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School Mental Health Guide for Educators

Yvonne Smith
Gardner-Webb University

School Mental Health Guide for Educators

by

Yvonne Smith

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Submitted by: Approved by:

_____   _____
Yvonne Smith   Dr. Cindy Miller

_____   _____
Date   Date

Approval Page

The following committee members have approved this capstone project:

_____   _____
Allison Gosda, MA, LPCS, LCAS, MAC   Date
Committee Member

_____   _____
Jill Duffy, MSW, LCSW   Date
Committee Member

_____   _____
Alicia Stanislaw, MSN, RN, NCSN   Date
Committee Member

_____   _____
Ashley McKinney, MSW, LCSW   Date
Committee Member

_____   _____
Nikki Lutton, MSW, LCSW   Date
Committee Member

_____   _____
Cindy Miller, PhD, RN   Date
Graduate Program Chair

Abstract

This Capstone Project explored the impact of providing a staff development program to
educators in a public school setting to address rising concerns over unmet student mental
health needs in this school setting. Student mental health response and referral had
become prominent concerns in the project school. The project leader developed two
separate sessions addressing adolescent depression and mental health. The sessions,
facilitated by the project leader and the project implementation team, represented the
interprofessional disciplines of nursing, counseling, and social work. Each session
addressed issues of confidentiality, definition and signs/symptoms of each conditions,
common treatments, evidenced-based classroom strategies and interventions, and
instruction in a simple, efficient school-wide referral process for educators to utilize to
refer students of concern to the building-based student support team. The participants
(91.11% of potential sample) demonstrated integration of the newly developed student
mental health referral procedure as evidenced by 213 referrals in the six-month post-
implementation period. Evaluation measures post-project were overwhelmingly positive
with all respondents answering strongly agree or agree to all project targets (improved
identification of adolescent depression/anxiety, awareness of common treatments and
side effects, knowledge of evidenced-based classroom interventions, the new school-wide
referral process, and understanding of the legal obligations of confidentiality regarding
student mental health information. Upon a two-month follow-up survey, 91.66% of
teachers surveyed had implemented at least one evidenced-based classroom strategy, and
97.22% of respondents reported greater comfort levels accessing student support services.

There was also an 80% reduction in psychiatric emergencies from the previous school year.

Keywords: adolescent depression, adolescent anxiety, school mental health, teachers

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all of you led me to continue when I was ready to give up.   I am so thankful God led me

to nursing; I have felt His support, comfort, and strength in each success and failure.

In Honor of

Tony, Zachary, & Isaac

Mom

Sue

In Memory of

Daddy

(1934-2009)

In Memory of

Cecil

(1936-2002)

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Problem Background and Significance

The public school classroom has evolved into an environment of diverse complexity as physical, mental, and social health needs and conditions have become paramount priorities, often overriding academic interventions and tasks. The capstone project, A School Mental Health Guide (SMHG): Education and Interventions for Teachers, focused on mental and psychosocial health education and interventions for classroom teachers in the school setting. According to Reinke, Stormont, Herman, Puri, and Goel (2011), 20% of children younger than 18 years of age have mental health concerns. This increases to 25% if children are living in conditions of adversity (Reinke, Stormont, Herman, Puri, & Goel, 2011). Mainstreaming efforts and practices have teachers in regular education classes, with no specialized training in student disabilities, attempting to educate and manage their classrooms with little to no staff development, or intervention-focused guidance (Capella et al., 2012). Although there are significant evidence-based interventions and approaches that encompass classroom management techniques and academic strategies for students with mental health conditions, the practice gap remains a reality, especially in the regular education classroom (Reinke et al., 2011).

The classroom environment in the school setting presents struggles on many levels as students try to reconcile emotional stability with academic progression and success. Classroom teachers struggle daily with the responsibility to educate not only these children but also other students who may not require mental health treatment but have additional educational and social needs. Due to current budget constraints and proposed additional funding cuts to decrease supportive services to these students,

classroom teachers are finding that they are providing care to students with serious mental health issues with limited community resources and few services or supports available during the school day. Issues of classroom and personal safety are paramount, as well as the additional issue of the weight of leaving these children behind educationally and socially. Neglecting the issues at hand may cause further deterioration and disconnect from school, compounded by the emotional wounds these children may already carry with them. At the current state of mental health service availability, it is a logical assumption that graduation rates may decline, youth legal services could implode, and school violence incidents may continue to rise. Students deserve mental health treatment and attention in school just as they receive care for diabetes, asthma, and other chronic health conditions. The treatment currently is unequal, as the emphasis has been on physical health concerns (Gampetro, Wojciechowski, & Siarkowski Amer, 2012). Without appropriate treatment, childhood mental health conditions may continue into adulthood. The National Institute of Mental Health estimates that approximately 26% of adults in the United States have a mental health disorder (Gampetro et al., 2012).

The public school classroom has evolved into an environment of diverse complexity as physical, mental, and social health needs and conditions have become paramount priorities, often overriding academic interventions and tasks. Teachers are required to provide instruction to all children but are not equipped with the specialized knowledge and information that may be critical in meeting the needs of children and adolescents with mental health conditions (Teacher Working Conditions Survey, 2014).

Problem Recognition

Below is information that demonstrates current student mental health data, nationally and locally, with a proposed staff development initiative to work toward improving instruction within the classroom and expediting student referral to appropriate agencies and personnel to facilitate treatment and care.

National statistics. Here is a brief overview of current mental health data in the United States.

- One young person commits suicide every one hour, 40 minutes (Facts and Statistics, 2013)

- Suicide is the 2nd leading cause of death for the young (1st accidents, 3rd homicide) (Fact and Statistics, 2013)

- One in five adolescents meet criteria for severe mental health impairment by 19 years of age, increasing to one in four if living in conditions of adversity

- In adolescents 12-15 years of age, 13% will meet criteria for a depressive episode within one year

- Currently only one in three youth that meet mental health diagnostic criteria receive treatment

- Only 50% of youth with a severe mental health disorder _ever_ receive treatment

- 80% of children in foster care have a severe mental health disorder

- Lesbian/Gay/Bisexual/Transgender (LGBT) youth are <u>twice</u> as likely to attempt suicide versus heterosexual peers (Centers for Disease Control and Prevention [CDC], 2015)

- Greater than 50 percent of transgender youth have at least one suicide attempt by the age of 20 (Youth Suicide Prevention Program, 2014)

- National Institutes of Health estimate 26% of adults have a mental health disorder

Local statistics. This information is pertinent to the designated county of the project population.

- County-wide data reveals 77 suicides, encompassing all race, gender, ages in 2010-2014, 55 males (Department of Health and Human Services [DHHS], 2016)

- 2013-2014 Local School District Student Health Report: 314 students with a diagnosed mental health condition, 1164 students have an Attention Deficit Hyperactivity Disorder (ADHD) diagnosis, approximately 10% of student population

- Local school district had 143 psychiatric emergencies for School Year 13/14, psychiatric emergencies were the leading cause of incident or injury, 2nd to 32 sprains/strains, 27 head injuries, 19 lacerations, and 18 fractures, (Department of Public Health, 2013-2014)

- School Year (SY) 13/14 had 3,277 individual nursing/student health encounters; 1,605 were encounters related to mental health (depression, mental health, suicidal ideation, self-injury, substance abuse, violence & bullying); 49% of school nursing encounters encompass mental health needs of students, (Department of Public Health, 2013-2014)

- County has approximately 254 children placed in foster care, with an estimated 102 placed in county, 223 students reviewed at district review team hearings, 17 alternative school placement hearings (Laws, personal communication, 2015)

- Local university has had four confirmed student suicides this academic year, with two additional cases with causes of death pending (Washburn, 2015)

Problem Statement

A significant number of adolescent students have severe mental health issues and concerns. Faculty and staff are not prepared or properly educated regarding classroom management and teaching strategies for this student population. The project leader will develop, create, and implement a staff development program to provide a foundation of information and knowledge to improve awareness of the conditions and symptoms of adolescent depression and anxiety, therapeutic communication within the classroom, and promote classroom management strategies for students who often demonstrate potentially unsafe and challenging behavior.

Project Purpose

The purpose of this project was to implement an education program for staff and faculty that included the provision of general information regarding the mental health diagnoses of depression and anxiety including presenting symptoms, commonly prescribed medications, therapeutic communication techniques, and classroom management strategies. This intervention seeks to improve academic, behavioral, and social outcomes for students with these mental health diagnoses, increase and expedite necessary student referrals, as well as increase comfort levels and bolster the teachers' skill repertoire.

Project Question or Hypothesis

Implementing a staff development program will increase knowledge and add to the faculty's skill repertoire. Program content included discussion and information of the conditions, symptoms, and treatment for adolescent depression and anxiety, classroom management and communication techniques for students with these mental health conditions, in addition to building a foundation and expanding the participants' knowledge of mental health issues for adolescents/children.

Definition of Terms

Definition and explanatory information for the following terms include:

- *Students*: Refers to students enrolled in a public school setting, grades kindergarten through 12th grade.

- *Mental health services*: Treatment options available to adolescents for mental health disorders, these are typically inclusive of medication management, outpatient counseling, family therapy, or intensive mental health services available in the home setting which usually involves up to three service contacts a week, parental support, and crisis management services.

- *School Year (SY)*: Refers to the academic school year, time frame includes first day of school year to the last required day of the school year, typically beginning in August and ending in June, 185 minimum instruction days or 1,025 hours of instruction.

Needs Assessment

The most current statewide Teacher Conditions Survey results showed that teachers report minimal staff education for classroom management strategies or specialized instruction for students with disabilities ("Teacher Working Conditions Survey," 2014). Results showed only 21% of teachers had 10 or more hours of training for classroom management issues and only 18% received 10 or more hours of staff education for students with disabilities issues, as opposed to over 75% for common core instruction ("Teacher Working Conditions Survey," 2014). An estimated 20% of adolescents will meet criteria for a severe mental health impairment by the age of 19 (Ramos et al., 2013); student mental health needs are lacking attention and teachers are ill prepared to address and understand a potential significant percentage of their classroom population. This creates a plausible unfair environment for the students and teachers involved. These understandable awareness gaps and omissions of teacher preparedness and knowledge can lead to a lack of supportive treatment referrals or jeopardize a sound, nurturing academic and classroom milieu. By happenstance, this may create an environment of stress and uncertainty, potentially nurturing failure for the student, family, and teachers involved.

Population. The population subject to data review and needs assessment determination involved a school district in the southeastern state United States. It has past history as a Tier 1 and Tier 2 county reflecting identified economic, job outlook, and employment hardship. All of the schools within the district are eligible for Title 1 funding. State education funding assistance provides monies to local education agencies who serve high numbers of children living in poverty. The delegation of Title 1 monies

is specific to funding the supportive efforts and services for high-needs children in an effort to meet state academic standards (Department of Public Instruction [DPI], 2015b). The project school has an enrollment of approximately 600 students in a traditional middle school (sixth, seventh, and eighth grades) and approximately 40 to 50 full-time faculty/staff members. Faculty range from beginning teachers to those with over 30 years teaching experience, with over 40% having ten years or greater career teaching experience (Department of Public Instruction [DPI], 2015a). The teacher turnover rate at the project school is comparative at 9%, versus 8% of the district, and 16% of the state, although there was a teacher turnover rate of 31% at the project school in SY 2012-2013 (Department of Public Instruction [DPI], 2015a).

Local school district data. Reviewing the county demographic student health data revealed significant student mental health needs and ensuing school nursing response and time investment. A thorough district post-school year review was completed to further investigate the needs and reality of the variables of school nurse encounters such as crisis involvement and response, chronic health conditions of students, and district school injuries/incidences (Figure 1). An injury/incident is identified as an occurrence which manifests in the contact of emergency medical services, immediate medical assessment, and one-half to full day of absence from school. The following analysis of district data revealed an overwhelmingly high percentage of psychiatric emergencies and school nurse student encounters. The school district for the SY 13/14 reported 143 psychiatric emergencies and 128 for SY 14/15, with the second leading cause of injuries/incidents noted as sprains/strains totaling 32 and 29 for respective years (Department of Public Health [DPH], 2013; Department of Public Health

[DPH], 2014). School nurse encounters overwhelmingly involve student mental health, as it is the leading origin of problem for the past two school years (Figure 2). As mental health issues and interventions are absorbing the majority of school nurse energy, there is an obvious logic to assume it is consuming the time and energy of classroom educators and administrators. The following graphs demonstrate comparative data over the current school year and preceding school year to further detail district information related to student mental health needs, district realities, and injury/incident identification origin and the campus location of injuries/incidences.
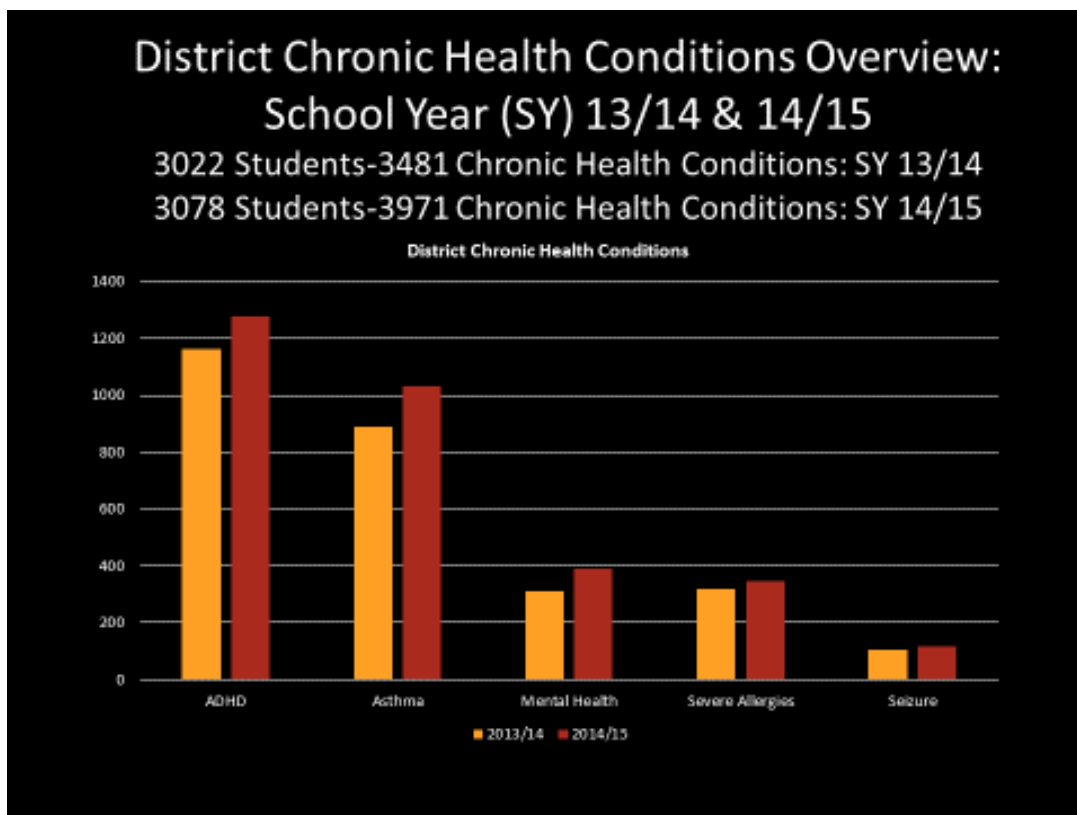
Figure 1. District Chronic Health Conditions: School Year 13/14 & 14/15
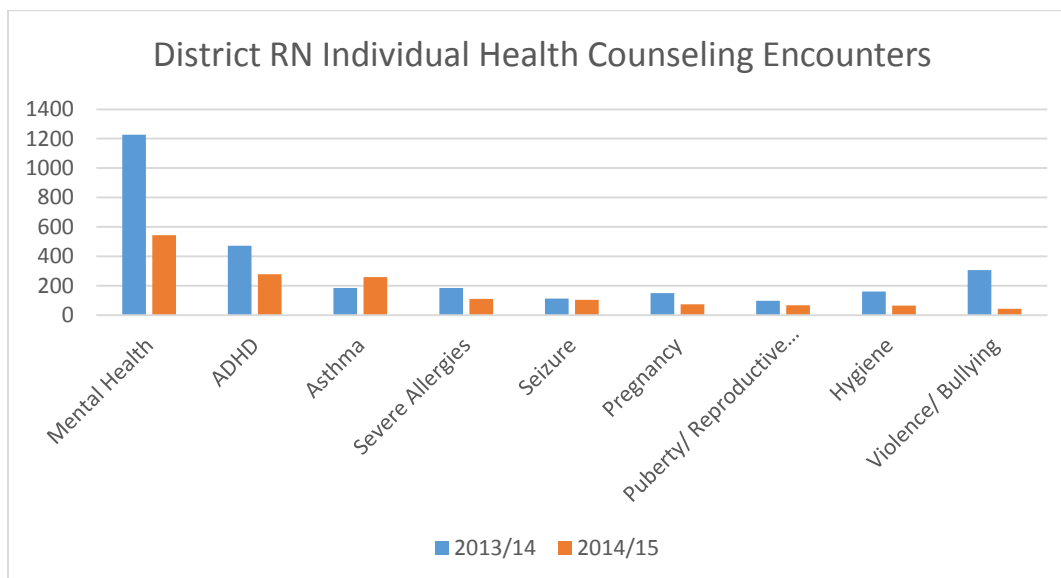
Figure 2. District School Nursing Encounters: School Year 13/14 & 14/15

The project county school nurses collectively provided 1227 student health counseling encounters in 2013-2014 for mental health disorders and depression, with the second most counseled health condition ADHD at 472 encounters (DPH, 2013). The year 2014-2015 revealed lower numbers of encounters but similar percentage variances as school nurse mental health encounters equated 545- with the condition of asthma a second leading origin of encounter at 260 (Figure 2). The following graphs demonstrate comparative data over the current school year and previous school year to further detail district information related to student mental health needs, district realities, and injury/incident identification origin as well as campus location. (Figure 3).
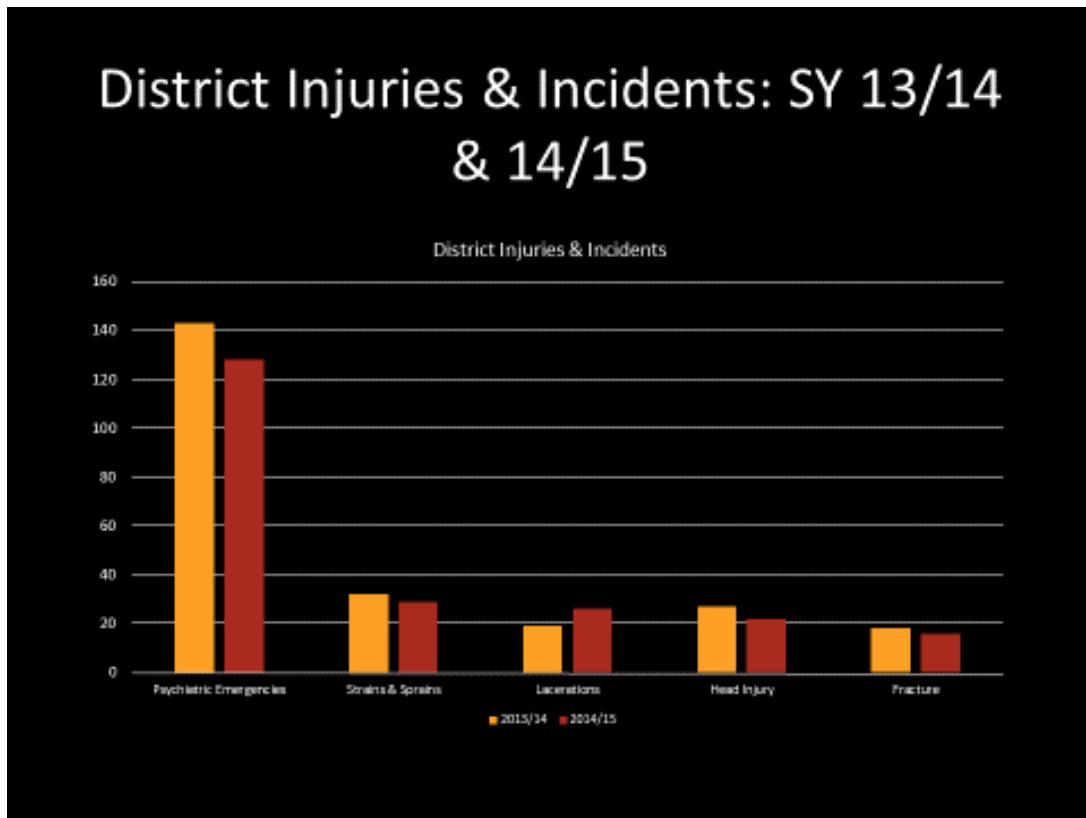
Figure 3. District Injuries/Incidences for School Year 13/14 & 14/15

