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Educators' Perceptions Of Youth Behavioral Health Training In Schools Across North Dakota

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EDUCATORS' PERCEPTIONS OF YOUTH BEHAVIORAL HEALTH TRAINING IN SCHOOLS ACROSS NORTH DAKOTA

by

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Elisa Diederich
August 15, 2021

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This paper is dedicated to my sister, Becca Werk.

ABSTRACT

During the 2019 North Dakota legislative session (the 66th Legislative Assembly), Senate Bill 2149 was introduced to amend the North Dakota Century Code (NDCC) at Title 15.1 Elementary and Secondary Education, Chapter 07 School Districts, Section 34, which addresses behavioral health (including mental health) in an educational setting. This bill was enacted.

The purpose of this flexible design qualitative study was to investigate experiences teachers, principals, and school counselors have had related to their students' mental and behavioral health. Furthermore, this study investigated the perceptions North Dakota educators have had related to professional development on student behavioral health. Finally, this study investigated how North Dakota educators have perceived their experiences related to social emotional learning and mental health program implementation in their schools.

This study was guided by ecological theory, which provides a framework for examining human behavior and development; ecological theory shows how environmental systems that people interact within can impact behavior and development. The study began with a Qualtrics survey of teachers, principals, and school counselors. Then, individual interviews and a focus group interview with elementary teachers, secondary teachers, elementary principals, secondary principals, and school counselors were (was) conducted. Educator perceptions identified several challenges in

implementing Senate Bill 2149 legislation, including lack of personnel to provide mental health support for students, challenges in obtaining and implementing effective mental health curricula, and limited funding available for professional development time to support this legislation.

Keywords: PreK-12 Education, Mental Health, Educators

CHAPTER I

INTRODUCTION

According to the University of North Dakota Educational Leadership Cohort #8 (personal communication, March 3, 2021):

> The purpose of the educational system in North Dakota, according to Article VIII of the Constitution of North Dakota, is to preserve democratic government and to provide for the "prosperity and happiness" (N.D. Const. art. VIII § 1), of the people. The writers of the state constitution believed that this required students to have, "a high degree of intelligence, patriotism, integrity, and morality" (N.D. Const. art. VIII, § 1). It is the responsibility of educators to uphold these values while recognizing that the educational system and its stakeholders continue to change. Preparing students to be prosperous and fulfilled citizens in a world that is ever-changing means that educational systems must also evolve to meet those changing needs.
>
> Education in North Dakota is guided by the North Dakota Century Code (NDCC) 15.1 statutes with the North Dakota Legislative Interim Education Policy Committee evaluating their effectiveness. As inferred by Chairman David Monson in the minutes of the Education Policy Committee meeting on October 2, 2019, it is time "to recommend changes to any laws found to be irrelevant, duplicative, inconsistent, or unclear" (Assel, 2019, p. 4).

The purpose of this study was to investigate the perceived effectiveness of NDCC § 15.1-07-34. Recommendations were made for changing the NDCC at Title 15.1, Chapter 07, Section 34 based on responses of participants.

Researcher's Background and Experience

Originally from Minnesota, I came to North Dakota to attend the University of North Dakota (UND). I graduated with a bachelor's degree in Communication Sciences and Disorders in 2000 and with a master's degree in Speech-Language Pathology in 2002. I was a resident teacher within the Grand Forks Public School District for the 2001-2002 school year. After graduating with my master's degree, I worked in Dickinson, North Dakota, and Fergus Falls, Minnesota, as a hospital-based speech-language pathologist. In 2009, I came back to the Grand Forks Public School district, working as a speech-language pathologist. In 2017, I accepted a position as a School-Wide Title 1 Program Coordinator. In the Fall of 2018, I was accepted into UND's Educational Leadership Doctoral Program, Cohort 8, where I was enrolled during this study. In the spring of 2019, I accepted a position as an associate principal and a principal designee. At the time of this report, I was an associate principal at an elementary school in Grand Forks, North Dakota.

Need for the Study

In North Dakota, there has been discussion about the mental health needs of students. With a mental health initiative occurring to provide continuing education on issues surrounding student mental health (N.D. Cent. Code, n.d., Section 15.1-07-34), more educators have been receiving training than in the past regarding how to help students who are facing issues related to their mental health. According to the NDCC,

Section 15.1-07-34, each school district must provide 8 hours of continuing education every 2 years for teachers at the elementary, middle, and high school levels. Each school district may choose training specific to identified needs at a school; however, there are selected topics the training must be chosen from. Those topics include trauma, social and emotional learning, suicide prevention, bullying, understanding the prevalence and impact that youth behavioral health wellness has on the family and community, knowing risks and symptoms of threats to behavioral health, being aware of referral sources and evidence-based strategies that help identify interventions needed for students, being aware of evidence-based strategies that can reduce risk factors for students, and evidence-based techniques to prevent or address risky behaviors for students (N.D. Cent. Code, n.d., Section 15.1-07-34).

During the 2019 North Dakota legislative session (the 66th Legislative Assembly), Senate Bill 2149 was introduced to amend the NDCC at Title 15.1 Elementary and Secondary Education, Chapter 07 School Districts, Section 34. When this bill was introduced, changes proposed to this statute included: renaming the statute, requiring teachers and administrators receive 8 hours of professional development on youth behavioral health every 2 years, requiring that each school within a school district designate a youth behavioral health resource coordinator, mandating instruction on mental health be provided to students in Grades 7-12, providing school districts with access to educational materials through regional educational associations, and forming a committee comprised of the state superintendent of public instruction, department of human services, state department of health, and student representatives from elementary, middle, and high schools (Senate Bill 2149, 2019). After this bill was enacted, changes to

NDCC § 15.1-07-34 included: renaming the statute, requiring teachers and administrators receive 8 hours of professional development on youth behavioral health every 2 years, requiring each school within a school district designate a youth behavioral health resource coordinator, providing school districts with access to educational materials through regional educational associations, and requiring the superintendent of public instruction maintain contact information for a behavioral health resource coordinator for each school (Senate Bill 2149, 2019).

Despite this progress, school safety remains a concern to North Dakota educators. According to the Youth Risk Behavior Survey given to North Dakota middle school students in 2019, the number of students who thought about ending their life increased from 17.5% in 2007 to 22.1% in 2019 (North Dakota Department of Public Instruction, 2019b). Similar increases have been noted in the number of students who developed a plan to attempt suicide and the number of students who attempted suicide (North Dakota Department of Public Instruction, 2019b. The number of high school students who thought about attempting suicide also increased throughout this time span from 10.4% in 2007 to 18.8% in 2019, the number of students who attempted suicide increased, from 8.8% in 2007 to 13.0% in 2019 (North Dakota Department of Public Instruction, 2019a).

National trends regarding teens and suicide are also alarming. According to the Centers for Disease Control and Prevention:

> During 2019, approximately one in five (18.8%) youths had seriously considered attempting suicide, one in six (15.7%) had made a suicide plan, one in 11 (8.9%) had made an attempt, and one in 40 (2.5%) had made a suicide attempt requiring medical treatment. (Ivey-Stephenson et al., 2020, p. 51)

Attempting suicide is a known risk factor for and a predictor of dying by suicide (Ivey-Stephenson et al., 2020).

Concerns about student mental health go beyond depression and suicide. The prevalence of other mental disorders has been significant. According to the Centers for Disease Control and Prevention (2020), 9.4% of students between 2 and 17 years of age have received a diagnosis of attention deficit hyperactivity disorder, 7.4% have a diagnosed behavior disorder, 7.1% have a diagnosed anxiety disorder, and 3.2% have been diagnosed with depression. As the Centers for Disease Control and Prevention (2020) explained, some of these diagnoses occur together. These mental health diagnoses are manifesting at a young age. In children between the ages of two and eight, one in six children has been diagnosed with a "mental, behavioral, or developmental disorder" (Centers for Disease Control and Prevention, 2020, para. 5). That equates to 17.4% of this population! Important to note is the fact that depression and anxiety are more likely to occur as a student ages (Centers for Disease Control and Prevention, 2020). However, behavior problems are more likely to occur in students between the ages of six and eleven (Centers for Disease Control and Prevention, 2020). These behavior problems can lead to disruptive behaviors in a classroom.

Student mental health has significant impacts in a classroom. Because of an underlying social-emotional learning or mental health need, children may demonstrate dysregulated behavior (Miller, Gouley, Seifer, Dickstein, & Shields, 2004, Valois, Zullig, & Revels, 2016). Additionally, students who have an underlying mental health disorder may be absent from school more often, have difficulties concentrating, disrupt a school climate, have difficulties making friends, and eventually drop out of school (Even &

Quast, 2017). These factors impact student success at school, including academic achievement. Therefore, to meet the needs of students who have mental health needs, it is vital that efforts are made to explore effectiveness of current programs and initiatives driven by NDCC § 15.1-07-34 that address student mental health, and to determine if there are gaps in current policies and practices that could be filled.

Statement of the Problem

During the 2019 biennium, NDCC § 15.1-07-34 was written to address youth behavioral health needs in schools across North Dakota. Since its implementation, little data has been developed to indicate how educators have perceived this law affects educators and students in North Dakota public schools.

Purpose of the Study

The purpose of this flexible design qualitative study was to investigate how North Dakota educators experience mental and behavioral health needs of their students. Additionally, this study investigated North Dakota educators' perceptions on the quality of professional development they have received on student behavioral health. Finally, this study investigated North Dakota educators' perceptions of their experiences on social emotional learning and mental health program implementation in their schools.

Results from this study may be used to provide an overview of North Dakota educator perceptions on student mental and behavioral health needs, educator perceptions on effectiveness of professional development for teachers on student behavioral health, and educator experiences surrounding social emotional learning and behavioral health programs that are implemented within a sampling of schools across North Dakota. Information obtained in this study may also be used by the North Dakota Department of

Public Instruction (NDDPI), North Dakota School Boards Association (NDSBA), North Dakota Council of Educational Leaders (NDCEL), and the North Dakota Educational Standards and Practices Board (ESPB).

Conceptual Framework

The conceptual framework of this study was built around NDCC § 15.1-07-34 and how it relates to student mental health (Figure 1). Through the lens of educators, I examined the effectiveness of current law at the time of this study. A literature review suggested that changing how this policy is implemented may be necessary to meet needs of students who come to school with concerns related to their mental health. Changing the structure and oversight of this statute may improve how it is

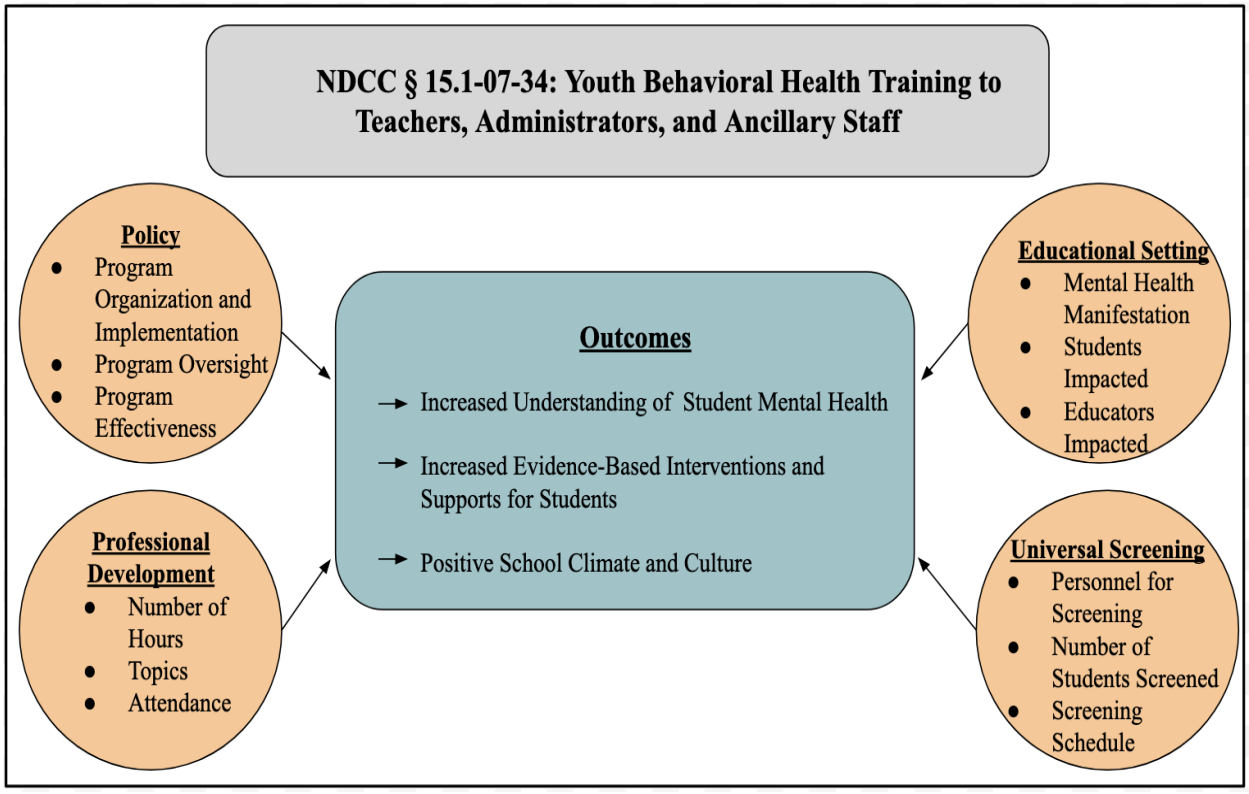

Figure 1. Conceptual framework for this study.

implemented. By adding program oversight to guide the structure of mental health programs, school districts may better ensure their mental health initiatives are implemented by staff who know and understand issues and concerns related to student mental health. By adding accountability for program effectiveness, districts will ensure a school's mental health initiative supports students in their educational programs.

Professional development is one area that can be used to support mental health of students. By ensuring professional development is focused on students' needs at each school, it is likely mental health initiatives will be carried out with fidelity and intentionality. Providing professional development on relevant topics builds capacity within a building's educators and helps ensure school settings support mental health for students who attend that school. Additionally, training in students' needs helps ensure interventions and supports provided for students who may have mental health needs are based on evidence.

Research suggests that effective professional development has specific characteristics. First, to be effective, professional development should be organized to meet an individual school's needs (Nishimura, 2014). When teachers are able to reflect on their learning and discuss implementation strategies with other teachers, provided professional development is more likely to be effectively implemented (Nishimura, 2014). Effective professional development is implemented with a coach and with follow-up sessions to further discuss new learning (Nishimura, 2014). When teachers are able to discuss implementation strengths and areas of improvement with a peer, they are more likely to develop an effective program (Nishimura, 2014). Effective professional development allows teachers time to collaborate with their peers (Nishimura, 2014). This

means teachers collaborate with other teachers, as well as special education staff and ancillary teachers such as music teachers and librarians (Nishimura, 2014). Collaboration with peers is an effective method of ensuring new learning is implemented. Finally, research supports professional development that embeds new practices within teachers' daily lives (Nishimura, 2014). New information that is taught must be relevant and align with what is expected of teachers in their daily teaching practice (Nishimura, 2014).

The goal of including professional development on student mental health for teachers is to have a school system that supports mental health needs of students that attend, promoting a learning environment that is safe and supportive of students. When educators have a better understanding of what their students need, they become better able to advocate for ways to deal with mental health needs that manifest in their classroom. Once students' psychological and emotional needs have been addressed, an academic program can be built.

Support for people who need mental health interventions has a history of being stigmatized by others. This can impact students because they may resist using or deny the existence of mental health services that are offered, in fear of being treated differently by teachers or peers (Smith & Applegate, 2018). Helping teachers understand this barrier allows them to understand why people who have a mental health disorder may be reluctant to receive services (Goldman, 2018). From here, practices that support mental health services can be developed and implemented that take into consideration individuals' reluctance to receive services.

Looking at an educational setting may reveal how underlying mental health conditions can significantly impact a classroom. Disruptive behaviors impact the climate

of a classroom, which affects student learning. Research indicates that having a learning environment where students feel safe and supported impacts student learning more than other factors, such as socioeconomic status (SES) or individual student characteristics (Blank & Shavit, 2016).

Supporting and addressing student mental health issues also supports educators. Stress teachers experience because of disruptive students can affect a teacher's cognitive functioning, well-being, intrinsic motivation, and self-efficacy (Jennings et al., 2017). Furthermore, this stress can influence relationships teachers form with students, as well as the classroom climate teachers establish. Eventually, teachers who experience chronic stress experience burnout (Jennings et al., 2017). As a result, they may leave the teaching profession.

Finally, the literature review supports universal mental health screening for all students to help identify common mental health conditions. By identifying a student body's mental health needs, effective school-wide mental health practices can be implemented. The structure of a school-wide mental health program can be organized into tiers of support. "Tier 1" interventions can be implemented throughout the school to support all students (O'Malley, Wendt, & Pate, 2018; Pearrow, Amador, & Dennery, 2016). For students who need more focused support, "Tier 2" interventions can be developed and implemented. Tier 2 interventions support identified students in small group settings. Students in need of intensive supports can receive "Tier 3" interventions that focus on specific, individualized needs (O'Malley et al., 2018). By knowing and understanding where students are at, educators can plan for mental health interventions to support all students (Ratnayake & Hyde, 2019).

Research Questions

By using the lens of viewpoints of educators – specifically elementary teachers, secondary teachers, elementary principals, secondary principals, and school counselors – this study explored how the NDCC's youth behavioral health initiative supports educators in schools across North Dakota. To achieve this, the following research questions were developed for this study:

1. How do North Dakota educators experience mental and behavioral health needs from their students?
2. How do North Dakota educators perceive their professional development on student behavioral health?
3. What are North Dakota educators' experiences of social emotional learning and mental health program implementation in their schools?

To answer these questions, a survey was sent through public school email to educators identified above – elementary teachers, secondary teachers, elementary principals, secondary principals, and school counselors. After analyzing the survey questions, interview questions were developed to further investigate how North Dakota educators are impacted by students who may present with mental health needs in their classrooms, and how educational programs and initiatives support the mental health of students.

Existing Theory

In schools, there has been a gap between research emerging from the field of mental health and ongoing interventions considered feasible to implement within an organization (Atkins, Rusch, Mehta, & Lakind, 2016). This is not a new issue. In 1999,

the Surgeon General identified mental health as a significant challenge our nation was facing. Since then, attempts have been made to integrate the science of mental health with the practice of treating it (Atkins et al., 2016). These efforts have largely been unsuccessful. Dissemination and implementation science, primarily based on social diffusion theory and organizational theory, has been the framework driving this initiative (Atkins et al., 2016). This study aims to focus research around a different theory. Using Bronfenbrenner's Ecological Systems Theory to guide dissemination and implementation science will allow researchers and practitioners to understand factors specific to people and settings as they adopt mental health practices that are sustainable in educational organizations (Atkins et al., 2016).

In Bronfenbrenner's essay explaining ecological theory, Bronfenbrenner described how this theory encompasses not just human behavior, but human development as well (Bronfenbrenner, 1977). In defining this theory, Bronfenbrenner said there are several aspects that encompass it. First:

> *The* ecology of human development *is the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives, as this process is affected by relations obtaining within and between these immediate settings, as well as the larger social contexts, both formal and informal, in which the settings are embedded*. (Bronfenbrenner, 1977, p. 514)

He furthered this definition by explaining that a person's "ecological environment *is conceived topologically as a nested arrangement of structures, each contained within the next*" (Bronfenbrenner, 1977, p. 514; see Figure 2). By taking into account the

environment and a person's reaction to their environment, one can begin to understand how social structures impact a person's development.

Within this model, a microsystem encompasses the relationship between a person and the person's immediate setting. A setting is defined as a place with distinct physical features where people engage in specific activities and roles (Bronfenbrenner, 1977). Examples of specific settings include daycares, schools, churches, or homes.

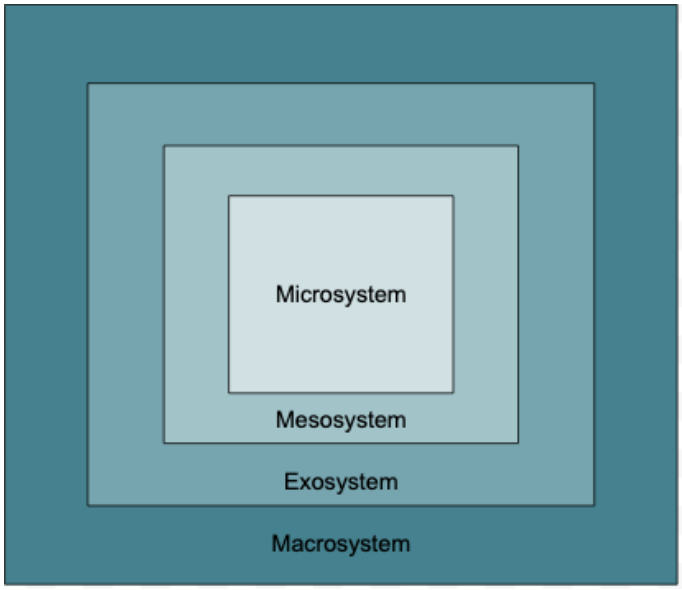

Figure 2. The structure of ecological theory described by Bronfenbrenner in 1977.

A mesosystem is constructed from interrelations between major settings that contain a person at a particular point in their life (Bronfenbrenner, 1977). A mesosystem is made from a system of microsystems (Bronfenbrenner, 1977). So, the interactions among daycare and home, school and home, home and church, church and school, and peer relationships make up a person's mesosystem.

An exosystem extends a mesosystem by embracing formal and informal social structures (Bronfenbrenner, 1977). These social structures do not necessarily contain a

person, but they do affect immediate settings where an individual might be found (Bronfenbrenner, 1977). Therefore, they have a significant influence on what occurs in those environments (Bronfenbrenner, 1977). Some examples of an exosystem include a person's neighborhood, media, governmental agencies, and social networks (Bronfenbrenner, 1977).

Finally, a macrosystem refers to a system of general prototypes that influence how patterns – cultural norms and values – are established (Bronfenbrenner, 1977). Macrosystems can be thought of as blueprints that affect how people or societies act (Bronfenbrenner, 1977). For example, although there are individual differences at each school across America, schools generally have a predictable manner in which they are run. A blueprint that provides this organization would be a good example of a macrosystem (Bronfenbrenner, 1977).

Ecological theory explains how the settings people exist in influence their behaviors (Atkins et al., 2016). Behaviors people manifest cannot be understood without adding additional contextual factors (Atkins et al., 2016). Ecological theory embraces a framework set around four principles: adaptation, succession, cycling of resources, and interdependence (Atkins et al., 2016; Kelly, 2006). By recognizing settings as responsive and dynamic, organizations are able to modify them to meet an organization's changing needs (Atkins et al., 2016). A strength of this theory is its focus on sustainability. By creating diverse and productive systems, there is a limited need to use additional outside resources (Atkins et al., 2016). Thus, systems can be modified to meet an organization's needs at a specific point in time without depleting resources (Atkins et al., 2016).

Applying ecological theory to a dissemination and implementation framework allows educators to bridge the gap between research and action. This framework allows each school flexibility to design a system that meets its individual needs and goals. An example that has been used to make this connection links schools, learning, parents, teachers, students, and mental health resources together so they become an interdependent network (Figure 3).

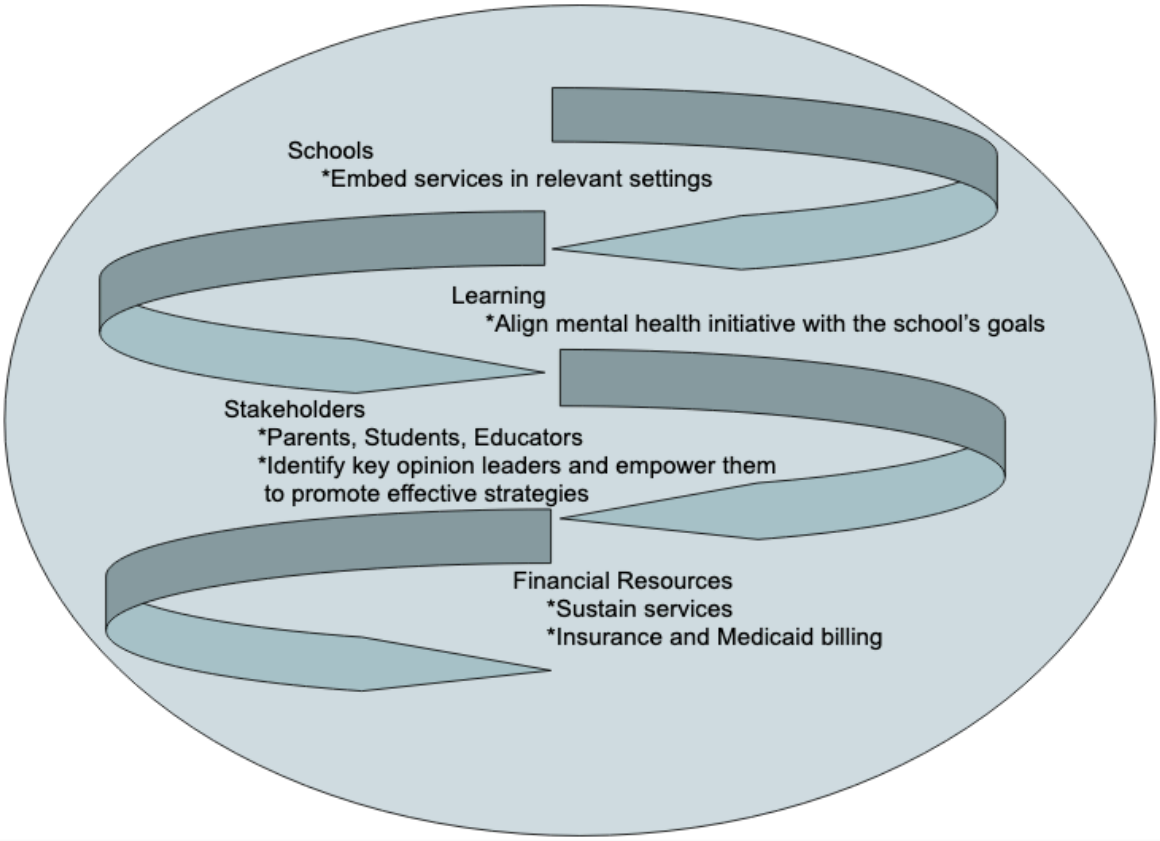

Figure 3. A mental health service model based on ecological theory. Adapted with permission (Appendix A) from "Future directions for dissemination and implementation science: Aligning ecological theory and public health to close the research to practice gap," by M. S. Atkins, D. Rusch, T. G. Mehta, and D. Lakind, 2016, *Journal of Clinical Child & Adolescent Psychology, 45*(2), p. 219. Copyright 2016 by Taylor & Francis Group, LLC.

