents lack training in nor do they have experience with mental health issues and may not be able to decipher between typical developmental stages versus a mental health concern. A second barrier parents may face is access to care. When dependent upon insurance providers dictating where you can receive treatment, some families may not have transportation to get to the mental health agency. Also, financial barriers often emerge as not all providers panel with all insurance carriers which leaves families with large co-pays, high out-of-pocket costs, or no treatment due to costs. Another barrier parents encounter is the lack of tools needed to navigate the mental health system. As so many providers have specialty niches, a parent may struggle to know whom to call. Because of this uncertainty, parents often turn to their child's medical provider and/or school.

Community agencies. In the early 1980s, the U.S. Government started to put into place many national and state-wide initiatives that were geared to support children and adolescents' mental health. Two of these initiatives were the Child and Adolescent Service System Program (CASSP), which was rolled out by the National Institute of Mental Health (NIMH), and the State Comprehensive Mental Health Services Plan Act, amended by the U.S. Congress. The government designed both of these programs to create systems to support children, and their families, who were struggling with mental and emotional health issues (Ghuman et al., 2013). CASSP emphasized the importance of services being community-based and provided ten guidelines for communities to consider when developing programming. These ten guidelines stipulated that children and adolescents with mental health and emotional disturbances should:

1. Have access to a comprehensive array of services addressing their physical, educational, psychological, and social needs.
2. Receive individualized services congruent with their unique needs and strengths.
3. Be served in the least restrictive and most normative clinically appropriate environment.
4. Receive services that are family-centered; that is, involving the family in all aspects of their planning and delivery, with families treated as *collaborators, not recipients* of care.
5. Receive services that are linked and integrated with other child-serving agencies and programs.
6. Be provided with case management to ensure that multiple services are delivered in a coordinated and therapeutic manner and to enable easy movement through the system of services depending upon their changing needs.
7. Have their problems identified and responded to as early as possible to increase the likelihood of positive outcomes.

8. Be ensured a smooth transition to the adult service system (if indicated) as they mature.
9. Have their rights protected and have access to effective advocacy programs.
10. Receive culturally competent services, provided without regard to race, religion, physical disability, or other characteristics. (Ghuman et al., 2013, p. 3).

However, these guidelines only offered assurance that adolescents with severe mental health issues could have access to care, still leaving those dealing with other mental health issues searching for care or flooding emergency rooms and doctor offices with concerns (Ghuman et al., 2013).

Another challenge with community-based facilities is the difficulty some families have in accessing the sites. The time that appointments are available may interfere with the child's parents' workday or transportation is sometimes a barrier in and of itself (Ghuman et al., 2013). In the 1990s, school-based mental health services began to expand. Ghuman et al., (2013) explain that "this proximity virtually eliminates transportation problems that are frequently issues for poor families trying to get to clinics in traditional outpatient settings" (p. 44). This expansion of community health into school settings broadened the scope of collaboration between community organizations and schools and strengthened the idea of supporting the whole child.

Schools. Families often turn to schools for assistance with their child when considering how much of a child's life is spent at school. If calculations have the average school day in the United States as seven hours (8:00 am–3:00 pm) and sleeping hours are removed, a student may spend 50% of their waking hours in school during the school year (National Center for Education Statistics, 2019). Another way to think about it is that throughout their twelve-year academic career, the average student spends 26% of

their entire waking life in school. This reality makes schools the most ideal place to support students (Dintersmith, 2018; Elias et al., 1997; Erasmus, 2019; Gur et al., 2012; Langley et al., 2010; Payton et al., 2000; Rothi & Leavey, 2006).

Blythe (1998), Perkins (2014), and other scholars (Dintersmith, 2018; Elias et al., 1997; Erasmus, 2019; Payton et al., 2000) speak to the important role educators have in creating safe environments for students while taking into account the impact that social, emotional and cultural factors have on a students' learning (National Academies of Sciences, Engineering, and Medicine, 2018). Educators' are not mental health experts and may feel inadequate around mental health issues, though researchers argue that educators are the ideal people to catch early warning signs in their students (Armstrong et al., 2015; Dix et al., 2012; Elias et al., 1997; Erasmus, 2019; Gur et al., 2012).

Schools encounter constraints within the conventional school setting, which can make incorporating mental health support services into the schedule challenging. Erasmus (2019) proposed five key aspects schools can consider in developing a mental wellness plan:

1. The school's role in providing curriculum time and space for mental wellbeing and to develop a culture in promoting positive mental wellbeing.
2. The individual students' level of engagement and seeing relevance to take part.
3. The role of staff and their own mental wellbeing.
4. The role of parents in engaging in mental wellbeing conversation and promoting lifestyle choices that encourage positive mental wellbeing.
5. The extent to which the local community gets involved, and engaging the services of local external agencies. (Erasmus, 2019, p. 14).

The first aspect Erasmus listed is the focus of this research study as it explores the tension between acknowledging the need for mental health support and the action of permitting students to access support during academic time.

One approach that schools can take to address this tension and improve the mental health of students to create a safe atmosphere for students and staff is to tackle some of the stigmas that are often associated with mental health. Erasmus suggests this can be as simple as starting open discussions with students about mental health and supporting existing campaigns that suggest mental health is okay to talk about (2019). Campaigns addressing stigma may assist not only students' perceptions but also teachers' attitudes and perceptions toward mental health. In her dissertation, Breuer (2016) explored high school teachers' attitudes towards mental health and the impact those had on their decision to refer a student for services the school setting offered. Her findings indicated that a teacher's level of indifference towards stigma was significantly related to their response of whether to refer a student for services when given scenarios to assess. This research study also explores teachers' indifference to stigma around mental health to determine what, if any, impact that perception has on their decision to release a student from class to receive services.

When implementing new policies and programming that focus on addressing and meeting the mental health needs of students, schools should strive to ensure these programs and services are whole child-centered and offer invaluable social and emotional support. To support this task, it is important not to tack mental health initiatives onto a special education coordinator's task load as it is important to differentiate special education, behavior support, and mental health support separately (Erasmus, 2019). By

creating a role within the school that is dedicated primarily to students' mental health, schools accomplish several key points, specifically: staff members share the workload; a link between special education, behavior support, and mental health support is evident, but individuals can seek out services separately; and the school can minimize the stigma associated with mental health (M. A. Atkins, 2016; Breuer, 2016; Erasmus, 2019). The literature that I reviewed up to this point demonstrates that there is a need for mental health services within the school setting. The next several sections explore some of the roles of staff within the school, their attitudes towards mental health, and their abilities to provide support for students.

Inside the Schools: Staff Roles

Many different individuals within a school are apt to support students academically and emotionally. In the text that follows, I highlight and discuss three specific positions within schools: the building administrator; the school counselor; and the teacher. Recognizing there are other positions in the building that are able and willing to support students, I selected these three mentioned positions because of their proximity to all students and the ability to work with the student on both an academic and emotional level.

Building administrators. As leaders of the school, building administrators need to ensure the implementation of school policies, the school climate is positive, the staff is productive and effective, and all students have the means to obtain academic achievement (Frabutt & Speach, 2012)**.** Administrators also determine what type of programming a school offers to its students and which outside agencies and organizations can come into the building. Principals must demonstrate a positive attitude towards mental health

support services to ensure that adequate and effective mental health support and professional development occurs within the school. Recognizing the important role played by a building administrator, it is important to look at administrators' attitudes towards and understanding of child and adolescent mental health issues. Similarly, it is important to evaluate their attitudes towards and understanding of the school counselor and the role counselors assume within schools as these attitudes and perceptions may impact their decisions towards implementing policies and programming and permitting services in the building (Bandura, 1986; Breuer, 2016; Tosi & Eshbaugh, 1976; Webb et al., 2010).

Graham et al. (2013) explored principals' understanding and perceptions of the school counselor's role against the backdrop of the ASCA model. Their findings demonstrated that principals who had training regarding the ASCA model had a more favorable perception of the role of the school counselor. Graham et al.'s study (2013) demonstrated the importance of ensuring that administrators, and school staff, have a clear understanding of the counselor's role and their ability to support students' social and emotional needs as a part of their overall academic achievement.

Another study measured principals' perspectives not only toward the school counselor but towards mental health and wellness, as a whole (Frabutt & Speach, 2012). Frabutt and Speach looked specifically at private, Catholic, elementary schools as their research demonstrated a gap with this population. Their findings showed that while these principals had an overall positive attitude toward mental health workers and the principals recognized a need for more mental health support, some barriers interfered with being able to support a student's mental health and wellness. The top three barriers

identified were: (1) no staff member available to coordinate services; (2) budget restraints prevent hiring a professional who can support mental health services; and (3) balancing efforts done at school with chaos or strife that may be occurring within the students' home (Frabutt & Speach, 2012). This study is encouraging as it offers the perspective that school staff desire mental health services for students and a larger international study (Rowling et al., 2009) with similar findings supports its results. However, it begs the question of why when some schools do not have these three barriers in place there is still resistance from some educators when mental health services pull students from academic time to receive support. The qualitative portion of my study asks educators to explore the dichotomy between recognizing a need for mental health support and resisting or hesitating to release students from academic time to receive mental health support.

School counselor. The role of the school counselor has evolved since its inception in the late 1800s (American School Counselor Association, 2012; Gysbers, 2012; Lambie & Williamson, 2004). The position was originally that of a vocational counselor, assisting students with career choices as they transitioned from high school into the workforce. Educators and administrators assumed this position and added this focus to their existing roles. In the 1920s, the role shifted into incorporating more psychometrics and placed a focus on childhood development. This shift was largely thanks to the work of John Dewey's cognitive developmental movement which pushed schools to teach the whole child (Gysbers, 2012; Lambie & Williamson, 2004). With each decade, the depth and breadth of the school counselor's role expanded, evolving into the elusive role of a guidance counselor. It was not until the late 1990s and early 2000s that the guidance counselor metamorphosized into who is now referred to as a school

counselor (American School Counselor Association, 2005; Lambie & Williamson, 2004; Zyromski et al., 2018). Where guidance counselors up through the early 1900s were classroom teachers with added duties we now have school counselors who "are state credentialed; are specialists in child and adolescent development; and are trained in learning styles, classroom behavior management, curricula, and instruction, student assessment, and achievement and/or have teaching experience"(American School Counselor Association, 2005, p. 90). The role of the school counselor continues to evolve as hybrid models of education have pushed school counseling programs to be responsive to the ever-present and ever-evolving digital platforms and different technology that is used by today's students (Goodrich et al., 2020). However, what remains to be true is that the "ultimate goal of a school counseling program is to support the school's academic mission" (American School Counselor Association, 2005, p. 52) and that the counselor is there to close achievement gaps by addressing barriers that may exist in the students' life.

Educators. From an outside vantage point, teachers, or educators, are in a prime position to support students' mental health based on the nature of their relationship with the student (Armstrong et al., 2015; Dix et al., 2012; Elias et al., 1997; Erasmus, 2019; Gur et al., 2012). Educators believe they are key components in supporting students' mental health, though report they often lack the time and skills required to provide adequate support (Mazzer & Rickwood, 2015). If this is the mindset of educators, then it could be argued that educators would feel a sense of relief if a trained, mental health professional was available in their school building and willing to work with the student.

The next few sections look at teachers' relationships with students' social, emotional, and overall mental health as well as their connection to this current study.

Educators Identifying Needs in Students

Though educators may be able to observe changes in students' behaviors and mood, this advantage only goes as far as their ability to identify when and if those changes signify a concern that needs a referral for intervention and support (Armstrong et al., 2015). Here a distinction should be made between "identifying" a mental health concern and "diagnosing" a mental health disorder. In the United States, teachers are not expected, nor are they allowed, to diagnose a student with any type of condition or disability, including and especially mental health disorders. A diagnosis of any condition needs to come from a trained and, in most cases, licensed professional in that field. Identification of a concerning behavior or issue is more related to the teacher's direct observation of that student and the knowledge of whether further intervention is necessary.

Recognizing the need for early mental health disorder identification in schools, researchers have looked at what is being taught in pre-service education programs (Armstrong et al., 2015; M.-A. Atkins & Rodger, 2016; Bryer & Signorini, 2011; Graham et al., 2013; Liang & Gao, 2016) especially as educators continue to report that they feel unqualified and ill-equipped to accurately recognize or handle mental health issues. Ely (2017) looked specifically at this correlation between a teachers' understanding of mental health issues and the teachers' readiness and ability to identify concerns and intervene if need be. Ely's results supported the need for more pre-service education in addition to specific professional development for existing teachers.

The pre-service education and training that educators could receive relates to the teachers' literacy on mental health—another widely researched concept (Armstrong et al., 2019; Atkins, 2016; Atkins & Rodger, 2016; Ely, 2017; Fortier et al., 2017; Jorm et al., 2006; Kutcher et al., 2013; O'Connor et al., 2014). Jorm et al. first coined the term "mental health literacy" in 1997 using the definition of "knowledge and beliefs about mental disorders which aid their recognition, management, and prevention" (Jorm et al., 1997, p. 182). In their years of research on this topic, Jorm et al. (2006) discovered that improved mental health literacy (MHL) has an impact on behaviors. This notion of MHL is especially relevant to this current study as I believe that teachers' understanding of mental health shapes their attitudes and perceptions of mental health. These altered attitudes and perceptions, in turn, impacts their decision to release a student from academic instruction for receipt of mental health support. The next section further explores educators' attitudes towards mental health.

Educators' Attitudes Towards Mental Health

Attitudes are very powerful attributes and shape our mindsets which influence our behaviors. Many scholars have studied attitudes as they relate to mental health (Atkins, 2016; Atkins & Rodger, 2016; Breuer, 2016; Fischer & Turner, 1970; Gur et al., 2012; Hammer et al., 2018; Hyland et al., 2014.; Mackenzie et al., 2004; Mazzer & Rickwood, 2015; Munson et al., 2009; Phillippo & Blosser, 2017; Raposa, 2019; Reinke et al., 2011; Soares et al., 2014). Researchers, Fischer and Turner (Fischer & Turner, 1970) developed an inventory, later revised by Mackenzie et al. (2004) to measure individuals' attitudes towards seeking mental health treatment. The scale not only measured an individual's attitude or willingness towards seeking mental health but also their attitudes towards and

perceptions of mental health professionals. Breuer (2016) used Makenzie et al.'s (2004) revised version of the IASHMHS in her research on high school teachers' attitudes towards mental health. Breuer (2016) believed like attitudes impact an individual's decision to seek help (Fischer & Turner, 1970; Mackenzie et al., 2004), teachers' attitudes and beliefs towards mental health may impact their decision to refer a student for services. Her findings indicated that there was a strong connection between a teacher's openness to seeking mental health for themselves and referring a student for services. Similarly, a strong connection was evident between a teacher's perception of mental health and their decision to refer a student for services (Breuer, 2016). This current research uses Breuer's (2016) dissertation as a guide to explore how teachers' attitudes and understanding of mental health impact their decision to release a student from academic instruction for mental health support.

Releasing Students from Academic Instruction

Though teachers may agree that mental health supports are necessary and beneficial, they assert that these services tend to usurp academic instruction (Ekornes, 2017). While most of the research shared so far has addressed educators' perceptions, attitudes towards, and understanding of mental health issues and services, there is a gap in the research when it comes to understanding how educators' attitudes towards mental health services drive their decision to release a student from academic instruction to receive services. It is important to explore this gap further through research as students can only benefit from referrals made to services offered during the school day if students have access to them; even if these services overlap with academic instruction.

Synthesis of Literature

The literature review demonstrates that because of the large amount of time students spend in the school setting, educators play a crucial role in identifying concerns that impact students' academics, safety, and emotions (Armstrong et al., 2015; Dix et al., 2012; Elias et al., 1997; Erasmus, 2019; Gur et al., 2012). The literature also showed that educators' literacy, attitudes, and perceptions about mental health influence their ability to identify mental health concerns while also influencing their decision to refer a student for services (Bandura, 1986; Breuer, 2016; Mackenzie et al., 2004; Reinke et al., 2011). A gap in the research helped form the research questions for this study. One question is what do educators understand (literacy) about children and adolescent mental health issues? Another question is what connection exists between a teacher's recognition of a need for mental health support for students and their practiced willingness to release students from class time? These questions are important to explore as Erasmus points out that, "our mental wellbeing is linked to our academic results and we need to ensure that as a society we don't neglect the first in pursuing the second" (2019, p. 14). Erasmus is echoing Maslow's Theory of Hierarchy of Needs (1943) and reminds educators that they need to focus on supporting the whole child sitting in their classroom and not only the assessing of content retention.

Theoretical Framework

The theoretical framework for this study is based on Bandura's social cognitive theory (1986). Bandura's theory asserts that learning comes through observations of others within the social context. Researchers have used this theory to explain human behavior, arguing that humans' thoughts, attitudes, perceptions, beliefs, experiences, and

environmental factors all influence humans' choices and behaviors (Tosi & Eshbaugh, 1976; Webb et al., 2010). Breuer (2016) cited Bandura's theory in her research arguing that teachers' attitudes and beliefs toward mental health impact their decision to refer a student for services. Breuer (2016) referenced the work of Han and Weiss, who looked at the impact of teachers' attitudes towards various interventions impacting the teachers' compliance with the protocol for the intervention (2005). As applied to this study, the theory holds teachers' attitudes and understanding of mental health influence their decision to release a student from class for services.

Figure 1.2 shows the three different components of this theory: cognitive factors; environmental factors; and behavioral factors.

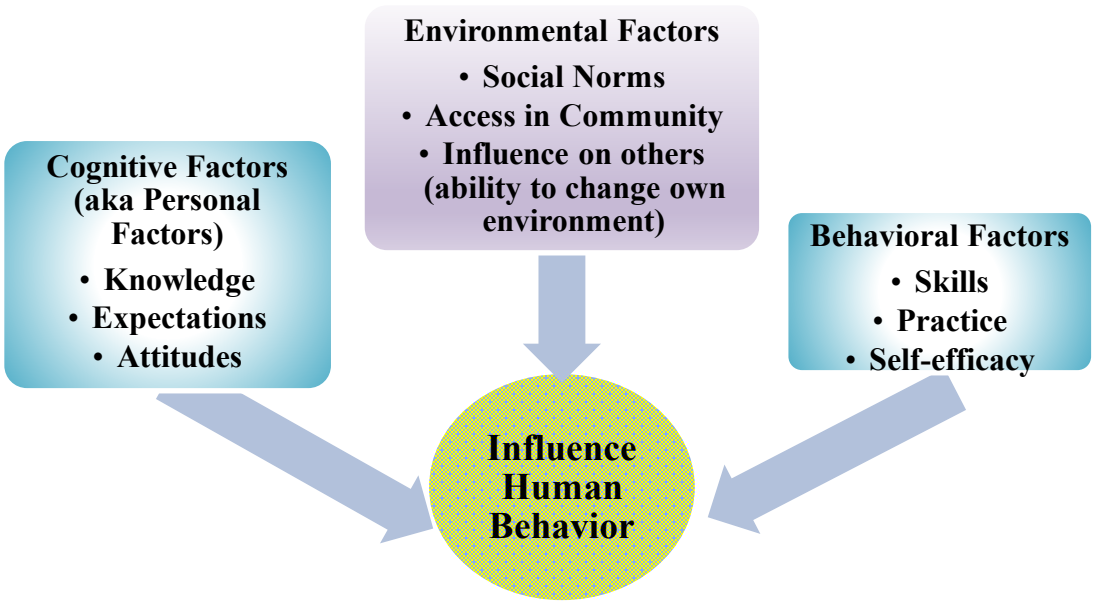

Figure 1.2. Model of Bandura's Social Cognitive Theory.

Note: Figure language quoted from the HTSP Implementation Kit, USAID, 2016, p. 38. https://sbccimplementationkits.org/htsp/annex-a-key-sbcc-theories-in-fp/

This model demonstrates that multiple facets can influence human behavior and shows how the components work collectively. Specifically, Bandura's (1986) model explains why two educators who have the same knowledge of mental health with adolescents may have different protocols (or behaviors) when it comes to releasing students from their class time since it is not just the knowledge of something that influences human behaviors, but the combination of knowledge, lived experiences, cultural norms and practice that influence our actions.

Conclusion: Purpose of the Study

The purpose of this study was to explore educators' attitudes towards mental health support offered within the school setting. This study also aimed to reveal educators' reasoning behind their decision to release, or not to release, a student from class time for support services. The design for this study was an explanatory sequential mixed methods design. This design entails collecting quantitative data first and then explaining the quantitative results with in-depth qualitative data.

The findings of this study provide educators, school administrators, parents, and other key stakeholders with crucial information regarding barriers to mental health services available in schools. This revelation of existing barriers to mental health services can help incite systemic change within schools for the betterment of students' mental health needs. The next chapter describes in greater detail the research design and methodology for this study.

CHAPTER TWO

Methodology

Introduction: Research Questions

As the previous chapter demonstrated, teachers serve an important role in helping students access needed mental health support. However, as the literature revealed, attitudes towards mental health and limited mental health literacy can influence a teacher's decision to release a student from class to receive mental health support services. Since previous research (Breuer, 2016; Jorm et al., 2006; O'Connor et al., 2014; and Reinke et al., 2011) looked at how teachers' attitudes towards seeking mental health and mental health literacy influenced their decision to refer a student for services, my problem of practice focused on the gap between recognizing referring a student for support and physically releasing the student from academic instruction for support. Therefore, my problem of practice bridged this gap by examining the relationship between educators' attitudes towards mental health and educators' mental health literacy and their combined influence on educators' decisions to release a student from class for the referred support services.

The guiding argument for my study was that teachers' knowledge, beliefs, and attitudes influence their decision to release a student from academic instruction time for mental health support services. Though these three components (knowledge, beliefs, and attitudes) appear to be synonymous, they are different. Collectively, one may view these components as making up the culture of an individual, a group, or an organization (Porter, 2000, p. 49), but individually they help to explain the identity of someone and

predict their behaviors in certain situations. For example, if an educator values academic achievement and believes that the course they are instructing is crucial to the academic development of each student, then their attitude towards anything that interferes with their class time may shape a negative perspective towards mental health services offered during the school day. With this mindset, the educator may be less likely to release a student from class to receive mental health support. The following figure is a table created by McLean (2012), which shows the delineation of these terms for a clearer understanding.

	Definition	Changeable?	Example
Attitudes	Learned predispositions to a concept or object	Subject to change	I enjoyed the writing exercise in class today.
Beliefs	Convictions or expressions of confidence	Can change over time	This course is important because I may use the communication skills I am learning in my career.
Values	Ideals that guide our behavior	Generally long lasting	Effective communication is important.

Figure 2.1. Definition of attitudes, beliefs, and values.

Note: From *Understanding Your Audience* (ch. 3) From *Communication for Business Success* (p.84), by S. McLean, 2012, CC by-nc-sa 3.0.

The specific research questions were:

> Quantitative: What is the relationship between a teacher's attitude towards mental health services and a teacher's mental health literacy?
>
> Qualitative: How do teachers describe the influence of cognitive, environmental, and behavioral factors on their willingness to release students for mental health services?
>
> Mixed Methods: How do the results of the survey data and the interview data explain teacher decision-making regarding releasing students for mental health services during academic instruction?

This study provided data that demonstrate how teachers' attitudes and perceptions towards mental health issues impact their decision to release a student from academic instruction for mental health support services.

Researcher Perspective and Positionality

I am a mental health clinician and school counselor who has worked in a variety of public and private schools over the past 20 years. I started my career in Central Virginia, where I worked in residential treatment facilities and alternative schools before transitioning into agency-based work where I contracted with various public schools and early intervention sites. My latter work involved overseeing therapeutic support staff while collaborating with teachers and administrators in developing effective treatment plans.

Early on in my career, I relocated to Central Pennsylvania where I worked in urban public schools as a school-based out-patient (SBOP) therapist. While my earlier experiences in Virginia had me working directly with the client in the classroom setting, the SBOP work introduced the challenge of coordinating my treatment schedule with the various teachers' classroom schedules. The frequent absences my clients tracked, due to disengagement with the school, compounded the difficulty of scheduling student sessions that were convenient for the teachers.

Following several years of direct treatment, I shifted to prevention and intervention work as I performed mental health (MH) and drug and alcohol (D&A) assessments for students in K–12 grades in Lancaster County whose teachers or other adults had referred them to their school's Student Assistance Program (SAP). In this role, I contracted with several public and private schools, in both urban and rural settings and

worked with approximately five to ten % of the student population. Again, I experienced the pressure of having timeframes within which the assessments needed completion and the limited access that some teachers offered for the students to participate in these services. The tension between meeting the students' needs and receiving access to students from their teachers was greater when working within 5th–12th-grade buildings.

After over a decade of clinical work, I shifted my career path again to my current role as a school counselor. Employed through a public educational intermediate unit in South Central Pennsylvania, I contract with two small private, faith-based schools located within rural and suburban portions of Lancaster County. In this role, I have the responsibility to work with the entire K–8 grade student population in both schools. For some of the direct contact with students, I push into the classrooms for Social-Emotional and Career lessons while individual and small group work comprises the other portion of direct time.

While all types of direct services involve coordination with the student's teachers, I encounter greater tension and difficulty with accessing students for individual and group support services. The clients with whom I have worked over the years come from a variety of socioeconomic backgrounds, races, creeds, and cultures. Despite the external differences that existed between the thousands of clients, they all struggled with academics and learning in some form or another. Except for a few outliers, most teachers had academic concerns listed for students as one of their referral reasons and behavioral and social concerns as close seconds.

Through my practice, I experienced the frustration of trying to support students in the school setting when teachers frequently do not release students during academic time

for this type of support. Due to the nature of the support services being school-based, the opportunity to provide the services for the student often overlaps with instructional time. I believe, and research supports, that focusing on the whole child (body, mind, and spirit) encourages greater academic success (Basch, 2011; Baskin et al., 2010; Daly et al., 2014; Dix et al., 2012; Michael et al., 2015; Suldo et al., 2014; Sutherland, 2018; Wells et al., 2003). I maintain a pragmatic worldview and argue that there is a positive correlation between teachers who measure with high levels of Mental Health Literacy (MHL) and with high (positive) attitudes toward mental health services. Since mental health providers view classroom teachers as the gatekeepers for releasing students out of the classroom, I chose to focus on teachers' beliefs, attitudes, and perspectives as these three components could impede a student's ability to access support services within the school.

Theoretical Framework Application

I used Bandura's social cognitive theory (1986) for the framework of this study. This framework, which chapter one introduced, asserts that three components influence human behavior. The three components which Bandura identified are cognitive factors (i.e., humans' mindset and experiences), environmental factors (i.e., work environment), and behavioral factors (i.e., practices or efficacy). During the qualitative phase, I used Bandura's framework and its components as a priori themes to guide in coding the participant's interviews. Breuer (2016) used this same theory for her research exploring high school teachers' perceptions of and attitudes toward mental health and how those components influenced the teachers' decision to refer a student for support services. Similarly, this framework supported this current study's design as I explored the three mentioned components of the theory by measuring teachers' attitudes and knowledge

about mental health, teachers' work environment (urban, rural, public, or private), their lived experience, and their thoughts and practice with releasing students from academic class time. These varying components were analyzed to determine what, if any, influences they have on the teachers' behaviors in deciding whether to release a student from academic time for mental health support.

Following this framework also guided the development of the research questions driving this study. The first research question addressed the cognitive factors component of the theory by asking: What is the relationship between a teacher's attitude towards mental health services and the teacher's mental health literacy? Similarly, the theory guided the questions used in the qualitative portion of the study with the question: How do educators describe the influence of cognitive, environmental, and behavioral factors on their willingness to release students for mental health services? All three components of the theory guided the development of the third research question by asking: How do the results of the survey data (cognitive factor) and the interview data (environmental factors) explain teacher decision-making regarding releasing students for mental health services during school time (behavioral factor)?

The social cognitive theory (Bandura, 1986) also guided the selection of inventories used for the quantitative portion of this study. Both the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS; see discussion in Mackenzie et al., 2004) and the Mental Health Literacy Scale (MHLS; see discussion in O'Connor & Casey, 2015) measure the cognitive and the behavioral factors of the theory. The protocol used in the qualitative portion of the study also addressed these two components while adding in questions related to the environmental factors of the theory when I inquired

about their autonomy or ability to control their classroom and their students' access to services.

As the sole researcher, I also relied on the theoretical framework to guide the analysis portion of the study. I looked for themes throughout the participants' responses that were related to the three components of the theory: cognitive/personal, environmental, and behavioral factors. During the integration of the data, I looked at how these three different components and their sub-themes merged to determine the teachers' behavior of releasing or not releasing a student from class. In conjunction, I explored how educators' attitudes towards seeking mental health services and educators' mental health literacy influenced educators' decision to release a student from class for services.