Figure 4 identifies almost 50% of psychiatric emergencies are occurring in the classroom setting. The location of "other" notes campus areas such as hallways, playground or athletic areas such as gyms or athletic fields of play, or outdoor campus locations. The location of psychiatric emergencies demonstrates a stark reality of point of intervention. School year 14/15 noted the location of psychiatric emergencies as 62 in 'other' location, 59 in the classroom setting, three in the cafeteria, three in the restroom locations, and one on a school bus. It is apparent that the public school classroom setting in this district is an area that could benefit from greater focus and education to assist in a reduction of psychiatric emergency occurrences.
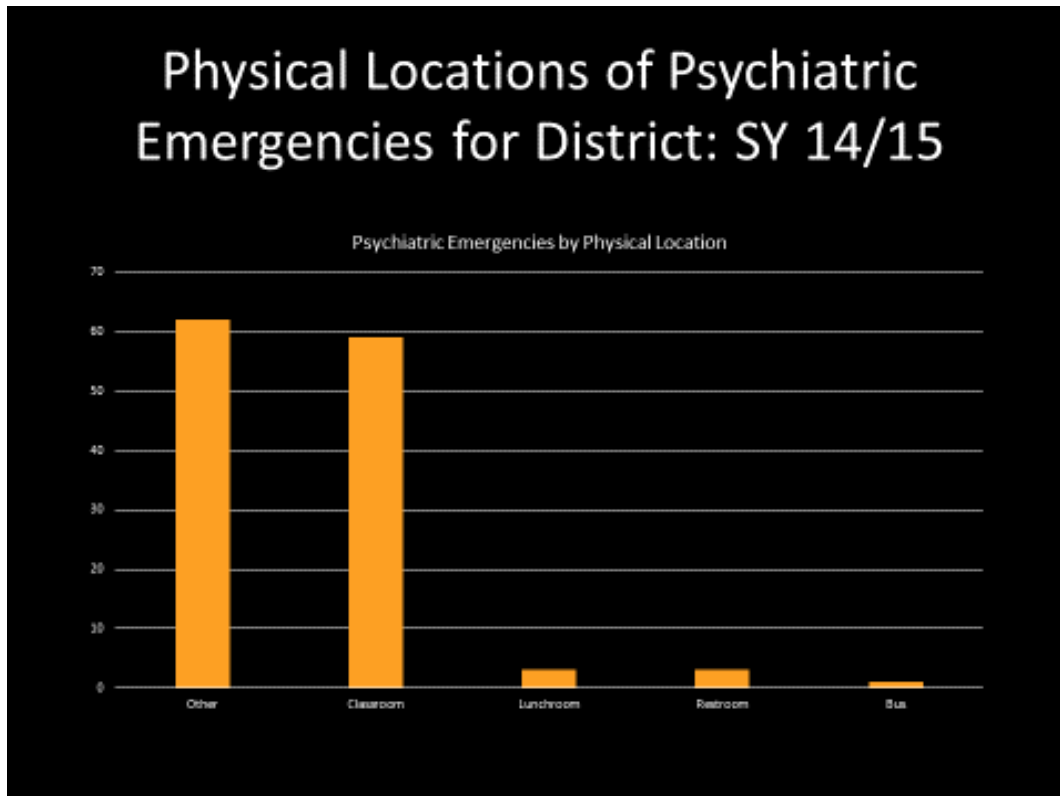
Figure 4. Physical Locations of Psychiatric Emergencies for District SY 14/15

Further detailed analysis of variables and demographic findings of individual

schools revealed trends of significance in the areas of poverty, chronic health conditions,

mental health conditions, and psychiatric emergency occurrence. The middle school

chosen for project implementation included leading percentages of the following

categories versus the other district traditional middle schools: Chronic health conditions

of project school 385 versus 283, 248, and 36.   Identified chronic mental health

conditions of the project school were 84 versus 24, 22, and zero; identified attention

deficit hyperactivity disorder (ADHD) of project school 108 versus 84, 73, and seven (Figure5).
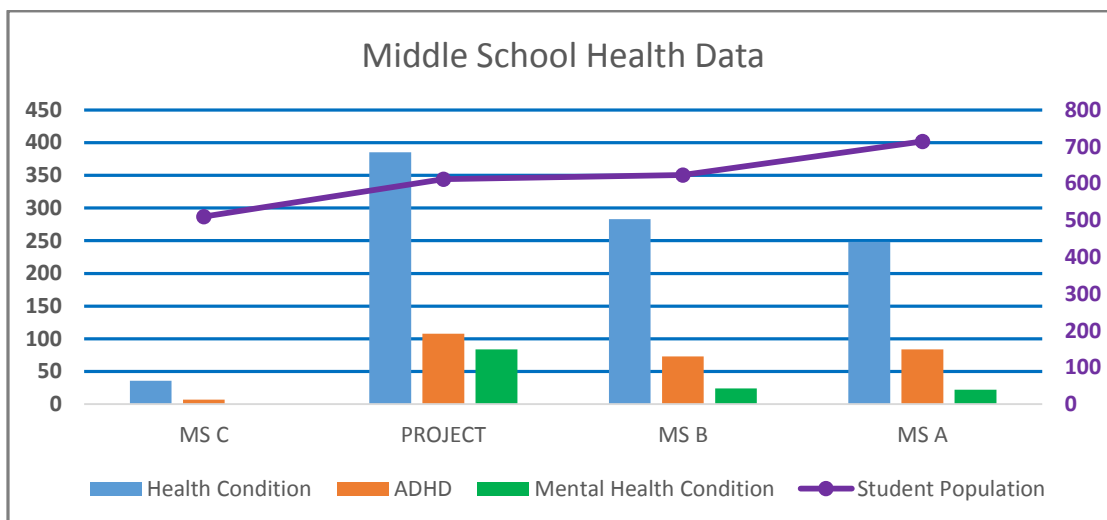
Note. Middle School Health Data with Student Population Variable. Project= middle school of Project Implementation; middle A= district middle school; middle B= district middle school; middle C= district middle school

Figure 5. Middle School Health Data with Student Population SY 14/15

This trajectory is nearly identical in the reported high school data as the high school, which receives students of the project middle school, reveals equally compelling significant health and mental health data compared to their high school counterparts. The feeder high school of the project middle school reveals 404 chronic health conditions versus 258, 254; 107 chronic mental health conditions versus 32 and 15; identified ADHD reveals 104 versus 78 and 52 (Figure 6). It is worth noting that student enrollment for the project middle school ranks it as the third in student enrollment of the four middle schools 714, 623, 612, and 510 (Figure 5). The feeder high school is the second largest as student enrollment follows as 1510, 838, and 783 (Figure 6).
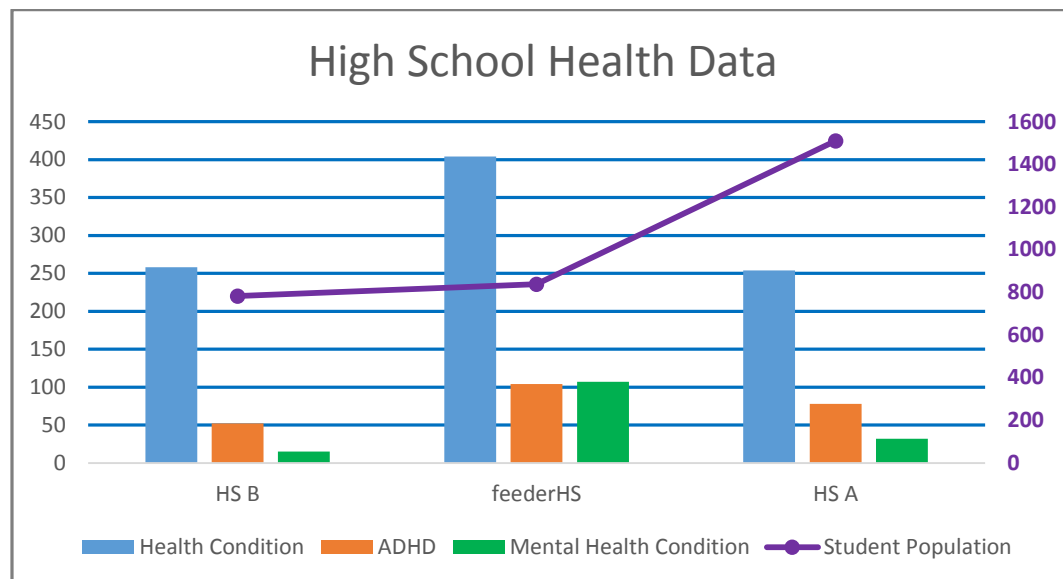
Note. District High School Health Data. Feeder HS= District High School that is in feeder catchment area of the Middle School of Project Implementation; HS A= district high school; HS B= district high school

Figure 6. High School Health Data for School Year 14/15

District poverty rates trend similarly to large numbers of chronic health conditions, mental health conditions, attention deficit hyperactivity disorder numbers, and high incidences of psychiatric emergencies. Of the top eight traditional schools (excluding alternative schools, K-8, and non-traditional high schools) for SY 13/14 poverty, the project middle school and feeder high school were fourth and seventh respectively; all of the elementary schools which are aligned in a feeder pattern with the project school ranked in the top eight for district poverty rates (Department of Public Instruction [DPI], 2014). The poverty rates of the top eight traditional schools were as follows: 100%, 97%, 96%, 80%, 77%, 74%, 73%, 72%, and 68% (Department of Public Instruction [DPI], 2014). All of the elementary schools which feed into the project school are in the top poverty rates of the eight traditional schools with all other remaining elementary schools within the district at poverty rates of 62% or below (DPI, 2014). The

poverty rates of the district middle schools were 80% for the project school, 55% for

middle school A, 49% for middle school B, and 61% for middle school C (DPI, 2014).

The poverty rates for the district high schools were 72% for the feeder high school, 45%

for high school A and 56% for high school B (DPI, 2014). (Figure 7)
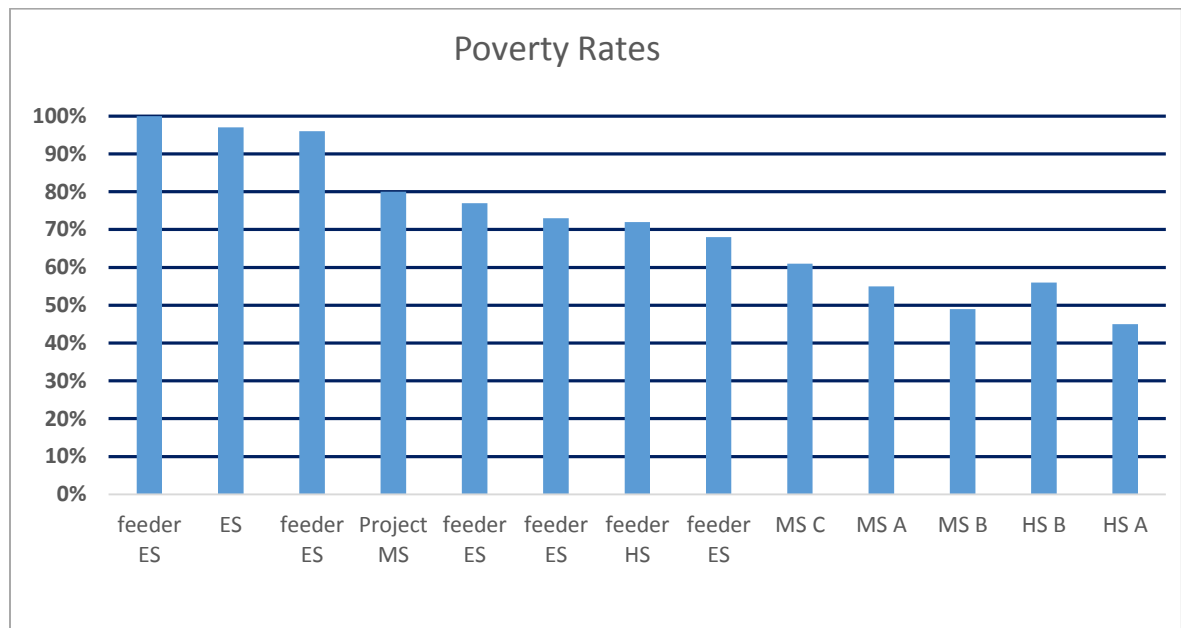
Note. District Poverty Rates for feeder elementary schools and all middle and high schools, available
elementary school data included (unable to access specific poverty numbers of all elementary schools).
Legend: Feeder ES= elementary schools which are aligned in a feeder catchment area of the project school;
Project= the Middle School of Project Implementation; feeder HS= District High School in feeder
catchment area of the Middle School of Project Implementation; ES= district ES outside of project school
feeder pattern; MS C= district middle school; MS A= district middle school; HS B; district high school;
MS B= district middle school; HS A= district high school

Figure 7. District School Poverty Rates

After review of student chronic health information, district school nurse health encounters by origin, district injuries/incidents, student poverty rates, district feeder patterns, and student enrollment/population numbers it required further investigation of those schools which showed patterns of extremely high rates of chronic health conditions, school nurse encounters, student poverty, and injuries/incidents. The middle school of project implementation and the aligned high school reveal overwhelmingly higher numbers of psychiatric emergencies than their counterparts (Figure 8). The culmination of this district data review identified a great need for further assessment and intervention to provide assistance and resolution to the significant disproportionate psychiatric emergencies occurring within these two schools.
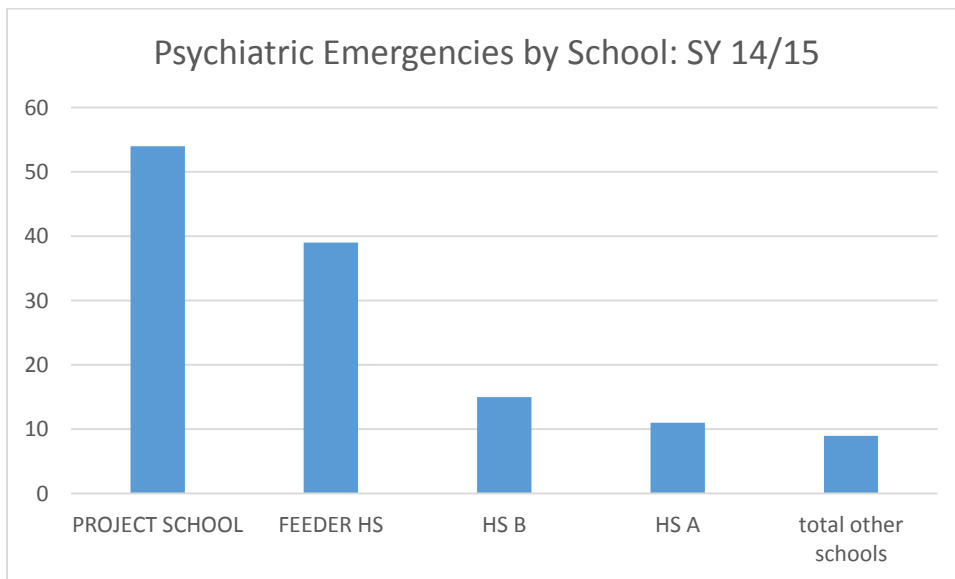
Note. Psychiatric Emergencies by School for School Year 14/15. Project School= middle school of project implementation; Feeder HS= high school which is in the feeder pattern of project middle school; HS B= district high school; HS A= district high school; total other schools= cumulative total of psychiatric emergencies for all remaining schools in the district.

Figure 8. Psychiatric Emergencies by School for School Year 14/15

Faculty survey. After the identification of the two schools that reported the largest number of psychiatric emergencies, identified chronic health conditions, and mental health conditions in their student population versus their middle school and high school counterparts. The project leader felt it critical to understand the perspectives and concerns of faculty related to student mental health needs and ensuing classroom management. All faculty members of the project school received a 10-question survey (via Survey Monkey) created and electronically distributed by the project leader. The response rate was 73.3% as 45 faculty members were included with 33 faculty members completing the survey. All of the respondents reported having experienced concern related to a student's mental health. The second question asked teachers if they had ever had a student in their classroom with one or more of the mental health diagnoses of depression, anxiety, post-traumatic stress disorder or emotional trauma, and/or oppositional defiant disorder. Respondents answered: depression 93.4% or 31 teachers; anxiety 93.4% or 31 teachers; post-traumatic stress disorder or emotional trauma 33.33% or 11 teachers; oppositional defiant disorder 75.76% or 25 teachers; none of the above had zero responses.

The follow-up survey question asked teachers to rank the most to least prevalent of student mental health diagnoses within their teaching career. The choices were depression, anxiety, post-traumatic stress disorder, and oppositional defiant disorder. These four mental health conditions were reflective of the most common in the school district's identified mental health disorders of students, as well as the most statistically common in the United States for adolescent mental health conditions (CDC, 2015). Teachers of the project school listed the four conditions in prevalence scoring as

depression 40.63%, anxiety 32.26%, oppositional defiant disorder 21.21%, and post-traumatic stress disorder or emotional trauma as 9.68%. This information supported prioritized project content area to address the most prevalent adolescent conditions of depression and anxiety.

Teachers were asked if they had experienced a student sharing or confiding with them their intent to commit self-harm or suicide. Respondents answered as follows: Yes= 27.27% or nine teachers; No- 69.70% or 23 teachers; Unable to Recall= 3.03% or one teacher. A follow-up question asked teachers if they had been approached by a student's peer regarding concern for their friend's intent to commit self-harm or suicide. This was a significant difference as teachers identified this as a more frequent communication related to adolescent depression behavioral risk in the school setting. Respondents answered in the following: Yes= 69.70% or 23 teachers; No= 24.24% or eight teachers; unable to recall= 6.06% or two teachers. This supports an adolescent developmental inclination toward securing and trusting peers as confidants as opposed to parents or supportive adults (Goodwin, Mrug, Borch, & Cillessen, 2012).

School and classroom safety are every state's and local district's concern. The project leader requested teachers to identify their presence of concern related to personal safety and their ability to manage and provide a safe classroom environment for their students. The faculty survey questions asked, "Have you ever been concerned about the safety of your classroom, other students, or your personal safety due to another student's fragile mental state"? Respondents answered Yes= 72.73% or 24 teachers; No= 27.27% or nine teachers; unable to recall= zero teacher responses. Nearly three-fourths of

respondents expressed past concerns about safety, be it personal safety or the safety of their student, related to mental health issues among students.