By using this framework, each school can create a system of universal mental health services that meet the needs of its students, families, and teachers. Figure 3 was adapted from a model developed by Atkins et al. (2016) and indicates how ecological theory can be applied to a dissemination and implementation framework to create self-sustaining systems and meet mental health needs of students within a school.

Delimitations

This study was conducted within North Dakota school districts and focused on recommendations for the NDCC Title 15.1 Elementary and Secondary Education statute(s), and therefore, was based solely upon North Dakota's educational needs. Another delimitation within this research was the focus on public education within North Dakota; private education and home education were not included in our research. Finally, a limited number of teachers, principals, and school counselors participated in this study. School psychologists, social workers, and nurses were not included in this study.

Definitions and Acronyms

The following terms were integral to this study and are defined to clarify their meanings within the context of the study.

Administrator: "An individual who holds an administrator's credential and who is employed by the board of a school district for the primary purpose of providing administrative services to the schools of the district" (N.D. Cent. Code, n.d., Section 15.1-13-01, para. 1).

Class A School: For purposes of this study, a school with 3,500 or more enrolled students.

Class B School: For purposes of this study, a school with fewer than 3,500 enrolled students.

Education Policy Committee: "An interim committee of the North Dakota Legislature tasked with reviewing educational policy at the state level" (University of North Dakota Educational Leadership Cohort #8, personal communication, March 3, 2021).

Elementary School: Concerning education in kindergarten through 5th grade.

Every Student Succeeds Act (ESSA): "Federal legislation signed into law in 2015 that reauthorized the Elementary and Secondary Education Act of 1965" (words of University of North Dakota Educational Leadership Cohort #8, personal communication, March 3, 2021; information taken from U.S. Department of Education, n.d.).

Mental Health: Having mental functions that allow one to be productive, engage in fulfilling relationships, cope with adversity, and adapt to change (U.S. Department of Health and Human Services, 1999).

Mental Illness: "A clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association, 2013, p. 20).

Middle School: Concerning education in Grades 6-8.

No Child Left Behind (NCLB) Act of 2002: "The 2002 update of the Elementary and Secondary Education Act" (Klein, 2015, para. 3).

North Dakota Century Code (NDCC): Contains North Dakota state laws (North Dakota Legislative Branch, n.d.).

North Dakota Department of Public Instruction (NDDPI): "Agency that oversees public instruction in North Dakota" (University of North Dakota Educational Leadership Cohort #8, personal communication, March 3, 2021).

North Dakota Educator: For purposes of this study, a person who holds a teaching license in the state of North Dakota and performs the duties related to teaching in a public or private school.

Pre-Kindergarten (PK): Concerning students ages 3-5 years old.

Secondary School: Concerning education in Grades 9-12.

Self-Regulation: Being able to control one's behavior according to the demands of the specific situation (Pallini et al., 2019).

Statute: A written law.

Student: A person who is studying at a school or college.

Teacher: An individual who teaches within a school.

Telehealth: Healthcare services provided at a distance through telecommunication technology (U.S. Department of Health & Human Services, National Institutes of Health, National Institute of Biomedical Imaging and Bioengineering, 2020).

Organization of the Study

This study was organized into five chapters. Chapter I provided my background, history of the problem, need for the study, purpose of the study, research questions, delimitations and assumptions, and definitions of terms and acronyms. Chapter II consists of a review of literature related to this topic. Chapter III outlines the

methodology used in this study. Chapter IV provides an analysis of the data. Finally, Chapter V completes this study by providing a discussion of results, limitations of the study, and recommendations.

CHAPTER II

LITERATURE REVIEW

Introduction

Schools are often the first place where concerns related to students' mental health are noticed (Kauffman & Badar, 2018). Because of their connection to students, school staff are in a place to recognize these concerns, then assist parents in finding appropriate interventions (Kauffman & Badar, 2018). The purpose of this literature review is to provide a background to understanding mental health needs students who attend public schools present with and to explore the impact schools can have on the mental health of students.

Federal Legislation

The No Child Left Behind (NCLB) Act of 2002 was an iteration of the Elementary and Secondary Education Act of 1965. The intent of the Elementary and Secondary Education Act has always been to promote equitable academic achievement in public schools, but methods for achieving this goal have evolved (Cronin, Kingsbury, McCall, & Bowe, 2005). At the federal level, NCLB emphasized school accountability, flexibility to allow schools to implement school improvement initiatives, evidence-based educational practices, and increased parent involvement (Washington Office of Superintendent of Public Instruction, n.d.). Each state was mandated to create academic standards, as well as a testing system to measure student progress and achievement. All

students were expected to meet or exceed state standards by 2014 (Washington Office of Superintendent of Public Instruction, n.d.). This act was written to improve student achievement by ensuring all children received a fair and equal chance at obtaining their education. The emphasis was placed on Title 1 schools – that is, schools where 40% or more of students are economically disadvantaged (Washington Office of Superintendent of Public Instruction, n.d.).

According to the U.S. Department of Education (n.d.), the NCLB law was scheduled for revision in 2007. However, it was not until 2010 that President Obama recognized the difficulties associated with NCLB and began working on a revision. In 2015, the Every Student Succeeds Act (ESSA) was passed, and states were given time to formulate their plans to align with the new requirements.

In January of 2017, the Trump administration, under the guidance of Secretary of Education Betsy DeVos, updated information regarding consolidated state plans (U.S. Department of Education, 2017a). In a press release sent out March 13, 2017, DeVos explained, "The updated state template will ensure states are able to better serve students with the freedom and flexibility they deserve, and which Congress requires" (U.S. Department of Education, 2017b, para. 2). DeVos believed an updated and streamlined ESSA consolidation plan would allow states greater flexibility for meeting educational needs of their students while ensuring protections remained in place for students who are at risk, including students who are economically disadvantaged, students who are disabled, and students who are English language learners (U.S. Department of Education, 2017b).

According to the U.S. Department of Education (n.d.), the revised consolidated State plan was "structured to promote innovation, flexibility, transparency, and accountability and to reduce burden, while maintaining essential protections for all students." The ESSA has provided for the education of all students by offering guidelines for states to develop policies for school districts to follow (U.S. Department of Education, n.d.). Some guidelines include continuing educational protections for economically disadvantaged and high-needs students, requiring all students to be taught to high academic standards, ensuring stakeholders are provided with assessment data regarding student achievement, supporting local innovations, increasing access to preschool, maintaining expectations for school district accountability, and outlining action steps to be taken to increase performance of the lowest performing schools. One crucial area not addressed in ESSA, or in any of the revisions of the Elementary and Secondary Education Act of 1965, is student mental health.

Definition of Mental Health

Mental illness and mental health are oftentimes used synonymously. Although these two terms encompass a similar concept, upon closer examination, they have very different meanings. Accurately defining these terms is essential to ensure measures are taken to promote mental health and help people who demonstrate signs and symptoms of a mental illness.

According to the Surgeon General, mental health is defined as having mental functions that allow one to be productive, engage in fulfilling relationships, cope with adversity, and adapt to change (U.S. Department of Health and Human Services, 1999). Mental health spans an entire lifetime, and is the foundation to how a person thinks,

communicates, learns, grows emotionally, copes, and views himself/herself/their self (U.S. Department of Health and Human Services, 1999). Mental health can be conceptualized as having positive thoughts and feelings and functioning positively in life (Keyes, 2002). A person's mental health can be described as existing on a continuum, from flourishing to languishing, by examining a person's symptoms related to their mood and emotional wellbeing (Keyes, 2002).

Mental illness, on the other hand, impacts how a person is able to socially engage with their world (Keyes, 2002). A mental illness is "a syndrome characterized by clinical significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association, 2013, p. 20). When one experiences a mental illness, his or her social, occupational, or daily functioning activities may be impacted (American Psychiatric Association, 2013). Examples of some mental illnesses include depression, anxiety, suicide ideation, and self-injury (Smith & Applegate, 2018).

To provide a framework for addressing mental health and mental illness, Keyes came up with a model that conceptualizes mental health and mental illness issues on separate continua (Keyes, 2002; Smith & Applegate, 2018). According to this model, the mental health continuum spans from *no mental health* to *abundant mental health* (Keyes, 2002). The mental illness issues continuum spans from *no mental illness issues* to *many mental illness issues* (Keyes, 2002). According to the Keyes' model, the label of flourishing means one has high levels of wellbeing and is, therefore, filled with positive emotions. People who are flourishing function well, in regard to their psychological and

social status (Keyes, 2002). Languishing, another term used in the Keyes' model, means one has low levels of wellbeing (Keyes, 2002). People who are languishing may feel empty, stagnated, or feel despair. Keyes argued that mental health and mental illness are not on opposite ends of a measurement continuum. Having high levels of mental health does not necessarily mean there is an absence of mental illness (Keyes, 2002). This is an important distinction to make in determining how schools could support students' mental health needs. Figure 4 represents a visual depiction of Keyes' model of mental health and mental illness. See how Keyes' conceptualized mental health and mental illness as two separate continua (Keyes, 2002).

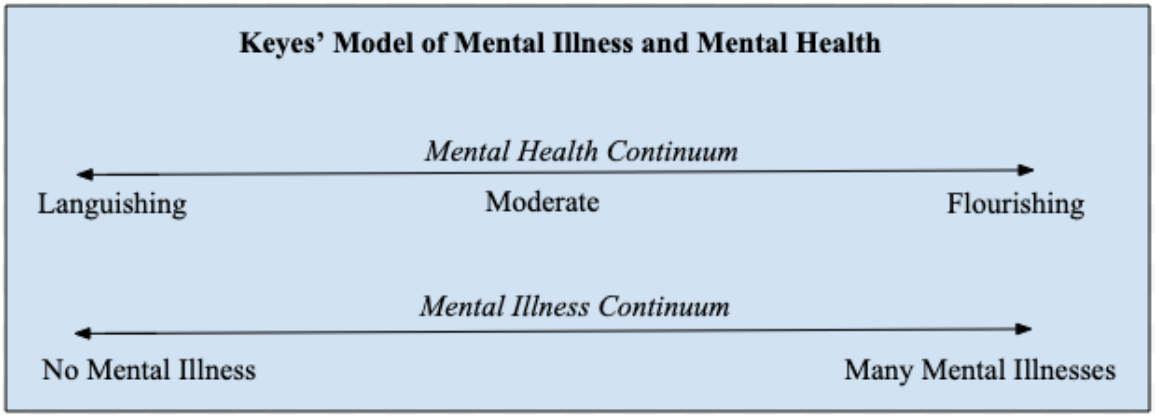

Figure 4. Keyes' model of mental health and mental illness.

Statistics surrounding students who have mental health needs indicate there are a significant number of students who experience a mental illness each school year. In estimation, 20-25% of youth between the ages of five and eighteen experience a mental health disorder each school year (Rose, Leitch, Collins, Frey, & Osteen, 2019; Swick & Powers, 2018; Yell, Smith, Katsiyannis, & Losinski, 2018). "Attention deficit hyperactivity disorder (ADHD) and disruptive behavior disorder (DBD) (i.e., oppositional defiant disorder [ODD] and conduct disorder) are the most common mental

health disorders in childhood" (Bustamante et al., 2016, p. 1398). However, types of mental health disorders prevalent in children can have a considerable range, including diagnoses such as depression, trauma, anxiety, suicide, substance abuse, and eating disorders (Rose et al., 2019). Impacts of living with a mental illness are profound. Demissie and Brener (2017) explained, “As children transition into adolescence, any existing mental health problems become more intense and complex, including the development of comorbid conditions” (p. 227).

Mental health disorders can impact a person throughout their life. More than 30% of children and adolescents experience a mental health condition at one point during their lifetime (Swick & Powers, 2018). Examples of disorders children experience include depressive disorder and generalized anxiety disorder (Swick & Powers, 2018). An identified risk factor for a child experiencing a mental health disorder is living in poverty (Whinnery, 2019). Additionally, coming from a minority background may increase the risk (U.S. Department of Education, National Center for Education Statistics, Institute of Education Sciences, 2019).

Children may demonstrate dysregulated emotions as one indicator of underlying social-emotional learning or mental health needs. Social-emotional learning (SEL) is an area that bridges a child's social-emotional needs and academic performance. SEL programs integrate mental health programs with school initiatives (Atkins, Cappella, Shernoff, Mehta, & Gustafson, 2017). SEL programs work to meet students' behavioral health needs. In a preschool setting, SEL needs can be demonstrated as negative emotions that are intense and impact a child's learning, intense motor activity, and physical and/or verbal aggression (Miller et al., 2004). As students get older, a manifestation of

underlying needs changes. Students may become more violent, demonstrating fighting, making threats to peers, and carrying weapons (Valois et al., 2016). As Even and Quast (2017) explained, "Among the many functional consequences of mental health and related social-emotional conditions, impairment in the school setting includes stress, absenteeism, behavior and discipline problems, poor concentration, disruptions to school climate, dropout, delays in learning, social skill deficits, and more" (p. 9).

Mental Health and Stigma

There is a stigma surrounding mental health, mental illness, and treatment options to support mental wellness. Mental health stigma is defined as “profoundly negative stereotypes about people living with mental disorders” (Smith & Applegate, 2018, p. 382). Over time, this stigma can impact a person with a mental health disorder. Discrimination practices may affect treatment options, choice in career, housing options, and relationships (Smith & Applegate, 2018). Students or their parents may resist accessing available services because they fear they will be treated differently by their peers, teachers, and school staff (Smith & Applegate, 2018).

Discussions surrounding mental health are oftentimes sparked by violent acts (Goldman, 2018). Mass shootings often preclude discussions about mental illness, adding to the stigma that people who have a mental illness tend to be dangerous or unpredictable (Goldman, 2018). In the classroom, some students who have mental disorders demonstrate externalizing or internalizing behaviors that negatively impact the classroom environment (Smith & Applegate, 2018). While these behaviors are disruptive to the educational environment, they may not have anything to do with the child's mental health (Smith & Applegate, 2018).

Educating staff is key in changing the conversation surrounding mental health. When school staff understand the barriers people with a mental illness face and the challenges they must overcome, staff members are able to advocate for students with mental health needs. This creates opportunities to grow mental health programs and supports students in participating in interventions (Goldman, 2018).

Disruptive Behaviors

Disruptive behaviors students manifest are important to address because they alter the climate of a classroom. Some students disrupt the classroom by refusing to cooperate, interrupting peers and/or their teacher, making distracting noises, being chronically tardy, or being disrespectful to peers and/or their teacher (Tyler, Burris, & Coleman, 2018). Other students are aggressive, fighting or bullying their peers (Tyler et al., 2018). When disruptive behaviors rise to the level of explosive or aggressive behavior, students or school staff can be injured (Owora et al., 2018).

Disruptive behaviors have a profound effect on student learning. As Blank and Shavit (2016) explained, "The effect of disciplinary climate on achievement surpassed the effect of school socioeconomic status (SES) and individual student characteristics" (p. 3). Having a supportive classroom environment helps students learn.

Classroom disruptions impact a learning environment. As Blank and Shavit (2016) explained, "Orderly classroom climate is generally considered to be a precondition for effective teaching and learning and, thus, to students' academic achievement" (p. 1). Behavioral or emotional events disrupt a teacher's teaching. As a result, the teacher must stop teaching to address the disruptive behavior. When the teacher returns to teaching, she/he/they must reengage the class so students are focused

and prepared to learn. This takes time away from teaching and disrupts students' academic engagement because, when lessons become disjointed and do not flow, students have difficulties concentrating and learning (Blank & Shavit, 2016, Gage, Scott, Hirn, & MacSuga-Gage, 2018). Even when students are focused, regulated, and ready to learn, disruptions dysregulated behavior brings negatively impacts affected classmates' academic engagement. "By effectively shortening class, disruptions hinder the learning process for students regardless of their personal conduct" (Blank & Shavit, 2016, p. 2). Said another way, dysregulated behavior reduces the time teachers have to teach and learners have to learn.

"Just as active engagement is a predictor of student success, disruptive behavior is a predictor of failure" (Gage et al., 2018, p. 303). Students who are disruptive in a learning environment are more likely to experience academic underachievement later or struggle with learning (Felver et al., 2017). This is especially true for students with or at risk for emotional or behavioral disorders (Gage et al., 2018). Unfortunately, it is not uncommon for disruptive behavior to first manifest early in a child's school experience, sometimes as early as kindergarten (Racz, O'Brennan, Bradshaw, & Leaf, 2016). Disruptive behavior young students demonstrate is a predictor of later adolescent delinquent behavior, as well as adult psychopathy and incarceration (Felver et al., 2017). Of substantial concern is emerging evidence that indicates students acting in disruptive ways can become a behavioral norm (Ingemarson, Rosendahl, Bodin, & Birgegård, 2020).

To engage students and teach them content, teachers must have strong classroom management skills. Research indicates that students who are disruptive to a classroom

environment are often excluded from instruction because they are sent to the office, suspended, or expelled (Gage & MacSuga-Gage, 2017). Having strong classroom management skills is essential to keeping all students in the classroom learning (Gage & MacSuga-Gage, 2017). Of importance, classroom management has been found to be the only significant predictor of differences between teachers who perform at the top-quartile and those who perform at the bottom-quartile (Gage & MacSuga-Gage, 2017). Therefore, teachers who are able to keep students *in* the classroom have more success helping *all* their students learn than teachers who are constantly sending students to the principal's office or counselor or some other place to get rid of disruptive behavior.

When dysregulated behavior persists, a teacher's style of classroom management is sometimes blamed. Teachers can become viewed as ineffective, and this stigma negatively impacts relationships formed between students and teachers (Blank & Shavit, 2016). Additionally, when teachers continually address disruptive behavior, they become frustrated, stressed, and may become less engaged in teaching (Owora et al., 2018). Classroom management, especially as it relates to disruptive behaviors, is often provided as one reason new teachers leave the profession (Gage & MacSuga-Gage, 2017).

It is essential to help teachers understand, especially in early years of teaching, that disruptive behaviors students demonstrate may stem from factors outside a school setting (Racz et al., 2016). Family factors have been identified as predictors of early disruptive behavior including: low parental involvement, inadequate parental monitoring, and discipline practices that are harsh and inconsistent (Racz et al., 2016). Additionally, how a family unit functions has an impact on a child's behavior. Children who experience high levels of conflict in their home, have a parent who has a mental illness, or have

parents who cannot implement effective parenting practices may show disruptive behavior at school (Racz et al., 2016). Knowing and applying effective interventions for students who have underlying mental health needs can lead teachers to understand their students' problems better and effectively implement evidence-based interventions (Racz et al., 2016).

School and teacher factors may also have an impact on student behavior. A school climate can be negatively impacted by high staff turnover rates (Racz et al., 2016). Teachers who have difficulty managing disruptive behaviors often view student behavior and learning difficulties as stemming from external factors, such as the home environment or parenting techniques (Racz et al., 2016). This leads teachers to lack efficacy when addressing problematic student behavior (Racz et al., 2016). Many times, teachers who lack efficacy in their teaching practices experience burnout (Racz et al., 2016). Over the course of a school year, the accumulating experience a teacher may have who feels ineffective or burnt out can have negative impacts on student behavior in the classroom (Racz et al., 2016).

Mental Health and Student Achievement

Research has suggested that cognitive self-regulation, or the ability to attend to what a teacher is teaching, being able to inhibit disruptive or maladaptive behaviors, and being able to plan, then execute that plan, are necessary precursors to learning (Friedman-Krauss & Raver, 2015). Additionally, understanding how to operate in a classroom is a foundational skill to ensuring a student experiences success as a learner. This is because student behavior predicts engagement. As Felver et al. (2017) stated, "Students who are more academically engaged (i.e., actively or passively participating in classroom

instruction) will accelerate in their rate of learning, have better academic achievement, and are less likely to drop out of school" (p. 358). Furthermore, students who follow a school's behavioral expectations can better relate to their peers and achieve higher academically in school (Atkins et al., 2017).

Emotional self-efficacy has been hypothesized as the necessary foundational skill children need to regulate their emotions (Valois et al., 2016). Valois et al. explained emotional self-efficacy as "the ability to avoid negative emotions or the ability to reestablish one's usual emotional state" (p. 270). Valois et al. expounded that children who have strong emotional self-efficacy skills are more likely to make healthy decisions. Students who have strong emotional self-efficacy skills are able to make choices that include refraining from using drugs or alcohol, making safe decisions regarding sexual behavior, and engaging in physical exercise (Valois et al., 2016).

Self-efficacy develops as a student becomes successful at a task and is then able to master it (Olivier, Archambault, De Clercq, & Galand, 2019). When students complete tasks, they often analyze their performance. When students feel successful with a task they have completed, they are more likely to feel efficacious (Olivier et al., 2019). Students who struggle to complete a task or who have negative views regarding their performance on that task will not develop self-efficacy (Olivier et al., 2019).

Having positive mental health indicators has profound effects on a classroom. Therefore, applying a model, such as the Keyes' framework, to address mental health and mental illness at a school provides a roadmap to address mental health concerns and potentially boost student achievement (Keyes, 2002, Smith & Applegate, 2018). According to Keyes (2002), students who are flourishing, in regard to their mental health,

are better able to regulate their emotions. This has been identified as a necessary skill to learn at school. As Friedman-Krauss and Raver (2015) explained, “Self-regulation has been argued to underlie children’s abilities to learn in educational contexts, whereby children who are better able to utilize strategies, plan ahead, pay attention without getting distracted, and persist on tasks are more successful academically” (p. 1727).

Furthermore, as Miller et al. (2004) explained, "The ability to regulate emotions and motor behavior in the classroom setting has been proposed as critical for a child's early success in school" (p. 148). Children who struggle to manage their emotions and outbursts are at risk of experiencing maladjustment at school (Miller et al., 2004). These students have more difficulties maintaining positive relationships with teachers and peers, and they have more difficulties completing academic tasks.

In addition to regulating one's emotions, it is vital students learn to regulate their attention. Teaching students to be aware of their attention helps ensure they remain focused on what is being taught (Pallini et al., 2019). Teaching students skills and strategies to use when they encounter a challenging task helps ensure they persist and learn, even when the task is complex. Additionally, attention influences the relationships we form with others. Having difficulties attending can reduce one's ability to attend to their emotional regulation (Pallini et al., 2019). Having difficulties paying attention to emotional stimuli can manifest in the inability to regulate one's behavior when strong emotions occur (Pallini et al., 2019). Teaching students to be aware of their emotions, as well as strategies to use when they experience intense emotions, helps ensure students form meaningful relationships with others (Pallini et al., 2019). Students learn these skills by engaging in a supportive relationship with a caregiver who can read emotional cues

and respond in a way that comforts the student (Pallini et al., 2019). In school, teachers can serve in this role (Pallini et al., 2019).

In contrast, students who are dysregulated have a more difficult time engaging in classroom learning activities, which influences their academic achievement. As Walter, Kaye, Dennery, and DeMaso (2019) explained, in schools, students with mental health concerns often manifest behavioral and emotional concerns. Family stressors and exposure to trauma adversely impact the teaching and learning that occurs in a classroom (Walter et al., 2019). Students who have mental health needs are more likely to have difficulty sustaining their attention to classroom learning, have difficulties with short-term recall, and cannot persist through challenging learning activities (O'Malley et al., 2018; Swick & Powers, 2018). Ultimately, these students are more likely to be absent from school (O'Malley et al., 2018; Swick & Powers, 2018). These factors influence a student's level of engagement and academic achievement.

If a student's mental health concerns are not addressed, the student's learning becomes impacted, and over time, effects of a mental problem often compound. Research has shown that children who demonstrate aggressive or withdrawn behaviors in first grade have decreased academic achievement by third grade and continue to have lower grades throughout their school career (Frauenholtz, Mendenhall, & Moon, 2017). Students who have mental health concerns are likely to achieve lower in reading and math, and have lower grade point averages (Swick & Powers, 2018). These students are more likely to be retained and/or drop out of high school (Swick & Powers, 2018). Alarmingly, students identified with an emotional and/or behavioral disorder were found to perform below grade level in 91% of studies between 1961-2000 (Even & Quast,

2017). Overall, students identified with emotional and behavioral health disorders have demonstrated performance below their peers in 65% of relevant studies (Even & Quast, 2017).

Students who demonstrate difficulties controlling their disruptive behavior in a classroom are often excluded from classroom instruction when they are disciplined by temporarily being removed from the classroom, receiving in or out of school suspension, or being expelled from school (Gage & MacSuga-Gage, 2017). These students are asked to leave a classroom to go to an office or are placed in more restrictive educational settings (Gage & MacSuga-Gage, 2017). Exclusionary discipline practices have profound impacts on a student's education (Albritton, Mathews, & Anhalt, 2019). By removing a student from classroom instruction, the student's ability to master curriculum is diminished (Baroni, Day, Somers, Crosby, & Pennefather, 2020). This reduces the student's opportunity to access a curriculum and learn, which negatively affects academic achievement (Baroni et al., 2020; Gage et al., 2018).

When students do not perform well at school, their career outcomes are often affected. Long term, how a child performs at school usually predicts how they will function in their career, family, and community (Atkins et al., 2017). Students with mental health concerns who do not do well in school are more likely to use drugs and alcohol, engage in sexual activity, and become involved with violence (Swick & Powers, 2018). These choices negatively affect a student's overall health and future employment opportunities (Swick & Powers, 2018). Sadly, of students with a serious mental health disorder, only 32% go on and attend post-secondary education (Frauenholtz et al., 2017).

Mental Health Services in Public Schools

It is generally accepted that schools have become the de facto setting for delivering mental health services (Atkins et al., 2017). This is because, in communities throughout the United States, mental health services are inadequate or unavailable to some children, such as those living in poverty (Atkins et al., 2017). Some argue that, as a society, we should provide mental health services. "Across the education, public health, and human and social services arenas, there has been renewed interest in bringing agency representatives together to work on the promotion of student mental health and wellness" (Woodbridge, Yu, Goldweber, Golan, & Stein, 2015, p. 1). Many view the role of education as not only to teach but to develop the moral compass valued by society (Aldenmyr & Olson, 2016). Students develop their moral compass by learning cognitive principles, judgments, and values of their society (Aldenmyr & Olson, 2016). Those in favor of this argue that schools are the most efficient place for children to receive mental health services because children are in school all day, so they can easily access mental health providers (Eklund et al., 2017). Mental health services impact student achievement. As Even and Quast (2017) explained, "It can be shown that mental health programming and related responsive services, when properly utilized as necessary conditions for change in PK-12 education, result in academic achievement gains where other expenditures fail" (pp. 4-5). Statistically, half of all mental health concerns arise by the time a child reaches 14 years of age, making schools an ideal place to identify students who are in need and provide mental health services (Pearrow et al., 2016).

Schools have been identified as an ideal place to provide mental health services to students because, by design, they address many of the barriers that keep students from

receiving these services. Some of these barriers include lack of health insurance, cost of mental health services, the stigma surrounding mental health services and supports, inability of parents to leave work to bring students to appointments, and timing and location of appointments (Doll, Nastasi, Cornell, & Song, 2017; Eklund et al., 2020; Swick & Powers, 2018). Many, if not all, of these barriers can be avoided by implementing a school-based mental health program.

There are several advantages to providing mental health services at schools. Students who would not otherwise receive mental health services can get them when they are delivered at school (Yell et al., 2018). According to research, if a child needs mental health services, they are more likely to ask for help if the service is provided within a school (Eklund et al., 2017). Students who are vulnerable or disadvantaged can be reached during school hours (Yell et al., 2018). Even students with insurance, either through Medicaid or private health insurance, have more access to mental health services when they are provided at school (Reback, 2018). When mental health services are embraced as part of a school's culture, parents and teachers can be included and taught how to foster mental health in students (Yell et al., 2018). When mental health services are provided as part of a student's education, a mental health professional can see what behaviors are occurring and create a plan to help a student succeed (Doll et al., 2017). The dropout rate of children not completing therapy from sources outside a school is high, ranging from 28-88%, depending on how it is measured (Dossett & Reid, 2019). Providing mental health services in school addresses many barriers, potentially allowing students to complete an entire course of therapy. Finally, a focus on prevention can occur.

Schools can promote healthy mental health practices and intervene early in a child's lifetime (Yell et al., 2018).

Providing mental health services in schools has become an issue that many school districts have felt the need to address. Statistics are alarming. "One in every five adolescents experiences some type of behavioral and/or social-emotional concern warranting a need for mental and behavioral health interventions" (Eklund et al., 2020, p. 490). More startling, "Approximately half of all children with emotional and behavioral disorders receive mental health services; . . . however, this statistic might be an overestimation of service utilization by low-income youth" (Eiraldi, Wolk, Locke, & Beidas, 2015, p. 124). Despite symptoms often appearing in childhood or adolescence, most low-income students do not get treatment (Swick & Powers, 2018). "When children and youth do receive mental health services, it is most likely to be in the schools that they attend" (Yell et al., 2018, p. 67). If students are not identified and treated, they are more likely to experience adverse school outcomes such as non-attendance, behavioral concerns, and academic challenges than their counterparts who do receive treatment (Swick & Powers, 2018).

How mental health needs impact students that receive special education services is another area that must be considered. "Students with identified disabilities are more susceptible to academic disengagement than their peers without disabilities and would therefore particularly benefit from empirically validated interventions to bolster academic engagement" (Felver et al., 2017, p. 359). The Council for Exceptional Children developed guidelines in 2014 to address mental health practices in special education (Cook et al., 2014). These guidelines provide a detailed framework to help practitioners

identify interventions based on substantial evidence that are effective for treating students in special education programs (Cook et al., 2014).

Suicide is another mental health issue elementary age children sometimes face. The suicide rate for children has increased. In 2006, the suicide rate for children between the ages of 5 and 14 was 0.5 per 100,000. In 2016, it was found to be 1.1 per 100,000 (Miller, 2018). Elementary schools have been identified as an appropriate place to focus suicide prevention efforts because children spend so much time there (Miller, 2018). At school, a mental health professional, such as a school counselor, social worker, or psychologist, should be trained to complete a suicide risk assessment for students who are demonstrating suicide ideation (Miller, 2018).

Students who are culturally and linguistically diverse (C.L.D.) face additional challenges and barriers to accessing mental health services. Data indicate that students from minority backgrounds are at a higher risk for experiencing a mental health issue but are less likely to receive mental health care (U.S. Department of Education, National Center for Education Statistics, Institute of Education Sciences, 2019). Students who are culturally and linguistically a minority are at a higher risk for being referred to special education for an emotional disturbance than are students who feel culturally and linguistically well adjusted – they "fit in" (Fallon & Mueller, 2017).

To intervene effectively with this population, care must be taken to ensure educators use culturally relevant teaching practices, relevant pedagogy, and multicultural curricula. This includes creating and implementing culturally responsive mental health practices. "Culturally responsive school-based practices in particular prioritize the culture, language, heritage, and experiences of CLD learners to facilitate students'

learning and development" (Fallon & Mueller, 2017, p. 201). Measures must be taken to recruit and hire more diverse teachers (Fallon & Mueller, 2017). Educators must understand both behavioral norms and mental and behavioral health concerns of a culture (Fallon & Mueller, 2017). The "Positive Behavioral Interventions and Supports" framework can be an effective way for schools to incorporate culturally responsive practices (Fallon & Mueller, 2017). Additionally, a framework such as this can help build collaboration with families to impact behavioral health outcomes for an entire community (Fallon & Mueller, 2017).

Definitions and models of effective school-based mental health services continue to be debated. One in-house definition of school-based mental health services expands the role that school-employed mental health providers can provide for students needing mental health support (Doll et al., 2017). An outside-in definition calls for funds to bring community-based providers into schools to provide mental health services (Doll et al., 2017). However, the purpose of school-based mental health services can be defined broadly enough to include all mental health services that are delivered by a provider in or near a school (Doll et al., 2017). As long as a mental health program focuses on addressing students' emotional, behavioral, and social functioning, a school-based mental health definition can be applied (Doll et al., 2017). Ideally, these services are focused on family, culturally competent, and adjusted to meet a student's individual needs (Doll et al., 2017).

There are opinions and views regarding who should coordinate and who should provide mental health services in schools. School counselors, psychologists, and social workers have all been identified as professionals who have some expertise in caring for

students' mental health. Some school districts employ all three types of professionals, while other districts have only a school counselor. The type of professional hired by a school district may depend on funding provided through the state. It is important to note that each of these professionals offers a slightly varied approach to identifying and treating students' mental health concerns.

School Psychologists

School psychologists can develop services to help students succeed academically, socially, behaviorally, and emotionally (National Association of School Psychologists, 2010). School psychologists attest they are highly qualified to organize and provide mental and behavioral health (MBH) services. "School psychologists are uniquely qualified providers of MBH services for children and adolescents, in part due to a comprehensive skill set in the application of services within school settings" (Eklund et al., 2020, p. 490). School psychologists have extensive training. School psychologists are taught about and understand psychology, behavioral intervention, classroom instruction, child development, and how schools work (Eklund et al., 2020). Because of this training, they are highly capable of adopting and implementing evidence-based practices to support student mental health (McCurdy et al., 2016). Additionally, school psychologists have the necessary education and training to implement culturally responsive mental health practices for students who are culturally and linguistically diverse (Fallon & Mueller, 2017). The foundation for the idea that school psychologists are capable of providing mental health services is their understanding that there is diversity in learning and development, their understanding of research and how to evaluate a successful

program, and their knowledge concerning legal and ethical professional practices (National Association of School Psychologists, 2010).

To widen the role of school psychologists beyond their current scope of practice requires a paradigm shift (McCurdy et al., 2016). Nationwide data has suggested school psychologists are currently (at the time of this study) used primarily for special education evaluation, identification, and planning (Eklund et al., 2020). "Given the unique training of school psychologists, one recommendation for role expansion is to promote the adoption and high fidelity implementation of evidence-based practices (EBPs), particularly in addressing the needs of high-risk student populations" (McCurdy et al., 2016, p. 375). By using school psychologists more globally within a school setting, the impact of their services on students could be much greater than it has been.

At present, the student to provider ratio for school psychologists does not allow for school-based mental health services to be provided. While the recommended ratio is one school psychologist for every 500-700 students, the current ratio is closer to one school psychologist for every 1,381 students (Eklund et al., 2020). With this ratio, school psychologists do not have the time or personal connection to students to provide needed interventions for dealing with mental health issues.

School Social Workers

The social work profession encompasses a wide variety of specializations. Therefore, only some school social workers will come with skills to assess and treat mental health concerns in students (Rose et al., 2019). However, in their graduate coursework, social work students are taught some foundational knowledge regarding how to help students who demonstrate mental health needs (Rose et al., 2019). School social

workers can provide both direct and indirect services to students, their families, and school personnel (Maras, Thompson, Lewis, Thornburg, & Hawks, 2015). Additionally, school social workers can complete social development evaluations and provide interventions for students who need emotional and/or behavioral support (Maras et al., 2015). Finally, school social workers can coordinate services between a school and community to support a student academically (Maras et al., 2015).

School Counselors

School counselors can provide school-based mental health services to students. School counseling services aim to help all students in academic achievement, social-emotional development, and career development (Maras et al., 2015). The American School Counselor Association attested, "Because of school counselors' training and position, they are uniquely qualified to provide instruction, appraisal and advisement and short-term counseling to students and referral services to students and their families" (American School Counselor Association, 2020, Summary section, para. 1). As professionals, school counselors are able to provide individual and small group counseling, as well as partner with parents to educate them on factors that support education (Even & Quast, 2017). Additionally, school counselors can help families process negative experiences that impact student performance (Even & Quast, 2017).

Beyond individual or small group supports, school counselors can assist with planning and implementing school-wide interventions and supports to address mental health concerns in students (Maras et al., 2015). This includes designing and implementing a Positive Behavioral Interventions and Supports (PBIS) program within a school, assisting with social-emotional learning opportunities, or assisting with the

implementation of a universal screening system for mental health concerns (Donohue et al., 2015).

School Nurses

School nurses are oftentimes not identified as school-based mental health providers. The National Association of School Nurses has a position statement regarding the role of school nurses to screen and provide mental health services in schools.

> It is the position of the National Association of School Nurses (NASN) that registered, professional school nurses (hereinafter referred to as school nurses) serve a vital role in promoting positive behavioral health outcomes in students through evidence-based programs and curricula in schools and communities. (National Association of School Nurses, 2018, para. 1)

The rationale is that school nurses often see somatic complaints a child with an underlying mental health condition presents (National Association of School Nurses, 2018). Furthermore, school nurses promote health and wellness. Mental health falls within this scope (National Association of School Nurses, 2018). Because school nurses do not receive training specific to mental health, ongoing professional development is necessary to ensure best practices for identifying and connecting students with appropriate interventions (Muggeo & Ginsburg, 2019).

Tiers of Mental Health Support

Like the multitiered system of supports and services (MTSS) or response to intervention (RTI) models of support, typically thought of as interventions for academic needs, the provision of mental health supports in schools can be organized into tiers. Through the use of tiers, effective interventions can be put in place to meet students'

diverse needs. To be most effective, strong partnerships between a family, school, and community must be established (Hoover, 2019). As Cook et al. (2015) explained, "The aims of MTSS are to prevent, reverse, and minimize mental health problems while promoting social, emotional, and academic success among all individuals in a school" (p. 167).

Tier 1 interventions are designed to meet the needs of all students in a school (O'Malley et al., 2018; Pearrow et al., 2016). These interventions are aimed at prevention and can be provided in a school community, within a grade level, or in classrooms (Hoover, 2019; Miller, 2018; O'Malley et al., 2018). These interventions focus on building social-emotional skills, forming positive and healthy relationships, learning skills to increase resiliency, implementing trauma-sensitive practices, and mental health and wellness education (Council of Chief State School Officers, 2019). Building students' skills to prepare them for challenging situations empowers students so they know how to react and help their peers. The result is a learning environment that remains peaceful, safe, and conducive to learning (Aldenmyr & Olson, 2016).

Advantages of providing Tier 1 interventions include: teaching all students to cope with difficult situations, a lack of stigmatization for these services because they are provided to all students, and effectiveness in reducing or preventing problematic behavior (Greenberg, Domitrovich, Weissberg, & Durlak, 2017). Tier 1 interventions can also reduce the likelihood that youth suicidal behaviors will develop or occur (Miller, 2018).

Tier 2 interventions are provided in small group settings (O'Malley et al., 2018). Students are identified as benefiting from Tier 2 supports through a screening or referral process (O'Malley et al., 2018). Tier 2 interventions include early identification of

students with mental health needs and/or concerns, screening and progress monitoring, interventions for students, wellness plans, and planning together with students, their families, and community providers (Council of Chief State School Officers, 2019, Donohue et al., 2015). At this level, school-based mental health professionals can implement specific interventions to ensure frequent positive interactions with students (Miller, 2018). The goal of Tier 2 interventions is to intervene early and ensure appropriate supports are in place (Hoover, 2019). An advantage to using Tier 2 interventions is the ability to select students who are most at risk – students who need more than Tier 1 supports to be successful – and then provide specific programs and interventions to meet their needs (Greenberg et al., 2017).

Tier 3 interventions focus on an intensive dose of therapeutic support (O'Malley et al., 2018). Often, these services are provided individually with students (Hoover, 2019). Tier 3 interventions include individual counseling and support, safety and/or reentry plans, referrals to appropriate mental health professionals, follow-up plans, and comprehensive collaboration plans with a student, their family, and if indicated, community provider (Council of Chief State School Officers, 2019). Additionally, coordinating wraparound services is part of Tier 3 interventions (Donohue et al., 2015). Tier 3 interventions are intense and can be expensive (Greenberg et al., 2017). However, because these interventions are individualized to a student's needs, they usually effectively mitigate any issue the student presents with (Greenberg et al., 2017). Thus, they are worth the cost (Greenberg et al., 2017).

Social Emotional Learning

Social and emotional learning (SEL) programs can profoundly impact student lives when implemented effectively (Greenberg et al., 2017). Interventions to address SEL are frequently part of a school's MTSS intervention program. “SEL curricula are primarily derived from social-cognitive or cognitive-behavioral theories and focus on teaching skills that are the foundation for social competence and resilience, such as self-regulation, emotion management, empathy, interpersonal problem-solving, and future orientation” (Cook et al., 2015, p. 169). SEL interventions focus on universal prevention (Cook et al., 2015).

SEL programs are part of a school's universal interventions and are available to all students (Greenberg et al., 2017). SEL programs support students in both the short and long term. In the short term, they increase engagement at school, promote desirable behaviors, and help students feel confident (Greenberg et al., 2017). Additionally, teaching social and emotional skills to students has been found to have a positive impact on academics and test scores. “A meta-analytic study of more than 270,000 students demonstrated an 11 to 17 percentile point gain in academic achievement when associated with universal social and emotional learning programs” (Pearrow et al., 2016, p. 1). In the long term, SEL programs support students’ social-emotional competence, leading to greater achievement and success into adulthood (Greenberg et al., 2017).

SEL programs address five clusters of competence: self-awareness, self-management, social awareness, relationship skills, and responsible decision making (Greenberg et al., 2017, Meyers et al., 2015). Self-awareness skills help students understand their emotions, values, and goals (Greenberg et al., 2017). Self-management

skills help students regulate their emotions and behaviors (Greenberg et al., 2017). Social awareness skills help students understand the perspectives of other people (Greenberg et al., 2017). Relationship skills teach students how to make and maintain positive relationships (Greenberg et al., 2017). Finally, teaching students how to make responsible decisions helps students think through a situation and potential consequences before acting (Greenberg et al., 2017). Assisting students in growing their skills in these five areas prepare students to effectively face challenging situations.

Positive Behavioral Interventions and Supports

Positive Behavioral Interventions and Supports (PBIS) is a program that focuses on student and staff behavior (Donohue et al., 2015). This program is grounded in applied behavior analysis and involves teaching, modeling, cueing, and reinforcing desired behaviors (Cook et al., 2015). The goal of PBIS programs is to create a safe, orderly, and productive learning environment while preventing problem behaviors (Cook et al., 2015; Ingemarson et al., 2020). While focusing on reinforcing desired behavior, problem behavior is systematically addressed (Cook et al., 2015).

PBIS programs can be implemented school-wide. When implemented school-wide, PBIS programs address behaviors throughout a school setting (McCurdy et al., 2016). PBIS programs work well within the three-tier framework of the MTSS or RTI systems. All students are targeted at the Tier 1 level by teaching behavioral expectations on a school-wide basis (McCurdy et al., 2016). At the Tier 2 level, students who continue to misbehave in spite of Tier 1 interventions receive additional interventions in small groups (McCurdy et al., 2016). At Tier 3, intensive strategies and supports are provided

to address specific students and their often chronic problematic behavior (McCurdy et al., 2016).

PBIS programs are driven by data. At the beginning of a school year, a “PBIS team” sets specific goals for an entire school (McCurdy et al., 2016). Data is collected on predetermined criteria, such as behavioral incidents and points are earned for positive behavior (McCurdy et al., 2016). Classroom teachers are provided with specific lessons to teach. Often, complementary curriculum is chosen to drive classroom lessons (McCurdy et al., 2016). Staff are trained on what lessons to teach, what behavior to track, and how to reinforce desired behaviors students demonstrate throughout their school (McCurdy et al., 2016). Because decisions surrounding the planning and implementation of behavioral interventions are driven by data obtained, interventions are tailored to specific needs of an entire student body.

PBIS programs are effective. "Longitudinal data across 15 years shows the sustained impact of the system-wide implementation" (McCurdy et al., 2016, p. 376). Furthermore, data supports that when PBIS systems are in place, there is a decrease in elopement (students running away, leaving school grounds, leaving safe places) and the need to physically restrain students. Additionally, there is an increase in students choosing to make positive behavioral decisions (McCurdy et al., 2016).

Mental Health Screenings

Universal mental health screenings are one tool that educators can use to identify students who need mental health support. As Donohue et al. (2015) explained, “Universal screening is the preventative, systematic, and standardized process of assessing every student for predetermined criteria (e.g., social-emotional or behavioral functioning), with

the aim of providing early identification and intervention to identified students" (p. 134). With universal screening, the focus is on prevention and early identification (Cook et al., 2015). Through the use of universal screens, schools can identify students who are at risk and need more intensive interventions (Reinbergs & Fefer, 2018).

Universal mental health screenings can assist with identifying common mental health conditions, such as anxiety. This is important because anxious students perform poorer in school than their peers. They are more likely to receive poor grades, are more likely to be retained, and have more disciplinary referrals (Muggeo & Ginsburg, 2019). Untreated anxiety can become chronic, with implications lasting throughout a child's life (Muggeo & Ginsburg, 2019).

Universal screens help bring awareness to mental health needs and what can be done to support all students' mental health needs. By understanding mental health needs students present with, access to appropriate services can be broadened. When school staff are able to identify risk factors, they have a better understanding of how to help students (Ratnayake & Hyde, 2019).

Universal screening aligns with a school's multitiered systems of support (MTSS) system. Universal screening tools can help identify students who need additional social-emotional or mental health support and then connect them with appropriate interventions (Donohue et al., 2015). Decisions school personnel make, based on results of universal screening, are driven by data (Fredrick, Drevon, & Jervinsky, 2019). This allows a baseline to determine if interventions in place are effective.

Using universal screenings within an MTSS framework may be an underused resource (Fredrick et al., 2019). Data suggests one in eight schools use universal

screening to identify students with behavioral or mental health needs (Fredrick et al., 2019). “The underutilization of universal screening for behavioral/mental health risk may contribute to the disparity between the number of students who have behavioral/mental health difficulties and the number who ultimately receive appropriate support services” (Fredrick et al., 2019, p. 159).

Universal screening aligns with the Individuals with Disabilities Education Act (IDEA) of 2004. This legislation requires schools to find students who qualify as having a disability. Emotional disturbance is one of the disability categories identified under the IDEA. Therefore, implementing universal screening is one method schools can use to identify students who have a mental health disability (Donohue et al., 2015).

Universal screens should be coordinated by either a school's or a district's leadership team (Donohue et al., 2015). Professional representation on this team is unique to each school and school district. A leadership team is often composed of teachers, school psychologists, school social workers, school counselors, and administrators (Donohue et al., 2015). This team selects a screener (an assessment tool) that meets their school’s specific needs, determines how parents will be informed of a screening, determines the timeline for completing a screen, and identifies where a screening tool will be administered to students (Donohue et al., 2015). Data obtained can be used to drive PBIS programs and MTSS interventions (Donohue et al., 2015). Through this coordinated effort, a leadership team can be specific and deliberate in planning for students’ mental health needs (Donohue et al., 2015).

Teacher Stress

Teaching is a stressful profession, and teacher preparation programs do not adequately prepare new teachers for challenges they will face (Atkins et al., 2017). However, teachers' stresses must be better understood if schools want to retain teachers (Jennings et al., 2017). Stress factors include addressing student behavior and supporting unmotivated students, among other factors (Jennings et al., 2017).

Stress teachers face often leads to negative emotions, impacting a teacher's cognitive functioning, wellbeing, intrinsic motivation, and self-efficacy (Jennings et al., 2017). Over time, continuing stress can lead to burnout (Jennings et al., 2017). Additionally, teachers who are chronically stressed or frustrated have an impact on students. Teachers can transmit stress to their students through something called "stress-contagion" (Jennings et al., 2017, p. 2).

Addressing students' mental health needs is complicated, and there is not always support for issues that arise (Atkins et al., 2017). However, there are interventions that can help teachers. To address teacher stress, it is helpful to create a school that allows teachers to support one another (Atkins et al., 2017). Additionally, helping teachers learn to regulate their emotions is key to preventing teacher stress (Jennings et al., 2017). This is because teachers who cannot deal with the demands of teaching face a decreased emotional wellbeing, which negatively impacts a classroom's climate and culture (Jennings et al., 2017). Providing teachers with social and emotional regulation tools can help them monitor and appropriately react to their emotions (Jennings et al., 2017).

Implementing professional development opportunities can help teachers and paraeducators better understand how to address students who demonstrate behaviors that

indicate there may be an underlying mental health condition (Eiraldi et al., 2015). Using a train-the-trainer model or providing coaching for teachers can be an inexpensive way to address this (Eiraldi et al., 2015). Along with this, ensuring trained staff remain employed at a school is essential for a program's longevity (Eiraldi et al., 2015). Therefore, implementing practices that promote teacher retention is vital to ensuring mental health initiatives remain viable at a school.

State Policies That Address Mental Health

Schools need to create a positive school climate and integrate social-emotional learning because results of this leads to positive outcomes.