Research Design and Rationale

For this study, I utilized a mixed methods approach and implemented an explanatory sequential research design which involves two distinct phases of research. The first phase focused on quantitative data collection and analysis and the second phase focused on qualitative data collection and analysis. The integration of the two phases discussed the implications of the findings. The benefit of this type of design was the value that both types of data brought to the research. I operated under a pragmatic worldview (Creswell & Plano Clark, 2018) in using an explanatory sequential mixed method design. This type of design required the integration of the quantifiable data with the qualitative data, creating a richer and more robust picture of the studied phenomenon (Creswell & Plano Clark, 2018). Figure 2.2 provides an overview of the steps followed in this two-phase study. I modeled this figure after Creswell and Plano Clark's examples shown in Figures 3.6 and 3.7 in their text (2018, pp. 79, 85).

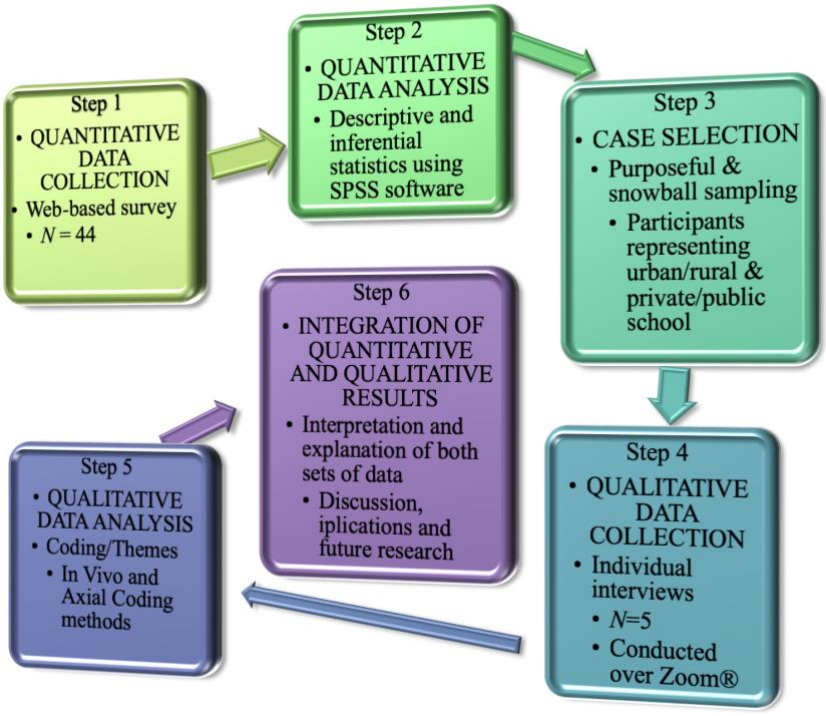

Figure 2.2. Diagram demonstrating flow for explanatory sequential design study.

Once I collected the quantifiable data and analyzed it, then generalizability of the data was possible. However, the collected qualitative data gives deeper insight into educators' perceptions and understanding of child and adolescent mental health issues (Creswell & Plano Clark, 2018).

Site Selection and Participant Sampling

Lancaster County, Pennsylvania is where I live and work, and it served as the backdrop for this research study. The target population for this study was teachers in public and private schools within Lancaster County, Pennsylvania (see Figure 2.3 for a map of Lancaster County). In addition to these 18 public school districts, Lancaster County is home to 1 charter school, 1 career technical school, and 97 private schools totaling 209 schools (National Center for Education Statistics, 2019). Within these

schools, there are 5,926.70 teachers employed (5,144.60 public; 782.10 private). I selected participants from this large population sample utilizing a mixed approach sampling strategy since there were two phases with this explanatory sequential design study. Creswell and Plano Clark (2018) suggest that when conducting an explanatory sequential design, participants for the qualitative portion of the study should come from the group of individuals who were a part of the quantitative portion of the study. This selection protocol is important to support the design's focus on using rich, descriptive data to explain the quantitative data (Creswell and Plano Clark, 2018).

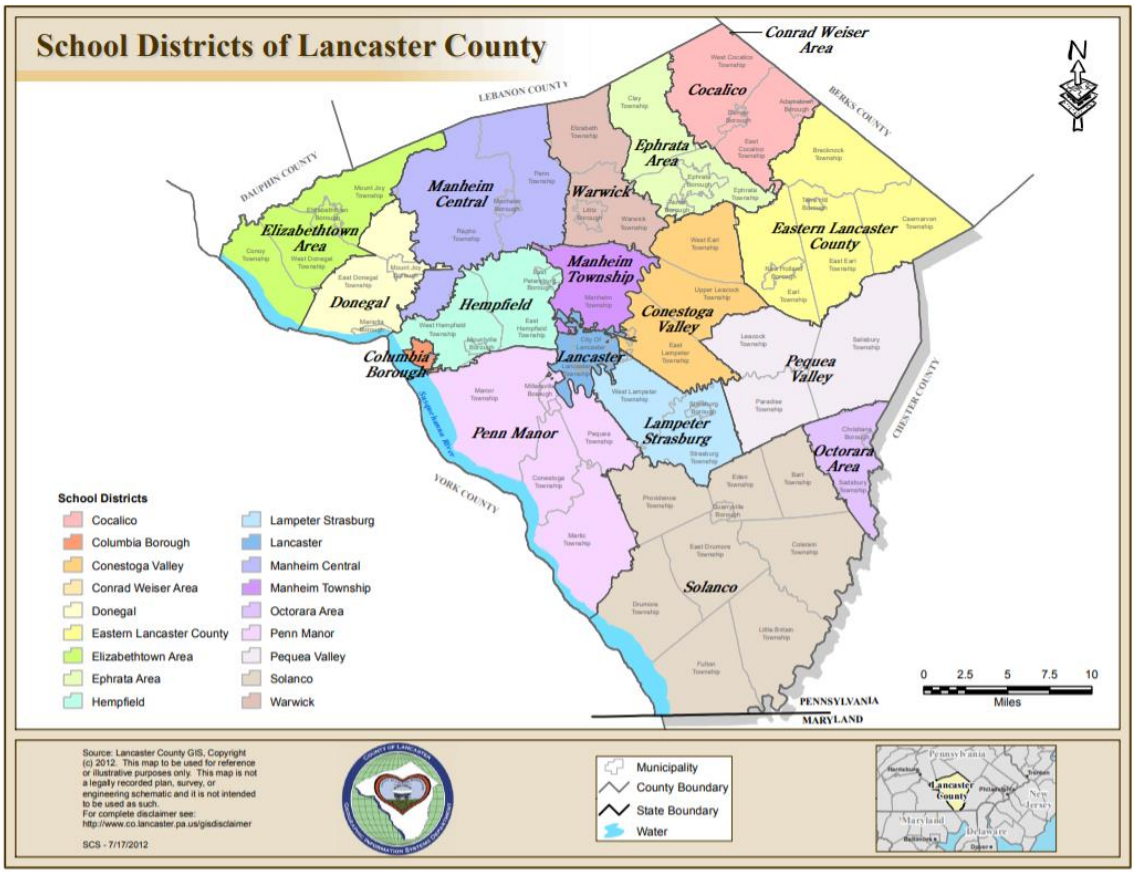

Figure 2.3. Map depicting the 18 public school districts comprising Lancaster County.

Note*:* Used with permission. Lancaster County GIS, 2012.
Retrieved from https://co.lancaster.pa.us/DocumentCenter/View/208/School-Districts

Phase One: Quantitative Phase

Site. The site for the quantitative phase of the study (phase one) was Lancaster County, PA. Only educators employed within Lancaster County could participate in the study. Residence within the county was not a requirement. Educators throughout Lancaster County, Pennsylvania received emails with an embedded link to the survey. The initial questions of the survey were screening questions to ensure that participants met the study's criteria. If a participant's response indicated that they did not meet the criteria, the survey ended. In the following section, I describe the criterion and participant selection process in more detail.

Participants. I selected participants for the quantitative phase using nonprobability and snowball sampling. An inclusion criterion was necessary to ensure that all participants' responses were related to the research question (Creswell & Plano Clark, 2018). Therefore, all participants needed to be full-time employed K–12 educators assigned as a primary teacher to a classroom at one of four site locations: public-urban school; public-rural school; private-urban school; or private-rural school. I sent emails out to educators who were employed at public and private schools within Lancaster County, Pennsylvania; however, for this study, I did not consider classroom aids or para-educators for participation. Other school counselors and educators throughout Lancaster County served as communication liaisons to encourage participation from educators in their buildings and to help ensure a large response. Additionally, a small number of superintendents and heads of schools permitted me to contact educators in each district and school. I obtained educators' emails through those schools that gave consent for their educators to participate, though some schools distributed the survey themselves. I also

posted the survey links on Facebook. I carefully reviewed participant responses and some demographic determinants, such as employment location (i.e., public or private; urban or rural) with the expectation that the sample offered a broad representation.

Though my personal experiences helped shape my problem of practice, it was important to me to be able to generalize my findings to a larger population. I wanted to ensure the validity of my lived experience and those of my colleagues, therefore, I wanted to collect feedback from as many educators as possible. Creswell and Plano Clark (2018) suggest that for a study to have rigor and to meet the conditions needed for analysis, the study requires a specific sample size. By calculating the appropriate sample size, I could ensure that the data collected provided "a good estimate for the parameters of the populations (reducing sampling error and providing adequate power)" (Creswell & Plano Clark, 2018, p. 177). To calculate the sample size, I used the sample size formula, depicted in Figure 2.4. For this formula, N= 5,926.70, which is the total number of teachers schools employ in Lancaster County, PA. Utilizing a 95% confidence measure with a 5% margin of error, the remaining variables completed the equation (z= 1.96; p= 0.50; e= 0.05). This calculation resulted in a sample size of n = 356.

$$\textbf{Sample size, n} = \textbf{N} * \frac{\frac{Z^2 * p * (1-p)}{e^2}}{[N - 1 + \frac{Z^2 * p * (1-p)}{e^2}]}$$

Figure 2.4. Sample size formula.

I completed this power analysis under the assumption that I would be able to collect data from educators in different schools throughout all parts of the county.

However, given the time constraint and complications brought on by COVID, that simply was not possible. Therefore, I collected data from 43 educators employed in schools throughout Lancaster County, Pennsylvania. Table 2.1 shows a breakdown of participants by school type, gender, and the educators' grade-level assignment.

Table 2.1

Breakdown of Participants for Phase One of Study

School Type and Setting *n*=44						Grade-Band Level *n*=44			Gender *n*=44	
PbUr	PrvUr	PbRu	PrvRu	PbSb	PrvSb	Elem	Scnd	Multi	M	F
7	1	7	10	6	13	18	21	5	8	36

Note*:* Pb = Public; Prv = Private; Ur = Urban; Ru = Rural; Sb = Suburban; Elem = Elementary; Scnd = Secondary; Multi = Multiple grade-bands

Phase Two: Qualitative Phase

Site. The sites for the qualitative phase of the study (Phase Two) were based on the employment setting of the participants selected for this phase. The schools represented by participants were all located within Lancaster County, PA. Table 2.2 provides the school type, location, and grade level of each participant's school.

Table 2.2

Classification of Participants' School Demographics

Participant	School Type	School Location	Building Grade Level
1	Private	Rural	K–12
2	Private	Suburban	K–8
3	Public	Rural	9–12
4	Private	Suburban	6–12
5	Public	Urban	5–6

Due to COVID safety mitigations, I did not physically visit the sites and instead met virtually with participants. I describe the criterion and participant selection process in more detail in the following section.

Participants. I selected participants for this phase based on specific criteria gleaned from the data responses from the quantitative sample used in Phase One (Creswell and Plano Clark, 2018). I considered some of the following criteria when selecting participants for this phase: ensuring even representation of the different school types and settings; diversity in gender; variance between the participants' scores on both inventories; varied responses within each represented school type and location; and participants indication of willingness to participate in Phase Two.

Responses provided during the quantitative phase of the study indicated if a participant was willing to participate in the second qualitative phase of this study. Participants provided their contact information if they consented to participate in Phase Two. Of the 43 participants who participated in Phase One, 40 participants completed both inventories, of which only 22 indicated consent and willingness for participation in Phase Two. I utilized a stratified purposeful approach for differentiation between school type and participant Mental Health Literacy Scores and to identify the best respondents and ensure representation from varied school types, grade levels, and participant scores on the IASMHS and MHLS inventories (Creswell & Plano Clark, 2018). I sent a direct invitation via email to six educators from a variety of private and public schools throughout the county asking for their participation. Of the six participants I contacted, five responded and gave consent for interviews.

For this qualitative data collection (Phase Two), I selected a smaller sample size from the larger sample that I used in the quantitative data collection (Phase One). Creswell and Plano Clark (2018) state that "if the researcher's intent is to triangulate the databases and produce corroborated and valid conclusions about a topic, then we recommend the use of two independent sources to ensure each separate database is rigorous and stands on its own" (p. 189). For this reason, I selected five teachers to participate in the semi-structured interviews in this phase, rather than include open-ended questions in the electronic survey. Table 2.3 gives a breakdown of the participants by school setting, grade level, gender, and education level of participants.

Table 2.3

Breakdown of Participants for Phase Two of Study: Qualitative

	Gender	School Type	Education Degree	Grade Level Instruction
Participant 1	Female	Private/Rural	Bachelor	Elementary
Participant 2	Male	Private/Suburb	Bachelor	Elementary/Middle
Participant 3	Female	Public/Rural	Masters	High
Participant 4	Male	Private/Suburb	Masters	High
Participant 5	Female	Public/Urban	Masters	Middle

Note: Elementary = Kg – 4; Middle = 5 – 8; High = 9 – 12

Data Collection Procedures

An explanatory sequential mixed method design consists of two distinct data collection phases. The first phase deals with quantitative measures and follows protocols congruent to a quantitative study. The second phase consists of qualitative data collection and the researcher adheres to procedures typical of qualitative research. The following sections discuss the data collection process for this study, which I broke down by each phase. During phase one of the study, I collected quantitative data and in Phase Two of

the study, I collected qualitative data. Table 2.4 is a joint display that shows how my qualitative protocol aligned with the different components of my theoretical framework and the two inventories that participants completed during the quantitative phase of my research.

Table 2.4

Joint Display for Theoretical Framework, Surveys, and Qualitative Questions

Qualitative Survey Question	Quantitative Inventories		Theoretical Framework Components			Teachers' Decisions to Release Students for Mental Health Services
	ATT*	MHL*	Cog Factors	Env Factors	Behav Factors	
1	X		X			
2	X	X	X			
3		X	X			
4	X	X	X			
5	X	X	X			
6	X		X			
7	X		X	X	X	X
8	X		X		X	X
9	X	X		X	X	X

Note: ATT represents the Inventory for Attitudes towards Seeking Mental Health Services and MHL represents the Mental Health Literacy Scale; Cog = Cognitive; Env = Environmental; Behav = Behavioral.

The above table demonstrates how the quantitative phase and theoretical framework directed the development of the interview protocol used for the qualitative phase. Since the IASMHS measured the educator's attitude towards seeking help for mental health

issues and the MHLS measured the educator's literacy as it relates to mental health, I wanted to be sure my qualitative interview delved deeper into these areas.

Having questions in the qualitative phase that connected to the data collected in the quantitative phase not only followed the guidelines for an explanatory sequential mixed methods model but also allowed for deeper exploration into the a priori themes established in Phase One.

Phase One: Quantitative Data Collection

For Phase One of this study, I wanted to measure educators' attitudes towards seeking mental health while also measuring their mental health literacy. I used two different inventories, which I combined into one survey and then electronically distributed to potential participants. In the sections that follow, I provide an overview of the two inventories participants completed in Phase One.

Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS). I replicated some of the quantitative methods Breuer (2016) used in her dissertation work (pp. 47–51). Breuer (2016) examined "the impact of high school teachers' personal beliefs regarding mental health on their decision to refer a student for services" (p. 8). Breuer argued that teachers' personal beliefs, along with their identifying characteristics, influenced their decision to refer a student for mental health services (2016). I applied Breuer's theory (2016) since educators' attitudes or beliefs towards mental health could also impact their decision to release a student from class for services. Breuer (2016) utilized the IASMHS along with a few scenarios where educators would indicate their expected behavior response (2016).

Mackenzie, et al., (2004) adapted the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS) into a 24-question inventory from a longer scale created by Fischer and Turner (1970). Though the original scale (Fischer & Turner, 1970) assessed individuals' perceptions of mental health that may be barriers to self-seeking support, Breuer (2016) used the scale to measure how educators' beliefs about mental health may be barriers to referring students for mental health services. The use of this scale in the study helped identify themes to look for in the qualitative portion of the study while also capturing a quantitative view of educators' beliefs towards mental health.

The IASMHS consists of 24 items with a Likert scale response ranging from zero (agree) to four (disagree) where participants' total scores can range from zero to 96. A higher score indicates a greater likelihood of seeking mental health services (Hyland et al., 2014; Mackenzie et al., 2004) Like Breuer (2016), I interpreted these scores as those teachers with higher scores indicating a greater likelihood to release a student for mental health support services. The 24 items measure three factors: Psychological Openness, Help-Seeking Propensity, and Indifference to Stigma (See Appendix A). Each subscale consists of eight items. The overall internal consistency of 0.87 of the IASMHS indicates that this scale is a valid measure of individuals' attitudes towards mental health (Mackenzie et al., 2004).

The first subscale within the IASMHS consists of eight statements and measures psychological openness. Participants could receive a score of 0–32 for this sub-scale. Item number nine on the IASMHS is an example of a statement that measured psychological openness which states, "people should work out their own problems; getting professional help should be a last resort." I also needed to reverse code this item,

meaning that if a participant answered with a four on the Likert scale, indicating they agreed with this statement, then I would have coded it as a zero to ensure their overall attitude score appropriately reflected their level of psychological openness. The reliability estimate for psychological openness was 0.82 (Makenzie et al., 2004).

The second subscale within the IASMHS measures an individual's help-seeking propensity. Specifically, this subscale measures an individual's willingness to seek mental health and their attitude towards others seeking health. Item number five on the IASMHS is an example of this subscale and states, "if good friends asked my advice about a psychological problem, I might recommend that they see a professional." Participants could also receive a factor score of 0–32 for this sub-scale of eight statements and the reliability estimate for help-seeking propensity measured 0.76 (Makenzie et al., 2004).

The final subscale within the IASMHS measures an individual's indifference to stigma. With my study, a high indifference to stigma score would indicate that educators are not interested in or concerned with any negative labels associated with mental health. Like the other two subscales, participants could receive a factor score of 0–32 for this sub-scale; I needed to reverse code seven of the eight statements during analysis due to the structure of the statement. Item number six is an example of one of the seven reverse coded statements that state, "having been mentally ill carries with it a burden of shame." If a participant selected the rating of 4, indicating that they strongly agreed with this statement, I would score the response as a 0 to reflect a lower overall score on the attitude scale. The reliability estimate for indifference to stigma was .79 (Makenzie et al., 2004).

Mental Health Literacy Scale (MHLS). I used the Mental Health Literacy Scale (MHLS; see discussion in O'Connor et al., 2014) to measure educators' understanding (knowledge) of mental health issues in adolescents (See Appendix B). O'Connor and Casey developed the scale "to provide a methodologically robust and time-efficient means to assess an individual's level of MHL" (2015, p. 511). The pilot scale began with 79 questions, though through a thorough and robust process of development, testing, and assessment, the final scale resulted in 35 questions. The items measured the following areas associated with mental health literacy:

- eight items measured the ability to recognize disorders
- four items measured knowledge of where to seek information
- two items measured knowledge of risk factors and causes
- two items measured knowledge of self-treatment
- three items measured knowledge of professional help available
- sixteen items measured attitudes that promote recognition or appropriate help-seeking behavior (O'Connor & Casey, 2015, p. 515).

During the development of the instrument, the initial descriptive data demonstrated strong reliability with a Cronbach's alpha of 0.88 (O'Connor & Casey, 2015, p. 514). The developers of the MHLS built the instrument based on the COSMIN (Consensus-based Standards for the selection of health status Measurement INstruments) checklist (Mokkink et al., 2010; Terwee et al., 2018) to establish validity. It is important to note, for transparency, that I changed the wording in two of the items on the scale. The authors of the MHLS (O'Connor & Casey, 2015), live in Australia and therefore their sample participants also lived in Australia. Naturally, they geared their scale to measure

the literacy and perceptions of individuals living in Australia, as evident on the scale's items #9 and #10. These two statements originally read:

- #9 To what extent do you think it is likely that in general in Australia, women are MORE likely to experience a mental illness of any kind compared to men
- #10 To what extent do you think it is likely that in general, in Australia, men are MORE likely to experience an anxiety disorder compared to women.

I changed these two items on the scale to reflect the demographics of the participants living in the United States. Therefore, I substituted "The United States" where it reads "Australia."

I acquired emails of teachers through district/school email lists, with the permission of some district superintendents and head administrators throughout the county. If I received administrator permission for educators in their building to participate, I enlisted the help of other school counselors in the county and asked the school counselors to forward the study's email to teachers within their assigned buildings to assist with teacher recruitment. Additionally, I posted a description of the study with a link to the survey on my personal Facebook page. Several friends and associates shared this post and the associated link on their personal Facebook pages which aided in my snowball sampling procedure. I also shared a link on a Facebook group page named EdD Graduate Students, which is a private group for Education Doctorate students interested in supporting other students and sharing ideas and insights. The group is a part of the Carnegie Project on the Education Doctorate (CPED) and currently has 759 members.

Participants (N= 44) provided informed consent with electronic signatures embedded into a Qualtrics Survey I created. Participants accessed surveys via an email or social media post containing an embedded link with the assumption that educators

participating would understand the questions asked of them and respond appropriately. The link posted on social media created a snowball sampling as educators who responded shared the link with their colleagues. The survey captured nominal data, such as demographics of educators, and included questions from the IASMHS and the MHLS. The survey took about 20 minutes to complete based on sample measures my colleagues and I completed in a practice session. The survey remained open for participants for one month before the link closed. Data analysis through Qualtrics demonstrated that 71 educators attempted to complete the study; however, only 44 met the criteria to continue with the study. Out of this sample, 44 educators completed the IASMHS, and 40 completed both the IASMHS and the MHLS.

Phase Two: Qualitative Data Collection

For the qualitative phase of the study, I conducted semi-structured interviews with five participants. Due to COVID safety mitigations physical, in-person interviews were not possible. I used the video conferencing platform, Zoom®, to conduct the interviews. However, the video conferencing platform, Zoom®, had built-in abilities to record the sessions and offered a built-in transcription of the session.

After analyzing the quantitative data, I identified ideal participants (n=5) for the qualitative phase based on their (a) consent to continue in Phase Two; (b) their school setting; (c) their gender; and (d) their scores tallied on the IASMHS and the MHLS to have a diverse representation of these components within this sample. A smaller sample from the original sample (N=44) enabled me to collect more detailed, descriptive data that helped spotlight different perspectives of educators. Creswell and Plano Clark (2018, p. 77) describe that though the primary intent of an explanatory sequential design is to

use the qualitative data to explain the results that a researcher obtains through the quantitative phase, it can also guide purposeful sampling, using participant characteristics as variables.

I contacted selected participants via email and invited them to participate in Phase Two of the study. I positioned the question of being interested in participating in Phase Two at the end of the survey implemented in Phase One, to avoid any high probability of refusal to participate. Due to time constraints within the study, I reached out to six participants; five educators responded to schedule interviews. Participants in Phase Two offered verbal consent during the recording of the interviews with the reminder that their participation in the study is voluntary. I let participants know at the start of the interview that at any point during the interview if they became uncomfortable or wished to discontinue their participation, I would stop the recording and end their participation immediately. Fortunately, all five of the participants completed the interview for Phase Two. I could not offer participants anonymity with their participation, since their Phase One responses link to their responses in Phase Two, but I did assure confidentiality to participants with the understanding that I would not use their names or the name of their school when sharing the results.

I developed the interview protocol to align with the measured components from the two inventories used during the quantitative phase since the goal of the qualitative phase is to explore further the results found during the quantitative phase (Creswell & Plano Clark, 2018). The nine questions I created were related to my theoretical framework so that I could collect thick and rich data that would describe educators' attitudes, thoughts, and beliefs related to mental health. For example, the first question I

asked each participant was: what are some thoughts or beliefs that come to mind when you think about mental health? In addition to exploring participants' attitudes, thoughts, and beliefs I also wanted to explore further participants' knowledge or literacy, as it relates to mental health. Jorm et al. (1997) linked knowledge to mental health literacy, which I measured in Phase One of this study. Jorm et al. first coined the term "mental health literacy" in 1997 using the definition of "knowledge and beliefs about mental disorders which aid their recognition, management, and prevention" (1997, p. 182). In their years of research on this topic, Jorm et al. (2006) discovered that improved mental health literacy (MHL) has an impact on behaviors. To explore educators' knowledge and understanding better, I asked questions like, "Describe any education or training you have received about mental health in adolescents." The semi-structured design enabled me to ask follow-up questions to responses participants offered which helped create a deeper understanding of the educators' perspectives. Appendix C offers the protocol that I used to guide the semi-structured interviews.

Due to COVID restrictions, I conducted semi-structured interviews using the Zoom® platform. Zoom® automatically created a transcription of each interview which I carefully reviewed for errors. I offered participants the opportunity to review the transcript to confirm the validity of their responses. The transcription also increased the reliability of the coding process as I used it to compare my notes taken during the interviews.

Data Analysis Procedures

Creswell and Plano Clark (2018) note that there are three specific phases to data analysis in an explanatory sequential mixed methods design and list them as the analysis

of the initial quantitative data, an analysis of the follow-up qualitative data, and an analysis of how the qualitative data helps to explain the quantitative data to answer the mixed methods question (pp. 234–235). The following sections discuss the data analysis conducted for this study, broken down by each phase. Phase One of the study used quantitative data for analysis and Phase Two of the study used qualitative data for analysis. In mixed method studies, integration of the data for meaningful interpretation is a major component of this design, and analysis and integration of data occur throughout the study.

Phase One: Quantitative Data Analysis

My quantitative analysis followed a linear path like the one described by Creswell and Plano Clark (2018) and outlined in Figure 2.5 below.

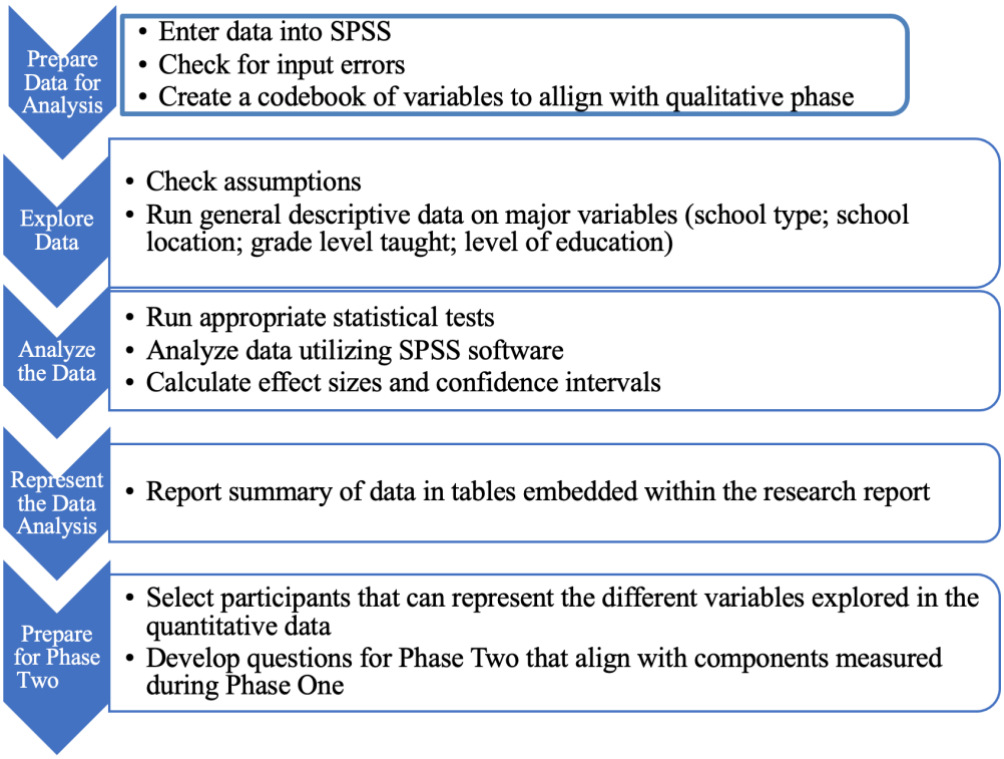

Figure 2.5. Flow of data analysis for Phase One.