The project leader felt it necessary to have an honest assessment of faculty buy-in, engagement, and estimation of cooperation and active participation prior to provision of a staff development program. The next question asked respondents if a voluntary staff education program would be beneficial to educators in improving the understanding of student mental health needs and classroom safety. Respondents answered as follows: Yes= 87.88% or 29 teachers; No= 3.03% or one teacher; Maybe= 9.09% or three teachers (Figure 9).
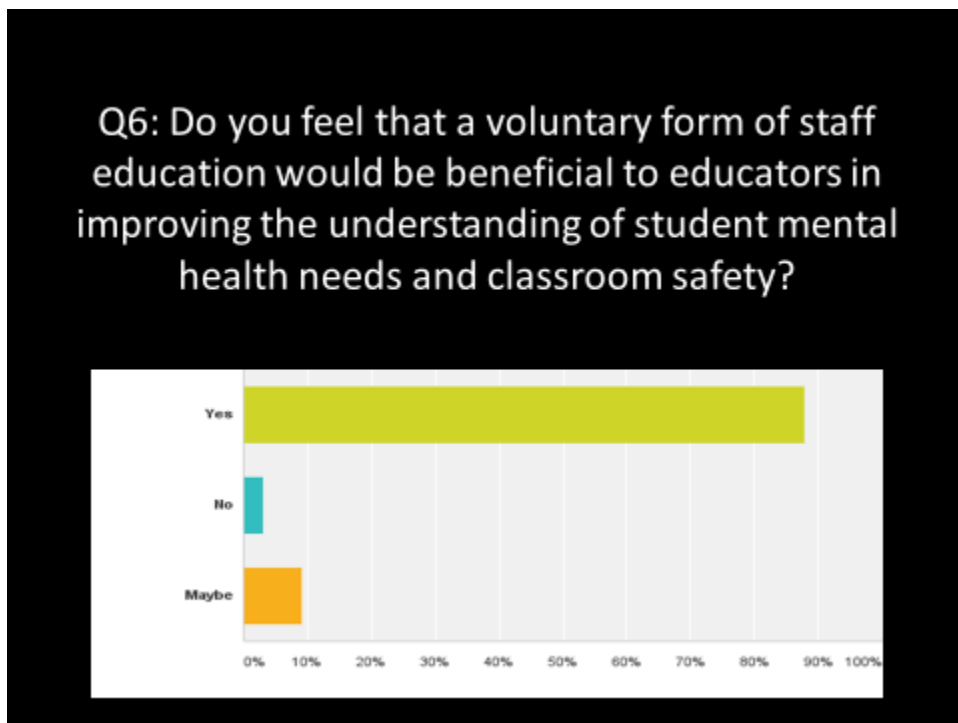
Note. Yes= 87.88% or 29 teachers; No= 3.03% or one teacher; Maybe= 9.09% or three teachers.

Figure 9. Faculty Survey Question #6

The faculty survey assisted in the establishment of project content and confirmed the shared vision and understanding of the need for targeted training to aid teachers in the academic instruction and care of students with mental health conditions. Concerns of safety were prevalent as well as 100% of faculty having experienced concern of a student's mental health condition. One gap identified upon examination of resources, student and faculty demographics, and detailed accounts of psychiatric injury/incidents was the lack of any formal referral process to the available school-based student support team (consists of school social worker, counselor, and nurse). There was no blanket policy or procedure for non-emergency student referral for mental health assessment or referral to the student support team, and it appeared various schools were approaching referral procedures in varied methods. The project school had no formal procedure for student mental health referral and there was no formal information-sharing for new faculty regarding this anticipated occurrence. A faculty survey question was asked to address use of the student support team in a situation originating from a student mental health need. The survey contained the question, "Have you ever made a referral to your student support team (school social worker, school nurse, or school counselor) because of your concerns regarding a student's mental health? Respondents answered as follows: Yes= 66.67% or 22 teachers; No= 24.24% or eight teachers; Unable to Recall= 9.09% or three teachers. The results of this question versus the initial question, where 100% of faculty reported experiencing concern for a student related to mental health needs, demonstrated an opportunity to develop and promote referral procedures, expedite appropriate treatment referrals within the community, assess immediate need and crisis

response, and better capture data related to the actual student mental health needs occurring within the school. Throughout the completion of the needs assessment, it became apparent there was a lack of communication, continuity, and protocol in the process of student referral to student support services for mental health concerns. The responses from this survey question solidified the need for clarity and procedural guidelines as 100% of teachers reported current/past concerns related to student mental health, yet only 66.67% had referred students for further clinical assistance within their school campus.

Survey question #9 was an open response with the prompt, "What student mental health disorder has concerned you or created the most personal unease for you?" The following responses determined specific concerns related to student safety, skill levels equipped to deal with serious mental health disorders, and various other issues. The teacher responses below encompass all of the answers with many responses with noted repetition. Twenty-seven teachers responded with six teachers electing to skip the question.

"What student mental health disorder has concerned you or created the most personal unease for you"? Faculty Survey Question #9

- "oppositional defiant disorders"
- "Students who seem to have no conscience or recognition of or concern for consequences of actions"
- "anxiety"
- "Anxiety and stress management"

- "Student poor self-concept and anger"

- "Personality disorders or early-onset schizophrenia"

- "Emotionally unstable students"

- "depression"

- "Suicidal behaviors"

- "Bi-polar"

- "Emotional trauma"

- "Concerns with their ability to handle students with mental health needs and how to assist them more"

The final survey question was an open text option asking teachers to add any information they felt would be helpful in addressing student mental health in the school environment. Ten teachers responded with 23 skipping the question. Their responses are as follows:

- "The more you know about any student the better they can be taught"

- "Understanding the impact of poverty on students"

- "Educating staff regarding mental health issues would be a huge help"

- "More information about how to talk to these students and what to say when addressing their needs"

- "We are understaffed when faced with these mental health issues"

- "A variety of small group sessions during advisory to help students learn skills to overcome their struggles"

- "It would be helpful if teachers were informed of their students' mental health issues. We tend to find out about these things too late, after the fact."

- "Protocol for students intending to harm peers/staff"

- "Eating disorders"

- "I'd like more information on self-harming and how to help those students".

The faculty survey reflected much of the data gleaned from the needs assessment regarding the acuity of the student population related to mental health needs and emergent incidents. Faculty overwhelmingly are concerned about the mental health of their students in addition to safety concerns. Most teachers (93.4%) had past or current experience teaching students with the diagnoses of depression and anxiety. Respondents overwhelmingly (72.73%) had concerns related to student, classroom, and/or personal safety regarding student mental health conditions. With the exception of one respondent, all the respondents felt that a staff development program addressing adolescent mental health would or might be helpful or needed. The needs assessment district data, faculty survey responses, high survey response rate-73.7%, and significantly high classroom and school-wide psychiatric emergency rate assisted in the solidification of the development and implementation of a Capstone project to provide change in the current environment.

Stakeholders. The stakeholders impacted by this Capstone project are far reaching.   These individuals and groups include the district superintendent, associate superintendents, departmental/divisional staff, school administrators, faculty, fellow student support team members of each discipline (social work, counseling, and nursing),

and the students as they will potentially benefit from a more readied, educated faculty pool in the management of student mental health conditions.

Organizational assessment. The project required a detailed needs assessment that also includes a clear, honest assessment of stakeholders and organizational readiness. The project leader met with two associate superintendents, two departmental heads, and project school administrator after securing and analyzing needs assessment data, transparently informing those key personnel within the organization of the significant findings. Each supervising stakeholder and project team member received data review in various methods including formal presentations as well as informal discussion, brainstorming, and conversation related to the current issue of student mental health. The project leader created and shared an executive summary detailing national and local mental health data with the district superintendent as well as school board personnel. Findings related to the needs assessment and literature review were shared in an interagency conference which included local law enforcement, all school administrators, district and associate superintendents, as well as the local mental health entity which provides supervision, credentialing, and approval of provision of mental health services in the project county.

SWOT analysis and resources. A SWOT analysis below (Figure 10) dictates the strengths, weaknesses, opportunities, and threats of project undertaking in this district. The district was quite generous with resources. The district supplied the project leader with all computer, technology, and office supplies; space; allowance of time devoted to project development, implementation, and evaluation; as well as continuous demonstrated advocacy and support of the project vision, mission, and undertaking.
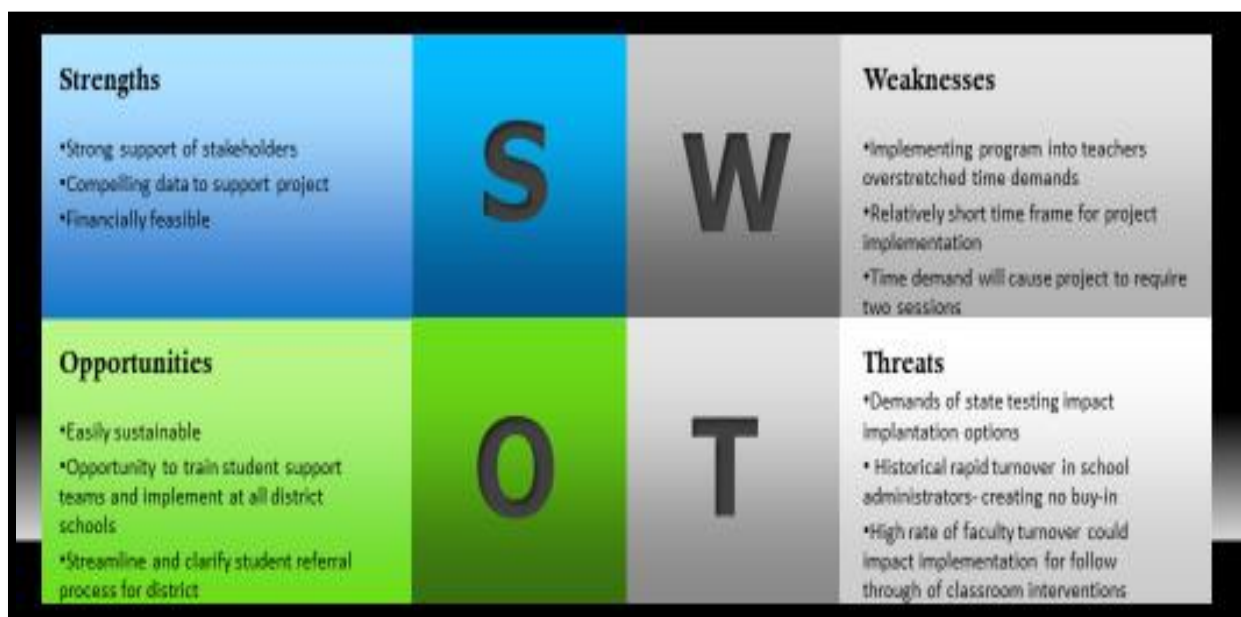
Figure 10. SWOT Analysis

Presence and Application of Jean Watson's Theoretical Framework

Jean Watson's Theory of Human Caring and the conceptual integration of her core theoretical principles into the clinical caritas can be an applied conceptual model in virtually all areas of nursing. The philosophical values contained and espoused by Watson include the focus on healing from the patient's perspective, not solely the health provider. Every individual has his or her own unique state of health. Casual generalization of health cannot occur as each human brings a different experiential background to the present moment in a carative relationship. The major concepts of Watson's Theory of Human Caring include the caring relationship between nurse and patient, as well as self, others, and the universe (Duffy, 2015). She endorses the concept of transpersonal relationships unifying the mind, body, and spirit, and then actively

proceeding with deliberate consciousness to encounter others and the environment, in the present and future. The evolution and application of these concepts occurred in the creation of the clinical caritas, an outline for successful healing that unified nurse-patient relationships in the clinical setting. As these concepts are applicable to multiple patient populations, this project will encompass their benefit and impact on the adolescent population.

In the period of adolescence there is marked accelerated physical, social, and emotional growth. Adolescent transitions may produce negative outcomes manifested in academic potential and outcomes (Ballard, Sander, & Klimes-Dougan, 2014). Emotional, social, and behavioral barriers affect the academic potential of up to 9% of United States children (Ballard et al., 2014). Emotional and mental health issues often initially present with somatic complaints and avoidance behaviors, quickly interfacing these students with a school nurse (Ramos et al., 2013). This is an ideal opportunity for a Watson-modeled nurse-client transpersonal relationship to become a valuable strength and support to an adolescent student.   True to Watson's concept, this is also a valued, honored relationship to the nurse.

Origin of Theory and Major Concepts

Watson promotes the philosophy that carative measures support and enhance curative measures, the foundation of the medical model (Duffy, 2015). Nursing is a supportive science to medicine, but it is also a separate and distinct profession. Four major concepts within her theory include the 10 carative factors, transpersonal caring relationships, the caring moment, and caring-healing modalities. Watson developed her theory based on the disciplines of educational counseling and psychology, later

integrating more spiritual and meditative aspects, further elevating the nurse-patient relationship component in the action and promotion of healing (Duffy, 2015). She identified Jungian psychology, Maslow's self-actualization theory, and feminist theory as inspirations and influences toward the development of the theory of human caring, as well as Buddhism and Eastern philosophies.

Originally based on Irvin Yalom's curative, therapeutic factors these 10 factors evolved into a more practical nursing-practice implementation guide for the nurse-patient caring relationship, endorsing the relationship as experiential to both parties (Nelson, 2015). The 10 clinical caritas are:

1. Embrace altruistic values and practice loving kindness with self and others.

2. Instill faith and hope and honor others.

3. Be sensitive to self and others by nurturing individual beliefs and practices.

4. Develop helping-trusting-caring relationships.

5. Promote and accept positive and negative feelings as you authentically listen to another's story.

6. Use creative scientific problem-solving methods for caring decision making.

7. Share teaching and learning that addresses individual needs and comprehension styles.

8. Create a healing environment for the physical and spiritual self that respects human dignity.

9. Assist with basic physical, emotional, and spiritual human needs.

10. Be open to mystery and allow miracles to enter (Duffy, 2015, p. 504).

The next concepts include the transpersonal relationship, the caring moment, and caring-healing modalities. The transpersonal relationship addresses an intentional action to connect with another person. The foundation of this connection is caring. It is dependent on a shared vision and commitment toward dignity, wholeness, and healing. Criteria also include affirming the significance, presence, and connection within the relationship. In order for there to be a successful relationship one has to move beyond self to complete a unified, purposeful relationship where one honors the patient's concerns, fears, and beliefs as equally as those of the person in the caregiver or nurse role. The concept of the caring moment includes the actual interactions between the nurse and patient, bringing their individual experiences, intentionally coming together in the present moment (Duffy, 2015). This must occur to forge a transpersonal relationship. Embracing nursing as a caring science promotes deeply humble, compassionate, and responsible connections toward positive human welfare and optimal human development and evolution (Watson, 2008). Caring-healing modalities are the actions of the nurse within the transpersonal relationship that allow healing to occur. These include behaviors, presence, communication, and holistic approaches and actions to address needs of the mind, body, and spirit.

Application of Theory Concepts to Practice Setting

A specialized facet of public health is school health. Health issues that affect children carry over to the school environment, influencing academic, social, and emotional development as children progress through childhood and adolescence. Like other areas of healthcare, school health encompasses its own specializations. Elementary health, exceptional children, or middle and secondary school issues may include health

conditions related to developmental delays, competitive athletics, teenage pregnancy, and substance abuse issues. The specific practice setting involved in this project includes adolescent mental health issues in the middle grades public school setting. There are few current research studies that explore adolescent mental health issues within the school setting as the focus has primarily been on physical health issues (Gampetro et al., 2012). It is estimated that 20% of children younger than 18 years of age have a mental health condition or immediate mental health concerns, increasing to 25% if the child is from an environment of adversity such as poverty, parental substance abuse, or violence (Reinke et al., 2011). This information supports the need for nurses to expand their knowledge and identify practice gaps in this setting. The attention to school mental health addresses immediate health issues but also provides a positive and necessary health promotion intervention as untreated youth mental health conditions often lead to adult disorders. It is estimated that 26.2% of adults in the United States have a mental health disorder (Gampetro et al., 2012).

Caring-healing actions originate from human-to-human caring interactions and authentic healing communication; these actions can transcend healthcare systems, institutions, and professions (Watson & Foster, 2003). The key concepts in Watson's Theory of Human Caring include the 10 clinical caritas, the transpersonal relationship, the caring moment or occasion, and caring-healing modalities. These concepts often overlap and provide foundational support for other concepts within the theory. The 10 clinical caritas are Watson's guide to the ideal and expected practice implementations that nurses should demonstrate within the nurse-patient relationship to truly promote healing and facilitate the concept of a transpersonal relationship. It is a project goal and

expectation that this will be replicated in teacher-student interactions related to mental health concerns. To facilitate the clinical caritas there must be an active intentional self-evolution toward the wholeness of the mind-body-spirit. One caveat to the clinical caritas is that the nurse/teacher needs to encompass these attributes to guide others in accomplishing these actions, thus the philosophical underpinning of this project. The adolescent population is extremely quick to identify disingenuous motives or hypocrisy in adults, further endorsing the need for the project leader to demonstrate, integrate, and profess the values that are within the caritas.

The transpersonal relationship from the school nurse/teacher to the adolescent demonstrates an intentional moral commitment to establishing or attempting to reestablish their dignity and healing the student's whole being, mind-body-spirit. The adolescent must feel that they are significant to their nurse/teacher as an individual and that the relationship is significant to that adult professional. A recognition of their value and uniqueness, their good and bad past experiences alike, must also occur before any healing interventions may occur. The transpersonal relationship is facilitated by the caring moment. This is the moment that the nurse/teacher and student intentionally come together, each with their own backgrounds and experiences, appreciating the uniqueness and value of each other, to purposely connect with each other in the present (Duffy, 2015). The transpersonal relationship cannot occur without a successful caring moment (Duffy, 2015).

These concepts need to be addressed within the context of a nurse/teacher-adolescent student relationship before caring-healing modalities may occur. Although the project focuses on the mental health conditions of depression and anxiety, there are

four specific behavioral manifestations common within those two diagnoses.   Conditions and behaviors that frequently occur in the school setting with the adolescent population are aggression, depression or self-injurious behaviors, anxiety, and emotional trauma. On review of these four problems, there is an extraordinary amount of disharmony, lack of peace, discomfort, and lack of self-control and self-worth in each issue. The caring-healing modalities promote inner healing, restoration of balance, and the value of both self and others. This is accomplished through the nurse/teachers' actions, words, behaviors, and the use of creative scientific problem-solving (Duffy, 2015). A caring, trusting, connected relationship between the nurse/teacher and student must be established for the work of healing to begin. Watson has suggested relationship concepts provide an applicable guideline for the most critical step in the promotion of health and wellness and restoration of self-worth for the emotionally complex adolescent population in a school setting.

Integration of Theory in Endorsement of Communication Techniques

It has become clear through working with high-risk children and families that they have historically rarely experienced a relationship with educational and healthcare personnel that encompasses dignity, personal significance, and an equality of investment in the nurse/professional-patient relationship. To have an authentic transpersonal relationship, Watson states that past experiences and subjective realities must be honored and accepted as part of the present individual (Duffy, 2015). Reinforcing this value and communication strategy can broaden a professional's (nurse or teacher) repertoire and listening skill set with students and families. It is one of the most basic project goals to establish a foundational communication practice where educators demonstrate Watson's

theoretical philosophies and caritas in action. This concept can be a fundamental approach in teacher-student relationships and predictably beneficial in problem-solving outcomes in sensitive classroom encounters that involve adolescent mental health. Watson's theoretical concept endorses everyone is significant and deserves an opportunity to heal.   This will hopefully emphasize the investment of the teacher-student-school relationship and reinforces that the student is a significant individual.