> Schools with positive school climate and integrated social emotional learning (SEL) are more likely than comparison schools to achieve higher standards of school safety, including less bullying (verbal, physical, cyber), less student isolation, more positive peer and teacher-student relationships, and less weapon threat and use on school campuses. (Hoover, 2019, p. 27)

Using legislative policies to create trauma-responsive training for teachers and school staff helps support educational leaders in providing a positive school environment (Hoover, 2019). State legislative policies can provide schools with the foundation for creating specific and targeted mental health policies that meet their student body's needs.

Through legislation, many states have addressed the need for policies that focus on SEL (Whinnery, 2019). In North Dakota, each school district must provide its elementary, middle, and high school teachers and administrators with at least 8 hours of professional development on youth behavioral health every 2 years (N.D. Cent. Code, n.d., Section 15.1-07-34). Additionally, North Dakota legislation has supported Medicaid

in covering a variety of mental health services. Specifically, Medicaid plans can cover mental health screenings for children and their mothers. These mental health services are provided in a pediatric or family medicine setting, in child care and early education programs, in the home, and/or for a parent and child together (Smith, Granja, Ekono, Robbins, & Nagarur, 2017). At the time of this study, North Dakota Medicaid plans did not cover programs that help parents of young children promote healthy social-emotional development. Additionally, North Dakota Medicaid has not addressed mental health needs or concerns, behavioral health case management, or care coordination services for children under seven (Smith et al., 2017).

In the 1990s, policymakers began to implement zero-tolerance policies to get tough on behavior that interrupted teaching in an educational setting (Skiba & Losen, 2015-2016). This impacted students by increasing the number of suspensions and expulsions students received. Over time, zero-tolerance policies have not proven effective. As discussed previously, policies that remove a student from a learning environment have been shown to increase the risk of students experiencing adverse school outcomes, often impacting students who are already at a social disadvantage (Skiba & Losen, 2015-2016).

Some policies and practices have targeted students from specific backgrounds (Mallett, 2016; Anderson, Saleem, & Huguley, 2019). Data indicate students from minority ethnic backgrounds are more likely to receive a consequence that removes them from an educational setting than students from majority ethnic backgrounds. “Data reported on disciplinary removals for the 2011-2012 academic year show that black students face the highest risk of out-of-school suspension, followed by Native American

and then Latino students" (Skiba & Losen, 2015-2016, p. 5). Students with disabilities are also more likely to be suspended, and when they are suspended, it will likely be for a more extended period of time (Skiba & Losen, 2015-2016). Finally, students who are lesbian, gay, bisexual, or transgender are more likely to be expelled (Skiba & Losen, 2015-2016). In contrast, students who are white, Asian, or Hawaiian/Pacific Islander are less likely to be suspended (Skiba & Losen, 2015-2016).

School-to-prison pipeline is a term that has emerged from policies and practices that led to punitive and harmful practices involving the juvenile court system for seemingly insignificant infractions. These policies and practices make it more likely that a child will become criminally involved with juvenile courts than attain an education (Mallett, 2016). Many students are often not a harmful threat to other students or educational community, yet they end up in juvenile courts (Mallett, 2016). Factors including poverty, trauma, mental health concerns, and cognitive or developmental deficit predict involvement in the juvenile justice system (Mallett, 2016). To ensure a school remains a place of education, policies and practices must be created to meet students' underlying needs. To support schools, a state legislature may consider examining policies that address school safety and security to ensure they align with trauma-informed principles (Murphey & Sacks, 2019).

Policy Changes to Support Student Mental Health

To address issues surrounding the school-to-prison pipeline phenomenon, policymakers must support strategies that focus on specific challenges people who are minorities or of low socioeconomic status face. By implementing policies that support schools in addressing underlying issues students who disrupt their educational

environment face, effective interventions can be actualized. Focusing on building positive relationships, teaching students social-emotional skills, and creating structural interventions are some ways discipline can be managed while building a positive school climate and culture (Skiba & Losen, 2015-2016).

Another way policy changes can support schools is by supporting legislation that addresses racial tensions (Anderson et al., 2019). Some people, educators included, believe we should not directly talk about race (Anderson et al., 2019). In theory, by not talking about race and racial tension, students will not develop racial bias (Anderson et al., 2019). However, "The evidence suggests that the real damage occurs when we choose not to talk to our students explicitly about race and racism" (Anderson et al., 2019, p. 21). This can be achieved by selecting a curriculum that encourages discussions about race and racism and supports professional development opportunities for teachers and administrators that specifically acknowledge race and racism (Anderson et al., 2019).

Finally, policymakers can advocate for school-based mental health services by allowing school psychologists to access Medicaid for services they provide (Eklund et al., 2017). Federally, allowing school psychologists to access Medicaid funds is supported (Eklund et al., 2017). If states align with the federal government to allow school psychologists to access Medicaid for services they provide, students who have Medicaid could have access to mental health services at school (Eklund et al., 2017). Additionally, because schools could access Medicaid funds, hiring of more school psychologists would be supported.

Supporting Mental Health in an Educational Setting

Some solutions to support mental health in students are relatively simple and require no additional programming or resources. For example, teacher behavior has a significant impact on student behavior. Having strong classroom management practices in place positively impacts student outcomes (Gage et al., 2018). When teachers communicate the behavior they hope to see, then reinforce students who show that behavior, they are more likely to see behavior that supports their learning environment (Gage et al., 2018; Mikami, Owens, Hudec, Kassab, & Evans, 2019). Teachers who post a classroom charter are more likely to have students who follow it (Mikami et al., 2019). Teachers can encourage their students to be inclusive, kind, and supportive to all students (Atkins et al., 2017; Ingemarson et al., 2020; Mikami et al., 2019). This is especially effective when a teacher reinforces this behavior (Mikami et al., 2019).

Teachers involving families when teaching social-emotional skills is another way to reach and support students without adding additional programs or requesting more resources. Including families in a child's schooling through home-based learning activities, involving parents in school activities, and communicating with families regularly have been shown to be effective (Atkins et al., 2017). In some situations, interventions with families must be targeted. An example includes daily communication between a teacher and a student's parents (Atkins et al., 2017).

Partnerships between schools and mental health providers is a particularly advantageous way to deliver mental health services. Community clinics often face high no-show rates (Atkins et al., 2017). Delivering mental health services to schools can help with this. As Atkins et al. (2017) stated, "There remains a critical need to coordinate

school and community health resources to develop a behavioral health model for children that reduces mental health disparities and advances a long-called-for public health approach" (p. 127).

Mental health programming that involves community partnerships requires a more significant commitment of time and resources; however, the impacts can be great (Grimmett, Lupton-Smith, Beckwith, Englert, & Messinger, 2018). Such programs often involve completing a needs assessment, finding community resources, and then aligning these two elements (Grimmett et al., 2018). Many resources are available that explain, in depth, how community programs can be run to meet the needs of children (Council of Chief State School Officers, 2019; Doll et al., 2017; Grimmett et al., 2018; Reback, 2018). Each program will look a little different because each school has different needs.

Adverse childhood experiences (ACEs), which are traumatic events a child experiences, can have lasting effects (Murphey & Sacks, 2019). Adults who have experienced at least three adverse childhood experiences are at a higher risk of developing alcoholism, drug abuse, depression, poor physical health, obesity, and attempting or completing suicide (Murphey & Sacks, 2019). Having trauma-sensitive teaching practices in place supports students who have multiple ACEs and can help students succeed in school.

Programs that address school-wide prevention are readily available and designed to be easily implemented within schools (Atkins et al., 2017). These programs, implemented with fidelity, support students by teaching them necessary social-emotional skills and behavior responses (Atkins et al., 2017). Developing positive social-emotional skills impacts student learning (Atkins et al., 2017). Strategies that teach students how to

regulate their behavior are especially beneficial because a student is dependent on himself/herself/their self to implement strategies and apply them across school settings (Felver et al., 2017). However, programs can be expensive, making them unavailable to schools seated within high-poverty communities (Atkins et al., 2017).

Mindfulness programs have become more prevalent in schools. Research supports the claim that mindfulness interventions can help students regulate their attention and engagement in classroom learning activities (Felver et al., 2017). Mindfulness programs can help students recognize and address emotional and psychological arousal (Felver et al., 2017). For some students, this means a student is able to implement strategies to gain control of their aggressive behavior (Felver et al., 2017).

Restorative practices can be effective in helping students learn how their behavior impacts others. Restorative conversations work to prevent conflicts between students or repair damaged relationships (Dubin, 2015-2016). Restorative practices can also be used to address misconduct. When restorative practices are used as a problem-solving tool, students learn that addressing conflict by talking can be an effective way to solve a problem (Dubin, 2015-2016).

Student mentorship programs can help students who demonstrate mental health concerns in an educational setting. When mentorship programs provide social support and teach social skills, emotional regulation techniques and skills, and problem-solving skills, a student feels supported in their educational setting (Owora et al., 2018). Positive mentor student relationships can help students recover and develop resilience to future adversities (Murphey & Sacks, 2019).

Programs that involve peers influencing one another's behavior can be especially impactful.

> Peers can have a significant social influence on one another's behavior, reminding fellow students about appropriate behaviors (Carden-Smith & Fowler, 1984; Stern, Fowler, & Kohler, 1988) and increasing prosocial behaviors of young teenagers who are socially rejected and delinquent (Jones, Young, & Friman, 2000). (Lum, Tingstrom, Dufrene, Radley, & Lynne, 2017, p. 371)

A program called *Tootling* involves students reporting one another's positive behaviors. These behaviors are then recorded and showcased by their teacher. This program has been shown to decrease disruptive behavior in a classroom (Lum et al., 2017).

There is evidence that having a space for students to go to when they become dysregulated, to process their emotions and then rejoin their class, is effective. This method draws from sensory integration theory to create an environment that is safe and supportive (Baroni et al., 2020). Using a space such as this helps students become aware of the state of their sensory system, thoughts, emotions, and behaviors (Baroni et al., 2020). This is an especially effective method in helping students who have experienced trauma to process their emotions (Baroni et al., 2020).

Often, children struggling with mental health concerns open up and talk with family, friends, neighbors, or community members (Rose et al., 2019). Educating community members on how to identify mental health problems and how to assist a child in accessing prevention and treatment services can be an effective way to intervene (Rose et al., 2019). During training in programs such as Youth Mental Health First Aid U.S.A. (YMHFA-USA), participants are taught how to recognize mental health problems that

manifest in children and adolescents and connect them with appropriate resources (Rose et al., 2019). Research has found programs such as YMHFA-USA to be effective because when people are more confident in their skills, they are more likely to offer assistance (Rose et al., 2019).

Summary

Chapter II provided a review of current literature. Through this literature review, federal legislation to support mental health was introduced, and a definition was established. Research explaining how mental health impacts students and teachers in an educational setting was discussed. Methods for identifying students in need of mental health support, as well as programs to support mental health needs of students was explained. Finally, effective policies and potential policy changes to support mental health needs of students in an educational setting were identified.

Chapter III provides the methodology for this study, including methods for recruiting participants, gathering and analyzing data, and validating data. Chapter IV provides an analysis of data collected. Finally, Chapter V includes a discussion of results, limitations, and recommendations for school leaders and districts, for legislative action, and for further study.

CHAPTER III

METHODOLOGY

Introduction

In Chapter I, the purpose and need for this study were established. In Chapter II, a literature review explained the understanding of mental health at the time of this study as it related to education, as well as programs and initiatives that have been effectively addressing mental health needs in an educational setting. The purpose of Chapter III is to outline the design for this study. Information related to the topic and participant selection is presented. Data collection tools are explained, and data analysis strategies are outlined. Finally, I explained how validity checks for collected data were applied.

The purpose of this flexible design qualitative study was to investigate the perception North Dakota educators have regarding their students' mental and behavioral health needs. Additionally, this study investigated North Dakota educators' perceptions regarding their professional development on youth behavioral health. Finally, this study investigated North Dakota educators' experiences regarding social emotional learning and mental health programs that have been implemented within their schools. Results from this study provide a comprehensive overview of programs and initiatives in place in North Dakota schools at the time of this study, explain the effectiveness of those programs and initiatives, and suggest changes to better serve students and educators across North Dakota.

Research Questions

By using the lens of perceptions of educators – specifically elementary teachers, secondary teachers, elementary principals, secondary principals, and school counselors – this study explored how students are impacted by issues related to mental health. To gain this information, the following research questions were developed for this study:

1. How do North Dakota educators experience mental and behavioral health needs from their students ?
2. How do North Dakota educators perceive their professional development on student behavioral health?
3. What are North Dakota educators' experiences of social emotional learning and mental health program implementation in their schools?

Research Design

I conducted a flexible design qualitative research study to gain an understanding of behaviors educators observe from students across North Dakota that may occur as a result of an underlying mental health disorder. Additionally, through this study, I investigated if educators perceive the programs and initiatives in place to support mental health of students prepare educators for behaviors students manifest in classrooms. Finally, I investigated if the mental health coordinator appointed by each school in North Dakota has been perceived to be effective in ensuring a school's mental health initiatives are implemented in an effective manner. I chose a flexible design qualitative study as the most appropriate methodology for this study because flexible design allowed me to combine different qualitative strategies to reach a wide variety of educators and then focus the study to gain a deep understanding of topics being researched. Using more than

one method to collect data is a strategy researchers use to gather information related to different aspects of a topic being studied (Maxwell, 2013). The survey aspect of this study allowed me to gather information related to a diversity of thoughts, beliefs, and experiences on topics relevant to the purpose of this research (Jansen, 2010). The interview portion allowed me to gather perspectives of a sampling of North Dakota educators (Maxwell, 2013). Using these techniques allowed me to gain both breadth and depth of understanding on relevant topics pertaining to this study (Maxwell, 2013).

In qualitative research, the goal of conducting a survey is to determine diversity within a topic being studied (Jansen, 2010). By conducting a survey, I was able to identify variations in perceptions within the research population (Jansen, 2010). For this study, I conducted a survey to gather perceptual information about programs and initiatives related to student mental health from educators across North Dakota. From the understanding gained through this survey, interview questions were refined to deeply explore themes that emerged.

In qualitative research, interviews allow a researcher to have access to a wider variety of settings and experiences than observations alone allow (Maxwell, 2013). The interview portion of this study allowed me to focus on specific experiences, observations, and understandings North Dakota educators have formed related to the effectiveness of current mental and behavioral health policies. In doing so, I gained insight into how North Dakota's behavioral health statute at the time of this study supported educators as they tried to address needs of students who may present with mental health issues.

The interview portion of this study included both focus group and individual interviews. Focus group interviews were chosen for several reasons. First, focus groups

allow data to be collected from a given number of people faster because number of participants participating in focus group interviews at one time is greater than one-on-one interviews (Onwuegbuzie et al., 2010). Engaging participants in focus group interviews can generate more responses because of dialogue that occurs among participants (Onwuegbuzie et al., 2010). Additionally, "focus groups have high face validity" (Onwuegbuzie et al., 2010, p. 711). Finally, some research suggests focus groups can create an interview environment that feels safer to participants than individual interviews (Onwuegbuzie et al., 2010).

Individual interviews were incorporated because, "Researchers typically choose individual interviews to collect detailed accounts of participants' thoughts, attitudes, beliefs, and knowledge pertaining to a given phenomenon" (Lambert & Loiselle, 2008, p. 229). One assumption for individual interviews was that, as long as questions were formed well and with intention, participants would be able to express their understanding of the topic being studied (Lambert & Loiselle, 2008).

In qualitative research, there is an advantage to using both focus groups and individual interviews. First, using both focus groups and individual interviews offers a way to triangulate data obtained (Lambert & Loiselle, 2008). Triangulation of data adds to a study's credibility. Combining methods of data collection can allow a researcher to generate complimentary views of a phenomenon being studied, leading the researcher to a more comprehensive understanding of a topic (Lambert & Loiselle, 2008). Because of these reasons, I chose to use both focus group and individual interview methods for this study. Before beginning actual research, this research design was presented to UND's Institutional Review Board for approval, and was approved (Appendix B).

For this study, most participants were more comfortable being interviewed individually. Therefore, participants who requested to be interviewed individually were granted this request. Two participants requested to participate in a focus group interview. These participants were granted this request. Most participants had limited time available to participate in an interview. To accommodate scheduling requests, focus group and individual interviews ran concurrently.

Participant Selection

Across North Dakota, at the time of this study, there were 4,992 primary teachers, 2,433 secondary teachers, 347 elementary principals, 184 secondary principals, and 405 school counselors from 178 public school districts available as potential participants (North Dakota Department of Public Instruction, 2019c). These educators were invited to participate in a survey designed by me using UND Qualtrics. The goal was to have at least 33% of participants respond to the survey. The survey was open for 2 weeks, then a reminder email to complete the survey was sent. The survey was open an additional week. By clicking on the link and completing the survey, participants granted consent to have their responses included in results.

The interview portion of this research was conducted through individual and focus group interviews. For the focus group interviews, two elementary principals participated. For individual interviews, I interviewed four school counselors, one elementary principal, two secondary principals, and one secondary teacher.

Schools were categorized by level to include elementary and secondary. Additionally, schools were categorized by enrollment to include Class A and Class B schools. For the purpose of this study, Class A schools were defined as school districts

that have more than 3500 students enrolled, and Class B schools were defined as school districts that have fewer than 3500 students enrolled. This delineation was chosen because it breaks the total number of students enrolled in North Dakota schools roughly in half. To select candidates for participation in the survey, focus group, or individual interviews, the first participants that responded were chosen.

For this study, public school educators in North Dakota were chosen because they have the commonality of being guided by NDCC and the North Dakota Department of Public Instruction. More specifically, teachers were selected because they directly teach students within our public schools. Therefore, teachers have first-hand experience regarding student mental health. Information provided by public school educators was used to gain insight into impacts students with mental health needs have on their educational settings.

Next, school principals were selected as participants. School principals drive programs, initiatives, and interventions that occur within a school building. Principals have an understanding of needs their students present with. Additionally, principals monitor effectiveness of initiatives in place and explore innovative solutions to current situations. Because of their position, school principals have a unique understanding of specific needs within their buildings. Therefore, they are ideal professionals to gain an understanding of how mental health needs of students present in educational settings.

Finally, school counselors were selected as participants. The rationale for choosing school counselors was, because of their training, counselors have educated insights into challenges and difficulties students who have mental health needs present with. Additionally, school counselors understand specific programs, initiatives, and

interventions being implemented within a specific school and the impact they have on students' mental health needs within their building.

Recruitment Process

To ensure a sampling of a variety of participants, teachers, principals, and school counselors from across the state of North Dakota were recruited, I made the study survey available through school districts' public emails. I contacted each regional education director in North Dakota with a request to email the study survey to teachers, principals, and school counselors.

Teachers, principals, and school counselors were recruited through public school emails to participate in a semi-structured focus group or individual interviews. Additionally, on the survey, my contact information was provided. Participants were directed to contact me by email, text, or phone, should they be willing to participate in one 30-minute semi-structured interview. I recruited four school counselors, one elementary principal, two secondary principals, and one secondary teacher for individual interviews. Additionally, I recruited two elementary principals for a focus group interview. After the first email attempt, an inadequate number of participants were obtained. Therefore, I sent a second recruitment email notification to each cohort of potential participants in an effort to encourage more participation.

Methods of Data Collection

Surveys

A survey link was sent through each school district's public emails to public school teachers, principals, and school counselors. This survey was aimed at determining what resources and interventions were in place at the time of this study, how the

effectiveness of resources and interventions were being measured, and who was responsible for overseeing mental health services provided within an educational setting. The survey also ascertained if participants were willing to participate in one semi-structured focus group or individual interview. I disseminated the link to this survey to each of seven regional education agencies, who were asked to forward the link to the teachers, principals, and counselors in their region. For the 2020-2021 school year, there were 4,992 primary teachers, 2,433 secondary teachers, 347 elementary principals, 184 secondary principals, and 405 school counselors from the 178 public school districts across North Dakota available as potential participants (North Dakota Department of Public Instruction, 2019c).

Informed Consent for Participating in Surveys

The first section of the survey provided participants with informed consent information; so informed consent was embedded within the survey (Appendix C), and was approved by the Institutional Review Board. This informed consent section explained how survey data would be stored and used, and that no identifying information would be available to link a participant with their data. Information contained within the informed consent section stated that completing the survey implied a participant had read the informed consent information and consented to participate in the research.

Interviews

Teachers, principals, and school counselors were recruited to participate in one 30-minute semi-structured interview. Focus groups and individual interviews were conducted over a digital conferencing platform to allow for safe social distancing practices. This was necessary due to the global COVID-19 pandemic. For these

interviews, four school counselors, three elementary principals, two secondary principals, and one secondary teacher from across the state, representing both Class A and Class B school districts, were interviewed. Participants were given the option of participating individually in one-on-one interviews or as part of a focus group. Eight participants requested individual interviews, and two participants agreed to participate in a focus group interview. Interview questions were determined before conducting interviews, and participants were emailed interview questions prior to participating in interviews.

Before each interview began, I introduced myself and explained the purpose of this study. Then, I explained how data would be stored, compiled, and analyzed. After this introduction, I began asking questions regarding demographic information, such as how long each professional had practiced working in their profession, and which school district(s) a participant had worked in.

Informed Consent for Participating in Interviews

Prior to initiating any research, participants were provided with an informed consent document (Appendix D) that was approved by UND's Institutional Review Board. This document outlined how data obtained would be stored and used, what data was reported in results, and how information would be kept confidential. Additionally, the informed consent form contained a statement regarding confidentiality for participants participating in the focus group interview.

Survey Instrument

Based on my education, concerns expressed by colleagues, information learned from the literature review, and a review of educational practices related to mental health services in schools, I developed questions for the online survey administered via UND

Qualtrics. Using a Likert scale, yes-no, and short-answer questions, this survey was designed to determine what behaviors North Dakota educators perceived to be manifested by students who may present with mental health needs within classrooms. Additionally, this survey gauged if participants felt programs and initiatives driven by NDCC § 15.1-07-34 supported teachers in helping students who may present with a mental health disorder, and if the youth behavioral health resource coordinator had been effective in identifying professional development needs of their school. The survey can be viewed in Appendix C.

Interview Questions

Based on the information learned from the Qualtrics survey, as well as my understanding of mental health services in schools based on the literature review, I developed interview questions. These questions were piloted on educators not part of this research study. I understood that, in focus group interviews, one question can generate another. Therefore, during interviews, additional questions were added to a conversation as necessary for clarification or further understanding. Interview questions can be viewed in Appendix E.

Collection of Data

Surveys were sent through a school district's public emails to potential participants. The final survey question ascertained if a participant was willing to participate in an additional interview. This information was collected and used to contact focus group participants.

Focus group and individual interviews were scheduled at a specific time, outside of school hours, convenient for each participant. Before each interview began, I

explained how a participant's personal identifying information would be kept private, how data would be stored, and when data would be destroyed. Participants were informed the meeting would be recorded through digital conferencing platform software, as well as through a digital voice recorder, to allow me to transcribe, code, and analyze data at a later date. They were also informed that, during the interview, field notes would be taken to capture observations and critical details.

Analysis of Data

For the survey, questions were developed to gain an understanding of: (a) behaviors educators experienced in their educational settings that may be related to student mental health, (b) whether or not required professional development on student mental health had been adequately preparing educators to address issues related to mental health needs of students, and (c) whether or not the mental health resource coordinator each school designated had been effective in identifying needs of students in regards to mental health and implementing professional development for teachers to learn more about student mental health. After an adequate number of surveys were returned, data were analyzed with the assistance of UND Qualtrics. Responses were recorded. A final survey question ascertained if a participant was willing to participate in an additional interview. This information guided focus group and individual interview questions.

Qualitative data, obtained from short-response and interview questions, was coded, then analyzed for themes that emerged. Throughout the analysis process, I looked for ideas and themes that were similar and noted when saturation had occurred. In this flexible design qualitative study, the following coding and analysis processes were applied.

Constant Comparative Analysis

Constant comparative analysis is a method of comparing information that emerges from data and using that information to generate and connect categories. What emerges will be themes and categories that are grounded in the data. To achieve this goal, the researcher must analyze data and organize it into indicators. Next, indicators will be compared to indicators, patterns will be compared to patterns, and categories will be compared to categories. By making these comparisons, indicators will form patterns, and the patterns that emerge will lead to the formation of categories (Creswell, 2012). For this study, I analyzed the data first by organizing it into indicators. Next, I compared these indicators to look for patterns within the data. Finally, I compared the indicators to search for categories that emerged.

Pattern Naming

By carefully applying constant comparison analysis to data, patterns emerge (Glaser, 2002). This is accomplished by comparing an emerging pattern until saturation occurs. For this study, I compared indicators and patterns that emerged from the data and organized them into categories. Categories were composed of groups of subcategories.

Coding

To complete this research study, it was necessary to utilize a variety of coding techniques. In the first cycle of coding, I coded data using in vivo codes. As Saldaña (2016) explained, "In Vivo Codes use the direct language of participants as codes rather than researcher-generated words and phrases" (p. 71). Oftentimes, in vivo codes are used during the constant comparison process to allow participants' voices to speak through the

research (Glaser, 2002). For this study, I used in vivo coding because it was necessary to ensure the first cycle of codes precisely reflected themes and ideas that emerged from responses participants provided.

Axial coding was used in the second cycle of data analysis. Axial codes helped me determine which codes were dominant in the study and which codes were less important (Saldaña, 2016). It is important to note that, in axial coding, an axis is a category determined during the first cycle of coding. By using axial codes, researchers are able to determine how categories link with subcategories (Saldaña, 2016). For this study, I used axial codes by identifying dominant codes, and then reorganizing data to ensure redundant or overlapping codes were removed. By doing this, categories and subcategories emerged, and data were grouped accordingly.

The goal of axial coding is to achieve saturation. Saturation occurs during the coding process when no new information emerges from data (Saldaña, 2016). Saturation indicates data has been collected and analyzed, and that further collection or analysis would not result in any new findings, understandings, or insights. For this study, I compared patterns that emerged until saturation was reached. I knew when saturation occurred when additional data was analyzed, but no new indicators, patterns, or categories emerged (Saldaña, 2016). Because each of the interview questions was created from data I analyzed from the survey, I was able to compare survey responses with interview responses. By comparing this data, I was able to ensure I had reached saturation. Additionally, this comparison indicated my triangulated data were consistent across my data streams.

Positionality

I am a white, middle-class female. I grew up in a small, conservative town in northern Minnesota, receiving her entire K-12 education in a public school. I have lived and worked in North Dakota for most of my professional career, working in healthcare and educational settings. I have not experienced life with a chronic mental health condition. I have two high-school-age sons, both of whom received their education from public schools in North Dakota.

Prior to working as an associate principal and principal designee, I worked in special education. I have extensive experience working with students who have a disability, including students who have an underlying mental health condition. As an educator, I have been impacted by students who may have mental health needs. Students with unaddressed mental health needs often become dysregulated. As an educator, I have sought professional development in the area of student mental health. I have learned de-escalation techniques, and is also certified in restraint and seclusion for students. I believe that, as an educator, I must keep students safe, protect academic environments, and teach students skills they need to live a fulfilling life.

Through my life experiences, as well as through my career, I bring thoughts and ideas related to student mental health to her research. As someone who believes in lifelong learning and the power of a growth mindset, I believe there is always room to grow, change, try new things, and ask for help. In educational programs, I believe programs and initiatives must be based on data and evidence-based practices. It is

essential that data collected be used to drive change within a system. Through this, school systems continually improve programs offered.

Validation of Data

Validity is defined as "the state of being well grounded or justifiable, relevant, meaningful, logical, confirming to accepted principles or the quality of being sound, just, and well founded" (Cypress, 2017, p. 256). For this research study, I used triangulation, member checking, and gathering rich data to ensure data would be valid.

As Maxwell (2013) explained, triangulation involves collecting data from a variety of participants from different settings using more than one method of data collection. For this study, data was triangulated by interviewing a variety of educational professionals from various locations around North Dakota, and by using different methods of data collection (an online survey, one-on-one interviews, and a focus group). Careful planning during the recruitment stage ensured both large and small school districts were included in this study.

Member checking is another means to ensure data collected is valid. This technique involves a researcher asking participants if the data collected from each participant matches what that participant intended to say (Maxwell, 2013). During interviews conducted for this study, I paused after every question to summarize the data collected to ensure it matched what the participant meant to say.

Gathering rich data ensures a researcher collects detailed data and it comes from a variety of sources (Maxwell, 2013). By gathering rich data, a researcher ensures an accurate understanding of an issue can be gleaned. For this study, I gathered rich data by ensuring a variety of educators in North Dakota were included in this study, that

participants represented a diverse group, and interview questions were written so they deeply explored this study's topic.

Summary

Chapter III provided the structure to how this flexible design qualitative research study was completed. Specifically, methods for recruiting participants, as well as gathering and analyzing data, were outlined. A plan for ensuring data obtained was valid concludes this chapter.

Chapter IV provides an analysis of the data obtained. Finally, Chapter V includes a discussion of the results, limitations of the study, and recommendations to school leaders and legislators, and also, recommendations for further study.

CHAPTER IV

PRESENTATION OF THE DATA

Introduction

In Chapter I, the purpose and need for this study were established. In Chapter II, a literature review explained the current understanding of mental health at the time of this study as it related to education, as well as programs and initiatives that effectively address mental health needs in an educational setting. Chapter III outlined the design for this study, including how participants were selected and how data were collected, analyzed, and verified.

Chapter IV presents an analysis of data collected. Survey and interview questions are presented with a narrative analysis. After the online survey was complete, questions were organized into response areas. Data that emerged within these response areas were used to form interview questions. For some survey questions, data was organized into figures for additional clarity. Chapter V provides a discussion, summary, conclusion, and recommendations.

Survey Data

For the online survey portion of my study, 48 participants responded. Survey responses included samplings from 20 elementary teachers, 18 secondary teachers, 5 elementary principals, 3 secondary principals, and 2 school counselors. Survey responses

were submitted by 6 participants representing Class A schools and 42 participants representing Class B schools.

Number of respondents did not reach the threshold of desired participants. At the time this survey was disseminated, schools continued to face issues surrounding a global pandemic caused by the COVID-19 virus. Added responsibilities this pandemic has brought to many educational professionals may have impacted the response rate from potential participants. Additionally, regional education agencies had agreed to distribute this survey. Later, when I was ready to have the survey disseminated, many agencies refused. Challenges in getting the survey sent to intended participants may have been because of issues surrounding the COVID-19 pandemic and the increased workload this pandemic has caused.

After the online survey was complete, questions were organized into response areas. These response areas were analyzed, and the data was utilized to create interview questions. Survey Question 1 contained the informed consent document for this study. By reading the informed consent and continuing to take the survey, participants acknowledged their consent. Survey Question 2 asked for demographic information. Forty-eight participants responded to this question with 42 (88%) of the 48 participants indicating they worked in schools that have 3500 students or fewer. Additionally, 6 (12%) of the 48 participants indicated they worked in schools with more than 3500 students.

Response Area 1: Mental Health Resources

Survey questions encompassed within this response area gathered information about what mental health resources were potentially available for students when they

were at school. Participants were asked to identify: (a) selected professionals hired within their school with the potential to provide mental health services (Survey Question 3), (b) if the school had a dedicated person to provide mental health services (Survey Question 7), (c) if the mental health professional hired at the school was utilized to provide mental health services (Survey Questions 8 and 23), and (d) if the school had a designated space for students to receive mental health services (Survey Question 26). The answers to these questions shaped Interview Questions 1 and 4. Survey questions and participant responses are indicated below.

Survey Question 3 asked, "Does your school have (mark all that apply). . . ?" Options to select included: school counselor, school social worker, school psychologist, school nurse, and other. According to survey results, 45 (94%) of the 48 participants indicated their school had a school counselor on staff to support the mental health needs of students. Additionally, 11 (23%) of the 48 participants indicated their school had a school social worker, 8 (17%) of the 48 participants indicated their school had a school psychologist, and 3 (6%) of the 48 participants indicated their school had a school nurse, one (2%) of which indicated their school nurse worked at their school half time. Figure 5 gives a visual representation of the distribution of mental health support professionals serving schools in North Dakota.

Survey Question 7 asked, "Does your school building have a person dedicated to the provision of mental health services for students who are at school?" On this question, 11 (31%) of 36 participants chose "yes," 14 (39%) of 36 participants chose "might or might not," and 11 (31%) of 36 participants chose "no."

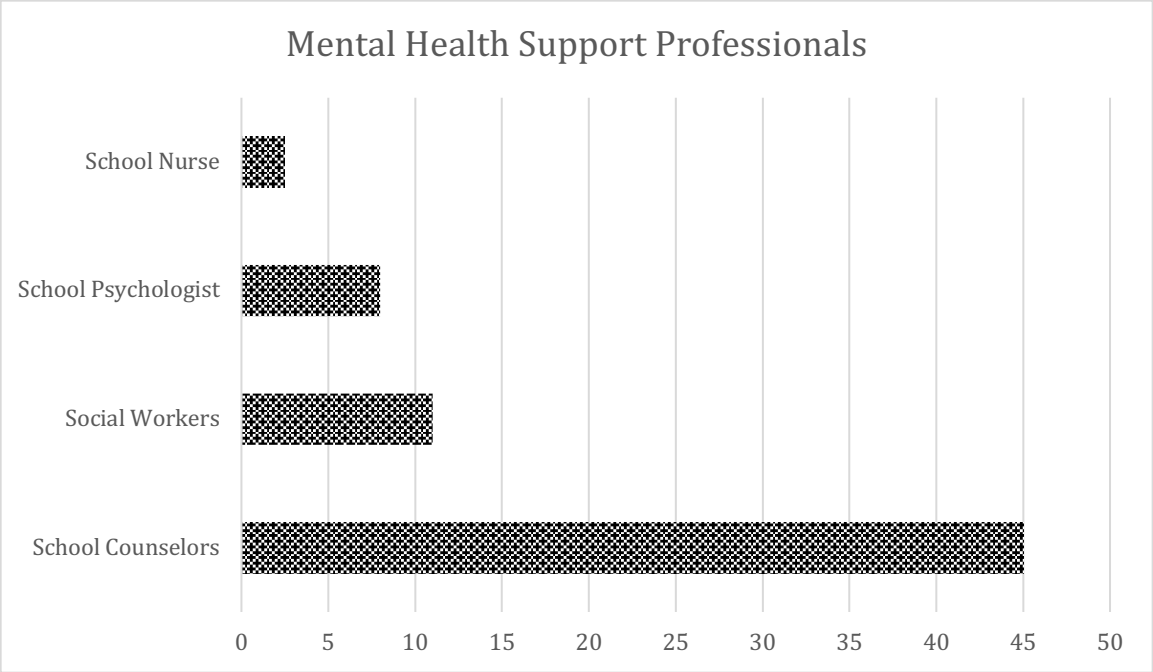

Figure 5. Mental health support professionals serving in schools across North Dakota. $N = 48$

Survey Question 8 asked, "Who provides mental health services at your school (select all that apply)?" Selection options included the school counselor, school social worker, school psychologist, school nurse, referrals are made to an outside agency, and other. Of the respondents who stated that their school had a dedicated person to provide mental health services for students at their school, 21 (58%) of 36 participants indicated a school counselor provided these services. Additionally, 9 (25%) of 36 participants indicated their school made referrals to outside agencies when they suspected a student needed mental health services, and 4 (11%) of 36 participants indicated their school social worker provided mental health services for students at school. Finally, 1 (3%) of 36 participants indicated they had a school psychologist provide this service. One (3%) of 36 participants indicated "other" Please see Figure 6.

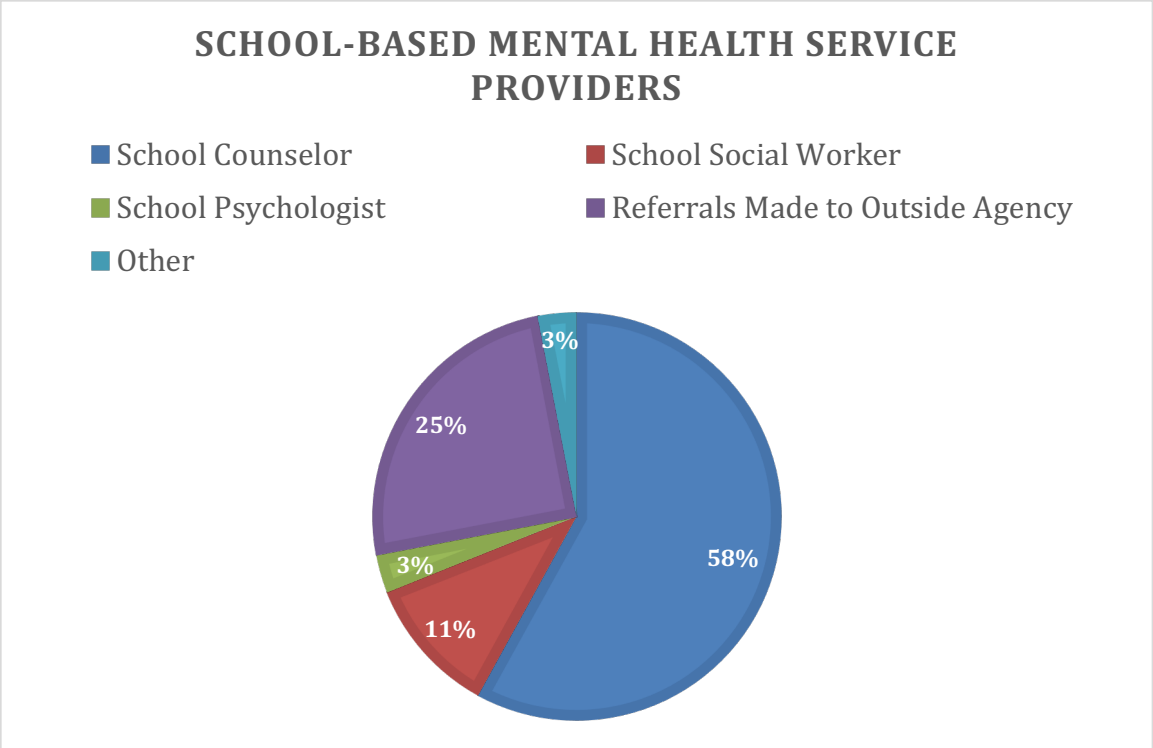

Figure 6. Mental health service providers available in schools.
N = 36

Survey Question 23 asked, "During the 2019-2020 school year, did a school counselor, social worker, or psychologist work with students to provide mental health interventions or supports?" On this question, 10 (40%) of 25 participants responded "definitely yes," 5 (20%) of 25 participants responded "probably yes," 6 (24%) of 25 participants responded "might or might not," 2 (8%) of 25 participants responded "probably not," and 2 (8%) of 25 participants responded "definitely not."

Survey Question 26 asked, "Does your school have a dedicated, private space that is available to provide students with mental health interventions or supports?" On this question, 6 (26%) of 23 participants responded "definitely yes," 9 (39%) of 23 participants responded "probably yes," 1 (4%) of 23 participants responded "might or

might not," 3 (13%) of 23 participants responded "probably not," and 4 (18%) of 23 participants responded "definitely not."

Response Area 2: School-Based Mental Health Resources

Survey questions encompassed within this response area gathered information about teams within schools that make decisions about mental health programming. Questions in this response area asked if the school a participant worked at had a mental health team (Survey Question 10), who was on this team (Survey Question 11), and if the survey participant was included on this team (Survey Question 29). The answers to these questions shaped Interview Questions 1 and 5. Survey questions and participant responses are indicated below.

Survey Question 10 asked, "Does your school have a team of school staff members who collaborate and determine appropriate interventions and supports for students who demonstrate behavioral problems or signs/symptoms of an underlying mental health disorder?" On this question, 12 (43%) of 28 participants answered "yes," 9 (32%) of 28 participants answered "maybe," and 7 (25%) of 28 participants answered "no."

Survey Question 11 asked, "Who makes up your school's mental health team (check all that apply)?" Options respondents could choose included: school counselor, school social worker, school psychologist, school nurse, administrator, teacher, special educator, and other. Twenty-two participants responded to this question. Of the responses, 17 participants (77%) indicated a school counselor was on their school's mental health team, 3 participants (14%) indicated a school social worker was on their school's mental health team, 3 participants (14%) stated a school psychologist was on

their school's mental health team, 1 participant (5%) stated a school nurse was on their school's mental health team, 18 participants (82%) stated a school administrator was on their school's mental health team, 16 participants (73%) stated a teacher was on their school's mental health team, 13 participants (59%) stated a special education teacher was on their school's mental health team, and 2 participants (9%) stated an "other" school professional was on their school's mental health team.

Survey Question 29 asked, "During the 2019-2020 school year, were you involved in the identification of students with possible mental health needs or planning for interventions for students, as it related to their mental health?" On this question, 11 (48%) of 23 participants answered "yes," 1 (4%) of 23 participants answered "maybe," and 11 (48%) of 23 participants answered "no."

Response Area 3: Mental Health Coordinator

Survey questions encompassed within this response area gathered information about the mental health coordinator school districts had recently been tasked with appointing. Participants were asked who coordinates mental health initiatives at the participant's school (Survey Question 6) and who received referral information when a concern about student mental health was identified (Survey Question 14). The answers to these questions shaped Interview Questions 2b and 4. Survey questions and participant responses are indicated below.

Survey Question 6 asked, "Does your school district have a person designated to oversee and/or coordinate mental health services?" On this question, 7 (21%) of 34 participants chose "definitely yes," 10 (29%) of 34 participants chose "probably yes," 8

(24%) of 34 participants chose “might or might not,” 7 (21%) of 34 participants chose “probably not,” and 2 (6%) of 34 participants chose “definitely not.”

Survey Question 14 asked, “Who received the form or information for concerns that were reported?” Twenty-one participants responded to this question, and 13 participants (62%) identified school counselors as receiving this information, 7 participants (33%) identified school administration as receiving this information, and 1 participant (5%) identified an “other” school professional as receiving this information. No participants (0%) indicated school psychologists, social workers, or nurses received this information.

Response Area 4: Data

Survey questions encompassed within this response area gathered information about data kept and how that data was utilized to make programmatic decisions regarding a school’s mental health initiatives. Participants were asked if data were recorded on number of students identified for mental health services (Survey Question 4), how many students were referred for mental health support each school year (Survey Question 5), if data were kept on how many students received Tier 1 (Survey Question 18), Tier 2 (Survey Question 20), or Tier 3 (Survey Question 22) support, and how many students a respondent personally identified to receive some type of mental health support (Survey Question 30). Answers to these questions shaped Interview Questions 3, 3a, and 3b. Survey questions and participant responses are indicated below.

Survey Question 4 asked, “At your school building, is there a record of the number of students referred for mental health services provided through the school

counselor, social worker, or psychologist?" In this question, 11 (23%) of 48 participants indicated their school district had a person designated to provide mental health services for students at school (i.e., there was a record of number of students referred to a school counselor, social worker, or psychologist). Additionally, 27 (56%) of 48 participants said their school district may or may not have a person dedicated to the provision of mental health services for students, and 10 (21%) of 48 participants indicated their school district did not have a person dedicated to providing mental health services for students (see Figure 7).

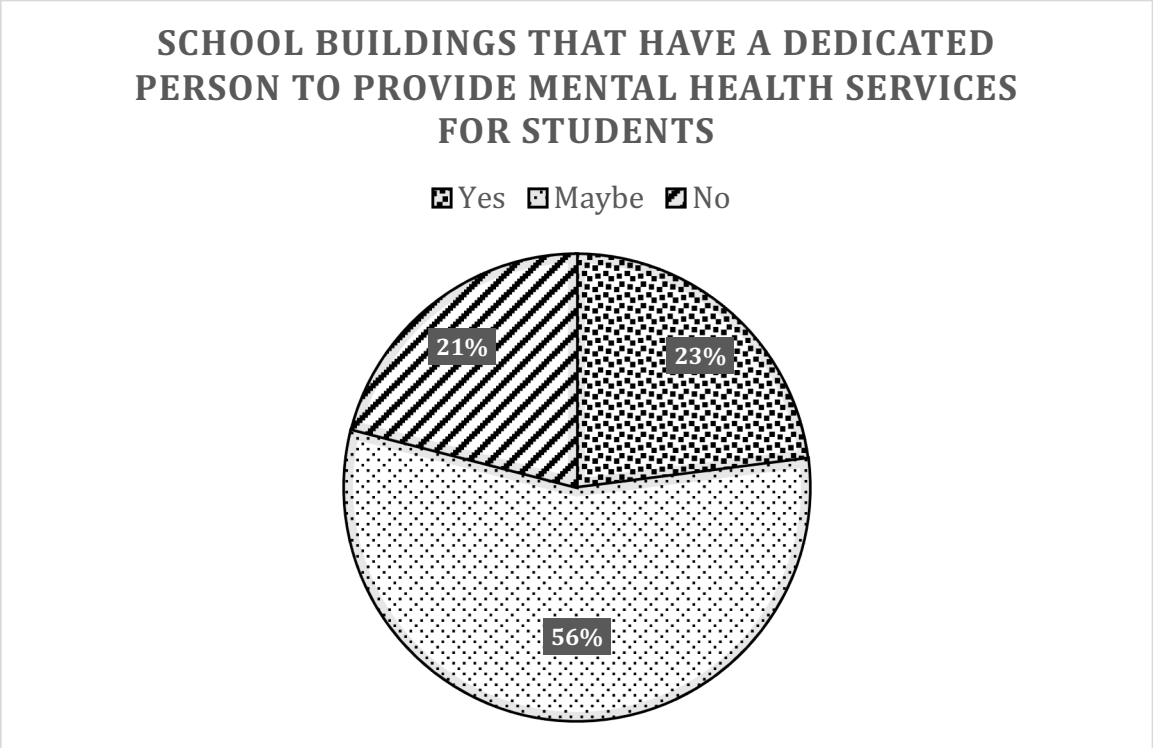

Figure 7. Schools with a dedicated person to provide mental health services. *N* = 48

Survey Question 5 asked, "How many students are referred each year?" On this question, 17 (55%) of 31 participants replied that 0-10 students had been referred during

the 2019-2020 school year. Additionally, 6 (19%) of 31 participants responded that 11-20 students had been referred during the 2019-2020 school year. Finally, 8 (26%) of 31 participants chose “other amount” for this question.

Survey Question 18, which targeted MTSS Tier 1 supports, asked, “Did you keep records or data on the number of students that were served through this program?” On this question, 3 (20%) of 15 participants answered “yes,” 6 (40%) of 15 participants answered “maybe,” and 6 (40%) of 15 participants answered “no.”

Survey Question 20, which targeted MTSS Tier 2 supports, asked, “Did you keep records or data on the number of students that were served through this program?” On this question, 4 (28%) of 14 participants answered “yes,” 5 (36%) of 14 participants answered “maybe,” and 5 (36%) of 14 participants answered “no.”

Survey Question 22, which targeted MTSS Tier 3 supports asked, “Did you keep records or data on the number of students that were served through this program?” On this question, 2 (15%) of 13 participants answered “yes,” 5 (39%) of 13 participants answered “maybe,” and 6 (46%) of 13 participants answered “no.”

Survey Question 30 asked, “How many students did you identify?” Twelve participants responded to this question. On this question, nine participants (75%) indicated they identified 0-5 students, two participants (17%) indicated they identified 6-10 students, and one participant (8%) indicated they identified 11-15 students. No participants (0%) indicated they identified 16-20, 21-25, 26-30, or any “other” amount of students.

Response Area 5: Community Mental Health Resources

Survey questions encompassed within this response area gathered information about community-based mental health resources available for residents in a participant's school district. Participants were asked if students had access to community-based mental health resources (Survey Question 9). Answers to this question shaped Interview Questions 2 and 6. Survey questions and participant responses are indicated below.

Survey Question 9 asked, "Do your students have access to community-based mental health providers, such as psychologists, mental health therapists, or counselors?" On this question, 12 (39%) of 31 participants chose "definitely yes," 5 (16%) of 31 participants chose "probably yes," 11 (35%) of 31 participants chose "might or might not," 2 (6%) of 31 participants chose "probably not," and 2 (6%) of 31 participants chose "definitely not" (Figure 8).

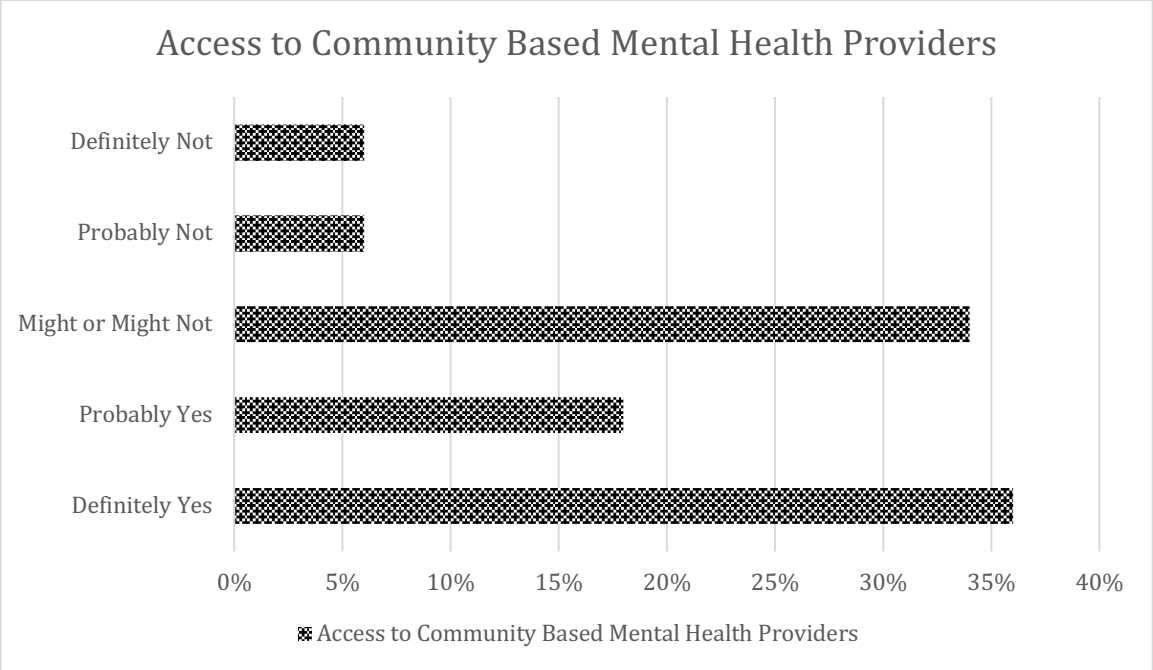

Figure 8. Do students access mental health providers in their community? *N* = 31

Response Area 6: Process to Access Mental Health Resources

Survey questions encompassed within this response area gathered information about a school district's processes for students to access mental health support. Participants were asked if their school district had a process to identify students who may have a mental health need (Survey Question 12), if staff members had a procedure to follow or form to fill out when they had a concern about a student's mental health (Survey Question 13), and if the school district had a way to identify potential threats made by students (Survey Question 15). Answers to these questions shaped Interview Questions 1a and 6. Survey questions and participant responses are indicated below.