I conducted several different statistical tests to analyze the quantitative data. The statistical computer program SPSS (*v.28)* enabled me to run a variety of tests to explore the relationship between different variables in my study. I conducted a Pearson *r* correlation to explore the relationship between the two scales I used in the electronic survey. I also conducted an independent samples *t*-test and a one-way analysis of variance (ANOVA). Both tests allowed me to compare the means of the different groups of participants within my study. I discuss each of these three tests in the sections that follow.

Pearson r correlation. The core of my research explored how educators' attitudes and knowledge related to mental health impacted their decision to release a student from academic instruction for mental health support. Bandura's social cognitive theory (1986) asserts that an individual's cognitive factors (attitudes and knowledge), combined with their environmental factors and behavioral factors influence their behavior (i.e., releasing a student from class). Therefore, I was interested in exploring the relationship between educators' scores on the IASMHS and their MHLS scores. To explore this relationship, I conducted a Pearson *r* correlation so I could explore if there is a statistically meaningful relationship between the two continuous variables (Field, 2018).

Before running the Pearson *r* correlation, I confirmed four assumptions (Field, 2018). The first assumption I checked ensured the dependent variables were continuous as opposed to categorical (Field, 2018). The dependent variables in my research were the educators' scores on the IASMHS and the MHLS. I visually inspected my data output to ensure that the IASMHS scores (n=44) ranged from 0 to 96 and that the MHLS scores (n=40) ranged from 35 to 160.

The second assumption I checked for the Pearson *r* confirmed both variables were normally distributed (Field, 2018). I checked these assumptions by using the Analyze feature in SPSS (*v.28*) and selecting Frequencies. I also constructed a histogram for each variable to see if I would see a resemblance to a bell curve. If the histograms display a shape that resembles a bell curve, with a peak in the middle and smaller frequencies on each end then assumption number two passes (Field, 2018).

The third assumption I checked for the Pearson *r* correlation was to confirm that the relationship between the two variables was linear. To check for linearity, I constructed a scatterplot using the same Graph and Legacy Dialogs feature found in SPSS (*v.28*). I then visually inspected the data to ensure that my data points formed a somewhat linear line (Field, 2018).

The fourth assumption for the Pearson *r* requires that no values are missing for each participant. I checked the fourth assumption when I input my data (Field, 2018) and confirmed that each of the participants had a score for both inventories. The sample size was different for each inventory (IASMHS, n=44; MHLS, n=40), therefore, during data cleaning for this analysis, I only used the 40 participants who completed both inventories. After I verified this final assumption, I was able to run the Pearson *r* correlation.

I ran the Pearson *r* correlation by using the Analyze feature in SPSS (*v.28*) and then selected Correlate and Bivariate. I followed the necessary steps and made sure that I checked Pearson, Two-tailed, and Flag significant correlation boxes. I also selected Bootstrapping and set the confidence intervals at 95%, just as they were with the previous two tests (Field, 2018). Again, this CI setting demonstrates the probability that my sample represents the population with 95% confidence.

When I analyzed the statistical output that resulted when I ran the Pearson *r* correlation, I looked closely at the first two rows in the correlations table. These first two rows revealed three things: the magnitude of the correlation; the direction of the correlation; and whether the relationship was statistically significant (Field, 2018). The bottom two rows reported the confidence intervals for the Pearson *r* correlation. The statistical significance calculated with any statistical test is important as it determines whether the relationship happened by chance, or if there is statistical significance supporting that these results are based on an actual relationship and not chance (Field, 2018).

Independent samples t-test. The second set of tests I ran were four independent samples *t*-tests. The purpose of this test is to compare the means of two different groups on a continuous variable (Field, 2018). Before running the independent samples *t*-test, I checked five assumptions associated with the variables (Field, 2018). I repeated this process for each set of different variables I tested. For the first assumption, I made sure that two independent and categorical groups made up the independent variable (Field, 2018), which meant that a participant's membership in a group needed to be exclusive.

The second assumption I checked for an independent samples *t*-test was to ensure the dependent variable was continuous as opposed to categorical (Field, 2018). The dependent variables in my research were the educators' scores on the IASMHS and the MHLS. I visually inspected my data output to ensure that the IASMHS scores (n=44) ranged from 0 to 96 and that the MHLS scores (n=40) ranged from 35 to 160.

The third assumption for an independent samples *t*-test required that I check for significant outliers with the data. Outliers are data points that exist far away from the

represented mean (Field, 2018). The Explore feature in SPSS (*v.28)* creates a Q-Q plot when running descriptive statistics. The Q-Q plots display a regression line with the various data points clustered along the line. I looked for outliers on the Q-Q plots keeping in mind most of the data points needed to appear clustered along the regression line to pass this third assumption. I used the same Explore feature in SPSS (*v.28)* that created the Q-Q plots to also check for the fourth assumption.

The fourth assumption that I checked was to ensure that the dependent variable follows a normal distribution for the different groups (Field, 2018). Here I looked for a visual representation of the participants' survey scores. A bell curve shape would indicate a normal distribution of scores, thereby meeting the conditions of the fourth assumption.

The fifth and final assumption that I checked for my independent samples *t*-tests ensured that the variances of the two groups are equal (Field, 2018). The Levene's test of homogeneity of variance is part of the output for each *t*-test. If the data indicates statistical significance in the variance, then the data violates this assumption.

After checking the five assumptions, I ran each independent samples *t*-test. Using the SPSS program, I explored the relationships between my dependent variables and my independent variables. For my study, my dependent variables were the scores participants received on the IASMHS and the MHLS scales. My independent, or grouping variables were the different categories in which I grouped participants. The specific grouping variables I explored in my study were:

- public versus private school settings
- rural public versus rural private school settings

I ran each independent samples *t*-test with a 95% confidence interval. It is important to note the confidence interval with each output of analysis as this speaks to the probability that my sample represents the population with 95% confidence (Field, 2018).

Once I ran the independent samples *t*-test using SPSS (*v.28*), the data output allowed me to see if there was a statistically significant difference ($p < 0.05$) between the groups' scores as well as the magnitude of the practical significance (Cohen's *d*). For example, if the results of my independent samples *t*-test indicated $p = 0.03$ when comparing the means of the IASMHS scores of educators in private and public schools, this would indicate that an educator's location of employment influenced their attitudes toward seeking mental health.

One-way ANOVA. The third set of tests I ran were four, one-way ANOVA tests. The purpose of this test is similar to an independent samples *t*-test, except a one-way ANOVA allows the analysis to compare the means of three or more groups, while a *t*-test only allows you to compare the means of two groups (Field, 2018). Rather than a Cohen's *d* effect size, I reported the eta^2 effect size for each ANOVA.

Similar to the independent samples *t*-test, there were six assumptions I checked before I ran the analysis (Field, 2018). The first assumption I ensured that my dependent variable was continuous. The second and third assumptions required that my independent, or grouping variable, had more than two, independent groups (Field, 2018). I described in detail how I checked these two assumptions in the section above on *t*-tests.

The fourth assumption I checked made sure there were no significant outliers with the data output (Field, 2018). I described in detail in the section above on *t*-tests how I checked this assumption using the produced Q-Q plots in SPSS (*v.28).* There is no

violation of the assumption if the data points all fall close to the line of regression. This visual inspection of the data points is especially important when working with smaller sample sizes as a uniform display of data can justify proceeding with the test, even if the data indicates that there is a violation of the fifth assumption, which has the researcher check for normally distributed variables for each category of the independent variable (Field, 2018). This fifth assumption can be hard to pass if the study, like mine, has a small sample population where a normal distribution of the data is not as likely since the sample is not statistically significant (Field, 2018).

The sixth assumption I checked before analyzing the one-way ANOVA looked at Levene's test of homogeneity of variance in the output. When I ran the one-way ANOVA in SPSS (*v.28*), the output provided a significance score. If the data shows there is statistical significance ($p<.05$), this would indicate that not all the groups had a similar variance in their scores (Field, 2018) and would violate this assumption.

After checking the six assumptions, I then proceeded with running and analyzing the four, one-way ANOVA tests. Using the SPSS program, I was able to explore the relationships between my dependent variables and the multiple independent variables. For my study, my dependent variables were the same used in my *t*-tests which were the scores participants received on the IASMHS and the MHLS scales. My independent, or grouping variables were the different categories where I grouped participants. The specific grouping variables I explored in the one-way ANOVA were:

- educators' grade-band level of instruction
    - primary
    - secondary

    - multi-level
- educators' reported age-band
    - 22–30
    - 31–40
    - 41–50
    - 51+

Like the *t*-tests, I ran each one-way ANOVA with a 95% confidence interval (CI) since the CI demonstrates the probability that my sample represents the entire population with 95% confidence (Field, 2018).

To interpret the one-way ANOVA I looked carefully at the various output tables created by the SPSS (*v.28*) program. Specifically, I looked at the Post Hoc Tests, the Multiple Comparison tables, and I looked at the calculated *p* score. If $p > .05$ then there was no statistical significance in any difference in scores (Field, 2018). Similarly, on the Post Hoc Tests and the Multiple Comparison tables, I looked at the significant columns to determine which group means, if any, were statistically significantly different from one another (Field, 2018).

While this section outlined the various statistical tests that I ran for my data analysis, I discuss data analysis results for each specific statistical test in Chapter Three. In the next section, I review the process I followed for my Qualitative Data Analysis.

Phase Two: Qualitative Data Analysis

I followed the qualitative data analysis model by van Manen introduced in Creswell and Poth (2018). Under van Manen's model, I conducted a thorough review of the data so I could extract various themes, both a priori and a posteriori, that emerged

from the participants. Following this qualitative data analysis framework, I analyzed teachers' experiences (the lived body) connected to releasing students from academic time to receive support and explored how these experiences manifest in different types of schools (space). By using van Manen's approach, I could also explore the knowledge base (epistemology) teachers have about mental health and its impact on students' academic performance (ontology).

The qualitative data analysis model by van Manen (as cited in Creswell & Poth, 2018), lends itself nicely to two different qualitative methods of data analysis which I utilized while reviewing the interview transcripts. The first method was analytic induction. Utilizing this method, I explored what teachers' understanding of mental health is and the reasons related to releasing or not releasing students from academic class time for support services. Through a review of the conducted interviews and surveys, I then assessed if the research question lined up with the accounts various teachers offered.

The second method applied to van Manen's model of data analysis was constant comparison. I utilized this method throughout the study to assist with the verification of the data. I reviewed data from interviews to discover significant a priori and a posteriori themes that I later coded. Similarities and repeated codes revealed categories that exposed the core focus of the study and helped give shape to educators' lived experiences through analytic induction (Creswell & Poth, 2018).

I wanted to ensure that my qualitative data and analysis were valid and reliable, so I implemented additional strategies for the data analysis process. Creswell and Poth (2018) suggest applying different lenses to the analysis to ensure a broad perspective and

in turn increase validity. One lens Creswell and Poth (2018) discuss is the researcher's lens. At the beginning of this chapter, and in chapter one, I identified my role as a school counselor and shared my personal experience with attempting to pull students for services. My positionality could lead to bias when interpreting the results, though I was keenly aware of this possibility and made attempts to prevent personal biases from impacting analysis.

Another lens mentioned by Creswell and Poth (2018) is that of the participant. Creswell and Poth quoted two other researchers, Lincoln and Guba, who stated that seeking participant feedback is "the most critical technique for establishing credibility" (as cited in Creswell & Poth, 2018, p. 261). This specific method, along with participant collaboration, assists with giving credibility to the study. I sent each participant a copy of their interview transcript and asked them to check for any errors or issues with the transcription to ensure appropriate documentation of the interview transcripts. The participants' ability to review their interview transcripts provided transparency since the participants could see the raw data from their interviews. It also provided accountability.

The third lens Creswell and Poth (2018) discussed is the reader's or reviewer's lens. If the study provides a rich, detailed description of the data, then the reader can discern on their own if the findings apply to their settings. The reader's lens can prove to be helpful to other school counselors, administrators, and teachers within Lancaster County. Additionally, I sought out peers and advisors who offered to review the study and process with an objective perspective.

In summary, I applied the methods and structures from this section while following the data analysis spiral introduced by Creswell and Poth (2018). Figure 2.6 provides a visual of the process I followed for the qualitative analysis.

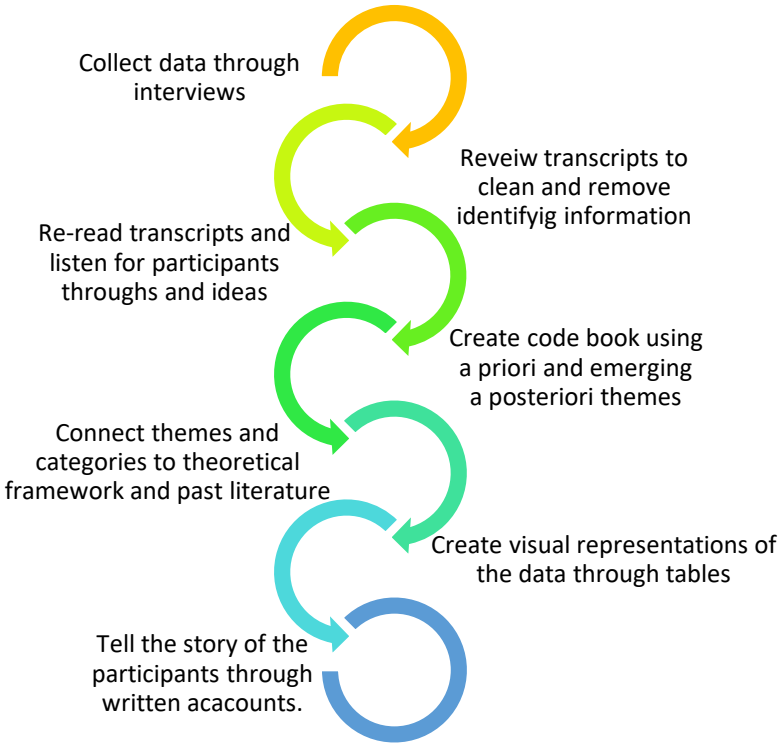

Figure 2.6. Qualitative data analysis process.

By establishing rigid management and organization from the onset of the study, as suggested by the spiral, the remaining aspects (reading/memoing ideas; describing codes and classifications; developing and addressing interpretations; and visualizing the data) developed naturally. Adhering to the guidelines and methods suggested for a mixed methods design approach not only ensured congruency, validity, and reliability for the study but also established a framework that displayed the rich, descriptive data collected. The integration of the qualitative data with the quantitative data can help incite systemic change within our schools for the betterment of our students' mental health needs.

Integration of Quantitative and Qualitative Data Analysis

After I finished the quantitative and qualitative data analysis, I completed the third step of analysis as part of an explanatory sequential mixed methods study. Creswell and Poth (2018) suggest that this phase is crucial to show "how the qualitative data helps to explain the quantitative data to answer the mixed methods question" (p. 235). One important step for successful integration is to select participants for the qualitative phase who provide a broad representation of the different, identified groups I note in the quantitative analysis phase (Creswell & Poth, 2018). Table 2.5 shows a breakdown of the Phase Two participants' characteristics as they relate to the selection criterion based on data analysis from Phase One data analysis. The table also shows that I considered the participants' scores for both inventories, which allowed me to add analysis to the stories participants shared in the qualitative study that related to variances in quantitative scores.

Table 2.5

Qualitative Study Participants Descriptive Characteristics

Participant	Age	Level of Education	Level of Teaching	School Type	IASMHS Score	MHLS Score
Celeste	26–30	Bachelors	Elementary	Private Rural	85*	150
Peter	36–40	Bachelors	Kg-7th	Private Suburban	59	125
James	36–40	Masters	High School	Private Suburban	82	152*
Evie	56–60	Masters	Middle School	Public Urban	48	123
Christina	41–45	Masters	High School	Public Suburban	77	129

Note: Names changed to protect the identity of participants. The "*" symbol indicates the highest score recorded on inventory out of all participants (IASMHS, *n*=44; MHLS *n*=40). The lowest scores recorded by participants on the inventories were 42 on the IASMHS and 113 on the MHLS

While the table provides a visual snapshot of each participant, it does not tell their entire story. I discuss the results from my analysis in more detail in Chapter Three.

Trustworthiness and Authenticity

The design for this study was an explanatory sequential mixed methods design. This design entailed collecting quantitative data first and then explaining the quantitative results with in-depth qualitative data. As I stated previously, the benefit of this type of design was the value that both types of data brought to the research. I operated under a pragmatic worldview (Creswell & Plano Clark, 2018) in using an explanatory sequential mixed method design. This type of design requires integration of the quantifiable data with the qualitative data, creating a richer and more robust picture of the studied phenomenon (Creswell & Plano Clark, 2018). Once I collected the quantifiable data and analyzed it, then generalizability of the data was possible. However, the collected qualitative data gives deeper insight into educators' perceptions and understanding of child and adolescent mental health issues (Creswell & Plano Clark, 2018).

Throughout Chapter Two, I provided clear and concise descriptions of the data collection protocols I used in both the quantitative and qualitative phases of my study. I also explained to the reader how I used the quantitative protocols and collected data to drive the qualitative phase. By doing so, I ensure replicability is possible should other researchers want to conduct similar studies with different populations.

In the previous sections, I also showed how I achieved trustworthiness and validity through triangulation methods used during analysis. I do not claim for my study to be without flaws; however, I can assert that throughout every step, I strived to show objectivity, transparency, and authenticity.

Ethical Considerations

I identified several ethical considerations for this study. Before beginning the study, I acquired the appropriate permissions. The collection of data from individuals and sites for this study required permission from four sources (Creswell & Plano Clark, 2018): participants, site administrators, my professional supervisor, and the Baylor University's IRB.

When a researcher is conducting a study under the umbrella of an educational institution, the researcher must seek approval from human-subject review boards. The purpose of these committees is to mitigate the level of harm or risk that could come from participation in the study. Creswell and Plano Clark point out that IRB approval is to protect not only the participants but also the reputation and funding of the college or university (2018).

Following university procedures and in adherence with the suggested protocol for a mixed methods design (Creswell & Plano Clark, 2018), I sent an Internal Review Board (IRB) Application Inquiry to the following individuals: Baylor University's IRB administrator, the Assistant Vice Provost for Research; Research Compliance; and the Research Compliance Administrator. The purpose of this inquiry was to have the IRB determine the need for a full IRB human-subject application. In addition to submitting these supporting pieces of evidence to the IRB, I also submitted proof of completion of the CITI social and Behavioral Training.

Before seeking participant involvement, I obtained the needed permissions to assure approval and transparency of the study. As mentioned earlier in this chapter, I sent a letter to all local superintendents and head administrators of private schools with a

description of the study to acquire their permission to survey teachers in their district. I offered participating superintendents a copy of the finalized study, at their request.

I first obtained permission from my direct supervisor because conducting the study required some hours during the work-day and some schools would recognize my name as a non-public school counselor. I also made certain to provide frequent updates to my supervisor demonstrating no conflict with expected work duties because of the study. My supervisor also had many contacts within the county educational system and was able to assist with connections to various schools. Finally, the supervisor also permitted the use of the study and findings as a professional goal for the 2021–22 school year with the expectation that a summary of the findings and implications would be shared with the entire non-public school counseling department.

Each participant provided informed consent before participating to ensure participants understood the nature of the study, the expectations for their participation, assured that I would maintain their information in a safe and protected manner, and assured participants that no harm would come from their participation. Informed consent is especially important in qualitative studies as data collection revolves around more personal experiences (Creswell & Poth, 2018).

Each participant volunteered for the study. I did not coerce participants, nor did I offer compensation to participate in the study. The study required each participant to provide consent and provide their electronic signature through the electronic survey. Participants knew through informed consent that they may stop the survey at any time and/or may skip questions that they did not want to answer.

Participants I selected for the qualitative portion of the study came from the sample of participants in Phase One of the study, therefore, I could not offer anonymity. However, I did ensure confidentiality by storing data in a password-protected file within a password-protected computer. I made sure I did not link participants' responses and specific or identifiable school information. Following data analysis, I removed and deleted all identifiers from all storage databases. Throughout the study, I followed the suggested protocol and adhered to all ethical standards to ensure human participants' identities were not associated with the results of the study.

Limitations and Delimitations

This study explored teachers' perceptions and understanding of mental health issues that impact adolescents. With no facilitator present to conduct the survey, there was a possibility of misinterpretation when participants read the questions which may have resulted in skewed data. Additionally, some limitations existed because I conducted the surveys and interviews electronically (i.e., missed opportunity to read and interpret the body language of participants), however, due to limited social contact, electronic communication was safer and more manageable. I also acknowledge that altering items #9 and #10 on the MHLS instrument without conducting a pilot study thi have impacted the validity and reliability of the instrument.

The dependent variables I investigated in this study were teachers' perception of mental health/school counseling services; teachers' understanding of mental health and teachers' experience of releasing students for support services. The independent variables I considered for this study were the physical location of the teacher's school (rural; urban); the type of school in which the teacher is employed (public; private); and the

grade level taught by the teacher (elementary; middle; or high school). I recognize that many other variables could influence the dependent variables, such as age; race; cultural background; socioeconomic conditions; personal experience with mental health issues; years of teaching; and religious beliefs, to name a few. However, due to the limitation of time I had to complete the study and the task of analyzing the data alone, I did not explore these variables at this time.

The sample size is another limitation of this study. A power analysis indicated that an N= 356 would be a significant sample size. However, I completed this power analysis under the assumption that I, as the researcher, would be able to collect data from educators in different schools throughout all parts of the county. However, given the time constraint and extra barriers brought on by COVID, that simply was not possible. I sent emails to 96 school administrators within Lancaster County and requested that they share the survey link with educators within their districts and school systems. Eleven administrators responded with their support and agreed to send my email and survey link to all staff within their school systems. This lack of response limited my access to the rich pool of educators within Lancaster County which caused data collection to rely more on a snowball sampling. I sent the request for participation in the study during an educator's busiest time of the year (May and August/September). In addition to the barriers COVID created, this timeframe presented another barrier as it is possible that more educators would have responded under different conditions and during a different time of the school year.

I also acknowledge the possibility of some preconceived biases due to my researcher's perspective. My career history and current position created an interesting

dynamic between myself and the faculty where I am and was employed. Though some schools see me as a "native", my role as the researcher creates a new positionality to the research.

Conclusion

This explanatory sequential mixed methods study examined teachers' attitudes, understandings, and perceptions of child and adolescent mental health issues as they influence teachers' decision-making process to release a student from class for mental health support services. The results of this study have implications to create systemic change within schools for the betterment of students' mental health needs. Specifically, the results of this study show teachers and administrators the importance of giving equal priority between mental health services and academic support services (i.e., speech; math; reading) when considering releasing students from academic class time. Finally, this study will help shape and develop practical and relevant professional development beneficial to teachers and administrators.

CHAPTER THREE

Results and Implications

Introduction

I started this research process with the purpose to explore educators' attitudes toward mental health support offered within the school setting. I also wanted to understand educators' reasoning behind their decision to release, or not to release, a student from class time for support services. In chapter one, I provided a robust literature review that demonstrated what other research has supported in regards to school-based mental health services and identified the gaps in the research. In chapter three, I outlined my explanatory sequential research design and provided a detailed account of the protocols I used for data collection. This chapter supplies the platform for me to provide the results I gathered from the surveys participants completed in Phase One, along with the interviews I conducted in Phase Two. In addition, I provide rich discussion and analysis to give meaning to the data and provide implications for the future.

The data that follows supports the primary argument for this study, which is that teachers' knowledge, beliefs, and attitudes, along with their own experiences, influence their decision to release a student from academic instruction time for mental health support services. The data shows that there is a positive correlation between teachers who measure with high levels of Mental Health Literacy (MHL) and high (positive) attitudes toward mental health services, as demonstrated through their IASMHS scores.

I present the results of this study in four sections. The first section of data answers research question one, which asks, what is the relationship between a teacher's attitude

towards mental health services and a teacher's mental health literacy? I use rich, descriptive statistics and analysis to demonstrate this positive relationship. In the second section, I address research question two, which asks, what influences a teacher's decision to release students from academic instruction to access mental health services? It is here that I use careful analysis to describe the codes and themes I discovered from the qualitative interviews. The third section allows me to integrate data I collected from both phases and answers research question three, which asks, how do the results of the survey data (quantitative) and the interview data (qualitative) explain teacher decision-making regarding releasing students for mental health services during academic instruction? I respond to this question by using the statistical findings from Phase One and connecting them to the themes and codes revealed in Phase Two. Finally, the fourth section integrates all the data and allows the rich, descriptive qualitative data to provide deep meaning to the descriptive statistics which I show supports Bandura's social cognitive theory (1986). I allow educators' voices to share their beliefs and values as they relate to mental health while they also express a desire for more education and resources that will enable them to better support their students.

Assumption Checking and Data Cleaning

Prior to analyzing the data, I collected from the participants, I followed the necessary steps of data cleaning and assumption checking. Data cleaning refers to the process of reviewing the data and checking for errors, such as missing or duplicate data, that may skew the data analysis (Field, 2018). Assumption checking refers to the process of confirming the collected data meets the pre-requisites for each statistical test I planned to run for analysis and ensures I am not drawing false conclusions (Field, 2018). In the

following sections, I review in detail the steps I followed for data cleaning and the different assumption checking measures I took for each statistical test.

Data Cleaning

To give meaning to the data I collected from participants, I sorted through the responses to ensure that the data was suitable for analysis. There is an increased propensity for error if I do not format response entries correctly when running analysis with SPSS. Therefore, I made sure I coded all categorical answers correctly. For example, educators could indicate on their survey what grade level(s) they instructed. For analysis purposes, I coded all elementary teachers as "1," secondary teachers as "2" and multi-level educators as "3." I completed this type of data coding for other categorical data, including school site (rural or urban) and school type (public or private).

Additional data cleaning measures included the creation of different data sets that I then used to run different statistical analyses. For example, though I had 44 educators participate in the quantitative portion of the study, only 40 of these educators completed both inventories that I included in the survey. Therefore, when running an analysis that looked at the second inventory (the Mental Health Literacy Scale), I utilized a sample size of n=40 as opposed to the full N=44. Similarly, when I compared responses between educators who teach in rural settings compared to those who teach in urban settings, I needed to re-code some participants' responses to align with my research question since some educators indicated they taught in both rural and suburban settings, despite only working in one building. Therefore, for the purpose of my study, I combined and coded responses that indicated "suburban" as "rural".

Assumption Checking

Before running the three, different statistical tests on my different variables, I checked various assumptions required for each test. This process of assumption checking enabled me to verify I had used the appropriate variables and to ensure that the variables had an even distribution. In the following sections, I review the different assumptions that I checked as they related to the specific statistical tests that I ran on the collected data.

Pearson r. *T*he Pearson *r* correlation required that I confirm four assumptions (Field, 2018). The first assumption I checked ensured the dependent variables were continuous as opposed to categorical (Field, 2018). The dependent variables in my research were the educators' scores on the IASMHS and the MHLS. I visually inspected my data output to ensure that the IASMHS scores (n=44) ranged from 0 to 96 and that the MHLS scores (n=40) ranged from 35 to 160. I passed assumption one.

The second assumption I checked for the Pearson *r* confirmed both variables were normally distributed (Field, 2018). The histograms I created displayed a shape that resembled a slightly skewed bell curve, with a peak in the middle and smaller frequencies on each end. I passed assumption number two (Field, 2018). Figure 3.1 shows the histogram I created when I ran my data through the Graphs and Legacy Dialogs features in SPSS (*v.28*).

The third assumption I checked for the Pearson *r* correlation was to confirm that the relationship between the two variables was linear. I visually inspected the data points on a scatter plot and ensured that they formed a somewhat linear line. This inspection validated that I passed assumption number three (Field, 2018).

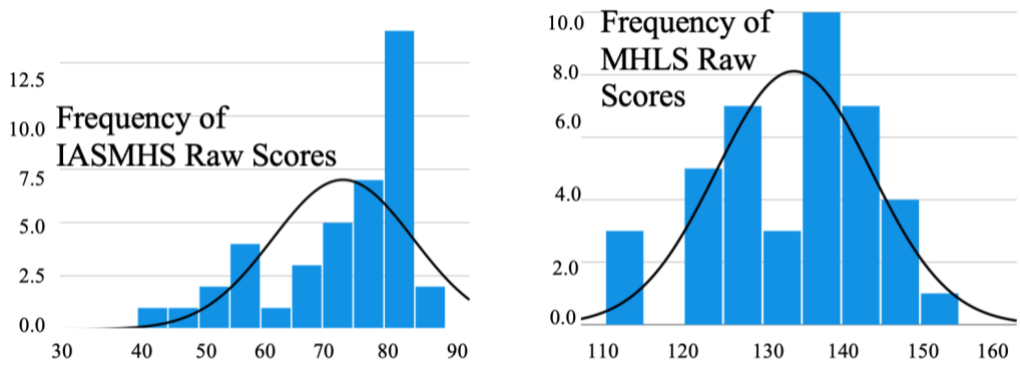

Figure 3.1. Histograms showing the output for testing assumption #2.