The Theory of Human Caring is applicable and transferable to almost any area of nursing and human interaction. Watson's theoretical concepts appear to especially address the needs of high-risk adolescents in the public school setting. Modeling therapeutic and professional relationships from the transpersonal relationship concept can potentially create an increase in feelings of school-connectedness for students and their families, as many of their parents had negative experiences during their school years. Many of the clinical caritas are encompassed in staff behaviors that convey support, meet students at an emotional and invested level, implement best-practice strategies, demonstrate fairness and equality, and encourage students to express their opinions and ask questions.   The clinical caritas can provide reciprocal benefit to practitioner, or in this case- teacher/educator. Through compassionate, intentional human-caring practice, improved community or facility milieu and morale can occur. Caring community transformation honors and sustains the honor and dignity of both patient and practitioner/educator (Watson, 2009).

Adolescents' perceptions of school account for approximately 13-18% of their emotional distress (Suldo, McMahan, Chappel, & Loker, 2012). Social support of peers, family, and school staff has demonstrated more positive indicators of adolescent life

satisfaction than in relation to their symptoms of psychopathology (Stewart & Suldo, 2011). It is critical to focus efforts on improving staff-student relationships. Theoretical foundations and creative problem-solving solutions need to be the cornerstone of therapeutic relationships. Establishing communication with adolescents, in efforts to promote healing and health, should not occur by happenstance. Watson's guidelines provide a framework for faculty and school staff to secure a sound, authentic relationship where education, holistic care, and problem solving may occur.

Literature Review

Child and adolescent mental health is a multi-faceted issue, impacting wellness, academic success, the ability to secure and maintain gainful employment, and the opportunity for future community and civic leadership. The school environment is responsible not only for academic achievement but for character and social development. Much of the time schools more than reach their goals as they guide children and adolescents academically and socially, instilling lifelong skills to become productive, well-rounded citizens, graduating 80.2% of four-year cohort students in the specific state of project implementation (DPI, 2015a). Unfortunately, there are numbers of youth with special mental health and emotional needs, conditions that may disrupt their academic and social progress and goal achievement. Twenty percent of United States children and adolescents will meet eligibility for a mental health disorder resulting in severe impairment before age 19 (Ramos et al., 2013). Frequently schools do not have resources for those students who present with great emotional needs and those that may require mental health service interventions.

It is difficult to name an individual that is more critical to a child's success than a teacher. The profession of teaching has evolved; academic standards, test scores, and benchmarks have become critical measures of success, creating an atmosphere of adversity and often unfair competition among teachers ("Parents across America," 2011). In addition to these pressures, the student population has greatly changed. Children present with more chronic health issues, complex custody situations and schedules, family stressors, and an increase in mental health disorders (Reinke et al., 2011). Teachers are currently dealing with mental health conditions and behaviors as their instructional responsibilities continue. Their educational preparation overall consists of the teaching strategies and concepts of their chosen educational specialty. This curriculum does not include preparation for teaching children with mental health conditions (Capella et al., 2012). This capstone project focused on providing strategies and a general educational overview related to the mental health conditions of depression and anxiety, common medications utilized, therapeutic communication, promotion of positive mental health classroom milieus, and targeted classroom management strategies for students exhibiting symptoms of, or diagnoses with, depression and/or anxiety. This will potentially arm educators with more knowledge, skills, and interventions to assist in the success of these students, not only while under their care but throughout their school careers, ultimately ending in high school graduation and a positive school experience. When effective classroom strategies and interventions are in place, children with mental health and adjustment issues show achievement and growth to equal their peers who do not have current mental health conditions (Capella et al., 2012).

The articles for this literature review were chosen to include criteria that reviewed teachers' perceptions, concerns, perceived skills levels, and readiness to be a central component in providing classroom management strategies, attitudinal changes, and potential referrals to school-based personnel. An additional article is included that elicits and analyzes school administrators' perceptions and attitudes related to school mental health services. As critical as teachers are to a child's success, school administrators often directly impact school climate and staff morale, as they additionally manage concrete tasks such as budgetary decisions, personnel issues, and structural campus and transportation issues. To ensure the buy-in to implement changes in classroom techniques and approaches, there must be administrative support and leadership to initiate and provide sustainability for a staff development program of this nature. Comprehensive and unified school mental health services must begin with the endorsement and public support of school administrators to become successful (Frabutt & Speach, 2012). The literature review also focused on the adolescent mental health conditions of depression and anxiety as they were identified as the most prominent concerns upon completion of a detailed district needs assessment, intensive district health data review, and analysis of pre-project faculty survey results. Common themes identified and explored during the literature review included: teacher identification of mental health symptoms, teachers' responsibility for mental health interventions, gaps in staff education and need for improvement in teacher proficiency in management of mental health behaviors, and critical developmental time frames where students were more at risk and teachers needed greater vigilance.

Databases and Keywords

A lengthy and systematic search was conducted for articles to further explore the structure, foundation, and potential limitations to improve the understanding of school mental health realities in addition to gaps within research and practice. Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases, Google Scholar, and the bb University's Bulldog advanced search engines were utilized to complete the literature search. The keywords included school mental health, educators, principals, teachers, child and adolescent mental health. Inclusive criteria included publication within five years and peer-reviewed scholarly publications. Each chosen study received institutional review board (IRB) approval, voluntary participation from all participants, and implemented informed consent.

Middle School Significance

School transitions are tough developmental experiences in the best circumstances. The transition to middle school can be especially tough. Peer selection is crucial and telling. The following study tracked adolescents from sixth to eleventh grade to investigate the potential relationship between adolescents' and their friends' depressive symptoms in middle school and in high school. It is pertinent to this capstone project as depression and anxiety identification and management was one of the basic principles of the project. Peer relationships and influence become the primary social network and a critical source of support in adolescence as self-disclosure creates intimacy (Goodwin et al., 2012). Several current studies have noted the implication of peer selection and socialization in adolescent depression, yet developmental focus has not been part of the study equation (Goodwin et al., 2012). Early adolescence lends to susceptibility in peer

socialization due to lacking, immature cognitive and executive functioning, whereas in later adolescence individuals experience more autonomy lessening peer impact (Goodwin et al., 2012). The research proposal posed the following elements and hypotheses within this study: adolescents seeking out and befriending peers with similar depressive symptoms thereby influencing one another to present homogenized levels of depression; selection effects would be more influential immediately after school transitions (grades sixth and ninth) versus other grades; the peer environment would stabilize post-school transition and become more influential; and females would be more susceptible to peer selection effects following school transitions.

The sample size in this study was a cohort of students in a public school system in a medium sized town in the United States northeast. Data was collected over a six-year period, through grades six to eleven. Students attended two middle schools and one high school, with a participation rate of 72% to 91%. Demographic ethnic representative data of participants were 51% female, 64% White, 20% African-American, 12% Latino, and 1% other ethnic representation. Participants in grade six completed the Children's Depression Inventory (CDI) with the intentional exception of one item that addressed suicidality. In grades seven through eleven, the measuring instrument Beck Depression Inventory Short Form (BDI-SF) was administered to participants. Friendship was assessed and measured through a developed school-based procedure. Students were given a roster of peers within their same grade and asked to identify their best friends. Friendship was identified through reciprocated nomination. After completion, the depressive symptoms of friends were computed as the average self-reported depression scores across all identified mutual friends of each child (Goodwin et al., 2012).

The results of this study included positive significance for stronger peer selection effects related to depressive symptoms following a school transition year as opposed to other adolescent school years. Results determined that within the first two years in a new school, adolescents chose friends with similar depressive levels and symptoms as themselves, significance was greater in middle school transition versus high school, yet both transitional periods demonstrated significance. The period of time between seventh and eighth grade appeared to be the most high-risk for depression-focused peer contagion (Goodwin et al., 2012). Gender differences related to depression level amongst peer selection and socialization effects were found to be non-significant within this study. The results of the study identify the seventh to eighth grade years as a fragile, high-risk developmental moment for depression contagion. The authors suggested the implementation of school-based programs to educate and inform adolescents, parents, and school staff in depression symptom recognition, increase knowledge and awareness of early treatment, and de-stigmatize the diagnosis. Improved identification of depressive symptoms can lower contagion effects and promote early intervention, thus improving symptoms and the concurrent negative outcomes of depression (Goodwin et al., 2012). Limitations of this study included the exclusion of students who transferred schools, dropped out of school, were absent during data collection and/or instrument completion, or students who identified no mutual friends or friendships (Goodwin et al., 2012). Friendship quality and stability was not examined within this study. All of these variables and limitations translate to limits on generalizability of conclusions.

Importance of Teachers

Adolescent depression is an international concern and public health issue. Western research has noted adolescents represent 2.0 to 8.0% of the general population with major depression, with 28.5% of high-school students reporting feelings of sadness and hopelessness impacting functioning over a period of two weeks and 7.8% attempting suicide more than once in the past year (Mizuta, Noda, Nakamura, Tatsumi, & Ojima, 2014). The presence of adolescent depression doubles the risk of adulthood depression along with the associated negative behaviors and outcomes such as bullying, substance use, somatization, self-harm, engagement in risky sexual behavior, and self-injury or suicidal behavior (Mizuta et al., 2014). This study examineed the effects of teacher support to explore preventative strategies for the protection of student mental health with a study-specific aim to evaluate the relationship between teacher support and depression in junior high school students.

The setting and sample involved in this study were students and their homeroom teachers in all public junior high schools located in two cities of Shizuoka Prefecture, Japan. The survey was conducted between the time frame of December 2012 and January 2013. All students were included in the study sample with the exception of developmentally-delayed students in special needs classes; the overall number of students who received and completed results was 2,780, with 93 teachers submitting completed questionnaires. Student questionnaires included demographic information related to gender, grade level, family unit, student-perceived economic status, satisfaction with academics, teacher support, and depression symptoms. The perception of teacher support from students was measured by the instrument, the Scale of Expectancy for Social

Support for junior high school students (SESS). Depression was assessed through the instrument, Depression Self-Rating Scale of Children—Japanese version. Teacher questionnaires included limited demographic data and teaching experience information; teachers were divided into two groups based upon fewer or greater than 10 years teaching experience. Data analysis of this cross-sectional study was conducted after appropriate statistical cross-tabulation to examine the relationship between depression, covariates, and logistic regression analysis which used the class average score for teacher support as an explanatory variable and depression as the objective variable (Mizuta et al., 2014). The following interactions and relationships of class average score for teacher support by grade satisfaction, economic status, and gender were concurrently examined.

The high-depression group consisted of 25% of the student population sample with nondescript differences in gender and junior-high grade level. Lower rates of depression symptoms were associated with scores reflecting high levels of grade satisfaction, stable economic status, and perceived high levels of teacher support. Findings demonstrated no significance between depression and family structure, gender of homeroom teacher, or years of teaching experience in students' depression symptom self-report. This study supported that teachers play an important role at the forefront of adolescent mental health difficulties and possible prognosis. It is recommended by the authors that school personnel provide teachers with opportunities to improve the mental health literacy of teachers and facilitate early detection of adolescent depression (Mizuta et al., 2014).

One significant study limitation or event was a local youth suicide related to victimization from bullying during this study which may have impacted results by

causing over- or underreporting of depressive symptoms. The event resulted in multiple studies and surveys being conducted within the district simultaneously. Additionally, results related to depression levels were based upon self-report as opposed to clinical assessment or diagnosis, possibly eliciting a large number of false positives (Mizuta et al., 2014).

Schools have become a service delivery point for mental health services of children as some studies suggested over 50% of students in urban school settings may present with serious learning, emotional, and behavioral problems (Franklin, Kim, Ryan, Kelly, & Montgomery, 2012). The authors of this article identified that student behavioral presentations may be more psychosocial in origin, not the manifestation of a mental health diagnosis. Whatever the etiology of the problem behavior, schools are points of identification for service delivery as determinations are necessary to improve academic performance, provide instructional services and accommodations, and implement appropriate mental health referral. This retrospective systemic study review posed the research question to investigate the extent to which primary-school teachers are the providers of service, their collaborative levels of service provision with mental health-related disciplines within the school, and to what levels the program framework of Response to Intervention (RTI) applies to recognition of student mental health concerns (Franklin et al., 2012). Response to Intervention (RTI) is a public health framework that promotes the three tiers of prevention by engaging regular education teachers in assessment of at-risk students and the promotion of unified, collaborative district approaches to support all children in the achievement of positive academic and behavioral outcomes (Franklin et al., 2012).

It was determined that 49 studies met criteria. Inclusion study criteria were resultant of a computerized multi-database search with the keywords of school, children or adolescent, youth, mental health service, and outcome study, effective or efficacy. Additional study criteria required a research design of either a randomized controlled trial or quasi-experimental with a comparison of the intervention and control group; publication between January 1999 through September 2010; study location in a school setting set in the United States; involvement in an intervention of prevention, risk reduction, and intervention/treatment; and strong statistical information present to calculate effect sizes. The effect size for each study was calculated and entered using Comprehensive Meta-Analysis software 2.0, Hedges's g effect sizes were calculated while odds ratio effect sizes were calculated for opposing outcomes then converted to Hedges's g effect sizes (Franklin et al., 2012). The majority of the studies utilized an experimental design (67.3%), with more than half using a non-treatment control group (57.1%). Grade level or student population targets were overall equally represented at 38.8% elementary students, 24.5% middle school students, 28.6% high school students, and 8.2% with multiple grade level inclusion. Student ethnic and racial diversity was present in the majority of the studies as 40.8% of students were identified as ethnically or racially diverse.

This meta-analysis found 40.8% of teachers were actively involved in mental health interventions and were the sole provider of mental health interventions in 18.4% of the studies reviewed. Many of the interventions were universal as opposed to individualized and were provided in the classroom setting. There are sweeping federal policy initiatives related to RTI implementation and additional school-wide behavioral

programs and supports. Teachers are not only providers of mental health interventions but will continue to hold larger authority and ownership of Tier 1 and Tier 2 student interventions (Franklin et al., 2012). Tier 1 entails universal strategies in classrooms, consisting of provision of clear rules and consequences, positive reinforcement to the selective interventions, and individualized progress monitoring of students exhibiting behavioral and academic decline (Franklin et al., 2012). Limitations of this review included the large number of studies exempt from inclusion due to failure to meet study criteria, thereby excluding many studies with contributable information. The lack of reporting of effect sizes between and within group contrasts also made statistical calculations very difficult or futile.

There is growing literature support for the inclusion of mental health services in the public school setting. Many advantages noted for this policy initiative and transition include opportunistic access to children and families via legally required compulsory school attendance, improved convenience and lessened stigma for mental health treatment engagement, and the correlative relationship of a positive learning environment with the attainment of social and emotional developmental competencies, reduction of risky behaviors, and improved academic success (Walter et al., 2011). With federal governmental support and broad professional healthcare organizational endorsement, universal preventative and clinical mental health services are considered necessary in the school environment; they are especially encouraged in disadvantaged and underserved communities (Walter et al., 2011). This study implemented the United States Department of Education endorsed behavioral program, Positive Behavioral Interventions and

Supports (PBIS) and assessed the effects of the model on mental health outcomes within the school staff perceptions and student data (Walter et al., 2011).

The sample and setting of this study occurred in two public elementary schools, composed of grades kindergarten through eighth grade, in different inner-city neighborhoods in a large Midwestern city in the United States. The setting and population criteria included the disadvantaged demographic, equal access and proximity to hospital and community-based mental health services, and the absence of the PBIS program. The instruments utilized within the study were the Strengths and Difficulties Questionnaire completed by teachers to assess significant student mental health problems (kindergarten and developmentally delayed students were exempt from the study). A School Climate Survey completed by teachers and sixth through eighth grade students to assess their perception about the prevalence of student behavior issues, and the overall school-learning environment. A Teacher Proficiency Survey developed by the investigators to assess teacher confidence level in their ability to manage classroom mental health situations, and a Satisfaction Survey developed by the investigators to assess school staffs' beliefs about the feasibility of PBIS program implementation (Walter et al., 2011). Study procedural interventions included guidance from screening and needs assessment data, teacher instruction in PBIS effective classroom management techniques, and instruction of teachers in the provision of appropriate developmental social skills education to students. The areas of student content where teachers learned proficiency included emotional/behavioral regulation, interpersonal skills, problem solving, and self-responsibility (Walter et al., 2011). Through teacher-led identification and team collaboration, students exhibiting the most extreme problem behaviors were

referred to on-site project clinical staff for resolution, debriefing, and assessment. Interventions also included parental education classes in addition to afterschool and summer camp interventional programs. On-site clinical interventions included standard psychiatric assessment and treatment for those students (first through eighth grade) who demonstrated clinically significant mental health problems. Data collection and analysis were conducted using SPSS software and descriptive statistics that included frequencies, means, and proportions. Inferential analysis involved the use of t-tests to assess changes in mean and chi squares to assess changes in proportions.

The teachers in this study identified 41% of students as having definite or severe social, emotional, behavioral, or learning issues; 56% and 67% of students were identified by their teachers to be experiencing medium to great distress and impairment in the classroom/peer relationships, respectively. An overwhelming majority of teachers (93%) and 55% of students rated aggression and disruptive behaviors as important problems in their school. These behaviors were identified as disrespect, arguing, teasing, bullying, threats, and physical fighting. Teachers also expressed a lack of confidence in their abilities to adequately manage mental health situations in their classrooms. Only 14% of teachers felt proficient in managing anxiety in students and only 2% if suicidal ideation was present. The mental health outcomes were encouraging at study conclusion as students exhibited significantly lower mental health difficulties, improved behavior and mental health awareness, and knowledge post-program implementation. Teachers reported significantly greater proficiency in addressing student mental health problems in the classroom setting. Limitations identified included a small sample size, no psychometric data for some of the instruments used within the study, incomplete

participation in outcome assessments, quick program start-up, and limited

generalizability (Walter et al., 2011).

Cunningham and Suldo (2014) posed the research question of accuracy of teacher

identification in the depression and/or anxiety levels of fourth and fifth grade students.

Often students with these two conditions, depression and anxiety, are underserved and

poorly identified in the classroom as they may not exhibit outward signs or symptoms, in

addition to non-engagement of classroom disruption or violating school rules which are

notable in externalizing conditions (Cunningham & Suldo, 2014). Children with the

internalizing disorders of depression and anxiety have significant potential for the

negative outcomes of impaired social relationships, engagement in substance abuse and

risk behaviors, development of future mental health disorders, and poor academic

achievement (Cunningham & Suldo, 2014). Universal screening for depression and other

internalizing disorders has incurred much discussion and debate. Schools have been

widely discussed as an opportune environment to administer such a screening. This study

asked fourth and fifth grade teachers within the select setting to nominate no more than

six students for the behavioral descriptors of childhood anxiety and depression. Teachers

were provided with written information that detailed the behavioral descriptors of both

conditions. The goal of the study was to determine the accuracy of teacher nomination in

the detection of students with the internalizing symptoms of depression and/or anxiety.

The student participant pool (238 students) was enrolled in one of two elementary

schools in a suburban school district in the southeastern United States. Both designated

schools are similar in school performance grades (A or B) and location (approximately

five miles apart). The teacher participants involved 26 teachers, predominantly female

(84.6%) and Caucasian (69.2%). Educational levels of teachers were bachelor-level (50%), masters (46.2%), and specialist (3.8%); four teachers reported they had received previous professional development related to children's mental health issues. Teachers were invited to participate and were offered a $25 gift card as an incentive; 100% of teachers consented. Parent consent forms were distributed with the incentive of a classroom party with 75% consent return and individual bracelets were provided to each student who returned their parental consent. The parental consent response rate was 55.8%. Students completed two instruments, Multidimensional Anxiety Scale of Children (MASC) and the Children's Depression Inventory (CDI), to determine the presence of risk for anxiety and depression. Based on the scores of the MASC and CDI, students were separated into two groups, at-risk= T score > 60 and not-elevated = T score <60. Teacher nomination of students was compared to the dichotomized rating scale for each separate instrument and result (Cunningham & Suldo, 2014).

