MENTAL HEALTH EDUCATION IN NEW YORK STATE SCHOOLS: THE TEACHERS' PERSPECTIVE

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by

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The undersigned, appointed by the dean of the Graduate School, have examined the dissertation entitled

MENTAL HEALTH EDUCATION IN NEW YORK STATE SCHOOLS:

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Dedication

To my dad, you have been the backbone of my academic foundation. Thank you for quizzing me every morning on the way to school, for framing every award I received from pre-school onwards, and for the countless tutors you worked so hard to provide for me growing up. You imbedded into me the value of education and reminded me of how blessed I was to have these opportunities. To my mom, thank you for being my constant cheerleader through every success and failure. You always believed that I would succeed and even when I stumbled, you'd have a hot cup of tea and a smile waiting for me at home.

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Abstract

In response to the rise in mental health issues among youth, New York State (NYS) now requires all schools' curriculums to include mental health education. The purpose of this study was to understand the perspectives of high school teachers in NYS – on school-based mental health education, its implementation, its effectiveness, and its impact on student and teacher mental health outcomes. The Theory of Organizational Readiness for Change can be used in an organization, such as a school system, to determine if the necessary factors are present for the successful implementation of new policies as incorporating a mental health educational program into the existing curriculum.

Participants (N=20) with a minimum of 3 years of classroom experience were recruited through Facebook and snowball sampling. Using a qualitative descriptive approach, a semi-structured, open-ended interview guide was developed and used to interview participants. Qualitative content analysis was used to analyze interviews and derive common themes. The main themes that emerged included the following: (a) a broken system, (b) mental health issues impact teachers and the classroom environment, (c) student mental health challenges in schools are complex and multifaceted, and (d) effective school mental health education needs a multi-faceted approach. Teachers play a pivotal role in the academic, social, and emotional development of students. This study highlights a need for policy changes that will support teachers in dealing with mental health issues in the classroom.

Chapter One: Introduction

Scope of the Problem

Across the world, mental health disorders are a principal cause for disability. Despite the availability of effective treatments, there continue to be delays between the first appearance of symptoms to when the individual seeks help (Wang, Berglund, Olfson, & Kessler, 2004). Early signs of mental illness often first appear during adolescence (Kessler et al., 2005). Some of the first signs of mental illness that emerge are behavioral changes (Centers for Disease Control [CDC], 2017b). These changes can vary from minor substance abuse to signs of psychosis (CDC, 2017b). Child and adolescent mental health are a critical social and public health issue. One out of every five children in the United States experience a mental health disorder in any given year (Adelman & Taylor, 2014).

According to the High School Youth Risk Behavior Survey, in New York State, the number of students that reported attempting suicide one or more times in the 12 months before the survey was nearly twice the national average (CDC, 2017b). In New York City (NYC), nearly one in three (30.4%) public high school students surveyed reported persistent feelings of sadness or hopelessness (CDC, 2017b). Adolescents spend a majority of their weekday in school; therefore, high schools present as an ideal setting to implement mental health interventions. Mental health education can play a role in teaching adolescents to recognize signs of mental health issues in themselves or others, and also help them learn what resources are available in their school or community and how to access them. However, until recently, schools in New York State were not

required to provide mental health education (New York State Education Department, 2018).

In July 2018, New York State passed a bill (NYSED Article 19 Education Law § 804) that amended the current law on health education in schools to require the inclusion of mental health education. The goal of this legislation was to increase students' mental health literacy and increase their ability to recognize signs of mental health issues in themselves and others, and get the right help (New York State Education Department, 2018). In this historic event, New York became the first state to mandate mental health education for all students. This bill emphasized that health is multi-dimensional and therefore, mental health is a crucial and necessary part of overall health (New York State Education Department, 2018). New York State law does not dictate a specific curriculum for mental health; development of the curriculum was left to the Board of Education (New York State Education Department, 2018).

Teachers are often tasked with the implementation of new school-based programs or interventions. Increasing the mental health knowledge of teachers and addressing their attitudes toward mental illnesses are likely necessary steps to enhance the effectiveness of this new addition to the health curriculum (Whitley, Smith, & Vaillancourt, 2018). As the interventionists, teachers have a unique and critically important perspective on the implementation of school-based mental health curriculums, and the actual impact of such interventions on students and the overall school climate. However, much of the research to date related to the implementation of mental health curriculums in schools largely focuses on the experiences and views of students (Ball et al., 2016), with little research that includes the perspectives of teachers.

Further, the implementation of school-based mental health interventions may affect teachers' mental health, well-being, and safety as well. Evidence suggests that student mental health and behavioral issues can lead to high levels of stress and adverse mental health outcomes in school teachers (Tyson, Roberts, & Kane, 2009). Teaching is an emotionally exhausting profession that often leads to burnout and is a principle reason for the high turnover rates in this population (Rumschlag, 2017). The high rates of teacher victimization or violence against teachers also contributes to the increased attrition rates among educators (Anderman et al., 2018; Mcmahon et al., 2014). Thus, this new mandate to include mental health education in the curriculum may have an impact on the health, well-being, and safety of teachers as well as students, although research on these impacts is also lacking. These gaps in research need to be addressed in order to increase the effectiveness and success of school-based mental health interventions and maximize their impact on both student and teacher mental health and well-being.

Therefore, the purpose of this qualitative descriptive study was to begin to address this gap and understand the perspectives of experienced high school teachers in New York State regarding a school-based mental health intervention, its implementation, and its effectiveness. Specifically, this study aimed to illustrate how the mandate to add mental health education to the curriculum has been carried out and the impact it has had on students and teachers from the viewpoint of the teacher. Interviews of New York State high school teachers were carried out using a qualitative descriptive approach, which allowed for a rich, in-depth description of participants' perspectives, prioritizing

their voice and expertise. This approach has been shown to be useful in intervention development and evaluation (Neergaard, Olesen, Andersen, & Sondergaard, 2009).

Specific Aims

The purpose of this qualitative descriptive study was to understand the perspectives of experienced high school teachers (defined as those teaching grades 9-12) in New York State on school-based mental health education curriculums, its implementation, and its effectiveness. Participants were recruited through the use of Facebook and interviewed over the phone.

The specific aims of this study were:

1. To describe teachers' strategies, challenges, barriers, and facilitators when implementing mental health education content into the school curriculum.
2. To describe teachers' perception of the impact of a mental health intervention as it relates to student and teacher mental health outcomes (i.e. stress, anxiety, and safety) in the classroom.

Research Questions were:

1. What factors do teachers perceive as facilitating or impeding their implementation of a school curriculum that includes mental health education?
2. What are teachers' perspectives on the impact of mental health education curriculums on student and teacher mental health outcomes, such as stress, anxiety, and safety?

The findings from this study will inform future research regarding barriers to real-world implementation of mental health curriculums in schools, and policies that may need to be changed or expanded within the school system. Ultimately, the goal of this work was to add to an emerging area of research that investigates school-based health interventions

and its relation to the overall mental health, well-being, and safety of students and teachers.

Chapter Two: Literature Review

In this chapter, I provide a synthesis of the literature as it pertains to this study.

State of Youth Mental Health in the United States

The United States is currently experiencing a mental health crisis among children. One out of every five children in the U.S. experience a mental health disorder in any given year (Adelman & Taylor, 2010; O'connell, Boat, & Warner, 2009), half of which had an onset before the age of 14 (Kessler et al., 2005; National Alliance on Mental Illness [NAMI], 2015). In children, mental health disorders may present as changes in the way the child usually learns, behaves, or manages their emotions, which ultimately causes them distress and difficulty getting through the day (Brauner & Stephens, 2006). It is reported that one out of ten youth meet the criteria for a serious emotional disturbance (González, 2005; U.S. Department of Health and Human Services, 1999), which can be described as a mental health issue that has a severe impact on the individuals ability to function in an emotional, academic, or social capacity (Brauner & Stephens, 2006; CDC, 2019a; Costello, Egger, & Angold, 2005).

The CDC's Youth Risk Behavior Surveillance System (YRBSS or YRBS) is a biennial, national survey that provides the most recent data on health behaviors and experiences among high school aged students (CDC, 2019a). The YRBS measures mental health by asking one question about persistent feelings of sadness or hopelessness and four questions about suicidal ideation, intent, plan, and action. In the YRBS survey, "persistent feelings of sadness or hopelessness" is defined as feeling sad or hopeless nearly every day for a minimum of two weeks within the one year prior to the survey (CDC, 2019a). The 2017 YRBS, which is the most recent report released, indicated that

31.5% of high school aged students across the country experienced persistent feelings of sadness or hopelessness (CDC, 2019a). In this data, approximately 17.2% of students seriously considered attempting suicide, 13.6% made a suicide plan, 7.4% attempted suicide, and 2.4% were injured in a suicide attempt (CDC, 2019a).

These prevalence rates are not surprising, as suicide is the second leading cause of death for persons between the ages of 10 and 34, with 90% of all completed suicides having an underlying mental illness (National Institute of Mental Health, 2017). Furthermore, suicide rates for females, under the age of 18, doubled from the year 2007-2015, and the suicide rate for males increased by a third (CDC, 2017b). Unfortunately, 75% of children with mental health problems do not receive treatment or mental health services (Stagman & Cooper, 2010) despite the increase in prevalence and incidence of mental health issues among youth (Mojtabai, Olfson, & Han, 2016; Waller, Bresson, & Waller, 2006). In addition to increasing the risk for suicidal behavior, untreated mental health disorders increase children's risk for academic failure (Fletcher 2009; McLeod, Uemura, & Rohrman, 2012; Needham, 2009), substance abuse (Mangerud, Bjerkeset, Holmen, Lydersen, & Indredavik, 2014; Substance Abuse and Mental Health Services Administration, 2011) and juvenile delinquency or violence (Ford, 2005; Rolf & Farrington, 2019).

Mental Health and Substance Use

Comorbid substance abuse is common among adolescents with psychiatric disorders. Several studies, ranging in sample size, show that mental health and substance use have a bidirectional relationship. Approximately 35% of adolescents suffering from depression develop a substance use disorder (Rao et al., 1999). A national survey of

adolescents (ages 12-17) across 26 states found that those who reported an episode of major depression in the last 12 months were nearly twice as likely to use alcohol or other illicit drugs (National Survey on Drug Use and Health Report, 2007), most likely as a self-medicating strategy. This survey also found that of approximately 20% of the 78,000 adolescents (age 12-17) admitted to the hospital for treatment of a mental health or substance use problem had co-occurring psychiatric and drug or alcohol problems.

Similarly, adolescents with a history of anxiety disorders are twice as likely to later develop a substance abuse disorder (Deas & Brown, 2006). In a study that surveyed 90 adolescents admitted to an inpatient psychiatric facility, it was found that 44% of adolescents had both an anxiety disorder and a substance use disorder (Deas-Nesmith, Brady, & Campbell, 1998). Another major concern is that a considerable amount of evidence indicates that suicidality risk is significantly higher among persons whose substance use begins during adolescent years, compared to those with a later onset of substance use (Deas & Brown, 2006; Mangerud, Bjerkeset, Holmen, Lydersen, & Indredavik, 2014; Skala & Walter, 2013).

Mental Health and Academic Achievement

The correlation of mental health issues with academic failure is well substantiated in the literature (Matingwina, 2018; Michael, Merlo, Basch, Wentzel, & Wechsler, 2015; O'Malley, Voight, Renshaw, & Eklund, 2015). Mendes, Crippa, Souza, & Loureiro (2012) reported that epidemiological findings suggest mental health disorders have a significant impact on social interactions and academic performance of youth, particularly when the disorder is untreated (Sznitman, Reisel, & Romer, 2011). A report from the U.S. Department of Education (2001) found that nearly 50% of students over the age of

14 with a mental health disorder dropped out of high school – the highest dropout rate of any other disability group. This was also confirmed in a study by Guerra, Rajan, and Roberts (2019), reporting that students identified as having a mental health issue or emotional disturbance have the highest school dropout rate, as well as the fourth lowest high school graduation rate.

In addition to academic failure, other consequences of unaddressed mental health issues include absenteeism, disciplinary problems, and juvenile delinquency (Davis, Kruczek, & McIntosh, 2006; Morris & Morris, 2006). The absentee and tardy rates for adolescent students with emotional disturbances is triple that of students not identified with emotional disturbances (Gall, Pagano, Desmond, Perrin, & Murphy, 2000). When left untreated, adolescent students with emotional or behavioral disorders are less likely to perceive themselves as academically competent (Masi et al., 2001), and those who perceive themselves as failing academically are three times more likely to report suicide attempts (Martin, Richardson, Bergen, Roeger, & Allison, 2005).

Students with higher psychosocial stress also report a higher level of difficulty concentrating in class and completing assignments (Humensky et al., 2010). Nelson, Benner, Lane, and Smith (2004) found that over 80% of adolescent students with emotional and behavioral issues scored below the mean in math, reading, and writing compared to those in the control group. This suggests that when mental health issues are effectively prevented or treated, students may have the greatest likelihood to succeed in school (Gracy et al., 2014). This is also the position of the National Association of School Psychologists (2006) who reported that having social-emotional and mental health support increases the likelihood of academic and personal success.

Mental Health and Juvenile Delinquency

Untreated emotional and behavioral disturbances are also risk factors for the development of delinquent behaviors in youth (Mallett, Stoddard Dare, & Seck, 2009; Moffitt,1993). Disruptive behaviors such as aggression or defiance towards adults before the age of 13 are often diagnosed as conduct disorder or oppositional defiance disorder (CDC Children's Mental Health, 2019), and have been found to be precursors for delinquency and violence in youth offenders (Mallett, Stoddard Dare, & Seck, 2009). Similar links have been found between adolescent delinquency and attention deficit disorder or childhood depression (McLeod, Uemura, & Rohrman, 2012; Zigler, Taussig, & Black, 1992).

As such, it can be assumed that mental health disorders are common among the juvenile delinquent population that have been incarcerated. It is estimated that approximately 60% of juveniles in detention centers meet the diagnostic criteria for a psychiatric disorder (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Another study found that 35% of juvenile offenders had a comorbid mental health disorder at the time of intake to a juvenile detention center (Teplin et al., 2006). With untreated mental health disorders being a risk factor for violence, it can be expected that this can also spill over into the school setting.

Violence in Schools. According to the School Survey on Crime and Safety (SSOCS), conducted by the National Center for Education Statistics' (2017), in the 2015-2016 school year, there were 68.9% violent incidents recorded in public schools. Although school associated violent deaths are rare, schools are expected to be a safe haven for learning and any form of violence is unacceptable (CDC, 2017a). Attention

deficits, hyperactivity, learning disorders, high emotional stress, a prior history of treatment for emotional or behavioral problems, antisocial beliefs and attitudes, and involvement in substance abuse, are all factors that have been identified as increasing the risk for severely violent behaviors in youth (CDC Violence Prevention, 2019).

In the last decade there have been far too many mass shootings at public schools. The U.S. Department of Education (the Safe School Initiative; SSI) analyzed 37 school shooting incidents, carried out by 41 adolescent offenders that occurred over a 25-year period (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002). Commonalities among the shooters that the SSI found were that most perpetrators were depressed, felt that they had been bullied, had experienced a significant loss, or had a history of suicide attempts. Evidence suggests a link between severe depression in adolescents with aggressive or violent behaviors. Studies that examined the link between adolescent depression and subsequent violent behaviors found that violent behaviors among youth with depression was significantly higher than that of the general adolescent population without depression (Knox, King, Hanna, Logan, & Ghaziuddin, 2000; Yu et al., 2017). These findings were consistent across three longitudinal studies, suggesting that clinical guidelines should consider risk assessment for violence in adolescents with depression (Yu et al., 2017).

Early Intervention

Often, the earliest signs of mental illness appear during adolescence (Kessler et al., 2005; NAMI, 2015). Some of the first signs of mental illness that emerge include behavioral changes varying from minor substance abuse and signs of psychosis, to aggression or self-harm. Despite the availability of effective treatments, there continues to be delay between the first appearance of symptoms and initiation of treatment

(Cheung, O'Donnell, Madi, & Goldner, 2017; Kessler, Olfson, and Berglund, 1998; Wang, Berglund, Olfson, & Kessler, 2004).

This delay in treatment may be attributed to several factors such as, low mental health literacy, the stigma around mental illness, access to mental health services, lack of or insufficient insurance coverage, as well as denial or the belief that symptoms are typical for adolescents (Cheung, O'Donnell, Madi, & Goldner, 2017; Goldman, Nielsen, & Champion, 1999). Delaying the treatment of a mental health disorder has been shown to have negative impacts on health outcomes such as the worsening of mental illness symptoms or an increased risk for suicidality (Altamura, Dell'Osso, Mundo, & Dell'Osso, 2007; Cheung, O'Donnell, Madi, & Goldner, 2017). Studies analyzing the extent of delays in treatment found that the median number of years between the first onset of mental illness symptoms and the first treatment contact is 7-11 years (Kessler, Olfson, and Berglund, 1998; Wang, Berglund, Olfson, & Kessler, 2004). Early identification and initiation of treatment is vital and may positively change the mental health trajectory of adolescents with mental health issues (Fazel, Hoagwood, Stephen, & Ford, 2014). Meta-analysis of studies related to adolescent mental health and academic performance support the notion that identifying and treating mental health concerns in children and adolescents can also improve school performance and academic success (Baskin, Slaten, Sorenson, Glover-Russell, & Merson, 2010; Prout & Prout, 1998).

School-Based Mental Health Services

School-based mental health (SBMH) policies and programs were developed to meet the growing mental health needs of students. School-based mental health can be loosely defined as mental health services within a school system that include, but are not

limited to, prevention, intervention, skill development, evaluation, referral, counseling, and education (Kutash et al., 2010). SBMH services provide easier access to care because they do not have the same "service access and stigma barriers as formal mental health services" (Desta et al., 2017). SBMH services help to address several barriers to accessing care. For example, service delivery at school reduces barriers related to transportation and distance to providers (Armbruster & Lichtman, 1999). Students also receive mental health support through school regardless of family income or insurance coverage.

Easier access to care increases compliance with mental health appointments and decreases the risk for premature treatment termination (Committee on School Health, 2004). Rones and Hoagwood (2000) found that 70-80% of children who receive some type of mental health services, accessed this care through a mental health provider in the school setting. For these and many other children, schools are often their sole source of mental health service (Burns et al., 1995; Weissberg, Kumpfer, & Seligman, 2003).

This understanding, along with the need for early intervention, provides a rationale for focusing mental health education and resources in the school setting. The considerable amount of time children spend in school also makes it an obvious location for the delivery of mental health services. The school setting serves as an opportunity to assess multiple indicators of mental health such as peer relations, behavior in the classroom, and academic performance in a setting that is natural for the student (Atkins, Graczyk, Frazier, & Adil, 2003).

Health Education in Schools

If school based mental health services are not possible, an alternate strategy to providing mental health care for students is through health education. Although the comprehensiveness of health education in schools can vary from state to state, health education is still either encouraged or required in all states. Currently, 46 states in the United States require some form of health education to be provided to all students (Child Trends, 2019). Health education can include aspects of physical, mental, emotional and social health. Education related to drugs, healthy diets, exercising, proper hygiene, and sexuality equips students with the knowledge to make healthier and safer choices. The relationship between health education and improved health outcomes is well established in the literature (Busch et al., 2014; Michael, Merlo, Basch, Wentzel, & Wechsler, 2015). When students are healthy, they learn better; and when students are educated, they can stay healthy (CDC Healthy Schools, 2019).

Evidence also indicates that the inclusion of mental health education in the curriculum can have a positive impact on academics. In terms of standardized tests, Payton et al. (2000) reported that scores on exams were higher when mental health or social and emotional learning was included as a component in the education curriculum. Mental health education, which can include conflict resolution, anger management, and mindfulness skills are steps toward addressing school violence and creating a safer learning environment for students and school personnel (Hahn et al., 2007). Teaching healthy coping skills and providing techniques or strategies to students who are facing emotional instability such as grief, anxiety, or anger issues, are helpful in showing them

how to resolve their issues in healthier ways rather than through acts of aggression or self-harm (Paolini, 2015).

Mental health education can be a vital tool in the early identification and initiation of treatment for mental health disorders. Education on mental health can increase the likelihood that students will be able to recognize signs and symptoms of mental health distress in themselves or others and know how to get the right help (New York State Education Department [NYSED], 2018). This is crucial as adolescents with undiagnosed or untreated mental health disorders have poorer physical health and are more prone to engage in high-risk behaviors such as theft, substance use, violence/weapon carrying, or un-safe sexual practices (Ozer et al., 2009).

Globally, school-based mental health education has also shown promising results. A study in Nicaragua found that the implementation of a curriculum that included mental health education was effective in decreasing the stigma of mental illness among students and teachers (Ravindran et al., 2018). Similarly, Kutcher, Wei, and Morgan (2015) found that embedding mental health education material into the teaching curriculum of schools was significantly effective in improving mental health literacy and decreasing stigma in Canadian students. Additionally, researchers in Tanzania determined that incorporating mental health education into the class curriculum decreased stigma, improved confidence, and increased positive help-seeking efficacy of teachers (Kutcher et al., 2016). Teachers often spend more time with and have easier access to adolescents than mental health professionals, primary care providers, and even parents; putting them in an opportune position to deliver vital health education programs. They may also play a key role in the early identification of students who have serious untreated mental health issues.

Teachers and Mental Health

Impact of Mental Health on Teacher and Student Well-being. Teachers play a pivotal role in the academic, social, and emotional development of students. However, their value in the delivery of mental health services is often overlooked, potentially making them the most underused resource in school mental health promotion (Lynn, McKay, & Atkins, 2003). Wilson and Wilson (1992) found, from their study of nearly 3,000 high school students, that there was a significant link between academic success and having a supportive relationship with the teacher. In addition, a study found that teacher support has also been linked to decreased psychological distress and improved educational performance (Wentzel, 1998).

In a separate study, Bowen, Brewster, and Bowen (1998) found that a student's sense of teacher support can be a protective factor, providing a feeling of security in the face of adverse events. More than any other school personnel, teachers have a far more profound effect on students' feelings and cohesiveness in school. In a large-scale study, researchers found that participants identified teachers as the most prominent factor impacting student learning (Sanders, Wright, & Horn, 1997). Additionally, Harding et al. (2019) found a strong association between teacher well-being with student well-being and psychological distress. Improved emotional health of the teacher was found to be associated with better student well-being and lower student psychological distress.

Conversely, mental health issues with students have an impact on the mental health and well-being of teachers as well. Student mental health and behavioral issues, along with the lack of resources, dramatically increases the stress level of teachers which can lead to mental health issues in themselves as well (Tyson, Roberts, & Kane, 2009).

This goes to show that policies that encourage the inclusion of mental health education in the teaching curriculum may have an impact on teachers' mental health as well as students' mental health. A healthy classroom where optimal learning can take place is when both the teachers' and students' mental health are considered.

Teacher Stress, Burnout, and Turnover. With so many students attending schools with untreated mental health issues, the mental health of teachers is an area in dire need of attention. A survey of 30,000 teachers, conducted by the American Federation of Teachers (2015), found that 78% of teachers reported feeling physically and emotionally exhausted by the end of the school day. This is evidenced by the high turnover rate in this population. A longitudinal survey from the National Center for Education Statistics (Gray & Taie, 2015) found that 10% of teachers left their school after one year of starting.

Common sources of teacher stress that influence teachers' perceptions of self-efficacy and present as barriers to supporting student mental health include student behavioral challenges, administrative pressures, inadequate resources, large class sizes, and lack of training (Gray & Taie, 2015). One particular factor that contributes to burn out, high stress levels, and turnover rates for teachers is compassion fatigue. Compassion fatigue is described as a type of secondary trauma experienced by those in helping professions working with people who are in distress (Figley, 1995). Thus, caregivers or professionals, such as teachers, that work closely with children who have had trauma or adverse experiences are at risk for compassion fatigue. This risk may be even higher for teachers who work with students from low-income or under-privileged communities (Breslau, Wilcox, Storr, Lucia, & Anthony, 2004; Lever, Maats, & Mayworm, 2017).

Teacher Victimization. In addition to compassion fatigue, another factor that has a severe impact on teacher stress level is violence and aggression in schools. The Teacher and Principle Survey (NTPS) and the Schools and Staffing Survey (SASS) are both national surveys that collect data on threats of violence and physical attacks on teachers by students. Results from both surveys show that the percentage of public-school teachers who report being physically assaulted by students between 2011-16 was higher than in all previous years (1993-2011) of the survey (National Center for Education Statistics, 2018). Teachers are three times more likely than students to be victimized by violent crimes in school (Kondrasuk, Greene, Waggoner, Edwards, & Nayak-rhodes, 2005). Heightened levels of fear and stress in teachers has been shown to lead to less effective teaching, less commitment to their job, less motivation, burnout, and high teacher turnover rates (Daniels, Bradley, & Hays, 2007; Elliott, Hamburg, & Williams, 1998).

Lack of Mental Health Knowledge and Training. In addition to compassion fatigue and teacher victimization, the American Federation of Teachers (2015) found that 71% of teachers identified "adoption of new initiatives without proper training or professional development" as a major source of stress in the workplace. Teachers are often the primary implementers of mental health promotion programs in schools (Han & Weiss, 2005). Although Bowen, Brewster, and Bowen (1998) found that involving teachers in the implementation of school mental health programs can enhance their ability to manage the classroom effectively, many teachers do not feel that they have the adequate skills and knowledge needed to promote mental health and resiliency (Koller & Bertel, 2006; Reinke, Stormont, Herman, Puri, & Goel, 2011).

Satterly (2011), using an experimental vignette design, found that special education certification was a predictor variable for rating of expectations for teacher self-efficacy. This study concluded that there is a clear indication of the need for additional training to increase teacher knowledge and confidence when working with mentally ill students. In addition, when asked about barriers to successful implementation of mental health promoting initiatives and programs in their school, Walter, Gouze, and Lim (2006) also found that most teachers reported a lack of knowledge, skills, and training as an obstacle.

Teachers' perceived role and self-efficacy. In addition to lack of knowledge, skills, and training, there are a fair number of studies that measure teachers' perceptions of their role, and their sense of efficacy or confidence in providing mental health education and support to students. However, little is known about teachers' experiences with fulfilling this role from a qualitative perspective (Gowers, Thomas & Deeley, 2004). The existing qualitative literature were of studies largely based in areas outside of the United States. Research exploring these phenomena in the context of the American culture is needed (Reinke, Stormont, Herman, Puri, & Goel, 2011). Of the few U.S. based qualitative studies, a study that included 292 teachers from 5 school districts found that teachers perceived school psychologists as having the primary role in mental health service delivery in regard to screening, behavioral assessments, and on-going monitoring (Reinke, Stormont, Herman, Puri, & Goel, 2011). However, teachers in this study perceived themselves as having the primary responsibility of classroom level behavioral interventions, with psychologists having the larger role of teaching overall social-emotional management.

Of the studies that explored teachers' perceptions of mental illness and their comfort with management of it in the classroom, Osagiede et al., (2018) found that teachers working in schools with in-house counselors were more comfortable accessing mental health services for students than those without in-house counselors. However, there was no significant difference in their comfort level with talking to the students about mental health. Overall, the existing body of literature largely shows that supporting optimal health for students calls for a team-based approach that includes both educators and health professionals such as the school psychologist or counselor.

Health Professionals and School Mental Health

Promoting school health is a responsibility shared by both educators and healthcare professionals. Collaboration between educators and school health professionals, such as the school psychologist, school social worker, school counselor, or school nurse, is essential in the promotion of health (Elias, Zins, Graczyk, & Weissberg, 2003; Paternite & Johnston, 2005), and in the development of a comprehensive health curriculum or school health policies. There are several advantages of a teacher-health professional partnership in the development of school mental health interventions. Littlecott, Moore, & Murphy (2018) point out that teachers have the largest impact on student well-being due to the extended periods of time they spend with students in a variety of school programs and settings. This ease in access to students may also mean that teachers are more successful with implementing mental health interventions in a way to positively impact student functioning and academic success than health professionals are (Littlecott, Moore, & Murphy, 2018).

The role of the school nurse, social worker, psychologist, or counselor in school mental health can vary from school to school. According to the NYS Office of Mental health, their duties can include providing counseling, individual student planning, and support to students in dealing with trauma, or emotional or behavioral challenges in the school. Additionally, school psychologists can conduct psychological assessments and educate staff on the learning and behavioral needs of students (Division of Integrated Community Services for Children and Families, 2018).

In the United States, the requirement for a school to have its own health professional can vary from state to state. In New York State, the law currently states that school districts must provide health services to all public-school students (NYSED Article 19 Education Law § 901, School health services to be provided). However, this does not mean that every school in each district will have health services or a health professional on site. For example, although all schools are required to provide the health-related accommodations needed for students to have full access to educational resources, NYS does not mandate that all schools have their own school nurse or psychologist (New York State Center for School Health, 2017).

According to the 2016-2017 New York State Education Department (NYSED) statistics, the average ratio of school nurse to student is 1:520, the school guidance counselor to student ratio is 1:355, and the school psychologist to student ratio is 1:547 (NYSED, 2018; New York State United Teachers [NYSUT], 2018). However, there are districts that were significantly below this average, such as the Brentwood School District where the nurse to student ratio is 1:9052, or Yonkers where the school psychologist to

student ratio is 1:1000, or in Islip Union Free School District where the school guidance counselor to student ratio is 1:2800 (NYSUT, 2018).

Health Education in New York State

Suicide continues to be a growing public health concern. According to the CDC (2019), in 2017, there were 1.4 million suicide attempts, with an estimated 47,000 deaths. This is equivalent to approximately one death every 11 minutes (CDC, 2019b). While these national trends are alarming, the 2017 CDC YRBS report shows that the state of New York in particular is experiencing a distressing adolescent mental health crisis. The YRBS defines suicide attempts resulting in injury as any injury, poisoning, or overdose that was severe enough to need the treatment of a medical professional. In New York State, adolescent suicide attempts resulting in injury was reported at a startling 4.1% in the 2017 YRBS report. This was nearly twice the national average of that year.

All schools in New York State are required to provide health education to students (NYSUT, 2018). However, this health education requirement did not necessarily have to include mental health. In 2018, New York State became the first state in the nation to pass legislation mandating mental health education for all K-12 students. With Virginia following soon after, only these two states now require by law the incorporation of mental health education in the teaching curriculum of every school in the state (Mental Health First Aid, 2018). As with many school-based interventions, teachers play a key role in providing mental health support to students. With children spending a large amount of their day in the classroom setting, teachers are well-placed to directly observe the mental health challenges of youth and the impact of this new mental health education mandate. This highlights the importance of understanding the teachers'

perception on mental health issues and education in schools. However, much of the research to date related to mental health curriculums in schools focus on the experiences, views, and attitudes of students (Ball et al., 2016; Kratt, 2018; Williams, Horvath, Wei, Van Dorn, & Jonson-Reid, 2007).

The purpose of this study is to form a description of the experiences of high school teachers in New York and their impressions of a school-based mental health intervention that has recently been implemented. This will begin to address a critical gap in the research, exploring factors important to the effectiveness and success of school-based mental health interventions and their ultimate impact on student and teacher mental health outcomes and well-being. Guided by the Theory of Organizational Readiness for Change (Weiner, 2009), this study uses a qualitative descriptive methodology to explore teachers' perceptions on the impact of an intervention on student and teacher mental health outcomes, as well as the barriers, challenges, and facilitators to its implementation.

Theoretical Framework

Implementation science is the study of the methods that promote the adoption of research findings into public policy and routine professional practice (Eccles & Mittman, 2006). The theoretical approaches within this area of science provide insight into how and why implementation succeeds or fails (Nilsen, 2015). Implementation science researchers aim to identify specific barriers and facilitators to the implementation of evidence-based practice. Within implementation science, the Theory of Organizational Readiness for Change (Weiner, 2009) explains that readiness for change in an organization, such as a school system, is a crucial and determining factor in the

successful implementation of new policies, programs, and practices (Shea, Jacobs, Esserman, Bruce, & Weiner, 2014).

The Theory of Organizational Readiness for Change was used as a framework to guide this study. Within the organizational readiness construct, readiness for change is determined by agreement on the value of the change, an assessment of task demands, access to resources, and situational factors (McIsaac, 2018; Macklem, 2013). If teachers agree on the value of the change in curriculum, have confidence in their ability to make the change, believe that they have the necessary resources and a conducive environment, there is a higher level of organizational readiness. Based on this theory, with a higher level of organizational readiness, teachers are more likely to initiate change, exert greater effort, and be more cooperative. All of which will result in an effective implementation.

This theory highlights that achieving the anticipated results of an intervention implementation requires the assessment of readiness. Readiness precedes change. Developing a culture of change is needed to support readiness (Hamilton, Cohen, & Young, 2010). Creating this culture of change means a recognition of negative attitudes among stakeholders and building a shared resolve for change (Hamilton, Cohen, & Young, 2010). Using this theory, the interview guide used in this study included questions that were framed in a way to help assess and understand the teachers' level of openness and readiness for this change in school curriculum.

Qualitative Descriptive Methodology

Given the dearth of research representing the voice and perspectives of the interventionists in school-based mental health interventions, this study employs a qualitative descriptive methodology to collect primary data. Qualitative description falls

within a post-positivist orientation. Within this methodology, there is a certain amount of factual information being sought, that can be corroborated, leading seekers of this information to agree on its veracity. The researcher asks people their perspective, then looks across the text of these interviews for common experiences described by the participants, and finally organizes and presents the information in a way that the reader is able to generate an understanding (Sullivan-Bolyai, Bova, & Harper, 2005).

According to Sandelowski (2000), qualitative descriptive research is categorical, less interpretive than interpretive description, and does not require a highly abstract rendering of data. Qualitative description does not seek "discovery" as seen in grounded theory, it does not attempt to "explain" or "understand" as is expected in ethnography, or try to "explore a process" as seen in case studies (Bradshaw, Atkinson, & Doody, 2017). Rather, it aims to provide a straight description, staying close to the participants own words, of the experience depicted. As opposed to description in phenomenology, qualitative description is a more low-inference technique that allows the researcher to remain close to their data and to the surface without dwelling in or diving into the meaning behind the words or events (Sandelowski, 2000). The overall goal of the researcher is to "seek a precise account of the experiences, events and process that most people (researchers and participants) would agree are accurate" (Sullivan-Bolyai, Bova, & Harper, 2005).

Chapter 3: Methods

Methodology

The research questions in this study did not attempt to derive the essence of an experience, but rather to form a direct and comprehensive summary of the phenomenon as experienced by the teacher and described in their own words. A "qualitative descriptive study is the method of choice when straight descriptions of phenomena are desired" (Sandelowski, 2000, p. 334). To address the research questions, an approach using in-depth, semi-structured interview questions, seeking un-interpreted descriptions was used. Given the goals of this study, a qualitative descriptive approach presented as the appropriate choice of methodology for this type of research.

Sampling and Recruitment

The participants of this study were high school teachers who were currently employed in a New York State high school. In order to capture the impact of the mental health curriculum in the school, it was necessary that teachers had a sufficient amount of experience teaching students prior to the curriculum change. Therefore, the eligibility criteria specified that the participant must have a minimum three years of high school classroom teaching experience prior to this change in health curriculum. Additionally, only teachers who spoke English and were over the age of twenty-one were included.

The primary method of recruitment used for this study was through social media. A purposive sample of New York public high school teachers was recruited through Facebook and snowball sampling. Qualitative research sample size is dictated by considerations of data saturation (Glaser & Strauss, 1967), in which no new themes emerge from interviews. Data saturation in this study was reached at 20 participants, at

which time recruitment was concluded. Using Valdez et al. (2014) as a guide, recruitment consisted of three parts: (a) identifying Facebook groups and pages targeting NY public school teachers, (b) notifying the administrators of identified groups and pages of the study purpose, and (c) posting a study Facebook page link to consenting groups and pages. To identify groups and pages, a keyword search of the terms "New York teachers" and "New York public school teachers" was conducted on Facebook. Pages or groups targeting preservice or retired teachers were excluded. Teachers who worked in private schools were also excluded. Additionally, groups and pages that did not allow the PI access to join or post were also not included.

A study Facebook page containing a flyer with general information about the study was developed (Appendix B). Permissions from the appropriate parties (i.e. moderator of Facebook page) were gained prior to the posting of any recruitment materials. Posting the link to the studies Facebook page in "closed" Facebook groups and pages, which have more stringent privacy settings, required membership. If membership was granted by the administrator, posting the study Facebook page link also required administrator approval. Facebook messenger was used to privately contact administrators. If the administrator granted permission, a link to the study Facebook page was posted directly to the page or group. "Open" to the public pages and groups, which have less restrictive privacy settings, granted automatic approval of all posts with or without membership.

The study Facebook page provided general information about the study including confidentiality, eligibility criteria, compensation availability, and the contact information for the PI. Although all interviews were confidential, a notation that (non-identifying)

demographic information will be collected was also included on the Facebook page. In addition, the study's Facebook page also provided information on time commitment and explained that interviews will be done in a single, 60-minute phone or video call session. Interested participants were asked to click on a link to a Qualtrics survey (Qualtrics, 2005). The Qualtrics survey presented a brief overview of the study procedures and then (for potential participants who chose to proceed) presented the following screening questions, asked in a yes or no format:

a. Do you speak and understand English?
b. Are you over the age of 21?
c. Are you currently employed in a New York State public high school as a teacher?
d. Do you have a minimum three years of high school classroom teaching experience prior to July 2018, when NYS passed the bill requiring the inclusion of mental health education in the school curriculum?

If potential participants were not eligible for this study based on their responses to these questions ("no" response to screening questions), they were shown a page informing them that they are not eligible and thanking them for their time. If they were eligible based on their responses ("yes" to all screening questions), they were taken to the demographic questionnaire (Appendix C) which was made optional to complete. Data such as age, race, gender, years of teaching experience, grade levels taught, grade level currently teaching, types of schools (e.g., public, private, charter, parochial) they have worked in, and if they currently teach in a rural, urban, or suburban school was collected through the demographic questionnaire. Potential participants were then able to continue

to the page containing the waiver of documentation of consent (Appendix A) for them to view and with the option to click agree and consent to participate. Participants were also allowed the ability to download and print the waiver of documentation of consent form.

If the potential participant consented to participate in the study, they were then asked if they preferred to be interviewed by phone or videocall and to provide a phone number or email address where they can be reached. The participant was also asked if they gave permission for the study team to contact them via text message to the phone number they provided. An email account and Google phone number specifically designated for study purposes and answered by the study PI was used for all communication with participants and to schedule the individual interviews. Only the study PI had access to these accounts. All participants who completed the interview were compensated. At the conclusion of the study, the PI sent a unique code for a $25 Amazon gift card to each participant.

Consent Process

No identifying contact information was collected during study interviews or linked with study data. Consistent with the Code of Federal Regulations, §46.117 ("Documentation of informed consent"), the study team used a waiver of documentation of informed consent for this study (Appendix A), as a signed informed consent form would have been the only identifying document in the study, and the principal risk in this study is a breach of confidentiality. Individual interviews were scheduled as per the participants' convenience and preference. Every interview began by confirming eligibility and then reviewing the contents of the waiver of documentation of consent in

order to ensure that the participants' questions were answered and that they agreed to participate.

If the participant agreed to participate and continue with the interview, they were made aware that at any time, he or she may interrupt the PI to ask questions. All participants in this study chose to be interviewed over the phone. At the beginning of each phone call, participants were made aware that all interviews were audio recorded for research purposes. The recording only began once the waiver of documentation of consent was reviewed with the participant and they agreed to participate. Participants were made aware of when audio recorder was started and they were also assured that any potentially identifying details shared by participants would be redacted from transcription and would not be included in the research reports. Participants were informed that they may skip any questions they don't wish to answer, ask the interviewer to stop the recorder at any time, and/or end their involvement in the study at any point.

Data Collection

Data in this study was collected through open-ended, in-depth, semi-structured interviews. All interviews were conducted through a single session, approximately one hour, phone call. The investigator-developed interview guide used in this study was formed based on the research questions, literature review, and the principal investigators clinical expertise and pre-understanding of this topic and gaps in research (Appendix E). All interview questions were open-ended and broad to allow for the participant to tell their story. Follow up questions/probes were used as necessary to elicit further descriptions. While there was an interview guide, questions were not always asked in the same order for each participant, however, all topic areas were covered. Although

interview questions evolved iteratively as themes emerged in the data, they stayed close to the specific aims of the study.

The main portion of the interview consisted of a series of carefully-worded and arranged, semi-structured, open-ended questions. In line with the Theory of Organizational Readiness for Change (Weiner, 2009), the interview guide also contained questions to determine the extent to which teachers perceived school personnel as "open" to changes in their curriculum. Teachers were asked if they perceived their school to be welcoming of mental health interventions and whether the administrators of their school were committed to incorporating mental health resources, such as counseling and education into the school. Questions also explored the types of mental health and behavioral challenges teacher's frequently saw in the classroom setting, as well as how these student mental health issues impacted their own mental and physical health and their ability to do their job.

Additionally, teachers were asked to describe their thoughts on mental health education and the requirement to include it into the school curriculum. Teachers' suggestions to change or expand school-based mental health interventions to improve the overall mental health for themselves and their students was also explored during the interview. Teachers were asked to identify challenges or barriers they anticipate, or have experienced, related to providing mental health services and education in schools.

To support confidentiality, participants were not asked to divulge the name of the school where they were employed. Each interview was concluded by asking the participant if they can share the link for the study's Facebook page or the Qualtrics survey with other teachers who may be interested in participating. Two separate digital

audio recorders, subject to participant permission, were used to record interviews. Two Sony Stereo Digital Voice Recorder's with a built-in USB were chosen as the recording device because it allowed each interview to be labeled and organized on the recorder itself and also for its ease in uploading directly to Box.com. Once it was verified that one clear and complete audio recording was available, it was uploaded to Box.com, a secure web-based platform approved by the University of Missouri. Audio files were then erased off of both recording devices.

Data Analysis

Qualitative content analysis as described by Graneheim and Lundman (2004) was used for data analysis. Content analysis focuses on the differences and similarities within and between text. Analysis using manifest content was chosen due to the more descriptive, and less interpretive nature of this study. The transcripts from the recorded interviews were read through several times, by at least two members of the research team, to obtain a better sense of the whole picture. Text related to the teachers' experience was extracted to form the unit of analysis. Meaningful units, which are words, sentences, or paragraphs of text that are related through content and context, were then drawn out and condensed. The condensed text was then abstracted and labeled with codes. The final step in data analysis was to compare the codes based on similarities and differences to be sorted into sub-categories and categories. These categories and sub-categories were then discussed by the principal investigator and another member of the research team to be formulated into themes.

All audio files were assigned a participant ID number and transcribed verbatim promptly after the interviews were concluded by a professional transcription service at

the University of Missouri. The original audio recordings and transcripts were stored on Box.com. Once the transcripts and audio files were reviewed for accuracy, the PI and another member of the research team read through all participant interviews. Codes and coding categories were then compared and discrepancies discussed before establishing a codebook.

Establishing Rigor

Due to the subjectivity that is inherent with qualitative work, studies must be done with extreme rigor. According to Polit and Beck (2019), rigor in qualitative work is measured in terms of whether "trustworthiness" is met. Researchers often argue that concepts of validity and reliability are empirical terms which are applicable to quantitative studies but not qualitative work (Polit & Beck, 2019). Lincoln and Guba (1985) replaced reliability and validity with the term trustworthiness.

Rigor in this study was established through transparency in the data collection and analysis process. For consistency, all interviews were conducted by a single researcher, the principal investigator. Interviews, which were digitally recorded, were all conducted over the telephone. Data saturation occurred after completing 20 interviews. The interviews were transcribed using a professional transcription service at the University of Missouri. A meticulous and thorough audit trail, including all strategic decision-making, data collection, and analysis, was maintained throughout the study.

A qualitative data analysis software program (Dedoose, Version 8.3.17, 2020) was used to help code and organize data. All interviews were read through to entirety by the principal investigator and two other members of the research team. The initial coding was done by the principal investigator, after which all codes were reviewed and discussed

with two other members of the research team to promote consensus and standardized coding. In terms of researcher credibility, the principal investigator is a trained and experienced mental health clinician in New York State with several years of experience working with at-risk adolescents in the community setting, out-patient mental health clinics, and in an inpatient psychiatric setting.

Protection of Human Subjects

The principal risk in this study is a breach of confidentiality. Given that participants are being interviewed about their workplace, participants may view their honest disclosure as a risk to their job. At no time during the interview were the participant's asked to disclose the school or school district where they were employed. Further, any potentially identifying details shared by participants were redacted from transcription and were not included in research reports. Participants were also informed that they may skip any questions they don't wish to answer, ask the interviewer to stop the recorder at any time, and/or end their involvement in the study at any point. To further limit breaches in confidentiality, participant contact information (i.e. phone number, email address) was kept on an electronic log and stored on Box.com. All study files such as the contact information log, audio recordings of interviews, and transcripts had only the participant identification number since information such as names were not collected. Approval was obtained from the University of Missouri Institutional Review Board (IRB) for all human subjects' procedures.

Chapter 4: Results

The purpose of this study was to form a description of New York State high school teachers' perceptions of mental health education in schools, as well as the barriers or facilitators to implementation of a recently mandated mental health curriculum in the State. Additionally, teachers' perceptions of common mental health issues and sources of stress and anxiety in the school setting were also explored. Analysis of this data can help illustrate the critical areas policy makers should direct their focus to form effective mental health policies, programs, and initiatives in schools.

Participant Selection

Twenty teachers were interviewed for this study. Only experienced teachers who were currently employed in a New York State high school were included. To be considered an experienced teacher, the participant had to have a minimum of three years of high school teaching experience prior to July 2018. The primary method of recruitment used in this study was through social media and snowball sampling. A Qualtrics survey was developed to screen potential participants and collect demographic information (Appendix C and D). In addition to posting the link to this survey on the study's Facebook page (Appendix B) participants were asked, at the conclusion of each interview, to share the survey link with other teachers who may be interested in participating. Nineteen participants filled out the Qualtrics survey. One participant contacted the principal investigator directly via text message to the google phone number set up for this study. This participant preferred not to provide demographic information but was willing to be interviewed.

Of the 19 teachers who answered the demographic questions, 14 were female and five were male. Thirty-seven percent (n=7) were between the ages of 25-34, 53% (n=10) were between the ages of 35-44, and 11% (n=2) were between 45-54 years old (Fig. 1). Fourteen participants identified as Caucasian, four identified as Asian, and one teacher identified as Black or African American. Years of teaching experience ranged from five years to 21 years. Eight teachers had between 5-10 years of experience, five teachers had

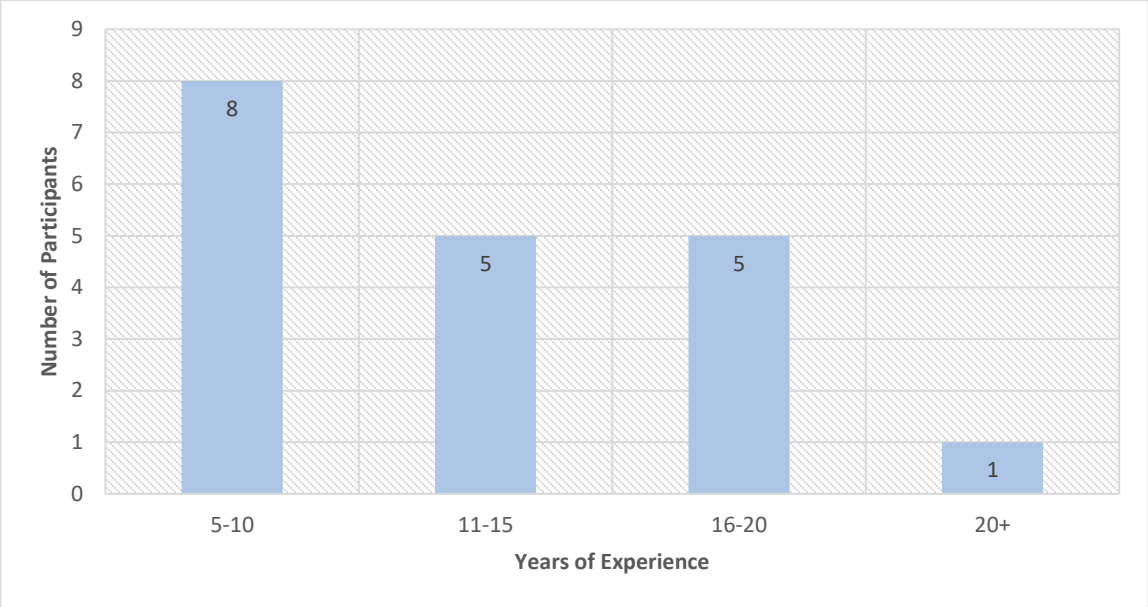

Figure 4.1 Years of Experience

between 11-15 years of experience, and another five teachers had between 16-20 years of experience. Only one teacher had over 20 years of experience.

All teachers have had past experience teaching grades 9-12, however, five teachers had additional experience teaching in middle schools, two had experience teaching elementary and middle school age children, and one teacher had taught in a middle school and in a college. All teachers had worked in a public school, but four teachers had past experience working in private schools as well. At the time of the study, all participants were currently teaching one or more grade levels in high school (defined

as grades levels 9-12 in this study). Two teachers, in addition to high school classes, also taught middle school aged students (7th & 8th grades) in their school. Most of the participants in this study taught in an urban school setting (n=12) and some taught in a sub-urban setting (n=7). No participant was teaching in a rural school setting. The

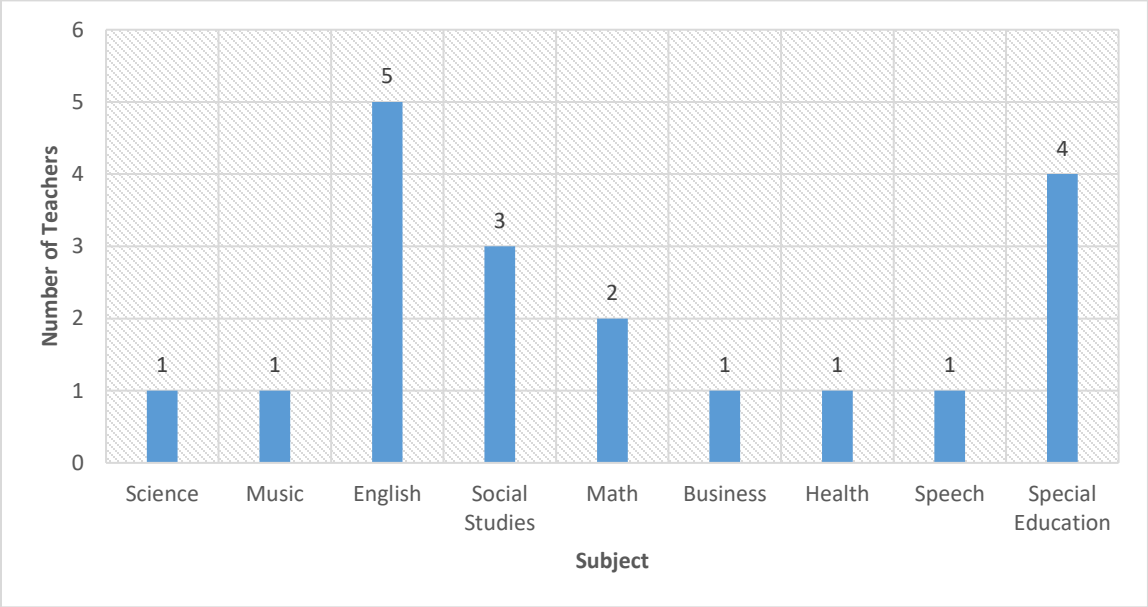

Figure 4.1 Class Subject

subjects that each participant taught varied. Figure 2 shows a breakdown of the subjects that participants taught at the time of the interview.

Themes

During content analysis, data from the interview transcripts were coded and divided into categories and sub-categories. Four main themes emerged from examination of these categories and sub-categories. The first theme was that teachers were working in a "broken system" where several factors such as lack of training, lack of communication or support from administration, and overwhelming class sizes made functioning in their role as a teacher very challenging. The second theme that emerged was that mental health issues had a significant impact on both the teacher and the overall classroom

environment. Theme three and four were that student mental health challenges in schools were complex and multifaceted and therefore, effective school mental health education needs a multi-faceted approach. These main themes are described in further detail below.

Theme 1: Broken System

Awareness. The first theme that emerged were the teachers' descriptions of a "broken system". The most obvious indication of a broken system was that none of the 20 teachers interviewed were aware of the state mandate to include mental health education in their school curriculum. Most teachers agreed that they had no awareness that mental health education was even a discussion, "No one ever told us about it at all, like no clue, didn't even know it was on the table". Another participant stated, "I mean, up until the time you told me, quite frankly, I had no idea that this had even passed. I had no idea". Although unaware of this mandate, a few teachers had noticed hearing about various mental health programs and resources in schools more frequently. One teacher stated:

> No, I didn't know that [that this was a new mandate] but I have noticed other schools in New York State revealing programs that they're enacting almost sort of as, almost sort of as a putting a spotlight out, like 'look what we're doing,' when I guess now looking at this bill they have to do it. So, they're almost making it look like it's their idea.

Lack of training. All teachers (N=20) stated that there was no formal mental health training in their graduate school curriculum. Some teachers said that the only mental health related classes they had taken prior to graduating as an educator were on how to modify lesson plans to make it easier for students with learning disabilities to

access. However, this teacher explains that those classes did not provide information on how to deal with behavioral issues, "there are some tactics … we learn … to like get kids refocused or to get them engaged, but as far as the emotional support in the classroom, there're not a ton of formal training in that." However, one teacher said that she was able to take elective classes during her time in graduate school on how to manage mental health issues in the classroom. She stated:

> I mean, they, you don't even have, like when I was in grad school, I took a behavioral, like a classroom management class because I was like this is something I should know about, … it wasn't part of like I was required to take it.

The frustration around a lack of training was also made clear by another teacher who stated,

> I have colleagues who have, kids have just flipped out in class or had breakdowns in class and have, you know … and we don't know how to deal with it … and also how to deal with the class at the same time.

One teacher discussed how a lack of training often led to teachers immediately taking a punitive stance and passing the responsibility of addressing behavioral issues in the classroom to administration or the school dean. This teacher stated:

> I have colleagues who can't handle any of that and, you know, call the deans every day to have students removed and, you know, it's just, again, just not beneficial for every, anybody, and so I think any, any training regarding mental health is key.

A few teachers also expressed fear that a lack of training can lead them to say the wrong things to a child in crisis: "what are signs to look for … how do we work with the

students … I don't want to do the wrong thing, … to say the wrong thing, and we have no training whatsoever, absolutely none." Especially since teachers "are on the front lines and, and dealing with these students and half the time they don't even know what they're dealing with." Some teachers said that when addressing student mental health is brought up by the school, it is usually discussed in terms of preventative strategies rather than on how to deal with situations as they happen.

> It's a lot of preventative stuff and there's no scenarios for like when this happens you should do this … I feel like a lot of people are like, well what do you do with this kid that's crying, … and I feel like a lot of the teachers are unprepared to deal with social or emotional crisis.

Some teachers (n=7) said that their school offered mental health related professional development (PD) courses and training. However, these teachers also spoke about the inadequacies of these courses and how these shortfalls were another part of the "broken system". One teacher shared an example of how poor the training provided to teachers on suicide is in her school:

> We have mandated, like abuse and neglect training … signs of this and that, like abuse in the home, like emotional abuse and educational abuse, things like that. As for suicide, like we, every year we're given like a 10-minute presentation by a guidance counselor/social worker to address and detect the signs of like a suicidal student, but it's not like 100% clear for a lot of people, but I know … my personal philosophy is that if I have any question … I need to just report it because I would rather report something that ends up being not a real issue than not reporting something that was an issue.

Many teachers mentioned that they did their own research or sought out mental health education or training themselves on their own time.

> So, they, you know, they try to coach and guide a little bit, but in terms of like formal classroom management and formal like even just identifying signs and symptoms of depression, you know … I feel like those are things that a lot of teachers (a) learn from experience but (b) like if you have an interest in it, you'll do the research. So, like I know that I've read more articles … looked into like childhood trauma and, and just become more aware because personally I didn't experience those things.

Lack of support from administration. Perhaps the most apparent contributor to the "broken system" in schools, mentioned by all teachers in this study (N=20), was the lack of support from school administrators. This lack of support was described in many ways. Some complained of the lack of communication from administration, some mentioned how their concerns about students were not taken seriously, others described a punitive school culture and their fear of reprimand, and some discussed the overall level of emotional support they had or lacked at the school.

Lack of Communication. Several teachers complained about the lack of communication from administration. Aside from the mental health education requirement not being communicated to the teachers interviewed in this study, a majority of complaints were about being left out of the loop on pertinent issues concerning students. Teachers spoke about how guidance counselors would know about something horrible the student was going through but wouldn't share that information with any of the teachers. One teacher gave the example of a student whose father had an extramarital

affair, and as a result, could not tolerate being around adult males. The teacher, in frustration, exclaimed,

> Why wouldn't you tell us so that we could, you know, be prepared … he's not speaking to his dad right now and he can't stand men. And I'm like how is this not pertinent to every single teacher in the school? So that they can speak to the child in a way that is meaningful, you know … understanding that what he's doing in class is not because of the class, it's because of something that he can't manage right now, the emotions that he can't manage. He doesn't know what they are, he's confused and, you know, why wouldn't that be pertinent?

This teacher explained that all teachers in New York State pay nearly $300 to have a background check and be fingerprinted to ensure that they are safe to teach kids, and yet, in her school, teachers were still not privy to this information about their students.

A particularly harrowing story shared by another teacher was about a student whose parents died in a murder-suicide. The student's father killed his mother and then himself. This teacher happened to overhear this story from someone and went on to describe the angst that took over her:

> So, he, he lost both of his parents on the same day, and I passed this kid almost every day, every day, and I never knew that … I used to see him in the hallway or in the cafeteria and I, I … I said, how come, like, like teachers don't know that? Like, you know, at faculty meetings why the hell are we talking about … BS stuff like there's no tissues in the bathroom? Who in the hell cares there are no tissues in the bathroom? Why don't I know that this kid is part of our school community?

Concerns not taken seriously. Teachers also spoke about how concerns about students or safety that they felt were not taken seriously by school administrators. One teacher, who was also a dean, explained that he was told to cut back on suspensions because they did not like how high the "numbers" were. He said that even students who were caught with drugs or were disruptive in school were just given a slap on the wrist. When asked why the number of students suspended mattered, he explained:

> Right now, we have our hands tied with certain things because it's all about numbers and if we have x-amount of suspensions then New York State will see that, they audit you and they don't give you certain funds allocations. It's, it's a whole web of, of craziness that prevents us from really doing our job how we should be doing it.

Echoing this frustration, another teacher, whose concerns were dismissed by administration, stated that he once had to go outside of the school's protocol and anonymously call the local authorities himself about a student he felt was dangerous and a threat to safety.

One teacher, who was concerned about the rise in opioid use and overdoses in her school, reached out to the principal, the head of guidance, and the school nurse about free Narcan training. Narcan, she explained, is a life-saving drug used in emergency situations to reverse opioid overdoses. Her concerns were not acknowledged and no one seemed interested in attending the training. Following the death of several current and alumni students to opioid overdoses, this teacher went to the training alone and now keeps Narcan on her at all times. She said the school is aware that she has it, should they ever need it.

Emotional support. Teachers were asked to describe what type of emotional support teachers and students received from administration. One teacher said that the emotional support provided at her school was poor because the school took a "tough love" approach to students. The school believed that, as kids learn more about mental health, it increases the possibility that students may use it as a way to seek attention and play the victim, "because they see that they're not getting the attention so while I'm depressed then, you know, more people will want to help me and talk to me." Similarly, another teacher also described the overall attitude of her school was to not put a spotlight on mental health. For example, she stated that her school,

> wanted to stay away from guest speakers that dealt with suicide because they were afraid of giving the students ideas about suicide cause they always … like even though there were options to bring in those guest speakers they didn't want to bring them in.

She further went on to explain that,

> they didn't want to bring in a guest speaker that … dealt with, you know, suicidal thoughts because they were like, oh, we're like kind of glorifying this person who tried to commit suicide and now this person is going around talking to other students and, you know, they're like in the limelight now.

This teacher stated that the stigma around mental health in her school was even apparent in the way the school approached the death of students. She shared a story of two students who had passed away. One was a girl, who was popular and well-liked by everyone in the school, who passed away in a car accident. The second was a boy who

was more of a "loner" and passed away from a drug overdose. The teacher described the response of the school to both deaths:

> They did like a rally for her and a bench was devoted to her and, you know, things were like dedicated towards her, too. But like there wasn't anything that, for a student that was like, that died because of a mental health issue.

She went on to say that students who died of mental health issues such as suicide or drug overdose were often isolated, with few friends, and not well-known by the faculty. She explained:

> I think honestly … this particular student [the girl] that passed away was a well-liked student from, you know, teachers liked her, the other students liked her. She had siblings in the school that everybody knew. Her parents were like kind of well-known within the school community, so I think it kind of depends on who the child is. If it's a person that's quiet and not friendly with too many other students, then they may not get the same type of attention … I think that may all play into … what's all done for that student in terms of like memorial.

Conversely, another teacher said that the lack of support that he felt from his school was the lack of "toughness." That it was from the school being too sensitive to student mental health needs, and not putting enough emphasis on discipline. This teacher felt that schools in general were becoming too "hypersensitive" and schools should be more about academics and less about the mental health of the students. This teacher believed this had something to do with the hiring process in schools nowadays. He stated that "back in the day" administration was mostly male gym teachers or male social studies teachers and now, administration is mostly female, special education teachers.

> Females especially. They're all female. So they're, the reason, you know, that the change has shifted is because … back in the day those phys ed teachers were just dry and straight to the point, like they weren't about feelings and how a kid feels and how a kid, you know, is going through their day, their experiences. All we talk about is experiences now. How does a kid perceive school? Do they enjoy being in school? And the number one priority is, do they enjoy being in school.

Fear of reprimand. Along with the lack of emotional support and skepticism about concerns being taken seriously, teachers described the punitive culture in their school as a main deterring factor to building a working relationship with administration. Many teachers spoke about how they were forced to internalize, and not voice their feelings or frustrations to administrators for fear of having a "target put on their back", or being told that "they did not have any classroom management skills", and that they were "not a good teacher." A teacher explained:

> And I think that that's what's been lost, the fact that teachers are still human beings with emotions and feelings that get hurt really bad. You know, it's definitely one of the things I struggle with…looking around and going nobody else cares, why am I doing this.

Another teacher stated that if you didn't give a 100%, then you were not seen as a good teacher, and that most administrators wouldn't hesitate to say "Well, then maybe you need to find another school." She added, "but nobody can give a 100%."

When asked what would be helpful in decreasing this fear toward administration, many teachers said they would just like a safe space to vent. One teacher explained that she felt guarded even during this interview:

> You know, even like talking to you I feel like I need to be like careful with … how I describe students and describe myself, like I don't want to say the wrong thing but, you know, I'd just like to be able to genuinely like describe what's on your mind even if it's … unfair towards the student, like even if you know like the student is going through a hard time and it's not their fault that they're acting out, you know, just to have that space to vent and … not fear retribution from administration or anything, like that would be helpful.

In lieu of this distrust between teachers and administrators, one teacher was asked if teachers ever tried venting their frustrations to the mental health professionals within the school. This teacher replied that he spoke to only the ones he trusted, stating, "I do on a rare occasion because I trust certain psychologists and social workers, that they won't just go run away and tell a principal." The severity of the toxic relationship between teacher and administrator led one teacher to seek outside counseling. She described how role-playing with her therapist gave her more courage to speak up for herself in school. She stated:

> And I also think that like I lacked the language to communicate with my superiors, so like sometimes, I would disagree or be frustrated by something that the administration would tell me to do, and I didn't know how to either say no or to interject and like make a suggestion, so I would always just be saying yes to things that would lead me to be frustrated and resentful. So basically, finding like

> a counselor was good for me to sort of like role-play scenarios and to find language that's still professional but enables me to like say no and … I think that sometimes like bosses … don't realize when they're sort of taking advantage, or like dumping too much on somebody. And if you don't know how to say no, or if you don't know how to advocate for yourself, I think you're just gonna kind of get buried in work. So that for me was like one of the, the real, I guess like catalysts behind wanting a counselor.

Several teachers also mentioned transferring to another school solely because of the toxic environment created by administration.

> I switched schools because the administration was horrible and I really thought they were going to ruin my career. I don't, like I don't know how many New York City DOE [Department of Education] teachers you've talked to but there is such a culture of like distrust and hostility of administration. Like some people are lucky to work in a school that's like really transparent and great administration, but principals have so much power to like make your life miserable, and I really saw that the first year and I really felt like I was being pushed out so I was like, okay, since you want me gone, I'll leave.

Another teacher described how she cried every day at her old school, adding that "everything was our fault. The kids failed; it was your fault. If the kids cut class, it was your fault." This teacher also said that the vulnerability that teachers without tenure felt was often used as a terror tactic against them by administrators, stating that,

> you have like these terror administrators, like at my old school, you know, literally it was, I'm out to get you, watch out and like, … they use like these terror

> tactics that like you're fearful because … not having tenure it's like you could lose your job at any minute … , one child's accusation can cost you your career … and there goes your teaching license…. But don't get me wrong … there are bad teachers out there but, you know, for the most part we're pretty good people.

One teacher described how her principal would publicly shame teachers. When asked to elaborate, the teacher explained:

> Like they would send out emails that were like clearly directed towards one person that could have been just addressed to one person, but to the whole staff. Or being yelled out in front of our class of students or in front of our coworkers…. I mean, it was like completely unnecessary, unprofessional work environment and that's the reason why we had 10 teachers leave last year … because it was miserable.

It was explained that this type of "harassment" that teachers felt was more common than the general public realized, however, not all schools had this level of severity. Teachers who had said that they transferred schools because of harassment from administration were asked to describe how they felt after the transfer. The relief some teachers felt was very apparent in their responses. One teacher exclaimed,

> I was like shocked and I was like, is this place real? I thought it was like an imaginary place where I was respected, because I just thought that what I was experiencing in my old school was the norm. And when I came here, I was like, wow, like I'm a professional. People are treating me like I'm a professional. At the old school I felt like I was still being treated like I was a student, you know.

When asked why the relationships between administrators and teachers were better in some schools and not others, some teachers felt that it was due to having a strong union presence or active parents who advocated for fairer treatment toward teachers. One teacher described the removal of the principal in her school:

> That person was fired, and we are lucky because we have parents of students who are, are very active and there were several protests that happened throughout the school year and … a lot of articles, a lot of interviews, and it was really bad.… So, we had a favorable outcome, but not every, not every school is that strong with their community.

Unrealistic demands. In addition to the lack of support from administration, another major component of the "broken system" identified by the teachers were the unrealistic demands placed on them by the school and the state department of education (DOE). Aside from mental health stigma, another frequently cited challenge to providing mental health education in schools was class size and an already demanding curriculum that left no time to add new material.

Class size. All teachers agreed that including this new addition to their curriculum would not be effective or even possible if class sizes were not reduced. On average, teachers taught five classes a day with about 34 students in each class. All teachers (N=20) agreed that teaching nearly 170 kids a day left it impossible to really know or build a rapport with each individual student they taught. Teachers said that the students they knew well were the more out-spoken ones or the students that spoke to the teacher after class. They also went on to explain that when providing education on a topic as sensitive as mental health, there needs to be level of trust and a relationship

between the student and teacher. Students need to connect with the teacher in order to feel safe talking about their mental health needs.

When asked to name one thing that would make it easier to spot signs of mental health issues in students, one teacher explained that having a smaller number of students in the class allowed the teacher the ability to pick up on patterns of behavior or non-verbal cues of distress. She stated:

> I think smaller class size is definitely, you know, make it more effective and given not having … as many kids lets you, you know, have better relationships with the kids that you do have. I mean … that would actually, I think would help in the scheme of things of noticing trends or picking up on, you know, mental health issues that, you know, you might not pick up on when you have 162 kids.

Another teacher emphasized how easy and common it was for emotionally troubled students to fall through the cracks or be completely overlooked solely because of the massive number of students in the school. In addition to smaller classes, she also mentioned needing more teachers, and more classrooms to spread students out. She explained:

> I think that the biggest thing that would help would be smaller classes. Hire more teachers because then we can know our students better and we can pay more attention, and sometimes that could be the frontline if it's something that's, you know, I had a class with 13 kids last year. That was unheard of. And I knew every single one of those kids. I knew their behaviors, I knew their feelings, you know, because you can't hide in 13. But when you have a class, cause New York State, with New York City you can have the most 34 kids in my class so it's, you

> can easily get lost in 34, especially if you're a quiet kid. But I think if you had smaller classes that would just help us as teachers both help the kids academically but also it would allow us to get to know them more so we can then see them. Like, so I, I would, that would be my first thing, smaller classes. More teachers, more rooms, smaller classes.

Time. Between the large class sizes and the existing curriculum demands, all teachers (N=20) said that finding time for themselves, their students, and the work that needs to be done was extremely challenging. As such, time was identified as one of most difficult barriers to the implementation of a curriculum inclusive of mental health education. Several teachers mentioned how they often worked an additional three hours past the end of the workday just to catch up. One teacher explained, "You know, in high school you don't have just one class, you have five classes, so that's 160 kids and, you know, when you give an essay that's 160 essays to grade." The immensity of the impact lack of time had on teachers' stress levels was a common thread throughout the interviews.

> I love everybody who says 'Oh, well, you get two months off in the summer.' I'm like, yeah, and I do 12 months' worth of work in 10, you know. And I say, everybody else has the opportunity to become a teacher, you know. And I say to them, 'spend one week in my shoes to see if you really can do this for 180 days.'

Every teacher interviewed also stated that it was rare that teachers ever took their whole break time. The allotted break time among the teachers varied from 30-45 minutes. One teacher estimated that at least 90% of the teachers in the school worked through lunch. Interestingly, one teacher said that her lunch period was too short to

actually even do work. When asked to elaborate, this teacher explained that her lunch break was 30 minutes and since her school did not offer food or have a cafeteria for teachers, she has to walk 10 minutes each way to buy lunch. This left her 10 minutes to eat lunch and be ready for her next class. Many teachers also said that, often, their lunch time was the only time they had to meet with students, and if a student needs to speak with the teacher "you're never gonna say no, and if that's your lunch period, that's gonna be your lunch period, you know." One teacher expressed sorrow over having to say no to students who have asked her "oh can you come to our basketball game" or "can you come to our play" because of the lack of time.

Additional challenges. New York State was referred to as a "big testing state" by one teacher. It was explained that in New York State, the Regents Examinations are standardized tests that measure student achievement in high school level courses. Passing Regents exams in at least five different subject areas is a statewide high school graduation requirement. Many teachers also felt that testing was emphasized more than actual learning, largely because teachers were rated by how well their students did on these specific exams. Without tenure, this "rating" affected their job security. According to several teachers, preparing students for Regents exams, along with the large class sizes and the limited amount of time, was near an impossible task, without the addition of the new mental health education requirement. This frustration was echoed by one teacher who firmly stated:

> So realistically, you know, it would be tough to implement if I'm being held to the high standards of the state assessment that I have to get my kids to pass, and that's just reality speaking. That's not my own personal opinion … If I gotta, you

know, stuff 10 pounds of crap in a five-pound bag as it is now, how would I be able to incorporate another two pounds into that bag?

This teacher was asked to share his thoughts and feelings on how mental health education could be successfully incorporated into his school's curriculum. He emphasized that,

> if you want to do it right and you want to really incorporate this into the curricula and make it really stick then, yes, I think you would have to shrink the already extensive curriculum that we have squeezed in, in order to do it right. I'm not talking about half assing. If you want to half ass you could probably half ass it. But if you want to really do it right and, and get this, this knowledge to the kids and, and have them understand and be able to cope then, yeah, you gotta cut from somewhere.

Teacher retention. Teachers were asked to describe how challenges such as the lack of support from administration or the unrealistic demands put on them affected teacher retention rates. All teachers agreed that this was a profession with a high risk for "burn-out" but most teachers also said that they wouldn't leave the profession because it was their "calling".

> I've definitely seen a lot of young teachers that haven't been in the profession for as long as I've been, they kind of pull back because it can be, one, emotionally draining, two, the demands of teachers, demands that are placed on teachers to, you know, they want, the administration sometimes want you to, you know, make wine out of water and sometimes there's a lot of unrealistic goals that are placed on educators and, you know, I do see a lot of it affecting teacher retention. I see a lot of people who might start off as teachers, once they get into the profession

> they see how it is and they see the respect that, you know, teachers get from sometimes the students, sometimes the administration, sometimes parents, you know, they say, they say it's not worth, it's not worth their time, it's not worth the money. Me, I'm a, I'm gonna be a lifelong educator. This is something that I love to do, something I am passionate about. You know, I love teaching. I love working with young students. I love working with students in general to try to help them, you know, reach goals and reach places that they didn't think, and for me it's more about giving back. You know, I wouldn't be around right now if I didn't have teachers or, or people help me along the way. So that's what I try to be, you know, to the students that I have at this point.

Several of the more experienced teachers (>10 years of experience) stated that they were concerned about the younger teachers. They felt that the turnover rates for the new teachers was the highest it's ever been. One teacher stated:

> I see it all the time. I've been a teacher, like I said, about half of my life. I always wanted to be a teacher, and I, since I was little, since I was 5, and I've always wanted to teach where I teach. It was just a calling for me. But I look at teaching like a calling. I'm, I'm, I'm scared I'm burning out but I don't plan on leaving it because what else am I gonna do? I worry for new teachers. I worry that they're not taking care of themselves in a way that's gonna allow them to stay in this for the long haul. I worry that they're too invested, which sounds horrible, but you have to at some point understand that you can't be a child's teacher, parent, counselor, friend. You can't. Not if you're gonna do this for another 30 years, you know. I, I, I have a fear of burning out, I'm tired a lot, but I do still

love what I do. I do love working with teenagers and I love teaching. It's all the stuff on top of teaching that's so hard, like dealing with mental illness. It's hard.

This sense of frustration and the high levels of anxiety and stress was a common thread in the responses from many of the teachers who spoke about burn-out. One teacher stated:

> For me, I'm, I'm an overachiever so, I mean, as much as I can get done in the shortest amount of time is my goal. So not decompressing, sure, it affects me. I'll have days where I come home and I'll just like, oh, my God, I didn't even eat lunch today or, you know, I've gotta grade all these papers and just like it doesn't turn off. There are days when I come home and I'm just like so exhausted mentally that, you know, my husband will say to me like 'Oh, what did you do all day, like you get home at 4:00 and why are you so tired?' Like I think, I think there's a common misconception with teachers in general where, there's a misconception with teachers in general that, oh, you know, they have all these days off and they have summers off, but we truly need that time to like rest our brains because our brain's just going a thousand miles a minute all day, and it doesn't stop when the school day stops because you're still coming home and doing a heck of a lot of work.

Many teachers also said that the burnout or even temptations to leave the profession were not so much from the students as it was from the pressures from administration.

> The thing that drives me to burnout is the administration and the constant changing of rules of what you can teach in a classroom and what you can't and … you have to test on certain things over the course of your year. You don't really have time to take 20 minutes to get to know your students. If somebody came in

and observed you, and it happens from time to time where you start a conversation and then, you know, things open up and this happens and that person talks and this person, and you learn a lot about your students that way and, and if someone ever observed you, you would get a development rating and then you would be on probation and that kind of threat is really a large stress and problem.

This teacher went on to say that over the last year, nearly 40 out of 100 teachers in her school left, primarily because of the principal at that time, who has since been replaced. "There was a lot of … people who left because they … were not given tenure, they were targeted … I know if they had known a new principal would have been established, they probably wouldn't have gone."

Insufficient resources. Another important indication of a "broken system" was the insufficient resources identified by the teachers. Primarily, the role of parents and other disciplines in the management of student mental health issues was discussed. One teacher also explained that providing mental health education to students will be ineffective if the system is so broken that these kids cannot even get resources such as basic healthcare. When asked to elaborate, she explained that in her school, the only health care provided to students was through an on-site clinic. However, access to this clinic requires the parents to register their child. Without being registered, student's "can't even get a Band-Aid." This teacher added that because of the urban setting where her school is located, many of the students' parents are illegal immigrants who don't want to fill out any paperwork out of fear or lack of understanding. So those students cannot access the free health services provided by the school.

Role of other disciplines. The ratio of mental health professionals to student body varied from school to school. Some schools had mental health professionals that were part-time and only came into the school a few days out of the week. One school did not have any mental health professionals; however, this school had a clinic where students had access to mental health professionals from the local hospital. In another school, the teacher said that they had one school psychologist for a student body of 4000 kids, but another said that their school had two psychologists for 1300 students. The teacher with 4000 students to one psychologist stated that they also only have one social worker and one mental health counselor, which is why, teachers prefer to deal with their students' mental health issues themselves rather than refer their students to these professionals.

> So that's why the teachers don't turn to the first line of defense because there are more of us and we see the kids, and we see them every day, and we can also sometimes judge how a child is because we see a change in behavior, you know, they're putting their head on their desk instead of sitting up, they're, you know, the kid who always dresses to the nines and comes to school like it's a fashion show, you know, for a couple of days they wear the sweat pants and not caring as much so that is where we, there again we're the first line. But, yeah, no, that's, the numbers are not on anyone's side and that's just I think part of being in an urban school setting unfortunately.

In another school with three psychologists to 2100 students, the teacher explained that she often hesitates to refer students to psychologist's that she doesn't have a friendship with. She stated, "I personally go out and find the psychologist/social workers if I am

friendly with them. If I'm not, I don't do that anymore cause I end up getting in more trouble than, than they do." When asked to elaborate, she stated:

> When I go talk to a psychologist sometimes what I say to a psychologist or a social worker they'll overreact and then be like a, you know, a situation that, I don't know, it just becomes something that I don't want it to become. Some people you can talk to, some people you can't, just like, I don't know, everywhere you work, I guess.

Several other teachers also described only seeking help from counselors or administrators with whom they had a friendship with because of similar fears.

All teachers (N=20) said that they had several guidance counselors in their schools but were unsure whether the guidance counselors had any type of mental health qualifications. Teachers were asked if guidance counselors, since they outnumbered the social workers and psychologists in each school, had a process for checking in on each student. One teacher stated that they had a policy that required all guidance counselors to meet with each student once a year, but the purpose of this meeting was mainly for scheduling classes for the following year. Several other teachers also stated that the primary role of guidance counselors was to monitor the student's academic standings, assist with scheduling, and provide guidance for the college application process. One teacher stated:

> It's really focused on like grades and how they're doing academically and like passing classes and things like that that seems to be like the concern. I don't know if there is time to be checking in emotionally … I don't know if they have opportunities to do that, check in with them emotionally frequently.

Although many teachers said guidance counselors did not have a process of regularly checking in on every student in the school, most teachers said that students struggling emotionally or having behavioral issues were still referred to the guidance counselors. In these cases, sometimes the guidance counselor would meet with the student directly, or redirect the student to the school psychologist or social worker. However, teachers also said that psychologists usually only dealt with students who had a documented disability or mental illness. Another teacher gave a lengthy description of her perception of the school psychologist and guidance counselors roles:

> They do have a school psychologist. There's one for about 3,000 students. And he mostly works with students who have IEP [Individualized Education Program/Special Education] situations, so developmental and intellectual, developmental, emotional, kind of things that are all tied into that. Students who have like clinically depressed or have medication, I don't think that he really sees them for that. If there's an episode perhaps maybe they would go speak to him but I don't actually know the process for that. The guidance counselors. I assume when students have an issue, they go to a guidance counselor…But I think that the primary role of the guidance counselor is college stuff and getting through academics. I don't really see it as an emotional support system at all. And there's a, and I've seen that over the course of, of many years, and even when I was in high school, I never went to my guidance counselor if I had a problem. It was always, I always had to go for sign up for this class or a grade or do we get the college letters in or whatever it was. So, I, I don't see much more than that now but it's not to say they don't do a lot of work. They do a tremendous amount of

> work, probably way too much from what they should be able to do, for them to be able to provide some sort of support but they do try to push kids into college, pump them out, like here's your letter, here's your letter, and you know, and that's good but I don't know what else they do provide to other students.

Similarly, one teacher was very clear in stating that "the guidance counselor's role really is to do scheduling and programming. It's not guidance."

Although often the only licensed healthcare professional in the school building, school nurses were not viewed as resource for mental health by nearly all (n=19) of the teachers interviewed. The only teacher who said the school protocol was to reach out to the school nurse when dealing with a mental health situation also went on to say that, "I mean you're supposed to call the nurse but I'll be honest with you, nothing usually happens after that." When asked to describe what role the school nurse had in mental health, one teacher replied:

> Very minimal. I'm not even sure, this, we, not even sure that she's really a nurse. I don't know her qualifications … the joke in the school is my kid says they have to go to the school nurse, you know, I ask them "do you need a Band-Aid or an ice pack?" That's all you get from her.

Two other teachers also used the terms "Band-Aid or an ice pack" when asked about the school nurses' role. One teacher said that she believed the school nurses' job was "almost just doing paperwork for vaccines." Another teacher felt that, "the nurse plays more of a, a role as far as emergency.… She would be coming up to, to check to see if the ambulance does need to be called. So more of a, an emergency role for the nurse."

When asked to elaborate why the nurse wouldn't be called in a mental health crisis situation, one teacher replied:

> I mean, I do know that nurses can administer medicine … but I just … don't think I would turn to her for any sort of like help, like, oh, this kid's, you know, having a breakdown in class, can you come help, because I don't really have a sense of confidence through my interactions with her that she would know what to do or really be of any, be of any, you know, I, I, again, I do know that nurses, kids will have, you know, they are limited by, by law what they can administer, which is minimal, but I, I think I would rather just have my colleagues help me on my floor near me than call her.

Role of parents. Teachers also identified parents as having the potential to be a great source of support for them and their students, however, often parents did not live up to this potential. One teacher described it as having "two sets of rules" or "school versus the family" situations. This teacher described how disheartening it is when he works closely with the students to teach them about healthy emotional outlets, only to have the student go home to parents who negate everything he's taught. Teachers also described how some of their kids came from homes where the parent was often absent and the responsibility of caring for themselves or their siblings often fell on the student.

> I also think in general a lot of our students don't have a great support network at home so some of them are in temporary housing, a lot of them are those sort of latch-key kids that come home and they're like left to their own devices, a lot of them are taking care of younger siblings or even like nieces and nephews that maybe one of their teenage siblings had a child very young, so I think that like all

> this responsibility and then they have to come to school and they have to sort of switch gears but they're not really able to do that because they're tired and they have so much on their plate and then, you know, all of that, they're not taking care of themselves and so I think small things can set them off

One teacher stated, "Many of them don't have the family support at home as a unit. You might have a family vacation but that's pretty much it.… They're going home to an empty house or they're eating dinner in their rooms." Another teacher described her failed attempts at trying to reach out to parents and involve them more in meeting the teacher's and student's needs. She explained:

> Like I've like texted parents, you know, your student is going to fail because they're not turning in assignments, or you know, whatever, and they'll just like text back, you know, 'Okay.' And to me it's like, you know, I wish you could like, or I've called, you know, to have a conversation about it and have gotten answers like 'Well, what do you want me to do' or like, you know, 'What do you expect me to do about that,' and it's like, all right, I don't think we're on the same page here, you know, if you can't get this kid to turn in their work. So, I don't know, I guess I just wish like they were a little bit more proactive when I reach out to them with issues.

When speaking about unsupportive or challenging parents, several teachers brought up "the parents who declassify their children are the worst in terms of their willingness to seek out real help." It was explained that some students who came into high school were classified as having issues such as learning disabilities or behavioral issues. Having this classification allows the student to have access to a variety of

services and accommodations in school such as mandated counseling with the school psychologist. However, when a parent thinks their child has no problems and say, "I don't want my child to be classified anymore … then all of those services go away and you're left, you know, you're left with what you're left with." When asked what steps the school can take when a parent de-classifies a student, teachers said that there was very little they could do other than just "wait for the other shoe to drop." One teacher stated:

> When a parent declassifies a student … we're stuck. It's very frustrating. You feel annoyed that you are responsible for this kid and, you know, in your face, whatever it is, and then there's that little bit of 5 or 10 percent where you feel bad because you know that most of these behaviors of this kid are not their fault, but then at a certain point you just, you lose that pity because you're like this is just, this is too much.

A teacher, who spoke about parents accusing the school of picking on the student and denying that their child needed help, made a striking remark that "if that parent's not worried about their kid then they're blind to the fact that that kid could just grab their weapon and come to school and do whatever they want." Teachers also spoke about the role culture and legal status played. Some families were resistant because mental health issues were "taboo" in their culture. Other families were residing illegally and the fear of deportation kept them from being in close contact with the school or seeking outside help for their child. Finally, when asked what the teacher would do to support better mental health for their students if they had a magic wand and unlimited resources, one teacher simply stated: "I would give all of my students a lot more supportive families. Is that an option?"

Theme 2: Mental Health Issues Impact Teachers and the Classroom Environment

All twenty participants interviewed agreed that mental health issues had a strong impact on both teachers and the overall classroom environment. Teachers shared stories about disruptions they have dealt with in the classroom, how they handled it, and how it impacted their ability to teach. Teachers also spoke extensively about the effect that issues with students had on their own mental health.

Impact on classroom environment. When asked if and how mental health issues among their students impacted the class, teachers explained that many times these issues caused disruptions that affected their ability to do their job effectively, one teacher explained:

> It's extremely, it can be very disruptive. It can also just affect the general tone of the class, you know, depending upon the severity of the situation. So, if it's somebody whose mental health issues are causing them to act out, you know, in an attention seeking way then obviously that can be very disruptive. If it's students who suffer from depression or from anxiety about participating, for example, then you can have low rates of participation. There's a whole spectrum of ways that it can affect the class.

Similarly, another teacher stated:

> With certain kids that I had who had really bad depression it kind of depended on what type of depression they had cause some kids would just be quiet and some withdrawn, whereas my more manic kids or bipolar kids, you know, would sort of snap out of nowhere and then all the attention would be taken from teaching to

> then trying to, to help the student who was completely derailing everything that was happening in class.

Some teachers described the importance of "choosing your battles" because addressing every "…outburst, every like, cursing, things like that, it just, you know, would get so excessive and sometimes, you know, you get the sense that like addressing it would escalate it even further …" and lead to turning it into a show for the whole class. One teacher feared that addressing behavioral issues with certain students could lead to aggression, explaining that:

> If it was a real extreme thing where, like I had a student who had, who had a bad anger issue and … it would escalate very quickly oftentimes into a physical altercation, so it really depended on the student, but typically I would, you know, address it to I acknowledged it, wrapped up so the other students could get working, and then deal with the student afterwards.

Teachers also explained that disruptive students who were sent out of the room frequently would miss class time, and often fall behind. However, they also recognized how difficult it is "…to get anything done in the class academically when they're struggling with their mental health." One teacher expanded on this stating:

> As a teacher I'm like trying to make these kids pass their test, make sure they understand math and little things but like there are times I forget that like they have lives outside of their class where they go back to homes where it's not always the best situation for them. You know, I think I have to always come back and be like they have other stuff going on, you know … but, yeah, I mean, I do after school like think about it all the time.

Several teachers also described feelings of guilt about taking learning time away from the other students by spending time with a student who was disruptive or having an emotional outburst:

> It was frustrating cause … I had goals to accomplish and I had students who needed to take exams at certain times and I, I also would feel badly for the students because they were impacted by this, but they wouldn't get my attention the way that other student would and oftentimes throughout the year, like last year I had three really rough classes, and I, I kept apologizing … 'I'm so sorry, you know, this is disrupting your education, … please know it's not personal' and, thankfully, my kids were great.

One teacher also shared a story of a time when she was speaking with a student and became concerned about his safety, and as a mandated reporter, had to report the situation. Knowing that the student wanted her by his side until he could be taken somewhere safe, this teacher explained that she missed "… like three periods of teaching that day. Luckily, I had a co-teacher for all my classes … so I was able to step away and take care of that business. It's not the first time something like that happened."

Impact on teacher mental health. The powerful impact that issues with students had on teachers' mental health was described by all participants interviewed. They described the difficulty of setting boundaries and not getting too emotionally invested. One teacher explained that, even with the knowledge that the student's anger or outbursts were probably due to stressors outside of the classroom, it was still difficult not to be hurt or take it personally, stating that:

> It is, it is upsetting … I feel so bad for so many abused kids … like they don't have another outlet for like expressing, you know, when they get angry or … overwhelmed or depressed, …I know … it's not like a personal thing like when they act out or they get angry at me … but it, it still feels upsetting ... especially when like from my perspective, you know, all I'm trying to do is, is help.

Many of the teachers interviewed spoke extensively about the painful struggle to not let issues with their students impact their mental health. They described how challenging it was, because " … you think about these kids, like, oh, did he go home and did he calm down, did she, you know cut herself," and at times, it was impossible to not be distraught by this worry:

> It affected me because it made me feel … upset that some students have had to live that type of life. It also kind of brought me back to what I kind of grew up with and making connections with some of the students, and it was just very hard sometimes to, to hear those stories and to not get emotionally involved.

Teachers also discussed the challenge of finding a healthy work-life balance without feeling like they failed their students or did not care for them.

> Before I became a mom, my sole purpose on this planet was to be a teacher … But now … I struggle with how do I split this, how do I give all my love to my son and all my love to my kids.… I don't want to say [I'm] not as invested … cause I still love my kids and I make sure that they know that on a regular basis because I know that my kids don't always hear that so I'll tell them."

Although all teachers explained that student mental health issues had a significant impact on their own mental health, some teachers stated that the ability to "not take

problems home" was a skill that they developed with experience. Several teachers recalled their first year of teaching to be one filled with anxiety and frequent crying.

> My first few years, definitely, but with experience comes, I guess, I don't know, the ability to like turn it off when you go home because it's one of the most important things if you want to be a teacher for a long time you have to have a separation between your personal life and your professional life, and if you don't it will destroy you.

One teacher recalled "… in the very beginning how I'd be crying every single day, every day" and another stated, "Being a first-year teacher, I would never, ever want to do that again, it was the worst year of my life." Many teachers described how it took years for them to develop coping skills and strategies to separate their professional life from their personal life. One teacher followed up that statement by adding in that she worried for the mental health of the newer and younger teachers who have not learned those lessons yet. Still, it was emphasized that this was "not the kind of job you can turn off in your head", and that there were always days when it was impossible not to bring home some worries, no matter how many years of experience they had teaching.

This could be why most teachers felt it was important to have a strong support system at home. A few teachers said that their best friend or significant other was also a teacher and that it made it easier to vent about their stress. One teacher said "I'm also fortunate that my husband is in the same business … and so are my best friends, and nobody, I think, understands teaching unless you are a teacher because it's a totally different from any other job." In addition to a support system at home, several teachers said that they were in therapy or on medication or knew other teachers who were. Two

teachers said that they hadn't realized the intensity of the emotional toll their job had on them until they started therapy. One stated about her first visit to a therapist:

> I wasn't planning to like talk about my job. It was, I was just going, you know, for other things that I wanted to talk about but, you know, she asked about teaching, and we got onto the subject of it and I realized like how much, you know, it was on my mind about it and how much I did want to talk about it. And I think it is like really cathartic to just be able to vent, I guess, and express frustrations.

Another teacher stated, "Well, I am on two different kinds of medication (laughs) for my own like mood stability, and a lot of times it didn't, like I never really put two and two together that the stress was work related." Throughout the interview process, it became very clear that student mental health issues had a powerful impact on the mental health of teachers and how difficult this made their jobs and being effective in the classroom.

Theme 3: Student Mental Health Challenges in Schools are Complex and Multifaceted

The third theme to emerge from content analysis was that student mental health challenges in schools were clearly a complex and multi-faceted problem. The teachers interviewed were able to identify some of the most common mental health challenges that their students face. Teachers spoke about depression and anxiety and how certain mood disorders presented in the classroom. The role that homelessness and hunger played among some students was also discussed. Teachers expressed their fears related to safety and shared stories about violence in the classroom. Several teachers spoke about students from their school who had passed away from suicide, homicide, or drug overdose.

Suicide and self-injurious behavior. Teachers were asked to talk about different mental health issues that were common in their school. Several teachers (n=10) said that suicidal ideation and self-injurious behavior was common among students in the school they taught.

> Self-harm is super, super common. It's way more common than a lot of people realize. It happens all the time. Which isn't something that is necessarily you have to report, but like if a kid comes up to me obviously, I would have to report it but a lot of times there's nothing that happens because cutting isn't necessarily related to suicidal ideation, right? They're two completely different, different things and cutting is super, super common. Suicidal thoughts are also very common. Like as an individual teacher … like students only come to me like a handful of times but like in the context of … the school … it happens, a lot, a lot.

When asked if they take these students' mental health issues home with them, one teacher spoke about the recent death of a student, and stated "When there's a death I have trouble sleeping for sure…Do I take it home? Absolutely, oh, absolutely. Does it cut into my life? Definitely. There is no way to turn it off and, and this is not just current students." Another teacher was asked if suicide impacted the way she behaved or interacted with her students:

> I absolutely believe that this is, this is, it's taxing. I, I had one particularly bad year that opened with one of my students completing suicide and then closed with a student attempting suicide by jumping off the 59th Street Bridge, … it was really intense for me. I was on edge a lot. Any time a student said anything to me I would like take it like … as though it were going to be a suicide attempt … I

became almost overprotective of my students and I didn't think about how much longer I could deal with that while it was, while it was happening.

This teacher was asked to describe what the school environment was like that year. She was asked if there was a supportive culture in the school that helped her work through her grief and emotions. She explained that the school personnel were often overwhelmed with the number of students they had to emotionally support, and often, this was prioritized over supporting teachers during these events. She stated:

> It's supportive to an extent. Like everybody's there to do their job and everybody's there to deal with, like we deal with 200 students a day so there … there's a lot of like dealing with students and then putting your own issues on the back burner and dealing with just students, just students who are having issues, like dealing with the suicide of their friend or dealing with, you know.

Teachers also spoke about the rapport that they built with their students. They explained that some students felt safer opening up to their teacher more than they did with the school counselor or even their parents. In these situations, dealing with the suicide or attempted suicide of that student was often devastating. One teacher described how strong the relationship with these students were by sharing a story about a past student who had graduated and started college. She said that she found out that this student had committed suicide, and that she was the only one invited to the funeral: "Even though I knew like the mother didn't want anybody at the funeral. She actually asked for no one at the funeral except for me." When asked to explain why the mother allowed just her to attend the funeral, she stated:

> Cause I, me and this student had a, like a very close relationship. She was my student … she talked to me and I might have been the only person in the building that she had like a relationship with, and she knew that her and I, the mom knew her and I were close.

This teacher, who clearly was speaking through tears during the interview, said she believed that this student struggled with leaving the familiarity of the high school building, entering college, and being separated from the only person she had a connection with. This teacher battled with the thought that, maybe if she had kept in touch or checked up on this student after graduation, it might have made a difference.

Anxiety and depression. Teachers were asked to share their experiences with anxiety and depression among the students they taught. Although most teachers said these were common issues they saw, two teachers attributed this to just "teenagers being moody". Several of the more experienced teachers (15+ years of teaching experience) felt that mental health problems such a depression had become more common than when they first started teaching. As one teacher put it:

> Well, I've been teaching in public school for 15 years and I have seen, the last three years I've seen such an increase of kids who are dealing with mental health issues, whether it be identity issues, whether it be, you know, social anxiety, whether it be, is they're curious about their sexuality. There are more and more kids who are seeking help from guidance and from the school psychologist, and also many of them who come to the teachers that they are close to and they confide in them. So I've seen this big shift in the classroom as well with kids just visibly, nonverbally, you know, their nonverbal body language, being upset or,

> you know, the way they dress and, with their hoodies on, their head always on the desk, and many of them are struggling with many other issues outside of academics. They're walking into the classroom with it, they're walking into the school with it, and very often I find that it's only in school that they feel that they are supported and cared for. So, there's a, there's such an imbalance in the last three years in terms of the content that we teach and everything else. So, I would say that a good 80% of what I do in my day is everything else.

Half of all the teachers interviewed (n=10) also spoke specifically about the severity of anxiety symptoms in the students they teach. When asked how prevalent anxiety among high school students was, several teachers commented that testing anxiety was the most common mental health issues they have come across in the school setting. Some teachers felt that testing anxiety had become more and more common throughout their years of teaching. One veteran teacher, when asked if dealing with anxiety, depression, or suicidal ideation was common, stated: "I will tell you this, in the 16 years that I've been teaching, it's become more prevalent in the last three or four years." When asked what this increase could be attributed to, one teacher pointed out that "New York State is a big testing state, there's a lot of mental health issues related to that." Another teacher gave an example of testing anxiety that they had observed in a student a few hours before their interview:

> The most thing is like test anxiety, specifically today I was giving a test and you see these kids like putting their heads down, they start like shaking their legs rapidly, you know, exhibiting signs of like anxiety, like being upset, visibly upset, visibly distraught.

Similarly, when asked what testing anxiety looks like or how anxiety presents itself in the classroom setting, a teacher explained:

> Oh, it depends on the kid. Some, some kids shut down completely. They'll put their heads down and like totally like cut themselves off. Other kids will act out, so like they'll start talking, they'll like throw things, they'll like try to get attention somehow so they don't focus on the test. Some kids won't come to school that day. Some kids will cry, you know. So, it really depends on the, there's a lot of different ways that test anxiety will, it kind of presents itself in a lot of different ways, a lot of different coping mechanisms that kids have learned over the years to deal with it.

Homelessness and hunger. Two teachers, who said they taught in a "very urban" school, spoke about the role that homelessness or hunger played in the behaviors of some students. They spoke about how they have to constantly remind themselves how challenging it is for a child to pay attention in class when the child was busy worrying about where they would sleep that night or where their next meal would come from. A teacher explained:

> Either you have kids, at least in my school, who have no food when they go home so, and, and that could be a big part of the depression and them being detached in class as well.

When asked about how their students, especially those who were minors, could be homeless when New York State has so many resources available, one teacher provided a very descriptive summary of what they have experienced:

> Yes … there are resources put in place but, you know, sometimes it could be … just not getting along with the mother or the parent. Parents have … thrown their kids out cause those kids don't want to listen … So, you know, we've had kids that have had to … bounce around and, you know, we as a school once we find about it … we try to … do everything in our power to make sure the kid is, you know, placed somewhere, whether it be a residential facility or … we'll try to talk to the police, you know … if you have home liaisons … that, you know, travel to the homes to talk to the parents … sometimes when you have kids homeless also … they might want to stay in our home district but they might have to be transported from over an hour away depending on where their shelter is. So, … like I said, that's something else that a lot of our kids have to deal with. They have to, you know, they don't want to start a new school, they don't want to have to go to a new place…. It kind of causes them to drop out.

Both teachers also discussed how such factors sometimes led to students acting out, or displaying aggressive behaviors, or becoming easily angered.

Violence, anger, and safety. When asked to share their experiences with aggression in the school setting, several teachers described feeling "on edge" around some students. They described always having to "be on your toes" with certain students because they tended to be impulsive with their reactions or had a history of "going from 0 to 100" as one teacher described it:

> He's had breaking points where, you know, he's physically harming himself in class so it's just a little concerning, especially like, you know, you have to be on

your toes with students like that, like you can't say the wrong thing to them cause you don't know if they'll lash out at themselves or if they'll lash out at you.

Another teacher described the feeling of terror when a student was "lashing out":

> You know, when a kid is sort of seeing red and flipping out, you don't know what they're gonna do. You don't know if they're gonna try to flip a desk, you don't know if they're gonna try to punch a window. So there have been a few times where I've definitely like gotten, I've moved. I've moved myself or I've gone behind a locked door where I know I'm not gonna be crossing paths with somebody who's upset. I think that's really, I think that's really the only times that I've felt unsafe, when, when a student is sort of in that heightened emotional state and I'm possibly in the line of fire.

Some teachers shared stories about the lasting effects an experience with a threatening or violent student had on them. One teacher described how an incident nearly 15 years ago still causes her to be on guard and fearful around some students:

> I get scared, I drive to work every day, and I park in front of the building and there are times that I have worried that a student would write down my license plate or destroy my car or something to that extent. When I was much younger in my teaching, close to, let me see, like 15 years ago I had a student who I had problems with in my class. I had taken a class trip and he like stalked me on this trip, like he followed us to where we were going, like got on the same train as us, and it scared the shit out of me. And then my apartment got robbed, I would say maybe like a year later, two years later, and one of the things that they kept asking me was like do you have anyone that like has a personal vendetta against you.

> I'm like, I'm a high school English teacher. I'm sure there's somebody that hates me … and I kept going back to that one kid, and I was like, oh, my God, like what if it was him?

Another teacher spoke about how a student who had assaulted her in the past was put in her class again, and described the detrimental psychological effects this had on her. She described feelings of being re-traumatized:

> And then they put the student who had assaulted me in my class, which … triggered me, yeah, it triggered me and I, I completely, I, I completely lost my shit which really is kind of the best way to describe it and it was, it's, it's been very difficult. I, you know, was in therapy for other reasons, for my own mental health, … I definitely suffered from some PTSD…. There were some points even last year that I had considered checking myself into like, you know, some type of psych center so I could just try and put my brain back together and just pull myself back together. It was very hard.

This same teacher went on to describe another situation where she witnessed another violent event in school:

> I mean, I watched the head of security, who's a very good friend of mine, literally like, like, like restraining this girl who was beating the shit out of him and, you know, just kept punching him and punching him and, and I was like I can't, like I can't even imagine, like I, like I said, I was assaulted. That was fucking difficult enough … but then seeing this it's just like horrifying.

Teachers were asked to describe some of the "types of students" they felt on edge about. Some teachers shared that they often were concerned about students who were bullied, or were "loners".

> There's a student in particular who displays signs of kind of like he was stalking students, … he would have way too much information about them or a teacher, he would be able to access addresses. So that was kind of scary because the students obviously didn't react well to that and that resulted in him being bullied a lot, so I think a lot of times if I'm seeing a student that is maybe socially bullied and is on the receiving end of a lot of bullying that's a little worrying to me. And then the other direction that I worry about is just that loner type of student who isn't connecting with anyone or has this pent-up frustration towards teachers or students for, for any reason basically.

One teacher discussed how easily many of the students he was concerned about had access to guns in their homes and the fears he had about those kids.

> You know, a lot of, there's a lot of gun owners in our area that I'm not aware of and, and these kids have access to those guns. And so these kids that … the kids that are struggling in school, the kids that are, that I personally don't know but I see and I kind of know them because, you know, I see them in trouble sometimes, do I know that that kid doesn't have a weapon a home. I have no idea. But I do fear that, because it's so readily available cause I do know parents that own guns. And I do know that those parents don't see the kids the same way that we see the kids in the school.

Teachers were also asked to describe how they managed situations where a student was violent or threatening and how they responded. One teacher who described working in a "very urban" neighborhood, was also asked how often he dealt with aggression and how he handled it. He responded:

> Every day. Every day. I'm doing it every day. You know, particularly for the few students that I have, but I'm a big guy so, you know, for me, you know, I try not to make them feel threatened where they have to be on edge or, you know, that they feel like I'm gonna do anything to them. So, I always try to come with … a warmer, soft approach, nothing aggressive because, you know … when you know that the students feel like they have, already have backs against the wall then that's when they're gonna lash out.

This same teacher was asked if he had any training on how to respond to aggression in the school building and if it was helpful. He replied:

> Yeah, yeah. They do, you know, the de-escalation techniques, you know, they always try to talk about like … deep breathing, they try to tell us to, you know, if a student is … being violent … to not put your hands on anybody … wait for … school security to come, or crisis team may have to come if they need to but, you know, some of the things that I have problems with is … God forbid I'm not gonna stand around and see a kid getting … beat up on and I do nothing and wait for somebody to come. You know, I'm gonna do my best to … intervene just to kind of … seize the other kid, you know, so at that point, yes, they do try to give us training but I think a human instinct takes over a little bit more and sometimes those techniques kind of get thrown out the window.

This teacher went on to describe the value of building a trusting relationship with students in these situations. When asked if he ever worried about weapon use in the school, he was able to depict just how powerful building a rapport with students was for the overall safety of the school. He stated:

> You never know what these kids are carrying in their bags. You know, we find everything from knives, tasers, pepper spray, blades, the major thing is, you know, for one building a rapport and a trust with the kids that I have and you know, knowing that, if they know that I'm gonna go to bat for them, they know that I'm gonna run through a brick wall for them. We've had that, that trust between us so if they do have something in their bag, you know, I always ask them 'Look, if you have something in your bag you need to give it to me right now.' I'm like … no judgment.

He also explained, in the neighborhood that he teaches in, many times his student may be carrying a weapon for their own protection. He spoke about how he hesitated confiscating the weapon indefinitely in those cases. He explained:

> Sometimes it's, I'm just gonna hold onto it, you know, because I don't want to see them get in trouble, cause I know these kids that I deal with, it's a safety issue sometimes. Sometimes they gotta walk home and some of the kids might get jumped or somebody might try to rob them. Sometimes they'll be carrying a weapon on themselves more so for protection and not cause they're gonna do something malicious in school. So, you know, I worry about that or I worry about a student getting to the point where they just get fed up and they might do

> something to another student but … not to be naïve, I don't think they'll try to do something to me.

This teacher went on to describe how intense his feelings of responsibility to protect the students, or "my kids", as he refers to them, was. He stated:

> I don't feel unsafe but I, I'm always on edge as far as, you know, keeping others safe. You know, as a father myself, my fear is, I want my kids to be as safe in their school as possible and to me it's their teachers' responsibility to make sure that they are safe, and if I have an incident with a student, I don't care where I'm at I'm going to try to defuse the situation as much as possible or, you know, get us to the point where that student that's causing the disruption is getting to a place where he can be safe or, where that student is, you know, at a place where he can be calmed down. I'll even remove my students from the room and call security for them to come in and, you know, I think at the end of the day, my job and my responsibility is to make sure everybody in that room is safe, the person that's the aggressor as well as the people that could be victims as well.

Drug use. All teachers (N=20) said they were aware of drug use in their school. Most of the teachers (n=18) stated that marijuana was the most used drug, along with the newer trend of vaping or JUULing. One teacher spoke about how it was hard to find students who didn't use Marijuana,

> you know, five, six, ten years ago you would find those kids who said 'But I, I don't do it, you know. My friends might do it but I don't,' … you found at least those few kids who said, 'I just, I don't smoke pot', but now they all do it. They all do it. It's not alcohol anymore, it's everything else."

However, several other teachers said that although Marijuana was still common, vaping and heroin use was also becoming just as common:

> I think like before like it just used to be like marijuana, weed. I think now it's like the whole vaping is a big, big thing, the whole Juuling thing now, and even now like I've said before the kid that passed away we heard it was a heroin overdose, and I heard that that's become a big thing around also.

Similarly, another teacher stated:

> Every kid, I would say probably 65 to 70% of students in my school smoke at least weed. I can say that a hundred percent. You know, and that's self-proclaimed. They have no problem admitting it, you know. I, I've dealt with a lot of kids who are literally high in school and then, you know, and the demographics of the district that I'm in, heroin is also, it starts with the pills and then it moves on to heroin.

Teachers who spoke about kids coming into their classroom high, were asked to describe how they knew the student was high. One teacher said "Sometimes we can tell that they're definitely under a substance in the classroom and in those cases that they're almost, you know, more subdued so they're, want to put their head down, they don't want to work." Another teacher shared an example of a student she had in the past that often came to the class high:

> Towards the end of the school year I could tell that he was either taking pills or something else and you're also not allowed to accuse anyone of doing that so for the guidance and the dean I would say 'You know what, he goes to the bathroom a lot. When he comes back or during these days, you know, I see this in his eyes

> or he doesn't answer very well,' and they take note but I can't call a parent and say 'I think your child is on drugs.' So there are things that I witnessed, when you're an adult, things that you see, that I can't prove that he went in there and did that and it wasn't a smell associated with anything, but when someone is under the influence, whatever it is, you can tell with their eyes and how they react and he had a personality when he was on, a personality when he was off, a personality on something else, and that's really hard to talk to anyone besides the school staff about.

Several teachers also shared stories about students who had died from overdosing on drugs. Perhaps the most profound statement that was really telling of how problematic drugs were, was from a teacher who stated,

> I've been to too many funerals as a teacher, to kids who have, who have overdosed in the past 16 years that I've been in education. So, it is definitely something that is prevalent and toxic in the district that I work in for sure … from the teaching standpoint, I gotta tell you, it's almost like, almost jaded or immune to the fact that once every two years or so I'm gonna hear about a student, a former student, that died, you know. It's kind of … I remember that kid. Yeah, it was one of those good kids that got with the wrong crowd, stuff like that. So, it's kind of like, almost expected. It's scary.

This teacher was asked if these overdoses were clustered in the more recent years or spread throughout her 16-year career. She responded:

> The last eight years I've been at the high school and, you know, you, you don't see it so much while they're in high school. It's like usually two, maybe three

years after they graduate is when you hear the, the horrible news that they did overdose, you know. But a lot of times I've, I had, I had one student two years ago who had two stints in rehab and he was a junior in high school. So, you know, it is starting at a young age and nowadays kids as young as the middle school are getting involved in … weed and, and experimenting with pills and stuff like that because they have older siblings that get it for them and, you know … pills become too expensive because, you know, it's like $90 or whatever for a pill, they turn to heroin which is way cheaper.

Theme 4: Effective School Mental Health Education needs a multi-faceted approach

Almost in response to the third theme that emerged, "student mental health challenges in schools are complex and multi-faceted", the fourth theme that emerged was that to address the problems found in the third theme, a multi-faceted approach needs to be taken in order to effectively address the issues the teachers were describing. It is questionable that the State's mandate to incorporate mental health education into the school curriculum would even begin to make a difference in the overall health of the students and/or teachers. To determine how teachers felt about this they were asked to describe what type of mental health related initiatives have been taken by their school, if any and whether they thought they were effective. Teachers spoke about various mental health programs and services or clubs their school offered. (NOTE: Since the names of the schools were not collected, it is possible that more than one participant may be talking about programs in the same school that they work in). Teachers also discussed facilitators to the successful implementation of the new mandate for mental health

education. The results obtained provide suggestions on how to encourage and support school administrator and teacher acceptance of this new mandate.

Current practices. Two teachers described a period in each student's schedule called "Advisory". Both teachers described this advisory class as "circle time" where the students are able to talk about their problems or vent. The frequency of this class each week depended on the grade level.

> Yeah, when they come in as freshmen they're assigned to an advisory teacher, and then that advisory teacher has them in freshman year five days a week, like a regular class. Half of it is advisory … and then the other semester is health … sophomore year, junior year, senior year, it's the same teacher but they're either two days a week or three days a week.

One teacher described the purpose of advisory is that, "these kids understand that there is one adult in their life that's not a teacher, that's not a parent, that's not a relative that's here to support them on a personal level … like 'hey, what's going on'." However, this teacher felt that this was too much of a "hippy-dippy" approach, and expressed skepticism about the effectiveness of this advisory program, explaining that since teachers are not required to teach anything during this period but just talk to the students, and because,

> it's not a class, it's not part of our rating, it's not part of anything, there are plenty of teachers who literally do nothing, like nothing, don't even acknowledge them. And what ends up happening is by the time these kids are seniors, 40% of them don't even show up anymore.

When asked what she does during her advisory period, this same teacher went on to state,

> Nothing. I talk with my girls, but for the most part I'm trying to work, and I tell them, I'm like 'listen, you know, this is the one class you girls see your friends, you know, it's a chance for you to treat it like a study hall,' and it's essentially a home room because the reality is I'm teaching five classes. I can't, I can't figure out how to do a curriculum for another class and it's, it's not worth, it's not worth anything either. It's not a credit.

Some teachers spoke about a certain day on the academic calendar dedicated to mental health. Two teachers described their schools having a "coping day" where speakers would come in and speak to the 7th and 8th graders about topics such as suicide, depression, eating disorders, and cutting classes. One teacher said that the first year they had coping day, it was only for the 7th graders and it went very well. However, the second year, they had both 7th and 8th graders, and since the 8th graders had already heard the speakers the previous years, they were very disruptive. Subsequently, "the 8th grade teachers were not too happy … so they're trying to do another Coping Day but the 8th grade teachers don't want to do it anymore. But the 7th grade teachers are willing to try again." Grades 9-12 were not included in Coping Day at this school and the teacher was unable to speak about why that was. The second teacher said that in her school, the speakers talk with the students for 40 minutes and then this is followed up with a "round table discussion" led by 11th and 12th grade students who ask the 7th and 8th graders about their daily lives and give advice on how to cope in certain situations. This teacher felt that coping day in her school was helpful for the students.

One teacher said her school had a "challenge day", which is an all-day event where the school hires an outside organization that comes into the school and,

> they pick out these, you know, kids who they feel have mental health issues or are depressed or whatever else, and they pool them together and they choose leaders, school leaders as well amongst the student body. So, you might have a good 70 kids participating in this, and you have some teachers who either volunteer or who are assigned and, you know, it's a whole way of kind of just sharing your emotions through the different activities, you know.

This teacher went to say that she felt this was just a "band-aid solution" where "they come in for a day and they're gone, and that's it." Several other schools also discussed programs where outside mental health organizations were hired to come into the school and work with the students, provided education on mental health, or offering counseling services. One teacher said that they had an outside organization coming in but they stopped that because "…the people were always late and it kind of turned into a hassle." Some teachers said that they had in-house counseling programs. A teacher described such a program in her school:

> There is like a full-time counselor. Students can go whenever they want pretty much. Like sometimes in class, you know, people will raise their hand and ask me like "Can I go see this guy," and I'll say yes…. It's like, you know, he has an office. It seems really welcoming. There's couches and I know it's kind of like a safe space for a lot of students.

At another school, which had grades 7-12, used "teaming", which was a process in their school where all teachers that teach the same group of students met once a day with the guidance counselor to talk about issues each saw in a student and get

background information on the student, as a way to help 7th graders transition into the school:

> So there's certain like 7th grade, you know, math teachers and science teachers and social studies teachers so we all teach the same group of students so we all meet together a period during the day and we discuss any type of issues that we see with a student and we try to see if it's something that is happening in all the classes. And sometimes the guidance counselor is talking to the parents and, you know, finding out extra information and letting us know about … any other type of issues that they were having.

This teacher explained that prior to teaming, teachers often did not speak to guidance counselors who were privy to such information. The teacher went on to say how it had tremendously helped in improving the effectiveness of their teaching because they had a better understanding of each individual student's issues and learning needs. When asked why such an effective approach was not continued for the other grades (8-12) the teacher explained that this was just to help students transition in smoothly from elementary school, but that she would love to see it happen for the other grades as well.

Another program, mentioned by only one teacher, was a peer mediation program where, a student who is trained mediates conflict instead of school personnel, such as the school dean. The teacher stated that this approach helped communicate to the students that,

> …you're not automatically gonna get in trouble for every little drama that you participate in but at the end of a peer mediation the students sign a contract where they have to agree not to continue whatever behaviors led to the mediation and

then if they violate that contract then they can face like school discipline, like a detention…. Whether or not it's really working I don't necessarily know. I don't have that data.

In order to become a peer mediator, there is an application and interview process on how a student would handle certain conflicts. The student also needs character references from teachers. If approved, the student trains after school with role-play scenarios and "learn the language and they learn how to sort of deescalate and to remain neutral if they were…put into a mediation situation".

When asked about what emotional support was available for teachers, most said there were no formal programs in place to help them. Some teachers said they felt comfortable approaching the school counselor with their own problems or the psychologist to vent, if they had a friendly relationship with that person, however, they did not know if this was "allowed". One teacher stated that an email was sent out saying that health services, including access to the school counselors was limited to students only. Of the 20 teachers interviewed, one teacher said that their school started a new program this year called "brain power" which was developed specifically for teachers. In addition to teaching about how to recognize signs of mental health issues in students, they also offered yoga and stretching exercises to help teachers decompress from their day. When asked how this fit into a teacher's schedule, which was often very hectic with little free time, the teacher explained:

We have mandated day and time … for professional learning and it's within that timeframe. Through our contracts we have … allotted amount of time, like 180

minutes or something, of professional development and they do it during that time.

Teacher acceptance needs. Throughout the interviews, all teachers made it clear that for a teacher to accept and follow through on this mandate, certain factors must first be addressed. One teacher spoke about how health education in her school was currently being provided:

> It's not really part of the curriculum. The way my school is structured is that the way health is taught and I think this is probably the way it ought to be schooled, they don't require a health teacher. They kind of just give us a day of training and say 'go for it,' except the focus is more on sex ed than anything else, … the lessons are there, they exist, but … you're teaching without a license and there's not enough training … like I am not comfortable teaching this. I have no training in this.

Teachers pointed out several other barriers to acceptance as well. For example, some teachers felt that it was not their job to teach mental health and did not want to have a role in supporting the mental health needs of the students. One teacher stated:

> We can't do that without being, without being, without having a degree in it. I can't speak of mental health and give people information or talk about things that I, I might say the wrong thing. I will never do that.

This teacher, when asked what they would do if the topic came up with one of their students, stated, "Then I would say 'Okay, you know, we can talk about this with the guidance counselor.' I can't give my, my opinions or feelings or anything. I would report it right away." Several teachers explained that there were some teachers, particularly

older teachers, who are more resistant to change. They explained that getting buy-in from those teachers would be difficult. Teachers were asked to share what they thought would help get buy-in from that group:

> It can't be that Band-Aid solution; it has to be something very mindful that we practice and apply every single day, and that has to be the culture of the entire school. You all have to buy into it. So if you had, so, you know, teachers who have been teaching for 30 years and say 'Well, you know, when I first started teaching we didn't have to do this, our kids just sucked it up or whatever and you're just gonna have to do it, too,' you have to have them onboard as well, period.

One teacher explained that mental health education must be introduced in a way where teachers don't feel like it's a "mandate" that is there just to make the "higher ups" feel good. This teacher compared mental health education to the mandatory sexual harassment online modules they take. The teacher pointed out that although sexual harassment is an important topic, most teachers look at the training with cynicism.

> Like we, … teachers have to take like a sexual harassment online workshop every single year … but is it actually gonna stop sexual harassment in the workplace? Like I'm doubtful about that. So, I think it would just have to be something that feels like genuine … and … meant to help the students instead of just being like some, you know, person in Albany … making us feel like we're doing something.

Another teacher, who also felt that most of the resistance would come from the older, more veteran teachers, stated:

> …but I think that now that we have a lot of younger teachers coming in and a lot of the older teachers are now phasing out, they see the importance of having it because of all of the things that are happening in schools, because of the school shootings, because … you have these kids vaping, because you have … the presence and drug use that's been going on and where a lot of our kids are now falling into those … type of perils. You know, I think that they really are seeing the benefits of having whereas … some teachers who have been teachers for a long time … they might have more of a tough love approach … whereas a lot of teachers who are a little younger they see the benefits.

When asked if mental health education is a good idea, although most agreed it was, they also added that as far improving the mental health of the students, mental health education alone would not be enough. That a multi-faceted approach that addressed class size, academic demands, availability and access to resources, educational material, more teachers, and more counselors were needed.

The teachers were also asked to expand on things that would increase their confidence in providing mental health education. Some teachers suggested better communication from the guidance counselors. One teacher pointed out that students are often pulled out of the class to meet with the psychologist or counselor. This teacher says she is never told ahead of time, so the student ends up missing valuable class time. She also suggested that the counselors communicate that these are the days the student will miss class and that "these students have identified or we have identified them they need these types of services. No teacher is going to say no." Teachers also shared that they receive almost no information on the personal background of their students. One

example a teacher gave is when the parents of her student died in a murder/suicide and she had no idea. She explained that it's difficult to teach student's if the "the red tape of HIPAA" prevents them from knowing what the child is struggling with.

One also spoke about having the autonomy to create a curriculum that works for them in their classroom. Another teacher spoke about the school having the autonomy to create mental health programs that work for their students. The example this teacher gave was about teaming. This teacher said teaming allowed her to tailor her teaching to meet the learning needs of each individual student. However, this model of teaming did not work well in the other schools in the district. She explained that as a district, "we're supposed to be doing the same things throughout all the schools." As a result, as effective and as beneficial as teaming was for her school, there was a chance that they would have to discontinue using that approach. This teacher emphasized that having the autonomy to create mental health programs or teaching curriculums that met the needs of the students in each individual school would help her feel more confident and accepting this new mandate.

When asked what else teachers felt they would need, several teachers mentioned access to resources, content material, sample curriculums and lessons, and the support and guidance of a mental health expert such as the school counselor. Teachers made it clear that providing mental health education would be a failed intervention if teachers are not given proper guidance.

> But as [with how] so many laws are, okay, we're gonna put this in your curriculum but we're not gonna tell you how, figure it out and, you know, again, I hate to even keep doing this but I've been in this long enough to know that, okay,

> you're gonna pass this law and in about three years everyone's gonna forget about it, and there's not gonna be any support or training so it's really not gonna be done right. It's gonna be done maybe half-assed and it's not really gonna help anybody cause at the end of the day there's not enough people to help the kids that need the help they need.

One teacher expressed that certain topics like suicide made some teachers uncomfortable and that training goes a long way in de-stigmatizing mental illness and helping them not see certain mental health terms as "dirty words". Another stated:

> You know, it's kind of a serious responsibility, you know, to think if I was the one to teach students about this, I would not want to get it wrong so I'd want to feel like the most prepared that I possibly could, whether that means training or, you know, in the beginning I got like actual lesson plans or curriculum would be the ideal.

Another teacher also agreed that before mental health education can be effectively provided to students, the teachers need to be trained appropriately first.

> I'd like to have some sort of training, … even some sort of certification in there to where I can, again, spot the symptoms, understand the symptoms, understand how to handle somebody who's having an outburst or a depressive state or whatever so that, again, I can handle that situation. So, the training I think is step number one.

This teacher was asked to expand on the specific topics he would want covered in this training. He replied:

> Well, … what am I looking for? What are the symptoms? How do I talk to this person who's dealing with bipolar? How do I deal with a person who's

> schizophrenic? How do I handle a person who has suicidal ideations? And what, what tools can I use to help that student, because if I don't have the tools, I'm not gonna go and put up sheetrock, you know, with glue. I, I need screws, I need a drill, I need spackle, I need all the correct tools to do the job. So, I can't help a student with these mental health issues unless I know how to handle it, and I have the tools necessary to handle it.

Similarly, another teacher also said that feeling confident enough to either teach mental health education or even to effectively support the mental health needs of her students, requires training. When asked how she would do the training, she replied:

> How can we do it? … I would say maybe just a weekly … some kind of weekly workshop, weekly prep, where it isn't given to you in one sitting like here … do this but it's almost like a, a development of the skill over time, not just, … we're gonna have this one 40-minute meeting, you're gonna learn about this and we expect you to use it all year…. A 20-minute meeting and, hey, try this this week, let us know how it goes. Try this … sort of development over time as opposed to just trying to build it all in one shot.

Aside from specific in-depth training, two teachers said that teacher buy-in depended heavily on whether the teachers believed mental health education works. "Teacher buy-in means results. So, like there needs to be something concrete that says this is beneficial for the students. If you can prove that what you're doing is helpful to students, teachers buy in."

In summary, there were four major themes presented with quotes supporting the theme or subcategories. All four present alarming evidence that there are serious issues

from the infrastructure down to the student level, and a simple, mandated mental health education program may not even begin to address the seriousness of the individual issues. However, the infrastructural issues are so severe, showing a completely broken system, that this may have to be the starting point before individual issues can be addressed. The results will be discussed further in Chapter 5.

Chapter 5: Discussion

This chapter discusses the findings of this study and the significance of this research. The implications these findings have for policy and practice are explored. Additionally, the limitations of this study and the areas for future research are also discussed.

Discussion of Results

The Theory of Organizational Readiness for Change (Weiner, 2009) asserts that "readiness" is a crucial and determining factor in the successful implementation of new policies or practice. Readiness precedes changes. According to this theory, one of the key factors affecting readiness to change is the belief of having the necessary recourses and a conducive environment for the change to occur. From the findings of this study, it became apparent that the depth and the complexity of the mental health challenges that teachers faced impacted their readiness to change and accept new policies or practices that may have seemed trivial compared to the reality of mental health issues as described during the interviews.

A good indication of the enormity of mental health issues New York State teachers were facing was by the question teachers spent the most time responding to during the interview. There were eight questions and several more probing questions that covered mental health education in schools, the New York State mandate, teachers' level of mental health training, and available resources and support. The first question asked during the interview was the only question that inquired about common student mental health challenges teachers faced and the impact it had on their own mental health. It was striking how each teacher interviewed spent most of the interview responding to this question rather than the other seven questions. The interviews may have been cathartic in

that teachers were able to finally tell someone outside the walls of their school, and was willing to listen, what they faced on a daily basis. Teachers spoke extensively about the various student mental health issues that they dealt with in school. They also shared how severely their own mental health was impacted by both student's severe mental health issues and school administrators who appeared less than supportive. In trying to direct the conversation to the questions about their feelings on mental health education, the mandate, and mental health resources, many teachers seemed to circle back to the first question. This seemed to be very telling of the extreme stress the teachers participating in this study are under when they go to work.

Towards the conclusion of each interview, participants were asked what they would do to support better mental health for teachers if they had a magic wand, and if policies or budget were not a concern. What was troubling about the responses to this question was just how simple most requests were and how some teachers just asked for the very basic things they needed to do their job. One teacher asked for 15 minutes of a mental health break during the day. Another wished to never struggle to find a copy machine to make copies for their class.

The students' mental health challenges that teachers identified were very complex and multifaceted issues. Several teachers talked about the time they were assaulted by a student or the fear they felt working with a student known for violent tendencies. Some teachers spoke about the times they found out that a student was not focusing in class because they were homeless or were busy wondering where their next meal would come from. Many teachers also shared stories about the students that they lost to suicide or to drug-overdoses. Despite the immensity of the mental health challenges teachers faced

with students, most teachers still described themselves as “life-long” educators and explained that teaching was a “calling” for them. One teacher described it as a her “sole-purpose” in life. The finding of dedication to the field of education was surprising when the results of the interviews revealed a very broken system with a lack of resources to help students overcome their personal issues, and an administration who seemed to ignore, or in fact punish, the teachers concerns and needs.

While discussing teacher retention and the factors that impacted the mental health of teachers or led to their burn-out, teachers described that it was not the students, but rather, it was the lack of support from school administration that was the biggest issue. This lack of support by the administrators was an unexpected finding. The lack of support from administrators in their school was described in terms of a lack of communication, concerns not being taken seriously, a punitive school culture, or an overall lack of emotional support. However, teachers appeared to be the most distressed by the fear of reprimand and the punitive culture in their school including threats to their job security.

The gap between school administrator and teachers, as well as the harassment from administration described by the teachers, created an environment not conducive to change. Additionally, teachers did not feel they had the adequate resources or the training to support the mental health of students or make changes in the curriculum to include mental health education that may or may not have been beneficial based on the complex issues these students appeared to be facing. As adequate resources are essential factors that impact organizational readiness for change, the findings from this study indicate that the successful implementation of this New York State law mandating mental health education for students would be extremely challenging, if not impossible.

Significance. The Theory of Organizational Readiness for Change falls within the constructs of implementation science, which is the study of the barriers and facilitators in translating research into policy and practice (Weiner, 2009). The results indicate there are problems in trying to implement this mandate in New York schools. First, the teachers interviewed in this study were not aware that such a law existed. Second, the findings from this study suggest that the breakdown was not between research and policy, but between translating this policy into actual practice due to a lack of resources as well as the complexity of mental health issues as described by the teachers. Although it was significant in discovering that there was a clear disconnect between the existing mandate for mental health education and implementing the curriculum into practice, discovering the severity of the mental health challenges impacting high school students and teachers in New York State was a far more significant finding of this study.

Policies on both the state and federal level that promote improvements in the mental health of youth is absolutely needed, however, there is a question whether the mental health curriculum alone can address the complexity of issues both at the student and faculty level found in this study. The Theory of Organization Readiness for Change (Weiner, 2009) points to the fact that even if the mandated curriculum was powerful enough to address the severe mental health issues students are faced with, the organization itself is too broken to implement the curriculum successfully. The results from this study can be a starting point in figuring out what, how and when changes could be made to make it more successful. At the moment, the results of this study indicate it would be a waste of time and effort to implement the curriculum under the conditions

found when these interviews were conducted. It should be noted that these interviews were completed a month before the COVID-19 pandemic ravaged through New York. Since that time, schools have been closed and the students with all these complex mental health issues are essentially on their own and may or may not be connecting with the school system virtually.

Limitations. There are several limitations to this study. First, the results are not generalizable to teachers in all U.S. schools or all areas of education. Policies affecting mental health services can vary from school to school. Resources and access to mental health services may also differ in each school, affecting the experience of the teachers. In addition, results are not generalizable to all school personnel. The different roles each person or discipline has in school mental health interventions can influence their experiences and perception of mental health differently. To support confidentiality, participants were not asked to divulge the name of the school where they were employed. However, this limited the ability to decipher if any teachers worked in the same school. For example, if half of the participants all worked in the same school, this would further limit the generalizability of the findings.

There is also a limitation in the method of recruitment. The use of Facebook limits the sample of participants to teachers who have Facebook accounts and are more likely to respond to Facebook posts. This method of recruitment is further limited to teachers who follow Facebook groups or pages for NY public school teachers, with the exception of those who were recruited into the study through the snowball effect (Valdez et al., 2014). Although the method of recruitment for this study is a limitation, recruitment in future research can be expanded to different social media platforms such

as, Twitter or Instagram – particularly focusing on the hashtag feature. Including relevant hashtags in the search terms can link the researcher to larger groups of users who may be interested in the study topic.

Recruitment on Facebook can also be a limitation in terms of verifiability of study participant identity. However, this limitation is outweighed by the benefits of social media recruitment. Facebook recruitment is an inexpensive and efficient way to quickly reach a larger group of eligible participants without having to recruit directly through the school setting. A single Facebook post can potentially be viewed by a vast number of eligible NY teachers at any given time. The ability for viewers to "tag" friends and share also allows for snowball recruitment to happen. In addition, Facebook recruitment can target a larger geographic area which helps achieve a level of diversity in regards to including teachers from rural, urban, and suburban areas of New York State (Dalessandro, 2018).

Policy and Practice Implications

The effectiveness of a policy is enhanced when all stakeholders are involved in the development of the policy (Kapiriri, 2018). However, the scarcity of qualitative research that explores the teachers' perceptions of mental health education, suggests that their perspective was not significant in the development of mental health education policies, programs, or curriculum changes. Teachers are highly involved in all facets of the school environment and are a key source of information on school practices. They have a unique perspective on the mental health needs and challenges facing students and are in an opportune position to observe the direct impact of a curriculum change through their close relationship with their students. Therefore, it is essential that both the health

and education sectors of the government recognize that teachers' perspective should be considered regarding what content is needed, but they should also be, included in policy development and the implementation of the program. The knowledge gained from this study highlights the integral role of teachers, the value of their input, and how they may potentially provide a bridge between the institutions they work in and policy makers.

The findings from this study also show that existing policies related to issues such as the maximum number of students in a class, the amount of break time allotted to teachers, and the allocation of educational funds and resources are not working and new policies that take into consideration the perspectives of all stakeholders need to be developed. Teachers are on the front-lines of this mental health epidemic, battling to protect our youth, while struggling to maintain their own mental health. More comprehensive health and safety policies need to be developed to support these teachers and provide them with the basic resources needed to educate some of our most vulnerable youth.

School nurses. One of the most alarming findings from this study was that school nurses seem to be invisible in the investigation of mental health in New York schools. Professional nursing organizations need to become more involved in developing policies that expand the role of the school nurse in promoting school mental health. It was discovered through the interviews that the teachers did not see that school nurses have a role in promoting the mental health of their students. This is an example of how a potentially valuable resource in supporting school mental health is gong unrecognized and underutilized. Several teachers used the term "ice-packs and band-aids" to describe what they believed the role of the school nurse was. This is unfortunate as evidence

shows that school nurses can play a key role in providing a link between educational and medical systems, even if not providing direct care services in the school. School nurses are well positioned to quickly recognize students who frequently visit the nurse's office with reports of aches, pains, and other non-specific physical symptoms. Research shows that children with such somatic complaints are four times as likely to screen positive with some form of anxiety or depression (Campo et al., 1999; Meesters et al., 2003). This can potentially make school nurses the first point of contact with children in emotional or mental distress, and provide an opportunity to intervene early by directing them to services within or outside the school setting. However, despite school nurses being a potentially valuable resource in promoting student mental health, school nurses were not acknowledged as a part of the mental health team by teachers.

Policies that mandate mental health education or any health intervention in schools should recognize that school nurses are licensed health professionals who can play a valuable role in improving the effectiveness of such policies. Including school nurses in the collaboration between education and mental health professionals can be crucial in the early recognition and treatment of student mental health problems and be a key step in improving the academic outcomes of children (Drake, et al., 2015). In particular, school nurses can play an essential part in the dissemination of evidence-based interventions to improve student mental health outcomes. With the increase in prevalence and incidence of mental health issues such as the high suicide rate among youth (Mojtabai, Olfson, & Han, 2016; Waller, Bresson, & Waller, 2006), the recognition and expansion of the school nurse's role in meeting the mental health needs of students is necessary.

Recommendations for Future Research

This study opens up many avenues for future research. It would be interesting to know how the demographics or socio-economic status of the student body affected the type of mental health issues that were commonly seen in the school. For example, in this study, one teacher who worked in an urban setting explained that the violence they feared was related to gang violence and drive-by shootings, and that school shootings were more of a risk in "white schools", referring to schools in the suburbs. Another teacher explained that the "choice of drug" varied between urban and suburban schools due to the higher cost of "harder drugs."

Another area to explore would be the perceptions of the school nurse. How do school nurses feel about not being seen as a mental health resource? Do school nurses prefer the basic "ice-pack and Band-Aid" role or would they like to see their roles expanded to support better mental health for students? Future research can also explore the role parents have in promoting or hindering the mental health of students and the impact parents have on the mental health of teachers. Additionally, a study re-evaluating the effectiveness of this mental health education mandate at the five-year mark could also be an area for future research.

Lastly, a study needs to be conducted when students return to school in New York State following the COVID-19 pandemic. With the severity of COVID-19 in New York, the student and teacher mental health issues identified in this study will possibly be amplified since the time this study was conducted. The current plan is for schools in New York to be opened by the Fall. When teachers and students return to school and

face this new post-pandemic reality of social distancing and mandatory masks, what will their mental health look like then?

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APPENDIX A

Consent with Waiver of Documentation

CONSENT WITH WAIVER OF DOCUMENTATION FOR

PARTICIPATION IN A RESEARCH STUDY

INVESTIGATOR'S NAME: NEETHU ARIKUPURATHU
PROJECT IRB #: 2016864
STUDY TITLE: New York State high school teachers' perceptions of the newly implemented mandatory mental health curriculum

STUDY SUMMARY

We would like to invite you to take part in a research study that we are doing to generate an understanding of the perceptions of experienced high school teachers in New York State on school-based mental health education curriculums, its implementation, and its effectiveness. If you are interested, this form will explain what will happen if you join the study. If there is anything in this form that you do not understand, please call 917-924-2890 or email NYSMentalHealthResearch@gmail.com for an explanation.

If you decide to take part in this study, we recommend that you print a copy of this form. Research studies help us to learn new things and test new ideas. Taking part in a research study is voluntary. You are free to say yes or no, and you can stop taking part at any time, without giving us a reason. There will be no penalty to you or loss of benefits. The purpose of this research is to form and understanding of the perception of experienced high school teachers in New York – on school-based mental health education curriculums, its implementation, and its effectiveness. High school, in this study, is defined as grades 9-12.

We are inviting you to take part in this research because you are a NYS public high school teacher. We will only include you in the study if you first give us your permission. We are asking about 20-30 people to take part in the study. Neethu Arikupurathu from the Sinclair School of Nursing at the University of Missouri is the Principal Investigator. Other members of the research team are: Dr. Tina Bloom and Dr.

Linda Bullock. Northwell Health, the Robert Wood Johnson Foundation, and the University of Missouri is paying for this study.

WHAT AM I BEING ASKED TO DO?

If you decide to take part in this study, we will ask you participate in an interview over the phone or through video chat, as you prefer. Although all interviews are confidential, information such as age, race, gender, years of teaching experience, grade levels taught, grade level currently teaching, types of schools (e.g., public, private, charter, parochial) you have worked in, and if you currently teach in a rural, urban, or suburban school will be collected through the demographic questionnaire.

You must give us permission to use the audio recordings we take of you during the study. For video interviews, only the audio of these interviews will be recorded. Audio recordings will not contain anything that might identify you. You will not be asked to share your name or the name of the school that you currently work at.

HOW LONG WILL I BE IN THE STUDY?

Each interview will last approximately 60-minutes.

CAN I STOP BEING IN THE STUDY?

Yes, you can stop being in the study at any time without giving a reason. Just tell the researcher or study staff right away if you wish to stop taking part. Also, the researcher may decide to take you off this study at any time, even if you want to stay in the study. The researcher will tell you the reason why you need to stop being in the study.

These reasons may be:

If you appear to be distressed during the interview related to sensitive topics such as mental health needs in schools, among staff and students, violence in schools, suicide or self-harm of students.

ARE THERE ANY RISKS TO TAKING PART IN THIS STUDY?

There are risks to taking part in any research study. There may be problems caused by the study that we do not know about yet. Some discomforts from being in this study include distress from interview questions, or discomfort that you or your school will be held accountable if the NYS mental health education requirements were not met. If at any point, you experience distress you will have the ability to terminate the

interview. Likewise, if the interviewer suspects that you appear to be distressed by the topic of the discussion, she may decide to end the interview.

Although you may be asked if your school has complied with the mandate, you will not be asked to share your name or the name of the school in which you are employed at any point during the study. If we learn about new important risks, we will tell you. We will tell you about any new information we learn that may affect your decision to continue taking part in the study.

WILL INFORMATION ABOUT ME BE KEPT PRIVATE?

The study team needs to collect some of your personal information. This information comes from questions we ask you during the interview and the Qualtrics survey you complete. One risk of taking part in a research study is that more people will handle your personal information. We are committed to respecting your privacy and to keeping your personal information confidential. The study team will make every effort to protect your information and keep it confidential to the extent allowed by law. However, it is possible that an unauthorized person will see it.

Please note that:

a) Participant names will not be collected in this study. The only identifiers in this study are phone numbers and/or email addresses to contact the participant.
b) Participants will be made aware of when the audio recorder is turned on.
c) Participants may end the interview at any time or skip any questions
d) For participants interviewed through video call, only the audio of these interviews will be recorded.
e) All study materials will be kept confidential and can only be accessed by the members of the study team. Only research team members with access to data will rigorously follow procedures to ensure confidentiality of data.

The information we collect from you for this study will not be used or shared with other investigators for future research studies. This applies even if we remove all information that could identify you from your information and/or samples. We might collect information from you that indicate the possibility of child abuse or neglect, or safety concerns of students such as self-harm, suicide, or imminent risk for violence. One or more of the study staff are mandated reporters. This means that they are required by law to report any of these findings to the appropriate state agencies. These agencies

include New York Statewide Central Register of Child Abuse and Maltreatment (SCR) and NYS Office of Children and Family Services.

ARE THERE ANY BENEFITS TO ME FROM TAKING PART IN THIS STUDY?

If you take part in this study, there may not be any direct benefit to you. However, we hope that by taking part, you will benefit from knowing that you are contributing to a knowledge base that has the potential to benefit students, teachers, and the overall school climate. Benefits are expected through the advancement of knowledge about common mental health issues, mental health resources, and skills needed to promote a culture of acceptance and safety within the school setting.

WILL IT COST ME ANYTHING TO TAKE PART IN THIS STUDY?

There is no cost to you for taking part in this study.

WILL I BE PAID FOR TAKING PART IN THIS STUDY?

In return for your time and effort, you will be receiving a $25 Amazon gift card.

WHAT ARE MY RIGHTS AS A STUDY PARTICIPANT?

Taking part in this study is voluntary. If you do decide to take part, you have the right to change your mind and drop out of the study at any time. Whatever your decision, there will be no penalty to you in any way. If the study investigator decides to take you off the study, she must explain the reasons. We will tell you about any new information discovered during this study that might affect your health, welfare, or change your mind about taking part.

WHO CAN I CALL IF I HAVE QUESTIONS, CONCERNS, OR COMPLAINTS?

If you have more questions about this study at any time, you can call the principal investigator, Neethu Arikupurathu at 917-924-2890. You may also contact the co-investigators, Dr. Tina Bloom at BloomT@missouri.edu, and Dr. Linda Bullock at lcb2u@virginia.edu.

You may wish to contact the University of Missouri Institutional Review Board (IRB) if you:

- Have any questions about your rights as a study participant;
- Want to report any problems or complaints; or
- Feel under any pressure to take part or stay in this study.

The IRB is a group of people who review research studies to make sure the rights of participants are protected. Their phone number is 573- 882-3181.

If you want to talk privately about your rights or any issues related to your participation in this study, you can contact University of Missouri Research Participant Advocacy by calling 888-280-5002 (a free call), or emailing MUResearchRPA@missouri.edu.

If you have any questions right now, please call 917-924-2890 or email NYSMentalHealthResearch@gmail.com.

APPENDIX B: Facebook Flyer

APPENDIX C:

Demographic Questionnaire

DEMOGRAPHIC QUESIONNAIRE

1. What sex do you identify as?
   ☐Male ☐ Female ☐ Other: _____
2. How old are you?
3. Which best describes your race?

   ☐ American Indian or Alaska Native

   ☐ Asian

   ☐ Black or African American

   ☐ Native Hawaiian or Other Pacific Islander

   ☐ White

   ☐ Hispanic

   ☐ Latino

   ☐ Other: _____

4. Are you currently employed in a New York State public high school as a teacher?
5. Do you have a minimum three years of high school classroom teaching experience prior to this law requiring mental health education in the school curriculum?
6. How many years of full-time teaching experience do you have?
7. What grade levels do you have experience teaching?
8. What grade level do you currently teach?
9. What types of schools have you worked in (i.e. public, private, charter, parochial)?
10. Do you currently teach in a rural, urban, or suburban school?
11. What type of classroom teacher are you currently working full-time as (i.e. math teacher, health teacher etc.)?

APPENDIX D

Pre-screening Script and Screening Questions

Note: Screening questions will be conducted through a Qualtrics survey to which a link is posted on the study Facebook page.

Pre-screening script and screening questions

Thank you for your interest in our school mental health research study. In July 2018, New York State passed a bill that said mental health education must be included in the curriculum of every public school in the state. Your school may or may not have responded to this mandate yet. The purpose of this research study is to hear about you, the teachers', experiences with mental health issues in school. We want to hear about your thoughts and feelings related to mental health education and about this new mandate. If you decide to participate in this study, you will be asked to take part in a private interview. The interview can be scheduled on a day and time that is convenient for you. You can also choose to be interviewed through a video conferencing app, Zoom, or through a telephone call. This interview is confidential – your name will not be put on anything and you will not be asked any questions that would identify you or the school you work in. You can skip questions you don't want to answer and you can also change your mind about being in the study even if you have already started the interview. If you decide to be in this study, you will be provided with a $25 Amazon gift card. You will be given this gift card even if you skip questions or change your mind about being in the study. If you are still interested in participating in this study, please answer the following questions to confirm that you meet the eligibility criteria for this study.

Screening Questions

1. Do you speak and understand English?

   ☐ Yes ☐ No

2. Are you over the age of 21?

   ☐ Yes ☐ No

3. Are you currently employed in a New York State public high school as a teacher?

   ☐ Yes ☐ No

4. Do you have a minimum three years of high school classroom teaching experience prior to July 2018, when NYS passed the bill requiring mental health education in the school curriculum?

☐ Yes ☐ No

If a participant answers "no" to any question, the survey will link to a page informing them they are not eligible and thanking them for their time.

If they are eligible based on their responses (yes to all screening questions), they will be taken to a page containing the waiver of documentation of consent for them to view and the option to "click here if you consent to participate".

APPENDIX E

Semi-structured Interview Guide

SEMI-STRUCTURED INTERVIEW GUIDE

The following is a general guide that will be used to interview participants. As participants answer questions, additional clarifying or probing questions may be added.

Examples of questions and possible probing questions are:

1. **Can you tell me about students' mental health issues you've had to deal with in school, and how this has affected you?**

   Possible probes:

   - How does this impact the classroom? your ability to do your job?
   - How do mental health issues in your students affect your own mental health or level of stress? (For example, are teachers having trouble sleeping, do they cry at home, do they feel burned out?)
   - How does this affect your own feelings of safety in the school?
   - How does mental health impact teacher retention? Do they think about leaving the profession, moving, or cutting back – or do they see other teachers doing this?

Can you talk a little about your level of preparation or support you have to address these kinds of issues?

Possible probes:

- Have you ever had any sort of mental health training? What kind? Is it enough?
- What kind of support is available in your school *for students* with mental health issues? Community? What is the role of the school nurse?
- What kind of support is available in your school *for teachers* to help them deal with these sorts of issues? Community?
- How do teachers talk about mental health with other teachers? With administrators?
- What is the "culture" in the workplace around mental health? Are they just supposed to suck it up, or is it supportive?

2. **Tell me a little about your thoughts on incorporating mental health education into the school curriculum?**

   Possible probes:

   - What has been the response in your school regarding mental health resources in the school or the idea of including mental health education in the school curriculum?
   - How helpful do you think it will be for you? For students?
   - How do other teachers feel about this?
   - How does school leadership feel about it?

3. **Are you aware that NYS law now mandates the mental health education in schools?**

Possible probes:

- How prepared do you feel to implement this curriculum?
- How prepared is your school for this change?
- What helps teachers feel more confident in making this change?
- What makes it more difficult to implement these kinds of changes? What are the challenges?
- Can you think of any factors that would facilitate the change in school curriculum?

4. **Can you tell me a little about whether your school has taken any steps to include mental health in the curriculum?**

   Possible probes:

   - What kinds of steps has your school taken?
   - What kinds of steps would you like to see your school take?
   - How do other teachers feel about this?

5. **If you had a magic wand and could do anything you wanted to support better mental health for your students, what would you do?**

   Possible probes:

   - What would you change or add?
   - What programs, resources?
   - What kind of support?

6. **If you had a magic wand and could do anything you wanted to support teachers in dealing with these issues, what would you do?**

   Possible probes:

   - What would you change or add?
   - What programs, resources?
   - What kind of support?

7. **Is there anything else I should have asked you that I didn't? Anything on this topic you'd like to add?**

VITA

Neethu Arikupurathu is a Robert Wood Johnson Foundation *Future of Nursing Scholar* residing in New York State. She holds a Bachelor's in Nursing from the New York Institute of Technology, a Graduate Certificate in Nursing Informatics from Chamberlain University, and a Master's in Psychiatric Mental Health Nursing Practice. She is board certified by the American Nurses Credentialing Center in Psychiatric-Mental Health Nursing. Neethu was the recipient of the Evelyn Schwartz Service Guild Award from the hospital that she currently works at, Northwell Health, for exemplifying the essence of nursing through leadership, volunteer work, and service. Neethu was also the recipient of the Sinclair School of Nursing Fellowship Award at the University of Missouri for her work supporting the healthiness of students within the public-school system.

Her research experience largely involves working with the high-risk adolescent population with mental health and behavioral issues. She has experience working with this population in the community setting doing mental health homecare visits and in outpatient mental health clinic settings. She also has several years of clinical experience working with psychiatric patients across the lifespan in an inpatient psychiatric hospital setting. Neethu is passionate about her research and hopes to continue her work advocating to local policy makers on vital issues concerning the mental health of high-risk adolescents.