The fourth assumption for the Pearson *r* requires that no values are missing for each participant. I checked the fourth assumption when I input my data (Field, 2018) and confirmed that each of the participants had a score for both inventories. The sample size was different for each inventory (IASMHS, n=44; MHLS, n=40), therefore, during data cleaning for this analysis, I only used the 40 participants who completed both inventories. After I verified that I passed this final assumption, I was able to run the Pearson *r* correlation. I discuss the results of the Pearson *r* test in the Quantitative Data Findings section.

Independent samples t-test. The second set of tests I ran were four independent samples *t*-tests. The specific independent variables tested were:

- public versus private school settings
- rural public versus rural private school settings

The *t*-tests required I check five assumptions before running the analysis (Field, 2018). I repeated this process for each set of the different variables I tested. The first assumption required that two independent and categorical groups made up the independent variable (Field, 2018), which meant participants' membership in a group needed to be exclusive.

Participants were educators in either a public or a private school for the first set of *t*-tests. Similarly, participants were educators in either a rural public or a rural private school setting for the second set of *t*-tests. I passed this assumption.

The second assumption I checked for an independent samples *t*-test was to ensure the dependent variable was continuous as opposed to categorical (Field, 2018). The dependent variables in my research were the educators' scores on the IASMHS and the MHLS. I visually inspected my data output to ensure that the IASMHS scores (n=44) ranged from 0 to 96 and that the MHLS scores (n=40) ranged from 35 to 160. I passed assumption number two.

The third assumption for an independent samples *t*-test required that I check for significant outliers with the data. Outliers are data points that exist far away from the represented mean (Field, 2018). The Explore feature in SPSS (*v.28)* creates a Q-Q plot when running descriptive statistics. The Q-Q plots display a regression line with the various data points clustered along the line. Figures 3.2 and 3.3 provide a visual of the produced Q-Q plots for the first independent *t*-test comparing public and private school educators' IASMHS scores, respectively.

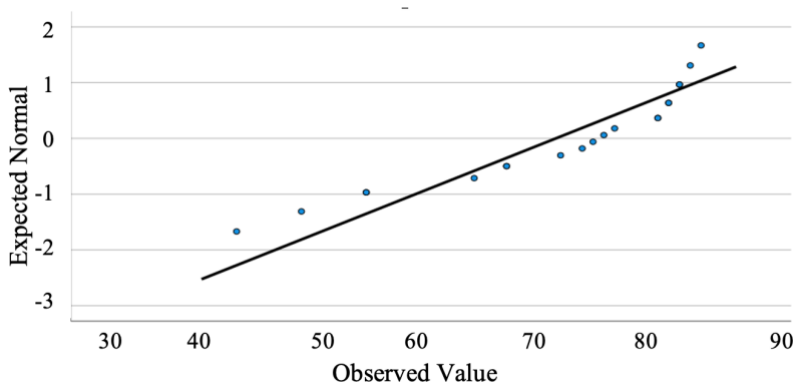

Figure 3.2. Q-Q plot testing assumption of outliers for first independent samples *t*-test of public-school educators IASMHS scores.

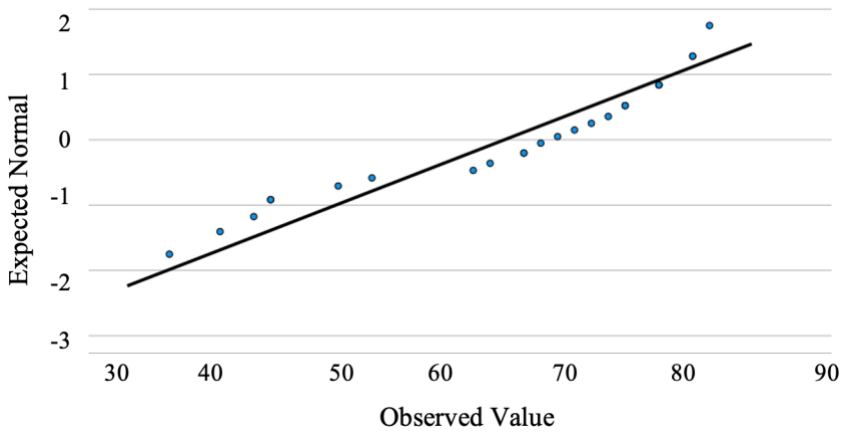

Figure 3.3. Q-Q plot testing assumption of outliers for first independent samples *t*-test of private-school educators' IASMHS scores.

Figures 3.2 and 3.3 show that the data did not violate assumption number three as there are no visible outliers on this data output. I repeated this visual inspection for outliers for all four independent samples *t*-tests. Figures 3.4 and 3.5 provide a visual of the produced Q-Q plots for the second independent *t*-test comparing public and private school educators' MHLS scores, respectively.

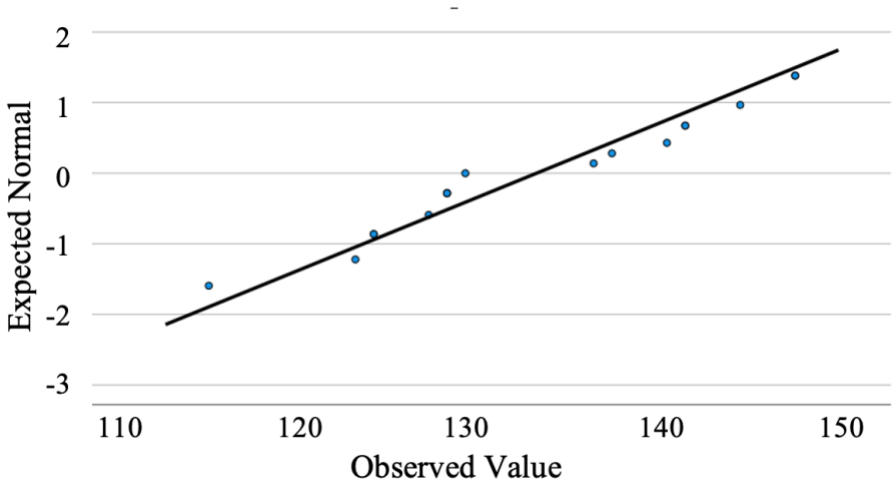

Figure 3.4. Q-Q plot testing assumption of outliers: Second independent samples *t*-test of public-school educators MHLS scores.

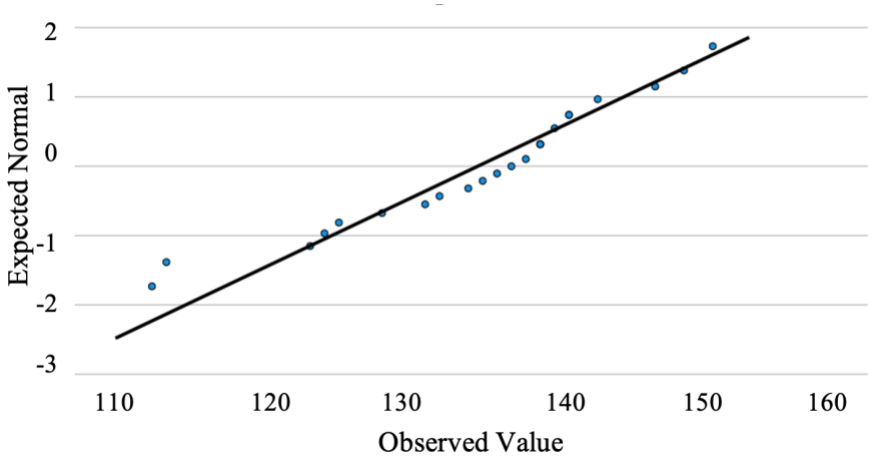

Figure 3.5. Q-Q plot testing assumption of outliers: Second independent samples *t*-test of private-school educators' MHLS scores.

Figures 3.4 and 3.5 show that the data did not violate assumption number three as there are no visible outliers on this data output. Figures 3.6 and 3.7 provide a visual of the produced Q-Q plots for the third independent *t*-test comparing public-rural and private-rural school educators' IASMHS scores, respectively.

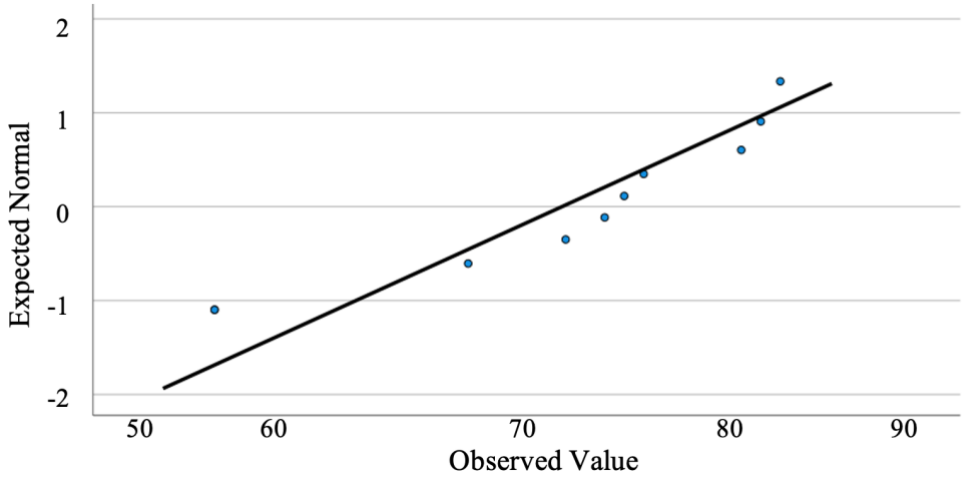

Figure 3.6. Q-Q plot testing assumption of outliers for third independent samples *t*-test of public-rural school educators' IASMHS scores.

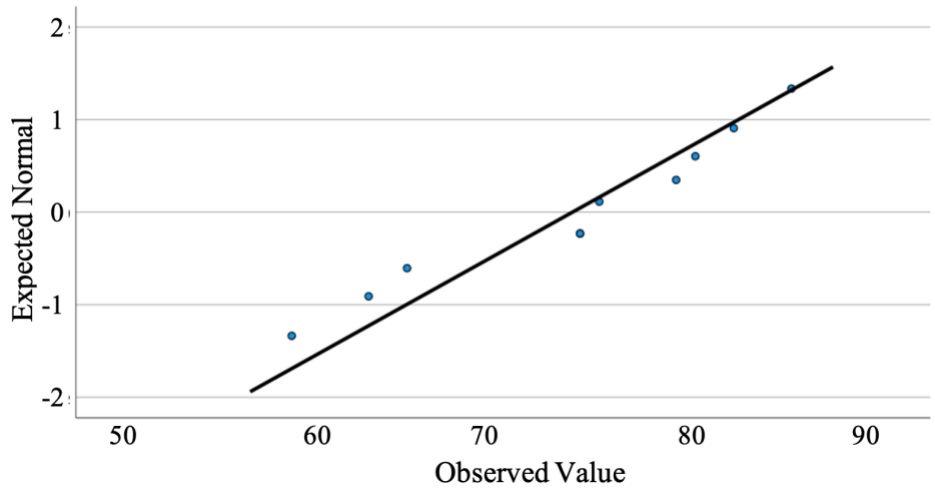

Figure 3.7. Q-Q plot testing assumption of outliers for third independent samples *t*-test of private-rural school educators' IASMHS scores.

Figures 3.6 and 3.7 show that the data did not violate assumption number three as there are no visible outliers on this data output. Similarly, Figures 3.8 and 3.9 provide a visual of the produced Q-Q plots for the fourth independent *t*-test comparing public-rural and private-rural school educator's MHLS scores, respectively.

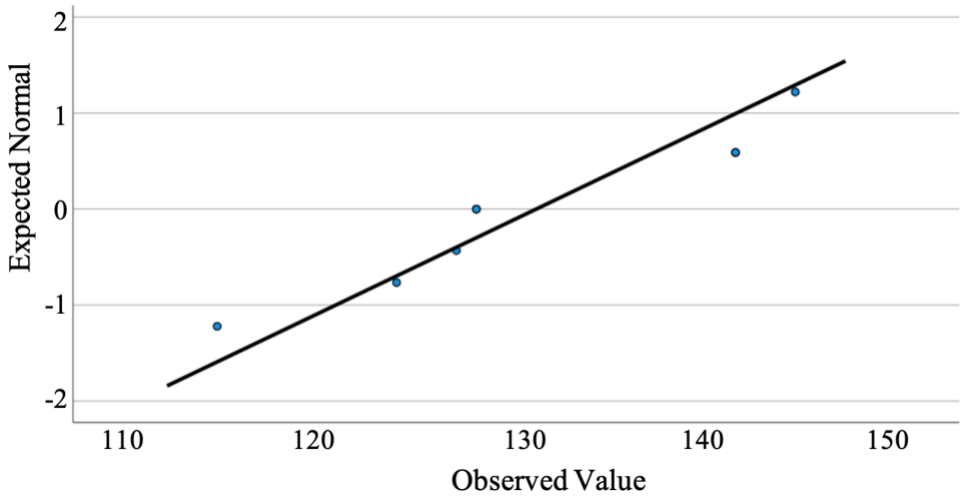

Figure 3.8. Q-Q plot testing assumption of outliers: Fourth independent samples *t*-test of public-rural school educators' MHLS scores.

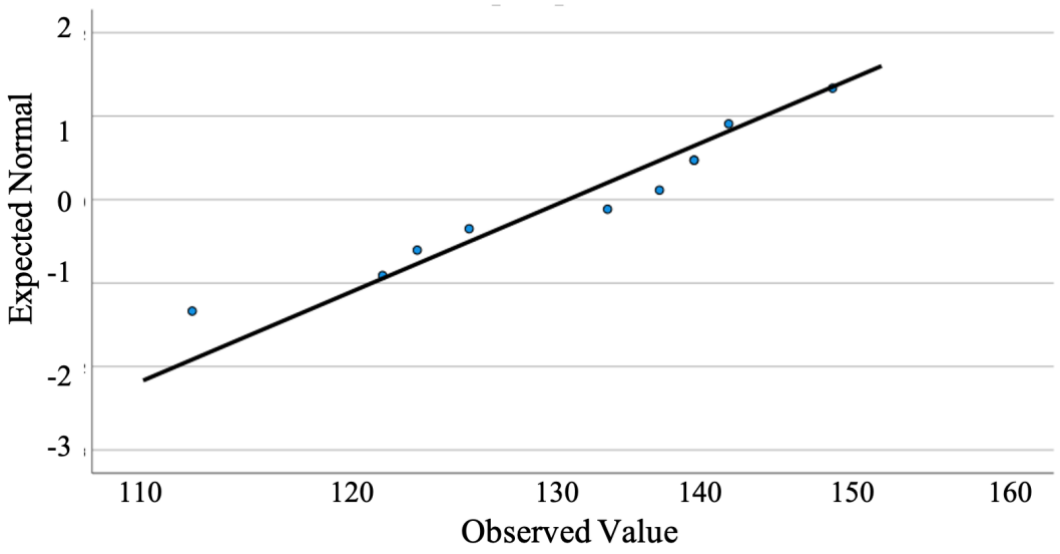

Figure 3.9. Q-Q plot testing assumption of outliers: Fourth independent samples *t*-test of private-rural school educators' MHLS scores.

Figures 3.8 and 3.9 show that the data did not violate assumption number three as there are no visible outliers on this data output.

The fourth assumption that I checked was to ensure that the dependent variable follows a normal distribution for the different groups (Field, 2018). Here I used the Explore feature in SPSS to create a Tests of Normality table. The column labeled Shapiro-Wilk indicated if the data had a normal distribution. To pass this assumption, the *p* score could not be statistically significant (<.05). Additionally, another review of the previously created Q-Q plots indicated a normal distribution if most of the data points fell along the line of regression (Field, 2018). Table 3.1 provides the Shapiro-Wilk *p*-value for each independent *t*-test.

Table 3.1

Independent t-Tests Assumption Four: Tests of Normality

Independent Samples *t*-Test	*p*-value for Shapiro-Wilk test	
	Public	Private
Public school vs. private school educators on IASMHS	*p*=.009*	*p*=.016*
Public school vs. private school educators on MHLS	*p*=.307	*p*=.227
Public-rural vs. private-rural school educators on IASMHS	*p*=.077	*p*=.470
Public-rural vs. private-rural school educators on MHLS	*p*=.350	*p*=.563

Note: *p* scores with * indicate significance and therefore does not allow assumption of a normally distributed dependent variable

According to Table 3.1, three of the four independent *t*-tests passed assumption number four since the *p* values for the Shapiro-Wilk test were not significant, affirming that the data met the conditions of the fourth assumption. After I carefully reviewed the Q-Q plots associated with the first independent samples *t*-test (Figures 3.2a and 3.2b), I observed that the data points displayed a normal distribution along the line of regression. Therefore, it was safe to assume a normal distribution and move on to the fifth and final assumption check.

The fifth and final assumption that I checked for my independent samples *t*-tests ensured that the variances of the two groups are equal (Field, 2018). The Levene's test of homogeneity of variance is an output that resulted when I ran a *t*-test. If the data indicated statistical significance in the variance, then the data violates this assumption. All four *t*-tests passed homogeneity of variances and therefore the data passed assumption number five (Field, 2018). Table 3.2 provides the *p*-values for Levene's test of homogeneity for each independent samples *t*-test.

Table 3.2

Independent t-Tests Assumption Four: Levene's Test of Homogeneity

Independent Samples *t*-test	*p*-value for Levene's test
Public school vs. private school educators on IASMHS	*p*=.254
Public school vs. private school educators on MHLS	*p*=.815
Public-rural vs. private-rural school educators on IASMHS	*p*=.605
Public-rural vs. private-rural school educators on MHLS	*p*=.662

Since I passed all four assumptions for each independent samples *t*-test, I was able to analyze and compare the mean scores of the dependent variables. I discuss the results of the four *t*-tests in the Quantitative Data Findings section.

One-way ANOVA. The third set of tests I ran were four, one-way ANOVA tests. The ANOVA allowed analysis to compare the mean scores (dependent variable) of three or more groups (independent variables). Similar to the Pearson *r* and the independent samples *t*-tests, the ANOVA has six assumptions I needed to check before running the analysis (Field, 2018). For the first assumption, I verified that my dependent variables were continuous. Then, for the second and third assumptions, I verified that my independent, or grouping variable, had more than two, independent groups (Field, 2018). For these tests, my independent variables were educators' grade band level of instruction (primary, secondary, or multi-level) and educators' age band (22-30; 31-40; 41-50; and 51+). For each ANOVA, participants could only be in one category. Both assumptions two and three passed for the different one-way ANOVA tests.

The fourth assumption requires that there are no significant outliers in the data output (Field, 2018). Figure 3.10 shows the three Q-Q plots produced when testing the fourth assumption.

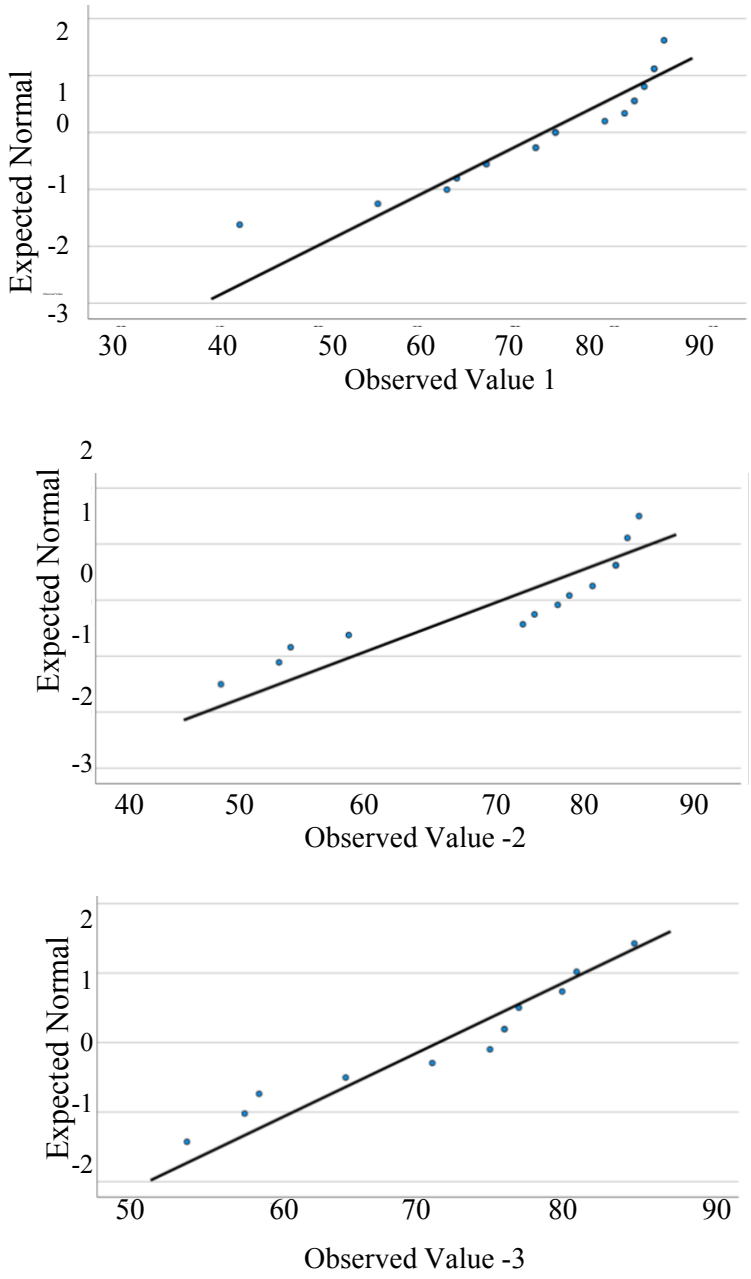

Figure 3.10. Q-Q plots for one-way ANOVA comparing IASMHS scores across grade band levels of instruction.

Note: 1 = primary level of instruction; 2 = secondary level of instruction; 3 = multi-level

I made a visual inspection of the data points on Q-Q plots to verify that all of the data points fall close to the line of regression. The collected data points all fell closely and thereby the data passed the fourth assumption. The first one-way ANOVA compared

educators' mean scores of the IASMHS across different grade bands (primary; secondary; and multi-level). The second one-way ANOVA compared educators' mean scores of the MHLS across different grade bands (primary; secondary; and multi-level). Figure 3.11 shows the three Q-Q plots produced when testing the fourth assumption.

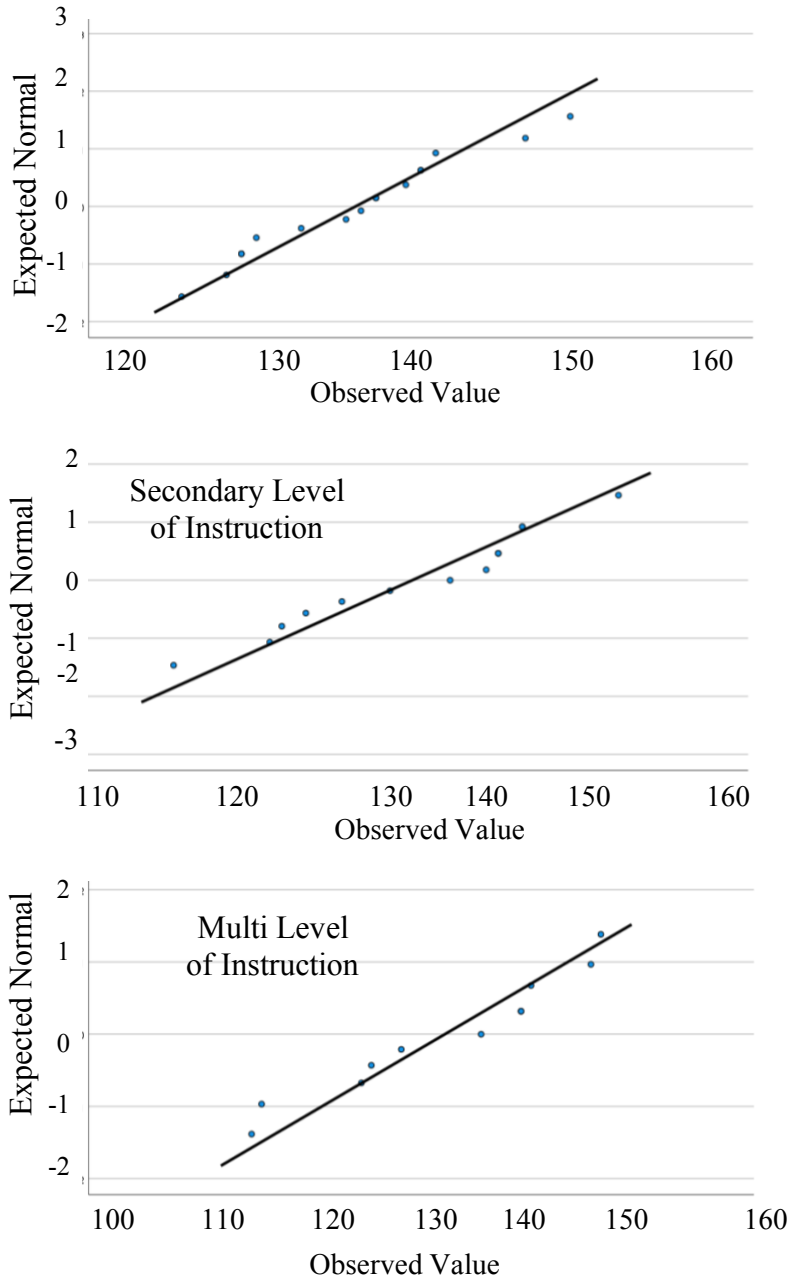

Figure 3.11. Q-Q plots for one-way ANOVA comparing MHLS scores across grade band levels of instruction.

The third and fourth one-way ANOVAs compared educators' mean scores of the IASMHS and the MHLS across four different age bands (22-30; 31-40; 41-50; 51+). Figure 3.12 shows the four Q-Q plots produced when comparing the IASMHS mean scores and Figure 3.13 shows the four Q-Q plots produced when comparing the MHLS mean scores.

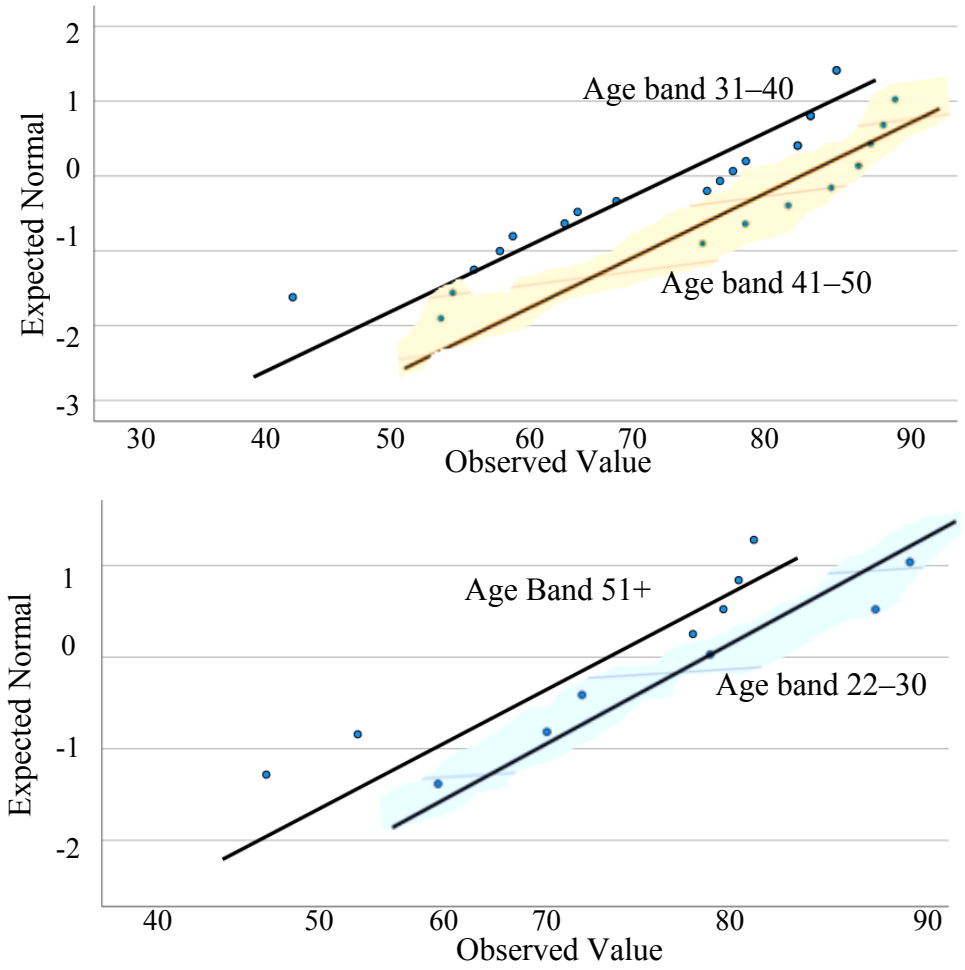

Figure 3.12. Q-Q plots for one-way ANOVA comparing IASMHS scores across age-bands.