Cunningham and Suldo (2014) reported teachers accurately nominated 50% of students who had positive at-risk results on the CDI for depressive symptomology and 41% of students with positive results on the MASC for anxiety. This reflected 11 students out of 22 correctly identified for the CDI and 11 out of 27 for the MASC; there is the converse miss rate of 50% for depression presentation and 59.26% for anxiety. The misidentified rates via teacher nomination translated to 16.20% for depression and 17.54% for anxiety. The conclusive merits of teacher screening or identification for childhood depression and anxiety produce mixed results within this study. While it is encouraging that there was an approximate 50% rate of accurate identification, there is an equally inaccurate rate of identification. Concerning results also demonstrated teacher

misidentification of students for depression and anxiety when there was neither condition present. This can bring to question the merit and feasibility of implementing universal screening measures in the school environment. Limitations of this particular study included a relatively small sample size of older elementary school-age children and the large parental refusal rate of children who may have had potentially significant symptomology and presentation of depression and anxiety. There was also a lower level of African-American student participation than demographically represented in the school population. The study did identify a research implication: that staff development training for teachers about the childhood symptoms of depression and anxiety would be beneficial (Cunningham & Suldo, 2014). It is also a significant finding that anxiety had a lower accurate identification and higher misidentified rate than depression. This may impact staff education provision to ensure detailed behavioral descriptors and instruction related to the oft-missed nuanced presentation, complexity, and implications of anxiety in children.

The study by Honkanen et al. (2014) follows the same theme as the preceding reviewed study as it investigates the predictive validity of teachers' assessments of children and the subsequent student self-report of mental health problems in adolescence. Recent studies have identified an increase of 38% in psychiatric disorders in Europe; the conditions of mood disorders, alcohol abuse, and dependence disorders are especially high in younger demographic populations (Honkanen et al., 2014). This study contained two goals: to investigate how accurately teachers' assessments of emotional and behavioral problems in children actually predicted subsequent student self-reported

mental health problems at the age of 16, and also how these self-reported mental health problems were related to life satisfaction among adolescents (Honkanen et al., 2014).

This longitudinal study was set in Northern Finland and encompassed the birth cohort of 1986. The sample involved 9,432 individuals with 4,865 boys and 4,567 girls born in the northernmost provinces in Finland (Oulu and Lapland). Parental and teacher data was collected at the ages of seven and eight (the age of entry to first grade) and then the cohort population data collection was aggregated at age 16. Parental response rate was 90%, teacher response rate was 91%, and adolescents had an 80% response rate in the completion of the study. Health and demographic data was collected from parents, data collection from teachers utilized the Rutter Children's Behavioral Questionnaire, and adolescents' data utilized the instrument Youth Self-Report (YSR). Data analysis was carried out with SPSS.

Teachers' assessments of anticipated behavioral problems included the following trends and positive impact upon their projections: female students, siblings in family, parents cohabitating, self-confidence, higher school performance, higher socioeconomic status, and higher levels of parental education. Student responses that correlated to low Youth Self-Report (YSR) demonstrated the following trends of males, parents cohabitating, self-confidence, stable family financial standing, and above average school achievement (Honkanen et al., 2014). Study results demonstrated those children at eight years of age whose teachers had assessed them to have emotional or behavioral problems also demonstrated significantly higher YSR scores for aggression, delinquent behavior, and attention disorders/problems but were less predictive for the internalizing mental health problems of withdrawal, somatic complaints, depression, and anxiety (Honkanen

et al., 2014). All of the self-reported problems demonstrated strong statistical

relationships to self-reported life satisfaction of adolescents (Honkanen et al., 2014).

Limitations within this study included a sparse comparative number of longitudinal

studies with an adolescent mental health focus and a gap in research on positive mental

health versus the present standard of problem-focused mental health research, as well as

gender differences and implications.

Schools are in a unique position to identify adolescents for symptoms of

depression. The period of adolescence is marked by accelerated depressive episodes with

considerable detriment to an adolescent's functioning and other negative consequences

(Martinez et al., 2015). The provision of brief training to school staff can offer effective

dissemination of adolescent mental health knowledge and information at minimal cost

and has been found to facilitate significant improvement in school staff knowledge

(Martinez et al., 2015). The authors of this article designed a workshop for school staff

with the goal of improving knowledge of adolescent depression. The content reviewed

contained information specific to relevance, epidemiology, clinical characteristics,

treatment, prognosis, myths and misinformation, and school approaches and interventions

(Martinez et al., 2015).

The workshops involved a four-hour session in four Chilean cities. The workshop

was facilitated by a child/adolescent psychiatrist. Learning methods and strategies

included the use of PowerPoint presentations, didactic methods, interactive group

exercises, and film/video segments. Hard copies of the presentation were provided along

with online resources to access for further reference. The sample size included 152 staff

members, with seven exclusions and 26 participants excluded because of incomplete

questionnaires. There were greater numbers of female participants and the mean age was 35.9 years (Martinez et al., 2015). The authors utilized The Knowledge Questionnaire of Adolescent Depression for School Staff before and after the workshop. This 26-item instrument had three potential responses (I agree, I disagree, I don't know) for questions and content reviewed in the workshop. The score range was 0 to 26. Descriptive analysis was performed with *t*-test analysis, and Wilcoxon signed-rank test if needed to establish or verify normality (Martinez et al., 2015).

The pre-intervention Knowledge Questionnaire of Adolescent Depression for the School Staff demonstrated 69.6% correct responses and 91.8% post-intervention. Each test-item had an increase in correct answers and a decrease in the response of "I don't know." There were significant improvements in correct answers that addressed myths of adolescent depression. The school support staff discipline of school psychologists scored higher on the questionnaire both pre-and post-workshop. The results of the workshop demonstrated the effectiveness of a brief workshop intervention to improve the knowledge of adolescent depression for school staff. This study identified that an improvement in knowledge was attained by staff, but the application of this knowledge positively influencing the management of depression is unknown in this study. Past research has revealed that improved awareness and knowledge positively impacts earlier identification, referral, treatment, and management of the disease (Martinez et al., 2015). The limitations noted within this study included lack of random assignment of participants; the sample was comprised of school staff who voluntarily chose to participate in the workshop through open invitation. This may skew results as this may not be a representative sample of school staff (Martinez et al., 2015).

In the study by Capella et al. (2012), the research question was to determine the impact and benefit of a teacher consultation, coaching, and behavioral support program that addressed not only targeted but universal strategies to improve child mental health. This endorses the concept that academic, psychosocial success, and well-rounded development at the elementary school level are dependent on communication and behavior between teachers and students that consists of warmth and respect, clear expectations which focus on positive behavior, and the use of engaging classroom instructions (Capella et al., 2012). Research studies up to present have focused mainly on targeted interventions for maladaptive classroom and school behaviors as opposed to general preventive universal instruction for all students (Capella et al., 2012). This study provided an intervention that encompasses both areas.

The setting for this research study involved five public elementary schools in an urban environment. Inclusion criteria for this location involved economic disadvantage with 89% to 99% free or reduced lunch eligibility and a close proximity to a partnering community agency that provided mental health services. The schools that were involved in the study also had large minority populations, consisting mainly of Latino (87%) and African-American (11%) students. Four of the schools served mainly Latino students and one school's student population was 69% African-American (Capella et al., 2012).

Participants included a recruited 12-person team of mental health consultants who provided the intervention instruction and observations. These individuals were employed by the school district or the partnering community agency. Pre-study implementation, they were provided education and training related to the study design and intervention implementation along with concrete information related to time investment and

professional conflicts of interest. All classroom teachers (154) were given a letter of

invitation to participate in the study. Among the study's teacher-participants, 23 were

regular education classroom teachers, with 13 teachers in special education or

combination classes serving both regular and special education. The average length of

employment at their current school was 10 years. The majority of the teachers were

female (81%), with the ethnic and racial breakdown of Latino (47%), White (36%), and

African-American (14%). All 828 children that were enrolled in consenting teachers'

classrooms were eligible to participate, with 364 children enrolled in kindergarten

through fifth grade giving active consent. The mean age was eight years with 43%

identified as female. There was a subsample of 159 students to provide a targeted and

comparison group. This included two children who presented with active behavioral

problems in each classroom and two students per classroom chosen through random

assignment to provide a comparison group. The majority of the students were Latino

(90%), with 99% of the students qualifying for free/reduced lunch services. This sample

replicates the ethnic and financial breakdown of the school district (Capella et al., 2012).

The intervention used in this study to promote teacher consultation and coaching

was Bridging Mental Health and Education in Urban Schools (BRIDGE). It is a

multifaceted approach to target solutions for children exhibiting maladaptive behaviors in

the classroom and also includes the promotion of improved classroom interactions and

relationships for all children. This hybrid program intervention was implemented by the

regular mental health school staff and integrated into their responsibilities. The

Classroom Assessment Scoring System (CLASS) was utilized to maintain study fidelity

and cohesion. Outcomes were measured pre- and post-intervention with data collection

received from teachers, children, consultants, and observers. Data was collected twice, in fall and late spring (Capella et al., 2012).

The results revealed significant gains to those classrooms which began with low levels of emotional support, although they did not improve to the levels of classrooms which were already eliciting high levels of emotional support. Classroom management, specifically student engagement, the management of behaviors, and organization were not improved by this intervention. The authors hypothesize that this lack of improvement may have been due to the intervention implementation occurring in the last half of the school year, making it more difficult to change classroom routines and expectations (Capella et al., 2012). The intervention was not found to have a positive impact on improving maladaptive behaviors. More serious mental health issues may require a more intensive intervention than what was included in this program.

Teachers did report an increase in closeness and supportive emotional relationships with students although they did not note an improvement in teacher-student conflict. Conflict is often the result of patterns of behavior and frustration of all parties involved. This may be harder to remedy as it may reflect a more inflexible attitudinal reaction, resulting in a more limited potential change in behavior (Capella et al., 2012).

Students reported more confidence as learners. It was noted that students perceive themselves as their teachers want them to be, demonstrating a positive trend as that relationship improves and they are seen as successful in the classroom. There was a noted decrease in victimization from peers, reinforcing that an overtly positive relationship with the classroom teacher may protect children vulnerable to peer cruelty (Capella et al., 2012).

This is a strong study as it relates to design, procedure, and methodology. It clearly identifies the research problem and need for a practice change in the issue of school mental health. It further identifies the critical role in potential outcome change that teachers may hold. Additional positive notes to include are that school mental health personnel were able to incorporate this program, with additional responsibilities, into their everyday workload and expectations. This will promote sustainability and addresses feasibility to continue the program as funding issues are continuously prevalent in public education. The outcomes of the study reinforced the concept that classrooms with low levels of emotional support can significantly improve with coaching and consultation, along with teachers' admission of the problem and commitment to being part of the change.

The limitations of this study are significant. The yearly reviewed time frame is extremely limiting, as a significant portion of that time was dedicated to researcher training and study sample selection (Capella et al., 2012). The individual influence of the consultants could not be factored into the results; some may have been more effective and engaging, creating more enthusiasm for the project. School climate and morale, which can be either a huge barrier or positive facilitator, was not noted or evaluated; whether positive or negative, results could have been greatly impacted. The study result that there was little to no impact for those that were most behaviorally disadvantaged suggests that the intervention may have been too broad. Ideally, a universal and targeted approach is needed. It is unclear if this can practically be provided within one intervention proposal. The lack of effect on maladaptive behaviors may reveal that the clinical and intensity

level needs to be upgraded to impact these children toward a more positive school experience.

Reinke et al., (2011) chose a different research perspective. The focus is the perception of teachers related to school mental health needs, especially their roles, responsibilities, and barriers they identify for their student population. Schools are often not currently equipped and organized to provide mental health services for students, although there is common agreement inclusive of research and sensibility that notes improved mental health treatment of children has significant advantages and outcomes on academic success as well as an improved school climate and milieu (Ballard et al., 2014). Teachers are in a position where they can potentially impact identification and treatment for mental health issues every day. Their critical position, impact, and access is why it is even more crucial to examine their perspectives, opinions, needs, and barriers to forge a positive change in the access and quality of mental health care in schools. The research statements and hypotheses asked and generated within this study included the examination of teachers' perceptions of the needs, barriers, practice gaps, and current training or knowledge deficits. The authors hypothesized that teachers would identify knowledge deficits and request more additional training and that knowledge and training deficits would be a legitimate barrier to service of students (Reinke et al., 2011).

Five school districts that represented rural, suburban, and urban areas in Missouri were utilized as the setting for this study. The participants included 292 early childhood and elementary teachers with an overwhelming majority (97%) female and Caucasian (97.3%) individuals. The mean career experience was 13 years. Regular classroom teachers (91.1%) were the majority with the remaining sample being special education

teachers. One district that had no participants represented a large urban student population where students were twice as likely to be African-American and to qualify for free/reduced lunch services. The respondent break-down related to setting was as follows: rural (40%), urban (31.8%), and suburban (27.7%) (Reinke et al., 2011).

A survey tool was established by the investigators based on a literature review and analysis of several similar surveys. Expert clinicians reviewed and provided feedback with specific emphasis to the areas of survey domains and their relevance and any omissions. The survey contained the following domains: mental health concerns, knowledge and skill training, barriers, reasons that children fall through the cracks, and the roles of school personnel. The survey consisted of Likert scale responses and open format questions and opportunities. Coding was utilized for open-ended responses. The completion rate of the entire survey was 91% (Reinke et al., 2011).

Teachers listed their top five child mental health conditions or concerns as follows: behavior problems (disruptive, defiant, aggressive, and conduct problems), hyperactivity and inattention problems, students with significant family stressors, social skill deficits, and depression (Reinke et al., 2011). Issues of victimization and bullying were also heavily represented. Eighty-nine percent of teachers agreed that schools should be involved in the mental health needs of children but only 34% of teachers felt they had the skills and knowledge to meet students' mental health needs (Reinke et al., 2011). The areas that teachers identified as the most needed for skill level promotion were working with children with overt behavior problems, the recognition and understanding of mental health conditions in children, and training in classroom management and behavioral interventions (Reinke et al., 2011). Teachers reported that defiant behavior was extremely

challenging to appropriately address, and nine out of ten teachers reported working with

children who exhibited defiant behavior in addition to having significant family stressors

(Reinke et al., 2011).

Barriers teachers also identified included the lack of adequate parent support

programs, prevention programs for both externalizing and internalizing behaviors, and

available staff education and consultation (Reinke et al., 2011). Supportive services are

an issue of concern for teachers as they recognize the need for student services, especially

school psychologists' role, to expand beyond assessment and evaluation. They would

prefer to see additional services provided by school psychologists that relate to social

competency in addition to more consultation and assistance with the development of

classroom and behavioral interventions for individualized student needs (Reinke et al.,

2011).

The study overall provided excellent information about how teachers feel and

what they identify as the real needs in the everyday life of the classroom. The study was

carried out with validity and with sound research principles. The sample size had many

attributes but also limitations as it was only completed in one state and only enlisted

elementary teachers. The racial and cultural diversity of the sample size was extremely

lacking as it encompassed a sample of 97% female Caucasians. Also middle and high

school teachers may have a much different perspective toward current mental health

needs of students and teachers' training needs. The student population excluded a school

that had significantly larger minority and high-poverty populations.

It revealed definite practice gaps as 75% of teachers within this study reported

working with children who currently have a mental health condition and 90% reported

working with children that demonstrated defiant and oppositional behavior, yet only 34%

of teachers feel that they are adequately trained to provide appropriate interventions and

care (Reinke et al., 2011). This study revealed a definitive need for more training for

teachers, as 89% feel that it is the school's responsibility to provide care and services for

this student population (Reinke et al., 2011). The study reinforced the research problem

of student mental health and gaps in service and knowledge within the school setting yet

also a desire for educators to be part of the solution.

School Administration Perspectives

The study by Frabutt and Speach (2012) provided an examination of school

administrators' perspectives related to mental health needs of children and the realities of

the school environment's ability to successfully address them.

Two main responsibilities of school administrators are to develop and support

teachers and to provide efficient and effective organizational management (Frabutt &

Speach, 2012). It is not feasible to hope for the implementation of programs and change

proposals for a student population without a school administrator's full support. As

administrators are pressured to improve academic outcomes it is easy to decrease

attention toward the social and emotional growth of students. The cooperation and

backing of a principal is profoundly instrumental in the success of any school mental

health program as staff buy-in and sustainability are at stake. The research questions in

this article addressed the examination of school administrators' perspectives on the

specific mental health needs in their schools, the areas of staff development to address

those needs, and any successful mental health interventions they are currently utilizing

within their schools (Frabutt & Speach, 2012).

The participants originated from 346 elementary school principals from 12 dioceses in cross-sectional geographic locations in the United States. These states included: California, Connecticut, Florida, Georgia, Illinois, Indiana, New York, and Ohio. Twelve dioceses out of 15 agreed to participate; out of these twelve, 261 principals participated. The average enrollment for each school was 300 students. Twenty-two percent of the students were minorities, with 14.4% eligible for free and reduced lunch. The geographical setting included 35% suburban, 31% urban, 25% rural, and 10% were considered inner city areas (Frabutt & Speach, 2012).

The method used to acquire answers to the research questions was a three question, open-ended survey. A qualitative analysis program was used for each data item. Qualitative analysts previewed the data to determine the context and legitimacy of the data responses. Text segments from the responses of the principals were placed in conceptual codes. An open coding approach was utilized, which led to thematic patterns (Frabutt & Speach, 2012).

Principals identified several areas that would need to be present or bolstered to provide support for students' maintenance and improvement of mental health. The top three areas of need were personnel, finances, and areas of specific issues and concerns. The staffing of professionals with mental health training was the top concern. In these parochial settings, support personnel often were only available on very restricted part-time contracts, such as a half-day to one day per week. The issue of limited to absent support personnel such as counselors, social workers, and nurses is directly impacted by available monies and lack of funds. Tuition covers only 54% of the cost to educate a child; the remaining cost is dependent on fundraising and donations. Principals put great

value on mental health support staff such as counselors, social workers, and nurses. It is

ultimately a financial decision and the need for the service is far beyond what monies are

available to support personnel (Frabutt & Speach, 2012).

The third area of concern included specific issues or areas of needs. These

included the need for group and social skill training, assistance addressing the bullying

issues, and more timely identification and informed responses to children experiencing

mental health crises. The need for staff development and specialized support for teachers

was identified by principals. The specific areas of staff education need involved: ADHD,

anxiety, crisis training and intervention, mental health conditions, self-esteem, and social

skill programs (Frabutt & Speach, 2012).

Three successful areas or interventions were predominant themes within their

schools. They enlisted specific interventions and programs as their first response, such as

grief counseling and social skill groups. The second most identified success was the value

and impact of school personnel, specifically the school counselor, nurse, and social

worker. The final intervention spoke to strong commitment with targeted focus on the

home to school connection, establishing communication that fostered school-

connectedness to students, family, and community (Frabutt & Speach, 2012).

The study has strength in procedural fidelity and data interpretation. The data

does validate many gaps in practice and access for this student population and educators.

There is a consensus among the participants about the need for further staff education and

for the insertion of full-time staff that can provide consultation and care. The limitations

within this study reflect many obvious issues. The setting is limited to Catholic private

schools, which may affect the application of results to a more generalized setting. The

student population will not be representative of the rest of the country as there is

potentially less diversity in race, socioeconomic status, religious practices and beliefs,

and family structures (Frabutt & Speach, 2012). The participants may have limited

diversity in these areas also. The student sample had 14.4% student eligibility for free

and reduced lunch, compared to 47.5% of the U.S. student population (Statistics and

Brain Research Institute, 2013). As staff development needs are well documented,

principals did neglect to address their own educational and specialized training

limitations that may impact how adequately they provide consultation or solutions to

school mental health issues (Frabutt & Speach, 2012). It would be beneficial to look at

specific training to benefit the school administrator so evidenced-based practice can be

soundly supported and sustained.