Survey Question 12 asked, "During the 2019-2020 school year, did your school have a process or procedure to identify students with mental health concerns or needs?" On this question, 5 (15%) of 33 participants responded "definitely yes," 10 (30%) of 33 participants responded "probably yes," 9 (27%) of 33 participants responded "might or might not," 6 (18%) of 33 participants responded "probably not," and 3 (9%) of 33 participants responded, "definitely not."

Survey Question 13 asked, "Do school staff members have a procedure or a form to report concerns, either through a written documentation or by talking to a designated person, related student mental health (e.g., suicidal ideation, bullying, anxiety, depression, etc.)?" On this question, 20 (67%) of 30 participants answered "yes," 6 (20%) of 30 participants answered "maybe," and 4 (13%) of 30 participants answered "no."

Survey Question 15 asked, "Does your school have a procedure to report and investigate potential threats (check all that apply)?" Options to check included threats: made against students, made against staff members, of students to harm him/herself, and

other. Twenty-two participants responded to this question. According to responses, 18 (82%) of 22 participants indicated their school had a procedure to report threats students make against other students, 16 (73%) of 22 participants indicated their school had a procedure to report threats students make against staff, 17 (77%) of 22 participants indicated their school had a procedure to report threats students make against themselves, and 3 (14%) of 22 participants indicated their school had a procedure to report other threats (Figure 9).

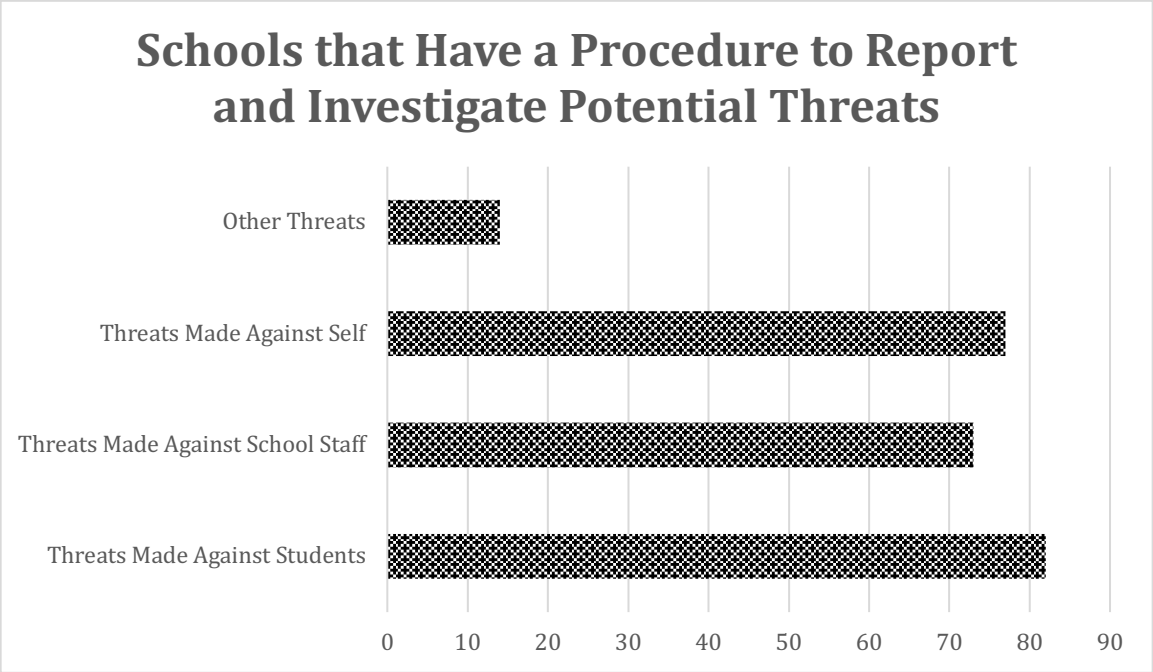

Figure 9. Types of potential threats school staffs report and investigate.
N = 22

Response Area 7: Tiers of Mental Health Programming and Support

Survey questions encompassed within this response area gathered information about MTSS Tier 1, Tier 2, and Tier 3 supports available to support mental health needs of students. Participants were asked if their school had a MTSS process in place to address student mental health (Survey Question 16), and if Tier 1 (Survey Question 17),

Tier 2 (Survey Question 19), and Tier 3 (Survey Question 21) interventions were offered at the participant's school. Answers to these questions shaped Interview Questions 2 and 2a. Survey questions and participant responses are indicated below.

Survey Question 16 asked, "Sometimes, schools use tiers of mental health support to meet the needs of students. Tier 1 is a comprehensive plan that all students in a school receive. Tier 2 supports are for students who need some support, [but] their needs can be met in small groups. Tier 3 is for students who need individualized support. Does your school use a tiered support system to provide mental health interventions and supports for students?" On this question, 3 (12%) of 26 participants responded "definitely yes," 5 (19%) of 26 participants responded "probably yes," 6 (23%) of 26 participants responded "might or might not," 6 (23%) of 26 participants responded "probably not," and 6 (23%) of 26 participants responded "definitely not."

Survey Question 17 asked, "During the 2019-2020 school year, did a school counselor, social worker, or psychologist help staff develop standard, Tier 1 school mental health activities for students?" On this question, 9 (35%) of 26 participants answered "yes," 6 (23%) of 26 participants answered "maybe," and 11 (42%) of 26 participants answered "no."

Survey Question 19 asked, "During the 2019-2020 school year, did a school counselor, social worker, or psychologist help staff develop standard, Tier 2 school mental health interventions for students who were identified through a mental health referral process?" On this question, 5 (19%) of 26 participants answered "yes," 9 (35%) of 26 participants answered "maybe," and 12 (46%) of 26 participants answered "no."

Survey Question 21 asked, “During the 2019-2020 school year, did a school counselor, social worker, or psychologist help staff develop standard, Tier 3 school mental health interventions for students who were identified through a mental health referral process?” On this question, 3 (13%) of 24 participants answered “yes,” 9 (37%) of 24 participants answered “maybe,” and 12 (50%) of 24 participants answered “no.”

Response Area 8: Family Involvement

Survey questions encompassed within this response area gathered information about family support students may have to address any mental health needs. Participants were asked if their school provided families with mental health information (Survey Question 24), and if so, how this information was provided (Survey Question 25). Answers to these questions shaped Interview Questions 2a, 6, and 7. Survey questions and participant responses are indicated below.

Survey Question 24 asked, “During the 2019-2020 school year, were families provided with information regarding mental health for their student(s)?” On this question, 9 (36%) of 25 participants answered “yes,” 13 (52%) of 25 participants answered “maybe,” and 3 (12%) of 25 participants answered “no.”

Survey Question 25 asked, “How were families provided with this information?” Nineteen participants responded to this question. Six participants (32%) responded “word of mouth,” 10 participants (53%) responded “school website,” 9 participants (47%) responded “school handbook,” 8 participants (42%) responded “calls from the school,” 6 participants (32%) responded “school newsletter,” and 2 participants (11%) responded “other.”

Response Area 9: Student Mental Health and Behavior

Survey questions encompassed within this response area gathered information about possible behavior educators notice while students are at school that may indicate a student could need mental health support. Participants were asked if they had concerns about a student's mental health or behavior (Survey Question 27), what the nature of that concern was (Survey Question 28), and what behaviors participants observed or experienced from students (Survey Questions 31, 32, 33, and 34). Answers to these questions shaped Interview Questions 1a, 5, and 7. Survey questions and participant responses are indicated below.

Survey Question 27 asked, "During the 2019-2020 school year, did you ever have concerns about a student's mental health or behavior?" On this question, 12 (52%) of 23 participants responded "definitely yes," 7 (31%) of 23 participants responded "probably yes," 1 (4%) of 23 participants responded "might or might not," 2 (9%) of 23 participants responded "probably not," and 1 (4%) of 23 participants responded "definitely not." Eighty-three (83%) of participants indicated they had concerns regarding a student's mental health or behavior. In contrast, 13% of participants did not have these concerns. Figure 10 shows a visual contrast between percentage of participants who showed concerns about their students' mental health or behavior, and those who did not.

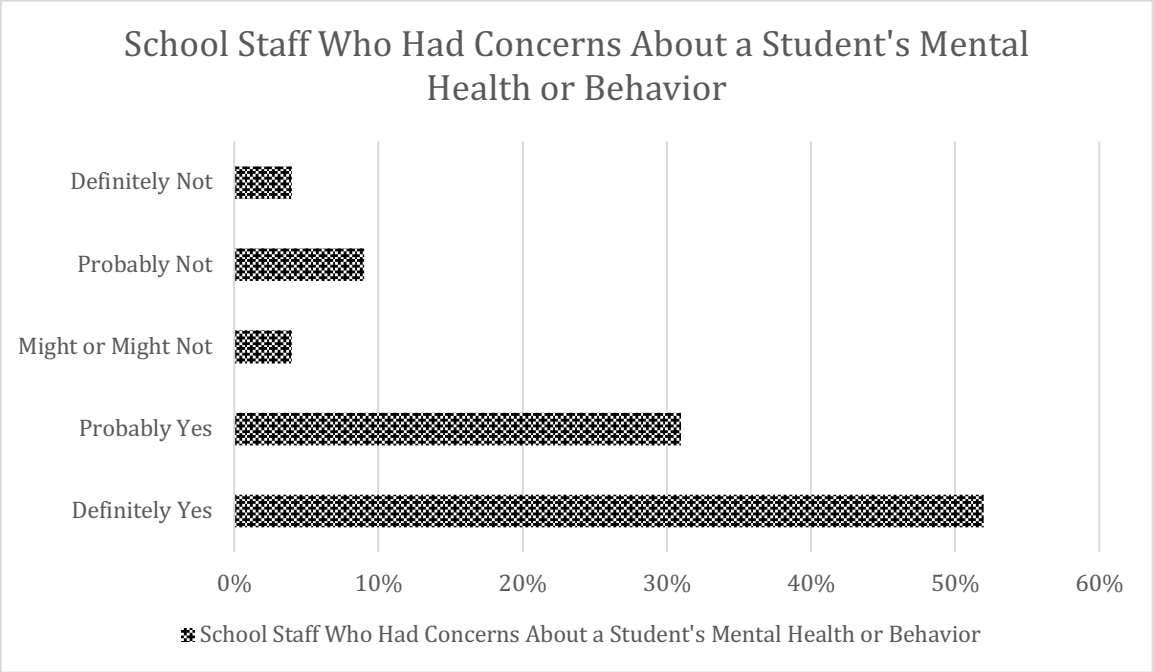

Figure 10. Participants had concerns about student mental health/behavior, 2019-2020. *N* = 23

Survey Question 28 asked, "During the 2019-2020 school year, what areas of student mental health did you have concerns about (check all that apply)?" Options to check included: students with possible anxiety, students with possible depression, students who had difficulty concentrating, students who were oppositional, students who had difficulties making friends, and I had no concerns with student mental health. Twenty-three participants responded to this question. On this question, 14 participants (61%) had concerns regarding students with possible anxiety, 11 participants (48%) had concerns regarding students with possible depression, 15 participants (65%) had concerns regarding students who had difficulties concentrating, 15 participants (65%) had concerns regarding students who were oppositional, 10 participants (43%) had concerns regarding students who had difficulties making friends, and no participants (0%) indicated that they had no concerns with student mental health.

Survey Question 31 asked, “During the 2019-2020 school year, did you experience (select all that apply) . . . .” Options to select included: students who were disruptive in the classroom, students who were defiant to directives, students who were aggressive toward staff, students who were aggressive toward students, students who were noncompliant towards school work, students who were not able to engage with their school work, and I did not experience these behaviors from students. Twenty-two participants responded to this question. On this question, 17 participants (77%) had concerns regarding students who were disruptive in the classroom, 15 participants (68%) had concerns regarding students who were defiant to directives, 9 participants (41%) had concerns regarding students who were aggressive toward staff, 13 participants (59%) had concerns regarding students who were aggressive toward students, 19 participants (86%) had concerns regarding students who were noncompliant towards school work, 15 participants (68%) had concerns regarding students who were not able to engage with their school work, and 3 participants (14%) indicated that they “did not experience these behaviors from students.”

Survey Question 32 asked, “During the 2019-2020 school year, did you experience (select all that apply) . . . .” Options to select included: students who were withdrawn or sad, students who seemed anxious, students who were not able to attend to their school work, students who indicated suicidal ideation, students who were bullied, students who bullied other students, and I did not experience these behaviors from students. Twenty-two participants responded to this question. On this question, 11 participants (50%) had concerns regarding students who were withdrawn or sad, 16 participants (73%) had concerns regarding students who seemed anxious, 17 participants

(77%) had concerns regarding students who were not able to attend to their school work, 6 participants (27%) had concerns regarding students who indicated suicidal ideation, 14 participants (64%) had concerns regarding students who were bullied, 13 participants (59%) had concerns regarding students who bullied other students, and 2 participants (9%) indicated that they did not experience these behaviors from students.

Survey Question 33 asked, "During the 2019-2020 school year, did you experience a student making threats about you or staff members at your school?" On this question, 6 (27%) of 22 participants answered "Yes I did," 4 (18%) of 22 participants answered "I did on more than one occasion," and 12 (55%) of 22 participants (55%) answered "No I did not." No participants (0%) selected "I prefer not to answer."

Survey Question 34 asked, "During the 2019-2020 school year, did you experience a student making threats about other students at your school?" On this question, 10 (46%) of 22 participants answered "Yes I did," 4 (18%) of 22 participants answered "I did on more than one occasion," and 8 (36%) of 22 participants answered "No I did not." No participants (0%) selected "I prefer not to answer."

Response Area 10: Perception of Mental Health Programming

Survey questions encompassed within this response area gathered information about educator perceptions of a school's mental health program(s). Participants were asked if they perceived their school's mental health program(s) as effective (Survey Question 35), and what additional insights they had on student mental health (Survey Question 36). Answers to these questions shaped Interview Questions 6 and 7. Survey questions and participant responses are indicated below.

Survey Question 35 asked, “Do you feel your school adequately addresses issues surrounding student mental health (e.g., depression, anxiety, aggression, attention, defiance, etc.)?” On this question, 3 (13%) of 22 participants responded “definitely yes,” 5 (23%) of 22 participants responded “probably yes,” 5 (23%) of 22 participants responded “might or might not,” 5 (23%) of 22 participants responded “probably not,” and 4 (18%) of 22 participants responded “definitely not” (Figure 11).

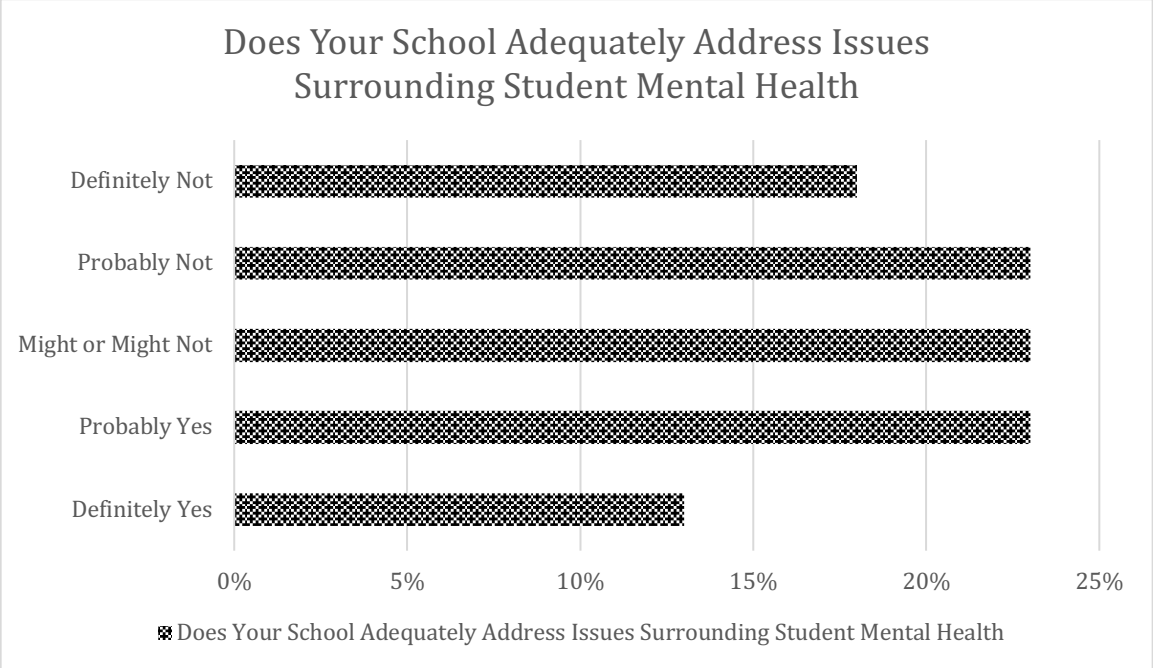

Figure 11. Responses to whether or not schools adequately address mental health. *N* = 22

Survey Question 36 asked, “Is there anything that you would like to add that has not been addressed?” One participant responded:

> We have a group that watches students for any sign, academic, mental, physical that is causing a student to struggle. We will suggest counseling by the outside source and additional supports, but we do not know what happens from that time on.

Another participant responded, “Parents are not very helpful when you try to help with mental health issues in my experience. A lot of times, they have the same problem types.” A third participant responded, “Mental health challenges are growing in schools, and we do not have adequate personnel to address these concerns.” A fourth participant responded, “The pressure of the administration to cook the meal without the ability to get groceries is overwhelming.” No further comments were recorded.

Interview Data

For the interview portion of this survey, 10 participants participated in individual or focus group interviews. For these interviews, four school counselors, three elementary principals, two secondary principals, and one secondary teacher participated. Participants were given the option of participating individually in one-on-one interviews or as part of a focus group. Eight participants requested individual interviews, and two participants agreed to participate in a focus group interview.

Identification of Students Who May Have Mental Health Needs

Interview Question 1 asked, “At your school, who identifies students when there are concerns with the student’s mental health?” Ten participants representing both Class A and Class B schools indicated teachers are often the first educational professionals who notice a student is having difficulties and may need mental health support. All ten participants indicated, once teachers identify a student as possibly benefiting from mental health services, that student is referred to other school professionals to determine if an intervention plan would be beneficial. Seven participants explained their school’s educational teams identify students as possibly benefiting from mental health support

through collected data. Data that indicate a student's behavior is disrupting a learning environment are especially critical and analyzed immediately.

For most schools represented in this study, a school counselor was identified as an essential resource in identifying students who may be struggling with their mental health. During interviews, nine participants indicated their school counselor was the person staff members go to regarding how to support a student or when determining a student needs additional mental health resources. Sometimes staff want their school counselor to meet with a student individually. Each interview participant outlined a slightly different intervention plan designed for the specific needs of their school. One counselor explained, "We don't actually have a formal referral, but I get emails and messages." At this school, educational staff used email to communicate concerns about students possibly needing services and to request their counselor's help. Other schools had more formal referral processes. One participant explained each student's individual needs are considered when determining how to help them. This participant stated, "We're trying to build out a pathway that allows our students to have access to the interventions wherever they land." This resulted in an individualized plan for each student.

Regarding Interview Question 1, eight participants indicated their school had a team of professionals who met to determine what interventions and supports students throughout the school have required. In seven schools, represented in these interviews, this mental health team consists of a school administrator, school counselor, and school social worker, if the school has one. One participant explained that not all schools have hired a social worker, and some small schools may or may not have access to a social worker. In fact, one participant explained there are *counties* in North Dakota that have not

hired a social worker. These counties contract with neighboring counties when a matter involving social services arises. Additionally, one participant from a Class B school district indicated their superintendent is part of their team. No participants from Class A school districts indicated their superintendent was part of their team.

To extend this question, I asked participants, "How do behaviors manifest in students possibly needing mental health support?" During interviews, all ten participants indicated they look for signs and symptoms of depression, anxiety, and trauma in students they work with. If trauma is expected, information regarding the student's background history is compiled. This task is completed by having a teacher work with a school administrator or counselor to gather background information. Information obtained guides a teacher in supporting their student in their classroom.

On this question, participants elaborated on specific externalizing behaviors students may exhibit that indicate there could be an underlying mental health concern. School counselors and administrators explained that depression, anxiety, or trauma symptoms might manifest differently in students. One participant explained, "They'll just shut down. Not do their work. Kind of in that freeze mode. The fight, flight, or freeze." All ten participants discussed students with anxiety. Anxiety can be difficult to identify, one participant explained, because it manifests differently for each student. Students may demonstrate anxiety by becoming physically or verbally aggressive, becoming dangerous to themselves, needing extra attention in the classroom, becoming defiant, withdrawing, crying, having difficulties with friends, or having suicide ideation.

In secondary schools, students may demonstrate signs and symptoms of anxiety, depression, and trauma differently than students do when they are younger. One

participant explained that, in addition to the previously listed signs and symptoms of anxiety, depression, and trauma, students in secondary schools might also be chronically absent, show signs they use drugs, or drop out of school altogether. All ten interview participants stated that teachers, school administrators, and school counselors watch for these symptoms, then meet to determine if their school has an intervention plan that could support a student displaying risky behaviors in their educational setting.

On both the survey and interviews, participants were asked about signs or symptoms they look for to determine if a student is struggling with their mental health. Eight interview participants indicated they look for specific characteristics. Three participants said they learned what characteristics to watch for through their professional program's coursework or professional development put on by their school. As one participant stated, "I think some of the PD and the training that we've had has opened a lot of our eyes as staff members on how to see the stress or the anxiety and those things building up in our kids." I created a word cloud (Figure 12) from interview responses to represent the most common signs and symptoms education professionals look for in students who may be struggling with their mental health. To create this word cloud, I entered exactly what each participant stated. The size of each word represents how many times that word was said. Larger words were stated more times, and smaller words were stated fewer times. Colors used in this word cloud are simply for visual aesthetics.

Figure 12. Possible symptoms students struggling with mental health may demonstrate.

School Programs and Initiatives to Support Mental Health

The next question (Interview Question 2) I asked was, "Does your school have educational programs or initiatives to support student mental health?" If so, Interview Question 2a was asked, "What programs does your school use?" All ten interviewed participants indicated their school had adopted programs to support student mental health. Five participants indicated their school used "Second Step" as a social-emotional learning curriculum to reach all students. Two participants described this as a Tier 1 intervention. Three participants indicated their schools had implemented, or were in the process of implementing, a "Multi-Tiered System of Supports (MTSS)" to reach students on a more individual basis. Interview participants indicated other programs schools have been

implementing across North Dakota including: Why Try, I Am Resilient, Mind Up, Circle of Courage, the social-emotional component of Edgenuity, and Restorative Justice.

During interviews, participants addressed community-based counseling services because parents have sometimes been given this type of information if a student demonstrates an identified need. Two participants from Class A school districts indicated they have provided families with information on how to access community-based mental health services if a student indicates a need or if families request this information. Two participants from Class B schools explained that they have a licensed mental health therapist who provides therapy for students, either through telehealth or by having a mental health therapist come into their school. Parents may be billed for this therapy; however, this is not always the case. One participant explained they recognized there were unmet mental and behavioral health issues in their school. This person stated, "I called around to local schools, and I called to University of North Dakota and talked to them because I knew that they have Master's and Doctoral students that need counseling time." This person established a Telehealth therapy program for their students through the University of North Dakota counseling program. Any student demonstrating a need for mental health therapy could be enrolled, as long as there was parental permission. A grant through the Burgum Foundation has covered the cost of this therapy.

In response to Survey Question 2a, two participants from Class B school districts indicated that community-based mental health resources have been limited because mental health providers serving rural communities are not widely available. Some rural communities do not have a provider that offers mental health counseling. As one participant explained, "I struggle with getting a mental health, getting kids into mental

health therapy. It's an hour drive." In small communities, hiring mental health providers may be difficult. This participant further explained, "We can't get anybody to come to our facility." Access to mental health services in a small community may have further challenges. If a community has a provider that offers mental health counseling, this provider may have personal connections to clients they serve. A participant explained, "It's hard to find somebody that they're not going to run into at the grocery store and be like, 'Oh my gosh! They know my life.'" Oftentimes, the only options to access mental health services are through Telehealth or by driving to the nearest large town. Accessing mental health services in a nearby larger town can mean families must drive an hour or more one way to access mental health services.