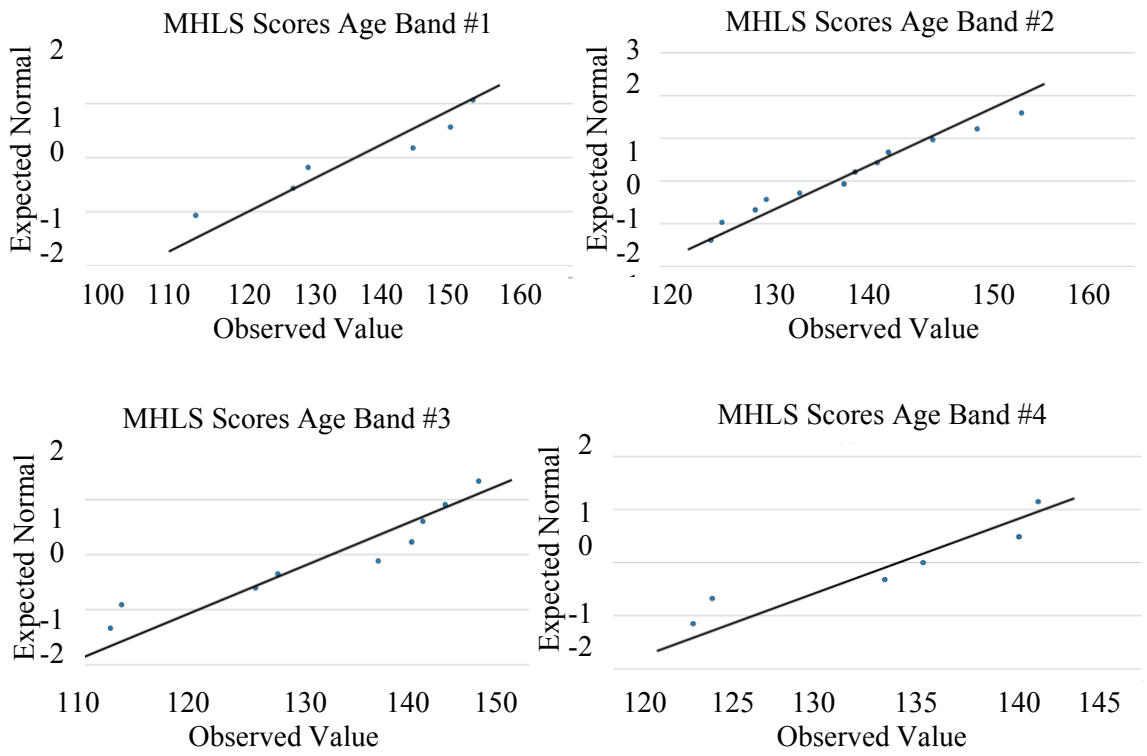

Figure 3.13. Q-Q plots for one-way ANOVA comparing MHLS scores across age-bands. Note: 1 = 22-30; 2=31-40; 3=41-50; 4=51+

This visual inspection of the data points is especially important when working with smaller sample sizes as a uniformed display of data can justify proceeding with the ANOVA, even if the data indicates that there is a violation of the fifth assumption.

The fifth assumption requires a normal distribution of the dependent variables for each category of the independent variable (Field, 2018). The fifth assumption can be hard to pass if the study, like mine, has a small sample population where a normal distribution of the data is not as likely since the sample is not statistically significant (Field, 2018). Similar to the process used with the independent samples *t*-test, I used the Explore feature in SPSS to create a Tests of Normality table. The column labeled Shapiro-Wilk indicated if the data had a normal distribution. To pass this assumption, the *p* score could not be

statistically significant (<.05). Additionally, another review of the previously created Q-Q plots indicated a normal distribution if most of the data points fell along the line of regression (Field, 2018). Table 3.3 provides the Shapiro-Wilk *p*-value for each one-way ANOVA comparing mean scores of the dependent variable across grade bands of instruction.

Table 3.3

One-Way ANOVA Assumption Five: Tests of Normality Across Grade Bands

Grade Band Level	*p*-value for Shapiro-Wilk test	
	IASMHS	MHLS
Primary	*p*=.029*	*p*=.691
Secondary	*p*=.005*	*p*=.616
Multi-Level	*p*=.249	*p*=.315

Note: *p* scores with * indicate significance and therefore does not allow assumption of a normally distributed dependent variable.

Table 3.4 provides the Shapiro-Wilk *p*-value for each one-way ANOVA comparing mean scores of the dependent variable across age bands of educators.

Table 3.4

One-Way ANOVA Assumption Five: Tests of Normality Across Age Bands

Age Band of Educators	*p*-value for Shapiro-Wilk test	
	IASMHS	MHLS
22–30 years	*p*=.609	*p*=.571
31–40 years	*p*=.026*	*p*=.456
41–50 years	*p*=.006*	*p*=.086
51+ years	*p*=.010*	*p*=.115

Note: *p* scores with * indicate significance and therefore does not allow assumption of a normally distributed dependent variable

The data passed the fifth assumption for nine of the 14 variables tested. However, the fourth assumption check provided a visual depiction of the data points, which showed them close to the regression line. Therefore, I moved on to test the sixth assumption.

The sixth and final, assumption I checked before running the one-way ANOVA required me to look at Levene's test of homogeneity of variance in the output. If the data showed there was statistical significance ($p<.05$) this would indicate that not all the groups had a similar variance in their scores (Field, 2018) and would violate this assumption. Three of the four one-way ANOVA tests I ran passed this assumption. Table 3.5 provides the *p*-values for Levene's test of homogeneity for each one-way ANOVA.

Table 3.5

One-Way ANOVA Assumption Six: Levene's Test of Homogeneity

One-Way ANOVA Test	*p*-value for Levene's test
Comparing across grade bands on IASMHS	$p=.600$
Comparing across grade bands on MHLS	$p=.043$*
Comparing across age bands on IASMHS	$p=.890$
Comparing across age bands on MHLS	$p=.063$

Note: *p* scores with * indicate significance and therefore does not allow assumption of a normally distributed dependent variable

When I checked this assumption with the mean MHLS scores compared between the different grade bands, the test of homogeneity of variance was significant ($p=.043$), therefore the data did not pass assumption number six for this ANOVA. However, considering the small sample size, I chose to proceed with all four one-way ANOVA analyses.

In the sections that follow, I explore the findings in more detail as they relate to each research question. I share which specific statistical tests I conducted, the argument for why I choose that test, and the significance and meaning of the results as it pertains to this study.

Quantitative Data Findings: Phase One

In the quantitative phase of this study, I explored the following research question: what is the relationship between a teacher's attitude towards mental health services and a teacher's mental health literacy? To answer this question, I asked educators (N=44) to complete a survey made up of two inventories. The IASMHS (Makenzie et al., 2004) measured the educators' attitudes towards seeking mental health services and the Mental Health Literacy Scale (O'Connor et al., 2015) measured the educators' knowledge of mental health issues. I conducted several different statistical tests to analyze the quantitative data. The statistical computer program SPSS (*v.28)* enabled me to run a variety of tests to explore the relationship between different variables in my study. I first conducted a Pearson *r* correlation to explore the relationship between the two scales I used in the electronic survey. I also conducted independent samples *t*-tests and one-way analysis of variance (ANOVA) tests. Both tests allowed me to compare the means of the different groups of participants within my study. Table 3.6 provides a snapshot of each statistical test, its purpose, and a brief overview of what I found in the results.

Table 3.6

Overview of Statistical Tests for Quantitative Analysis

Statistical Test	Purpose	Results
Pearson *r* correlation	To explore the relationship between teachers' attitudes toward mental health services and their mental health literacy	Moderate, positive, statistically significant relationship
Independent samples *t*-test	To compare the mean scores of the IASMHS and MHLS between educators employed in public or private schools and between public rural and private rural schools	No statistically significant difference in educators' IASMHS and MHLS scores between school locations or school types
One-way ANOVA	To compare the mean scores of the IASMHS and the MHLS across age bands of educators and the different grade levels taught	No statistically significant difference in educators' IASMHS and MHLS scores among age bands and grade levels taught

I discuss the results of each of these tests in the sections that follow.

Pearson r Statistical Findings

The main question of the quantitative phase explored the relationship between a teacher's attitude towards mental health services and a teacher's mental health literacy. To answer this question, I explored the relationship between the mean scores of the IASMHS (Makenzie et al., 2004) and the MHLS (O'Connor et al., 2015). I ran a Pearson *r* correlation between the IASMHS Raw Scores and the MHLS Scores of 40 participants. A moderate, positive, and statistically significant relationship was found (r= .62, 95% CI 0.46, 0.77, p<.001). Figure 3.14 shows a scatter plot of educators' responses. The results

indicate that those who demonstrated high, or favorable, attitudes on the IASMHS Inventory (Makenzie et al., 2004) also scored high on the Mental Health Literacy Scale (O'Connor et al., 2015).

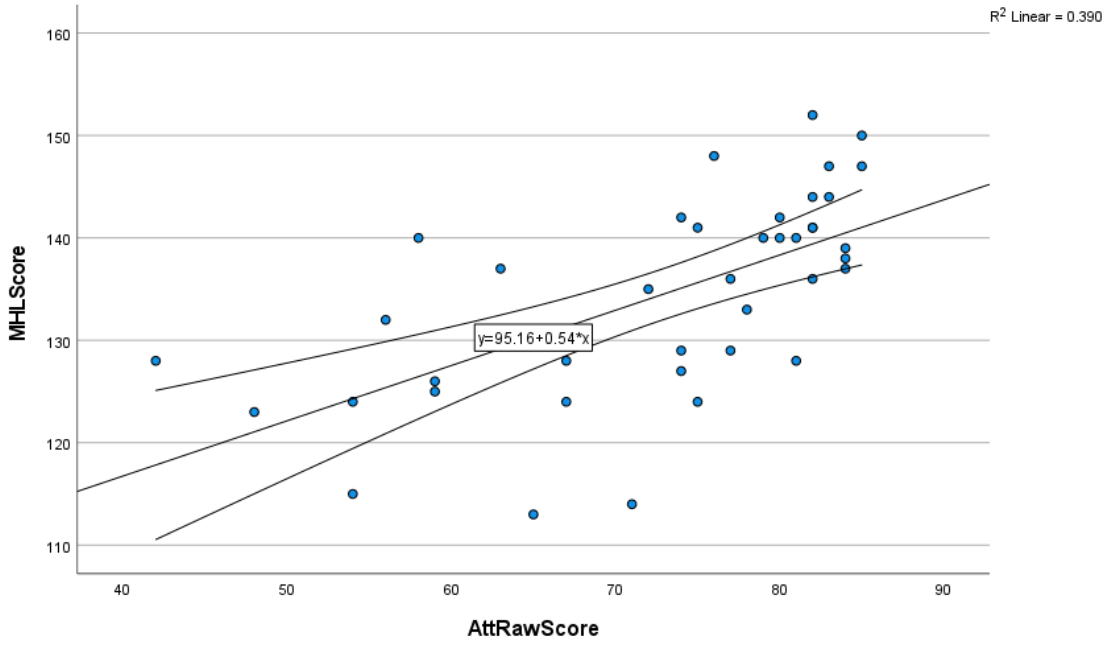

Figure 3.14. Scatter plot of MHLS and IASMHS raw scores.

Note: The x-axis labeled AttRawScore are the raw scores from the IASMHS.

This positive relationship between the two scores indicates that teachers who have a stronger understanding (literacy) of mental health issues may have a more positive attitude towards mental health services. Previous research revealed that educators' literacy, attitudes, and perceptions (cognitive factors) about mental health influence their ability (behavioral factor) to identify mental health concerns while also influencing their decision to refer a student for services (Bandura, 1986; Breuer, 2016; Mackenzie et al., 2004; Reinke et al., 2011). If I follow the research from the literature review and I apply Bandura's (1986) framework to the Pearson *r* analysis, the educator's attitude (cognitive

factors) towards seeking mental health support and their knowledge of mental health (cognitive factors) may influence a teacher's willingness and decision to release a student from class (human behavior). I ran additional statistical tests to explore one of the other two components of Bandura's (1986) framework: environmental factors.

Independent Samples t-Test Statistical Findings

Part of the theoretical framework for my study suggests that an individual's environment can influence their behavior (Bandura, 1986). In light of this component of Bandura's social cognitive theory (1986), I explored the data further to see if there was any relationship between educators' work environments. Specifically, I examined the data to see what relationship, if any, existed between the participants' IASMHS and MHLS scores depending on whether they worked in a public or private school.

The first independent samples *t*-test found that public school educators (M = 71.55, SD= 12.99) scored lower on the IASMHS scale than private school educators (M=72.83, SD=9.99). The difference between the two groups was not statistically significant ($t(42) = -0.37$, p=.25; 95% CI -8.27, 5.71). The effect size was small (d=0.11).

I ran a second independent samples *t*-test to compare the means of the MHLS scores between public and private school educators. The test showed that public school educators (M = 132.88, SD=9.45) scored lower on the MHL scale than private school educators (M=135.65, SD=10.16). The difference between the groups was not statistically significant ($t(38) = 0.88$, p=.39; 95% CI -9.16, 3.62). The effect size was moderate (d=0.28). These two tests indicate that the type of school in which a teacher works has no bearing on their attitude towards mental health. Similarly, the data does not support any

relationship between how literate an educator is in mental health and the type of school in which they work.

The third independent samples *t*-test compared the means of the IASMHS scores for educators who work in public rural schools and private rural schools. Of the total sample population (*N*=44), half indicated they worked in a rural setting (*n*=20). Therefore, I wanted to compare the means of educators in both public and private schools within a rural setting to see if there was any difference. The independent samples *t*-test found that educators who work in rural public schools (*M*=71.80, *SD*=10.56) scored lower on the IASMHS than educators who work in rural private (*M*=73.60, *SD*= 8.64). However, the difference between the two groups was not statistically significant (*t*(18) = -0.42, *p*= .68; 95% CI -10.87, 7.27). The effect size was small (*d*= -0.02).

The fourth independent samples *t*-test also compared mean scores for educators who worked in public rural and private rural schools, but this time compared the MHLS scores. The independent samples t-test found that educators who work in rural public schools (*M*= 131, *SD*=10.06) scored lower on the MHLS than educators who work in rural private (*M*=134.70, *SD*= 11.32). However, the difference between the two groups was not statistically significant (*t*(16) = -0.72, *p*= .48; 95% CI -14.55, 7.15). The effect size was small (*d*= -.03).

Though the data did not demonstrate a relationship between the educators' survey results and the type of school in which they work, I continued to use Bandura's social cognitive theory (1986) to explore other types of environments which could impact an educator's decision to release a student from class. Therefore, I compared the mean

scores of educators who worked in urban, rural, and suburban schools. Since I was comparing more than two mean scores, I needed to run a one-way ANOVA test.

One-Way ANOVA Statistical Findings

When I compared the mean scores of the IASMHS for educators in Urban, Rural, and Suburban schools, the results demonstrated that educators who teach in urban settings scored higher than those educators who work in rural or suburban settings. A one-way ANOVA found that these findings were not statistically significant different between site location ($F(2,41) = 0.45$, $p = .64$, with a small effect size ($\eta^2 = .02$). Table 3.7 provides a breakdown of the mean IASMHS scores.

Table 3.7

Descriptive Statistics for the IASMHS Based on School Location

Location	*N*	Mean	Std. Dev.	Std. Err	Lower Band	Upper Band	Min	Max
Urb	8	75.50	12.456	4.404	65.09	85.91	48	84
Rural	17	72.24	9.808	2.379	67.19	77.28	54	85
Sub	19	70.89	12.409	2.847	64.91	76.88	42	85
Total	44	72.25	11.326	1.708	68.81	75.69	42	85

Note: Urb = Urban; Sub = Suburban; 95% Confidence Interval for Mean

When I compared the mean scores of the MHLS, the results demonstrated that educators who teach in urban settings scored higher *(M*=136.71, *SD*=8.56) than those educators who work in rural (*M*=132.13, *SD*= 11.03) or suburban (*M*=135.56, *SD*=9.37) settings. A second, one-way ANOVA found that these findings had no statistically significant difference between site location ($F(2,37)) = 0.70$, $p = .50$, with a small effect size ($\eta^2 = .04$). Both statistical tests indicate that the location of an educator's school is

not a strong indicator of their attitude towards seeking mental health services nor is it a good indicator of their level of mental health literacy.

While Bandura's (1986) social cognitive theory was the primary driving force behind the various statistical tests I completed, the literature review also helped guide some of the exploration. Since research shows that more serious mental health issues develop as children enter adolescence and teenage years (Blad & Decker, 2020; Center for Disease and Control and Prevention, 2018; Mercado et al., 2017; Substance Abuse and Mental Health Services Administration, 2019; Twenge et al., 2019), I chose to explore the relationship between educator's grade-band level of instruction and their IASMHS and MHLS Scores.

Descriptive statistics revealed that educators at the primary level scored higher on the IASMHS (M=72.83, SD=11.52) than educators at the secondary level (M=72.21, SD=12.81) and educators' who instruct across multi-grade-bands (M=71.42, SD=10.07). A third, one-way ANOVA found that there was not a statistically significant difference in educators' IASMHS scores between the grade-band level of instruction ($F(2,41) = 0.54$, p=.95), with a small effect size (η^2= .003).

I completed a fourth, one-way ANOVA with the MHLS scores where I compared the mean scores between educators' current grade band. The data showed that educators who offer instruction at the primary grade level scored higher on the MHLS (M_1=135.63, SD_1=7.31) than those who instructed at the secondary or multiple levels (M_2=134.85, SD_2=10.72; M_3=132.36, SD_3=12.32;). The one-way ANOVA found that there was not a statistically significant difference in MHL scores between educators' current grade-band

($F(2,37) = 0.36$, $p=.70$), with a small effect size ($\eta^2= .02$). This test shows that the teachers' current grade band of instruction does not impact their Mental Health Literacy.

Though the majority of the statistical tests I ran produced no statistically significant results, they answered the quantitative research question with statistically significant findings which indicated there is a positive relationship between an educator's literacy and attitude as they both relate to mental health. I discuss the implications of this finding at the end of this chapter. In the following section, I report the findings that came out of the qualitative portion of my study.

Qualitative Data Findings: Phase Two

In Phase One, the statistical tests demonstrated little to no statistical significance with the variances in the participants' responses. However, the findings did help shape the research questions that I used in the semi-structured interviews. The rich, thick, descriptive data gathered in Phase Two augment the findings from Phase One and provide the significance of this study through the voices of the participants. One of the benefits of a mixed method study is that the qualitative data uncover a broader explanation of a phenomenon than what quantitative data alone can reveal. In the sections that follow, I introduce the participants from Phase Two and, through their combined voices, I uncover the themes that emerged through my careful analysis.

Qualitative Research Question

The research question used to guide Phase Two of my study was: How do teachers describe the influence of cognitive, environmental, and behavioral factors on their willingness to release students for mental health services? To answer this question, I conducted semi-structured interviews with five participants. Since I desired

transferability and confirmability with the results, I used a mixed sampling approach. This approach helped ensure data triangulation and allowed me to share the voices of different lived experiences with the same phenomenon. I contacted six educators with an email invitation based on the following criterion:

a. The participants needed to indicate a willingness to continue with Phase Two of the study.

b. The participants represented various site locations (public/private; urban/rural)

c. The participants represented varied demographics with their gender and age band. desired to have mixed demographics

d. The participants represented varied grade-band levels of instruction.

e. The participants represented a span of scores on the IASHMHS and MHLS inventories completed during the quantitative phase of the study scores. I purposely looked for participants who scored in the high, medium, and low range for each inventory.

Participants' Stories

Following the guidelines of a phenomenological qualitative study, within my mixed methods study, the focus of the research is on the experience of each participant. Though I used specific criteria to select the participants, each educator has their own voice and lived experience which adds value and transferability to this study.
Each of the educators who participated in Phase Two, like others in their field, has their own story rich with experiences that have formed their attitudes, thoughts, and beliefs, which in turn impact their daily practices. In the following paragraphs, I share a broader picture of each participant before reporting the outcome of their interviews.

Celeste. My first interview was with a White, female first-grade teacher in her early thirties. She worked at a small, private school located in a rural suburb of Lancaster

County, Pennsylvania. Early in her career, Celeste was employed at a public elementary school located in a poverty-stricken urban area. In this experience, she says she received her education on how mental health impacts students' learning and the reality of Maslow's Hierarchy of Needs (1943). Celeste reported to me how her students would come to school hungry or traumatized from events that happened within the home and how these realities would dictate if her lesson plans would be successful or not on any given day. Celeste also recalled how Active Shooter Practices were not drills but instead responses to what was happening in the community outside of the school building. Despite these glaring issues which demanded a need for mental health support for the students, these services were the first to be cut when budget issues arose. Celeste shared,

> …they had to cut all of their kind of mental health support. Even though that's what the kids needed more than academics, and so I think that really, I knew that [academics] was important don't get me wrong, but I think they really opened up my eyes to the fact that kids can't learn if their mental health needs are not met.

Celeste's experience in this educational environment impacted her beliefs about mental health which have influenced her practices when she considers the needs of her current students.

Peter. When I sent out my first wave of requests for participation in the Spring of 2020, Peter was the first educator to respond with a willingness to participate. He also offered to help with snowball sampling, indicating he would talk to some of his colleagues to enlist their participation in the quantitative portion of the study. Peter is a White male in his mid-30s who teaches technology for K–8 students in a large, private school located in a suburb of Lancaster County, Pennsylvania. Similar to Celeste, Peter

shared with me in his interview how his personal experiences with mental health have shaped his attitudes and beliefs toward mental health. He shared,

> … and so I had to go through counseling and stuff … my college had a therapist I would go to every so often and was one of the greatest things she ever taught me was the three R's, was retreat, rethink, respond … and here I am almost 20 years later, and I still have the poster on my wall in my closet."

These lessons Peter learned did not come from a classroom or professional development, but rather through his personal experience with mental health support. This experience, and others, have in turn impacted his interactions with his students.

Evie. While the majority of the participants from my quantitative study were educators in private schools, Evie represents the voice of the urban-public school educator. Evie is a White female, in her mid-50s and teaches fifth-grade reading in a fifth- and sixth-grade building. Similar to Peter and Celeste, Evie spoke with me about her lived experiences with mental health that involved some students and also her son. She shared, "I think, having gone through it with my son was probably more of a benefit to me … sitting through different counseling sessions with him …". Her account speaks again to the impact that personal experiences have on mindsets and practices.

James. The fourth participant in the qualitative portion of the study was another White male in his mid-30's who teaches math in a suburban-private school. One of the reasons I invited James to participate in Phase Two was because he scored the highest out of all participants (n=40) on the MHLS with 152 out of a possible 160 points. After talking to James, I learned part of the reason for his high MHLS score was his educational background, his work experience, and his personal experiences with mental health. James shared that he majored in Psychology while an undergraduate and worked

for several years in mental health treatment facilities. James stated, "… having that experience in the mental health field, I think, in itself, is the best - would be the best – education" (personal conversation, September 23, 2021). In theme with my other participants, the lived experience of James, in conjunction with his knowledge, helped shape his attitudes and beliefs surrounding mental health. It is these first-hand experiences that shape his practices with releasing his students when they need mental health support services.

Christina. Similar to my other participants, Christina, who is a White female in her early 40s, discussed with me her lived experience with mental health and spoke with rich detail about how mental health issues have manifested in the lives of her students, her family members, and her journey. Our conversation uncovered themes that were both within and outside the scope of this current study as she shared with me barriers that exist for students who need access to mental health support as well as struggles that impact educators' mental health. Christina's role as an educator in a public-suburban-high school is unique to that of my other participants as she is a foreign language teacher which she states creates a different relationship between her and her students and impacts her ability to identify needs in her students. As she states:

> … certainly, there are issues, but sometimes, you know, I get SAP (Student Assistance Program) referrals to fill out and I'm like, yeah, I would have no idea. I don't … I don't see those things so sometimes I wish I could teach in English because then I feel like we could have those conversations …but because I'm teaching, like, all in the target language, then [my students] don't have that opportunity to express themselves (personal conversation, September 21, 2021).

Christina's conversation with me continued as she admitted that even if she could recognize the needs of the students in her public-rural high school, she does not feel well

equipped to know what to do to support them adequately. This theme of adequate training and education was prevalent with many of the participants and one of many that I discuss further in the sections that follow.

Coding and Thematic Analysis

I conducted direct content analysis to do descriptive coding using a priori themes that came from Bandura's social cognitive theory (1986). The a priori themes stem from the three factors: cognitive, environmental, and behavioral, which Bandura (1986) claims to be the main components that influence an individual's behavior. These three factors served as guideposts throughout my analysis. I then did axial coding to link the themes and *in vivo* coding to capture the voice of the participants. From this analysis, four major themes emerged, three of which were a priori (cognitive factors, environmental factors, and behavioral factors) and one of which was a posteriori (barriers to mental health support). Table 3.8 provides a breakdown of these four themes by order of the a priori themes and their nine different categories, and the a posteriori theme and its seven distinct categories.

Table 3.8

Themes and Categories from Descriptive Coding

Themes	Categories
a priori	
Cognitive Factors	1. Knowledge
	2. Lived Experiences
	3. Attitudes
	4. Beliefs
	5. Values
Environmental Factors	1. Work Environment
	2. Grade Level of Instruction
Behavioral Factors	1. Practices
	2. Self-Efficacy/Training

Themes	Categories
a posteriori	
Barriers to Mental Health Support	1. Money 2. Uncertainty of Need 3. Parent Pressures/Opposition 4. Academic Balance/Tension 5. Time/Scheduling 6. Perception/Stigma 7. Administration

Note: a priori themes are derived from Bandura's social cognitive theory (1986).

This table of four themes and their 16 categories represents 29 pages of rich transcript that are the result of the interviews I conducted with the five participants.

In the sections that follow, I explore each of the themes and categories and I share the participants' voices through quotes that confirm and offer credibility to the themes pulled from Bandura's social cognitive theory (1986). In addition, I provide a platform for the individual and collective voice of the participants while I use their responses to answer the qualitative research question, how do teachers describe the influence of cognitive, environmental, and behavioral factors on their willingness to release students for mental health services?

Theme One: Cognitive Factors

Cognitive factors are one of the three main components of Bandura's social cognitive theory (1986) and are one of the three a priori themes that guided my analysis of the interview transcripts. This theme also represents the largest amount of data that came from the participants' interviews. Cognitive factors include the five categories: knowledge, humans' attitudes, values, beliefs, and lived experiences. After conducting a second round of axial coding, I found there was some overlap between these different categories as they all helped illuminate what educators understand about mental health

issues and their impact on adolescents. In the following paragraphs, I guide the reader through the categories of this first theme, cognitive factors, while the participants' voices share the essence of their lived experience.

Knowledge. I noted that knowledge emerged as a category from the qualitative data, which is not surprising as many of the interview questions sought to uncover the essence of each participant's understanding of mental health. To explore educators' knowledge and understanding better, I asked questions like, "Describe any education or training you have received about mental health in adolescents." The responses I received from each participant varied greatly. Of the five participants, only one reported extensive training and education in the area of mental health. For example, James was a Psychology major in his undergraduate years and worked in the mental health field prior to entering education. This is unlike the experience Evie shared, who stated her only formal education on child and adolescent mental health was one professional development her school received several years ago. Evie says the training was "maybe on suicide prevention and looking at the signs of what students might display and how we could address students to help them." Evie's experience was more in line with what the other three participants reported in regards to their education as Celeste and Peter recalled one child development course in their pre-teacher education. Christina, however, was a foreign language major so received no childhood development courses.