Gaps in Practice

This capstone project interest began by a personal observation of a daily problem in clinical practice. Children with mental health issues are receiving underwhelming treatment; it is projected that only one third of adolescents with mental health issues are receiving treatment (Ramos et al., 2013). The problem of appropriate care, service provision, and the ability to stabilize and promote academic achievement is relatively inarguable. Teachers' perceptions in each study agree that school mental health care and educational impact are a problem. They also agree that they are collectively undertrained and unprepared to address the needs of often seriously mentally ill children in their classrooms (Capella et al., 2012; Reinke et al., 2011). School administrators support their statements regarding lack of formal and specialized training and agree it is a staff development need (Frabutt & Speach, 2012). Utilizing current student support personnel may aid in sustainability and feasibility of implementing an evidenced-based practice program.

An additional gap in knowledge and practice application by teachers is that experts may provide training or in-service, then leave as teachers return to classrooms (Reinke et al., 2011). Consultation and support to integrate interventions and new knowledge into the classroom are just as critical in the staff development process as the initial training. Providing general education regarding mental health conditions in children's diagnoses, medications, and classroom interventions to teachers through staff development by the student support personnel (school counselors, social workers, psychologists, and nurses), then utilizing those professionals to provide ongoing consultation and support, may provide a comprehensive, multidisciplinary approach to

solutions and improve academic and social outcomes for students, as well as staff morale

and school climate, and ensure a fiscally sustainable program for the school district.

Strengths and Limitations of Literature

The strengths of the reviewed literature began with sound study foundations.

Ethical considerations were in place, confidentiality and informed consent were enforced.

Data collection was completed systematically and objectively. Each article was

submitted to peer review and published in scholarly journals. The articles revealed data

and results that are within a relatively recent time frame of less than five years. The issue

of school mental health is a relatively new emerging issue in education with extremely

important consequences. The problem focus and research questions in each article

demonstrated a significant societal and educational impact, so the research effort is valid

and worth pursuing.

The limitations of the literature are noted in some limitations of the sample

population, most notably in some of the homogeneous participants; an example is one

article's participants were 97% female and Caucasian (Reinke et al., 2011). The articles

chosen in the literature review primarily addressed the adolescent mental health

conditions of depression and anxiety; additional mental health focus areas of substance

abuse, conduct disorders, and trauma and trauma-focused interventions were not selected

for review although they are very present in elementary, middle, and high school student

populations. School mental health issues are very diverse and adolescent mental health

has its own concerns, priorities, and needs. The literature review was limited to inclusion

of depression and anxiety as primary mental health conditions because those were

identified as prioritized concerns through district data review and needs assessment data.

Literature Review Summary

Each of these articles supports current literature, international, and national statistics regarding the crisis of the mental health needs of students in school-based settings. Generally, the main goal of a school district is to graduate young adults with a sound education and social bearing, either ready to enter employment or further their education. With statistics that reinforce the epidemic of mental health disorders by the age of 19, as 20% of children are affected, increasing to 25% if students come from disadvantaged backgrounds, it is a significant health and educational issue (Reinke et al., 2011). This assists in the identification of the current student population, but the support and needs of teachers must be equally explored to begin to address the problem. Teachers often identify disruptive student behavior as cause for leaving the profession; children who demonstrate maladaptive behaviors and emotional illnesses are mainstreamed into regular classroom settings and are received by teachers with no significant specialized training (Capella et al., 2012). Through the literature review it was brought to light that the middle school years, involving grades six, seven, and eight, are especially critical for the identification of mental health conditions, peer contagion and influence, and the positive impact of perceived emotional support from teachers (Goodwin et al., 2012; Mizuta et al., 2014; Cunningham & Suldo, 2014; Honkanen et al., 2014; Capella et al., 2012). The specific year of seventh to eighth grade was noted as the most high-risk time period for peer contagion (Goodwin et al., 2012). Peer contagion during this fragile time period may lead to increased symptoms, high-risk behaviors, and additional negative outcomes (Goodwin et al., 2012). Teacher recognition and buy-in to enhance their skill repertoire related to student mental health needs and interventions are

soundly endorsed within the literature review (Walter et al., 2011; Martinez et al., 2015; Reinke et al., 2011). Misappropriated interventions and lack of purposeful, evidenced-based actions and reactions allow less time for educational instruction and the implementation of engaging learning techniques and strategies. Federal and state developed policies and programs for adolescent mental health, such as RTI and PBIS, are prevalent within the literature review as well as endorsed district practices (Franklin et al., 2012; Walter et al., 2011). Yet currently 83% of teachers within the designated project state report one to five hours of each day is utilized to address disruptive student behavior and discipline issues (North Carolina Department of Public Instruction, 2014). The literature review also supports that school administrators are keenly aware of the modern mental health crisis in schools. There is a recognition of gaps in adequate expert student support personnel, monies to secure and retain these support personnel (counselors, social workers, and nurses), and significant faculty knowledge deficits in the recognition and management of students' presenting mental health conditions (Frabutt & Speach, 2012).

A capstone project that provides a staff development intervention developed for teachers that can be carried out by school support staff (counselors, nurses, social workers) currently employed within schools, who know their school's culture, can provide improved guidance, multi-disciplinary support, classroom management interventions to teachers, as well as a general mental health educational program. This also supports this intervention's feasibility and sustainability as it would require no additional staffing or monies, therefore optimistically engaging school administrators and district level support.

CTE Construction

Adolescents' perceptions of school account for approximately 13-18% of their emotional distress (Suldo, McMahan, Chappel, & Loker, 2012). Social support of peers, family, and school staff have demonstrated more positive indicators of adolescent life satisfaction (45%) than in relation to their symptoms of psychopathology (16-29%) (Stewart & Suldo, 2011). It is critical to focus efforts on improving staff-student relationships. Theoretical foundations, as well as creative problem-solving solutions, need to be the cornerstone of establishing therapeutic relationships. Watson's guidelines provide a framework to secure a sound, authentic relationship where education, holistic care, and problem-solving may occur. This framework translates to universal human contact and interaction, especially the critical relationship of teacher to adolescent student. Modeling therapeutic and professional relationships from the transpersonal relationship concept can potentially create an increase in feelings of school-connectedness for students and their families, as many parents may feel a generational cyclical disenfranchisement of the public educational setting. The inclusion of communication principles that convey support, meet students at an emotional, invested level, implement best-practice strategies, demonstrate fairness and equality, and encourage students to express their opinions and ask questions, encompass many of the clinical caritas. Both modeling and implementing authentic guidance in the practice of loving-kindness, restoring and honoring dignity, and appreciating the significance and uniqueness in each student is critical to move successfully toward appropriate modalities.

The clinical caritas listed in the theoretical portion of this manuscript provide a framework to move toward action to heal. Accepting negative and positive feelings and

encouraging expression with active listening allow the student to begin to heal and the

teacher to begin to use creative evidenced-based solutions to aid in the establishment of

trust, symptom identification, early referral, and improved outcomes. The establishment

of a caring, trusting, connected relationship between the teacher and student must be

present for the work of healing to begin. Watson's concepts provide an applicable

guideline to the most critical step in promotion of health, wellness, and restoration of

self-worth for the emotionally complex adolescent population in a school setting.

  The Conceptual-Theoretical-Empirical diagram below (Figure 11) illustrates the

connected components of Watson's clinical caritas and transpersonal relationship model,

the effect of teachers using Watson's theory in communication and relationship with

depressed and/or anxious adolescent students, and the empirical measurements and data

that will appropriately measure theory utilization and defend linkage adequacy.

CTE Construction

Watson's Theory of Human Caring
Transpersonal Relationship & Caritas
(Conceptual model)

Effect of Teacher utilization of Watson's Clinical Caritas on adolescent depression and anxiety in middle school students

(Theory)

Depression	**Self-injurious behaviors**	**Anxiety**	**Psychiatric Emergencies**
Utilization of Student Support Referral Process, RN office visits, Project Evaluation Instruments (Empirical)	Utilization of Student Support Referral Process, RN office visits Project Evaluation Instruments (Empirical)	Utilization of Student Support Referral Process, Post Evaluation Instruments (Empirical)	Injury/Incident Reporting RN Office Visits Project Evaluation Instruments (Empirical)

Note. Post-project evaluation instrument: developed by project leader, administered and completed immediately after final project session Two-months post project evaluation instrument: developed by project leader, administered two months post-project implementation

Figure 11. CTE Construction

Project Design

After completion of a thorough, detailed district data review and needs assessment, the project was initiated and implemented at the district school that had demonstrated the greatest need for teacher and staff support. The goals of the project were to provide assistance for improved support, knowledge, and management of student mental health conditions, initiate a streamlined referral process for teachers to their building-based student support team, and to reduce psychiatric emergency situations and occurrences.

Project Population

The project population for the Capstone Project, "School Mental Health Guide (SMHG) for Educators," included the faculty and staff members of the project school. The population included 43 faculty and staff members: 27 female teachers and six female staff members (77% of project population), and 10 male teachers (23% of project population). The racial demographic of the project population was 93.02% white. Additional recipients and attendees of the SMHG educational program included the project school's administrators, one school board member, three project team members (Licensed Clinical Social Worker (LCSW), Masters-prepared registered nurse, Director of Student Support Services), the district director of middle schools, and one instructional facilitator.

Project Setting

The project setting was a middle school (grades six, seven, and eight) in a rural southeastern state in the United States. The school population includes approximately 500 to 550 students, a poverty rate of greater than 80%, racial demographic largely

White at approximately 60%, with 20% Black or Multiracial, and 20% Hispanic (Department of Public Instruction [DPI], 2014). The school faculty consists of 41 teachers and 14 staff members. The student support team (Registered Nurse [RN], Social Worker [SW], and Counselor) are included in staff numbers. The project school follows a traditional school calendar with a 185-day school year.

Project Team

The project team consisted of four members outside the project leader. These members included a district department administrator who also is a master's-prepared licensed clinical social worker with approximately 30 years' experience as a mental health clinician, with clinical supervision and administrative experience; two master's-prepared licensed clinical social workers with experience in adolescent mental health; and a master's-prepared advanced practice nurse with approximately 25 years of experience in clinical nursing, adolescent health, and nursing research. Project clinical supervision was provided by a master's-prepared licensed professional counselor with approximately 20 years of clinical and administrative experience in varied mental health populations, substance abuse, and program supervision and management. The project leader additionally sought frequent counsel from several district administrators and school board personnel regarding project logistics, content, sustainability, implementation, and project evaluation.

Project Development

After thorough review of health and incident district data and a detailed needs assessment, it was determined that the two most prevalent and acute district student adolescent mental health conditions were depression and anxiety. A 10-question faculty

survey was developed and electronically disseminated to all faculty to further identify

concerns and perceptions of teachers regarding the subject of adolescent mental health

and classroom implications. The survey was disseminated at the conclusion of SY 2014-

2015. The response rate of survey completion was 73.3% (n=33). This information was

gathered, analyzed, and reviewed by the project leader in collaboration with the project

team. A comprehensive literature review also validated and reinforced the need to focus

on these two conditions. Recent research, expert opinion, and public policy initiatives

have identified the opportunity and need for teachers and school personnel to have

increased knowledge and expertise in the identification of depression and anxiety

symptoms in adolescents as well as improved management of mental health crises in the

classroom and school setting (Walter et al., 2011). Improved identification of the

behaviors manifested by adolescents from the conditions of depression and anxiety can

facilitate earlier recognition, treatment referral, family intervention, and better academic

outcomes. As problem identification and project setting were established, the inputs,

constraints, activities, outputs, desired outcomes and impacts were considered in detail to

create a comprehensive project of significance. The logics model provides a progressive,

systematic explanation to early project development (Figure 12).

Logics Model: School Mental Health Guide/ Project Leader

Inputs	Constraints	Activities	Outputs	Outcomes	
				Shorter Term	Longer Term
Project leader	Timeframe	*Literature Review *Needs Assessment	Training provided to approximately 42 faculty	Improvement in knowledge of mental health (MH) diagnoses: depression & anxiety	Utilization of and measurable increase in faculty-led referral of students with MH concerns to Student Support Team (SW, RN, counselor)
Project team	Conflicting additional responsibilities	*Cost-benefit analysis *Completion of goals & mission statement	Product or artifacts: educational booklet, PowerPoint Referral grid and/or flowchart for educators to follow regarding student mental health referral	Ability to recall appropriate student referral process to school Student Support Team (SW, RN, counselor)	Teacher-led implementation of project recommended classroom intervention strategies for students with depression & anxiety
Clerical personnel					
Clinical review and study	Budget & financial resources Existing culture	*Complete study of theoretical underpinnings of project *Work planning to include budget & timeline *Detailed clinical study & review to complete project content	Meeting attendance Attendance for trainings Clinical study hours for project leader Two 1.5 hr educational trainings provided to grade level teachers 6th,7th,8th	State awareness of applicable classroom intervention strategies for students with MH disorders	Teachers report greater confidence and ease working with students with mental health disorders
Financial					
Time	Time constraints of faculty population	*Development of evaluation plan *Secure IRB approval *Develop quality improvement measures *Implementation			
Project materials	Technological difficulties Facility space Time constraints of school/workday				
Facility space		*Project Closure *Analysis & interpretation of data *Complete oral, written, & electronic dissemination of results	Statistical & Evaluative Data Results Written project document, oral presentation		
Faculty target group	Possible personnel turnover during project				
office supplies	Administrative personnel shifts or change in support	*Present findings to facility and offer tools to promote sustainability *Meetings with chair, team, stakeholders prn *Attend appropriate trainings to support clinical content & project success			
Computer					
Travel					

Impact(s)

Improved Faculty and Student Relationships.
Improved access and use of student support teams.
Strengthen Student School-connectedness.
Increase early referral and identification of students with mental health needs.

Figure 12. Project Logics Model

The project leader developed two separate educational sessions for faculty and staff. The project educational sessions were administered in a two-part series. The first program addressed adolescent depression, specifically the signs and symptoms of depression in adolescents, common medications and resulting side effects, and classroom interventions. The second program addressed adolescent anxiety with the similar content coverage of symptom recognition, common medications and side effects, and specific classroom interventions to promote success in the classroom for the adolescent with an anxiety disorder. Legal implications of confidentiality under Family Educational Rights and Privacy Act (FERPA) guidelines were addressed in the first session and reviewed at the concurrent second session.

Each session was 90 minutes in length and occurred during grade-level planning periods. This allowed for small group instruction and communication. It also allowed discussion of concerns for specific students that all grade-level faculty either had in their classrooms or were familiar with from shared grade-level responsibilities and activities. Careful consideration was given to the availability, demands, and ongoing responsibilities of teachers and staff. There were many obligations for faculty members after school (coaching sports, personal child-care limitations, part-time work, supervision of after-school detention, and various sponsorship of student clubs); it was not feasible or responsible to request or expect additional time commitment of faculty after their workday. The sessions were administered in the Fall, with the second session following the first after a period of two weeks. Faculty and staff were encouraged by their school administrators and district directors to attend each session. Incentives included receiving

district continuing education credits for attending all sessions. No other incentives were

provided and there were no punitive measures for non-attendance.

Timeline of Project

The SMHG for Educators Project encompassed a time period of approximately 42

weeks, although preliminary research of literature, project setting, and early logistical

parameters occurred before the 42-week time period. Overall, the project followed the

schedule noted on the project Gantt chart (Figure 13). Implementation dates were chosen

after collaboration with the project team, implementation team, school administrators,

district directors, and associate superintendents. Project evaluation instruments were

completed immediately after the second and final session and a four-question evaluation

was administered at eight weeks post-project to address longer-term outcomes and

impact.

Project Leader Project Planner (Gantt)
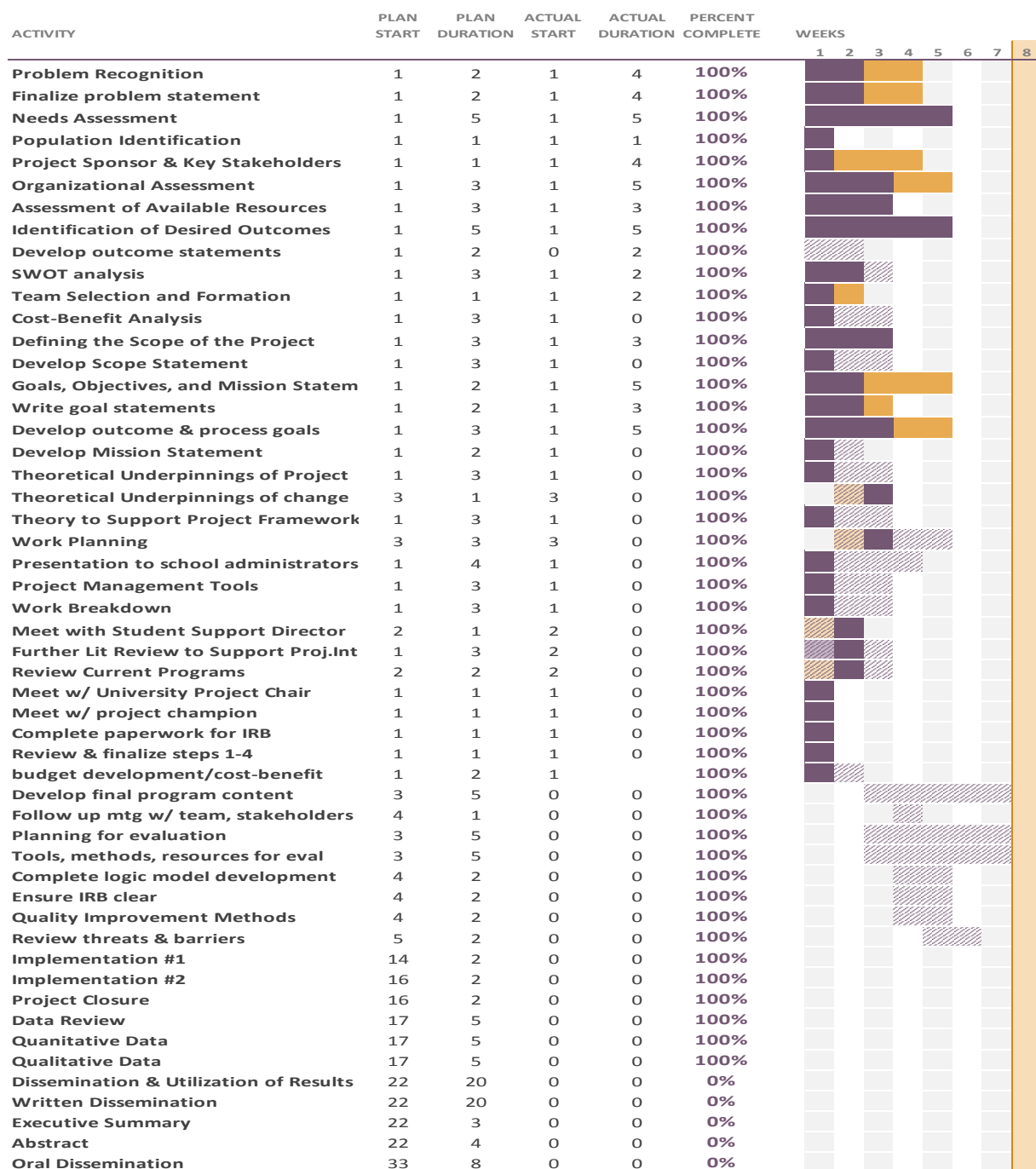
Week Highlight: 8

