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# Teachers' Mental Health Literacy and Capacity towards Student Mental Health

Tamara D. Daniszewski  
*The University of Western Ontario*


Supervisor  
Dr. Susan Rodger  
*The University of Western Ontario*

Graduate Program in Education

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TEACHERS' MENTAL HEALTH LITERACY AND CAPACITY TOWARDS  
STUDENT MENTAL HEALTH

(Thesis format: Monograph)

by

Tamara Dawn Daniszewski

Submitted in partial fulfillment  
of the requirements for the degree of  
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The University of Western Ontario

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## **Abstract**

The current youth mental health care system is ineffective at meeting the needs of Canadian youth. More than ever, teachers are placed on the frontlines of mental health care provision, including identification and intervention delivery. The present study explored teachers' mental health literacy and capacity in the context of providing help to their students. Secondary data from a large-scale survey of teachers in one Ontario school board was analyzed to assess teachers' current levels of knowledge, awareness and comfort levels in student mental health care. Teachers were compared based on teaching experience, school division, and school location, in terms of what actions they currently take when students present with mental health problems, and their perceptions of mental health supports. Last, a thematic analysis of teachers' written comments about improving student mental health was performed. In general, teachers requested more professional development and increased contact with mental health experts.

**Keywords:** School-based Mental Health, Teachers, Students

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## Introduction

Epidemiological studies reveal that one in five children in Canada under the age of 18 suffers from at least one mental health illness, a risk that rises for children from indigenous populations and in adverse conditions (Canadian Paediatric Society, 2009). About half of all mental illnesses, including anxiety, depression, severe emotional disorder and attention-deficit/hyperactivity disorder, begin in childhood or adolescence (Kirby & Keon, 2006). Suicide is frequently the result of underlying mental health problems and is currently the second leading cause of death among Canadian youth (Health Canada, 2006), ranking us third highest rate in the industrialized world for this tragic consequence (Canadian Mental Health Association, 2012). Only a minority of children and youth (approximately 1 in 6) receive professional help for mental health issues, and for those who do, services are often inadequate (Canadian Psychiatric Association, 2012; Koller & Bertel, 2006).

There are good reasons to focus on the school and school performance when considering children's mental health. First, while all children attend school, few will have access to mental health treatment service through the health-care system (Canadian Psychiatric Association, 2012); second, mental health has a significant impact on academic performance and drop-out rates (Koller & Bertel, 2006; Owens, Stevenson, Hadwin & Norgate, 2012); third, children spend approximately eight hours a day in the presence of education professionals (Kirby & Keon, 2006), often longer than they do at home or in leisure activities. More than ever, teachers are needed on the frontline of mental health service provision for their students, yet with limited training in mental health awareness or care, teachers have little support to effectively fulfil this role (Koller & Bertel, 2006; Short, Ferguson & Santor, 2009).

The purpose of this thesis is to provide an understanding of school-based student mental health services from the teachers' perspective. An analysis of secondary data from a large scale survey of teachers in Ontario will be presented, which expands our current knowledge about teachers as mental health providers. Specifically, the data provides information about teachers' knowledge, awareness and comfort levels in dealing with student mental health, actions teachers most often use in dealing with student mental health, and specific school supports considered most important in helping them fulfil a provision role. The implications of the current study include the potential to inform the development of preservice and inservice teacher training programs, and more broadly, assist in the success of a strategic plan addressing mental health in classrooms.

### **Definitions and Prevalence**

Early definitions framed *mental health* as the absence of mental illness, but there has been a significant reconceptualization in recent decades (Canadian Mental Health Association, 2012). The World Health Organization defines mental health as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (2009, para. 2). A consequence of this holistic definition is that mental health is not an absolute, but rather a continuum where people can improve (or regress) in overall health. Mental health encompasses fulfilling relationships, adaptive thinking and behaviours, high self-esteem and coping strategies (Santor, Short & Ferguson, 2009).

The Canadian Psychiatric Association defines mental health *illness* as “significant patterns of behavioural or emotional functioning that are associated with some level of distress, suffering (pain, death), or impairment in one or more areas of functioning (such as school, work, or social and family interaction)” (2012, para. 6). Mental illnesses are

collectively all diagnosable conditions classified in the DSM-IV (Santor et al., 2009). In comparison, a mental health *problem* or *concern* is often referred to as a non-diagnosable, yet significant difficulty in navigating relationships, problem-solving or managing emotions and stress. In other words, the child may experience sub-threshold symptoms of specific mental health illnesses, without meeting intensity or duration requirements for diagnostic recognition (Koller & Bertel, 2006; Santor et al., 2009). The alarming prevalence rates of youth with mental health illnesses are limited to those who meet requirements for a diagnosis, leaving the true number of students with severe functional difficulties unknown (Repie, 2005).

The most common mental health illnesses facing American children and adolescents today were highlighted in a recent study conducted by Merikangas and colleagues (2010). Lifetime prevalence of DSM-IV categories in a large, nationally representative sample of teenagers suggest that anxiety disorders are the most common (32%), having the earliest age of onset (approximately six years). Nineteen percent of the sample had a diagnosable behaviour disorder, such as oppositional defiant disorder, conduct disorder or attention deficit/hyperactivity disorder. Behaviour disorders were found to have a median onset of 11 years of age. Mood disorders (14%), including bipolar and depression, and substance abuse disorders (11%) followed with slightly older onsets (13 and 15 years, respectively). Comorbidity was found to be 40%, such that almost half of students with one disorder met criteria for another.

### **School-Based Mental Health**

In 2006, the Honourable Michael Kirby, who was at that time a Senator and Chair of the Mental Health Commission of Canada, expressed the urgent need to take action to address the number of children and adolescents suffering from mental health issues.

Highlighting the finding there are 1.2 million Canadian children living with mental illness, the Commission advanced their position that early prevention and intervention is key in the successful treatment of mental health problems. In Kirby and Keon's (2006) national report, *Out of the Shadow's at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, the Commission suggested that the most effective and promising way to provide these preventative efforts is ensuring "mental health services for children and youth be provided in the school setting by the school-based mental health teams" (Section 6.2.2, pg. 140). In response to this report, a mental health strategy for Canada was released in 2012 which includes an evidence-based school mental health curriculum for secondary schools. The project is currently being used by some Ontario school boards, and is expected to be applied to more than 150 schools in Canada for the 2012-2013 school year (Mental Health Commission of Canada, 2011).

School-based prevention and intervention is necessary to bridge the gap between children's needs and the current availability of mental health resources (Ringeisen, Henderson & Hoagwood, 2003). School-based mental health can be defined as "any mental health or substance abuse service or program that can be delivered in a school setting" (Santor et al., 2009, p. 18). Youth mental health care literature describes countless evidence-based interventions intended to be delivered in a school setting, such as pharmacological, psychosocial, integrated community and preventative services (Ringeisen et al., 2003). Children spend significant amounts of time at school and consequently there is unprecedented opportunity to assess multiple indicators of mental health such as academic performance, peer relations and classroom behaviour (Atkins, Graczyk, Frazier & Adil, 2003).

Often, there is a direct link between mental health problems and negative school performance (Owens et al., 2012), and in some cases, serious mental illnesses require referrals for special education services (Roeser & Midgley, 1997). The emotional distress related to having a mental health issue can seriously compromise student learning potential (Repie, 2005), and contribute to absenteeism, poor grades and school dropout (Koller & Bertel, 2006; Perfect & Morris, 2011; Weist, Goldstein, Morris & Bryant, 2003). Additionally, disruptive behaviour disorders are associated with poor school adjustment (Atkins, Frazier, Adil & Talbott, 2002) and even occasional referral to the juvenile justice system (Koller & Bertel, 2006). Following students for several years after childhood, Alatupa and colleagues (2011) found that certain mental health problems, such as hyperactivity in girls and aggression in boys, were strong predictors of later school performance.

Emotional, behavioural, psychological and physical functioning are all intertwined (Weist et al., 2003). The mission of schools should encompass not only academic learning but also psychosocial and emotional wellbeing (Repie, 2005). This is demonstrated in research findings that schools which have expanded mental health care services (i.e. school-based mental health clinics and programming) report higher grade point averages, fewer dropouts and better attendance among students who receive services in the school setting (Center for School Mental Health Assistance, 2003). Both elementary and secondary schools provide ideal settings to effectively improve youth social and emotional competence which can positively influence academic performance and challenge any barriers to learning (Reinke, Stormont, Herman, Puri & Goel, 2011).

Early resistance to school-based mental health stemmed from the belief that maintenance of such services are too costly and interfere with academic responsibilities

(Perfect & Morris, 2011; Weist et al., 2003). Growing recognition that mental health and academics are inherently complementary led to the progressive movement of more comprehensive research and practice related to school-based centres (Han & Weiss, 2005; Paternite, 2005; Weist et al., 2003). Furthermore, financially sustainable programs are possible by utilizing existing school personnel, such as general and special education teachers (Atkins et al., 1998). School-based mental health also reduces costs through preventative actions, ultimately reducing the number of children who would otherwise require more intensive services later in school, such as special education (Weist & Murray, 2007). Currently, mental health care for youth is the second biggest hospital care expenditure in Canada (Canadian Mental Health Association, 2011). Thus, sustainable early prevention programs could help significantly lower these costs and reduce the number of hospital beds filled by patients with mental health illnesses.

### **Barriers to Mental Health Services**

Several factors contribute to the failure of youth mental health services, resulting in multiple barriers to proper identification and treatment for children and adolescents. Problems facing children are complicated by the fact that, unlike adults, they may lack insight into their own conditions, having to rely on an adult (parent or teacher) to act as their referral agents.

One identifiable barrier is the difficulty in detecting a child's internal symptoms, such as depression and anxiety, these being less noticeable and less likely to be identified than overt behavioural symptoms (Koller & Bertel, 2006; Repie, 2005). Furthermore, detection is limited by teachers' and parents' minimal awareness of mental health problems and their accompanying symptoms. Teachers currently receive little to no preservice training in the identification of children who present with mental health issues

(Koller & Bertel, 2006). Furthermore, teachers report having a minimal role in conducting screening and behaviour assessments for mental health issues in their students, believing this to be the primary responsibility of the school psychologist (Reinke et al., 2011).

Owens and colleagues (2002) suggest that there are three major groups of barriers to proper child and adolescent mental health services. These three groups include 1) structural barriers (i.e. expense or lack of awareness of community resources) 2) perceptions of mental health problems (i.e. belief that certain symptoms are not serious and can be controlled without professional assistance) and 3) perceptions of mental health services (i.e. lack of confidence in professionals, fear of stigma, resistance from the child). The Canadian Institute for Health Research (CIHR) (2010) proposes a similar model of barriers to youth mental health care: structural barriers, community barriers and individual barriers. In their report, structural barriers included the fragmentation of services, workforce concerns, wait times and funding. Community barriers included the child's geographic location and social location (gender and socioeconomic status). Individual barriers to proper access to mental health care included fear of stigma, help-seeking attitudes, parental involvement, and attitudes towards mental health care. Many of the barriers proposed in both Owen's and CIHR's reports are addressed in school-based mental health services such as minimizing costs, improving accessibility, increasing mental health knowledge and education for both staff and students, and reducing the stigma of seeking help (Paternite, 2005).

Although many efforts have been made to eliminate the stigma associated with mental illnesses, they are still a widely misunderstood class of diagnoses (Owens et al., 2002). Through media portrayal, individuals learn inaccurate and unfavourable

stereotypes of mental illnesses, such that all people with mental health problems are dangerous, responsible for their condition, and should be marginalized (Canadian Mental Health Association et al., 2001). Students may feel embarrassed about their abnormal thoughts or behaviour, affecting their willingness to disclose such experiences with peers, teachers, parents or health care professionals. In a survey of Canadian youth, 63 percent of respondents indicated peer pressure, fear, embarrassment and stigma as significant barriers to youth seeking help (Davidson & Manion, 1996 in Canadian Institute for Health Research, 2010). The fear of stigma may also help explain why females are more willing to use health care services than boys. Studies have suggested boys are more likely to perceive disapproval from parents and fear mental health stigma than their female counterparts (Chandra & Minkovitz, 2006).

### **Fragmentation of Services**

Segments of the health sector, which have historically held a prominent role in the mental well-being of youth, have been criticized as being largely ineffective in meeting the needs of children and adolescents (Atkins et al., 1998; Whitley, 2010). The common practice of guarding one's own health profession has resulted in a variety of 'silo' community and hospital based treatment and counseling centers, these having limited or no correspondence with one another. These 'silos' have contributed to a fragmented and disorganized system of mental health services, leaving certain populations underserved, contributing to inadequate funding, and limiting children's and adolescents' access to sufficient care. For the mental health consumer, it is both time consuming and geographically challenging to find proper services (Canadian Institutes of Health Research, 2010; Kirby & Keon, 2006; Whitley, 2010).



Research shows that access to mental health care is drastically improved when services are offered at school. *Access*, in this context, is defined as the power of an individual to use and benefit from health services. Access has three core dimensions: availability, affordability and acceptability (Canadian Institute of Health Research, 2010). The drastic improvement in mental health care access was demonstrated by Catron, Harris and Weiss (1998), finding that 96% of individuals referred to school-based mental health, compared to 16% referred to community-based treatment programs, actually followed through on their referral.

### **Canadian Context**

In Canada, mental health service and funding is a provincial responsibility, which contributes to many variations in delivery and accessibility across the country. Some provinces have specific mandates to integrate mental health education, promotion, intervention and clinical services in schools (Canadian Institutes of Health Research, 2010). For example, Alberta Education, alongside Alberta's Health Services, created the Mental Health Capacity Building Initiative in 2006, investing 19 million dollars in 2010 towards the creation of school-based mental health (Alberta Health Services, 2010). British Columbia demonstrated success with their elementary-school prevention and resiliency program, *FRIENDS for Life*, which was part of a 44 million dollar investment of the Child and Youth Mental Health Plan in 2003 (Canadian Institutes of Health Research, 2010). Although some provinces are making positive shifts towards collaborative care, many do not have mental health plans or have been criticized for declining services. Along with this push for national synchrony in mental health care that is underway, Kirby and Keon (2006) urge each province to act immediately and make the

changes necessary for a collaborative mental health system, with the school acting as the hub.

The Auditor General revealed that Ontario had an overall decrease in funding in youth mental health over the span of 2 years (2007 to 2009), contributing to a significant slip in rank in comparison to other provinces in youth mental health planning (Canadian Pediatric Society, 2009). In June 2011, the long-awaited Comprehensive Mental Health and Addictions Strategy was released in Ontario, along with 257 million dollars in funding over the next three years to directly help youth suffering from mental health problems (Ministry of Children and Youth Services, 2011). One of the key goals in the strategy is “placing mental health workers and nurses with mental health expertise in schools...and giving educators, social workers and other professionals tools and training to identify mental health issues early on” (Ministry of Children and Youth Services, 2011, para.3).