While knowledge goes hand in hand with formal education, educators also absorb knowledge through professional development training and conferences, similar to the suicide training mentioned by Evie. When I asked the other educators about this type of

learning, I received varied responses though the consensus was there is not enough continuing education or training that is offered. Christina specifically commented:

> The district does require us to watch videos every summer, so a variety of safe schools videos. So, I'm sure there are some, you know, on suicide … I wish I could be more specific; I just don't remember because there's literally like 15 or 20 and they vary in length. But so, a little bit about probably about recognizing mental health issues, but I can't say that we have any dedicated time in the school day verses, or you know, the teacher in-service.

The fact that she says she does not remember the content speaks to the need for districts to abandon the "once and done" mentality and move to a model of professional development that is impactful and engaging for the educators. Celeste echoes this sentiment in her reflection on professional development:

> It [mental health] should definitely come up more … because I think sometimes it's easy to say it's not going to happen here; we're in rural Lancaster county; we're in a private school… and I saw so many people at a loss, and that's sad. Because, we're probably going to see it [mental health] more, like, especially with going through a pandemic and kids probably still processing that for sure.

Celeste's comment brings attention to the fact that mental health issues among adolescents are increasing throughout the United States but raises two questions: (1) are educators able to notice mental health issues in a student; and (2) do educators know what to do to support the student? Christina answers this for herself when sharing:

> I think that I could probably recognize it sometimes… since I had the experience myself, I could recognize that but in terms of supporting it, I don't feel like I necessarily have those tools as a classroom teacher largely.

This self-reflection Christina offers leads to another sub-category that I uncovered within the category of knowledge: lived experiences.

Lived experiences with mental health. Another common thread that participants discussed in their interviews were the personal experiences with mental health that each

educator lived. Whether it was with students, family members, or their own struggles, each of the five educators agreed that it was those lived experiences that offered them an awareness of mental health and more training than any class or professional development. As I heard through Evie's voice above as she shared about her experience with her son, Celeste also stated:

> I think that it's … hard to put into words. Like, I feel like once you experience it, whether that's you personally in your own life or you know you witness it and experience it at school, I think, then it's really easy to be like, 'oh yeah, mental health is so important.'

This understanding of mental health was not something she gleaned from her textbooks in her undergraduate years and it was not from multiple professional developments, but rather the understanding came from her lived experiences. Celeste's lived experiences included the loss of her friend to suicide, counseling as a teenager to deal with her own depression and self-esteem, and then teaching students in an inner-city school that was no stranger to gun violence and other trauma. James, who worked through his own trauma with a past diagnosis of PTSD, shared with me how that experience, in addition to his past work experience, prepared him for his role as a teacher. James told me:

> Every once in a while, there will be a student who will be out for … they can be a week to two weeks, where they have to do something in an inpatient hospital or something like that and actually, I think that's where my experience is most helpful because I understand. I worked a part of my work was in an inpatient hospital so understanding what kind of environment they're in and yeah … It hurts the academics because I know they're not getting any academic help while they're there and I've worked in those kinds of places and they're not … they're good people are working but they're not doing … not able to help them so then they will fall behind for two or three weeks and that's really, really difficult to catch up.

The lived experiences of each participant are not something that can be replicated and taught to other educators. Fortunately, each of the five participants indicated that even

though their lived experiences were more educational compared to any formal learning in their journey, I unsurfaced other categories within this theme of cognitive factors that could influence an educator's decision to release a student for mental health support services.

Attitudes. The first component of Bandura's social cognitive theory (1986) is Cognitive Factors. Bandura (1986) discusses attitudes as a category under this component. Figure 2.1 differentiated the terms attitudes, values, and beliefs and specifically defined attitudes as "learned predispositions to a concept or object" (McLean, 2012, p. 84). All five of the participants discussed attitudes during Phase Two to some extent, though Evie, Celeste, and Christina spoke more in-depth on this category. The participants each discussed variations of how their attitudes and way of thinking about a student's situation may differ from that of their colleagues and how these attitudes influence their decision to release a student from class. The participants revealed their attitudes towards mental health when I asked the question, "describe how you feel when a student is pulled from your class. Do your feelings or thoughts change depending on the reason the student is being pulled?" Evie's attitude demonstrated a positive mindset as she responded:

> if it's going to help the student then, by all means, they need to pull the kid … even if it's a test, I say to [whoever is pulling the student], if this is the time you have, and this child needs it please take them because they can make a test up with me later.

Evie's attitude puts the child's needs first and allows testing to come second. Celeste and Christina shared Evie's attitude as evidenced when Celeste said, "I don't necessarily have an issue with releasing students … I don't feel like it's my right to say [no they cannot

leave my classroom]" and when Christina stated, "I don't believe it's my choice, so if I'm told that they are being pulled then they're just being pulled."

Though Evie, Celeste, and Christina all shared positive attitudes toward mental health, each of them admitted that their attitudes differ from the attitudes of their colleagues who sometimes demonstrate negative attitudes toward mental health support. According to Celeste, some of the teachers in her building, "still don't want to release their kids at certain times," despite there being a known need for mental health support. Christina shared similar sentiments when she discussed the fine line of tension that exists between being an educator who supports students getting help but struggles with the seemingly inconsiderate times counselors sometimes call into the classroom. She expanded on this idea by adding that counselors, "don't get what it's like to be in the classroom so they just call at like anytime and say, can I see so and so." This perception of the counselors not caring about the schedule of the classroom teacher can affect the attitude and mindsets of educators, which in turn can impact their willingness to release a student from instruction time.

In addition to educators' attitudes and mindsets, the participants discussed the mindsets of their students and how these mindsets can also impact their decision to release a student for support services. For example, Evie shared:

> We all need to be in a good frame of mind to be able to be successful. Having seen my own son struggle with some mental issues with depression as a teenager and not being able to see him think that he can be successful because of it was really hard and then seeing my students in the classroom some of them will express to me that they just don't think they're worth anything and … that breaks my heart. . . if the kids aren't in the right frame of mind, there isn't anything I'm going to do that's going to be worthwhile for that child at the moment.

Celeste shared a similar mindset to Evie and echoed Maslow (1943) with the following:

> I say it all the time to anybody that will listen anytime it comes up, I said, I always say that if the kids' mental health is not… like if their needs are not being met mentally, emotionally, physically, I mean they're hungry they're not going to learn and so be prepared … I believe that [mental health] comes first, before academics and I've seen that… I saw that at my last school and I constantly felt like I had to just stop the lesson… it wasn't gonna work.

Though Evie and Celeste referenced their student's mindsets in these last examples, they speak to the impact that a student's mindset can have on an educator's attitude which will impact their decision to comply with releasing a student from their classroom.

Beliefs. When thinking about attitudes being our opinions or a stance towards an idea, it is logical to follow that our attitudes can shape beliefs. Therefore, it is no surprise that beliefs were discussed as another category of the theme of cognitive factors. McLean (2012) said beliefs are "convictions or expressions of confidence" (p. 84) which Celeste exemplified clearly when she claimed with confidence, "[Mental health] is important." I tested this expression of belief with each participant when I asked them, "What impact or connection do you believe exists between a students' mental health and their academic issues?" Again, Evie answered with confidence, "oh, I think there's a huge connect there", as did Peter whose response to the connection was "I believe 100% … 100% … I think it has an effect on a variety of things in your life." The voices of these two educators support Maslow's (1943) Hierarchy of Needs which asserts that higher-level processing required for academic learning cannot occur until social and emotional needs are met.

However, not all educators' beliefs about mental health were backed with such confidence and certainty as those shared by Celeste, Evie, and Peter. Christina's response, for example, did connect academic performance to mental health issues when

she responded "so I think typically, at least we are told, that we see a decline in academic performance." However, her response carries with it some ambiguity or uncertainty which tells me she is not sure if there is a connection. This uncertainty or ambiguity in beliefs towards mental health also came across through James when he shared the following with me:

> I would say, significant I think I have two thoughts on this … but. I, I it's a very real thing, and I think it definitely has a significant impact on a child, and it can make it harder in the classroom for various reasons; but, with that being said, it also feels like it has been a crutch given to some students too at times where … someone didn't have a diagnosis, and when they struggle with something they look to get a diagnosis …

What is concerning about what James shared is not so much the ambiguity or uncertainty within the context, but the idea that it comes from someone like James: a psychology major with a history of work experience in the mental health field. If his beliefs about mental health issues in adolescents can waver, then what does that mean for the general educator whose background is not as rich in lived experiences with mental health?

Values. As our participants' attitudes exposed their behaviors, their behaviors uncover some of their values and how they pertain to mental health support for students. Again, looking back at McLean (2012), he describes values as long-lasting "ideals that guide our behaviors" (p. 84). Following this concept, an educator's values would have a great impact on their practice with releasing students for mental health support.

The participants revealed their values as each answered the following question: "what are your thoughts on the need for mental health support in schools?" All five participants indicated they valued mental health services and view them as something important that should be offered in schools. Christina expressed her support for school-based mental health services when she shared the following:

> I do think it's important … I think that our counselors are spread thin, to begin with, and you know, at some point … so this is my 18th year teaching we had four counselors. Now we're down to three. So, I do feel like there is a place in the school system for outside agencies to come in and provide counseling, certainly.

James echoed Christina's notion of welcoming more support services for students when he shared his thoughts saying, "I think as much service as possible … most beneficial. I think, whether it's outside or inside the school, I think it's all beneficial". While James and Christina's expressed values stemmed primarily from their experiences in the classroom, Peter's placement of value on mental health services was rooted in his personal experience, as an individual and as a father, and connected those lived experiences with his role as a classroom educator. Peter shared with me the following:

> I believe in 100 … 100% like it, I guess that I was brought up on [counseling] …and again I just now see as a teacher, you know, seeing it from an adult perspective. Last year I taught sixth-grade homeroom - my daughter was a sixth-grade student at a public school and you know, seeing different things, and so like, I'm like, wait a minute, this is happening here … what is my daughter experiencing at home? So, what a counselor sees or what a parent sees in the home is different than what a teacher sees in the classroom so you know getting everybody on the same page … so you know just having everybody on the same page and communication.

Peter's voice here demonstrates Bandura's (1986) theory that the lived experiences and values (cognitive factors) influence an educator's decision to release a student for mental health support.

While Peter, Christina, and James all expressed a value in mental health services, their responses were broad and included mental health services from outside agencies. Evie and Celeste's responses, as they related to the value of mental health support, were centered on the role of the school counselor. Evie shared the following:

> I think, especially now that it is vital to have a counselor in every building and to have outside resources that can make the connection between school and home

> because a lot of these kids they're coming in and the problems are at home and it's bleeding over into the school.

Evie's voice speaks to the importance of having dedicated school staff personnel who is focused on the social, emotional, and mental well-being of each student. Celeste expounds a bit further than Evie when she shared the following:

> I think that every school should definitely have a counselor, but I think also, especially in elementary, I love the idea of like play therapy and I think that there should definitely be more than one counselor in a school…there's different ...types of mental health, different types of services, and so I think it's just it should be something that…I had a hard time because we did have one play therapist and it was like, "wow I'm sorry, I can only take eight kids" and I'm like, I have 12 in my own classroom, and so I feel like that's a service …it's not like … (itinerant) math where you have to qualify, I think that that [counseling] is something that should be offered. And if a kid needs that, they should be able to go. So, I think they should be in every building, even if it's the older kids.

All five participant's voices provided evidence that each educator values mental health services as indicated by their support to have it present in the school. These values were formed by their knowledge, their lived experiences, their attitudes, and their beliefs. All these together make up the cognitive factors Bandura (1986) described as one of the components of his social cognitive theory. In the following section, I explore the second a priori theme, environmental factors, that emerged during Phase Two, which is the second component of Bandura's (1986) theory.

Theme Two: Environmental Factors

In this section, I explore this a priori theme of environmental factors through the voice of the participants while I discuss the various categories that make up this particular theme. According to Bandura (1986), environmental factors have to do with those forces that exist outside of an individual's control. For example, the cultural or societal norms of a community and the physical makeup or demographics of a neighborhood are all factors

that impact an individual's behaviors, but the individual has little to no control over these factors. In the context of educators and schools, the environmental factors may include the physical location of the school building (i.e., urban vs rural) as well as the type of school (i.e., private vs public) and the social norms or policies that exist within each building. In addition, I needed to consider the grade band of the school building or the educator's level of instruction as other environmental factors. In the following sections, I use the participant's voices to delve deeper into the theme's two different categories which were discussed by the five participants.

Work environment. Three of the five participants discussed their work environment as a factor that impacted their decision to release a student from class. Specifically, the participants discussed their school setting (rural versus urban) and school type (private versus public) during their interviews. Though all five participants touched upon this notion of work environment, James and Celeste discussed it the most, with Evie also contributing some poignant thoughts.

James and Celeste had the added experience of being able to work in both a public school and a private school setting. Because of this dichotomous experience, each felt equipped to make comparison statements between the two different settings. James said:

> I would think my mindset is of the majority of our school. and I can't speak for other schools or something, but I think our school does pretty well with that … I was in public school before this, and I probably wouldn't say the same thing there so … Honestly, I think it's the Christian school. I think it's that Christian, the way that our community is wrung as a Christian school has that type of feeling set.

Celeste added to James' experience with her account:

> Where I was, all the teachers saw [mental health issues], and so I felt like we all were… witnessed you know a lot of things, and so we were constantly pushing for more training, we wanted the books, we wanted the, just the support. we wanted to get the play therapist and so, but we'd see it every day. Where I'm at now, some are seeing it whether that's in their personal lives or not, but I definitely feel like I'm kind of like a little bit different and I push for it differently or have a little bit more acceptance, not because… I just feel like sometimes experience is important and that's kind of why I think it is important to speak up and I try to share stories when I can,

What is interesting about the accounts of both James and Celeste is that their experiences are opposites. James describes his current private, Christian school as being more open-minded and understanding of student mental health issues compared to his experience in the public school where he worked. However, Celeste indicated that because mental health issues were more prevalent in her public-school experience, she and her colleagues saw mental health support and training as more of a priority when she compared them to the views of her colleagues at her current, private school.

> and like, so I think still it's like one of those things until you go through it, but at least… maybe not at least… but we all are going through this pandemic together and so I think that that is probably opening up a lot of eyes that a lot of people are not okay; adults and kids and you know, I guess, if we can get more mental health support then that's one good thing COVID brought out but that's about it because…we're done with it! but yeah, so it seems like at least a few of the… some like teachers, where we're at now it seems like they're starting to…come to terms with mental health needing a bit more of a focus.

Evie's experience is a blend of each of their accounts. As I shared earlier, Evie works at a public school, however, the building is only 5th and 6th grade so it has the feel of a smaller, private school. Evie reported:

> At our building, we're so small and we're really close-knit and I think all of us want what's best for our kids even if it's sometimes I've had kids that I've made connections with and they go to sixth grade and they see me and passing in the hallway and say, 'hey can I talk?' During my planning period I'll go find that student and that teacher is always willing to let me have the child for a little bit, so I would say in our building, we're all pretty much on the same page as far as the students' mental well-being is concerned … I think, over time, teachers have

> become more receptive to [mental health support] because they realize that our kids, especially with this pandemic, have become needier.

This dichotomy of experiences reported by James, Celeste, and Evie supports Bandura's theory (1986) by demonstrating how other components, such as those cognitive factors I discussed in the previous section, impact an individual's behavior, and not just one singular factor.

Grade level of instruction. Another factor that seems to influence if a teacher will release a student from class for services is the grade level and subject of instruction. As Celeste put it:

> … but I am first grade, so it is like the younger kids. I just, I'm just an elementary teacher, but I like it. I try to bring [mental health] into the classroom. I love when [the school counselor] come[s] in, I just think, If we can teach some kind of, anything - tools - anything for them, even at a young age it's just the best; it's going to help them later in life. So, I love, seeing it more, and I hope it keeps continuing to be a conversation. I love, seeing it in the world because I feel like we can bring that into the classroom, and yeah. I mean, I don't love seeing people struggle, but I love, seeing it talked about.

Celeste rationalizes that at this grade level, any content a student misses during class instruction can be worked on individually with the student at a later time. The higher grade-band educators had a different perspective, however. Christina shared her thoughts about having students pulled from instruction time:

> ... so, I don't know if it's as big of a deal during when they're in elementary school or even maybe when they're in middle school, but in high school, I feel like a better time is, when they don't have class. And that is that is complicated so...Now I do think that with like flexible scheduling almost, meaning like you know they can take some classes online or whatnot, that that could work better.

Christina's perspective makes a student receiving mental health support at school seem like a challenge when schools operate under the traditional model of instruction. James, who teaches higher-level math classes at the high school level, agrees with Christina on

this aspect and argues that a student can fall behind easily if not there for instruction. This is where Peter is split between the two perspectives. Peter teaches STEM and computer courses to K–8 students. He shared with me his thoughts on having students pulled from his class:

> I believe, on that level, we're all for it. I think there's certain teachers who are 100% in their lessons and [will say] 'please do not take my child during [this class]; take him out during another class', but I think it's like it's one of those things where, if you really have an awesome lesson and you, you know … like I do STEM and if I need certain students there on certain days … [but] I don't do that, you know; if I know I can get [a student] caught up or I'll work on a project myself [with them so they can go get the support they need].

This last statement made by Peter is the essence of what all the participants felt in regards to having students pulled. I believe they would agree that though it is not ideal to have a student miss instructional time, ultimately what matters is ensuring that the various facets in a student's life are meeting all their needs. Again, these educators support Bandura's (1986) social cognitive theory as their voices tell us that there is not just one factor they consider when deciding to release a student from class.

Theme Three: Behavioral Factors

The third a priori theme that I unpacked was behavioral factors. This theme is the third component of Bandura's (1986) theory. When I combine this theme of Behavioral Factors with the previous two themes I discussed, the result contributes towards an individual's behavior and decision making, which includes the decision to release a student from class. For the purpose of my research, Bandura's (1986) theory asserts that these behavioral factors present as the skills, or self-efficacy that educators have to recognize a student's need for mental health support, just as they can recognize academic needs. Educators increase their self-efficacy through many experiences, including

education and professional training. Additionally, this theme revealed another category which is the practice, past and current, of the educator. These two categories were discussed by participants when I asked the question, "do you feel your teacher training and previous education prepared you for being able to recognize and support social, emotional, and mental health barriers that may exist in a students' life?" In the sections that follow, I allow the voices of the participants to respond to this question as they share their experiences related to their self-efficacy and their practice.

Self-efficacy. Educators are trained to recognize the academic needs of a student and are taught the skills which help bridge gaps in the fundamentals of knowledge. Unfortunately, this specialized training only addresses one component of the student and does not align with a whole student approach in the classroom. Research has shown that educators want to support the whole student, including their mental health, but often feel as if they are not able to (Askell-Williams and Lawson, 2013; Mazzer and Rickwood, 2015). Celeste brings this research to life as she said she feels, "some of [my experience] was baptism by fire in the classroom … I was not prepared at all for them." Educators' skills and efficacy to support students would improve with more education and training specific to child and adolescent mental health issues. Evie's experience shines a light on how little training is provided to educators. In fact, besides the one professional development, Evie can recall from a few years ago, her primary training on how to support students was self-directed. Evie shared her desire to increase her efficacy to support her students pushed her to "just learning on my own really, looking online like, 'how can you help a student?'" Celeste and Evie bring attention to the need for more formal training for educators. If schools desire to support the whole student in the

classroom, then educators need to have more skills and self-efficacy which requires more training in this area.

James reiterated the importance of more training for educators in his response to this question. Though James has a degree in Psychology and work experience in the field of mental health, he recognizes that his colleagues have not had the same experiences. James shared:

> I think it would be helpful if I knew more [about a student's situation]. But I know some people aren't just trained in it as well [as I am], so I think they would need to have a better training of, 'okay, this student has such and such mental illness, what does that mean for the classroom', … but I do think communicating how students are doing would helpful for us as teachers to better understand why 'oh, they didn't do their homework last night' and well, maybe 'oh, ok, we know they're struggling with something'; that helps us to know how to best deal with those type of things.

According to James, an educator may be more likely to release a student for support services or make accommodations within the classroom if someone not only provided information but explained the student's situation outside of academics. Celeste agreed with James and acknowledged that as educators, they do not know the whole story of their students. Celeste expanded upon this thought by sharing that in addition to having additional information about a student, educators need more training on what to do with that information. Celeste added that the training that is provided for educators is dependent upon the individual school. Celeste recalled that at her school in urban Harrisburg,

> … they did a day of, like, I still remember, we sat and like, listened to water dripping on stone … like stuff that was just things we could set up in our classroom but, yeah, I mean … I know [our current counselor] did stuff with us, I think, last year. But, my school prior to that – nothing. So I guess it just depends on the school whether it's prioritized.

Peter shared with me that his school counselor does staff training at the start of each school year where the educators are given training on how to recognize certain issues and tools on how to optimize the classroom layout so students not only can learn but feel comfortable. Peter continued his discussion about efficacy and training and shared with me,

> … you know, in college, it's like, 'I have to go back to school; I have to go back for credits'; but now as an adult, it's like, 'I need this', because you know, the world is changing, you know, how I was brought up is different than … how kids are being brought up now.

The accounts of each of these educators support the need for educators to receive more standardized training in adolescent mental health issues with the same fidelity as other professional developments.

Practices. This notion of practice relates to the procedures that teachers follow when they release students from academic time. Often the decision to release a student from academic instruction is up to the teacher to determine, though sometimes there are school-wide norms with a pass system that all classrooms follow. From my experience working within school systems, schools design most of these dismissal procedures to optimize the students' time in the classroom. However, as Peter pointed out schools are constantly

> gearing towards a test … but I think the biggest thing to remember as people, we as teachers have to remember that there's so much going on in life that it's not just school, school, school, school, school, school, school. That, you know, kids are beaten, kids have seen different things that affect the rest of their life … I think we have to remember it's not just the classroom and having that tunnel vision of 'during my classroom, this is how it has to happen'; we have to keep a wide-open perspective of everything that's going on in the world; going on in their lives …

This "tunnel vision" as Peter phrased it can cause a teacher to make choices that in hindsight are not supporting the students' needs. As Celeste pondered over her own practices, she was vulnerable and shared, "sometimes I think back to some of those experiences … thinking, 'oh, I wish I could have done this differently' … ." Yet, as the previous section demonstrated, if an educator is not trained properly or adequately on how to recognize and best support a student's mental health and social-emotional needs, then their practices and protocols will be impacted. These protocols then, rather than supporting a student, can become barriers to them getting the support they need. Barriers are an a posteriori theme that emerged when I was collecting the qualitative data. I discuss this theme, and its seven categories, in the following sections.

Theme Four: Barriers

As I mentioned in the previous sections, sometimes an educator's attitudes, experiences, or practices can be barriers for students who need access to mental health support. However, there are often factors that are outside of the educators' control that impede a student's ability to access services. The theme of barriers was the fourth theme that emerged a posteriori from the participant's interviews. In the following sections, I again give a stage to the voices of the participants and allow them to talk in detail about some specific barriers they see from their perspective.

Money. Even though social-emotional curriculums exist for schools to use with their students and even though mental health services are available within the community, schools often struggle to have the funds they need to implement the programs or to hire a professional. Lack of funds can also impede a school's ability to bring in quality training that will equip educators with the skills needed to support mental

health in their classrooms. Celeste talked about this dilemma when discussing her time working in the urban, public school when budget restraints dictated the services available for her students. Celeste believes mental health services should be more accessible but added:

> that probably means that we need to hire more, so yeah, like I said, it probably goes back to money; but I don't think [money] should be important, like, it's sad to me that, that was the first thing cut at my last school.

Celeste's account connects back to the previous statement she made about what different schools prioritize and also links to the previous statements the educators made about the need for more training.

Uncertainty of need. This barrier of money and the need for more training links to another discussed barrier for students, which is educators' uncertainty about the students' need. Celeste was adamant that when it comes to releasing a student from class, she does not necessarily have a problem doing so, "unless I just felt like they were trying to get out of doing work." James shared a similar sentiment when he asserted his belief that some students, or parents, claim that there is a need for extra support or accommodations, yet professionals cannot always substantiate these claims. He shared with me from his experience the following:

> and I know talking to my wife, who works in the mental health field and even those doctors are saying, certain diagnoses, are being given too easily because they're looking … some people are looking for that extra help. When it might not be that a mental health issue might not actually be there; so it's tough because it's very real and it can be a hindrance, but it also, I feel, like, has way too many people being not diagnosed; it takes away from the people who really are struggling with it.

James and Celeste make a strong argument, again, for the crucial need for educator training in classroom mental health. In addition, these personal accounts connect to the

participant's earlier statements where they expressed their value of and the need for mental health professionals to be available within each school to consult with classroom teachers when uncertainties do arise.

Parent pressures or opposition. As the participants' voices indicate, sometimes, it is the student's parents who are throwing up roadblocks for support instead of the educator. Celeste shared that besides her uncertainty of the current needs of the student, the only other reason she may not refer or release a student for mental health support is if the parent of the child said no or denied there was an issue for concern. James shared Celeste's perception and indicated that parents are sometimes the reason why he cannot release a student from class. James shared with me the following:

> So I, you know, at being at a private school, we don't have to deal with standardized testing but we do, but parents are much more expectant of higher grades. So you want the student in class to … So they can succeed as well as possible in academics;

When Evie was asked the follow-up question, "do you think that parents are more of a barrier to their child getting support than the school would be", she quickly answered, "I think so because sometimes I think they're almost in denial. I've had parents that have said, 'I send them to you – you're just their teacher,' which is sad." Evie went on to share about one student who disclosed to her that the student thought she was going to kill herself. When asked what she did in that situation, as an educator, Evie recalled:

> I immediately got in touch with the counselor and our principal … and the counselor had contacted the parent and the parent just kind of pooh-poohed it actually at the beginning. She was like, 'I have an older son who did this and he's fine… [we] just kept calling mom every time this child would open up and finally mom did take her for some counseling and they did prescribe some meds as well to help with her mood and she seemed to perk up and she kept in touch with me over the summer; she emailed me quite a bit.

Evie's description of this one incident is not an uncommon occurrence. Christina also admitted that she has been "that mom" with her son, who is in middle school. She recalled times he needed support services. She shared,

> I try really hard to schedule [his pull-out time] during his, like, IE time, like that intervention and enrichment time, but, like last week, he said, 'I didn't go [to my pull-out service] mom because it was my extra recess.' And I tried so hard not to make it, like, during a class … I'm that mom; you know that message the teachers, and I was like, 'this is when you may meet with him; you may not pull him out of math or ELA or something else'; but anyway, and then he wasn't happy so I'm like, I like can't win.

As Celeste, Evie, James, and Christina shared, parents' input and pressure also impact an educator's decision to release a student from academic instruction.

Academic balance and tension. Despite the participants' expressed desires to support the whole student and allow access to mental health services, they cannot deny the academic demands of school. Christina told me,

> You know, with grades … I always talk about, you know, with a child, being in eighth grade right now it's like literally, grades do not matter in eighth grade, so I would not be as worried about grades, as opposed to content; but, in high school, grades really matter.

James added to Christina's thoughts with his own as he spoke to me about his high school level students. James has a strong mental health background and values the importance of mental health support being accessible for students, yet feels the tension that exists with the academic piece of school. He shared:

> … for myself, I know higher-level math, missing a class for that, makes it difficult, like catching up with that rather than, not to put down another subject but, pulling them out of a gym class rather than a higher-level math class. I think one makes more sense than the other. I'm aware that if they're really mentally in a bad state that they're not going to catch any of it anyways. So it depends, where they are in that mental state…and you can see if they're struggling [academically] and…they're struggling with mental health, those two things combined don't help either. But grades are important too…

James touches on the overlap in factors I discussed earlier. Here, the voice of James highlights his attitude toward mental health (cognitive factors); the difference in the type of class from which a student may be pulled (environmental factors), and his self-efficacy and skills in knowing how to identify if a student is "mentally in a bad state) (behavioral factors). In addition, this snippet of James' voice highlights some of the barriers (i.e. academic pressures and parent pressures) that also influence his decision to release a student. It is clear that more than just one factor influences a teacher's decision to release a student from class. Christina even stated that this pressure to do well academically is so strong that the students sometimes do not want to be pulled from their core classes. Peter's voice echoes those of James and Christina, yet he also recognizes how students missing academic time could compound issues at home for some students, which could in turn make mental health issues worse.

Time and scheduling. This tension of academic success ties to another barrier that participants discussed, which is the issue of time and scheduling. With twenty-four hours in a day never feeling enough for most humans, the average school day with only seven and a half hours can feel even more restrictive. To compound this issue a bit more, those schools that operate on block scheduling may experience more of a challenge when they try to allow time for activities outside of the core subjects, even if those activities are necessary mental health support services. With block schedules, if a student misses one class, it is the equivalent of that student missing two days' worth of work.

Peter pointed out that classroom educators are not just dealing with requests to pull students for mental health support, but there are other demands for their time and

attention. He shared educators need to "factor in the musical instruments … you've got certain specials… then you have to factor in the grades as well." He went on to point out that if each of these pull-out services and specials is taking the student at the same time each day, then this interruption can impact the academic learning. In the instance of cycle days, it could also fall on a day where the student is missing an elective, like physical education, or art, which they may see as a highlight in their day.

Christina spoke more about the challenge of time and said that in her school schedule, students do not have "a lot of time unless they could eat lunch with [the support staff] while they eat … I don't know—the kids need that break so I'm not sure [what the answer is]." Though Christina brought up a good point of the social component and mental break that lunch affords to some students, Evie brought up another issue that surrounds lunch, which is that is the traditional time school counselors are allotted to run groups, especially at the elementary and middle school levels. These inconvenient times brought me back to the question: when can a counselor pull individual students for support if counselors are only allowed to use lunch periods to meet with structured groups?

Parental and academic barriers can compound and enlarge this barrier of time as I discussed earlier, which forces some counselors to only pull students during homeroom periods. This restriction of time does not leave room for the crises that occur or meetings that the counselor is expected to attend. However, when a school district or agency requires a counselor or therapist to split their time between multiple buildings, this barrier of time becomes more challenging. Peter noted that their school counselor is only in the building two and a half days a week. If he could only meet with kids during lunch or

homeroom, that would equate to roughly about three hours a week to meet the varied needs of each student in that building, while he also performed prevention services like classroom lessons. This barrier highlights the need for more counselors in the buildings; however, it also goes back to the first barrier which emerged from the participants: money.

Perception and stigma. Two of the five participants touched upon the notion of perception and stigma associated with mental health support as a barrier. Peter believed that, from a child's perspective, there may be a fear that they will appear different or peers may tease them if a counselor pulls them. Peter went on to share his curiosity and posed the questions, "what do other students think? What do students worry about when they are pulled?" These are some of the questions that Peter brought up when follow-up questioning led to the theme of barriers. Celeste noted this stigma not only is present amongst the kids sometimes but also, and often worse, among fellow teachers. In her words:

> I think sometimes the kids don't even know who a counselor is; like they have no idea; they never meet this counselor; they don't know what the service is or maybe, [the counselor] pops in at the beginning of the year, and I think that just like we're trying to push mental health to not be so taboo in, you know, in society, I think it's also just as important school-wide and whatnot to make it less taboo and for kids to be like, it's okay if I need to go to the counselor … I see so many different kinds of … just a wide range of needs and, yeah, mental health is a tough one. I think it's a tough discussion. It definitely has become less taboo over the years, I think, but, yeah, just seeing that it's not kind of one, you know, straight road. It's a lot of different kinds of things: needs, experiences.

Celeste and Peter suggest that this notion of stigma is another factor that can impact an educator's decision to release a student. If students are leery of mental health support, or if educators view it as taboo or with little value, then the likelihood of releasing a student

may decrease. Again, the voices of Celeste and Peter point us back to how important good training, education, and open communication are regarding mental health.

Administration. One final barrier that emerged as a category in the participants' interviews was the expectations, guidelines, and policies put into place by school administrators. Sometimes these expectations or policies come from the state or district level, but often they are building specific. Evie and Peter both suggested that the building administrator dictates when support services are allowed to pull students during the day. Evie specifically stated that their principal "usually sways them away from pulling [students] from tested subjects". This influence leaves only specials or lunch for students to meet with support staff, which are typically times to socialize with peers or have some fun distraction. Peter also stated that the administrator is the gatekeeper for their school counselor. The school counselor checks in with the principal each day he comes into their building to get a list of students to prioritize seeing that day. Christina's viewpoint of the administrator as a barrier was not as much linked to scheduling as Evie and Peter suggested, but instead spoke to the academic pressure that is prevalent at the high school level. She stated, "we are told that if their grades drop below this [level] then, you know, these are the steps you need to follow, so… then you need to contact parents and then there are lots of questions." I felt the stress in her voice as she shared this worry that she needs to consider as she balances her roles as the students' educator, advocate, and supporter.

The administrator can also become a barrier to the component I highlighted earlier, which is classroom mental health training. Building principals, or district administration, are often in charge of setting the agendas for teacher in-service days or

professional developments. These roles circle back to Celeste's voice as she observed that mental health training and policies related to student's access to support services "depends on the school whether it's prioritized".

The previous sections highlighted the a priori and a posteriori themes that were discussed with the five participants during the qualitative interviews. As the participants shared their voice about what impacts their decision to release a student from class, their experiences revealed some barriers outside of their control that also impact their decision to release a student. This discussion of barriers spurred a follow-up question, "how can mental health services in school balance with academic needs to reach the whole child?" I discuss the educator's recommendations in the following section.

Participant's Recommendations

All five participants shared recommendations on how schools could improve access for students to mental health support services. Table 3.9 provides a summary of the various recommendations that emerged from the educators that discussed them in their interviews.

Table 3.9

Participant's Recommendations for Balancing Mental Health and Academics

Recommendation	Celeste	Christina	Evie	James	Peter
More counselors in schools	X	X		X	X
More training and education	X	X	X	X	X
Priority is given in the budget	X			X	X
Flexible schedules in school		X	X	X	
Increase in communication between support staff and educators	X	X		X	X
Less focus on test outcomes	X	X		X	X

Throughout the interview, some of these suggestions came out organically as each participant processed a different barrier and ways to make it better. Other recommendations were a response to a follow-up question like, "what needs to change within schools in order to balance the academic needs and the social-emotional-mental health needs of the students, in order to reach the whole child?" Table 3.9 reflects each participant's belief that there should be mental health support services within the school and that more training is needed for them and their colleagues.

Celeste was passionate in her stance that mental health support "should be offered at every school; and I know that, you know, there's budgets and funding and all of that, I feel like it . . . it shouldn't matter.". James wholeheartedly agrees with Celeste. In his response he shared the following:

> I would like to see, just like there are, you know, after-school activities, I would like to see the availability. I would like to see mental health and mental health professionals, like those services, be free for students, so that it was - they would be able to go and get in; go see a therapist or psychiatrist - whoever they're seeing on a semi-regular basis. So just like an after-school activity, so they could stay as mentally fit as possible. So, I think that in itself, whether that means, I mean if you could have someone on campus that would be great, but I know they don't tend to budget for those things, even though it's just as important. Because if someone has that mental illness they're going to struggle with academics, so they need to become mentally healthy first before. Then I know academics will go well.

James summarized the essence of each participant's experience with students' mental health needs. Yes, the academics that provide the foundation for education are important, but the students' basic needs need to be met first (Maslow, 1943; Pearlman, 2020).

As the participants' own voices showed through the themes, many factors overlap and impact an educator's decision to release a student from academic instruction for the

purpose of mental health support. Some of the factors revealed in the qualitative data that influence their decisions include:

- educators' cognitive factors
- environmental factors
- behavioral factors
- various barriers to mental health support (i.e. parents; lack of funding; academic pressures; and stigma)

The solution, just like the problem, is not simple. I must take note of the recommendations that emerged from the voices of the participants. If I valued their voices to help provide an understanding of what influences a teacher's decision to release students from academic instruction to access mental health services, then I should give value to their voices when they offer suggestions to create more balance.

Integration of Data Findings

For this study, I followed an explanatory sequential mixed method model (QUAN → qual), which consists of three phases. The first phase was the collection and analysis of quantitative data. The second phase was the collection and analysis of qualitative data. The third phase required that I integrated the data and analysis of my quantitative and qualitative portions of the study.

The purpose of this integration phase of the study is to connect the themes that emerged in qualitative analysis to the factors and concepts I measured during the quantitative phase. The mixed methods research question I used to integrate the quantitative and qualitative data was: "how do the results of the survey data and the interview data explain teacher decision-making regarding releasing students for mental

health services during academic instruction?" In the sections that follow, I provide a detailed description of the integration process as well as share my findings from this analysis. I will highlight each instrument I used in Phase One and then connect each with the a priori and a posteriori themes which the participants discussed in Phase Two.

Inventory of Attitudes Towards Seeking Mental Health Services Scale

In Phase One, I used the IASMHS to measure educators' attitudes towards seeking mental health services. Breuer (2016) used this inventory in her research to show how a teacher's attitude towards seeking mental health may impact their decision to refer a student for services. I was interested in educators' decision to release a student from class for mental health services. Therefore, I explored the educators' scores from the IASMHS to see if there was a relationship with an educator's decision to release a student. Table 3.10 provides a visual of the five Phase Two participants' scores, their propensity to seek mental health services for themselves, and personal statements that relate to their decision to release a student from academic instruction to receive mental health support.

Each of the five participants scored in the moderate to high range of the IASMHS. The lowest score a participant could receive is 0 and the highest potential score is 96. Celeste scored the highest out of all participants (n=44). Evie scored the second to lowest score with the lowest score, 42, belonging to a participant from Phase One. What is interesting about the results shown in Table 3.10 is that there is no strong correlation between the IASMHS score and an educator's decision to release a student from class. Evie, who scored the lowest of the five qualitative participants and has no personal experience with counseling, was perhaps the most emphatic in her willingness to release

a student. This is different from James and Peter who stated a willingness to release students but indicated some hesitation if academic needs seemed weightier. Celeste and Christina did not feel it was their choice to refrain a student from receiving mental health support services.

I also looked closely at the data from the IASMHS and any relationship to the stories shared by participants in Phase Two. The IASMHS consisted of 24 questions in total that would provide participants (n=44) with a possible Raw Score between 0 and 96. This survey also had three sub-factor scales, each consisting of eight questions. These sub-factors measured psychological openness (Factor 1); help-seeking propensity (Factor 2); and indifference to stigma (Factor 3). I carefully reviewed the qualitative data to explore any relationships between participants' factor scores and their shared lived experiences.

Table 3.10

Educators' Attitudes towards Seeking Mental Health and Their Decision to Release a Student from Academic Instruction for Mental Health Support (MHS)

Participant	IASMHS Score	Personal Experience	Statement about releasing students from academic instruction for MHS
Evie	48	Counseling for son	"If it's going to help the student then, by all means, they need to pull the kid … even if it's a test, I say to [whoever is pulling the student], 'if this is the time you have, and this child needs it please take them because they can make a test up with me later'.
Peter	59	Individual counseling Learning Support for learning disability	"Certain teachers who are 100% in their lessons and [will say] 'please do not take my child during [this class]; take him out during another class'…I don't do that, you know; if I know I can get [a student] caught up or I'll work on a project myself with them [so they can go get the MHS]."

Participant	IASMHS Score	Personal Experience	Statement about releasing students from academic instruction for MHS
Christina	77	Individual counseling	"I don't believe it's my choice, so if I'm told that they are being pulled then they're just being pulled."
James	82	Individual counseling Worked in MH field Majored in Psychology	"The only time I might hesitate to have someone go is if I know it's like a really important or difficult class lesson and I just may say, 'hey, can you do it tomorrow, or is there, another period that might be also available?' But, if they say no, then I allow them to go…I'm aware that if they're really mentally in a bad state that they're not going to catch any of it anyways."
Celeste	85*	Individual counseling Worked in trauma centered school	"I don't necessarily have an issue with releasing students … I don't feel like it's my right to say [no they cannot leave my classroom]."

Note: Celeste scored the highest on the IASMHS out of all participants (n= 44); MH = Mental Health; MHS = Mental Health Support

The first subscale within the IASMHS consists of eight statements and measures psychological openness. Participants could receive a score of 0–32 for this sub-scale. Item number nine on the IASMHS is an example of a statement that measured psychological openness which states, "people should work out their own problems; getting professional help should be a last resort." During the qualitative phase, the participants discussed this factor when I asked them, "can you share any personal experiences you may have or had with mental health in your life," along with, "what are some thoughts or beliefs that come to mind when you think about mental health?" Out of the five participants from Phase Two, the lowest Factor 1 Score was 17; the highest Factor 1 Score was 28.

The Factor 1 scores of the five participants indicate a moderate to a high level of psychological openness, further supported by the participants' willingness to participate in the qualitative study. Additionally, all five participants reported that they had

participated in some form of therapy or counseling in their life, either for themselves or for a family member. Similar to the integrated results reported previously, there does not appear to be any relationship between an educator's Factor 1 score and their willingness to release a student from academic instruction to receive mental health support. Again, Evie, who had the lowest Factor 1 score in Table 3.11, indicated a strong willingness to release students and later discussed how she has requested to speak with a student during another educator's instructional time. Evie's positionality is in line with the stances reported by the two participants with the highest scores, Celeste and James. Peter and Christina scored in between the three other participants. Their responses reflected a willingness to release a student from academic time, yet also indicated some hesitations and concerns. Table 3.11 shows the participants' Factor 1 score and their alignment with participants' responses as they relate to psychological openness, along with participants' comments on releasing students from class.

Though I could argue there is some correlation between an educator's Factor 1 score and their willingness to release a student from class for mental health services, the integrated data is not conclusive in this area. Despite the fact the data displayed in Table 3.11 does not conclusively support a correlation, this first factor of psychological openness does relate with Bandura's (1986) first component of Cognitive Factors, where attitudes, beliefs, and knowledge are developed. Bandura (1986) stated that these cognitive factors, along with other factors, influence an individual's actions and decisions, including an educator's decision to release a student from class. Therefore, when I apply Factor 1 to the backdrop of Bandura's (1986) social cognitive theory, the

participants' moderate to high scores on this Factor 1 scale does point to the participants' willingness to release a student from class.

The second subscale within the IASMHS measures an individual's help-seeking propensity. Specifically, this subscale measures an individual's willingness to seek mental health and their attitude towards others seeking health. Item number five on the IASMHS is an example of this subscale and states, "if good friends asked my advice about a psychological problem, I might recommend that they see a professional." For instance, when I asked about personal experiences related to mental health, participants shared lived experiences they had with mental health issues, including if they had participated in counseling themselves (Factor 2).

Table 3.11

IASMHS Factor 1: Psychological Openness, Participation in Counseling, and Statements Related to Releasing Students

Participant	Factor 1 Score	Participation in Counseling	Statement about releasing students from academic instruction for MHS
Evie	17	Yes	"I think all of us want what's best for our kids… During my planning period, I'll go find [a] student and [their] teacher's always willing to let me have the child for a little bit; much on the same page as far as the student's mental well-being is concerned."
Christina	20	Yes	"I don't believe it's my choice, so if I'm told that they are being pulled then they're just being pulled… [counselors] don't get what it's like to be in the classroom so they just call at like anytime and say, 'can I see so and so'."
Peter	25	Yes	"[If the student misses] this lesson [they]'ve got to do it for homework, well then, you know you're adding more to their plate at home and if they're having issues at home and you're adding this to their plate you're just making things worse. More factors you gotta take place."

James	28	Yes	"I would like to see mental health services be free for students… because if someone has a mental illness they're going to struggle with academics, so they need to become mentally healthy first before."
Celeste	28	Yes	"I think that [counseling] is something that should be offered…if a kid needs that, they should be able to go."

Note: Factor scale score ranges 0–32; higher scores = greater psychological openness.

Again, when I apply these outcomes to Bandura's (1986) theory, the educator's willingness to seek help themselves has a direct impact on their attitude towards mental health services. Bandura (1986) asserts that attitudes are one of the factors that can influence an individual's decisions, including an educators' decision to release a student from academic instruction for mental health services. Table 3.12 shows the participants' Factor 2 score, which measured their help-seeking propensity and the relationship between attending counseling.

Table 3.12

IASMHS Factor 2: Help-Seeking Propensity and Participation in Counseling

Participant	IASMHS Score	Factor 2 Score	Personal statements related to counseling
Evie	48	17	"I think, having gone through it with my son was probably more of a benefit to me; sitting through different counseling sessions with him.
Christina	77	20	"I think when I was about 16, I started counseling. And…in college, it was also an issue, and then I started antidepressants in college."
Peter	59	25	"I was brought up on therapy. Because I was… on medication, and so I had to go through counseling and stuff through there …in college, my college had a therapist I would go to every so often and was…one of the greatest things she ever taught me was the three r's was retreat, rethink, respond; and I still have the… and here I am almost 20 years later, and I still have the poster on my wall in my closet."

Participant	IASMHS Score	Factor 2 Score	Personal statements related to counseling
James	82	28	"I had, without going into any detail, like I experienced some PTSD myself. And, so I have, or had, I had dealt with at this point."
Celeste	85	28	"I… through high school, I lost a friend to suicide and just kind of dealt with my own… I'm adopted…dealing with my own kind of abandonment questions and things so I actually started counseling I think my junior year, and it was, I say, it was the hardest-best-thing-ever that I did. I think it's underrated and not talked about enough, but I think everybody should go to counseling and have that support there."

Note: Factor scale score ranges 0–32; higher scores = greater propensity to seek help.

As the table demonstrates, those participants in the qualitative study who shared more intense experiences with counseling or reported more severe issues (i.e. suicide; abandonment; PTSD), scored higher on the Factor 2 scale than those whose counseling experience was less intense. James and Celeste, for example, both scored a 28 on this scale whereas Evie scored a 17, out of a possible 32. This data also reflects a positive correlation between the IASMHS Scores and the Factor 2 scores of each participant. Applying Bandura's (1986) theory to these findings, an individual's willingness to seek mental health services is related to their attitude towards seeking mental health (cognitive component) which in turn influences their decisions (human behavior). Therefore, educators' willingness to seek mental health services and their attitude toward seeking mental health treatment (cognitive component) impacts their decision (human behavior) to release a student from class.

Another sub-factor scale measured a participant's indifference to stigma related to mental health. Regarding my study, a high indifference to stigma score would indicate that educators are not interested in or concerned with any negative labels associated with

mental health. Like the other two subscales, participants could receive a factor score of 0–32 for this sub-scale. As I was integrating the data, I explored the relationship between an individual's Factor 3 score and a participant's expression of this category during Phase Two of the study. Peter's and Evie's Factor 3 scores (14 and 13 respectively) were lower than the other three Phase Two participants. Celeste had the highest score out of the five participants with 31 points out of a total possible score of 32. What is interesting is that Peter and Celeste are the two participants who discussed this category of stigma and perception the most in their interviews. Peter touched more upon this concern of stigma as he expressed concern for how other students would look at a peer who needed to see the counselor. Celeste, however, discussed stigma and mental health as a taboo topic from the perspective of other educators. Table 3.13 shows participants' Factor 3: Indifference to Stigma score and their thoughts related to the perception surrounding mental health.

Table 3.13

IASMHS Factor 3: Indifference to Stigma and Perceptions Towards Mental Health

Participant	Factor Score	Personal statements related to mental health stigma
Evie	13	"I work really hard at the beginning of the year, to try to build relationships with the students and make those connections, hoping that they will open up, I had a student last year, who really opened up to me, there were several incidents where she said to me that she just thought she was going to kill herself."
Peter	14	"The biggest thing…with the kids [they may say] 'Oh well, hey Johnny got pulled from this [class]', so I think, from a kid's perspective I think that's one reason why they might not want to go."
Christina	27	"… teach them the important skills that they need to be adults or maybe to handle the mental health issues that are inevitably going to arise throughout the high school."

Participant	Factor Score	Personal statements related to mental health stigma
James	28	"[mental health] is a very real thing, and I think it definitely has a significant impact on a child, and it can make it harder in the classroom for various reasons."
Celeste	31	"…it's just important to have those professional developments and have those open conversations. I think sometimes it's easy to say it's not going to happen here, we're in rural Lancaster county, we're in a private school, that's not here, but it is. At my previous private school, I saw so many people at a loss, and that's sad. Because we're probably going to see it more… especially with going through a pandemic and kids probably still processing that for sure … make it less taboo and for kids to be like, it's okay, if I need to go to the counselor."

Note: Factor scale score ranges 0–32; higher scores = greater indifference to stigma.

If I observed the participants' scores without context I may have concluded that some of the participants, specifically Evie and Peter, hold a negative view of mental health issues, and therefore a low attitude towards seeking mental health services. This view would negatively impact their decision to release a student. However, the context provided from the qualitative interviews through the participants' lived experiences shows a different perspective. This context is the power of qualitative data: it brings life and deeper meaning to quantitative results through rich, descriptive data collected from the voices of participants.

Mental Health Literacy Scale

As I continued through the integration phase of the study, I continued to explore the mixed method research question: how do the results of the survey data and the interview data explain teacher decision-making regarding releasing students for mental health services during academic instruction? In the previous section, I integrated the IASMHS Scores with data I collected during Phase Two. In this section, I look at the

MHLS Scores of the participants and the relationship between the cognitive, behavioral, and environmental factors that influence an educator to release a student from academic instruction, which participants' discussed in Phase Two.

In Phase One of the study, I used the MHLS to measure educators' (*n*=40) literacy as it relates to Mental Health. Similarly, I had five questions on the qualitative interview protocol that explored educators' knowledge (literacy) of mental health. Specifically, questions 2, 3, 4, 5, and 9 related to Mental Health Literacy. Bandura's (2016) theory includes literacy under the component cognitive factors. An individual's attitudes and beliefs are also categories in this component. Therefore, I explored the relationship between the IASMHS and MHLS scores while exploring the participants' work setting (environment) and their self-rating of their ability (behavioral factors) to recognize and support a student in need. Table 3.14 provides a visual representation of the participants' IASMHS and MHLS scores, along with their education, work experience, and personal experience as these are all measures of mental health literacy.

Table 3.14

Lived Experiences Related to Participant's IASMHS and MHLS Scores and Their Willingness to Release Students from Class

Participant	IASMHS Score	MHLS Score	Education/ Training	MH Work Experience	Personal Experience with MH	Releases Students
Celeste	85	150	A lot of professional development	Title 1 schools; trauma	Individual counseling for Trauma	Yes
James	82	152	Psychology major	In-patient facilities	Individual counseling for PTSD	Yes

Participant	IASMHS Score	MHLS Score	Education/ Training	MH Work Experience	Personal Experience with MH	Releases Students
Christina	77	129	Some professional development	None	Individual counseling	Yes
Peter	59	125	Some professional development	None	Individual counseling Learning support for learning disability	Yes
Evie	48	123	Little professional development	None	Counseling for son	Yes

Note: MH = Mental Health; PTSD = post-traumatic stress disorder

This table supports the findings from Phase One that demonstrates a moderate, positive correlation existed between the IASMHS and MHLS scores. In addition, the table shows a relationship exists between an educator's lived experiences (education; work; and personal) and their MHLS score. This relationship is evident when the reader compares the MHLS scores and lived experiences of Celeste and James with the MHLS scores and lived experiences of the other three participants. The table shows Celeste and James had the highest MHLS scores out of the five participants along and also shows their lived experiences (education; work; and personal) had a more significant mental health focus (i.e. both James and Celeste reported personal trauma in their lives and both had extensive experience with mental health in their work and educational settings).

This integration of data supports the framework I used for my study, Bandura's social cognitive theory (1986), which suggests that multiple components (cognitive,

environmental, and behavioral) contribute to an educator's decision to release a student from academic instruction for mental health services.

Discussion

The research other scholars have completed in the past has addressed educators' perceptions, attitudes towards, and understanding of mental health issues and services (Bandura, 1986; Breuer, 2016; Mackenzie et al., 2004; Reinke et al., 2011). However, there is a gap in the research when it comes to understanding how educators' attitudes towards and understanding of mental health services drive their decision to release a student from academic instruction to receive services. My study aimed to address this gap by exploring how teachers' attitudes towards and understanding of mental health impact their decision to release a student from academic instruction. Bandura's (1986) social cognitive theory demonstrates that multiple facets can influence human behavior and shows how the components work collectively. Specifically, Bandura's (1986) model explains why two educators who have the same knowledge of mental health with adolescents may have different protocols (or behaviors) when it comes to releasing students from their class time since it is not just the knowledge of something that influences human behaviors, but the combination of knowledge, lived experiences, cultural norms and practice that influence our actions.

Bandura's (1986) social cognitive theory provided the framework for this mixed methods explanatory sequential design study. I used the three main components of his theory as a priori themes which enabled me to reveal several categories and a posteriori themes from the qualitative data. Where Breuer (2016) used Bandura's (1986) theory to discuss how teachers' attitudes and beliefs impact their decisions to refer a student for

services, I used Bandura to discuss the next step after the referral: releasing the student from the classroom for participation in the referred services.

I used a mixed methods design because it enabled me to collect thick, rich, descriptive data that a quantitative study would not have captured (Creswell & Poth, 2018). Conversely, a qualitative study would not have allowed me to measure educators' attitudes towards and knowledge of mental health in a quantitative means. Using the IASMHS and the MHLS inventories in Phase One, helped me select a diverse pool of participants for Phase Two and helped guide my semi-structured interview protocol. The mixed methods approach helped me look for relationships between the themes while I was also able to explore deeper issues related to an educator's attitude and mental health literacy (Creswell & Poth, 2018). For example, if I only measured educators' attitudes towards and literacy associated with mental health, then the ability to only make observations about relationships between and within groups would stifle my analysis. However, because I incorporated a qualitative phase into my study, I was able to ask questions that pertained to the educators' lived experiences. The integration of the data also helped me to see how the three components of Bandura's (1986) theory overlap with one another to impact a teacher's decision to release a student from class. I recognize it is not just one factor that influences an educators' decision to release a student, but multiple factors.

In this study, I explored educators' decisions to release students by asking the following specific and direct question in my qualitative phase: "What are some reasons (factors, concerns, or beliefs) that contribute to your decision to release or not release a student from class?" This question generated a lot of discussion among the five

participants; however, I could have improved this study by incorporating more qualitative and quantitative data that would help answer this question. For example, I could have collected classroom sign-out logs that track how frequently a teacher releases students and for what purposes as an additional form of quantitative data. Similarly, if time permitted, I could have collected additional qualitative data in the form of classroom observations for each of the participants. Through observations, I would have been able to take notes of teachers' behaviors and interactions with students, specifically on how they relate to releasing a student from class for support services. Finally, I believe the study would have been stronger had I been able to recruit more educators and achieve significance in my sample size for Phase One. The larger sample may have improved statistical significance for the quantitative analysis and would have increased the generalizability of the results.

As I stated previously throughout Chapter Two, I modeled part of my study off of the research conducted by Breuer (2016). Part of her analysis looked at the sub-factor scale that measured indifference towards stigma on the IASMHS inventory and its relationship to a teacher's decision to refer a student for services. Breuer's (2016) findings indicated that a teacher's level of indifference towards stigma was significantly related to their response of whether to refer a student for services when given scenarios to assess. I anticipated similar findings with my quantitative research, believing that an educator's sub-factor score of indifference towards stigma would influence a teacher's decision to release a student from class. However, I was surprised by the analysis I conducted with the qualitative interviews that an educator's indifference towards stigma had seemingly little influence on whether or not an educator would release a student.

Peter and Evie had the lowest scores related to indifference towards stigma when I compared them to the other three participants. However, their overall feelings and beliefs surrounding releasing a student were positive with both Peter and Evie indicating that if the pull-out service is what the student needs, then they have no problem with excusing them from class. Here is where quantitative measures for releasing students would provide strength to the research and would have enabled me to make direct comparisons to an educator's inventory score and their frequency of releasing students from class.

The careful analysis I conducted demonstrated that my results support what previous literature has reported. One of the biggest categories that emerged under the *a priori* theme of Cognitive Factors was education and training. All five participants indicated that they have received little professional development from their schools of employment and four of the five participants agreed that they had little to no preparatory training before becoming a teacher. The lived experiences of the five participants support the literature that revealed how ill-equipped educators feel to recognize or support mental health issues (Ekornes, 2017; Ely, 2017), specifically in pre-service education programs. In addition, the five participants in Phase Two each expressed that they want to support their students, but they do not know how to or do not have the skills, resources, or time. Again, these lived experiences support what Mazzer and Rickwood (2015) found in their study on teachers' desire to support a student and support what Armstrong et al., (2015) found on teachers' ability to identify needs in their students.

While lack of training and education is a common theme in past research and my study, Erabutt and Speach (2012) identified other barriers that arise within schools when trying to support students. Specifically, Erabutt and Speech (2012) identified three main

barriers: (1) no staff available to coordinate services; (2) budget restraints; and (3) balancing school expectations with home stressors. Rowling et al.,(2009) supported these findings, as did my current study, as these three barriers were among the barriers that the participants identified as categories in my qualitative study.

I completed my research; however, future research is still needed to bring a deeper understanding of this topic that explores those factors which influence an educator's decision to release a student from class. As I suggested earlier in this section, research that quantifies an educator's practice and protocol for releasing a student would enable researchers to make stronger comparisons to assess relationships between educators' attitudes towards and literacy related to mental health and their practice of releasing a student. Another area for future research could look closer at educators' personal lived experiences with mental health and explore if an educator does not have a personal lived experience with mental health, does this impact their willingness to release a student from class to receive mental health support? Additionally, it would be interesting if future research conducted an embedded experimental mixed methods study where quantitative measures were collected before implementing an intervention such as professional development and training on mental health issues in adolescents. Then post-quantitative measures would be collected and followed by a semi-structured interview that would capture the feelings and perceived benefits of the training from the educators' perspective. Finally, I think future research should focus on pre-service teaching programs at the university and post-graduate level to determine what content future educators receive in terms of children and adolescent mental health issues.

Implications

Now that I have shared the results of this study, the question remains of how will my study create systemic change that will improve a student's access to mental health support? My results suggest several implications for the various stakeholders connected to student mental health. In the sections that follow, I outline the implications of my research with their relationship to each stakeholder.

For Administrators

Administrators within school systems operate very differently from one building to the next. The data indicate that educators need more training and education on mental health issues that impact children and adolescents. This training and education can be in the form of Professional Development and opportunities to attend conferences. This implication is supported by the literature that shows educators, as a whole, feel ill-equipped and untrained to support students' mental health in the classroom (Armstrong et al., 2019; Atkins, 2016; Atkins & Rodger, 2016; Ely, 2017; Fortier et al., 2017; Jorm et al., 2006; Kutcher et al., 2013; O'Connor et al., 2014).

In addition to more training, the voices of the educators I interviewed in Phase Two suggest that if administrators would adjust the schedule of the school day to allow for support services, it could help ease the tension between academic demands and mental health needs. Ekornes (2017) found similar outcomes in their results which found that even if services were available for students, they often competed with academic instruction time. One of the participants, Evie, took a page from Erasmus (2019) and suggested that school administrators build time into the schedule where students can

receive the support services they need or go back to a teacher to work on missed assignments from missed academic class time.

Additionally, district administrators should look at reallocating funds within the budget so more counselors and social workers can be hired. Each building should have at least one, full-time counselor to ensure a trained individual is always in the building to deal with any type of mental health crisis that may arise. The hiring of more counselors, in addition to contracting with more local, social service agencies, is something Erasmus (2019) supports. Having more mental health support within the school reduces the need for students to be absent to attend appointments outside of school. However, should the need arise for a student to leave school for mental health support, then the administrator can create a policy that allows teachers to make allowances for mental health issues as they may impact classwork or homework.

For Educators

When schools do not have standing policies that guide academic curriculum and accommodations, classroom educators set the syllabi and expectations for their classes. Christina shared that she often will extrapolate work that is not necessary or crucial for a student who missed her class for an appointment. She stated, "I am more concerned about learning than I am about grades, which is why I let the kids redo assignments and hand things in late . . ." Christina did point out that more formal accommodations would probably need a 504 plan, or its equivalent, which allows special accommodation for students with medical needs. These special accommodations can include an Individualized Education Plan (IEP), which allows accommodations for a student with a learning disability. This push for a formalized, legal document to implement modification

supports James' concern that some students, and their parents, take advantage of mental health issues and get diagnoses for issues they are not struggling with, making it harder for those students who are experiencing mental health issues. This implication is supported by Maslow (1943) and his Hierarchy of Needs whom Erasmus (2019) echoes when she encourages educators to focus on supporting the whole child and not only assessing their ability to retain content.

For Counselors

The American School Counselor Association (2020) recommends a counselor-to-student ratio of 250:1. However, aggregated data collected by ASCA indicates that Pennsylvania averages approximately 369:1. When an average of 10% of the student population needs additional mental health supports (Centers for Disease Control and Prevention, 2013), the counselor needs to ensure that there is an organized system in place that enables them to meet with not only the students who are in-need but with their entire caseload. Therefore, counselors should consider attending grade-band team meetings to discuss the specific needs of students and set up a schedule, with teachers' input, on when to meet with the students.

Additionally, since school counselors are viewed as mental-health experts within the school, it would benefit the student to have them lead, or facilitate, professional development that will increase awareness of mental health issues while also helping educators understand the different services the district or school offers throughout the building.

For Students and Families

The voices of the five educators who participated in the qualitative phase of the study indicated that mental health services are important and should be offered in the school setting. If more services are to be made available, then families need to advocate for more funds to be made available for such services. Parents and students need to talk to their school boards and express the importance of having more counselors, more space in the buildings, and more accommodations with the schedule to help facilitate any support services that would be available for students.

For Colleges and Universities

The data presented in this study shows that mental health literacy among educators needs improvement. Education programs, both four-year and graduate programs, should ensure that their curriculum includes learning about mental health as it pertains to children and adolescents. Educators need training in how to identify issues and concerns as well as how to support a student in the classroom. Student teaching rotations could expand to include time at adolescent residential mental health treatment facilities. This experience will give educators experience with teaching challenging populations while also allowing the opportunity to observe and interact with various mental health issues.

Summary and Conclusion

While national headlines and local data (Blad & Decker, 2020; Center for Disease Control and Prevention, 2020; Holland et al., 2019; Lancaster, 2019; Mercado et al., 2017) demonstrate a need for more mental health services, some educators still hesitate to release students from class to receive mental health support. So, what are educators'

attitudes towards mental health, and what are the reasons behind their decisions for frequently not releasing students to receive support? This study explored both questions to improve students' access to mental health support.

To explore this problem, I conducted an explanatory sequential mixed methods study. The focus of this study was more on the qualitative measures, which was why the notation used was QUAN →qual (Creswell & Plano Clark, 2018). The benefit of this type of design was the value that both types of data brought to the research. In an explanatory sequential mixed method design, there are typically three phases of the study: quantitative; qualitative; and the integration of data phase. Each phase has its distinct research question, which I summarize in the following sections.

The quantitative question I explored asked, "what is the relationship between a teacher's attitude towards mental health services and a teacher's mental health literacy?" The findings showed that there was a moderate, positive, and statistically significant relationship (r= .62, 95% CI .46, .77, p<.001). The qualitative question asked, "how do teachers describe the influence of cognitive, environmental, and behavioral factors on their willingness to release students for mental health services?" The educators who participated in Phase Two of the study supported Bandura's social cognitive theory (1986) by giving voice to the fact that many factors within each of Bandura's (1986) three identified components influence their decision to release a student. For example, the five participants discussed throughout their interviews how their cognitive factors (i.e. lived experiences, knowledge, attitudes, and beliefs) impact their decision to release a student from class) as much as their behavioral factors (self-efficacy and training) impact their ability to identify and support a student in need.

Bandura's (1986) three components of his social cognitive theory, along with the a posteriori theme of barriers, all impact educators' decision to release a student from class. Yet, they all agreed that if the child needs the services, then the academics come second. all five participants stated that if a child needs mental health services and their class is the time that is available for them to receive the support, then they would work with the student on making up any needed academic instruction.

The mixed methods question was, "how do the results of the survey data and the interview data explain teacher decision-making regarding releasing students for mental health services during academic instruction?" During the integration phase, I noticed that the lived experiences of each participant aligned somewhat with each of their IASMHS and MHLS scores; meaning, the more education, training, and personal experiences a participant in Phase Two disclosed during the interview, the higher their score was on both the IASMHS and the MHLS. This could imply that the personal lived experiences and exposure to mental health impact the attitudes and knowledge regarding mental health. The integrated results also demonstrate that multiple factors impact an educator's decision to release a student. These findings also support Bandura's social cognitive theory (1986) which suggests that multiple components (cognitive, environmental, and behavioral), contribute to an individual's behaviors, in this case, an educators' decision to release a student for mental health support services.

My research has many implications for various stakeholders. However, the findings will make the biggest impact on education and training. The data I collected supports the need for educators to receive more training and experience in topics related to child and adolescent mental health, specifically how it presents in the school setting.

My findings support the research done by Ely (2017) who found a need for more pre-service education in addition to specific professional development for existing teachers. Additionally, school counselors and other mental health professionals need to become bigger advocates for students' mental health. One way counselors can advocate is through offering and leading continued education, through professional developments and in-services. These types of training can help students, families, educators, and administrators understand the cruciality that Maslow (1946) outlines in his theory of the Hierarchy of Needs. Erasmus (2019) believes that schools can successfully support the mental health of students by providing time and space, empowering students, prioritizing staff mental wellbeing, onboarding parents, and rallying support from local agencies. Research supports, that focusing on the whole child encourages greater academic success (Basch, 2011; Baskin et al., 2010; Daly et al., 2014; Dix et al., 2012; Michael et al., 2015; Suldo et al., 2014; Sutherland, 2018; Wells et al., 2003).

CHAPTER FOUR

Distribution of Findings

Executive Summary

Untreated mental health issues have led to a crisis of sorts for the United States. Twenge et al., (2019), found that mood disorders and suicide-related outcomes for adolescents aged 12 to 17 increased by 52% over a twelve-year range from 2005–2017. Lancaster County, Pennsylvania is not exempt from these sad statistics as they reported 40 suicides between January and August 2020. This statistic is higher than in 2019, which reported 36 deaths by suicide between January and August of 2019 and 52 suicides for the entire year (Lancaster, 2019). I responded to three deaths of students who completed suicide between November 2018 to May 2019. This is three deaths too many.

A child or teen struggling with mental health issues may not find respite during the hours of the school day. Mental health issues, including family stressors that can cause mental duress, coupled with the pressure to perform in the school setting can exacerbate pre-existing conditions or create heightened levels of stress that may present like anxiety, depression, or behavior issues. A child's social and emotional needs, if left unaddressed, can have serious implications for their academic success (Elias et al., 1997; Gur et al., 2012; Loades & Mastroyannopoulou, 2010; Maslow, 1943; Rothi & Leavey, 2006) including low to failing grades, gaps in knowledge and disciplinary issues. Repie (2005) goes a step further and asserts that children who do not receive much-needed mental health support are at risk of having ongoing issues throughout adulthood that can impact their way of life and future generations.

The literature review demonstrates that because of the large amount of time students spend in the school setting, educators play a crucial role in identifying concerns that impact the students' academics, safety, and emotions (Armstrong et al., 2015; Dix et al., 2012; Elias et al., 1997; Erasmus, 2019; Gur et al., 2012). The literature also showed that educators' literacy, attitudes, and perceptions about mental health influence their ability to identify mental health concerns while also influencing their decision to refer a student for services (Bandura, 1986; Breuer, 2016; Mackenzie et al., 2004; Reinke et al., 2011). A gap in the research helped form the research questions for this study. One question is: what do educators understand about children and adolescent mental health issues? Another question is: what connection exists between a teacher's recognition of a need for mental health support for students and their practiced willingness to release students from class time? These questions are important to explore as Erasmus points out that, "our mental wellbeing is linked to our academic results and we need to ensure that as a society we don't neglect the first in pursuing the second" (2019, p. 14). Erasmus is echoing Maslow's Theory of Hierarchy of Needs (1943) and reminds educators that they need to focus on supporting the whole child sitting in their classroom and not only the assessment of content retention.

Overview of Data Collection and Analysis Procedures

To explore my problem of practice, I conducted an explanatory sequential mixed methods design research study. The focus of this study was more on the qualitative measures, which was why the notation used was QUAN →qual (Creswell & Plano Clark, 2018). The benefit of this type of design was the value that both types of data brought to the research. I explored three key questions with each phase of the study, which were the

quantitative, qualitative, and integration phases. I chose Bandura's social cognitive theory (1986) as my theoretical framework. This theory guided my selection of inventories for the quantitative phase, as well as guided my participant selection for the qualitative phase and the protocol used for the semi-structured interviews. Bandura (1986) asserted that individuals' cognitive factors, environmental factors, and abilities combine to influence a person's behavior. Bandura (1986) supported my argument that a teacher's attitudes, beliefs, and lived experiences impact their decision to release a student from academic instruction to receive mental health support services. Bandura's framework also guided my analysis, as I used the a priori themes that came out of his framework to conduct rich thematic analysis during the qualitative phase where a posteriori themes emerged.

Summary of Key Findings

In Phase One, I asked, "what is the relationship between a teacher's attitude towards mental health services and a teacher's mental health literacy." I had participants (n=44) complete electronically complete the Inventory of Attitudes towards Seeking Mental Health Services (IASMHS) developed by Makenzie et al., 2004. The IASMHS quantitatively measured an educator's attitude towards mental health. In the same survey, I asked participants (n = 40) to complete the Mental Health Literacy Scale (MHLS) which was developed by O'Connor and Casey (2015). The MHLS quantitatively measured an educator's literacy, or knowledge, surrounding mental health. The findings showed that there was a moderate, positive, and statistically significant relationship between a teacher's attitude towards mental health services and a teacher's mental health literacy (r= .62, 95% CI .46, .77, p<.001).

In Phase Two, I asked the qualitative question "how do teachers describe the influence of cognitive, environmental, and behavioral factors on their willingness to release students for mental health services"? Educators participated in a semi-structured interview with me to answer questions that explored deeper the main components of Bandura's Theory (1986) as they relate to the educator's reasoning for releasing, or not releasing, a student from class. The educators who participated supported Bandura's social cognitive theory (1986) by giving voice to the fact that many components, including past experiences and education, influence their decision to release a student. Yet, they all agreed, that if the child needs the services, then the academics come second. The mixed methods question I asked was, "how do the results of the survey data and the interview data explain teacher decision-making regarding releasing students for mental health services during academic instruction?" During the integration phase, I noticed that the lived experiences of each participant aligned somewhat with each of their IASMHS and MHLS scores; meaning, the more education, training, and personal experiences a participant in Phase Two disclosed during the interview, the higher their score was on both the IASMHS and the MHLS. Future research can explore this perceived relationship further to achieve a greater understanding of the impact an individual's lived experiences and exposure to mental health have on the attitudes and knowledge regarding mental health. This implication creates the argument that teachers who have more positive attitudes and higher knowledge related to mental health may be more inclined to release a student for services.

Implications and Recommendations

Many implications come out of my research that impacts several stakeholders including administrators, educators, counselors and mental health workers, students and families, and colleges and universities. One of the a posteriori themes that emerged during the qualitative analysis was teacher recommendations. Educators are just as frustrated as counselors when they see their students struggle, but they feel ill-equipped to know how to support them when they need to balance the tension that exists between the social-emotional and academic needs of a student. The recommendations that emerged from the educators include:

- more counselors in schools
- more training and education
- priority is given in the budget
- flexible scheduling during the school day
- increase in communication between mental health support staff and educators
- less focus on test outcomes

The solution, just like the problem, is not simple; however, it is important to take note of the recommendations that emerged from the voices of the participants. Because I valued their voices to help provide an understanding of what influences a teacher's decision to release students from academic instruction to access mental health services, I also value their voices when they offer suggestions to create more balance.

Findings Distribution Proposal

My problem of practice impacts several key stakeholders. The information disseminated to them would vary based upon their role and level of investment in the

problem of practice. Table 4.1 is a gridded outline that identifies the different stakeholders and the type of information that I will share with them, along with the format in which I will deliver the data.

Table 4.1

Distribution of research findings proposal

Identified Stakeholder	Type of Information	Format of Data Delivery	Length of Presentation and Viewing	Goal of Presentation and Data Sharing
EdD-LOC Online Faculty Advisors and Doctoral Candidacy Committee at Baylor University	Full submission of dissertation	>Electronic submission of full dissertation >Live (Zoom) presentation to report findings and defend dissertation	>Reading of dissertation will vary by reader. Estimated to be two to four hours. >Presentation length is TBD; estimated between 15 and 30 minutes.	> To earn EdD credentials
Lancaster-Lebanon iu13 Supervisors	>Summary of research and findings >Implications for School Counseling program at iu13	>PowToon presentation >Written report of experience with process and potential impact for program	>Five minute presentation >Reading length will vary with each reader. Estimated to take 15 to 20 minutes to review	>Accountability for employee tuition reimbursement program >Share out implications for school counselors within the iu13 program. >Brainstorm next steps for nonpublic school counseling programs.
County Superintendents and County School Principals	>Summary of findings	>PowToon - electronically delivered >PDF of results electronically delivered	> Viewing time approximately 5 minutes >Reading will vary based on the reader. Estimated time is 5 minutes	> Accountability of completed research that recruitment letter highlighted >Invitation for future professional developments with staff regarding mental health needs of students

Identified Stakeholder	Type of Information	Format of Data Delivery	Length of Presentation and Viewing	Goal of Presentation and Data Sharing
County School Counselors	Summary of research and findings	PowToon – delivered by email PDF of results delivered by email	Viewing time estimated at 5 minutes Reading will vary based on the reader. Estimated time is 5 minutes	Bring awareness of Lancaster County educators' attitudes and beliefs toward mental health support Invite discussion for future professional developments and action steps counselors can take to advocate for MH
Participating School Teachers	Summary of research and findings	PDF of results delivered by email (or link provided to the static site)	Reading will vary based on the reader. Estimated time is 5 minutes	Sign of gratitude for their participation Bring awareness of Lancaster County educators' attitudes and beliefs toward mental health support Invitation to participate in pilot PD educating teachers on mental health needs of students
Students in researcher's two contracted schools	Continue curriculum of SEL skills and MH topics	Live classroom instruction	Weekly for 30 minutes in classrooms	Continue to bring awareness about mental health issues Continue to bring awareness of support offered
Students' Families at the researcher's two contracted schools	Summary of research and findings	Electronic Newsletter Possible Coffee with Counselor night at schools	Reading will vary based on the reader. Estimated time is 5 to 10 minutes. Coffee with Counselor would be presentation style with Q&A. 1 hour	Awareness of counseling support services offered in the school. Awareness of impact mental health issues have on academic success

Conclusion and Summary

Blythe (1998), Perkins (2014), and other scholars (Dintersmith, 2018; Elias et al., 1997; Erasmus, 2019; Payton et al., 2000) speak to the important role educators have in creating safe environments for students while taking into account the impact that social, emotional and cultural factors have on a students' learning (National Academies of Sciences, Engineering, and Medicine, 2018). Educators are not mental health experts and may feel inadequate around mental health, though researchers argue that educators are the ideal people to catch early warning signs in their students (Armstrong et al., 2015; Dix et al., 2012; Elias et al., 1997; Erasmus, 2019; Gur et al., 2012). In addition, schools encounter constraints within the conventional school setting which can make incorporating mental health support services into the schedule challenging.

I began my research with the intent to understand what factors influence an educator's decision to release, or not release, a student from academic instruction to receive mental health support. What I found is that most educators are not against students receiving support during the school day; on the contrary, most favor the support and desire more for the students. This study showed that educators, counselors, and mental health professionals are all on the same side with a strong desire to support the whole student: body, mind, and soul.

APPENDICES

APPENDIX A

Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)

Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)

The term *professional* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term *psychological problems* refers to reasons one might visit a professional. Similar terms include *mental health concerns*, *emotional problems*, *mental troubles*, and *personal difficulties*.

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

	Disagree Agree
1. There are certain problems which should not be discussed outside of one's immediate family.	[0 1 2 3 4]
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.	[0 1 2 3 4]
3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.	[0 1 2 3 4]
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	[0 1 2 3 4]
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.	[0 1 2 3 4]
6. Having been mentally ill carries with it a burden of shame.	[0 1 2 3 4]
7. It is probably best not to know *everything* about oneself.	[0 1 2 3 4]
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.	[0 1 2 3 4]
9. People should work out their own problems; getting professional help should be a last resort.	[0 1 2 3 4]
10. If I were to experience psychological problems, I could get professional help if I wanted to.	[0 1 2 3 4]
11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.	[0 1 2 3 4]

12. Psychological problems, like many things, tend to work out by themselves.. . . . . [0 1 2 3 4]
13. It would be relatively easy for me to find the time to see a professional for psychological problems. . . . . [0 1 2 3 4]
14. There are experiences in my life I would not discuss with anyone.. . . . . [0 1 2 3 4]
15. I would want to get professional help if I were worried or upset for a long period of time. . . . . [0 1 2 3 4]
16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it. . . . [0 1 2 3 4]
17. Having been diagnosed with a mental disorder is a blot on a person's life. . . . . [0 1 2 3 4]
18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help.. . . . . [0 1 2 3 4]
19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.. . . . . [0 1 2 3 4]
20. I would feel uneasy going to a professional because of what some people would think. . . . . [0 1 2 3 4]
21. People with strong characters can get over psychological problems by themselves and would have little need for professional help. . . . . [0 1 2 3 4]
22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family. . . . . [0 1 2 3 4]
23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up." . . . [0 1 2 3 4]
24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.. . . . . [0 1 2 3 4]

Note. No permission is required to use this inventory.

APPENDIX B

Mental Health Literacy Scale

The purpose of these questions is to gain an understanding of your knowledge of various aspects to do with mental health. When responding, we are interested in your degree of knowledge. Therefore, when choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely
Unlikely = I think it is unlikely but am not certain
Likely = I think it is likely but am not certain
Very Likely = I am certain that it IS very likely

1
If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have **Social Phobia**

Very unlikely Unlikely Likely Very Likely

2
If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry and had physical symptoms such as having tense muscles and feeling fatigued then to what extent do you think it is likely they have **Generalised Anxiety Disorder**

Very unlikely Unlikely Likely Very Likely

3
If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep then to what extent do you think it is likely they have **Major Depressive Disorder**

Very unlikely Unlikely Likely Very Likely

4
To what extent do you think it is likely that **Personality Disorders** are a category of mental illness

Very unlikely Unlikely Likely Very Likely

5
To what extent do you think it is likely that **Dysthymia** is a disorder

Very unlikely Unlikely Likely Very Likely

6
To what extent do you think it is likely that the diagnosis of **Agoraphobia** includes anxiety about situations where escape may be difficult or embarrassing
Very unlikely Unlikely Likely Very Likely

7
To what extent do you think it is likely that the diagnosis of **Bipolar Disorder** includes experiencing periods of elevated (i.e., high) and periods of depressed (i.e., low) mood
Very unlikely Unlikely Likely Very Likely

8
To what extent do you think it is likely that the diagnosis of **Drug Dependence** includes physical and psychological tolerance of the drug (i.e., require more of the drug to get the same effect)
Very unlikely Unlikely Likely Very Likely

9
To what extent do you think it is likely that in general in the United States, **women are MORE likely to experience a mental illness of any kind compared to men**
Very unlikely Unlikely Likely Very Likely

10
To what extent do you think it is likely that in general, in the United States**, men are MORE likely to experience an anxiety disorder compared to women**
Very unlikely Unlikely Likely Very Likely

When choosing your response, consider that:
Very Unhelpful = I am certain that it is NOT helpful
Unhelpful = I think it is unhelpful but am not certain
Helpful = I think it is helpful but am not certain
Very Helpful = I am certain that it IS very helpful

11
To what extent do you think it would be helpful for someone to **improve their quality of sleep** if they were having difficulties managing their emotions (e.g., becoming very anxious or depressed)
Very unhelpful Unhelpful Helpful Very helpful

12
To what extent do you think it would be helpful for someone to **avoid all activities or situations that made them feel anxious** if they were having difficulties managing their emotions
Very unhelpful Unhelpful Helpful Very Unhelpful

When choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely
Unlikely = I think it is unlikely but am not certain
Likely = I think it is likely but am not certain
Very Likely = I am certain that it IS very likely

13
To what extent do you think it is likely that **Cognitive Behaviour Therapy (CBT)** is a therapy based on challenging negative thoughts and increasing helpful behaviours
Very unlikely Unlikely Likely Very Likely

14
Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.
To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:
If you are at immediate risk of harm to yourself or others
Very unlikely Unlikely Likely Very Likely

15
Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.
To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:
If your problem is not life-threatening and they want to assist others to better support you
Very unlikely Unlikely Likely Very Likely

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
16. I am confident that I know where to seek information about mental illness					
17. I am confident using the computer or telephone to seek information about mental illness					
18. I am confident attending face to face appointments to seek information about mental illness (e.g., seeing the GP)					
19. I am confident I have access to resources (e.g., GP, internet, friends) that I can use to seek information about mental illness					

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
20. People with a mental illness could snap out of it if they wanted					
21. A mental illness is a sign of personal weakness					
22. A mental illness is not a real medical illness					
23. People with a mental illness are dangerous					
24. It is best to avoid people with a mental illness so that you don't develop this problem					
25. If I had a mental illness, I would not tell anyone					
26. Seeing a mental health professional means you are not strong enough to manage your own difficulties					
27. If I had a mental illness, I would not seek help from a mental health professional					
28. I believe treatment for a mental illness, provided by a mental health professional, would not be effective					

Please indicate to what extent you agree with the following statements:

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
29. How willing would you be to move next door to someone with a mental illness?					
30. How willing would you be to spend an evening socializing with someone with a mental illness?					
31. How willing would you be to make friends with someone with a mental illness?					
32. How willing would you be to have someone with a mental illness start working closely with you on a job?					
33. How willing would you be to have someone with a mental illness marry into your family?					
34. How willing would you be to vote for a politician if you knew they had suffered a mental illness?					

Note: In the original MHLS, items #9 and #10 read as follows:
#9 To what extent do you think it is likely that in general in **Australia**, women are MORE likely to experience a mental illness of any kind compared to men
#10 To what extent do you think it is likely that in general, in **Australia**, men are MORE likely to experience an anxiety disorder compared to women.
I changed them to reflect the demographics of the participants living in the United States

Scoring

Total score is produced by summing all items (see reverse-scored items below). Questions with a 4-point scale are rated 1- very unlikely/unhelpful, 4 – very likely/helpful, and for 5-point scale 1 – strongly disagree/definitely unwilling, 5 – strongly agree/definitely willing

Reverse scored items: 10, 12, 15, 20-28

Maximum score – 160

Minimum score - 35

APPENDIX C

Teacher Interview Protocol

Phase Two Qualitative Interview Questions
1. What are some thoughts or beliefs that come to mind when you think about mental health?
2. Can you share any personal experiences you may have or had with mental health in your life (with yourself, students, family members, friends)?
3. Describe any education or training you have received about mental health in adolescents (i.e., college or graduate courses; professional development workshops/conferences; books, etc.).
4. Do you feel your teacher training and previous education prepared you for being able to recognize and support social, emotional, and mental health barriers that may exist in a students' life?
5. What impact or connection, if any, do you believe exists between a student's mental health issues and their academics?
6. What are your thoughts on the need for mental health support in schools?
7. What has been your experience with students needing to be pulled for support services?
8. Describe how you feel when a student is pulled from your class. Do your feelings or thoughts change depending on the reason the student is being pulled? (i.e., meeting with ancillary support services such as speech, reading, or counseling; medical appointments outside of school; or rehearsing for a school event, such as sports or musical performance).
9. What are some reasons (factors, concerns, or beliefs) that contribute to your decision to release or not release a student from class?

Note: These questions were the framework for the semi-structured interviews. Follow-up questions were asked based on the responses provided by the participants.

APPENDIX D

Letters Indicating Permission to Use Images

Permission from Lancaster County Chief Clerk

RE: Permission to use map

George, Lawrence <GeorgeL@co.lancaster.pa.us>
Fri 11/27/2020 1:46 PM
To: Valdez, Elizabeth <Elizabeth_Valdez1@baylor.edu>

Hello Ms. Velez,

Thank you for your inquiry. The County welcomes opportunities for its materials and resources to be utilized for research and educational purposes, and asks only that you provide source acknowledgement. I wish you well with your dissertation; the nature of which is both timely and very worthy.

Sincerely,
Lawrence M George
Chief Clerk/Administrator
County of Lancaster
150 North Queen Street
Lancaster, PA 17603

From: Valdez, Elizabeth <Elizabeth_Valdez1@baylor.edu>
Sent: Thursday, November 26, 2020 5:29 AM
To: George, Lawrence <GeorgeL@co.lancaster.pa.us>
Subject: [EXTERNAL] Permission to use map

Hello,
My name is Elizabeth Valdez. I live in Lancaster County and work for the Lancaster-Lebanon iu13. I am currently pursuing my doctorate and am working on my dissertation. The focus of my research is exploring the connection between teachers' attitudes and understanding of mental health issues and needs for children and adolescents and how that links to their decision to release, or not release, a student from academic instruction for the purpose of the student receiving support services.

While discussing my sample size and location, I had secured a map from the county website. I noticed it has a copyright insignia attached to it so am following the suggested protocol by seeking permission from the Lancaster County Commissioners.

Here is the link to the map I am referencing:
School-Districts (lancaster.pa.us)

I thank you in advance for your assistance and willingness to consider allowing my use of this image for my research.

Respectfully,

Elizabeth J. T. Valdez, M.Ed., N.C.C., L.P.C.
PA Certified School Counselor, prek-12th
Baylor University – EdD in Learning and Organizational Change

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