ACTIVITY	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Problem Recognition	1	2	1	4	100%
Finalize problem statement	1	2	1	4	100%
Needs Assessment	1	5	1	5	100%
Population Identification	1	1	1	1	100%
Project Sponsor & Key Stakeholders	1	1	1	4	100%
Organizational Assessment	1	3	1	5	100%
Assessment of Available Resources	1	3	1	3	100%
Identification of Desired Outcomes	1	5	1	5	100%
Develop outcome statements	1	2	0	2	100%
SWOT analysis	1	3	1	2	100%
Team Selection and Formation	1	1	1	2	100%
Cost-Benefit Analysis	1	3	1	0	100%
Defining the Scope of the Project	1	3	1	3	100%
Develop Scope Statement	1	3	1	0	100%
Goals, Objectives, and Mission Statem	1	2	1	5	100%
Write goal statements	1	2	1	3	100%
Develop outcome & process goals	1	3	1	5	100%
Develop Mission Statement	1	2	1	0	100%
Theoretical Underpinnings of Project	1	3	1	0	100%
Theoretical Underpinnings of change	3	1	3	0	100%
Theory to Support Project Framework	1	3	1	0	100%
Work Planning	3	3	3	0	100%
Presentation to school administrators	1	4	1	0	100%
Project Management Tools	1	3	1	0	100%
Work Breakdown	1	3	1	0	100%
Meet with Student Support Director	2	1	2	0	100%
Further Lit Review to Support Proj.Int	1	3	2	0	100%
Review Current Programs	2	2	2	0	100%
Meet w/ University Project Chair	1	1	1	0	100%
Meet w/ project champion	1	1	1	0	100%
Complete paperwork for IRB	1	1	1	0	100%
Review & finalize steps 1-4	1	1	1	0	100%
budget development/cost-benefit	1	2	1		100%
Develop final program content	3	5	0	0	100%
Follow up mtg w/ team, stakeholders	4	1	0	0	100%
Planning for evaluation	3	5	0	0	100%
Tools, methods, resources for eval	3	5	0	0	100%
Complete logic model development	4	2	0	0	100%
Ensure IRB clear	4	2	0	0	100%
Quality Improvement Methods	4	2	0	0	100%
Review threats & barriers	5	2	0	0	100%
Implementation #1	14	2	0	0	100%
Implementation #2	16	2	0	0	100%
Project Closure	16	2	0	0	100%
Data Review	17	5	0	0	100%
Quanitative Data	17	5	0	0	100%
Qualitative Data	17	5	0	0	100%
Dissemination & Utilization of Results	22	20	0	0	0%
Written Dissemination	22	20	0	0	0%
Executive Summary	22	3	0	0	0%
Abstract	22	4	0	0	0%
Oral Dissemination	33	8	0	0	0%

Figure 13. Project GANTT Chart

Outcome Measurements

The project leader, through consultation with project chair, project champion, and project team, developed two evaluation instruments. The first evaluation instrument consisted of a 10-question evaluation administered to project participants immediately at the conclusion of the second and final project session. The participants received an evaluation form which first requested identification of faculty or staff evaluation recipient. The answer grid format included the possible responses of strongly agree, agree, disagree, strongly disagree. An open text section was included for comments with the following prompt: "What was helpful? What additional information would you like to know? Any thoughts, comments, or suggestions for future presentations." This evaluation instrument was created and implemented to provide project information related to short-term outcomes and impact of the project. All completed evaluations were placed in a large, non-transparent enveloped labeled "evaluations." It was placed in the corner of the classroom utilized for the program session, distanced from the project leader and other project team members. Anonymity was honored as there was no identifying demographic information, no project team member collected the evaluations, and the evaluations were completed individually, not as a group.   A copy of the post-implementation evaluation is found in Appendix A.

The second evaluation was a follow-up survey distributed two months post-implementation. The rationale and goal of this survey was to glean an understanding of broader, longer-range outcomes and impact of the project implementation. The participants received a hardcopy survey in their routine grade-level meetings. There were no demographic identifiers on the survey tool with the exception of the request to identify oneself as a teacher or staff member in an effort to sustain anonymity of participants. For each question, the answer grid format included the possible responses of Yes, No, Unable to Recall. There was an open text comment section included with no prompts. Collection of the completed evaluations followed the same protocol as the post-implementation evaluation. All completed evaluations were placed in a large, non-transparent envelope by the individual program participant. The envelope was located in a corner of the classroom well-distanced from the project leader and other project team members. A copy of the two-month follow-up survey is found in Appendix B.

Cost/Benefit Analysis

Upon initial project planning, cost projection was completed with awareness of the district's limited budget constraints and project facility limitations. The main areas identified by the project leader requiring potential costs included project planning, workshop registration/fees, travel, statistical evaluation cost, office expenses, and provision of refreshments for program participants on each day of project implementation. The facility provided much coverage of expenses by unlimited access to computer and facility technology, office space for the project leader and project team, and use of work time to develop and implement the project. The project leader's personal expenses included the cost of two content-related workshop registration fees and travel,

purchase of Statistical Package for Social Science (SPSS), office expenses such as copy

paper, large envelopes, and various travel needs to meet project chair, project champion,

and district administrators. The largest cost to the project leader was identified in the

purchase of refreshments for faculty and staff. The projected total project cost was

estimated to be $1,390.00 versus the actual project cost of $1,005.00. Figure 14

demonstrates project cost projection and actual cost to project leader.

Capstone Project
Project Planning and Implementation

	Budget	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total Spend
						Actual Spend						
Initiation / Planning	$0.00											$0.00
Workshop (2)	$ 200.00	100		100								$200.00
Travel	$ 540.00	45		45	30	30			30	30		$210.00
Statistical evaluation cost	$ 300.00									75		$75.00
office expenses	$ 350.00				50						100	$150.00
Refreshments for participants					185	185						$370.00
												$0.00
												$0.00
Total	$1,390.00	$145.00	$0.00	$145.00	$265.00	$215.00	$0.00	$0.00	$30.00	$105.00	$100.00	$1,005.00

Figure 14. Project Cost Tracker

Ethical Considerations

Even though all faculty and staff participants were encouraged by their school administrators and district supervisors to attend, it was still voluntary. There were no repercussions for absences. Informed consent protocol was reviewed with the project leader prior to project implementation and was approved by the project chair and university IRB committee. All participants received and completed informed consent prior to dissemination of project content. Evaluations were developed and maintained to secure anonymity of all participants. University IRB approval was granted prior to project implementation. Consent was given by the project setting administrators for the project to occur. Project implementation was presented by the project leader and two master's-prepared clinicians. These additional clinicians included a LCSW with an additional certification as a school social worker and a school counselor with a National Certification in School Counseling designation. The project leader elected to include a multi-discipline approach to offer the best opportunity and learning situation for participants but to also reinforce the strength of interprofessional collaboration. The three individuals responsible for project implementation (project leader-RN, LCSW, School Counselor) were the building-based student support team. These individuals were readily accessible to all participants should there be any personal concerns or reactions from the project participants related to sensitivity to the project content. They were credentialed clinicians and were well-prepared to provide short-term resolution and/or appropriate clinical referral if indicated. This was not necessary for any active participants of the program although several participants sought out individual counsel of

their children/family members after program implementation. No individuals reported or experienced any harm or negative repercussions from program attendance.

Project Implementation Process

Project Process

The SMHG was presented to the faculty and staff of the designated project school in the Fall of SY 15/16. Implementation intentionally began approximately six weeks after the school year began so teachers would have a working knowledge of their students' behaviors, abilities, and personal inclinations but there would still be a significant portion of the school year remaining to integrate classroom interventions and implement appropriate student referrals if indicated. Learning formats and strategies for instructional provision included didactic methods, small-group sessions, video, and the sharing and transparency of national and local school mental health data. The location of instruction was performed at an onsite, grade-level chairpersons' classroom for each session. The SMHG consisted of two separate sessions, one approximately six weeks into the first nine-week grading period and the second session occurring two weeks after the first session, or near the end of the first nine-week grading period (first half of the first semester). Each session was completed in a 90-minute time frame. The project leader coordinated, developed, and facilitated the implementation of the SMHG with additional assistance from the remaining student support team members of the project school (project leader, [RN], school social worker [LCSW] and nationally certified school counselor).

The first SMHG session began with an explanation of project need, review, completion, collection of informed consent, and the sharing of data which included

injury/incident and student population statistical information. Any and all questions related to informed consent were addressed and answered by the project leader. Voluntary informed consent was completed by all project participants. Anonymity, the participants' project requirements, and voluntary participation choice were addressed and reinforced to all participants. The first session of the SMHG addressed the adolescent mental health condition of depression, signs and symptoms of depression, common prescribed medications and side effects, classroom interventions and management, and the specific legal confidentiality parameters for school personnel regarding student mental health guidelines (Health Insurance Portability and Accountability Act, FERPA, and federal guidelines related to mental health and substance abuse information). The following list notes the specific timeline of content presentation in session one:

- Learning outcomes

- Definition of depression

- Pathophysiology and role of cognition in depression

- National, state, and local statistics related to depression and adolescent depression

- Signs and symptoms of adolescent depression

- Risk factors for adolescent depression

- Signs of suicidality

- Protective factors related to adolescent depression

- Review and discussion of self-harm behaviors, cutting

- Review of common treatments (medication and side effects, psychotherapy, health interventions)

- Classroom strategies and interventions

- Legal implications for educators, especially related to FERPA and CFR 42, Part 2

- Review and discussion of the student referral process

- Emergency building-based response for psychiatric emergencies/suicidal comments or self-injurious student behaviors

- Questions and discussion

No evaluation data was administered during session one. There were 49 individuals present for the first SMHG session, with 43 present for the second one. There were four office staff absent from the second session due to staff illness and coverage concerns and needs. The two director-level staff members were unable to attend due to previous district obligations. The project was implemented on two separate days with a total of four sessions provided by the project implementation team each day. The schedule followed for each project day was the following successive schedule: encore teachers (computers, music education, Spanish, physical education, art, engineering, Communities in School), sixth grade faculty, seventh grade faculty, and eighth grade faculty. Throughout each of the two project implementation days, supportive staff and stakeholders attended the time period that was the most convenient for them. Learning methods and strategies included PowerPoint, storytelling, small group venues, pertinent data review, and free-flowing question and answer opportunities. Small group discussion and settings were chosen to elicit the most discussion, encourage grade-level cohesion, and promote ownership and collective concern of student mental health. Small group

discussion has demonstrated the highest levels of participant satisfaction and critical-thinking skills (Hamaan, Pollack, & Wilson, 2012). The content utilized for each SMHG session was derived from the recommended educator resources supported and endorsed by the state Department of Public Instruction Student Mental Health Guidelines for Educators (School Psychiatry Program & Madi Resource Center, n.d.).

The second session of the SMHG was implemented approximately two weeks after the inaugural SMHG session. The topic of this session was adolescent anxiety. The session began with a review of session one content which included signs and symptoms of depression, common medications and side effects, and evidenced-based classroom interventions and recommendations. The importance and legally binding stipulations for educators regarding student mental health were additionally reviewed prior to anxiety content. A loosely-competitive game format was used during this review where the first individual with the correct answer could receive prize choices of candy bars or NFL accessories. There was also a random prize drawing at the end of each session where the winner received a NFL decanter with candy. Each teacher that hosted a session in their classroom received a large candy bar in a NFL can cooler as a token of appreciation. The anxiety session followed the same format as the preceding session in content flow and learning methods. The following list notes the specific timeline of content presentation and topics in session two (anxiety):

- Learning outcomes for session two
- Review of session one (confidentiality, signs and symptoms of depression, common medications and side effects, classroom interventions, and student referral process)

- Learning activity to identify historical figures, artists, political figures, celebrities with anxiety disorders

- Definition of types of anxiety disorders, signs and symptoms, classroom interventions, and treatments

  - Generalized Anxiety Disorder

  - Social Anxiety Disorder

  - Phobic Disorders (specific phobias, social phobias, and agoraphobia)

    - Phobias in children

    - Phobias in adolescence

  - Separation Anxiety Disorder

  - Panic Disorder

  - Obsessive-Compulsive Disorder

    - Video depicting obsessive component

    - Video depicting compulsive component

- Brain pathology in specific anxiety disorders

- Questions and discussion

- Post-implementation project evaluation

As in session one, program content and instruction was facilitated by the project leader and the project implementation team (project leader [RN], school social worker [LCSW], and nationally-certified school counselor). Four sessions were provided the second day of implementation as previously for session one. All sessions were administered in a 90-minute grade-level setting. The schedule remained the same as

session one with encore teachers first, followed by sixth grade teachers, seventh grade

teachers, and lastly eighth grade teachers. Each session ended within the allotted time

frame (90 minutes). PowerPoint materials were available through electronic distribution.

Every session provided the opportunity for questions and discussion for participants,

spontaneously and at the conclusion of the session, and the project implementation team

staff was also available for individual and/or confidential discussion.

Outcome/Evaluative Measures and Interpretation

 Evaluation instruments. At the end of the second session the post-

implementation evaluation instrument was provided for faculty and staff to complete.

The completion of each evaluation instrument was encouraged but was a voluntary

exercise for each participant. The evaluation was completed within approximately five to

10 minutes. There were 36 teachers out of 39 classroom teachers (two teachers out due

to absences, one elected to not participate) and five staff members out of six (one staff

member unable to attend due to scheduling conflicts and class coverage difficulties) that

completed the Capstone Project Evaluation: Post-implementation. The raw data is listed

below for each evaluative question/response.

1. I understand the legal mandates regarding student health issues and

    confidentiality.

    Strongly Agree= 32 teacher respondents, 88.9%; four staff respondents, 80%

    Agree= four teacher respondents, 11.1%; one staff respondent, 20%

    Disagree= zero respondents

    Strongly Disagree= zero respondents

2. I can recall and identify the signs of depression in adolescents.

Strongly Agree= 29 teacher respondents, 80.6%; four staff respondents, 80%

Agree= seven teacher respondents, 19.4%; one staff respondent, 20%

Disagree= zero respondents

Strongly Disagree= zero respondents

3. I can recall common side effects of medications frequently prescribed to treat depression.

Strongly Agree= 29 teacher respondents, 80.6%; four staff respondents, 80%

Agree= seven teacher respondents, 19.4%

Disagree= zero respondents

Strongly Disagree= zero respondents

4. I am aware of at least three interventions that may assist a student with a diagnosis of depression.

Strongly Agree= 29 teacher respondents, 80.6%; five staff respondents, 100%

Agree= seven teacher respondents, 19.4%

Disagree= zero respondents

Strongly Disagree= zero respondents

5. I can recall and identify the signs of anxiety in adolescents.

Strongly Agree= 30 teacher respondents, 83.3%; five staff respondents, 100%

Agree= six teacher respondents, 16.7%

Disagree= zero respondents

Strongly Disagree=zero respondents

6. I can recall common side effects of medications frequently prescribed to treat anxiety.

Strongly Agree= 28 teacher respondents, 77.8%; five staff respondents, 100%

Agree= eight teacher respondents, 22.2%

Disagree= zero respondents

Strongly Disagree= zero respondents

7. I am aware of at least three interventions that may assist a student with a
diagnosis of anxiety.

Strongly Agree= 29 teacher respondents, 80.6%; five staff respondents, 100%

Agree= seven teacher respondents, 19.4%

Disagree= zero respondents

Strongly Disagree= zero respondents

8. I can recall the referral process to the student support team when I feel a student is
having a potential emotional/mental health concern.

Strongly Agree= 34 teacher respondents, 94.4%; four staff respondents, 80%

Agree= two teacher respondents, 5.6%; one staff respondent, 20%

Disagree= zero respondents

Strongly Disagree= zero respondents

9. I feel more confident in my abilities to instruct, engage, and assist students who
have or may have mental health conditions.

Strongly Agree= 31 teacher respondents, 86.1%; five staff respondents, 100%

Agree= five teacher respondents, 13.9%

Disagree= zero respondents

Strongly Disagree= zero respondents

10. I feel this presentation would be helpful to certified teachers or staff in a middle

school setting.

Strongly Agree= 32 teacher respondents, 88.9%; five staff respondents, 100%

Agree= four teacher respondents, 11.1%

Disagree= zero respondents

Strongly Disagree= zero respondents

There was an optional comment section after the concluding question. The

prompt on the comment section included, "What was helpful? What additional

information would you like to know? Any thoughts, comments, or suggestions for future

presentations." Ten out of 41 participants elected to write comments in this open-text

section; eight were teachers and two were staff members. The comments written and

proposed by participants are listed below.

- "This info was very helpful. Thank you."

- "Super helpful and very informative!"

- "Wonderful information! Would prefer more professional development/PLC

  meetings similar to this."

- "Prefer more handouts for signs of mental health issues."

- "This should be presented at all levels within education setting- elementary,

  middle, and high."

- "This was very helpful. Thank you for sharing. All educators and administrators

  need to know these things."

- "This has been an invaluable presentation and one that was desperately needed.

  We could benefit from doing this every year or every other year at a minimum."

- ▪ "Enjoyed the recommended interventions! They were helpful."

- ▪ "Great presentation and the information will be used to help me work with my students better."

- ▪ "Very helpful information as to signs to look for and how to assist our students."

Two months after project implementation an additional evaluation instrument was given to faculty members at the project school to attempt to retrieve more long-range outcome data and determine project impact in the project goals of: increased knowledge and teacher comfort levels, integration of evidenced-based classroom interventions and strategies toward applicable students, and improvement, solidification, and unification of the student mental health referral process to the school-based student support team. There were four questions included on the Capstone Project Evaluation: Post-implementation two-month follow up survey. The number of respondents completing the two-month evaluation was 36 out of 39 potential respondents. Three participants were absent the day of evaluation implementation. Certified teachers received the final evaluation instrument for completion as some of the questions addressed concerns related to classroom interventions, which would not be applicable to general staff. The questions with the raw data responses are listed below.

1. I have referred a student to the student support team for an emotional or mental concern since the school mental health staff development sessions.

   Yes= 21 teacher respondents, 58.33%; No= 13 teacher respondents, 36.11%; Unable to recall= two teacher respondents, 5.55%.

2. I have utilized at least one communication technique or classroom intervention since attending the school mental health staff development sessions.

   Yes= 33 teacher respondents, 91.66%; No= two teacher respondents, 5.55%; Unable to recall= one teacher respondent, 2.77%

3. I have independently sought out more information about adolescent mental health disorders since the school mental health staff development sessions.

   Yes= 16 teacher respondents, 44.44%; No= 20 teacher respondents, 55.55%; Unable to recall= zero teacher respondents

4. I am more comfortable accessing the student support team (school nurse, school social worker, & school counselor) for potential student mental health concerns.

   Yes= 35 teacher respondents, 97.22%; No= one teacher respondent, 2.77%; Unable to recall= zero teacher respondents.

There was an open comment section at the conclusion of the survey with no text prompts. Eight participants out of 36 elected to write comments in this section. Their responses are as follows:

- "This was very timely as that week had an incident with a student."

- "Training was very informative and meaningful."

- "Thank you for all you do, y'all do a great job."

- "This program is an asset to any school setting and I believe all staff that has supervision duties of students should have this professional development as part of every year training."

- "I learned so much from your sessions! I feel more confident about talking to students!"

- "We need a full-time school nurse."

- "Great information! In light of this we need a full time school nurse!"

Psychiatric incidents/injuries. Upon review of pre-project psychiatric injury/incident data for the project school there had been a total of 54 psychiatric incidents/emergencies in the previous school year. Data collection has been ongoing for the current school year. Upon review up to the completion of the third nine weeks or 75% of the school year, there had been a total of eight psychiatric emergencies in the project school during the year of project implementation.   If the current trend continues, the target school is on track to have no more than 11 psychiatric emergencies for this school year which will be a reduction of approximately 80%.