In the current Ontario curriculum, there are some formal opportunities for teachers to address mental health awareness and promotion in their classrooms, such as in physical education, health and social science courses (Canadian Mental Health Association et al., 2001). However, as many teachers have not had formal training in mental health, they lack the knowledge to effectively and confidently teach this topic (Koller & Bertel, 2006). Most teachers report having little or no training in child mental health although they demonstrate awareness that many children in their classrooms are challenged by mental health problems (Gowers, Thomas & Deeley, 2004). There is an urgent need for educators to be properly trained in implementing evidence-based practices and recognizing mental health issues in their students (Reinke et al., 2011).

### **Ecological Perspective and System of Care Approach**

Bronfenbrenner's (1989) developmental-ecology theory (recently revised as the bioecological model in Bronfenbrenner & Morris, 2006) provides one framework for research and practice of school-based mental health. In short, this theory highlights the interrelations and impact of a child's school, peers, parents, community and society on his or her development (in this case, mental health). In this theory, the child is the center, nested within rings of ecological systems which mutually accommodate each other, influencing the way the child functions in his or her world. Thus, a good understanding of a child's mental health takes into account all individuals, contexts, and situations, including the complex interactions between them. Due to the interrelatedness of the child and their ecology, interventions directed towards the child will, in turn, affect the surrounding agents and institutions (Huebner, Gilman & Furlong, 2009). This model implies the necessity of involving stakeholders, such as the school and parents, for complete and effective interventions to take place (Nastasi, 2004).

The ecological model suggests that there should be many stakeholders in the creation, implementation, and participation of school-based mental health. Bronfenbrenner's revised bioecological model includes the distinction between proximal influences on development, such as family, teachers and peers, and more indirect or distal factors, such as neighbourhood, crime rates, socioeconomic status and health care (Bronfenbrenner & Morris, 2006; Cook & Kilmer, 2010). Proximal and distal factors both have a significant impact on the child's mental health, implying that all students, teachers, school support staff, school social workers and psychologists, parents of students, community centers, community leaders and policy makers participate in mental health care. These stakeholders, who are active participants in the child's ecology, must play a

dynamic role in the child's mental health to ensure a complete and holistic system of care (Whitley, 2010).

The systems of care approach, first proposed by Stroul and Friedman (1986) to address the needs of children with severe emotional disturbances, is a child centered, community-based and culturally sensitive model of health care (Rones & Hoagwood, 2000). Ecological theory serves as a powerful lens to understand the strategies and goals of a system of care: broadly, collaboration of all resources to improve access to mental health services (Cook & Kilmer, 2010). For more than 20 years, system of care has been an improvement on previous health care models by including not only a continuum of services for children, but also a philosophy of “mechanisms, arrangements, structures or processes to ensure that the services are provided in a coordinated, cohesive manner” (Stroul & Friedman, pg. 11). This approach calls for collaboration and integration of both private and public mental health providers and services to ensure the most complete mental health care system to reach all children rather than a select few (Center for School Mental Health Analysis and Action, 2007). As a result, national and local legislation, funding and practice of children's mental health care has been recently transformed (Hodges, Ferreira, Israel & Mazza, 2010). By conceptualizing schools as part of a systems of care approach to child and youth mental health, collaborative efforts can be delivered in a central hub that is effective in reaching all children rather than the select few.

Although it is an encouraging philosophy, system of care has not been implemented to its fullest potential in regards to children's mental health (Cook & Kilmer, 2010; Hodges et al., 2010, Weist & Murray, 2007) Youth services are fragmented, despite collaboration between services, and access is hindered by the poor

availability of services. Without proper access to services, the meaning of ‘system of care’ is lost (Hodges et al., 2010). Additionally, system of care models have ignored preventative efforts and focused solely on treatment (Rones & Hoagwood, 2000). They are also critiqued for their focus on “formal services” (i.e. mental health care providers, juvenile justice agencies) while ignoring the “informal support systems” (i.e. extended families, teachers or role models such as sport coaches) (Cook & Kilmer, 2010).

Unfortunately, an overwhelming part of the child’s ecology is being ignored in current mental health promotion and intervention. Schools are the backbone of creating a comprehensive system of care (Rones & Hoagwood, 2000).

### **Mental Health Needs by Geography and School Level (Division)**

In a recent provincial report, *Taking Mental Health to School*, Ontario researchers were urged to help define “factors that may moderate the effectiveness of interventions (including...socio-economic and regional differences).” (Santor et al., 2009, pg.13).

Student mental health concerns can vary and this variability has been traced to important geographical factors, such as the area in which the school is located, and a rural versus urban context (Atkins et al., 2003). Following an ecological model, students and school personnel from different geographical regions have distinct ecologies which uniquely shape their own mental health and experiences in dealing with mental health. It is important to understand distinctions between urban and rural schools in terms of what students need and which resources are available *before* the planning and implementation of school-based mental health services. This preliminary analysis is important, considering that the sustainability and effectiveness of mental health programs are reliant on indigenous resources (Atkins et al., 2003).

Many schools have created expanded mental health services without the preliminary research and assessment of the community in which the school exists (Weist et al., 2000). However, programs that are most successful are those that are developed around targeted behaviour problems and consider multiple levels of the child's ecology, including the community (Rones & Hoagwood, 2000). Therefore, instead of assuming school-based mental health is a "one size fits all" fix, researchers should assess the differences between urban and rural schools to individualize school-based mental health sites.

Previous findings on the impact of rural and urban dwelling on the mental health of children are inconsistent, with some studies indicating that urban children are at greater risk and others suggesting that rural children present with more mental health difficulties (Maggi et al., 2010). The geographic locale of schools may be less important than the culture and economic differences related to rural and urban contexts (Weist et al, 2000). For example, Weist and colleagues (2000) surveyed school personnel from varied locations and found that urban children are more likely to encounter crime, alcohol, drugs and other life stressors which contribute to higher rates of internalizing behaviour problems than suburban or rural students. Rural living was found to be associated with a different set of stressors, such as parental unemployment and domestic abuse. In contrast, Repie (2005) found that school personnel from rural areas indicated drug and alcohol use as significantly more problematic than urban personnel. However, urban environments rated impulsive/dangerous behaviour and classroom disruptiveness as more concerning than schools from non-urban areas. These contrasting findings suggest the creation of differentiated services based on preliminary assessments of the geographic locale (Weist et al, 2000).

Not surprisingly, barriers to mental health services also vary depending on location. To illustrate, rural and urban dwellers are more likely to rate transportation problems as a barrier to mental health services than do suburban residents (Repie, 2005). Clearly, the culture and socioeconomic statuses related to school geography should be taken into account when planning services for youth. In this respect, school personnel are an unprecedented resource in understanding mental health problems and access to care specific to their schools.

In addition to the location of the school, it is essential that researchers study the differences in mental health concerns across levels of school, such as the elementary and secondary divisions. Stressors and certain behaviours, such as alcohol and drug use, vary with age. Specific psychological disorders have different ages of onset, such as anxiety disorders first appearing in the first few years of schooling, while mood disorders onset much later (Merikangas et al., 2010). Little is known about teachers' experiences with mental health problems in the classroom specific to the age level of their students. Repie (2005) found that counsellors, psychologists and teachers working at the secondary level rated depression, suicidal thoughts, alcohol/drug use and inappropriate sexual behaviour as more prevalent than did school personnel working with younger age groups. Elementary teachers rated attention deficit/hyperactivity disorder, impulsive/dangerous behaviour and classroom disruptiveness as primary concerns. The differences in services required depending on division warrant more research in this area.

### **Teacher Experience**

It is believed that there is a distinct difference between a beginning teacher and one who has gained ground in their teaching career in terms of what knowledge they possess, and how that knowledge is applied (Weston, Anderson-Butcher & Burke, 2008).

Novice teachers have been found to voice more concern over their classroom management skills and disciplinary actions than more advanced teachers (Berliner, 1986), suggesting that teaching experience may raise confidence in handling emotional and behavioural problems. Berliner also suggests that expert teachers hold different schemas about students than their less experienced colleagues, such that they are better able to speculate about home experiences, skills and knowledge levels of their students even before they enter the classroom.

Teaching expertise has been linked to the use of preventative and anticipatory measures taken in classroom management and discipline (Elliot & Stemler, 2008). Although it may seem as though novice teachers spend more time on classroom management, this may be due in part to the fact that they are more reactive to student behaviour, while expert teachers take more preventable actions (Stough, Palmer & Leyva, 1998). Although the literature examining teacher experience as it relates to student mental health is scant, these findings suggest that because expert teachers are more sensitive to the classroom contexts (Elliot & Stemler, 2008), they are better able to read students' emotional and behavioural needs.

Weston and colleagues (2008) argue that beginning teachers should enter the field with all competencies in children's mental health provided from their preservice training, and consequently, with professional experience, they will develop a deeper understanding of how to better apply their knowledge to the field. It is important to consider how beginning teachers differ from more experienced teachers in terms of how they currently deal with student mental health and which supports and resources they consider important in helping them achieve student well-being. This type of comparison will aid in the



development of differentiated in-service mental health training programs which take into account the experience of the teacher.

### **Teacher Efficacy and Burnout**

Numerous studies have found teachers to be at risk for high stress and burnout, especially those teachers in urban settings (Haberman, 2004). Recognized as a process rather than as an event (Friedman, 1995), burnout is defined as a psychological syndrome having three core dimensions: emotional exhaustion, depersonalization and reduced personal accomplishment in response to occupational stressors (Alvarez, 2007; Maslach & Goldberg, 1998). Decline in quality of work related to occupational stress is not only detrimental to the worker, but also everyone who is in contact with that worker - in this case, the students (Haberman, 2004; Maslach & Goldberg, 1998).

Teachers often spend precious time on discipline, safety and classroom management for students with emotional and behavioural concerns, thus limiting learning opportunities for the entire class. Indeed, an imbalance between the demands of a job and the resources to carry out those demands, such as time and support staff, is an underlying theme in almost all occupational burnout (Maslach & Goldberg, 1998). Many teachers report deficiencies in professional training regarding classroom management, although they consider these skills of great importance to their profession (Merrett & Wheldall, 1993). Merrett and Wheldall (1993) also found that many teachers believed that better training in classroom management would reduce occupational stress.

Teacher-student interactions, such as the management of disruptive student behavior, discipline problems, low motivation and minimal effort are consistently reported to be the main source of stress for teachers (Friedman, 1995). Many of these

problematic behaviours are linked to student mental health issues (Perfect & Morris, 2011; Wei, Kutcher & Szumilas, 2011). Teachers are expected to not only educate students but also handle their personal problems (Maslach & Goldberg, 1998).

Self-efficacy, grounded in Bandura's social cognitive theory (1977), is perceived as one's own capability to execute the appropriate actions to meet his or her goals. Underlying this theory is what Bandura terms "personal agency": one's ability to intentionally have influence over his or her actions. This theory maintains that self-efficacy determines how opportunities and obstacles are perceived, how much effort will be expended towards a goal, and how long one will persevere when faced with challenges (Skaalvik & Skaalvik, 2010). Self-efficacy theory has been used as a promising theoretical framework for studying teacher burnout (Evers, Tomic & Brouwers, 2004).

Teacher self-efficacy has been found to be related to responses to student behavior problems, such that teachers with higher efficacy were more likely to use positive and active interventions than those having lower efficacy (Alvarez, 2007). Teachers' sense of efficacy has also been found to influence special education placement decisions (Soodak & Podell, 1993), and teachers' willingness to experiment with new methods to address students' needs (Han & Weiss, 2005). In sum, teaching efficacy affects the different roles teachers take (Alvarez, 2007) and their perceived ability in affecting student educational achievement, even for those students who present with difficulties (Guskey & Passaro, 1994).

In a review of teacher-implemented school-based mental health programs, Han and Weiss (2005) suggest that high teaching efficacy is related to successfully

implementing such programs. Conversely, a sense of professional burnout may be associated with the endorsement of negative attitudes towards new mental health programs. To improve the implementation of school-based mental health programs, Han and Weiss stress the importance of creating training programs for teachers which consider individual factors, such as self-efficacy beliefs and teachers' misconceptions or concerns about the program.

Teachers entering the profession with the will to succeed, yet lacking in the required skills and training are at higher risk of failure and low self-efficacy (Tschannen-Moran, Hoy & Hoy, 1998). Assuming there are strong relationships between teacher efficacy, teacher burnout and student wellbeing and achievement, ensuring that teachers feel confident in addressing student mental health must be a goal in training programs.

### **Teachers' Role in Mental Health**

Teachers may be the most underused resources in mental health delivery (Lynn, McKay & Atkins, 2003). Teachers are frontline professionals who have daily contact with children, and are therefore most likely to have the biggest impact on their students (Reinke et al., 2011). There is a well-documented association between teacher characteristics and child outcomes, such as the child's mental health, behaviour, educational engagement and academic performance (Atkins et al, 1998; Whitley, 2010). Many early studies confirmed that higher levels of teacher support are associated with academic motivation and attainment of goals, reduced levels of psychological distress and student prosocial behaviour (Atkins et al., 2002; Lynn et al., 2003). The effects of teacher support (i.e. warmth, concern and respect) on the student's emotional and academic wellbeing may have a bigger impact than the home environment and act as an important

protective factor against adverse home environments (Bowen & Bowen, 1998). Utilizing teachers in the early identification of students in need, delivery of mental health services, mental health promotion and intervention can not only have a powerful impact on youth in the classroom, but also the teacher's ability to manage the classroom (Han & Weiss, 2005; Kirby & Keon, 2006).

In the past few decades, some programs have been implemented to promote mental health in Ontario classrooms. Although school-based mental health programs appear promising (see Rones and Hoagwood (2000) for a synthetic review of similar programs), little is known about the teachers' perceptions of delivering these interventions or their everyday experiences in the classroom (Gowers et al., 2004). For example, what are teachers' levels of awareness of mental health problems and their accompanying symptoms? What are teachers' comfort levels in providing assistance to children with mental health illnesses?

Teachers have a consistent presence in the classroom, rendering them central in the development and generalization of positive mental health skills among children and adolescents (Han & Weiss, 2005). In addition, interventions aimed towards children usually require teachers to promote and maintain behaviour change in the classroom (Power & Blom-Hoffman, 2004). Even though there are expectations for teachers to take on these roles, there is a lack of research exploring the extent to which teachers are knowledgeable about mental health issues within their classroom (Gowers et al., 2004). As an outcome of the inclusion philosophy adopted by Canadian schools, more than ever, general education teachers are faced with students who present with some mental health need. Yet, teachers are not being equipped with fundamental knowledge about mental illness or preventative skills that contribute to resilience (Koller & Bertel, 2006). In a

recent study on teachers' perceptions of their roles for supporting children's mental health, only 4% of teachers strongly agreed that they had the level of knowledge required to meet their students' needs in this respect (Reinke et al., 2011). Similarly, novice and experienced teachers reported having scant training in mental health provision and therefore felt ill-prepared to recognize and assist children presenting with mental health needs (Koller, Osterlind, Paris, & Weston, 2004; Whitley, 2010)

Teachers often serve as providers of evidence-based mental health programs which are supported by the ministry (Canadian Mental Health Association et al., 2001; Han & Weiss, 2005; Whitley, 2010). Many of today's evidenced-based programs are preventative, district-wide programs targeting all students. Some program topics that teachers currently deliver include social and emotional development, violence and drug prevention, AIDS prevention and social skills training (Nastasi, 2004). Significant evidence exists suggesting that program-specific training has an impact on the quality of the program delivered, such that extensive training for teachers increases likelihood that they will fully and successfully implement a program (Han & Weiss, 2005). However, most of the training teachers currently receive prepares them to be reactive to problematic behaviours, which is in sharp contrast to the preventative nature of the programs they are expected to deliver (Koller & Bertel, 2006). Being able to only recognize pathology (such as symptoms related to DSM-IV diagnoses), rather than have competence in prevention of pathology, is unfortunately only a very small part of what is necessary to be an effective mental health provider. Also, there is a risk in encouraging teachers to become diagnosticians, a role which is limited to licensed and regulated health professionals.

School psychology research and practice has witnessed an important shift in the direction of mental health care promotion rather than a sole focus on treatment (Huebner

et al., 2009). Certain perspectives, such as the recent ‘positive psychology’ movement, demonstrate that the traditional medical model of children’s psychology is ineffective while promotion of positive traits are most effective in reducing psychological dysfunction (see Gilman, Huebner and Furlong’s *Handbook of positive psychology in schools*). Mounting research suggests that childhood is the optimal time to begin learning the skills for resilient, long-term mental health (McEwan, Waddell & Barker, 2007). Focusing on the assets of children and developing resiliency is consistent with the competency-building framework and mission of schools (Power & Blom-Hoffman, 2004).

Teachers are in a unique position to promote positive mental health among students by practicing positive psychology principles, such as health promotion, resilience and subjective well-being, integrating these with academics. For example, an intervention targeted towards students with internalized behaviour problems such as anxiety or depression is to assist them in defining clear goals, discover there are many paths to reach these goals, and garner the self-efficacy and motivation to achieve them. This type of intervention, sometimes termed ‘hope therapy’, has been found to decrease depression and anxiety and may protect against school-dropout by building hope and optimism in youth participants (Miller, Nickerson & Jimerson, 2009).

### **Teacher Education**

Preservice teachers report learning about internalizing mental health symptoms (i.e. anxiety, depression, low self-esteem) mainly through practicum experiences and discussions with supervising teachers, rather than through official university training (Bryer & Signorini, 2011). Additionally, almost all teachers report having little or no child mental health training (Gowers et al., 2004). At most, teachers may complete a basic

general educational psychology course which focuses on instructional theory with the exclusion of mental health principles and its relationship to learning (Koller & Bertel, 2006). In-service mental health assistance also falls short of providing teachers with proper supports to help their students and is limited by the availability of mental health professionals who consult with schools (Walter, Gouze & Lim, 2006). For those training programs teachers do receive, most is centered on being reactive (as opposed to proactive), and lack strategies associated with prevention (Koller & Bertel, 2006).

In a survey of more experienced elementary teachers (career average of 15 years), it was found that few educators received preservice *or* inservice training regarding major mental health problems facing children, such as attention deficit/hyperactivity disorder, disruptive behaviour disorder, depression, anxiety and suicide. This lack of education was congruent with their limited knowledge and self-efficacy in managing mental health problems. When asked what barriers were associated with improper mental health provision in their schools, teachers most frequently reported lack of information and training (Walter et al., 2006).

An important first step in the planning of preservice and inservice education programs for teachers is a needs assessment (Walter et al., 2006). In learning what teachers already know and actions they currently take, feasible and acceptable training programs can be created. By involving teachers in this planning stage, a comprehensive school-based mental health strategy can begin directly in the classroom. The result of properly educating hundreds of teachers impacts the thousands of children (and their families) who will be in their classrooms.

### **The Current Study**

It is increasingly recognized that teachers receive limited training to meet the mental health needs of the large number of students who present with clinical or subclinical symptoms. The intensity and urgency of the issue of student mental health calls for a significant shift in teacher preparation. Although some research has been carried out on the teacher's role in mental health provision, little is known about his or her perceptions of fulfilling this role. For effective teacher training to proceed, it is essential that they be an integral part in the planning of preservice and inservice programs. This study seeks to answer the following questions:

1. What are teachers' current levels of knowledge, awareness and comfort in dealing with mental health concerns?
2. What resources do teachers currently use and which would they find useful in the future in regards to managing mental health issues in their classrooms?
3. Are these findings influenced by demographic factors such as teaching experience, geographic location of the school (rural/urban) or grade level taught (elementary/secondary)?
4. What suggestions do teachers put forth regarding the improvement of student mental health?

## **Method**

### **Purpose**

The purpose of this study was to analyze secondary data which reflects feedback from teachers in terms of their views and knowledge of mental health issues in their schools. The data was obtained from a previous project employed by Psychological Services and Research and Assessment Services of an Ontario school board. As a



collaborative process among key players in these departments, a Mental Health Literacy and Capacity Survey of Educators was created and issued to all teachers in the district to collect information about their perceptions of mental health issues in schools. This survey was designed to collect information about teachers' perceptions of mental health issues in schools rather than estimates of prevalence or severity. The current study aims to organize and analyze this data to search for useful patterns in the teachers' responses, ultimately assisting in the creation of teacher training programs regarding student mental health.

### **Participants**

Survey respondents were teachers from one of the largest school boards in Ontario, working in both general and special education classrooms and from all backgrounds and grade levels (Kindergarten to Grade 12). The survey yielded an 87% response rate, which represents approximately 79.5% of all teachers in the school board. Of the 3913 respondents, 30% were male and 70% were female. Teachers report having taught an average of 14.02 years (*SD*: 9.11) in an average of 3.43 different schools (*SD* = 3.29).

Respondents were divided into two groups based on the division taught, with 58% (*n* = 2271) teachers in elementary only (primary, junior and intermediate grade levels: kindergarten to Grade 8) and 32.1% (*n* = 1256) in secondary (senior: Grades 9 to 12) only. The remaining 9.9% (*n* = 386) of teachers taught at both the elementary and secondary levels. For the purpose of comparing elementary and secondary teachers in subsequent analyses, the responses of teachers who taught at both levels were removed from the data. Teachers were also divided into two groups based on geographic local:

teachers from rural districts accounted for 32% (n = 1251) of the respondents, while 64.8% (n = 2536) of the teachers reported working in urban settings. Refer to Table 1 for a summary of participant demographics and elementary teachers' class demographics.

## **Materials**

The survey used for the purpose of the current study was created, modified and endorsed by representatives of Psychological Services and Research and Assessment Services of the school board. The final version of the survey consisted of five sections (49 items) intended to help address gaps in the literature review:

1. Background information for comparison analyses of specific subgroups of teachers
2. Information about the teachers' students (for elementary only)
3. Strategies and approaches, to assess which actions teachers are currently taking
4. Level of awareness and knowledge of student mental health and comfort levels in dealing with mental health
5. School and community supports teachers find most valuable in helping them with mental health provision

Most sections concluded with an open ended question to allow the teacher to add to the lists of items provided. Refer to Table 2 for a survey topic guide.

*Background information* collected from the teachers included gender, school district and division (grade level) at which they currently teach, years of teaching

Table 1:  
*Participant Demographics and Elementary Teachers' Class Demographics*

*Teacher Demographics*

<b>Characteristics</b>	<i>Elementary</i>	<i>Secondary</i>	<i>Rural</i>	<i>Urban</i>	<i>Total</i>
Teachers <i>n</i>	2271	1256	1251	2536	3913
Gender <i>n</i> (%)					
Male	431(19)	575(46)	337(27)	786(32)	1145(30)
Female	1803(81)	664(54)	905(72)	1699(68)	26.93(70)
Years Teaching <i>M</i> ( <i>SD</i> )	13.95(8.87)	14.12(9.59)	13.39(9.39)	14.41(8.95)	14.02(9.11)
Different schools <i>M</i> ( <i>SD</i> )	3.63(3.47)	2.95(2.99)	3.26(3.14)	3.51(3.39)	3.43(3.29)
<hr/>					
<b>Elementary Only <i>M</i>(<i>SD</i>)</b>					
Boys in class	12.29(5.67)		12.90(6.62)	12.82(7.43)	
Girls in class	11.17(5.35)		11.39(5.79)	11.42(6.63)	
Students referred to counseling	2.79(3.02)		3.19(4.25)	2.79(2.81)	
Remaining students with mental health issues	3.87(3.21)		3.91(3.85)	4.06(3.32)	

*Note: Percentages and frequencies may not add up to total amounts due to rounding error or incompleteness of data*

Table 2:

*Survey Topic Guide*

Section	Scale	Sample Question
Background Information Gender District Grade Level Length of Teaching Career Number of Schools in Career	Check all that apply  Provide Numbers	How long have you been teaching (including this year)?
Information about your Students How many boys/girls. Students with mental health issues.	Provide Numbers	How many of your students have been referred to PDT or to Board Counseling services this year due to significant emotional or behavioural issues?
Strategies and Approaches Describe the issues. Actions taken in dealing with issues.	Check all that apply  Open ended	What actions did you take? (Check all that apply) I met with the parents to get a better understanding of the student's needs and home situation.
Awareness (A), Knowledge (K), Comfort (C) Awareness of range of mental health issues, risk factors and causes, treatments, community services, and steps to access services. Knowledge of signs/symptoms, appropriate actions to take, mental health legislation, school services and resources. Comfort in talking with students and parents about mental health, providing support, accessing services.	5 point scale: 1 - Not at all aware/knowledgeable/comfortable 3 - Somewhat aware/knowledgeable/comfortable 5 - Very aware/knowledgeable/comfortable  Open ended	Rate your awareness on each of the following: The risk factors and causes of student mental health issues.  Rate your knowledge on each of the following: About legislation related to mental health issues (confidentiality, consent to treatment etc.)  Rate your comfort level with each of the following: Providing support to students with mental health issues
Supports Importance of each support in helping teachers deal with mental health. Importance of addressing specific student mental health issues.	5 point scale: 1 - Not important 3 - Somewhat important 5 - Very important  Open ended	Rate how important you consider the following: Greater access to specialized mental health consultations within schools.  How important are the following issues to address? Anxiety, Stress, Bullying, Depression

experience and number of schools they had taught in. Next, elementary teachers only were asked to report the number of boys and girls in their classrooms, how many students they had referred for counseling services, and how many remaining students they believed to have emotional or behaviour issues.

*Strategies used to cope with children's mental health problems.* Strategies and approaches that teachers currently use were assessed by asking the teacher to think of a recent time when they had a student with a significant emotional or behavioural issue and to “check all that apply” from lists of potential problems the student could have demonstrated and actions the teacher took to deal with these problems.

*Awareness, knowledge, and comfort* with respect to children's mental health. This was assessed by having teachers rate themselves, using 5 point Likert scales (e.g. (1) not knowledgeable, to (5) very knowledgeable), on several questions related to children's mental health. To determine a measure of internal consistency, Cronbach's alpha ( $\alpha$ ) was calculated for each subset of Likert scale questions. The survey sections ‘awareness’ (5 items), ‘knowledge’ (4 items) and ‘comfort’ (4 items) had acceptable internal consistency (.892, .853 and .879, respectively).

*Knowledge of supports and the importance of addressing mental health in schools.* Again, using a 5 point Likert scale, teachers were asked to rate the importance of specific mental health supports (e.g. professional development, staffing, resources) in helping them deal with student mental health, with higher scores indicating more importance ( $\alpha = .918$ , 11 items). A final set of Likert scale questions was created to collect information on teachers' perceptions of how important specific emotional and

behaviour issues are to address in schools (e.g. anxiety, stress, bullying etc.), with higher scores indicating more importance ( $\alpha = .912$ , 9 items)

The final item was a short response question intended to collect teachers' opinions and ideas about actions or supports which are important in addressing good mental health in schools. A total of 1185 teachers (30.28%) provided written comments.

### **Procedure**

In April 2010, a hardcopy of the Mental Health Survey was delivered to all teachers in the school district during a professional activity day. Teachers were informed that the purpose of the survey was to aide in the development of a strategic plan to address mental health issues in schools. Anonymity and confidentiality were maintained throughout the collection process. Surveys were completed, collected by individual schools, and forwarded to Research and Assessment services for electronic scanning. All questions, with the exception of open-ended responses, were coded into an SPSS file. A preliminary descriptive report of the quantitative findings was prepared by Research and Assessment in May 2011.

In July 2012, the data from the initial project was obtained by the current researcher for further analyses. The data consists of an SPSS file with coded responses, and scanned copies of each survey for analyses of the open-ended responses. Confidentiality was maintained by the Research and Assessment Department by the removal of any staff or student names mentioned in the completed surveys.

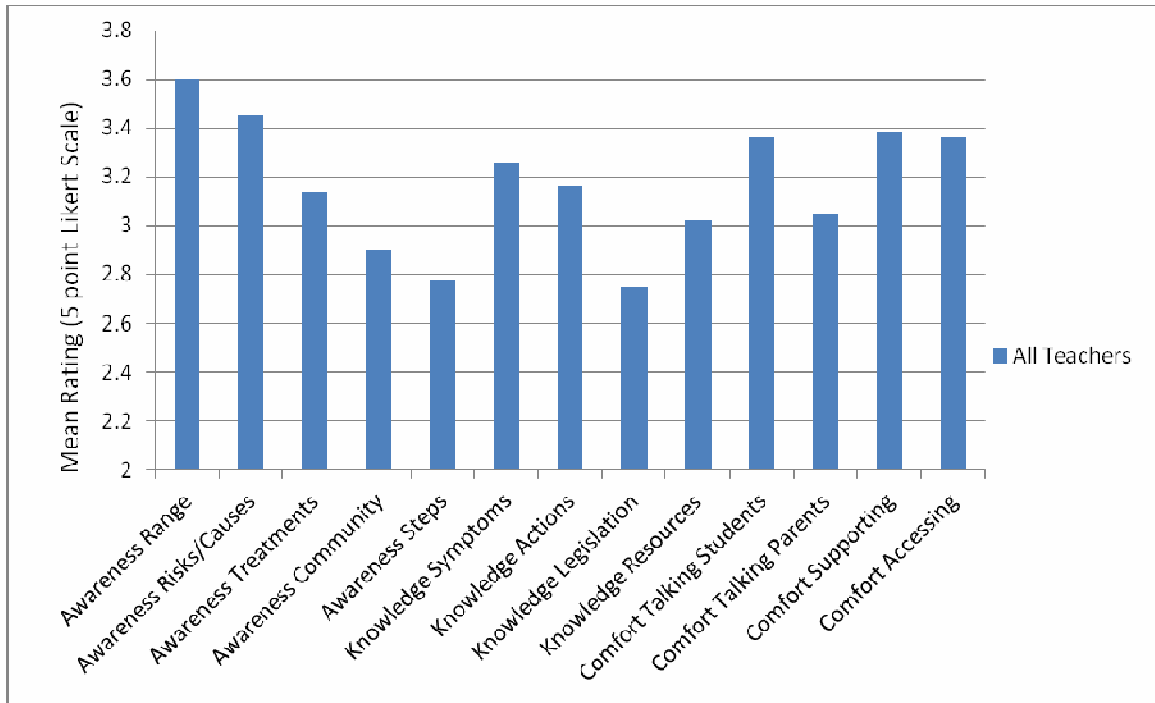
Acknowledging that the researcher's own biases (i.e. personal matters that make it difficult to be objective) and expectations (i.e. beliefs that emerge from reading relevant

literature) are unable to be completely removed from qualitative analysis of teacher responses (Yeh & Inman, 2007), a second reader coded a sample of responses to check for inter-rater consistency. In doing this, all short answer responses were anonymized by separating the transcribed versions from the original surveys. Then, each response was assigned an arbitrary number. A random sample of 100 were chosen for coding by both the author and the second reader, independently. Using the Kappa statistic, an interrater reliability analysis was performed to determine consistency among the two raters.

## **Results**

### **Awareness, Knowledge and Comfort Levels**

Teachers were asked, on a 5 point Likert scale ((1) not at all to (5) very), to rate their own levels of awareness surrounding student mental health, knowledge of student mental health and comfort in dealing with student mental health (Figure 1). Teachers reported being most aware of the range of mental health issues children and youth experience in school years ( $M = 3.60$ ,  $SD = .89$ ), and least aware of the steps necessary to access local community services for mental health issues ( $M = 2.77$ ,  $SD = 1.02$ ). The mean ratings of teachers' own awareness of risk factors and causes associated with mental health ( $M = 3.45$ ,  $SD = .90$ ), types of treatments ( $M = 3.14$ ,  $SD = .91$ ) and local community services ( $M = 2.90$ ,  $SD = 1.02$ ) fell in-between, close to the midpoint of the Likert scale. Teachers were most knowledgeable about the signs and symptoms of student mental health ( $M = 3.26$ ,  $SD = 8.6$ ) and least knowledgeable about legislation related to mental health issues ( $M = 2.75$ ,  $SD = 1.07$ ). Knowledge about the appropriate actions to take and school system services ( $M = 3.16$ ,  $SD = .89$ ;  $M = 3.02$ ,  $SD = .97$ , respectively)



*Figure 1: Mean Ratings of Awareness, Knowledge and Comfort in Student Mental Health*



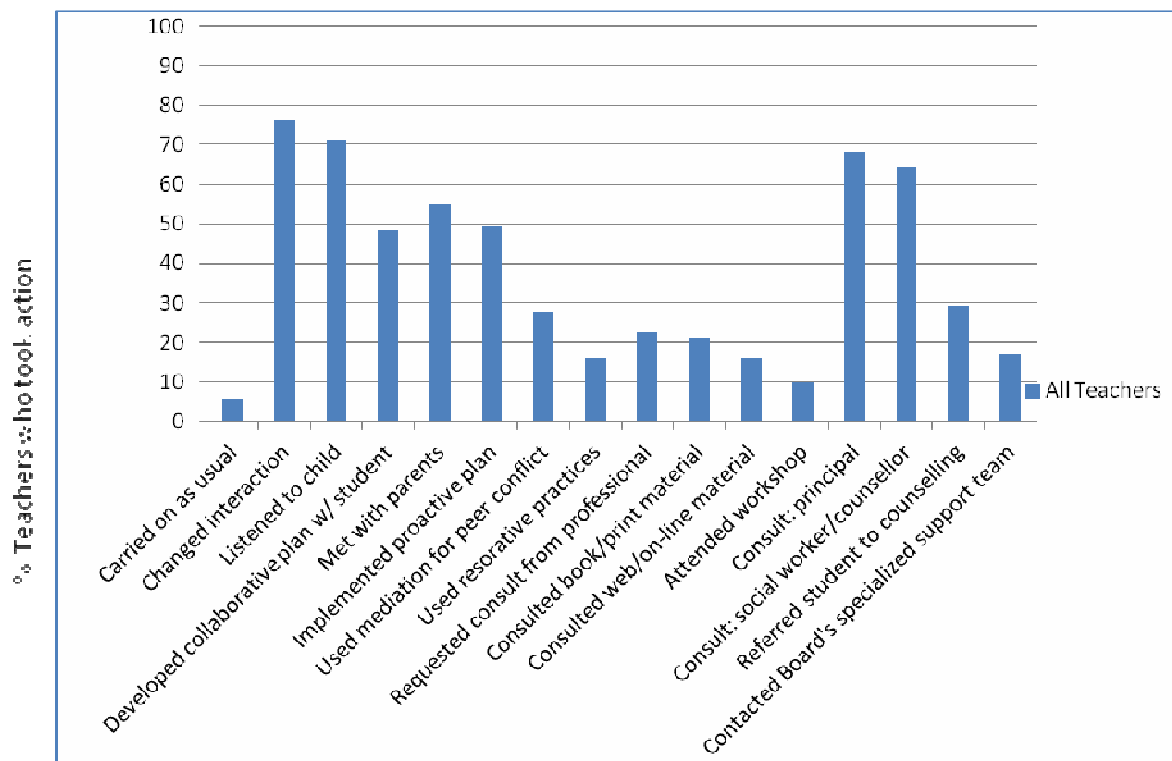
hovered just above the midline, ‘somewhat knowledgeable’. Teachers’ mean ratings of their comfort levels in talking with students about mental health ( $M = 3.36$ ,  $SD = 1.12$ ), providing support to students ( $M = 3.38$ ,  $SD = 1.06$ ), and accessing school and system services for students with mental health issues ( $M = 3.36$ ,  $SD = 1.06$ ) were approximately equal. However, teachers’ comfort levels in talking with parents about their child’s mental health were, on average, lower ( $M = 3.05$ ,  $SD = 1.15$ ).

### **Actions Currently Taken**

Teachers were asked to think of a recent time when they had a student with a significant emotional or behavioural problem and to “check all that apply” from a list of actions they took in dealing with this situation (Figure 2). Teachers were most likely to change the way they interacted with the student in order to “reach” the child more effectively ( $n = 2978$ , 76.1%) and listen to what the child had to say about his or her problem and provide empathic support ( $n = 2791$ , 71.3%). Many teachers also reported discussing the student’s issues with a vice-principal or principal ( $n = 2667$ , 68.2%) and discussing the student’s issues with a social worker, counselor or other psychological staff member ( $n = 2509$ , 64%).

Approximately half of teachers reported that they met with the parents to get a better understanding of the student’s needs and home environment ( $n = 2149$ , 54.9%), implemented a proactive plan to support the student’s behavioural needs ( $n = 1942$ , 49.6%) and developed a collaborative plan with the student ( $n = 1895$ , 48.4%).

Teachers were less likely to report attending a workshop relevant to the student’s needs ( $n = 390$ , 10%), consulting on-line resources ( $n = 626$ , 16%), using restorative practices to deal with the student’s specific behavioural issues ( $n = 626$ , 16%), and contacting the



*Figure 2: Percentage of Teachers who Reported Taking Action towards Student Mental Health*

board's specialized behavioural services ( $n = 665$ , 17%). Teachers were least likely to report that they carried on as usual and the issue went away ( $n = 221$ , 5.6%).

### **Importance of Mental Health Supports**

Teachers rated a list of mental health supports, on a scale of 1 (not important) to 5 (very important), in terms of the importance of each one in helping them deal with students' emotional and behavioural issues in the future (Figure 3). The highest mean ratings were for more availability of support staff ( $M = 4.25$ ,  $SD = .88$ ), better preparation in teacher training ( $M = 4.20$ ,  $SD = .88$ ), more in-school support from school teams ( $M = 4.16$ ,  $SD = .90$ ) and easier access to community based agencies and resources ( $M = 4.09$ ,  $SD = .90$ ). More workshops in schools on mental health ( $M = 3.98$ ,  $SD = .97$ ), access to peer support and mentoring ( $M = 3.83$ ,  $SD = .97$ ) and availability of telephone support ( $M = 3.81$ ,  $SD = 1.00$ ) were rated just under a four. The three supports rated the least important were increased access to web based resources ( $M = 3.49$ ,  $SD = 1.06$ ), more availability of print/how-to materials ( $M = 3.26$ ,  $SD = 1.12$ ), and more availability of videos/DVD's ( $M = 3.23$ ,  $SD = 1.13$ ).

### **Factor Analyses**

For two sections of the survey (Actions Currently Taken and Importance of Supports), a exploratory principle components analysis was performed to test if these scales could be reduced to meaningful factors to aide in the interpretation of teachers' responses. The following section lists the statistics and interpretation of these statistics in this decision to factorize each scale:

#### **Actions Currently Taken**

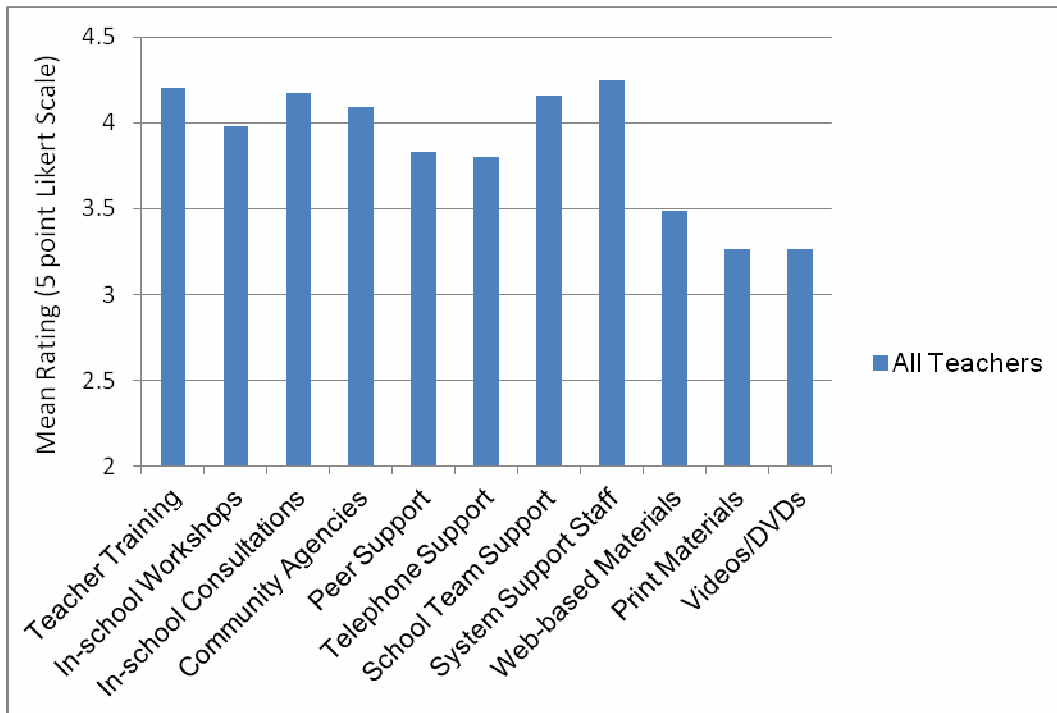


Figure 3: Teachers' Mean Ratings of the Importance of Mental Health Supports

For the 16 actions listed on the survey which teachers reported either taking or not taking during a recent time they had a student with an emotional or behavioural issue, it was of interest to test if these items meaningfully grouped together into distinct categories. Initially, the factorability of the 16 actions was assessed. Ten of the 16 items correlated at least .3 with one other item. However, the item “I carried on as usual and issue went away or the student moved” correlated close to 0 with all other items, so it was removed from the factor analysis (Table 3). Secondly, the Kaiser-Meyer-Olkin measure of sampling adequacy was .870, above the recommended value of .6, and Bartlett’s test of sphericity was significant,  $\chi^2(120) = 9358.89, p < .000$ . Finally, communalities were all over .3, with the exception of 11a, 11g (“I used mediation to help the student deal with peer conflict”) and 11h (“I used restorative practices to deal with the student’s specific behavior issues”). For this reason, 11g and 11h were removed from the factor analysis, along with 11a. Given these indicators, the factor analysis was deemed suitable for 13 of the 16 actions listed on the survey.

Principal components analysis was used because the primary goal was to combine composite scores based on the identification of underlying factors. With the removal of 11a, 11g and 11h, Kaiser-Meyer-Olkin’s measure of sampling adequacy was .855 and Bartlett’s test of sphericity was significant,  $\chi^2(78) = 8227.57, p < .000$ . Initial eigenvalues showed that three factors explained 45.88% (approximately 28%, 9% and 9%, respectively) of the variance. Other factors did not reach an eigenvalue of 1, and were therefore not included in the analysis.

To provide a more parsimonious description of the components, Varimax rotation with Kaiser normalization was employed. All variables loaded over .4 on at least one

Table 3  
*Correlation Matrix for Actions Taken by Teachers in Dealing with Student Mental Health*

Action (Q11)	Action															
	11a	11b	11c	11d	11e	11f	11g	11h	11i	11j	11k	11l	11m	11n	11o	11p
a) Carried on as usual and the issue went away	1	.022	.018	.024	.001	0.16	.050	.041	.012	.027	.038	.041	.015	.000	.001	.001
b) I changed the way I interacted with this student	.022	1	.185	.163	1.58	.201	.150	.116	.076	.168	.127	.085	.167	.161	.114	.098
c) I listened to what the child/provided empathetic support	.018	.185	1	.263	.130	.172	.209	.122	.148	.136	.130	.082	.150	.171	.134	.079
d) I developed a collaborative plan with the student	.024	.163	.263	1	.242	.339	.199	.175	.192	.207	.161	.134	.175	.195	.197	.156
e) I met with the parents	.001	.158	.130	.242	1	.343	.193	.143	.219	.268	.210	.192	.302	.298	.368	.284
f) I implemented a proactive plan	.016	.201	.172	.339	.343	1	.197	.221	.229	.269	.214	.204	.248	.260	.296	.249
g) I used mediation to help the student deal with peer conflict	.050	.150	.209	.199	.193	.197	1	.235	.160	.219	.188	.129	.201	.178	.198	.190
h) I used restorative practices	.041	.116	.122	.175	.143	.221	.235	1	.171	.217	.172	.224	.127	.141	.181	.145
i) I requested consultation from a mental health professional	.012	.076	.148	.192	.219	.229	.160	.171	1	.247	.257	.191	.224	.302	.392	.235
j) I consulted book/print material	.027	.168	.136	.207	.268	.269	.219	.217	.247	1	.495	.285	.186	.217	.251	.210
k) I consulted web/on-line resources	.038	.127	.130	.161	.210	.214	.188	.172	.257	.495	1	.239	.164	.193	.220	.161
l) I attended a “best-practice” workshop	.041	.085	.082	.134	.192	.204	.129	.224	.191	.285	.239	1	.106	.136	.151	.154
m) I discussed the student’s issues with Principal	0.15	.167	.150	.175	.302	.248	.201	.127	.224	.186	.164	.106	1	.307	.297	.213
n) I discussed the student’s issues with psychological staff	.000	.161	.171	.195	.298	.260	.178	.141	.302	.217	.193	.136	.307	1	.335	.229
o) I referred the student to PDT or Board counselling services	.001	.114	.134	.197	.368	.296	.198	.181	.392	.251	.220	.151	.297	.335	1	.401
p) I contacted the board’s specialized services	.001	.098	.079	.156	.284	.249	.190	.145	.235	.210	.161	.154	.213	.229	.401	1

Note: 11a, 11g and 11h were removed from principal component analysis

factor (Table 4), and were retained as part of that factor. Internal consistency was examined for each of the 3 retained components using Cronbach's alpha. Alphas were moderate for the first component, labeled "Institutional Practices" (7 items and an alpha of .71) and the second component, labeled "Research" (3 items and an alpha of .61). The final factor, labeled "Child Approaches" had a low measure of internal consistency, with 4 items and an alpha of .46. No substantial improvements in the alphas could be achieved by removing any items. Composite scores were created for the 3 factors (institutional practices, research and child approaches) based on their primary loadings on each factor for those variables with a loading over .4. However, 11f was composited into both institutional practices and child approaches, as it loaded similarly on both and increased the internal consistency of each factor. Higher scores indicated the teacher reported taking more of these types of actions. Although Varimax rotation was used, the scales were moderately correlated with each other: .436 for institutional and research, .466 for institutional and child-centered and .329 for research and child-centered actions, all significant at the  $p < .001$  level.

Considering the low internal consistency of the factors and the moderate correlations between them, it was decided that the mental health actions listed on the survey would not be factorized, and instead assessed individually in further analyses.

### **Importance of Supports**

For the 11 mental health supports listed on the survey, to which teachers rated their importance in a school setting, a Principal Component Analysis was used to assess if composite scores could be created based on underlying factors. A preliminary look at the

Table 4

*Factor Loadings based on a Principal Components Analysis with Varimax Rotation for 13 Actions Teachers reported taking for Student Mental Health*

Action	Component		
	Institutional Practices	Research	Child-Approaches
b) I changed the way I interacted with this student			<b>.609</b>
c) I listened to what the child/provided empathetic support			<b>.696</b>
d) I developed a collaborative plan with the student			<b>.624</b>
e) I met with the parents	<b>.575</b>		
f) I implemented a proactive plan	<b>.412</b>		<b>.441</b>
i) I requested consultation from a mental health professional	<b>.545</b>		
j) I consulted book/print material		<b>.764</b>	
k) I consulted web/on-line resources		<b>.774</b>	
l) I attended a “best-practice” workshop		<b>.616</b>	
m) I discussed the student’s issues with Principal	<b>.557</b>		
n) I discussed the student’s issues with psychological staff	<b>.586</b>		
o) I referred the student to PDT or Board counselling services	<b>.756</b>		
p) I contacted the board’s specialized services	<b>.647</b>		

*Note.* Factor loadings < .3 are suppressed  
Numbers >.5 load strongly on that factor



intercorrelations among the variables revealed that all items correlated at least 0.5 with one other variable (Table 5). The Kaiser-Meyer-Olkin measure of sampling adequacy was .895 and Bartlett's Test of sphericity was significant,  $\chi^2(55) = 26416.70, p < .000$ . Finally, communalities were all over .5, and so all items were considered appropriate for the factor analysis.

Initial eigenvalues showed that 2 factors explained 68% of the total variance (55% and 13%, respectively). Additionally, no other factor reached an eigenvalue of 1, and so 2 factors were retained. The initial component matrix revealed that all items loaded over .7 on the first factor, suggesting that there was an underlying structure to all 11 items. However, to obtain clearer distinctions, Varimax rotation with Kaiser normalization was used (Table 6). Internal consistency for the components was strong: the first component "Actions" had 8 items and an alpha of .90, and the second component, labeled "Resource Materials", had 4 items and an alpha of .88.

Composite scores were created for the 2 factors (actions and resource materials) based on each variable's highest loading. Higher scores indicated teachers' perceptions of the supports as higher in importance. Actions and materials were highly correlated with each other with a Pearson correlation coefficient of .697, significant at the  $p < .001$  level.

Due to the strong correlation between the two factors, it was decided that the composite scores were not good indicators of distinct underlying dimensions, and the items regarding the importance of supports would be analyzed individually in further analyses.

Table 5

*Correlation Matrix for Ratings of the Importance of Supports by Teachers in Dealing with Student Mental Health*

<b>Support (Q25-35)</b>	<b>Support</b>										
	<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>	<b>30</b>	<b>31</b>	<b>32</b>	<b>33</b>	<b>34</b>	<b>35</b>
Q25: Better Preparation in teacher training to deal with mental health issues	1.000	.746	.560	.508	.503	.425	.460	.438	.416	.408	.384
Q26: More workshops in schools on mental health	.746	1.000	.588	.526	.520	.488	.482	.436	.470	.469	.459
Q27: Greater access to specialized mental health consultations within schools	.560	.588	1.000	.750	.541	.467	.573	.586	.370	.364	.343
Q28: Easier access to community based agencies and resources	.508	.526	.750	1.000	.617	.524	.577	.593	.428	.411	.394
Q29: Access to peer support and mentoring on mental health	.503	.520	.541	.617	1.000	.626	.532	.480	.541	.512	.493
Q30: Availability of telephone support for dealing with student mental health issues	.425	.488	.467	.524	.626	1.000	.507	.445	.553	.532	.508
Q31: More in-school support from school teams	.460	.482	.573	.577	.532	.507	1.000	.741	.425	.398	.379
Q32: More availability of system support staff	.438	.436	.586	.593	.480	.445	.741	1.000	.400	.367	.351
Q33: Increased access to web based resources and materials	.416	.470	.370	.428	.541	.553	.425	.400	1.000	.762	.727
Q34: More availability of print/how to manuals	.408	.469	.364	.411	.512	.532	.398	.367	.762	1.000	.836
Q35: More availability of videos, DVDs	.384	.459	.343	.394	.493	.508	.379	.351	.727	.836	1.000

*Note:* All items were retained for factor analysis

All correlations are significant at the  $p < .001$  level

Table 6

*Factor Loadings based on a Principal Components Analysis with Varimax Rotation for 11 Supports Teachers rated based on Importance for Student Mental Health*

<b>Support</b>	<b>Component</b>	
	<b>Actions</b>	<b>Resource Materials</b>
Q25: Better Preparation in teacher training to deal with mental health issues	<b>.678</b>	
Q26: More workshops in schools on mental health	<b>.665</b>	.380
Q27: Greater access to specialized mental health consultations within schools	<b>.843</b>	
Q28: Easier access to community based agencies and resources	<b>.807</b>	
Q29: Access to peer support and mentoring on mental health	<b>.619</b>	.478
Q30: Availability of telephone support for dealing with student mental health issues	<b>.515</b>	<b>.547</b>
Q31: More in-school support from school teams	<b>.769</b>	
Q32: More availability of system support staff	<b>.773</b>	
Q33: Increased access to web based resources and materials		<b>.844</b>
Q34: More availability of print/how to manuals		<b>.900</b>
Q35: More availability of videos, DVDs		<b>.892</b>

*Note.* Factor loadings < .3 are suppressed

Bolded numbers (>.5) load strongly on that factor and were included as part of that factor.

In summary, both of the survey scales (Actions and Supports) which were initially eligible for factor analysis could not be satisfactorily reduced to a smaller number of dimensions. For the comparison analyses which follow, the items on both of these scales were looked at individually.

## **Comparison Analyses**

### **Years Experience**

Years teaching experience was correlated with individual items on the survey, specifically, questions about which actions teacher's took for mental health and how important they consider school-based mental health supports. Table 7 shows the correlations between each item and the teachers' years experience. Seven of the actions were significantly positively correlated with years experience ( $N = 3861$ ,  $df = 3859$ ), such that teachers with more experience were more likely to take these actions (meet with parents,  $r = .043$ ,  $p < .05$ , implement a proactive plan,  $r = .041$ ,  $p < .05$ , use restorative practices,  $r = .066$ ,  $p < .001$ , request mental health consultation,  $r = .069$ ,  $p < .001$ , attend workshop,  $r = .041$ ,  $p < .05$  refer students to counselling services,  $r = .051$ ,  $p < .001$  and contact boards' specialized behavioural services,  $r = .040$ ,  $p < .05$ ). One action, "I changed the way I interacted with the student" had a significant negative correlation with years experience, such that teachers with fewer years in the classroom were more likely to take this action.

Table 7

*Correlations between Teachers' Experience (Years) and Actions they Took towards Mental Health and their Perceptions of the Importance of School-based Mental Health Supports (N = 3861)*

Action (Q11)	Correlation with Teaching Experience			Support	Correlation with Teaching Experience		
	r	p	r <sup>2</sup>		r	p	r <sup>2</sup>
a) Carried on as usual and the issue went away	-.002	.889		Q25: Better Preparation in teacher training	.021	.191	
b) I changed the way I interacted with this student	-.054**	.001	.003	Q26: More workshops in schools on mental health	.021	.188	
c) I listened to what the child/provided empathetic support	.001	.966		Q27: Greater access to specialized mental health consultations within schools	.040*	.012	.002
d) I developed a collaborative plan with the student	.031	.058		Q28: Easier access to community based agencies and resources	.042*	.009	.002
e) I met with the parents	.043*	.008	.002	Q29: Access to peer support and mentoring on mental health	.031	.060	
f) I implemented a proactive plan	.041*	.011	.002	Q30: Availability of telephone support for dealing with student mental health issues	.064**	.000	.004
g) I used mediation to help the student deal with peer conflict	.016	.328		Q31: More in-school support from school teams	.031	.059	
h) I used restorative practices	.066**	.000	.004	Q32: More availability of system support staff	.055**	.001	.003
i) I requested consultation from professional	.069**	.000	.005	Q33: Increased access to web resources	.011	.488	
j) I consulted book/print material	.020	.224		Q34: More availability of print/how to manuals	.043*	.008	.002
k) I consulted web/on-line resources	-.034	.036		Q35: More availability of videos, DVDs	.056*	.001	.003
l) I attended a "best-practice" workshop	.041*	.011	.002				
m) I discussed the student's issues with Principal	.022	.170					
n) I discussed the student's issues with psychological staff	.011	.500					
o) I referred the student to Board counselling services	.051**	.001	.003				
p) I contacted the board's specialized services	.040*	.014	.002				

\*Significant at the  $p < .05$  level

\*\*Significant at the  $p < .001$  level

Six of the 11 supports which teachers rated based on importance were positively correlated with years experience, such that teachers with more experience rated these school-based supports as more important. Specifically, access to specialized mental health consultations ( $r(3821) = .040, p < .05$ ), access to community agencies ( $r(3793) = .042, p < .05$ ), availability of telephone support ( $r(3796) = .064, p < .001$ ), availability of system support staff ( $r(3735) = .055, p < .001$ ), availability of print/how-to manuals ( $r(3788) = .043, p < .05$ ) and availability of videos/DVDs ( $r(3786) = .056, p < .001$ ) were significantly correlated with years experience. However, the total variance explained by the significant correlations ( $r^2$ ) is very low.

### **School Division**

A Chi-Square test of independence was performed to examine the relation between the grade level in which teachers worked (i.e. elementary or secondary) and the actions they took in dealing with a recent student presenting with a mental health concern. The relation between these variables was significant for 14 of the 16 actions listed on the survey, such that elementary teachers were more likely than secondary teachers to have taken action for student mental health. However, it should be noted that question 11a is related to taking no action (i.e. 'I carried on as usual and the issue went away or the student moved'), which primary teachers were also more likely to check than secondary teachers,  $\chi^2(1) = 16.04, p < .001$ . Table 8 lists the percentage of elementary and secondary teachers who reported taking each action and Chi-Square statistics associated with questions 11a to 11p of the survey, comparing the two groups of teachers.

Table 8

*Chi-Square Analysis of Elementary versus Secondary Teachers and Actions Teachers Took*

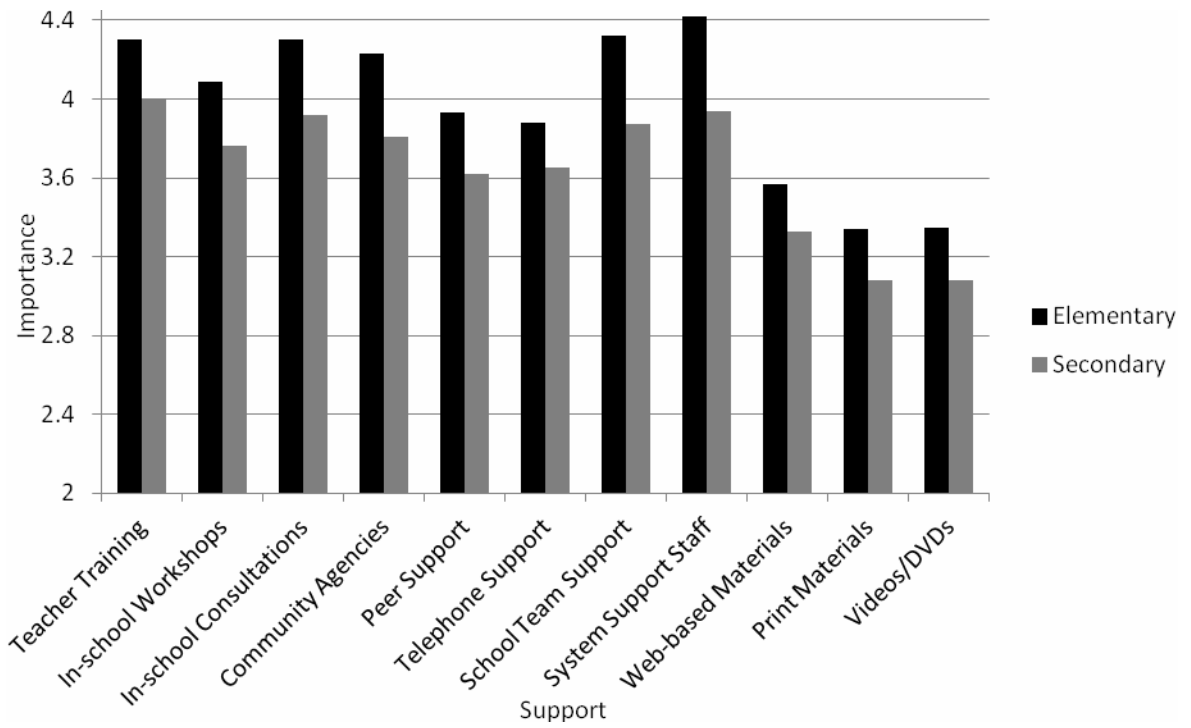
Action	Elementary (N = 2271)		Secondary (N = 1256)		Pearson Chi Square Test		
	N	(%)	N	(%)	$\chi^2$ (1)	Significance Level (2 tailed)	Cramer's V
a) Carried on as usual and the issue went away	153	7	44	4	16.04	$p = .000^{**}$	$V = .067$
b) I changed the way I interacted with this student	1802	79	891	71	31.67	$p = .000^{**}$	$V = .095$
c) I listened to what the child/provided empathetic support	1635	72	899	72	0.70	$p = .791$	$V = .004$
d) I developed a collaborative plan with the student	1182	52	529	42	31.92	$p = .000^{**}$	$V = .095$
e) I met with the parents	1552	68	397	32	441.34	$p = .000^{**}$	$V = .345$
f) I implemented a proactive plan	1307	58	427	34	179.53	$p = .000^{**}$	$V = .226$
g) I used mediation to help the student deal with peer conflict	744	33	231	18	83.48	$p = .000^{**}$	$V = .154$
h) I used restorative practices	387	17	177	14	5.23	$p = .002^*$	$V = .039$
i) I requested consultation from a mental health professional	492	22	295	23	1.55	$p = .213$	$V = .021$
j) I consulted book/print material	594	26	161	13	85.51	$p = .000^{**}$	$V = .156$
k) I consulted web/on-line resources	412	18	151	12	22.58	$p = .000^{**}$	$V = .080$
l) I attended a "best-practice" workshop	265	12	81	6	24.91	$p = .000^{**}$	$V = .084$
m) I discussed the student's issues with Principal	1675	74	756	60	69.48	$p = .000^{**}$	$V = .140$
n) I discussed the student's issues with psychological staff	1545	68	743	59	27.96	$p = .000^{**}$	$V = .089$
o) I referred the student to PDT or Board counselling services	832	37	193	15	177.47	$p = .000^{**}$	$V = .224$
p) I contacted the board's specialized services	568	25	26	2	303.90	$p = .000^{**}$	$V = .294$

\*Significant at the  $p < .05$  level\*\*Significant at the  $p < .001$  level

Using Cramer's  $V$  as a measure of effect size, the biggest differences between elementary and secondary teachers were 1) meeting with parents to get a better understanding of the student's needs (68% of elementary and 32% of secondary), 2) implementing a proactive plan (58% of elementary and 34% of secondary), 3) referring the student to PDT or Board counseling services (37% of elementary and 15% of secondary) and 4) contacting the school board's specialized behaviour support team (25% of elementary and 2% of secondary).

Elementary and secondary teachers were compared on their ratings of the importance of specific mental health supports in helping them deal with students who present with emotional and behavioural issues in their classrooms (Figure 4). A Mann-Whitney  $U$  test was performed to assess if there were significant differences between teachers working at the elementary level compared to those at the secondary level and their perceptions regarding the importance of supports. The results of the test were in the same direction for all the supports listed on the survey, such that elementary teachers rated each support as significantly more important than did secondary teachers. Table 9 outlines the Mann-Whitney  $U$  statistics for questions 25 to 34 of the survey. Effect sizes were calculated, showing that differences between elementary and secondary teachers were greatest for 1) availability of system support staff ( $U = 966812.5$ ,  $z = -14.43$ ,  $p < .001$ ,  $r = .247$ ) and 2) more support from in-school support teams ( $U = 1009574.5$ ,  $z = -13.84$ ,  $p < .001$ ,  $r = .235$ ), with elementary teachers perceiving these supports as significantly more important than secondary teachers.





*Figure 4: Elementary versus Secondary Teachers' Mean Rankings of Importance of Mental Health Supports*

Table 9

*Mann-Whitney U Test for Elementary versus Secondary Teachers and Importance of Supports*

Support	Elementary		Secondary		Mann-Whitney U Test			
	N	Mean Rank	N	Mean Rank	U	z	Significance Level	Effect Size
Q25: Better Preparation in teacher training	2261	1861.95	1245	1556.55	1162274.50	$z = -9.20$	$p = .000$	$r = .115$
Q26: More workshops in schools on mental health	2253	1855.93	1237	1544.37	1144684.50	$z = -9.20$	$p = .000$	$r = .157$
Q27: Greater access to specialized mental health consultations within schools	2260	1890.33	1235	1487.54	1073888.00	$z = -12.09$	$p = .000$	$r = .205$
Q28: Easier access to community based agencies and resources	2239	1885.32	1231	1463.01	1042667.50	$z = -12.61$	$p = .000$	$r = .214$
Q29: Access to peer support and mentoring on mental health	2232	1829.88	1219	1535.79	1128544.00	$z = -8.68$	$p = .000$	$r = .148$
Q30: Availability of telephone support	2242	1807.25	1228	1604.50	1215725.00	$z = -5.96$	$p = .000$	$r = .101$
Q31: More in-school support from school teams	2241	1896.50	1226	1436.97	1009574.50	$z = -13.84$	$p = .000$	$r = .235$
Q32: More availability of system support staff	2215	1874.52	1203	1405.67	966812.50	$z = -14.43$	$p = .000$	$r = .247$
Q33: Increased access to web based resources and materials	2233	1798.49	1221	1597.67	1204721.00	$z = -5.89$	$p = .000$	$r = .100$
Q34: More availability of print/how to manuals	2233	1807.60	1229	1593.23	1202249.00	$z = -6.26$	$p = .000$	$r = .106$
Q35: More availability of videos, DVDs	2235	1811.07	1226	1585.03	1191094.50	$z = -6.59$	$p = .000$	$r = .112$

*All significant at the  $p < .001$  level.*

### **School District**

A Chi-Square analysis was performed to assess whether rural and urban teachers differed in the actions they took in dealing with student mental health. Of the 16 actions listed on the survey, 4 of them were statistically different between rural and urban teachers (Table 10). Urban teachers were more likely than rural teachers to develop a collaborative plan with the student (urban 50%, rural 45%),  $\chi^2 (1) = 7.34, p < .05$ , use restorative practices (urban 18%, rural 13%),  $\chi^2 (1) = 15.74, p < .001$ , and attend a “best practice workshop” (urban 11%, rural 8%),  $\chi^2 (1) = 8.28, p < .05$ . However, rural teachers (73%) were more likely than urban teachers (66%) to discuss the student’s issues with a vice-principal or principal  $\chi^2 (1) = 22.62, p < .001$ . A Mann Whitney *U* test was performed to assess differences between rural and urban teachers and their perceptions of importance of supports (Table 11). Urban teachers rated 5 of the 11 supports (workshops  $U = 1485211.5, z = -2.34, p < .05, r = .038$ , telephone support  $U = 1476811, z = -2.05, p < .05, r = .034$ , in-school support from school teams  $U = 1459695, z = -2.72, p < .05, r = .045$ , web-based resources  $U = 1467405, z = -2.02, p < .05, r = .033$  and DVDs/videos  $U = 1455126.5, z = -2.52, p < .05, r = .041$ ) as significantly more important than rural teachers rated them. However, it should be noted that effect sizes for the significant items are low (.033 to .045).

### **Teachers’ Written Responses**

A total of 1185 teachers provided written responses to the question, “What more can be done to support or address good mental health and well-being in schools?” Of these responses, 95 were illegible due to poor resolution from scanning and 4 were

Table 10

*Chi-Square Analysis of Rural versus Urban Districts and Actions Teachers Took*

Action (Q11)	Rural (N = 1251)		Urban (N = 2536)		Pearson Chi-Square Test		
	N	(%)	N	(%)	$\chi^2$ (1)	Significance (2 sided)	Cramer's V
a) Carried on as usual and the issue went away	67	5	148	6	.36	$p = .548$	$V = .010$
b) I changed the way I interacted with this student	960	77	1928	76	.24	$p = .627$	$V = .008$
c) I listened to what the child/provided empathetic support	884	71	1819	72	.46	$p = .496$	$V = .011$
d) I developed a collaborative plan with the student	566	45	1266	50	7.34	$p = .007^*$	$V = .044$
e) I met with the parents	683	55	1403	55	.18	$p = .672$	$V = .007$
f) I implemented a proactive plan	605	48	1285	51	1.79	$p = .181$	$V = .022$
g) I used mediation to help the student deal with peer conflict	340	27	716	28	.46	$p = .496$	$V = .011$
h) I used restorative practices	159	13	450	18	15.74	$p = .000^{**}$	$V = .064$
i) I requested consultation from a mental health professional	262	21	589	23	2.51	$p = .114$	$V = .026$
j) I consulted book/print material	250	21	557	22	1.96	$p = .162$	$V = .023$
k) I consulted web/on-line resources	188	15	415	16	1.12	$p = .290$	$V = .017$
l) I attended a "best-practice" workshop	99	8	276	11	8.28	$p = .004^*$	$V = .047$
m) I discussed the student's issues with Principal	918	73	1667	66	22.62	$p = .000^{**}$	$V = .077$
n) I discussed the student's issues with psychological staff	817	65	1612	63	1.11	$p = .293$	$V = .017$
o) I referred the student to PDT or Board counselling services	355	28	754	30	.742	$p = .389$	$V = .014$
p) I contacted the board's specialized services	212	17	431	17	.001	$p = .970$	$V = .001$

\*Significant at the  $p < .05$  level

\*\*Significant at the  $p < .001$  level

Table 11

*Mann-Whitney U Test for Rural versus Urban districts and Importance of Supports*

Support	Rural		Urban		Mann-Whitney U Test			
	N	Mean Rank	N	Mean Rank	U	z	Significance Level	Effect Size
Q25: Better Preparation in teacher training	1245	1851.08	2518	1897.29	1528957.50	z = -1.32	p = .186	
Q26: More workshops in schools on mental health	1239	1818.72	2509	1902.05	1485211.50	z = -2.34	p = .019*	r = .038
Q27: Greater access to specialized mental health consultations	1240	1904.33	2511	1862.01	1521688.50	z = -1.21	p = .227	
Q28: Easier access to community based agencies and resources	1235	1879.59	2490	1854.77	1517084.00	z = -.70	p = .481	
Q29: Access to peer support and mentoring on mental health	1226	1815.42	2481	1873.06	1473559.50	z = -1.62	p = .106	
Q30: Availability of telephone support	1233	1814.74	2494	1888.35	1476811.00	z = -2.05	p = .040*	r = .034
Q31: More in-school support from school teams	1238	1798.58	2485	1893.60	1459695.00	z = -2.72	p = .006*	r = .045
Q32: More availability of system support staff	1217	1825.28	2448	1836.84	1480212.00	z = -.34	p = .735	
Q33: Increased access to web based resources and materials	1229	1808.98	2485	1881.49	1467405.00	z = -2.02	p = .043*	r = .033
Q34: More availability of print/how to manuals	1229	1816.08	2492	1883.15	1476126.50	z = -1.86	p = .063	
Q35: More availability of videos, DVDs	1231	1798.07	2486	1889.17	1455126.50	z = -2.52	p = .012*	r = .041

\*Significant at the  $p < .05$  level

removed for confidentiality reasons, leaving 1086 responses suitable for thematic analysis. Categories and concepts were identified in the responses, from which four central themes emerged: knowledge, culture, skills and resources (Table 12). These themes are neither mutually exclusive nor exhaustive, but simply recurring ideas or attitudes voiced by the teachers.

To test interrater reliability, a colleague who was familiar with the project rated 100 teacher responses based on which of the four themes was most prominent. The interrater reliability for the raters was found to be Kappa = 0.674 ( $p < .0001$ ), 95% CI (0.558, 0.794), which is considered substantial agreement (Viera & Garrett, 2005). The crosstabulation of the codings showed that almost all disagreement lay between two of the themes: knowledge and skills. This was not surprising because of the similarities between them and the fact that many teachers mentioned both themes in their responses. Therefore it was assumed the four themes were a good representation of the ideas and attitudes within the teacher responses.

The first theme, *knowledge*, represents responses that pointed to a lack of, or need to, increase mental health knowledge among key stakeholders. Specifically, many teachers wrote about the value of increasing teachers', students' and parents' understanding of the symptoms or risk factors associated with youth mental health. Similarly, teachers wrote about the need for school personnel to learn how to accommodate and assist those who suffer through effective classroom strategies. Many teachers suggested that mental health knowledge could be enhanced by professional development for teachers, workshops for kids, or presentations for parents. This is illustrated by a female elementary teacher who wrote, "[We need] better training and

Table 12

*Themes within Teacher Responses regarding Improving Mental Health in Schools*

<b>Theme</b>	<b>Key Points</b>	<b>Example</b>
<i>Knowledge</i>	<ul style="list-style-type: none"> <li>- Change in mental health knowledge for key stakeholders (teachers, parents, students)</li> <li>- Gaining knowledge through workshops, professional development, assemblies</li> <li>- Spreading awareness of mental health symptoms, strategies</li> </ul>	“I have a student who is on medication that I looked up online and it looks like he has schizophrenia. No one has told me! There should be professional development on possible dangers and ways to help if we are to teach a mentally ill student”, (female, secondary).
<i>Culture</i>	<ul style="list-style-type: none"> <li>- Change in the school culture: values, beliefs, attitudes, behaviours</li> <li>- Improved communication and collaboration among key stakeholders</li> <li>- Increasing general support and acceptance for students with mental health issues</li> <li>- Fighting stigma</li> </ul>	“To acknowledge that mental illness is a serious disease. The more open we are about discussing these issues, the more we will be able to eliminate the stigma associated with these disorders and get the proper help for our students”, (female, elementary).
<i>Skills</i>	<ul style="list-style-type: none"> <li>- Change in the number/presence of experts with professional skills</li> <li>- Training people to be experts/professionals</li> <li>- Improve access to specialists and increase time spent with them</li> </ul>	“Professionals in the mental health field (i.e. psychologists) to spend time talking to students and parents. School support counselors, learning support teachers and principals have some knowledge but are not professionals in mental health. Therefore [they] have some answers but our students and parents often need extra assistance beyond what school staff can give them”, (female, elementary).
<i>Resources</i>	<ul style="list-style-type: none"> <li>- Structural changes: class size, specialized classes</li> <li>- More time to help students</li> <li>- Mental health resource material: books, videos</li> <li>- Funding</li> <li>- Change in curriculum</li> </ul>	“A lot of lip service is paid to the needs of our students’ behavioural issues. Paperwork doesn’t solve the problem – the consistent availability of personnel who the students trust is critical. Teachers need to play a role in this without having to do so while juggling a full roster of students”, (male, elementary)

support for teachers to recognize and handle mental health problems with students. I'm not a trained counsellor, but am required to be one every day". Teachers also demonstrated a lack of knowledge regarding proper protocols or legislation associated with student mental health: "It would be very helpful if there was a clear set of guidelines that everyone knows and follows with regards to behaviours as they present in classrooms. For example, there is not a clear outline of what to do to help guide parents and other staff and the children themselves when they are experiencing these emotional difficulties" (female, elementary).

A second theme that emerged from the teachers' responses was the idea of *culture*, operationalized as the values, beliefs, attitudes or behaviours of those involved at the school level. Many teachers voiced the need for change in attitudes towards those with mental health problems through methods such as increasing awareness, collaboration, and communication of major stakeholders. A teacher in her 22<sup>nd</sup> year of teaching wrote, "[We need] opportunities for staff to problem solve together to create the best programs, environment etcetera for students. [We need the] opportunity to have candid discussions with health care professionals, rather than video presentations with no interaction". Some teachers wrote about the necessity of increasing perceptions of safety and support in the school environment - as one secondary teacher simply wrote, "Teachers should be more approachable to students".

*Culture* was also evident in the teacher responses that highlighted the need to fight stigma attached to mental illnesses. It appeared as though many respondents were aware that stigma is one of the major barriers to students receiving help, often acknowledging that the fight against negative perceptions of mental illness is a necessary first step to



improving care for these children. For example, an elementary teacher voiced, “[We need] to acknowledge that mental illness is a serious disease. The more open we are about discussing these issues, the more we will be able to eliminate the stigma associated with these disorders and get the proper help for our students”.

*Skills* was the most frequent theme among teacher responses. This theme encompasses the idea of enhancing the number of, or presence of, mental health experts. Many teachers voiced concern about the ratios of experts to children in their schools, stressing the need for more trained professionals. Long waiting lists for testing, rare contact with social workers or psychologists, and infrequent opportunities to collaborate with any school personnel with mental health expertise, were a few of the main complaints teachers shared.

The core difference between *skills* and *knowledge*, is the concept of professional training. There was a noticeable difference in teacher responses such that some would suggest increases in general knowledge for non-professionals (i.e. teachers and students) while others proposed that schools would best improve through increases in professional skills as it relates to experts with advanced degrees in mental health (i.e. counsellors, social workers and psychologists). For example, one teacher shared, “[We need] consultation with professionals – we are not the experts here and should not be made to act as such. We have some great insight into our students and should be used in a support role”.

Although a consistent and important theme, *resources* was least frequently mentioned among teachers. This theme encompassed physical or material changes to the

school environment. Some teachers mentioned the desire for more books and videos illustrating classroom strategies or demonstrating mental health symptoms: “Have videos available for students to watch designed for teenagers by mental health professionals. Have tips included for teachers to help [them] be prepared for class discussions after viewing” (female, secondary). Many teachers also stated the need for more funding, both in personnel and resources, while others suggested structural changes to the school environment, including reducing class sizes, creating more special education classrooms, or reducing curriculum expectations.

### **Summary of Results**

*1. What are teachers’ current levels of knowledge, awareness and comfort in dealing with mental health concerns?*

On average, teachers felt “somewhat” knowledgeable, aware or comfortable with different aspects of student mental health. They reported being least knowledgeable about mental health legislation and most aware of the range of mental health issues.

*2. What resources do teachers currently use and which would they find useful in the future in regards to managing mental health issues in their classrooms?*

Teachers reported that they are most likely to change the way they interact with, and provide empathetic support to, students with mental health issues. They were least likely to carry on as usual or attend workshops relevant to the students’ needs.

All supports were rated as more than “somewhat important”, with the highest importance given to the availability of support staff and preparation in teacher training.

*3. Are these findings influenced by demographic factors such as years of teaching experience, geographic location of the school (rural/urban) or grade level taught (elementary/secondary)?*

Teachers with more experience tended to report taking more action for student mental health and rate most supports as more important than did teachers with less teaching experience. However, the statistical significance of this relationship was too low to warrant practical significance.

Elementary teachers reported taking more action for student mental health than secondary teachers. Elementary teachers also placed higher importance on mental health supports than secondary teachers.

Few differences between urban and rural teachers were found in terms of the actions they take and how important they consider mental health supports.

Urban teachers tended to rate the supports as more important than rural teachers.

*4. What suggestions do teachers put forth regarding the improvement of student mental health?*

Four main themes were extracted from teachers’ suggestions: *knowledge* (increasing awareness and mental health knowledge of non-expert stakeholders), *culture* (change in the school environment, values, beliefs, behaviours), *skills* (change in the number or presence of mental health professionals), and *resources* (physical or material changes within the school).

## **Discussion**

One in five youth suffers from a mental health illness (Canadian Paediatric Society, 2009), significantly contributing to negative school performance and dropout rates (Koller & Bertel, 2006). Unfortunately, only 1 in 6 of these students receive any professional help (Canadian Psychiatric Association, 2012), demonstrating that youth mental health services are severely inadequate. To contribute effectively to school-based mental health services, teachers need to have the skills to screen and help identify children in need, and provide observations, interventions, and feedback in liaison with other mental health care providers and school staff. To adequately and confidently fulfill this role, teachers require proper training and resources. The current study was carried out to develop a better understanding of the teacher's perspective of student mental health services and to help inform teacher education activities at both the preservice (university) and inservice (working professional) levels. In order to develop and deliver the most comprehensive and relevant training to teachers about children's mental health, a necessary first step was to assess teachers' current levels of knowledge, attitudes and awareness and their use of strategies and supports while working with students presenting with mental health concerns. This paper explored four research questions based on the results of a survey of nearly 4,000 working teachers in one large Ontario school board:

1. What are teachers' current levels of knowledge, awareness and comfort in dealing with students' mental health concerns?
2. What resources do teachers currently use and which of these would they find useful in future management of mental health issues in their classrooms?

3. Are these findings influenced by demographic factors such as teaching experience, geographic location of the school (rural/urban) or grade level taught (elementary/secondary)?

4. What suggestions do teachers put forth regarding the improvement of student mental health?

Developmental-ecological theory (Bronfenbrenner, 1989) was used to frame the results of this survey, such that the teachers in this study are viewed as important components of a holistic system of care. Emphasis on multidisciplinary and coordinated approaches to mental health care are necessary, as all stakeholders in the child's ecology play a vital and essential role in the child's mental wellbeing. Therefore, in interpreting the results from the survey, teachers are viewed as integrated and well-connected sources of help for their students. The use of ecology theory helps generate goals that are not necessarily aimed at the teachers themselves, but are rather directed at improving collaboration and strengthening the interconnectedness of the teachers and other stakeholders involved in student mental health.

The current survey, consistent with previous studies about self-ratings of knowledge, awareness, and comfort levels regarding student mental health (such as Walter et al., 2006), revealed that teachers rate their capabilities and comfort levels as close to the midpoint (*somewhat*) of the designated rating scales. This may be interpreted that, although teachers have some experience with mental health in their classrooms, they may not feel fully prepared to take on a provision role with the current mental health training that is available to them. Similarly, in a previous study of teachers' perspectives of providing help to students who had experienced traumatic exposure, one of the most prominent themes was their struggle with providing optimal support, partly because of

their limited knowledge and skills (Alisic, 2012). Furthermore, teachers in Koller and colleagues' (2004) study rated, on average, that they felt less than "prepared" to deal with their own stress and burnout or to identify and address student mental health issues.

Together, these results point to the urgent need to include mental health courses in teacher preservice training in order to increase teachers' general knowledge and comfort levels in dealing with both student mental health and their own stressors.

This study found that teachers are not, on average, aware of the steps necessary to access community agencies and are not generally knowledgeable about mental health legislation. Clearly, there is lack of training related to the formal actions teachers should implement when presented with a struggling student. This finding corresponds to previous research, such as Alisic's (2012) interviews with teachers who often admitted that they were not aware of the protocols or guidelines related to mental health within their own schools. This may create a problem for parents as well, as they often call upon teachers for information, resources and protocols regarding the referral process. Information on how to access community services and guidance on legal issues should, therefore, be made more available to teachers to not only increase their own knowledge, but to also enable teachers to act as reliable sources of information for parents.

When asked to rate their comfort levels in dealing with mental health, such as talking with students, providing supports, and accessing services for students, teachers reported they were least comfortable in talking with parents about their child's mental health issues. This poses a concern as one considers the importance of the child's home environment in proper identification and intervention (Weston et al., 2011). In addition, past research has suggested that the teacher's perception of the degree of parental support may have a direct effect on their decision to refer a student for mental health services

(Williams, Horvath, Wei, Van Dorn, Jonson-Reid, 2007). It has also been shown that teachers believe that a lack of adequate programming which supports parents (Reinke et al., 2011), and parents' refusal to follow through with recommendations from the school (Williams et al., 2007), are two major barriers to children receiving help. Collectively, these findings reveal the need for teachers to feel confident in effectively engaging and working with families when a problem arises (Reinke et al., 2011). As highlighted in the current study, the low levels of teacher comfort in conversing with parents suggest that teacher training programs should emphasize both the necessity for, and teach the importance of, creating an open and ongoing alliance between teacher and parent. Learning to sustain these types of relationships with parents is grossly under-appreciated in current mental health training programs (Weston et al., 2011).

In light of the fact that many teachers may be uncomfortable in communicating with students' parents regarding mental health, most teachers reported consulting with another staff member (such as a principal, vice principal, social worker or counsellor) when a problem arose, indicating that teachers appreciate and seek some form of outside support. One of the most frequent comments from teachers was related to the need for increased communication with other staff and professionals. As one elementary teacher expressed, "(We need) opportunities for staff to problem solve together to create (the) best programs and environment for students. (We need) opportunity to have candid discussions with health care professionals, rather than video presentations with no interaction". A dynamic collaboration between mental health professionals and teachers has shown to have positive effects in the classroom, teachers' sense of professional competence, and student academic outcomes (Lynn et al., 2003).

The most frequent actions teachers reported taking when presented with a student with an emotional or behavioural issue were both, changing their interaction with the child to reach him or her more effectively, and listening to the child describe his or her problem. This finding reveals that teachers are in a position to provide empathic support, and are choosing to do so in their classrooms. Interestingly, teachers may be taking on this de facto therapeutic role without the benefit of consulting relevant literature or resources such as books, videos or workshops. Teachers appear to be acting on their own intuition and draw from their own experiences, as well as following suggestions from colleagues, when supporting children with mental health issues in the classroom. It may be that teachers are not confident in this role, but are rather using their own strategies because of a lack of professional help or resources in the school. Indeed, many teachers expressed frustration with not having enough contact with, and support from, mental health professionals.

Overall, an exploratory analysis regarding teachers' experiences with student mental health suggests that teacher training programs should be provided in consultation-communication formats which include a variety of experts and other members of the school-based health team. This finding is notably similar to that of previous research, which shows that teachers believe that school mental health services would benefit most from increased opportunity for teachers to consult and collaborate with mental health experts (Rothi, Leavey & Best, 2007). For example, many studies lend support to the efficacy of collaboration between school social workers and teachers, as consultation between these two groups allows not only for the education of teachers in regards to student mental health, but also the creation of effective behavioural interventions for those students who demonstrate special needs (Lynn et al., 2003). It would benefit



teachers to be provided with resource contacts and information about mental health resources and the process of accessing these.

## **Differences among Teachers**

### **Years Experience**

The current study assessed the relationship between years of teaching experience and both the actions teachers take and their ratings of supports. In one study, preservice teachers reported learning about mental health symptoms more from practicum experiences than from any university level course (Bryer & Signorini, 2011), suggesting that classroom experience is the major source of knowledge for teachers in terms of student mental health. The current study found that although teachers with more experience were more likely to report taking action in regards to student mental health, this association was not strong for any of the actions listed on the survey. Therefore, it should not be assumed that teachers with more experience are more likely to take the necessary steps to help those suffering with mental health problems.

Koller and colleagues (2004) found that experienced teachers felt less prepared as a result of their university training to deal with student mental health than did novice teachers. As Koller and colleagues explain, the significant restructuring in preservice education leading to a student-centered approach may have influenced “new teachers (to) be more attuned to the individual instructional needs of children, (fostering) consideration of the mental health issues that children face” (pg.43). A second explanation for these findings could be that newer teachers have not yet had amassed the body of experiences, as have their more advanced colleagues, in dealing with students presenting with serious mental health problems and therefore, have not yet discovered a high need for extra supports. The current study found that the association between experience and perceived

importance of mental health supports was not strong. Although past research has suggested that newer and more advanced teachers differ in their perceived ability to intervene with students presenting with mental health problems, the current study demonstrates that the number of years of teaching experience does not influence the perception of the importance of school-based mental health supports.

It is important to emphasize that the association was not strong between teachers' professional experience and their actions regarding student mental health or how important they consider specific supports. This is interesting, as some previous studies suggest a significant difference between expert and novice teachers in classroom management skills, discipline, (Berliner, 1986) and preventative measures (Elliot & Stemler, 2008). In terms of student mental health, it appears that all teachers, regardless of how many years spent in the classroom, perceive and deal with issues in a similar manner.

Corresponding with the current study, Rothi, Leavey and Best (2008) interviewed both experienced and novice teachers and found little difference in their ability to identify mental health needs. Additionally, Weston, Anderson-Butcher and Burke (2011) believe that there is no basis on which to assume that novice and expert teachers differ in knowledge, understanding, commitment or ability. Instead, advanced teachers may differ in their application of new knowledge, such that they may be able to use what they learn from training, in a way that helps all students rather than only those who display symptoms. The data from the current study suggests that differentiated inservice training corresponding with the length of a teacher's career may not be helpful. Rather, teachers should be learning the same material and strategies, regardless of how many years they have spent in the classroom.

### **School Division**

Survey and epidemiological studies show that specific psychological disorders increase in intensity and severity with age. Therefore, there is an assumption that teachers working with different age levels deal with students presenting with varied types and degrees of mental health symptoms (Merikangas et al., 2010). The current study compared the perceptions of teachers working in elementary schools to those working in secondary schools. Elementary school teachers reported taking more action to support student mental health than did secondary teachers. Similarly, elementary teachers rated each mental health support as more valuable in helping them deal with mental health issues, suggesting that they could be more inclined to utilize these supports. These results parallel Repie's (2005) survey which revealed that elementary teachers were more fervent about requiring and supporting mental health programs than were the teachers at higher grade levels.

Some possible explanations exist as to why secondary teachers may not be as involved with student mental health when compared to elementary teachers. Firstly, secondary teachers usually teach many more students than elementary teachers, which may result in weaker personal connections between teacher and student. Considering that secondary teachers have less time to spend with each individual student, they may not be able to fully recognize mental health symptoms that are progressive and persistent. Yet another possibility could be associated with the very nature of more typical mental health problems in adolescence: perhaps symptoms of specific disorders such as drug and alcohol dependency or depression could be assumed by teachers to be part of an "adolescent stage" that individuals will eventually and independently leave behind.

Future research should seek to identify those specific factors that may prevent secondary teachers from having limited concern and involvement in their students' mental health.

### **School District**

One of the barriers to accessing information and services continues to be the situation of living in a rural (versus urban) location (Repie, 2005). In light of this, a comparison of teachers in rural and urban areas was undertaken in an attempt to assess if there was a difference in the actions teachers take and the supports they consider important to be in the classroom, school and community. This type of preliminary assessment based on geography has been recommended in previous research (Atkins et al., 2003; Santor et al., 2009).

Urban teachers reported taking actions such as developing a collaborative plan with the student, using restorative practices and attending workshops more so than the rural teachers. However, rural teachers were more likely to discuss student behaviour with their principal or vice principal. Rural teachers may have fewer opportunities (i.e. attending workshops) and resources available to them, relying more on staff members such as the principal for support. When asked to rate the importance of specific mental health supports, urban teachers rated 5 of the 11 supports as being significantly more important than did rural teachers. Effect sizes however, were very low, thus any conclusions drawn from these differences should be made with caution. Previous literature is inconsistent in the finding that rural and urban areas differ in mental health services (Maggi et al., 2010), thus it is not surprising that the current study found few significant differences as well. Furthermore, Repie (2005) found few differences in the nature of problems children face, barriers to accessing mental health resources, and types of school mental health services based on geographic locale, which may explain the

current study's finding that there were not many differences between rural and urban teachers' actions and perceptions of student mental health.

### **Suggestions from Teachers**

The current study provided a wealth of input from teachers regarding their perceptions of strategies to improve the mental health and wellbeing in their schools. Previous research in this area has predominantly relied on face-to-face interviews, and has not yet utilized such a large number of teachers from both the elementary and secondary divisions. The four main themes that emerged from teacher responses (knowledge, culture, skills and resources), contribute to a better understanding of what types of supports are required for teachers, students and schools in enhancing mental health and wellbeing.

Although a large number of teachers expressed interest in furthering their teacher education in respect to mental health knowledge and strategies, many teachers showed resistance to change, both in their professional development and their role as a teacher. This is in contrast to previous studies that concluded that the majority of teachers believe that addressing students' mental health is part of their role (eg. Roeser & Midgley, 1997; Rothi et al., 2007).

Some teachers in the current study expressed disinterest in teacher training or the restructuring of the teacher's role regarding mental health. This is an important barrier to overcome in training programs, and may be directly related to mental health stigmas, which are so ingrained in our culture (Owens et al., 2002). Past research has also demonstrated that some teachers show resistance to the implementation of recommended mental health programs and practices (Reinke et al., 2011), although the reasons for this resistance have not been thoroughly investigated. It could be considered that teachers may

appear uncooperative with mental health professionals because the interventions they are expected to deliver may exceed their levels of training (Ringeisen et al., 2003). As per the teachers' comments in the current study (in addition to other studies of teacher attitudes (i.e. Reinke et al.)), teachers demonstrate an unwillingness to fulfill a provision role because they perceive doing so would be beyond their scope of practice, thereby deferring to the expertise of a mental health professional.

In general, teachers expressed a desperate need for supports in their classrooms and schools. The most frequently mentioned support by far, was professional personnel, such as the need for more social workers and psychologists. This is comparable to another study which found that 82% of teachers *agreed* or *strongly agreed* that an insufficient number of school mental health professionals was a major barrier to providing proper support for children (Reinke et al., 2011). Interestingly, there seemed to be a divide among the teachers: some requested an increase in professional personnel to reduce the extra work involved in teaching students with mental health issues, while others seemed to want more experts in the schools to provide mental health education or consultation for teachers. Although the reasons varied for wanting increased access to professional colleagues, it is clear that teachers turn to people with specialized education for support. Having limited knowledge in mental health symptom screening and intervention strategies, teachers appear to rely on the staff who are deemed "experts" in helping them manage their classrooms. Indeed, past research has shown that teachers view psychologists as having the primary role in most school mental health identification, delivery and monitoring procedures (Reinke et al, 2011).

Teachers in the current study rated themselves as being less than "somewhat aware" of local community services and the process required to access those services.

This could present a major barrier for teachers in their ability to request help from experts. There exist many community agencies that can serve as resources for teachers, yet teachers are not knowledgeable about those available. Instead, they seem to rely solely on the school psychologist or other support staff for assistance, while finding it difficult to make meaningful contacts with these people. Therefore, teachers could benefit from enhanced awareness of community agencies, such as having current contact lists provided to them on an ongoing basis.

### **Helping Teachers, First**

In the teachers' responses, it is evident that they are dealing with high levels of stress related to student behaviour and emotional difficulties. Using Bandura's self-efficacy theory (1977) as a framework for interpretation, many of the comments revealed that teachers are experiencing significant levels of stress and may have low self-efficacy in their ability to manage their classrooms. Considering that teacher self-efficacy has a demonstrated effect on one's perseverance when faced with challenges (Skaalvik & Skaalvik, 2010), special education referrals (Soodak & Podell, 1993), and the use of strategies for students with special needs (Han & Weiss, 2005), it is discouraging to find that many teachers are feeling helpless when it comes to helping their students with mental health issues. For example, one desperate teacher wrote, "Help us please!" at the bottom of her survey. Other teachers expressed fear that new mental health programming would "overload" the teachers, a well-known precursor for professional burnout (Maslach & Goldberg, 1998; Skaalvik & Skaalvik, 2010). Furthermore, some teachers suggested that school-based mental health programs should focus initially on enhancing their own mental health before they should be expected to deliver such programs to their students.

Teachers have a difficult and complex job which requires the constant balancing of academic, social and emotional priorities, making it one of the most stressful professions. Consequently, occupational stress is linked to both physical and mental health (Alberta Teachers' Association, 2012). The current study reveals that teachers often feel stressed when dealing with student mental health problems. They, too, need effective strategies in stress reduction, which can in turn, positively affect their students (Haberman, 2004; Maslach & Goldberg, 1998). Teachers are more willing to embrace new initiatives and projects aimed towards students when their own workload is sufficiently manageable (Alberta Teachers' Association). Therefore, when developing mental health programs, it is vital that the workload of the teacher is taken into account. Specifically, teachers in the current study adamantly requested the receipt of strategies and knowledge, rather than being overloaded with more time-consuming responsibilities that may interfere with teaching.

### **Strengths/Limitations**

The current study has many strengths, including its large sample size and high response rate. Very few studies have examined teachers' perceptions about mental health supports and provision, through the breadth of questions that this survey included. In addition, this study utilized both quantitative and qualitative data and synthesized them into a better understanding of teachers' perspectives. For example, the qualitative data from this survey afforded teachers the opportunity to put forth suggestions without the fear of judgment or criticism that previous studies may have inadvertently caused by face-to-face interviews. The themes that emerged from teachers' responses were useful in better understanding the patterns of responses on the multiple choice and rating scales.



The findings from the current study may not be generalizable to all teachers and schools. For example, the schools pegged “rural” in the current study may not have much in common with more remote schools in other areas of Ontario. In addition, because this study focused on teachers’ perceptions and self-ratings, it would be inaccurate to draw definitive conclusions about how teachers are actually intervening with students in their classrooms. It would be valuable for future researchers to measure both student and teacher behaviours in the classroom (as they relate to mental health) in order to attain a more accurate description of classroom proceedings. Lastly, the inability to factorize the two survey scales (Actions and Supports) suggests that the survey instrument used in the current study could be revised for future use. Although the items on the questionnaire are still valuable independent of one another, it would have been beneficial to look at the responses in a more parsimonious manner, using congregated test items.

### **Implications for Teacher Education**

Unfortunately, there is a large research to practice gap regarding effective classroom management strategies. Given the robust literature regarding valuable mental health screening techniques, interventions, and monitoring strategies (Ringeisen et al., 2003), it is unfortunate that so many teachers are feeling unprepared to deal with, and burdened by, specific students. In fact, recent research has shown that approximately half of teachers are unfamiliar with “evidence-based practice” (Reinke et al., 2011), demonstrating that the dissemination of useful educational information to teachers is limited. Reinke and colleagues (2011) suggest that school mental health professionals (e.g. school psychologist) can play a vital role in providing teachers with the means to employ evidence-based practice in their classrooms, such as through in-service training.

Although the current study did not assess the specific training in mental health that teachers have undertaken, past research has shown that teachers have little to moderate formal (preservice and inservice) training in this area (Koller et al., 2004; Reinke et al., 2011; Whitley, 2010). The teachers in the current study often requested professional development workshops, especially those run by experts. In addition, “teacher training” was rated as one of the most important mental health supports, demonstrating that there is a strong interest among teachers in learning competencies and strategies in youth mental health.

As part of the request for more professional training in mental health, many teachers suggested that the focus of this training be on recognizing symptoms. Previous studies have shown that teachers sometimes struggle with the interpretation of specific behaviours of their students. It is sometimes unclear as to which behavioural issues are persistent or significant enough to warrant mental health intervention and referral. For example, Rothi, Leavey and Best (2008) found that teachers grappled with the definition of “mental health” and were not confident in identifying indicators of related issues. In fact, teachers used a core set of indicators to help them identify students with mental health concerns: failure to follow rules, poor social integration, behaviour that deviates from other students, knowledge of developmental and personal norms, and the teacher’s general experience with the student. As the authors suggest, relying on the teachers own ideas of “normal” versus “deviant” behaviour can have precarious consequences: “Without good guidance and training as well as firm systems and procedures, identification becomes a chance event based on the knowledge, motivation and capacity of individuals within the school environment” (pg. 1226).

In addition to improving teachers' knowledge of externalized symptoms of mental illnesses, it is also important that teachers learn to be aware of less apparent symptoms. There is significant concern that more internalized mental health problems (mostly depression, anxiety, and social withdrawal) are being overlooked by a majority of teachers because of their low visibility. Teachers must be trained to use a diverse set of multiple indicators when assessing the mental health of a student, such as academic progression, ability to form relationships with peers, and significant changes in social behaviour (Rothi et al., 2008). By knowing how to include multiple indicators in the identification process, teachers are more likely to detect mental health issues that contribute to silent suffering.

Professional development for teachers often takes the form of a one-day workshop, although there is general agreement that such short-term training is rarely successful in sufficiently changing teacher behaviour (Timperley et al., 2007; Whitley, 2010). In a large synthesis of teacher professional learning and development studies from America and New Zealand, Timperley and colleagues (2007) identified several elements of the teacher education context that are good predictors of success. Some of the key findings, which can be applied to the creation of effective mental health preservice and inservice teacher training programs, include:

- 1) Provision of extended time for learning opportunities
- 2) Engagement of external expertise
- 3) Teachers' engagement in the learning process
- 4) The opportunity to challenge prevailing discourses
- 5) Opportunities to participate in a professional community of practice
- 6) Consistency with wider trends in policy and research

### 7) Active school leadership

In creating mental health literacy programs for both preservice and inservice teachers, it is important that these are not proposed to be a “one-day fix”. Programs need to challenge any stigmas attached to mental health, provide knowledge about the strong relationship between academics and emotional well-being, teach the ability to recognize, manage and prevent emotional and behavioural problems (Wei et al., 2011), and address the actions, steps and legislation associated with school-based mental health. In-service programming is also more successful when combined with ongoing informal or formal professional networks (Ringeisen et al., 2003).

Lastly, teacher training must consider individual factors, such as the self-efficacy of the teachers and hesitance they may have about new programs (Han & Weiss, 2005). Han and Weiss stress that program implementation is dependent upon the willingness and motivation of the teacher to embrace the new initiative.

### **Conclusion**

Utilizing a survey of almost 4000 teachers in one Ontario school board, this study served to answer several questions about the teacher’s perspective of the current mental health system in schools. With the alarming rates of children and youth suffering from mental health issues, the mental health care system requires immediate restructuring, including the use of the school as the hub (Kirby & Keon, 2006). Unrealistic expectations have been placed on teachers to act as both educators and mental health care providers (Maslach & Goldberg, 1998) considering that little formal training has been offered to them to do this in a successful manner. As a result, teachers are feeling overwhelmed, stressed, and are at risk of occupational burnout. This study confirmed that, indeed, teachers lack the knowledge and comfort in dealing with student mental health. However,

teachers showed strong interest in professional development in this area, and put forth many suggestions for additional supports.

This study aimed to better understand the position of the teacher as a de facto mental health provider, and his or her perceptions of fulfilling this role. One important finding was that, although most teachers perceive a definite need and concern for improved mental health care among schools, there are still many teachers who are resistant to the idea of being positioned on the front lines of these initiatives. Fortunately, with the promotion of a system of care approach to mental health, the school is in a position to act as a reliable and effective hub for these services. It is certain that greater numbers of students can be the recipients of much needed mental health supports through strategically minimizing barriers to providing mental health services in schools while concurrently developing preservice and inservice teacher training and encouraging collaboration among schools, home and community sectors.

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## **Appendices**

### **Appendix A**

## Curriculum Vitae

### Tamara Daniszewski

#### EDUCATION

**Wilfrid Laurier University, Kitchener, ON** 2013- 2015  
Master of Social Work

**Western University, London, ON** 2011- 2013  
Master of Educational Psychology/Special Education

**Western University, London, ON** 2005-2009  
Honors BA Psychology, minor in Criminology

**Oxford Seminars, London, ON** 2009  
TESOL (teaching English as a second language) certification

#### EMPLOYMENT

**YMAP Program Facilitator, YMCA of Western Ontario, London, ON**  
**March 2012- Present**

YMAP is a program for adolescent newcomers to Canada, which supports successful social integration into immigrants' academic and community life. Responsibilities include facilitating a variety of programs and workshops for students throughout London, such as resume building and employment workshops, networking for volunteering opportunities, and providing seminars regarding the requirements for Canadian citizenship.

**Research Associate, Western University, London, ON**  
**Sept 2012 - Present**

Researching academic integrity among students and professors in 17 Universities. This project is the largest in Canada regarding integrity policies, and includes a wealth of information on electronic cheating. Responsibilities include distributing online surveys, collecting and organizing quantitative and qualitative data and data analysis. Results will be prepared for individual faculties at each University including suggestions about improving integrity throughout campus.

**Research Associate, Thames Valley School Board, London, ON**  
**May 2012 - Present**

In conjunction with the University and Thames Valley School Board, we are completing a government-funded research project using data from nearly 4000 teachers regarding their awareness and comfort levels in mental health care provision. Personal responsibilities include preliminary research, literature review, data analysis, and preparation for publication.

**Applied Behaviour Analysis Therapist, The Behaviour Institute, London, ON**  
**Feb 2012 - Present**

Use of ABA principles to deliver therapy programs to children and adolescents with autism within the London community. Trained in effective ABA strategies, crisis intervention, and management of difficult behaviour. Assist clients with successful social integration at various community facilities and create and facilitate programs in helping them master life skills.

**ESL Teacher, JNS Academy: Reading Star, Gwangju, South Korea  
Feb 2010 - July 2011**

Taught elementary and middle school students advanced English (reading, writing, comprehension and debate). Assisted in the creation of the curriculum, publication of books and helped manage Korean/Foreign teacher relations. The academy is well-known for ongoing, comprehensive training of all staff with continuous seminars and programs aimed at improving teaching skills and classroom management. Project manager of Korean Teacher training.

**VOLUNTEER WORK**

**London Regional Mental Health Centre, Adolescent Unit  
Sept 2011 - Present**

Two major responsibilities include co-facilitation of an occupational therapy program and the tutoring of patients in various high school subjects (senior level maths, geography, English, business, sciences). Patients have a wide range of mental health problems including schizophrenia, drug and alcohol dependency, eating disorders, mood disorders or learning difficulties including autism spectrum disorders.

**RESEARCH SKILLS AND WORK**

Daniszewski, T. *Teachers' Mental Health Literacy and Capacity towards Student Mental Health*. London, Ontario (Master's thesis).

Daniszewski, T., Rodger, S. & Killip, S. (anticipated date 2013). *Educators on the Front Lines of Mental Health*. London, Ontario (In-progress research paper). Approved for presentation at Canadian Psychological Association's 2013 Annual Research Symposium.

McCabe, D., Meadows, K. & Daniszewski, T. (anticipated date 2012). *Academic Integrity Among Canadian University Students*. London, Ontario (In-progress research report).

Daniszewski, T. (2010). *The Essence of Debate Workbook*. Gwangju, South Korea. J&S Academy.

Daniszewski, T. (2010). *Essay Writing Basics Workbook*. Gwangju, South Korea. J&S Academy.

Daniszewski, T. (2009). *The Effects of Sexist Humour on Judgements of Domestic Abuse*. Unpublished Honors Thesis. Western University, London, ON

Extensive knowledge of SPSS and other statistical software for the social sciences.

**AWARDS / SCHOLARSHIPS / CERTIFICATION**

Non-Violent Crisis Intervention Certified, 2013

Red Cross Standard First Aid (CPR/AED) Level C Certified, 2013

Western Graduate Research Scholarship, The University of Western Ontario, 2011, 2012, 2013

Foreign Teacher of the Year, J&S academy, South Korea, 2010

Dean's Honor List, The University of Western Ontario: 2007, 2008, 2009

Top Student - TESOL Certification, Oxford Seminars, 2009

Entry Level Scholarship, The University of Western Ontario, 2005