Finally, interview responses indicated that Class B school districts often have few resources to gather information regarding student mental health. One participant explained there was no team of professionals to collaborate with because the school district may have only one counselor and one administrator hired. As one participant from a Class B school stated, "Well, that's the struggle with the rural school. Nobody wants to come help you until you have a crisis." Two participants explained that finding evidence-based mental health resources is time-consuming. The person who works to find appropriate professional development offerings is often stretched thin because regular job responsibilities should take up all their time. Teaching is a full time job, so any additional tasks must occur during a teacher's personal time.

Additionally, three participants stated there has been little funding to support mental health programs and professional development. One participant explained the challenge of providing high-quality professional development on matters surrounding

student mental health. This participant stated, “No one is going to come for free.” In addition to the cost of providing a professional development offering, two participants explained money is needed to train people to implement evidence-based programs. If this step is overlooked, professional development offerings become irrelevant or difficult to apply. Follow-through or application of knowledge becomes limited.

Some Class B schools are better supported in regard to mental health initiatives. Two participants from Class B schools explained they are well-supported, financially, with mental health programs and initiatives for students. One participant explained, “We just received a behavioral health grant through the state. It’s a pilot program.” This money was being utilized to buy additional hours (more days per week) for a clinical social worker to come to their school and provide mental health therapy for students.

Data Keeping and Program Evaluation

To investigate how data has been utilized to drive program improvement, I asked Interview Question 3, “What data are kept regarding the success, or lack thereof, of these programs or initiatives?” The ten interview participants in this study varied in their responses regarding what mental health data have been kept and how it has been used to shape programs and initiatives. All ten participants indicated their school district had identified data points they track. Participants reported collecting and analyzing the following mental health data:

- Number of students who demonstrate suicide ideation,
- Number of students identified as emotionally disturbed on an individual education plan,

- Number of behavioral referrals a student has received,
- Data obtained through the Student Engagement Survey, and
- Data obtained through the Youth Risk Behavior Survey.

In response to Interview Question 3, five participants reported that talking to and observing students throughout a school day provides the most relevant and applicable data. However, this data was not formally collected or analyzed. One participant explained, "I do five-minute check-ins in the hallway. 'How are you today?' You know, 'Is there anything I can do to help you today?'" This participant further explained:

> I call these my barometer checks. I stand in the hallway in the morning as the kids come in. I check faces and posture and attitude, and then I do a check out on Friday afternoons to see who is reluctant to go home.

In response to Interview Question 3, three participants indicated there has been no good method of collecting and analyzing data related to behavioral or mental health because this type of data is more qualitative than quantitative. One participant explained, "I've had six students this year with suicidal ideations. I'm not necessarily going to see that on a survey." Participants voiced that quantitative data is necessary to drive mental health programs, initiatives, and professional development. As one participant stated, "We use that data to coach teams forward and then to support them." Another said, "I've been trying to get some more quantitative data to support having another counselor or things like that."

When asked more specifically about data obtained through standardized assessments, three participants indicated their school did not keep this type of data related

to student mental health. Therefore, data was not used to drive mental health programs, initiatives, or professional development. These three participants did indicate their schools track informal, non-standardized data. Four participants indicated program completion data showed how many students finish an offered mental health course. Two counselors stated they create their own pretest and posttest of the curriculum taught to determine how many concepts students learned. Two participants indicated their school has used the School-Wide Information System (SWIS) platform to analyze school-wide behavioral data. By looking at SWIS data, school data teams can identify trends related to student behavior. The two participants who used SWIS data explained although their school uses the SWIS platform, it has not been used very robustly. More training would be necessary for teachers and staff to become more proficient with using SWIS. Beyond that, data I collected during these interviews indicated school districts represented in this study have limited access to standardized data to drive mental health programs and initiatives in schools.

From interview responses obtained, it appeared school district personnel were under the impression they should use quantitative data to support mental health programs, initiatives, and professional development offerings. However, available data is qualitative. During interviews, no participants reported their school collected, analyzed, or reported qualitative data. Perhaps at the time of this study, there was a gap between educators' understandings of how to collect and analyze quantitative and qualitative data and how to apply data. Understanding how to use qualitative data to evaluate mental health initiatives may help school districts drive their mental health programs forward.

Mental Health Coordinator

At the time of this study, NDCC § 15.1-07-34 indicated that an administrator in each school district must appoint a mental health coordinator to oversee their district's mental health program. Interview Question 4 asked, "Who makes decisions regarding mental health programming at your school?" Who was involved in selecting and adopting a curriculum and/or seeing professional development opportunities were available varied greatly from Class B school districts to Class A school districts. Three participants from Class A school districts indicated they had a social-emotional learning specialist, district mental health coordinator, or curriculum director that coordinated these offerings. One participant from a Class A school district explained their district had a wellness coordinator who "has MTSS, both academic and behavior." This person also oversaw a counseling program, as well as social workers. This wellness coordinator had developed a comprehensive plan to address student mental health.

Another participant from a Class A school explained, "Last year we hired a curriculum director." This person had been the driving force behind some of this school district's new mental health initiatives for students. Three participants from Class A schools furthered their explanation by stating their building-level school counselor and school administrator often had input regarding decisions on student mental health. Building-level administrators can make decisions as to how an initiative is implemented in their building. One participant explained, "What we do in our building falls upon admin."

For Class B school districts, four participants indicated their superintendent made decisions regarding how mental health programming was coordinated at their school.

Three participants from Class B schools stated their superintendent collaborated with a school counselor or teachers when making these decisions, while one participant said their superintendent independently drove these decisions.

Planning for professional development offerings is one area a mental health coordinator may oversee. Participants indicated a variety of methods their mental health coordinator used when planning professional development related to student behavioral or mental health. One participant explained, “Basically we have our assistant superintendent who is responsible for planning professional development for the teachers. Also, any planning goes through our assistant principal. I think sometimes he does and works with our counselor.”

Participants varied in knowing how their mental health coordinator determined what professional development educators would benefit from related to student behavioral or mental health. One participant explained their school leaders used informal conversations with staff to determine their district’s needs. Three participants explained their school leaders would send surveys out to staff to gather input. One participant stated school leaders sought input from their special education unit on what professional development was needed. Five participants were unsure how the need for professional development programming related to student mental health was determined.

During interviews, one participant stated their school district was intentional about choosing what professional development opportunities were offered, including professional development offerings that address student mental health. When new professional development opportunities arose, a district committee reviewed the presented information and assessed each program for research-based evidence of

effective programming. Decisions regarding professional development offerings were driven by multiple data points collected and analyzed. As this participant explained, "Organizations have to come and do a presentation, and we have to determine if this is staff PD that you're offering? Is it therapeutic services to students? Is it staff wellness stuff that you're providing?" From there, this committee determined if a presented professional development offering duplicated other programs or initiatives already in place. This participant explained why their district does this. "How are we justifying the taxpayers that we paid this money to your organization?" This participant further explained, "Now everybody has to be held accountable." This procedure eliminated redundant programming in their school district, as well as professional development offerings that are "feel good" programs that have little to no impact on education. This participant explained this procedure assured professional development the district offered was intentional, specific, and relevant, and helped ensure the learned information would be meaningful and applicable.

Effectiveness of Mental Health Programming

Next, I asked participants Interview Question 5, "Do you believe your school's current mental health program is effective? Why or why not?" This question was created to further investigate Survey Question 35, which asked, "Do you feel your school adequately addresses issues surrounding student mental health (e.g., depression, anxiety, aggression, attention, defiance, etc.)?" According to survey results, 41% of participants responded that their school definitely or probably does not adequately address student mental health issues. In comparison, 35% of participants indicated their school probably or definitely addresses issues surrounding student mental health. During interviews, I

clarified Interview Question 5 targeted the 8 hours of professional development school administrators, teachers, and ancillary staff were required to receive every 2 years, per NDCC § 15.1-07-34. The response from eight of the ten participants was, "No."

Administrators' responses indicated they felt staff can identify students who are possibly having difficulties related to their mental health. Initiatives in place at the time of this study supported teachers learning more about student mental health, but this knowledge did not translate to teachers being able to meet students' mental health needs. Eight participants explained that teachers have received training and are sensitive to student needs. However, with all the teaching demands on educators, there has been limited time to support students' individual mental health needs. Additionally, not all teachers felt qualified to provide mental health services. As one interview participant stated, "I don't know if it's my place to teach."

Another discussion point made was the fact that NDCC § 15.1-07-34 has been an unfunded mandate. Three participants said they believed their district could do more if this mandate were funded. Two participants responded that the quality of professional development offerings has not meet their school's needs because school leaders must find professional development opportunities their district can afford. One participant explained:

> These 8 hours' worth of mental health training – there's no money for that. So, we grab and pick whatever is cheap. We send a person to training on something, and they're expected to come back and give it, and we mark that down.

This participant explained that a recent professional development offering was provided online. Staff had a day to listen to the information. There was no discussion or

collaboration on the presented information, and there was no follow-up meeting to discuss how to implement the learned information. This participant summed up their ideas about this professional development offering by saying, “And you know that was good stuff. But there was never really an opportunity for us, as a staff, to be able to really listen and help each other.” A final point one participant brought up is the fact that no additional professional development hours were added to the school year with this mandate (NDCC § 15.1-07-34). Therefore, this mandate takes away from overall time administrators have available to address all school programs and initiatives.

On Interview Question 5, three participants indicated they need mental health support professionals to intervene with students who are identified as possibly needing mental health services. At the time of this study, school staff members were tasked with identifying students who may have had an underlying mental health condition, but resources to address the identified mental health condition were limited. One participant indicated that teachers feel responsible for helping their students in some way; however, ultimately, teachers are hired to teach. They do not have time or knowledge to provide students with mental health therapy they need. As one participant explained, “Nobody has the time to be a therapist, right? And that’s what these kids actually need.” It seems some educators felt responsible to help students with their mental health; however, educators I interviewed indicated they did not feel adequately prepared to provide this intervention.

Barriers to Mental Health Programs

The next question (Interview Question 6) I asked was, “What barriers does your school face when implementing mental health services?” In response to this question, one

participant explained, “The biggest barrier is money.” If more money were available, funds could be used to purchase curricula or invest in quality professional development. Five participants stated that stigma surrounding mental health services is a barrier to them doing more to support students who have possible mental health needs. One participant noted that obtaining parental consent has been a barrier and is impacted by parents’ values and beliefs surrounding mental health services. Overall, themes that emerged from these conversations included: (a) lack of a community network related to mental health, (b) lack of community-based mental health providers, (c) lack of money, (d) values and beliefs held within a community, and stigma surrounding therapy for one’s mental health.

Survey Question 9 asked, “Do your students have access to community-based mental health providers, such as psychologists, mental health therapists, or counselors?” Alarmingly, 34% of participants were not sure if they had access to community-based mental health services, and 12% of participants stated they probably or definitely did not have access to these services. When asked about this, all five interview participants from Class A school districts in North Dakota indicated their school has access to community-based mental health providers. However, two interview participants from Class B school districts indicated there have been communities in rural North Dakota that do not have a local mental health provider available. One participant explained that accessing a mental health provider from another community costs money and takes time. When asked further about rural access to mental health services, this participant explained, “Yeah, tell me where, and I’ll do that. Because the closest one is an hour and fifteen minutes away, and it’s going to take me three months to get into.” To access mental health services, members of rural communities must either drive to a larger community or access these

services through Telehealth. Accessing services by driving to a larger community is expensive due to costs associated with taking time off work, driving to the larger community, and paying for the mental health service. Accessing these services is especially expensive if the client does not have health insurance.

Three interview participants from Class B school districts further explained that Telehealth is an option that some rural community members use; however, there are drawbacks to using this service. A client's lack of personal connection to a mental health provider is most concerning. Having an internet connection that is stable and fast enough to handle this service is another concern. A student having insurance to cover this service is a final concern.

An additional barrier to providing mental health services in schools in rural communities is the fact that if a community has a mental health provider, that provider may encounter their clients outside a clinical setting. Mental health providers may see their clients at a grocery store, church, or community events. Not all mental health providers or their clients are comfortable with this.

Two interview participants from a Class B school indicated the lack of a professional network available to collaborate regarding providing mental health programs in schools is a barrier to implementing a more effective mental health program at their school. These participants indicated that it is challenging to deliver 8 hours of professional development and manage their other job responsibilities. Three counselors from Class B schools indicated they take on a larger role than their job title suggests. The additional responsibilities are necessary because their school has a smaller staff yet has the same educational obligations larger schools have. An added responsibility to

coordinate and provide mental health programming is demanding. One participant advocated that this strain could be minimized if there were a network of professionals available to collaborate about relevant mental health professional development offerings and determine what offerings would most likely have a positive influence on their school. One participant pleaded, “Find resources for us. Give us a list of people who are willing to do it that doesn’t cost us an arm and a leg.”

A final barrier to accessing mental health services seven interview participants discussed was a community’s values and beliefs regarding mental health services. One interview participant explained their community has believed mental health issues can be overcome by working harder or not allowing one’s self to be sad or anxious. Four participants from Class B schools affirmed this belief. One participant indicated community members do not want others to learn they are receiving therapy for mental health because it would impact how they are viewed in their community. This stigma has prevented some people from accessing or receiving mental health therapy that could be beneficial.

Recommendations for Change

The final question (Interview Question 7) interview participants were asked was, “What recommendations for change to NDCC § 15.1-07-34 do you suggest?” Again, themes emerged from recommendations participants provided. From funding NDCC § 15.1-07-34 to allowing access to Medicaid funding for school-based mental health providers, participants provided many thoughts and ideas on how this bill could be improved. Making these changes is urgent. As one participant stated, “We’ve got schools

throughout this state crying for help. Right now, I think we're only digging ourselves a deeper hole."

All ten interview participants recommended funding NDCC § 15.1-07-34. They explained that providing a mandate such as this, but not providing money to implement the professional development it requires, places a strain on school districts. Two participants indicated they value having local control of professional development courses offered. However, lack of funding that accompanies this mandate leads schools to find an inexpensive means to meet this mandate. As one participant explained, having funds to engage in professional development, then network with colleagues throughout the state, would help guide effective program development.

Another recommendation two interview participants provided was that it would be helpful if districts could form a mental health network to allow schools to collaborate. One participant explained, "It's the people that you need, even more than the money. The network and the access to high-quality PD that can guide program development." Having this network would allow school districts to focus on finding relevant, evidence-based interventions. If this network also focused on creating a "playbook" on developing and implementing a comprehensive mental health program within a school district, it would be especially beneficial.

Another recommendation for change by participants involved time required to teach. One interview participant suggested teachers be afforded a break from their academic teaching to provide social-emotional learning lessons. Supporting teachers in providing for their students' social-emotional learning needs would help ensure students received a well-rounded education. As this participant explained, "I hate to put more on

teachers, but at the same time, how are we going to get this?" The suggestion this participant made was, instead of having 8 hours of professional development every 2 years, teachers could build social-emotional lessons into their teaching. Effective ways to support mental health could also be addressed. This participant further explained, "If it is integrated into our classrooms more, I think that it would be huge for the kids' learning and for changes if they understand their mental health and that will help with behavior." Evidence has suggested supporting social-emotional learning in classrooms has lasting impacts on students' academic learning (Keyes, 2002, Smith & Applegate, 2018). The effects of implementing more social-emotional learning could be substantial.

Hiring qualified professionals to support student mental health was another suggestion. One participant from a Class B school indicated rural schools need financial support to attract and retain qualified professionals to support student mental health. One participant from a Class A school and one from a Class B school explained that hiring positions, such as school counselors or school social workers, can be nearly impossible in rural areas because of a lack of applicants. The participant from the Class B school explained it would be helpful if the state would support rural communities in attracting and retaining mental health staff.

Another recommendation for change involved providing support for student mental health at schools. Three participants from Class B schools indicated they have formed partnerships with a Telehealth agency to meet their students' mental health needs. This partnership has been effective. One drawback is cost. One participant explained their school offers Teletherapy as an option for students to receive mental health therapy at school; however, families must use their own insurance to access this therapy. One

participant stated their school has partnered with a state university and has written for a grant to cover this service's cost. Although these two participants explained data has indicated Teletherapy and school partnerships effectively meet mental health needs of students, these participants felt money would be better spent by allowing school-based mental health providers to access Medicaid to bill for therapy. By doing this, a mental health provider could intervene early and often with a student, ensure the student completes recommended therapy, and help educational teams plan for the student's individual learning needs.

A final recommendation that one interview participant provided was for the Department of Education to work more closely with the Department of Human Services on student mental health. Mental health is not an issue that schools can, or should, take on alone. As this participant explained, the opportunity that presents is to form a partnership that would allow the Department of Human Services to work closely with the Department of Education. Through this partnership, mental health services that are relevant, evidence-based, and culturally appropriate could be provided within an educational setting to reach students who need them.

Summary

Chapter IV provided an analysis of data obtained from the online survey disseminated, as well as from interviews conducted. This data examined how students have been identified as possibly having mental health needs, examined some mental health programs that have been implemented in schools across North Dakota, questioned what data are kept regarding mental health programs and initiatives, discussed the make-up of school mental health teams, and examined what school districts have been doing

with the professional development requirement set by NDCC § 15.1-07-34. Barriers to implementing mental health programming are included, as are recommendations for change. Coming up, Chapter V includes a discussion of the findings, limitations of the study, and recommended changes to school-based mental health services, recommendations to change North Dakota legislation, and recommendations for further study.

CHAPTER V

DISCUSSION AND RECOMMENDATIONS

Discussion of Results and Research Findings

The first concept that emerged from this research surrounded the topic of allowing school-based mental health service providers to bill Medicaid for mental health therapy they provide at a school. This change would need to come from North Dakota state legislators. My literature review and data collected in this study indicated that mental health professionals, such as social workers, are already employed in some schools across North Dakota. Some social workers hold a license that allows them to provide mental health therapy. However, in a school setting, social workers are not able to use this portion of their license. If funding sources were changed to allow school-based mental health providers to bill Medicaid for mental health services, students who have Medicaid insurance could access mental health therapy at their school. Furthermore, it would be financially feasible for schools to hire a social worker because a portion of their salary would be covered by any Medicaid billing they submit.

This finding aligns with Bronfenbrenner's ecological theory. Within this model, a school could be considered a microsystem because it encompasses a student within their educational setting (Bronfenbrenner, 1977). By creating a structure of intervention and support at the microsystem level, mental health therapy is able to reach a student during times the student needs intervention, and a therapist is able to intervene during times that

are most impactful. By building in interventions at the microsystem level, an educational community begins to construct a self-reliant structure that can assist students who need mental health support.

My literature review indicated there is data available that shows that providing students with mental health therapy by a school employee has some key advantages. School-based mental health providers can collaborate with school staff to identify specific interventions that target students in situations they need help with (Doll et al., 2017). By focusing therapy to target these situations, a school-based mental health provider could provide therapy in contexts that would have the highest benefit for students. This is important because research indicates an educational setting can have lasting impacts, teaching children lifelong skills for success in life.

> Classroom behavior management that promotes safe and productive peer interactions provides the structure for students to engage appropriately in classroom activities, and it may protect against the negative mental health and academic effects of exposure to violence in the home or neighborhood. (Atkins et al., 2017, p. 133)

Mental health services provided in schools can help further these positive feelings and teach students about helpful resources available to them at a young age. Finally, a school-based mental health provider can involve family members in therapy to address healthy routines, schedules, and parenting practices that support a student as a learner. In this way, schools begin to build into Bronfenbrenner's mesosystem. By connecting a student's school community with their home life, the intervention becomes woven into more microsystems. These interactions build to create a student's mesosystem, which

increases the influence a mental health intervention provided at school has on the student (Bronfenbrenner, 1977).

A concept that emerged from data I collected in this study involves providing school districts with guidance for contacting regional education agencies to support school districts in planning and providing professional development for a mental health initiative. According to NDCC § 15.1-07-34, regional education agencies can help school districts meet this law's requirements; however, in interviews I conducted, evidence suggested regional educational agencies have not been used for this purpose. Regional education agencies have the means to find evidence-based workshops that are beneficial for stakeholders. Additionally, regional education agencies could plan events that allow schools within a region to meet and collaborate on topics surrounding student mental health. Providing professional development in this way would not cost districts any additional money and would provide like-minded professionals the means to collaborate on issues surrounding student mental health. School districts already have this resource available to them; however, I recognize that school districts may need additional information to understand how regional education agencies could be used to support youth behavioral health.

A third concept that emerged from this research involves time to provide required professional development. This recommendation impacts NDCC § 15.1-07-34 and NDCC § 15.1-06-04. Interview participants indicated that mandating 8 hours of professional development without making changes to the funding formula or the amount of time districts have to implement professional development impacts the number of initiatives school districts can undertake and sustain. Because NDCC § 15.1-07-34

already requires 8 hours of professional development on youth behavioral health every 2 years, it only makes sense for the North Dakota legislature to amend NDCC § 15.1-06-04 and increase the required number of professional development days per year from three to four. Making this change would support districts in meeting statute requirements regarding mental health of students while allowing them time to pursue other initiatives to support the academic portion of education.

During interviews I conducted, two professionals requested a "playbook" or guidance on starting and sustaining a comprehensive mental health program for their school district. I note that this suggestion could be shared with the North Dakota Social Emotional Learning Network. This organization could then determine if this is an initiative they would support.

One final concept that emerged from this research was the idea for the North Dakota Department of Human Services to work with the North Dakota Department of Public Instruction on the issue of student mental health. Both the literature review and data I collected supported the idea that mental health is not the sole responsibility of an education system; however, current statistics indicate students are demonstrating a profound need for mental health services. Furthermore, there are many communities in America in which schools offer the only resources available to meet children's mental health needs (Atkins et al., 2017).

This recommendation envelops Bronfenbrenner's ecological theory at the exosystem level. Social behaviors that happen across environments influence behaviors of society (Bronfenbrenner, 1977). How people living in neighborhoods and communities interact, how social networks and the media influence these relationships, and how

governmental agencies support their people shapes behaviors of all people living within a society (Bronfenbrenner, 1977).

To help students receive mental health services in schools, changes must be made to how mental health services are delivered. Society must understand the problem and then determine ways to address the underlying needs students present. “Lack of access to high-quality health services for all people is a national problem further compounded when the focus is mental health” (Grimmett et al., 2018, p. 201). It is crucial we help students succeed in school because school success is a reliable indicator of a student’s overall wellbeing and is a predictor of adult success (Atkins et al., 2017). Creating mental health services in schools requires a paradigm shift in how mental health is defined and how services are delivered (Atkins et al., 2017). To comprehensively meet students’ identified needs in North Dakota, the North Dakota Department of Human Services and the North Dakota Department of Public Instruction must innovatively work together to create a comprehensive plan that supports students and the education they receive.

The concept that emerged here completes Bronfenbrenner’s ecological theory at the macrosystem level. By creating an encompassing approach to mental health initiatives, new cultural norms and values can be established (Bronfenbrenner, 1977). Ultimately, new approaches to mental health services can lead to new expectations for how people living within a community view mental health and approach mental health services (Bronfenbrenner, 1977).

Challenges in Supporting Student Mental Health

Data collected indicated there are several challenges to supporting mental health needs of students. One participant expressed concerns with the dual roles educators are

expected to fill – providing academic instruction while supporting students' social-emotional needs. This challenge is not unique to North Dakota schools. "Schools in most communities, and especially in high-poverty communities, have neither the capacity nor the expertise to deliver effective academic programming and mental health services concurrently" (Atkins et al., 2017, p. 126). While schools are equipped to deliver academic programming, this is often not the case with mental health services. There are more students in need of mental health services than there are mental health providers (Atkins et al., 2017).

Another challenge to providing mental health services in schools is the lack of procedures to monitor quality of mental health programming. In this study, two participants indicated concerns regarding collecting, analyzing, and utilizing meaningful data. In this study, one participant voiced concerns with collecting qualitative data while depending on quantitative data to drive program improvement. Without a means to measure a mental health program's effectiveness, it is difficult to determine the program's impact (Atkins et al., 2017). Schools must make conscious efforts with processes, practices, and budget to overcome barriers to supporting students and their mental health needs.

Limitations of this Study

The number of participants who completed the online survey or participated in interviews is a limitation of this study. The global pandemic COVID-19 may have impacted survey responses, as well as interview responses. The number of participants in this study may have been affected by educators feeling overwhelmed by the educational

tasks they were having to manage and lead for students. They may have felt they did not have time to participate by completing the online survey or participating in an interview.

Recommendations for School Districts to Support Youth Behavioral Health

The data collected from this study supports several recommendations I make to school districts in North Dakota. First, I recommend school districts create a path to allow school-based mental health service providers to provide mental health services for students in schools. The advantages that emerge from providing mental health services at schools are vast, and include: allowing mental health providers to collaborate with school staff and target specific needs students demonstrate at their schools (Doll et al., 2017), teach students about helpful mental health resources available to them at a young age, and involve family members in therapy sessions to address healthy routines, schedules, and parenting practices that support a student as a learner.

Another recommendation I make to school districts on this issue is to use "regional education agencies" to assist with planning and implementation of any youth behavioral health mandate. Because school districts are already members of regional education agencies, using this resource would not cost a school district any additional money. If school districts began using this resource, opportunities for school districts to collaborate and plan initiatives could emerge. By working together, school districts and regional education agencies have potential to create and implement effective, innovative, and comprehensive plans that meet the diverse learning needs of students.

The Youth Behavioral Health mandate requires professional development. I recommend school districts add additional professional development time into their calendars. This ensures the essential elements of this mandate can be implemented

without compromising other initiatives the school district is implementing. Along with additional professional development, I recommend school districts engage families and stakeholders in planning mental health initiatives and include them when teaching information about mental health. In the data I collected, several participants indicated values and beliefs held by members of their community hinder mental health initiatives their district may be trying to implement. I believe that teaching community members about mental health and mental wellness, as well as mental health strategies and resources, is essential for community members to accurately view the problem and find new solutions.

The final recommendation I make to school districts is for them to create documents that outline how student mental health initiatives are to be implemented. These playbooks could be created through collaborative efforts of several school districts working with regional education agencies. These playbooks could outline mental health resources, how to access those resources, evidence-based practices and resources, and how to evaluate a school's mental health program.

Recommendations for Legislative Action to Support Youth Behavioral Health

First, I recommend the North Dakota legislature should create a path to allow school-based mental health service providers to bill Medicaid for the mental health therapy they provide at schools. at the time of this study, mental health professionals, such as social workers, were already employed in some schools across North Dakota. However, in the school setting, social workers were not able to bill for mental health therapy provided for students. If this funding source was changed to allow school-based mental health providers to bill Medicaid for mental health services, students who have

Medicaid insurance could access mental health therapy at their schools. Furthermore, it would be financially feasible for schools to hire more social workers because a portion of their salaries would be covered by the Medicaid billings they submit.

In Chapter I, I explained ecological theory to create a framework for understanding how settings people exist in influence their behaviors (Atkins et al., 2016). As explained in Chapter I, ecological theory embraces a framework set around four principles: adaptation, succession, cycling of resources, and interdependence (Atkins et al., 2016; Kelly, 2006). By recognizing that settings are responsive and dynamic, organizations are able to modify behaviors to meet an organization's changing needs (Atkins et al., 2016). This framework creates a sustainable context to meet an organization's needs because creating diverse and productive systems often results in a limited need to use additional outside resources (Atkins et al., 2016). Thus, systems can be modified to meet an organization's needs at a specific time without depleting resources (Atkins et al., 2016). Applying ecological theory to mental health services provided in schools allows each school flexibility to design and implement a system that meets its individual needs and goals. Linking schools; promoting learning; involving parents, teachers, students; and sharing mental health resources together creates an interdependent network that is sustainable and meets specific needs an organization exhibits.

Another recommendation I make to the North Dakota legislature is to increase the required number of professional development days per year. Currently, NDCC § 15.1-07-34 requires 8 hours of professional development on youth behavioral health every 2 years. Therefore, it only makes sense for the North Dakota legislature to amend NDCC §

15.1-06-04 and increase the required number of professional development days per year from three to four. Making this change would support districts in meeting statute requirements at the time of this study while allowing them time to pursue other initiatives to support academics in education.

I recommend the North Dakota legislature fund professional development offerings, as well as evidence-based resources and curriculum. If this money were available, school districts would be able to create a comprehensive mental health plan without taking away from a school's academic programs.

In North Dakota, some communities do not have access to mental health providers. This problem is of grave concern, as it profoundly impacts so many aspects of mental health programs. I recommend the North Dakota legislature study this problem to discover innovative ways to attract and retain mental health professionals to serve all of North Dakota.

The final recommendation I make to the North Dakota legislature is for the North Dakota Department of Human Services to work collaboratively with the North Dakota Department of Public Instruction on the issue of student mental health. Statistics at the time of this study indicated students have been demonstrating a profound need for mental health services. During the interview portion of this study, I repeatedly heard principals and counselors saying they have had students who indicated suicide ideation, have attempted suicide, or have died by suicide. This data indicates a profound need. To meet this need, an innovative approach is warranted.

Recommendations for Further Study

Participants in this study indicated that tracking relevant data related to student mental health is complicated. Future research could investigate meaningful and relevant methods to measure effectiveness of student mental health initiatives. In this study, participants indicated community stigmas surrounding mental health services impacts mental health services students receive. Future research could also investigate community stigmas, as well as how student mental health supports can be implemented with more community support. Finally, the study described in this report does not investigate the impact student mental health programs have on teachers. s

Summary

In Chapter V, I included a discussion of study results and recommended changes to school-based mental health services available at the time of this study. Suggestions that emerged from the data and literature were discussed, as were some challenges associated with supporting student mental health and implementing change. Finally, limitations of the research were presented, and recommendations provided for school districts, legislative action, and further study.

APPENDICES

Appendix A
Permission to Use Figure 3

From: Atkins, Marc S <atkins@uic.edu>
Sent: Tuesday, April 6, 2021 6:37 AM
To: Diederich, Elisa <elisa.diederich@und.edu>
Cc: Mehta, Tara G <tmehta@uic.edu>; Rusch, Dana B. <drusch1@uic.edu>; Davi Lakind <lakind_rd@mercer.edu>
Subject: Re: Figure for Dissertation

Hello Elisa — We are fine with you using the figure. Your adaptations make it relevant to your use which makes sense and you reference our paper appropriately. We are glad you found the paper and the figure useful. Thanks for reaching out. Best of luck with your research.

Marc S. Atkins, Ph.D.
Professor of Psychiatry and Psychology
Director, Institute for Juvenile Research
Director, Community Engagement and Collaboration
Center for Clinical Translational Science
https://www.psych.uic.edu/profile/marc-atkins

University of Illinois at Chicago
Institute for Juvenile Research
1747 W. Roosevelt Rd., Room 212
Chicago, IL 60608
312-413-1048

> On Apr 5, 2021, at 3:39 PM, Atkins, Marc S <atkins@uic.edu> wrote:
>
> Anyone have any objections?
> Tara — You should copyright as a work of art
>
> > On Apr 5, 2021, at 2:15 PM, Diederich, Elisa <elisa.diederich@und.edu> wrote:
> >
> > Good Afternoon, I am a doctoral student at the University of North Dakota. I am completing my dissertation, looking at mental health programming in our K-12 schools. In my research, I discovered your article that provides a framework for applying ecological theory. I adapted it and am requesting to use it in my paper. Please let me know if I have your permission to use this adapted figure.
> >
> > Sincerely,
> >
> > Elisa Diederich
> > <Ecological Theory Screen Shot.png>

Appendix B
Approval to Conduct Study by UND's Institutional Review Board

UNIVERSITY OF NORTH DAKOTA

UND.edu

Office of Research Compliance & Ethics
Tech Accelerator, Suite 2050
4201 James Ray Drive Stop 7134
Grand Forks, ND 58202-7134
Phone: 701.777.4279
Fax: 701.777.2193

July 31, 2020

Principal Investigator:	Elisa Diederich
Project Title:	An Analysis of Youth Behavioral Health Training in Schools across North Dakota
IRB Project Number:	IRB-202007-022
Project Review Level:	Expedited 6, 7
Date of IRB Approval:	7/28/2020
Expiration Date of This Approval:	7/27/2021
Consent Form Approval Date:	7/28/2020

The application form and all included documentation for the above-referenced project have been reviewed and approved via the procedures of the University of North Dakota Institutional Review Board.

The waiver of written consent has been approved under 45 CFR 46.117(c)(2) for the survey portion of the study.

Attached is your original consent form that has been stamped with the UND IRB approval and expiration dates for the focus groups/interviews. Please maintain this original on file. ***You must use this original, stamped consent form to make copies for participant enrollment. No other consent form should be used.*** It must be signed by each participant prior to initiation of any research procedures. In addition, each participant must be given a copy of the consent form.

Prior to implementation, submit any changes to or departures from the protocol or consent form to the IRB for approval. No changes to approved research may take place without prior IRB approval.

You have approval for this project through the above-listed expiration date. When this research is completed, please submit a termination form to the IRB. If the research will last longer than one year, an annual review and progress report must be submitted to the IRB prior to the submission deadline to ensure adequate time for IRB review.

The forms to assist you in filing your project termination, annual review and progress report, adverse event/unanticipated problem, protocol change, etc. may be accessed on the IRB website: http://und.edu/research/resources/human-subjects/

Sincerely,

Michelle L. Bowles, M.P.A., CIP
RC&E Manager

Cc: Sherryl Houdek, Ed.D.

Appendix C
Mental Health Online Survey

Mental Health Services in Public Schools Across North Dakota

Start of Block: Default Question Block

Q1
UNIVERSITY OF NORTH DAKOTA
Institutional Review Board
Study Information Sheet

Title of Project: *An Analysis of Youth Behavioral Health Training in Schools across North Dakota*

Principal Investigator: *Elisa Diederich, elisa.diederich@und.edu*

Co-Investigator(s): *N/A*

Advisor: *Sherryl Houdek, (701) 330-5212, sherryl.houdek@und.edu*

Purpose of the Study:
The purpose of this study is to investigate the behaviors that educators perceive to manifest by students who may have a mental health disorder. Additionally, this study will investigate if the current statute requiring eight hours of professional development on a mental health topic every two years is sufficient in preparing North Dakota educators to support students who may present with mental health needs in the classroom. Finally, this study will investigate if educators feel the school's youth behavioral health resource coordinator effectively ensures their school's mental health initiative meets the needs of students and educators within their school.

Procedures to be followed:
You will be asked to answer 35 questions on a survey. Upon completion of the survey, you will have the opportunity to participate in a focus group or individual interview. If you are interested in participating in the focus group or individual interview, you will contact this researcher using the information provided.

Risks:
There are no risks in participating in this research beyond those experienced in everyday life.

Benefits:
Results from this study will be used to develop a comprehensive overview of the programs and initiatives that are in place to support the mental health of students, explain the effectiveness of those programs and initiatives, and to suggest changes to the North Dakota legislature on how North Dakota Century Code § 15.1-07-34 could better serve students, as well as educators, across North Dakota.

Duration:
It will take about 15 minutes to complete the questions.

Statement of Confidentiality:
The survey, does not ask for any information that would identify who the responses belong to. Therefore, your responses are recorded anonymously. If this research is published, no information that would identify you will be included since your name is in no way linked to your responses.

All survey responses that we receive will be treated confidentially. However, given that the surveys can be completed from any computer (e.g., personal, work, school), we are unable to guarantee the security of the computer on which you choose to enter your responses. As a participant in our study, we want you to be aware that certain "key logging" software programs exist that can be used to track or capture data that you enter and/or websites that you visit.

Right to Ask Questions:
The researcher conducting this study is Elisa Diederich. You may ask any questions you have now. If you later have questions, concerns, or complaints about the research please contact Dr. Sherryl Houdek at (701) 777-3577 during the day.

If you have questions regarding your rights as a research subject, you may contact The University of North Dakota Institutional Review Board at (701) 777-4279 or UND.irb@UND.edu. You may contact the UND IRB with problems, complaints, or concerns about the research. Please contact the UND IRB if you cannot reach research staff, or you wish to talk with someone who is an informed individual who is independent of the research team.

General information about being a research subject can be found on the Institutional Review Board website “Information for Research Participants” http://und.edu/research/resources/human-subjects/research-participants.html

Compensation:
You will not receive compensation for your participation.

Voluntary Participation:
You do not have to participate in this research. You can stop your participation at any time. You may refuse to participate or choose to discontinue participation at any time without losing any benefits to which you are otherwise entitled.

You do not have to answer any questions you do not want to answer.

You must be 18 years of age older to participate in this research study.

Completion and return of the survey implies that you have read the information in this form and consent to participate in the research.

Please keep this form for your records or future reference.

Q2 What is the size of your school district?

- ○ More than 3500 Students (1)
- ○ Fewer than 3500 Students (2)

Q3 Does your school have (mark all that apply):

- ☐ School counselor (1)
- ☐ School social worker (2)
- ☐ School psychologist (3)
- ☐ School nurse (4)
- ☐ Other (5) _____

Q4 At your school building, is there a record of the number of students referred for mental health services provided through the school counselor, social worker, or psychologist?

- ○ yes (1)
- ○ Maybe (2)
- ○ No (3)

Skip To: Q6 If at your school building, is there a record of the number of students referred for mental health ... = No

Q5 How many students are referred each year?

- ○ 0-10 (1)
- ○ 11-20 (2)
- ○ 21-30 (3)
- ○ 31-40 (4)
- ○ 41-50 (5)
- ○ Other Amount (please enter a number) (6)

_____

Q6 Does your school district have a person designated to oversee and/or coordinate mental health services?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ Might or might not (3)
- ○ Probably not (4)
- ○ Definitely not (5)

Q7 Does your school building have a person dedicated to the provision of mental health services for students who are at school?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Skip To: Q9 If Does your school building have a person dedicated to the provision of mental health services for... = No

Q8 Who provides mental health services at your school (select all that apply)?

- ☐ School Counselor (1)
- ☐ School Social Worker (2)
- ☐ School Psychologist (3)
- ☐ School Nurse (4)
- ☐ Referrals are made to an outside agency (5)
- ☐ Other (6) _____

Q9 Do your students have access to community-based mental health providers, such as psychologists, mental health therapists, or counselors?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ Might or might not (3)
- ○ Probably not (4)
- ○ Definitely not (5)

Q10 Does your school have a team of school staff members who collaborate and determine appropriate interventions and supports for students who demonstrate behavioral problems or signs/symptoms of an underlying mental health disorder?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Skip To: Q12 If Does your school have a team of school staff members who collaborate and determine appropriate in... = No

Q11 Who makes up your school's mental health team (check all that apply)?

- ☐ School Counselor (1)
- ☐ School Social Worker (2)
- ☐ School Psychologist (3)
- ☐ School Nurse (4)
- ☐ Administrator (5)
- ☐ Teacher (6)
- ☐ Special Educator (7)
- ☐ Other (8) _____

Q12 During the 2019-2020 school year, did your school have a process or procedure to identify students with mental health concerns or needs?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ Might or might not (3)
- ○ Probably not (4)
- ○ Definitely not (5)

Q13 Do school staff members have a procedure or a form to report concerns, either through a written documentation or by talking to a designated person, related student mental health (e.g., suicidal ideation, bullying, anxiety, depression, etc.)?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Skip To: Q15 If Do school staff members have a procedure or a form to report concerns, either through a written ... = No

Q14 Who received the form or information for concerns that were reported?

- ○ School Counselor (1)
- ○ School Social Worker (2)
- ○ School Psychologist (3)
- ○ School Nurse (4)
- ○ School Administrator (5)
- ○ Other (6) _____

Q15 Does your school have a procedure to report and investigate potential threats (check all that apply):

- ☐ Made against students (1)
- ☐ Made against staff members (2)
- ☐ Of students to harm him/herself (3)
- ☐ Other (4) _____

Q16 Sometimes, schools use tiers of mental health support to meet the needs of students. Tier 1 is a comprehensive plan that all students in a school receive. Tier 2 supports are for students who need some support, their needs can be met in small groups. Tier 3 is for students who need individualized support. Does your school use a tiered support system to provide mental health interventions and supports for students?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ Might or might not (3)
- ○ Probably not (4)
- ○ Definitely not (5)

Q17 During the 2019-2020 school year, did a school counselor, social worker, or psychologist help staff develop standard, Tier 1 school mental health activities for students?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Skip To: Q19 If During the 2019-2020 school year, did a school counselor, social worker, or psychologist help sta... = No

Q18 Did you keep records or data on the number of students that were served through this program?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Q19 During the 2019-2020 school year, did a school counselor, social worker, or psychologist help staff develop standard, Tier 2 school mental health interventions for students who were identified through a mental health referral process?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Skip To: Q21 If During the 2019-2020 school year, did a school counselor, social worker, or psychologist help sta... = No

Q20 Did you keep records or data on the number of students that were served through this program?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Q21 During the 2019-2020 school year, did a school counselor, social worker, or psychologist help staff develop standard, Tier 3 school mental health interventions for students who were identified through a mental health referral process?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Skip To: Q23 If During the 2019-2020 school year, did a school counselor, social worker, or psychologist help sta... = No

Q22 Did you keep records or data on the number of students that were served through this program?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Q23 During the 2019-2020 school year, did a school counselor, social worker, or psychologist work with students to provide mental health interventions or supports?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ Might or might not (3)
- ○ Probably not (4)
- ○ Definitely not (5)

Q24 During the 2019-2020 school year, were families provided with information regarding mental health for their student(s)?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Skip To: Q26 If During the 2019-2020 school year, were families provided with information regarding mental health... = No

Q25 How were families provided with this information?

- [ ] Word of mouth (1)
- [ ] School website (2)
- [ ] School handbook (3)
- [ ] Calls from the school (4)
- [ ] School newsletter (5)
- [ ] Other (6) _____

Q26 Does your school have a dedicated, private space that is available to provide students with mental health interventions and supports?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ Might or might not (3)
- ○ Probably not (4)
- ○ Definitely not (5)

Q27 During the 2019-2020 school year, did you ever have concerns about a student's mental health or behavior?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ Might or might not (3)
- ○ Probably not (4)
- ○ Definitely not (5)

Q28 During the 2019-2020 school year, what areas of student mental health did you have concerns about (check all that apply)?

- ☐ Students with possible anxiety (1)
- ☐ Students with possible depression (2)
- ☐ Students who had difficulty concentrating (3)
- ☐ Students who were oppositional (4)
- ☐ Students who had difficulties making friends (5)
- ☐ I had no concerns with student mental health (6)

Q29 During the 2019-2020 school year, were you involved in the identification of students with possible mental health needs or planning for interventions for student, as it related to their mental health?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Skip To: Q31 If During the 2019-2020 school year, were you involved in the identification of students with possible ... = No

Q30 How many students did you identify

- ○ 0-5 (1)
- ○ 6-10 (2)
- ○ 11-15 (3)
- ○ 16-20 (4)
- ○ 21-25 (5)
- ○ 26-30 (6)
- ○ Other (enter number) (7) _____

Q31 During the 2019-2020 school year, did you experience (select all that apply):

- [ ] Students who were disruptive in the classroom (1)
- [ ] Students who were defiant to directives (2)
- [ ] Students who were aggressive toward staff (3)
- [ ] Students who were aggressive toward students (4)
- [ ] Students who were noncompliant towards school work (5)
- [ ] Students who were not able to engage with their school work (6)
- [ ] I did not experience these behaviors from students (7)

Q32 During the 2019-2020 school year, did you experience (select all that apply):

- ☐ Students who were withdrawn or sad (1)
- ☐ Students who seemed anxious (2)
- ☐ Students who were not able to attend to their school work (3)
- ☐ Students who indicated suicidal ideation (4)
- ☐ Students who were bullied (5)
- ☐ Students who bullied other students (6)
- ☐ I did not experience these behaviors from students (7)

Q33 During the 2019-2020 school year, did you experience a student making threats about you or staff members at your school?

- ○ Yes I did (1)
- ○ I did on more than 1 occasion (2)
- ○ No I did not (3)
- ○ I prefer not to answer (4)

Q34 During the 2019-2020 school year, did you experience a student making threats about other students at your school?

- ○ Yes I did (1)
- ○ I did on more than 1 occasion (2)
- ○ No I did not (3)
- ○ I prefer not to answer (4)

Q35 Do you feel your school adequately addresses issues surrounding student mental health (e.g. depression, anxiety, aggression, attention, defiance, etc.)?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ Might or might not (3)
- ○ Probably not (4)
- ○ Definitely not (5)

Q36 Is there anything that you would like to add that has not been addressed?

_____

_____

_____

_____

_____

Q37 As part of this research study, I am going to conduct interviews, either in small groups or individually. If you are willing to participate in one 45-60 minute interview that is conducted over Zoom, please contact me. I can be reached by email at elisa.diederich@und.edu, or by text/phone at 701-317-0331.

End of Block: Default Question Block

Appendix D
Informed Consent for Interviews

THE UNIVERSITY OF NORTH DAKOTA
CONSENT TO PARTICIPATE IN RESEARCH

Project Title: An Analysis of Mental Health Services in Public Schools Across North Dakota

Principal Investigator: Elisa Diederich

Phone/Email Address: elisa.diederich@und.edu

Department: Educational Leadership

Research Advisor: Sherryl Houdek

Phone/Email Address: 701-777-3577 / sherryl.houdek@und.edu

What should I know about this research?

- The researcher will explain this research project to you.
- Taking part in this research is voluntary. Whether you take part is up to you.
- If you don't take part, it won't be held against you.
- You can take part now and later drop out, and it won't be held against you.
- If you don't understand, ask questions.
- Ask all the questions you want before you decide.

How long will I be in this research?

We expect that your taking part in this research will only require responding to a survey, which will take approximately 10-15 minutes. If you agree to be interviewed, an additional 45-60 minutes will be necessary.

Why is this research being done?

The purpose of this research is to gain an understanding of the programs and initiatives that are in place across North Dakota to support student mental health, to gather feedback regarding the success of these programs, and to determine if there is a need to expand these programs and initiatives.

What happens to me if I agree to take part in this research?

If you decide to take part in this research study, you will complete a brief Likert scale and yes/no question survey. You are free to skip any questions that you would prefer not to answer. At the end of the survey, you will be asked if you are willing to participate in a 30-minute focus group or individual interview that will be scheduled for a later time. For the focus group survey, participants will be assigned to a small, 3-4 person group that is made up of participants who are North Dakota educators with the same job title (e.g.

teachers will be grouped with teachers, principals will be grouped with principals). You may know some people in your group. Confidentiality expectations will be addressed prior to all interviews; however, you may opt out at any time. All interviews will be conducted on a digital conferencing platform. Interviews will be recorded and stored on the researcher's personal computer that is password protected so that they can be analyzed. Additionally, the researcher will take field notes during the interview. These notes will be stored in the researcher's home in a locked safe for three years. Identifying information will not be recorded in these notes.

Could being in this research hurt me?
The most important risks or discomforts that you may expect from taking part in this research include psychological or emotional discomfort because the questions discuss student mental health. Additionally, you may feel uncomfortable about your privacy because focus group questions will be conducted with small groups of people.

Will being in this research benefit me?
The most important benefits that you may expect from taking part in this research include the suggestions made to amend North Dakota Century Code as it relates to student mental health.

Possible benefits to others include the future knowledge that may be gained from this research.

How many people will participate in this research?
Approximately 2,625 people will take part in this study at the University of North Dakota. The survey will be emailed through school districts' public email to teachers, principals, school counselors, and school psychologists. The goal is to obtain a 33% response rate. For focus group and individual interviews, 12 participants will participate.

Will it cost me money to take part in this research?
You will not have any costs for being in this research study.

Will I be paid for taking part in this research?
You will not be paid for being in this research study.

Who is funding this research?
The University of North Dakota and the research team are receiving no payments from other agencies, organizations, or companies to conduct this research study.

What happens to information collected for this research?
Your private information may be shared with individuals and organizations that conduct or watch over this research, including:

- The research advisor,
- The Institutional Review Board (IRB) that reviewed this research.

We may publish the results of this research. However, we will keep your name and other identifying information confidential. We protect your information from disclosure to others to the extent required by law. We cannot promise complete secrecy.

Data or specimens collected in this research will not be used or distributed for future research studies, even if identifiers are removed.

You should know, however, that there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if we believe you have abused a child, or you pose a danger to yourself or someone else.

As a research participant, you have the right to review audio and video recordings. The researcher will be the sole person having access to these recordings. They will be deleted upon the conclusion of this research study.

What if I agree to be in the research and then change my mind?
If you decide to leave the study early, we ask that you inform the researcher prior to participating in an interview. There are no consequences for withdrawing from this study.

Who can answer my questions about this research?
If you have questions, concerns, or complaints, or think this research has hurt you or made you sick, talk to the research team at the phone number listed above on the first page.

This research is being overseen by an Institutional Review Board (IRB). An IRB is a group of people who perform independent review of research studies. You may talk to them at 701.777.4279 or UND.irb@UND.edu if:

- You have questions, concerns, or complaints that are not being answered by the research team.
- You are not getting answers from the research team.
- You cannot reach the research team.
- You want to talk to someone else about the research.
- You have questions about your rights as a research subject.

You may also visit the UND IRB website for more information about being a research subject: http://und.edu/research/resources/human-subjects/research-participants.html

Your signature documents your consent to take part in this study. You will receive a copy of this form.

Subject's Name: _____

_____ _____

Signature of Subject Date

I have discussed the above points with the subject or, where appropriate, with the subject's legally authorized representative.

_____ _____

Signature of Person Who Obtained Consent Date

Appendix E
Interview Questions

1. At your school, who identifies students when there are concerns with the student's mental health?
    a. How do behaviors manifest in students possibly needing mental health support?
2. Does your school have educational programs or initiatives to support student mental health?
    a. What programs does your school use?
    b. Who coordinates mental health initiatives at your school?
3. What data are kept regarding the success, or lack thereof, of these programs or initiatives?
    a. How are programs or initiatives evaluated?
    b. What data drives new programs or initiatives?
4. Who makes decisions regarding mental health programming at your school?
5. Do you believe your school's current mental health program is effective? Why or why not?
6. What barriers does your school face when implementing mental health programs?
7. What recommendations for change to NDCC § 15.1-07-34 do you suggest?

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