Faculty/Staff referral numbers. Several issues and process gaps were noted during needs assessment review. One of the most fundamental was the lack of procedure, structure, and awareness of student mental health referrals to the school-based student support team. The referral process had previously been an informal and often haphazard process, typically communicated by phone calls or in a face-to-face encounter. Referral information rarely involved the three disciplines of the school-based student support team. There was no course for tracking such an informal, vague process. One constant, reinforced theme of each project session was the new procedure for student mental health referrals. The two-step process for student referral was developed, taught, and reinforced to project participants as follows:

Behavioral, Emotional, Environmental/Financial, Mental Health Student Concern

1. Contact ALL three Student Support Staff (RN, Social Worker, Counselor) via email with student's first and last initial and student ID number.

2. Give a brief descriptive sentence or two stating concern/situation. Honor confidentiality.

Emergency Concern regarding a student's emotional status or a safety issue

1. Call the front office so Student Support Staff and Administration can be notified.

2. Do not send or allow a student to be left alone (go to front office/RN/counselor, etc.).

3. A student support member or administrator will go to student/classroom.

As there was no present or historical referral process in place, there was also no emergency procedure for faculty/staff to follow. This was extremely concerning considering the large number of psychiatric emergencies that were occurring. A simple three-step school-wide procedure was developed and included in the project content. Due to the absence of a referral process or procedure for student mental health concerns there is no pre-project referral data to provide a comparative analysis. The referral data from the month of project implementation initiation and the six-month period following project implementation are as follows:

October: 19 student mental health referrals (second session completed last half of month)

November: 46 student mental health referrals (17 school days in month due to holidays)

December: 24 mental health referrals (14.5 school days in month due to holidays)

January: 28 mental health referrals (16 school days in month due to inclement weather)

February: 39 mental health referrals (19 school days in month due to inclement weather)

March: 57 mental health referrals (18.5 school days in month due to holidays)

A total of 213 teacher-led mental health referrals in the six-month period post-project implementation.

Initiation of school administration and student support team staffing. After detailed review of communication concerns and deficits among student support team members and faculty regarding student mental health referrals, there was also a noted lack of communication and information exchange between student support staff and the administrative team. Historically school administrators had responded to many student mental health events and often neglected to share incident-related information with student support team members. In responding to mental health incidents solely from educational and school administrative backgrounds there was an obvious opportunity for delay or neglect of mental health symptom identification, parental involvement, and facilitation of mental health treatment. Likewise, student support staff were not communicating student issues and concerns in a timely manner with administrators, if at all. The hectic, crisis-driven responses and demands of school support team members frequently led to poor or absent communication between the three disciplines as well. The project leader suggested a daily and brief morning staff meeting between all student support staff and the school administrative team. The project school's administrative team was extremely receptive to the idea. This intervention began immediately upon recommendation. While this intervention did not provide hard data, it did provide great benefit to the mental health needs of students, families, and classroom management through significant improvement in communication between the two parties (administration and student support) responsible for student well-being and crisis response. This process aided in an inclusive multi-disciplinary approach, creative strategies, transparency, and a unified approach and working knowledge of students' needs and situations.

Project Evaluation

In review of the project evaluative data there is a notable positive trend. With 91.11% of eligible teachers and staff completing the post-implementation evaluation there appears to have been positive response to the project content. There were no negative responses (noted as disagree or strongly disagree) in any portion of the post-implementation evaluation. Participants stated an understanding of legal mandates regarding student health and confidentiality (Strongly Agree 32 teachers= 88.9%, four staff= 80%; Agree four teachers= 11.1%, one staff= 20%). Confidentiality has been a long-standing problem area for various invested parties, teachers, student support staff, administrators, and students alike. FERPA and CFR 42, Part 2 guidelines were reviewed with staff regarding the applicability to responsibilities of educators related to student mental health information (Title 42-Confidentiality in Patient Records, 2015).

Improved Symptom Identification and Treatment Awareness

Participants also reported overwhelmingly positive response in their ability to recall and identify the signs of adolescent depression and anxiety (depression: Strongly agree= 29 teachers (80.6%), four staff (80%); Agree= seven teachers (19.4%), one staff (20%); anxiety: Strongly agree= 30 teachers (83.3%), five staff (100%), Agree= six teachers (16.7%), and the common medications and the accompanying side effects of medications utilized in the treatment of adolescent depression and anxiety (depression: Strongly agree= 29 teachers (80.6%), four staff (80%), Agree= seven teachers (19.4%); anxiety: Strongly agree= 28 teachers (77.8%), five staff (100%), Agree= eight teachers (16.7). Better screening and improved awareness, education, and symptom identification recognition for teachers is strongly supported within the literature review and endorsed

through the federal and state developed policies and interventions of RTI and PBIS (Walter et al., 2011; Martinez et al., 2015; Reinke et al., 2011; Franklin et al., 2012). Improved symptom recognition and awareness of common treatment interventions is important to academic success and overall classroom management. As many students are prescribed medications to decrease symptoms of depression and anxiety, it is important for teachers to be aware of common side effects and potential adverse reactions to be watchful for, especially in the early phases of medication initiation.

Other figures to support the target school staff's improved education and symptom identification involve the heavily-utilized referral process to the school-based student support team and a decrease in the number of psychiatric emergencies. The volume of student support referral numbers remained consistent monthly and there is an approximate 80% reduction in psychiatric emergencies. These two areas and data sets also support the potential benefit of improved symptom recognition and identification.

Awareness and Integration of Evidenced-Based Classroom Interventions

The post-project implementation asked participants to gauge their level of recall and/or awareness of specific evidenced-based classroom interventions that may be utilized to assist an adolescent student with depression or anxiety. Participants were asked their awareness of at least three recommended classroom interventions for depression and anxiety-related behavioral manifestations. Participants noted positive awareness levels for classroom interventions for students with depression and anxiety (depression: Strongly agree= 29 teachers (80.6%), five staff (100%), Agree= seven teachers (19.4%); anxiety: Strongly agree= 29 teachers (80.6%), five staff (100%), Agree= seven teachers (19.4%)). Arming teachers with improved skills and broadening

their classroom technique repertoire in the management of these conditions can have a multi-fold positive impact through greater understanding of RTI and PBIS responsibilities, improving students' perception of positive emotional support from teachers, and improved professional satisfaction (Franklin et al., 2012; Capella et al., 2012).

The two-month evaluation follow-up survey results supported longer range use and integration of evidenced-based classroom interventions for students with these mental health conditions. Of the 36 respondents (a 92.31% response rate), 33 teachers (91.66%) stated they had utilized at least one evidence-based communication technique or classroom intervention since attending the project educational sessions, with two teachers (5.55%) stating they had not utilized those techniques or interventions and one teacher (2.77%) unable to recall. This was encouraging with regard to the feasibility and appropriateness of the interventions, demonstration of relevance and buy-in of teachers, and overall value of the project.

Teacher Confidence and Comfort

The positive results related to improved awareness and identification of symptoms, information recall of recommended treatments and common prescriptions, and the utilization of evidence-based strategies and classroom interventions can translate to improved confidence by teachers. Participants responded positively when asked if they felt more confident in their abilities to instruct, engage, and assist students who have or may have mental health issues. Participants responded with 31 teachers (86.1%) and five staff (100%) strongly agreeing and five teachers (13.9%) agreeing to improved confidence levels. Improving teacher confidence levels and skill-sets was an original

project goal and was a foundational task to demonstrate improvement in psychiatric emergency occurrences.

It was also important to consider the comfort level of teachers utilizing and soliciting guidance and consultation from their school-based student support team. The two-month follow-up survey asked teacher participants if they were more comfortable accessing their student support team for potential student mental health concerns; the responses were 35 teachers (97.22%) said yes, one teacher (2.77%) said no, with no teachers unable to recall. Improving teachers' education and skill level while concurrently enhancing access to their first line of defense for student mental health needs—the student support team—was a critical, fundamental step in changing the management of student mental health needs for the better.

Developing and Solidifying the Referral Process

One key process problem and gap noted early in project development was the complete lack of any protocol within the school-based staff for student mental health referrals to the building-based student support team. This process was revealed and reinforced during each project session. The post-implementation evaluation asked participants of their ability to recall the referral process to the student support team when a student is having a potential mental health concern. Participants responded with 34 teachers (94.4%) and four staff (80%) strongly agreeing, two teachers (5.6%) and one staff (20%) agreeing that they could recall the referral process. The two-month follow-up survey asked two questions related to the referral process. The first question asked if teacher participants had made a referral to the student support team for a student mental health concern since attending the project sessions. Of the 36 teacher participants 21

teachers (58.33%) said yes they had made referrals, 13 (36.11%) said no, and two

(5.55%) were unable to recall. Student mental health referral numbers remained overall

quite consistent throughout the six-month post-implementation period with the peak

referral months being November, February, and March. Many student days were limited

in January and February due to inclement weather either by cancelled school days,

teacher work days, or two- to three-hour delays for students and staff. It would be

interesting to do an additional follow-up survey to faculty and see if the results would be

similar. The question addressed in the previous section related to teacher comfort in

accessing their student support team is applicable in discussion of the referral process.

Teachers overwhelmingly (35 out of 36 teachers, 97.22%) stated they were more

comfortable accessing their student support team for student mental health concerns.

Developing and communicating a simple referral process and emergency response was a

critical component to increasing student support team referral numbers, increasing

teacher comfort levels, and reducing psychiatric emergency incidents.

Teacher Perceptions

It was important to the project leader to discern two teacher-led perspectives from

the project process. In order to promote project sustainability and guided, realistic

professional development the question was posed to teacher participants two months after

the project implementation. Teacher participants were asked if they had independently

sought out more information about adolescent mental health since the school mental

health staff development sessions. The majority of teachers responded no (20 teachers,

55.55%) with 16 teachers (44.44%) responding yes, and zero participants unable to recall.

This information is important as it demonstrates the need to provide school staff sound,

evidence-based information on site in a convenient fashion as the demands of professional and personal life are extremely taxing on teachers. This can support the efforts to integrate this project into annual staff development opportunities that would not incur after-school time investment, workshop and travel fees, or interfere with additional responsibilities of teachers as they coach, tutor, provide club sponsorship, and meet with parents with great frequency after their workday with students has concluded.

After participating in the project sessions it was important to evaluate the benefit of the program from the perspective of the participants. Project participants were asked if they felt this project would be helpful to certified teachers or staff in a middle school setting; 32 teachers (88.9%) and five staff (100%) responded they strongly agreed, and four teachers (11.1%) responded they agreed. Several participants noted in the open-text comment section of both project evaluations their endorsement of project implementation in all schools and an annual required professional development training. Many of the comments written in the optional sections spoke to improved comfort levels, strengthened communication skills, and benefit to students' well-being and school performance.

Literature and Theoretical Support

The project content was developed and based upon recommendations and evidence-based practice revealed upon literature review. Children are receiving underwhelming treatment based upon the frequency and acuity of their mental health needs (Ramos et al., 2013). Although teachers are on the front lines in this public health issue, they are generally underprepared and undertrained—whether a beginning or veteran teacher—to address the needs of students with mental health conditions (Capella et al., 2012; Reinke et al., 2011). The faculty survey for the project school revealed that

100% of teachers had experienced concern over the mental health of a student, with the two most prominent student conditions being depression and anxiety. These two content areas were also supported within the literature. The literature supported many facets of the project and was reinforced in the project evaluation. Noting that general education and training of teachers was extremely important to student success and managing classroom mental health issues, leaving teachers without access to quick, effective consultation and assistance could potentially negate the gains accrued from providing increased education. Historically, experts and consultants have left teachers after training or in-service instruction; the development and monitoring of the new student mental health referral process was inspired by this gap noted in the literature (Reinke et al., 2011). Streamlining the referral process improved all facets of communication: teachers and student support, the individual student support team members, and the school administrative team and student support staff.

Choosing to implement this project into a middle school setting was supported by the district data and also in literature. The middle school years are revealed to be especially critical in the emergence of mental health conditions and peer contagion influence, and they can be positively swayed when a student perceives positive emotional support from teachers (Goodwin et al., 2012; Mizuta et al., 2014; Cunningham & Suldo, 2014; Honkanen et al., 2014; Capella et al., 2012). The demonstration and integration of evidenced-based practices, empathetic therapeutic communication, improved understanding of the far-reaching impact of depression and anxiety, and simple referral and consultative access to mental health professionals within their school building can provide teachers significant resources to improve assistance to students.

Jean Watson's Theory of Human Caring is at the core of the recommended classroom interventions and strategies. Communication involves caring and empathetic principles as well as the awareness and knowledge that everyone matters. Increasing awareness and knowledge of these two mental health conditions translates to a better, more empathetic understanding of what the individual may be going through. Utilizing this awareness along with creative classroom strategies in a consultative, sharing relationship between the teacher and student allows for the student to perceive the teacher more positively and demonstrates a relationship of concern and significance as opposed to an adversarial one.

Achievements

Many of the project achievements have been addressed in the earlier project evaluation portions of this manuscript. Overall the project was extremely well-received and supported by participants, stakeholders, and district administrators alike. It was extremely advantageous to have a project implementation team facilitate the project, displaying an interprofessional approach to participants, concurrently reinforcing the simple, streamlined student mental health referral process. It also impassioned the student support team to improve their collective response to teachers, administrators, and each other. Faculty initial and sustained buy-in were huge positives as their attendance, response rates, and continued adherence to the new referral process were active throughout the project implementation year. There has been a huge reduction in psychiatric emergencies/incidents at the project school, down 80% from last school year. This is attributed to greater recognition of student symptoms and behaviors from teachers, a streamlined and trackable referral process, daily staff meetings between

student support and administration, correcting communication gaps, and a greater school-wide respect and ownership from faculty/staff/and administrators of the problem and the manner student needs were unmet. Both project evaluations demonstrated excellent recall of project content, improved confidence in skill levels, integration of the new student mental health referral process, awareness of confidentiality guidelines, and buy-in of project participation.

Recommendations for Improvement

As successful as this project was there are opportunities for improvement. Project development was extremely time-intensive for the project leader. Developing two complete sessions was almost equivalent to two projects, yet both conditions were so prevalent it was too difficult to omit one for the other. Each project day required the project implementation team to provide four separate 90-minute sessions. This was very physically and emotionally draining for all members. It may be advantageous to break each session up in two days to avoid this and to allow facilitators to address their daily clinical responsibilities. Yet there was an advantage to having all faculty receive the information on the same day and having a single date set aside for each session. This avoided the potential obstacle of scheduling negotiations and provided a clear expectation of attendance. To break a session into two days will require more thought and consideration. Providing instruction in the small group grade-level setting was an advantage and allowed for discussion of common students that were of concern in each grade level and possible suggested strategies for addressing those needs. While this was advantageous as a learning strategy, it created more sessions for the team to facilitate and the logistics of moving the training throughout the school building as opposed to utilizing

one setting. The choice to provide the training in the classroom of the grade level chair allowed for more time efficiency for teachers with the benefit of being able to start the session in a timely manner but it was an additional demand on the project implementation team.

Since this was a completely inaugural undertaking there was not a clear opportunity for comparative analysis. Teacher and administrator turnover had created a situation where everyone was essentially at a beginner/novice level in the area of adolescent mental health education. There was no formal procedure for school-based student mental health referral so statistical analysis is absent regarding the impact of historical reference to the post-project impact. These are data references which can be useful in the future to guide project content and direction.

An additional limitation or area of improvement is the involvement of only one school in project implementation. As favorable as the evaluative results and the significant decrease in psychiatric incident/injury occurrences are at the project school, there is no way to know if the same results would occur in a different school setting. Each school setting has its own culture, faculty personalities, and unique student characteristics. While it is an assumption that it would be beneficial across the district, there is no definitive proof that would be the case.

Plan for Sustainability

This project can be easily sustained throughout the district. The two sessions for adolescent depression and anxiety are prepared and can be electronically distributed to every student support team housed at individual schools. There could be a singular training for all student support teams to review information, discuss learning strategies,

troubleshooting for project implementation, and lessons learned from the inaugural project implementation. The training of student support staff would require no expense to the district as the project leader and other original team members could provide the training to the larger group. This training could occur during an early-release day or a required professional development day. Sharing the positive results related to the evaluation instruments, dramatic reduction in psychiatric emergencies, and the implementation of an efficient, effective student mental health referral process should be shared with school administrators, stakeholders, and district supervisors to further sustainability efforts and support. It will be important to convey the convenience of project attendance to these individuals as no substitutes will be required and there will be no travel cost, no scheduling changes, and no after-school requirements for certified or classified staff to attend the sessions. These personnel logistics are positive points to bring forward as these issues are quite problematic in the public school environment.

Conclusion

This project was developed through detailed needs assessment, extensive literature review, and formal and informal consultation with stakeholders, mental health clinicians, school administrators, and peers. It was led by data, research, a theoretical framework, and evidenced-based recommendations. The success of the project reflects the commitment to data, research, and literature guiding the content, learning strategies, and evaluation of the project. The project leader was fortunate to uncover a significant, data-supported problem and need. This allowed for the project to follow a clinical path throughout development, implementation, evaluation, and dissemination.

The public health issue of adolescent mental health is a global, national, and local issue. It is non-discriminatory, with the potential to affect anyone regardless of race, gender, socioeconomic status, faith, personal talents or failures. Educating teachers about mental health gives children an additional protective layer as they are in a position to notice nuanced changes in behavior, cognition, and physical appearance. This awareness can potentially expedite referral to appropriate treatment, improve parental involvement and attention, and enhance academic success. It was humbling to see the concern and commitment teachers have for the students they are charged with the responsibility to teach. Their dedication and investment in their students surpasses their classroom academic responsibilities. They care about the whole student, appreciating their individual struggles, and worry deeply about their overall well-being. As the project leader it was surprising and humbling to see how seriously the project participants absorbed and integrated the content, recommendations, and goals of the project. They responded enthusiastically and determinedly as they were made aware of the problem regarding student mental health needs. They eagerly accepted shared input and responsibility toward solutions and positive outcomes. Their demonstrated collective ownership, resolve, and commitment to assist and protect their students deserves recognition and gratitude.

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Appendix A

School Mental Health Guide for Educators

Capstone Project Evaluation: Post Implementation

Please check the response that best describes your understanding of the following comments:

Please check: ____ Teacher ____ Staff	Strongly Agree	Agree	Disagree	Strongly Disagree
1. I understand the legal mandates regarding student health issues and confidentiality.				
2. I can recall and identify the signs of depression in adolescents.				
3. I can recall common side effects of medications frequently prescribed to treat depression.				
4. I am aware of at least three interventions that may assist a student with a diagnosis of depression.				
5. I can recall and identify the signs of anxiety in adolescents.				
6. I can recall common side effects of medications frequently prescribed to treat anxiety.				
7. I am aware of at least three interventions that may assist a student with a diagnosis of anxiety.				
8. I can recall the referral process to the student support team when I feel a student is having a potential emotional/mental health concern.				
9. I feel more confident in my abilities to instruct, engage, and assist students who have or may have mental health conditions.				
10. I feel this presentation would be helpful to certified teachers or staff in a middle school setting.				

Comments: (What was helpful? What additional information would you like to know? Any thoughts, comments, or suggestions for future presentations.) Use back if needed.

Appendix B

School Mental Health Guide for Educators

Capstone Project Evaluation: Post-Implementation Follow-up Survey

Please check the response that best describes your understanding of the following comments:

Please check: _____ teacher or _____ staff	Yes	No	Unable to Recall
1. I have referred a student to the student support team for an emotional or mental concern since the school mental health staff development sessions.			
2. I have utilized at least one communication technique or classroom intervention since attending the school mental health staff development sessions.			
3. I have independently sought out more information about adolescent mental health disorders since the school mental health staff development sessions.			
4. I am more comfortable accessing the student support team (school nurse, school social worker, & school counselor) for potential student mental health concerns.			

Comments: