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Combatting Mental Illness in Schools: Are Teachers Ready?

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by

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A Dissertation submitted to the Education Faculty of Lindenwood University in partial fulfillment of the requirements for the degree of

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Declaration of Originality

I do hereby declare and attest to the fact that this is an original study based solely upon my own scholarly work at Lindenwood University and that I have not submitted it for any other college or university course or degree.

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Acknowledgments

I would like to extend my sincerest thanks to my dissertation chair, Dr. Sherrie Wisdom for all of her support and guidance during this arduous process. Dr. Wisdom had faith in my ability as a student and a belief in me as a person. Even on the days when I felt as if I could not go on, she would simply smile and tell me that I could do it. Her words of wisdom and confidence in me led me through some of the hardest chapters of my life. And for that, I'd like to say thank you. I would also like to express my gratitude to my committee, to whom I will be forever indebted. Thank you for always providing me with not just constructive but reflective feedback. I'm a better and stronger person for it. My family and friends, who continued to support and fill me with encouraging words of affirmation, do not go unnoticed. It was those words that lit the fire inside me to continue to push through the tough times, even when I was adamant about not. Most importantly, to God, for blessing me with my parents, Mr. Albert Wilson Bass and Ms. Mary Lee Payton, who have both since passed on; without you, there would be no me. Their words of wisdom, confidence, and work ethic made me feel that I could do anything and become anyone. Their profound commitment to me and my success will never be forgotten. Thank you for loving me, exactly as you did. It shaped me into the woman I am today.

Abstract

If ever there was a time school districts, principals and teachers had to worry about providing a quality education for students, it is now, at the time of this writing. Due to the Nation's current state in dealing with a worldwide pandemic, the education system as a whole has suffered traumatically, both mentally and emotionally. No longer will teachers be solely responsible for providing students with the essentials necessary to be academically, emotionally, and socially successful in schools. Hundreds of thousands of students suffer from some form of mental illness within our schools. And, the teachers who service and support them are ill-prepared. Say goodbye to the times when teachers were held accountable for providing students with 100% of what they needed to become productive citizens. At this high-stakes level in schools and communities, a joint effort from each stakeholder is warranted. Mental health was an unspoken "curse" that went unacknowledged for centuries. But now, educators have been forced to take a deeper look into the support provided for those students, starting with the ones who have the most impact on their success, teachers. By utilizing research-based best practices and implementing meaningfully differentiated professional development for teachers, a school and classroom culture could have a tremendously positive effect.

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Chapter One: Introduction

Introduction

If ever there were times school districts, principals and teachers had to worry about providing a quality education for students, it's now, at the time of this writing. Due to the Nation's current state in dealing with a worldwide pandemic, COVID-19, stakeholders within the education system as a whole have suffered traumatically, both mentally and emotionally. One important key for educators is helping children cope during this crisis. When teachers are better equipped with the knowledge of providing their students with calmness and confidence, they can then provide the best support for them (Center for Disease Control and Prevention, 2021). No longer will teachers be solely responsible for providing students with the essentials necessary to be academically, emotionally, and socially successful in schools. During the pandemic, parents and caregivers also shouldered this responsibility (Center for Disease Control and Prevention, 2021).

Millions of people suffer from some form of mental illness across the nation. In 2017, research showed that 792 million people were diagnosed with one of the following: depression, bipolar disorder, and anxiety disorder (Ritchie & Roser, 2018). Say goodbye to the times when teachers were held accountable for providing students with 100% of what they needed to become productive citizens. At this high-stakes level in schools and communities, a joint effort from each stakeholder is warranted. There has been a stigma about mental illness for centuries (Jutras, 2017). But now, educators have been forced to take a deeper look into the support that is provided for those students affected with mental illness, starting with the ones who have the most impact on their success,

classroom teachers. By utilizing research-based best practices and implementing meaningfully differentiated professional development for teachers, a school and classroom culture could have a tremendously positive effect.

This is a study of newly implemented school-based best practices and professional development that supports the emotional, social, and academic needs of students who suffer from mental illness. The study seeks to understand and gain insight into the myths, history, and resolutions related to providing a climate and culture most conducive for students who suffer, ensuring that these students do not fall through the cracks; not only in the educational realm but also in life.

Local Perspective

Although the Saint Louis Public School System (SLPS) has not implemented targeted and differentiated professional development for teachers who interact with students' mental illnesses, it could look to re-strategize its blueprint on how supporting both the students and teachers could look (Brown, 2020). In the last five years as an administrator, the researcher attempted to address the needs of students with trauma-informed workshops for teachers. However, there was a lack of equity, as all schools were not privy; only selected ones for a pilot program.

The district currently hosts 68 schools; 14 high schools, 9 middle schools, and 45 elementary schools. Educators working in an urban district witnessed the fact that students experienced higher levels of trauma daily, compared to their counterparts in suburban districts. The severity of these events oftentimes led to some level of mental illness, leaving children to fend for themselves emotionally and mentally when there was no stability at home. This left teachers in a dilemma once students came to school and

exerted their feelings, sometimes in an unsafe manner; not due to any fault of their own, they simply did not know how to cope. In most if not all cases, the responsibility of making cultural connections and building trust with students falls on the classroom teacher (Personal communication, Pendleton, SLPS, 2020).

Justification for Pursuing the Topic

The purpose of this study was to examine general education classroom teacher needs and district-provided professional development concerning trauma and difficult student-oriented situations, to assess the effects on the mental well-being of classroom teachers, at the elementary school level, in urban schools. The goal was to provide recommendations for educators concerning the most effective research-based strategies that support the academic, social, and emotional growth of students who suffer from mental illness. The research was gathered and conducted through surveys, questionnaires, interviews, and focus groups.

The reason this study was important was that there was an achievement gap in the success rate of students who suffered from mental illness and those who did not. Students with mental health issues tended to drop out of school entirely, which led them down a path of underemployment and unemployment, reduced quality of life, and even prison (Child Mind Institute, 2016). The issue of mental health in schools, in the researcher's opinion, has always been a problem and has been around since the beginning of time, even in our homes (Child Mind Institute, 2016).

In its current state, we are not given the option of continuing to ignore the "elephant in the room." This ever-growing problem of a lack of training to support the mental health of our youth while at school has spiraled out of control and the lives of our

youth are literally at stake. Unfortunately, schools are witnessing mental illness in students as early as preschool (C. Burton, personal communication, 2021).

The need for intentional and effective support for teachers who instruct students with mental illness was growing daily. The district was losing teachers at an alarming rate in comparison to other neighboring districts, 214 during the 2019-2020 school year (C. Burton, personal communication, 2021). As a result, the district struggled to attract highly qualified teachers, which makes for a substantially limited hiring pool. Every school year, teachers were given paid time off (PTO) and sick days. According to the Chief Human Resources Officer of SLPS, during the past five years, a high percentage of SLPS staff used all of their sick and personal days. Some teachers, once they exhausted their days, even opted to miss work knowing that they would not be compensated (C. Burton, personal communication, 2021).

Working in an urban educational setting can be both daunting and stressful. Teachers could easily begin feeling inadequate and sometimes resentful. These feelings oftentimes carried over into their daily instruction. When there was no proper support or training for schools and teachers who served students with mental illness, was when educators began to second-guess themselves. Difficult working conditions were considered to be the number one barrier to quality professional development for teachers (Burns, 2015).

Providing teachers with high-quality professional development gives them a sense of ownership and empowerment. When teachers feel a sense of efficacy, it has a positive effect on students' efficacy. Robinson (2017) shared four key techniques that built confidence in students, focusing on the 'end game;' explaining to students that if they are

not able to complete a task now or tomorrow, they will be able to in the future. Do not overcorrect; refraining from interrupting students when they make mistakes supports students' efficacy. Making extra time for the students who need it is also critical; by prioritizing one-on-one time with students supports their willingness to speak up and speak out in class, which will build trust. Give students an active role; this will bring out each student's knowledge. (Robinson, 2017). The bars of expectation are set high and all students, even those who struggle with mental illness, can reach and then surpass them (Robinson, 2017).

Classroom teachers are already faced with wearing multiple hats and playing major key roles for students; they are expected to be a parent to students when the biological guardians are absent, a counselor when students need to express their feelings, the doctor when a student has a bruised knee or elbow, the provider when students do not have food or other necessities in the home, and sometimes the confidant when students do not feel comfortable sharing sensitive information with anyone else. They are the primary decision-makers whose expertise or lack thereof, can have a lasting impact on a student's academic, social and emotional well-being. Teachers are eager to be their best. They show up to work daily to make a difference in students' lives out of genuine concern (Edgenuity, 2021). They want to be part of a collaborative effort in living up to the district's core values; put children first in everything that is done, acknowledge the fact that all people matter, and ensure that all decisions are data-informed. Teachers want to believe and invest in the district’s and school's mission. With newer research on highly effective and qualified teachers along with best practices, teachers want the opportunity to participate and take full advantage of what the district and other networking

collaborations have to offer. decisions (Hodges, 2018). Only seven percent of teachers say they have some input in school decisions. Fifty-two percent of teachers say they should have a great deal of input. Teachers feel that state and federal governments should have the least input in school.

History of the Problem

For decades, the topic of mental illness was avoided (Dombrowski, 2019). Some feared that it was taboo, while others chose to ignore it. Mental illness was not new to society. However, it has been a hot topic within our schools over the last four to five years. Some may even refer to it as a silent pandemic. Research shows that one in five children living in the United States shows signs or symptoms of some type of mental health issue in a given year. But of those students, most of them, nearly 80% will never receive the services that they need (Anderson & Cardoza 2016). Not only are we seeing more cases of mental illness in schools, districts are now attempting to provide more trauma-informed services for schools. Providing a supportive culture, climate, and atmosphere can help those students who have experienced trauma in their lives. Many teachers were making conscious efforts to modify their classrooms to provide the support that students needed for types of trauma, like exposure to violence, neglect, and poverty which harms a child's brain and can negatively affect his or her learning (Schwartz, 2019).

Mental illness was also looked at as a community issue. Now, it has become the school’s issue. Mental health illnesses in America and how it affects students in the school system were running rampant. Millions of our students had not received adequate services due to them. Only a minute percentage of students, who suffered from mental

illness, actually received the services needed to be productive citizens. A study done by Mostafavi (2019) showed that half of the U.S. children with mental illness were not treated. However, one in seven children, including teens, exhibited at least one mental health illness that was treatable.

Sixty-two percent of college students reported feeling “overwhelmingly anxiety” over the previous year in 2016, up from 50% just five years prior. More alarming still, hospitalizations for mood disorders among children aged 17 years and under leaped by 68% between 1997 and 2011 (Mahnken, 2017).

At the elementary level, educators experienced working with students who suffered from mental illness, as young as age three. As the number of cases increased with students diagnosed with a mental illness, the number of educators who were qualified to teach them decreased (Personal communication, Pendleton, SLPS, 2021). In our current state, over 10 million students, ages 13 to 18, required professional help due to mental health conditions. Of these conditions, anxiety, depression, bipolar disorder, and attention deficit hyperactivity disorder (ADHD) are the most common among young students (IBCCES, 2019). It has been researched that only half of all students with a mental health diagnosis or who have psychological challenges, receive services. Mahnken (2017) felt that relationship building was crucial, as it allowed schools to ascertain appropriate mental health information from the families about the students. This relationship would also include services provided by doctors, hospitals, and other mental health agencies.

Are schools ready to tackle the mental health crisis? That is the million-dollar question. In short, Walker (2018) would give it a hard “no.” Students with mental

illnesses and the resources they have or have not received have been less than adequate (Walker, 2018).

Teachers need a framework, or at least a construct to work from, to be remotely successful. For example, if they had the basic information, such as strategies or techniques in their "tool kit," they would be in a better position to support children who struggle mentally. Providing the assistance children need would have a more positive and beneficial result to the classroom, school's culture and climate, and entire learning environment and atmosphere. Programs that are holistically designed and school-based tend to be more successful for both students and teachers. This approach would provide the support that examines the whole person, considering their emotional, social, and physical well-being, not just their mental health needs, alleviating some of the pressure off the individual teachers, so they do not have to carry the load of training their respective colleagues (NSW Government, 2020).

Seventy percent of students with a mental health disorder do not receive adequate treatment (Walker, 2018). Unfortunately, a larger percentage of those students did not receive or have access to treatment. In the past few years, society pivoted to acknowledging that mental illness in children exists and that it is rampant. The approach to try and mitigate the issue has been more systematic than in the past, as there are no cookie-cutter or one-stop-shop solutions (PEW, 2018). Teens have been faced with an overwhelming amount of pressure, including, but not limited to anxiety, depression, and stress, not to mention the negative effects of poverty and schools' discipline policies. Taking proactive approaches to issues of this magnitude and starting early has proven to be most effective (Center for American Progress, 2016).

The challenge for underprivileged districts is that, with budget cuts and understaffing, these schools are already at a deficit, hindering their ability to properly address the challenges they are faced with daily. Even though schools attempted to hire more school counselors and social workers, they were not the same as real doctors. They too required adequate training to effectively meet the needs of students who suffered from mental illness. Having to provide services for those students only added to the already inundated caseload, making it impossible to manage their caseloads and provide one-on-one support. Luckily, more and more students, at an early age, feel more comfortable with asking for help and talking about issues that may cause them distress. They know that if they cannot get the help they need from anywhere else, they can count on the school to provide them with the support they need (American School Counselor Association, 2020). Studies show 81% of teens with anxiety, 71% of teens with depression, and 85% of teens with Attention Deficit Hyperactivity Disorder (ADHD) get better with treatment (Walker, 2018).

Current State of the Problem

Mental health in schools across America is on the rise. Research shows that there are over 10 million students; ages 13 through 18 who require professional help due to a mental health condition. Unfortunately, schools are not equipped to even graze the surface to address the issue. There is not enough being done as it relates to training and awareness, which can be detrimental to children, schools, and districts alike. Educators are on the front lines daily and are the key to creating effective and long-lasting change. There is no one size fits all approach; but, at least now, the issue is being acknowledged and discussed (IBCCES, 2019).

We have a long hard road ahead of us as a nation, as one in six U.S. children has a mental illness and 70% of them do not receive adequate treatment if any treatment at all. Most of them do not even have access to treatment. This is evident in several urban education populations. With that being said, only a fraction of students received adequate support. The issue is continuing to grow (Devitt, 2019).

> The numbers are what they are and the data does not lie. School districts, in my opinion, need a more proactive and preventive approach to combating this problem, by providing schools with the awareness and tools needed so that every child can be successful, academically, emotionally, and socially. Stakeholders in the education field, cannot work to promote awareness with their students until mental health education is a mandatory aspect of all schools (Barile, 2018, p. 2).

There are several benefits to mental health services that can be provided to schools for children. If children are mentally healthy, it makes for a more successful academic career. If there was sufficient support in schools, it would be ideal because students are in schools at least six hours each day for at least 180 days out of the year. Optimized time and efforts would catapult more positive results into the future and change the current state that we have been in for decades and generations. Research shows that students who receive social-emotional and mental health support achieve better academically (Mahnken, 2017).

Research Question

How does teacher preparedness affect the quality or level of support provided to students with mental illness, as measured by interview questions, survey questions, and focus group responses?

Definitions of Key Terms

- **Mental Illness:** Good mental health is critical to children's success in school and life. ... Mental health is not simply the absence of mental illness but also encompasses wellness promotion; social, emotional, and behavioral health; and the ability to cope with life's challenges. (National Association of School Psychologists, 2021)
- **Social & Emotional Learning (SEL)**: is the process of developing the self-awareness, self-control, and interpersonal skills that are vital for school, work, and life success. People with strong social-emotional skills are better able to cope with everyday challenges and benefit academically, professionally, and socially. (Committee for Children, 2021)
- **School-to-Prison Pipeline (STPP)**: "a disturbing national trend wherein children are funneled out of public schools and into the juvenile and criminal justice systems" (American Civil Liberties Union, 2021, para. 1).
- **Transgender and Non-Conforming (TGNC)**: An umbrella term for people whose gender identity differs from the sex they were assigned at birth and/or whose gender expressions do not match society's expectations with regard to gender roles. The term may include identities such as transsexual, genderqueer, gender nonconforming, FTM, MTF, and gender variant. Transgender people may or may not choose to alter their bodies hormonally and/or surgically. (Anti-Defamation League, 2014) Gender nonconforming is a term given to people who don't conform to the gender norms that are expected of them. The term usually refers to gender expression or presentation (that is, how someone looks and

> dresses). It can also refer to behavior, preferences, and roles that don't conform to gender norms. Gender nonconforming can be used to describe people as well as actions, dress, and ideas. Being gender non-conforming doesn't necessarily mean you're transgender or nonbinary, although you could be both. (Healthline, 2021)

Summary

This is a study of the abundant number of students in schools who suffer from mental illness and the lack of training teachers to support them in the classroom. The study seeks to understand and gain insight into the research and best practices that will effectively train teachers in the most effective best practices to utilize to support students with mental illness. The results would include but are not limited to lower teacher absenteeism rates, teacher burnout, and resignations.

The current state of the leadership within the district, but specifically at the school level heavily relies on the administrator to be the primary decision-maker and the one who provides professional development for teachers. This affects the morale, absenteeism rate, and teacher buy-in with this top-down approach. It is extremely difficult to sustain a positive school climate and culture when teachers feel there is no meaningful and effective training that is differentiated to fit the needs of the individual schools and their students. In Chapter Two, research-based theories connected to mental illness and teacher training will be analyzed.

The research will represent attempts of professional development opportunities on inclusiveness, diversity, pedagogical choices for teaching diversity, and cultural responsiveness and the results of those implementations shared in studies. The framework design that will be used for the successful implementation of this Action Research will be

discussed in Chapter Three.

Chapter Two: Review of Literature

History

This chapter begins with a brief historical overview of mental health illnesses in America and how they affect students in the school system. Since the beginning, there has been a hidden mental health crisis in America's Schools. Millions of our students had not received adequate services due to them. Only a minute percentage of students, who suffer from mental illness, actually receive the services needed to be productive citizens. Unfortunately, the rampancy is steadily increasing at alarming rates (Mahnken, 2017).

> Sixty-two percent of college students reported feeling "overwhelming anxiety" over the previous year in 2016, up from 50 percent just five years prior. More alarming still, hospitalizations for mood disorders among children ages 17 and under leaped by 68 percent between 1997 and 2011. (Mahnken, 2017, para. 2)

At the elementary level, educators have experience working with students who suffer from mental illness, as young as age three. As the number of cases increases with students who have been diagnosed with a mental illness, the number of educators qualified to teach them has decreased. In our current state, over 10 million students, ages 13 through 18, require professional help, due to a mental health condition. Of these conditions, anxiety, depression, bipolar disorder, and attention deficit hyperactivity disorder (ADHD) are the most common among young students. It has been researched that only half of all students with a mental health diagnosis and/or who have psychological challenges, receive services. Mahnken (2017) felt that relationship building is crucial, as it allows schools to ascertain appropriate mental health information from the families about the students. This relationship would also include services provided by

doctors, hospitals, and other mental health agencies (Mahnken, 2017).

Are schools ready to tackle the mental health crisis? That is the million-dollar question. In short, Walker (2018) would give it a hard "no." Students with mental illnesses, and the resources they have or have not received, have been less than adequate. Teachers need a framework or at least a construct to work from, to be remotely successful. For example, if they had the basic information, such as strategies or techniques in their proverbial "tool kit," they would be in a better position to support children who struggle mentally. Providing the assistance children need would have a more positive and beneficial result to the classroom, school's culture and climate, and entire learning environment and atmosphere. Programs that are holistically designed and school-based tend to be more successful for both students and teachers. This takes some of the pressure off the individual teachers, so they do not have to carry the load of training their respective colleagues (Walker, 2018).

Seventy percent of students with a mental health disorder did not receive adequate treatment (Walker, 2018). Unfortunately, a larger percentage of those students did not receive or have access to treatment. In the past few years, society has pivoted to acknowledging that mental illness in children exists and that it is rampant. The approach to try and mitigate the issue has been more systematic than in the past, as there are no cookie-cutter or one-stop-shop solutions. Something as severe as mass shootings had to occur before lawmakers addressed the idea of mentally ill children. Teens have been faced with an overwhelming amount of pressure, including but not limited to anxiety, depression, and stress, not to mention the negative effects of poverty and school discipline policies. Taking proactive approaches to issues of this magnitude and starting

early has proven to be most effective (Walker, 2018).

The challenge for underprivileged districts is that, with budget cuts and understaffing, these schools are already at a deficit, hindering their ability to properly address the challenges they are faced with daily. Even though schools attempted to hire more school counselors and social workers, these professionals are not the same as real doctors. They too require adequate training to effectively meet the needs of students who suffer from mental illness. Having to provide services for those students only adds to the already inundated caseload, making it virtually impossible to manage their caseloads and provide one-on-one support. Luckily, more and more students, at an early age, feel more comfortable with asking for help and talking about issues that may cause them distress. They know that if they cannot get the help they need from anywhere else, they can count on the school to provide them with the support they need. Studies showed 81% of teens with anxiety, 71% of teens with depression, and 85% of teens with Attention Deficit Hyperactivity Disorder (ADHD) get better with treatment (Walker, 2018).

Research has also shown a connection between adolescents who suffer from mental disorders and their socioeconomic status. There are several ways to define low SES, as there are multiple factors that attribute. For example, a family may be considered poor according to a governmental definition of absolute poverty or inadequate income or may have low income in comparison to others in the community. A family may live in a high poverty area, considered as a community inequality, or in a population that lives in both poverty as well as in an area of high-income inequality. These factors have critical implications for interventions. Some researchers have debated back and forth that these social factors, such as inequality in income and poverty are fundamental causes of mental

disorders because they hinder and or limit the access necessary for people who suffer from mental illness to the resources that promote positive health and well-being. If this is the instance, then the support, preventions, and interventions should align with factors at a societal level (McLaughlin, 2012).

Figure 1

Fixed Mindset vs. Growth Mindset

Note: Source, Taima (2021).

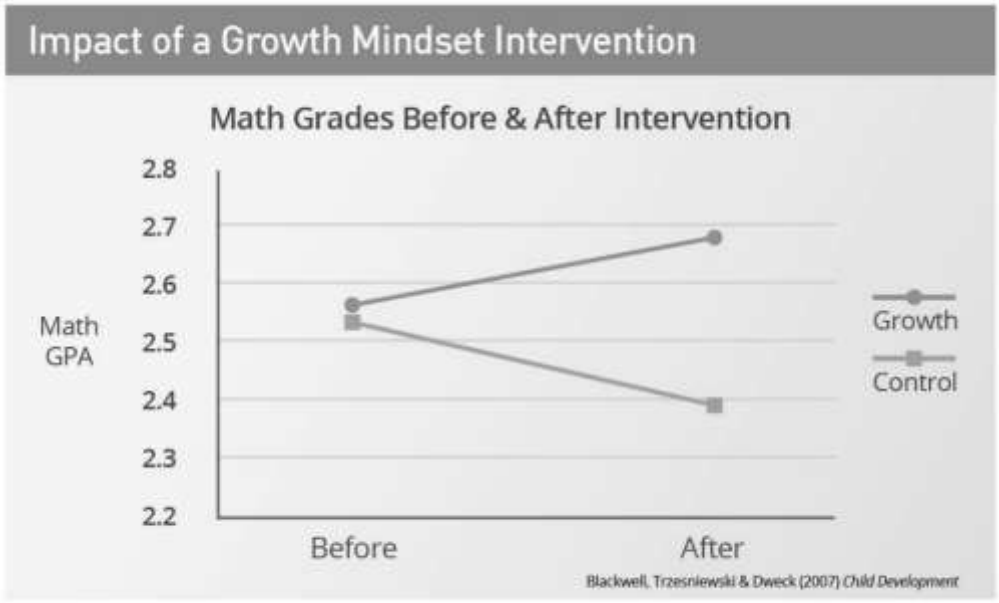
When considering the history of mental illness, one must keep in mind the influences of parents and the vital role they play in how their child's mental health and well-being manifests itself. Schleider (2016) expressed that the belief system of a family can strongly influence and affect children's mental health and behavior. This is through what is called the parental *intelligence mindset.* The intelligence mindset is the

adaptability of intelligence and growth mindset versus fixed mindset (Pine & Leibenluft, 2015).

Researchers found that most parents, guardians or caregivers who exhibited a more dominant fixed intelligence mindset had children who internalized their problems more, especially social anxiety in comparison to those children of families who had a growth mindset (Pine & Leibenluft, 2015). It was also concluded that the parents with fixed intelligence mindsets were associated with males who experienced depressive symptoms, instead of with girls. These symptoms included but were not limited to the inability to control feelings of worry or stress, restlessness or edginess, fatigue, difficulty concentrating, irritability, muscle tensions, and problems sleeping (Pine & Leibenluft, 2015).

Figure 2

The Impact of Growth Mindset Intervention



Note: Source, Dweck (2017). Growth shows an upward slope; control shows downward.

The diagram in Figure 2 shows the impact of a growth mindset intervention on math grades before and after the intervention.

Not only does the mindset of children's parents affect their behavior and how they show up in society, but so does the non-incarcerated residents of high-incarceration neighborhoods. The United States leads the world in the percentage of its population who are incarcerated and or have served time in prison or jail. Nearly, 3 % of the American adult population experienced the justice system in an adverse manner. That equates to 7 million men and women were either on probation, parole, or under some form of community supervision. There is also a disproportionate number of Black males incarcerated and who will be incarcerated in the future in comparison to their white male counterparts. one out of every three Black men will serve time in prison in their lifetimes. The terms mass imprisonment and hyper-incarceration refer to the scope of incarceration within particular subgroups and currently describe the US criminal justice system. There are two main categories that research has grouped the health consequences of incarceration, one focuses on individuals directly involved in the criminal justice system, and the other evaluates the broader health consequences of incarceration, which is called the "long-arm" of corrections or collateral consequences of mass incarceration. If a person lives in a neighborhood or community that experiences a high level of incarceration, it can change the social ecology of the community by destroying social capital and impeding the kinds of family and social networks and relationships necessary for developing and maintaining individuals' mental health as well as the well-being of those communities (Hatzenbuehler, 2015).

Jones and Guy-Sheftall (2015) conducted a study that looked into the correlation

of oppression among black women struggling with psychiatric issues and developed a framework for the practices of mental health with this population. A women's busy nature in life has a direct impact and effect on her mental health inevitably. When women experience challenges at work or the domestic issues that typically occur, black women, in particular, are known to endure several oppressions associated with racism, sexism, classism, and heterosexism. Black women reported experiencing isolation, alienation, and denigration that was associated with their identified "isms.". To cope with the adverse effects of mental health, some women have reached out and tried feminist therapy to provide services. Feminist therapy promotes that social inequality between genders is at the core of mental health problems among women. It acknowledges that women's minority status, sex roles, and female socialization are sources of psychological difficulties (Jones & Guy-Sheftall, 2015).

Treatment

In defense of schools' efforts, many have attempted to improve students' learning and well-being by providing mental health awareness. Barile (2018) talked about mental awareness in schools and its importance. As this issue continues to plague the country, educators, mostly administrators and especially teachers are on the front line daily. It has a devastating effect on students' academic growth and success. Getting to know your students and building meaningful relationships are easy ways for educators to recognize the signs in students; prevention and early intervention are the keys to supporting students who suffer from mental health issues. Another way that educators can be proactive in supporting students with mental illness, is to create situations and environments where students feel safe; not just physically safe, but emotionally safe. The

overall goal of these practices is to "break down barriers to learning so the general well-being of students, families, and school staff can be enhanced in collaboration with other comprehensive student support and services (Barile, 2018).

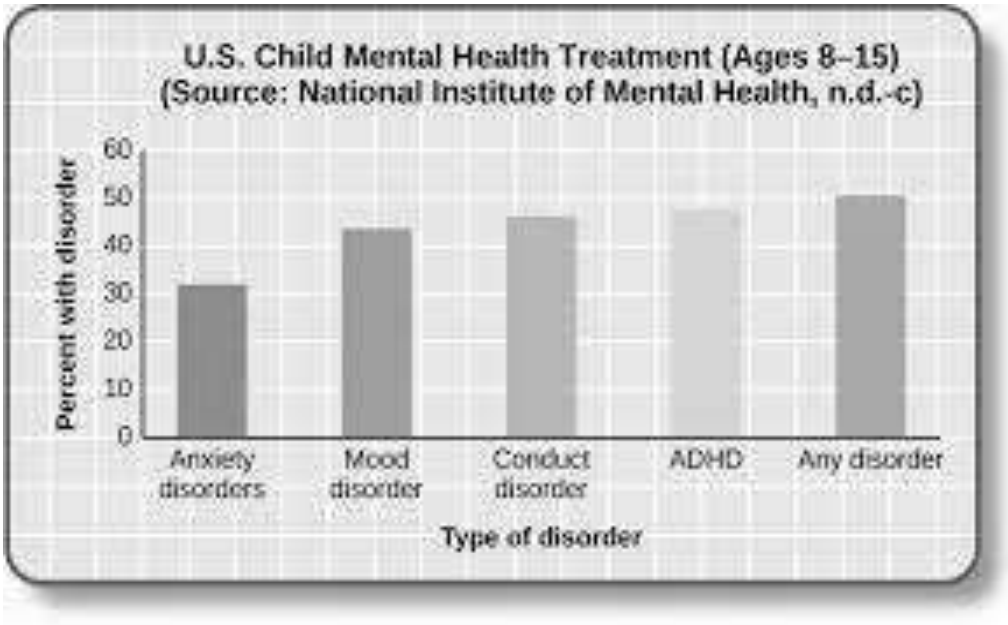
Providing the support that students need is crucial. At the school level, several practices can be put into place. The National Association of School Psychologists (NASP, 2016) believes that for schools to be and remain safe, adequate mental health services are essential. In the aforementioned paragraphs, a high percentage of students who suffer from mental illnesses either have never been diagnosed or do not receive treatment. Being mentally healthy allows students to be able to problem-solve and critically think, both of which are essential to academics but also social and emotional well-being. School support services provide these students with as much normalcy as possible while assessing the magnitude or severity of the student's illness. If schools were fortunate to have mental health professionals, and not just school social workers and counselors, they would be further along with supporting students with mental health issues, as they are specially trained to provide the type of counseling and therapy needed for a child to be successful. Unfortunately, that is not the case in urban school districts. The school counselor and social worker are the primary resources for students who struggle mentally.

Having effective plans in place both inside and out of schools, for students who struggle with mental health issues is paramount. During Cordell and Snowden's (2014) research, they discovered that even though adolescents who experience traumatic experiences regularly are at higher risk of being negatively affected mentally, the literature addressing this issue is limited (Cordell & Snowden, 2014). The problem

continues to not be addressed in a manner that is significant enough to support youth. So, when crises occur, schools are ill-prepared to handle them if treatment has not been implemented. It is likely that over some time, adolescents may experience a myriad of emotions, and the crisis intervention strategies that school counselors are trained to use must be utilized. At times, these same strategies that are meant to help, actually harm causing children even more distress. Far too often, when school staff is unable to successfully deescalate a situation, it can result in situations that involve 911 being called and or district safety officials, jail time, hospitalization, injury to self or staff, or runaway. During these hyperarousal states, students are in most need of services that provide mental health for students.

Figure 3

U.S. Child Mental Health Treatment (Ages 8-15)



Note: Source, OpenStax (2019).

Approaching one half of youth in residential (46%) and school (44.3%) settings experienced any crisis event, and the rate of events per youth who served for 6 months

was high in these settings (8.31 for residential programs and 4.58 for school) as compared to others settings. However, when describing those events which escalated to a point that required emergency responses, 40.4% of youth served in residential settings experienced a mental health emergency crisis event as compared to <25% for all other types.

Current State

Mental health in schools across America is on the rise. "Research shows that there are over 10 million students; ages 13-18 who require professional help due to a mental health condition" (IBCCES, 2019, p. 1). Unfortunately, schools are not equipped to even graze the surface to address the issue. There is not enough being done as it relates to training and awareness, which can be detrimental to children, schools, and districts alike. Educators are on the front lines daily and are the key to creating effective and long-lasting change. There is no one-size-fits-all approach; but at least now, the issue is being acknowledged and discussed.

We have a long hard road ahead of us as a nation, as "70% of students with a mental health disorder do not receive adequate treatment" (Walker, September 13, 2018, p. 3). Most of them do not even have access to treatment. This is evident in several urban education populations, including this researcher's experience. These numbers are gut-wrenching, to say the least. With that being said, only a mere fraction of students received adequate support. The issue is continuing to grow.

> Sixty-two percent of college students reported feeling "overwhelmed anxiety" over the previous year in 2016, up from 50 percent just five years prior More alarming still, hospitalizations for mood disorders among children ages 17 and under leaped by 68 percent between 1997 and 2011, (Mahnken, 2017, para. 2)

The numbers are what they are and the data do not lie. School districts, in my opinion, need a more proactive and preventive approach to combating this problem, by providing schools with the awareness and tools needed, so that every child can be successful, academically, emotionally, and socially. “Until mental health education is a mandatory aspect of all schools, teachers, and administrators can work to promote awareness with their students” (Personal communication, Pendleton, SLPS, 2019).

There are several benefits to mental health services that can be provided to schools for children. If children are mentally healthy, it makes for a more successful academic career. If there was sufficient support in schools, it would be ideal, because students are in schools at least six hours each day for at least 180 days out of the year. Optimized time and efforts would catapult more positive results into the future and change the current state that we have been in for decades and generations. “Research demonstrates that students who receive social-emotional and mental health support achieve better academically” (C. Burton, personal communication, June 20, 2019). Isn’t this what we work so hard for, as educators?

Table 1

Youth with Severe Major Depressive Episode (MDE)

Rank	State	Percentage	Number
1	Mississippi	6.3	15000
2	Alabama	6.4	23000
3	District of Columbia	6.8	2000
4	Pennsylvania	7.1	64000
5	New York	7.8	105000
6	South Dakota	8.0	5000

Continued

7	New Jersey	8.1	54000
8	Hawaii	8.5	4000
9	North Dakota	8.5	8000
10	Massachussettes	8.5	40000
11	California	8.7	256000
12	Colorado	8.7	36000
13	New Hampshire	8.7	8000
14	Connecticut	9.0	24000
15	Nebraska	9.0	14000
16	Ohio	9.1	79000
17	Texas	9.2	219000
18	Louisiana	9.2	33000
19	Tennessee	9.2	46000
20	Florida	9.3	128000
21	Georgia	9.3	78000
22	Delaware	9.3	6000
23	Rhode Island	9.5	7000
24	Kentucky	9.6	31000
25	Iowa	9.8	23000
26	Maryland	9.8	42000
27	Minnesota	9.8	41000
28	South Carolina	9.8	36000
29	Kansas	9.9	23000
30	Virginia	10.2	62000
31	Washington	10.4	53000
32	Montana	10.4	8000
33	Missouri	10.4	47000
34	Alaska	10.7	6000
35	Arkansas	10.7	25000
36	Vermont	10.7	4000

Continued

37	Illinois	11	104000
38	Michigan	11.3	84000
39	Nevada	11.8	26000
40	Utah	11.9	36000
41	Wyoming	12	5000
42	West Virginia	12.5	15000
43	Arizona	12.5	66000
44	North Carolina	12.6	98000
45	Idaho	12.7	19000
46	Indiana	12.7	66000
47	Oklahoma	12.7	39000
48	Oregon	13.1	37000
49	New Mexico	13.1	21000
50	Wisconsin	13.4	58000
51	Maine	13.5	12000

Note: Source, Mental Health America (2021).

Stigma

The reason that more than half the people who suffer from mental illness do not receive help is that oftentimes they avoid or put off seeking help. Some of this hesitation stemmed from the fears of negatively affecting their livelihood or losing their jobs. The stigma, discrimination, and prejudice against these people is still very much a significant problem (Ho et al., 2018). This treatment can be subtle or obvious; both can lead to harm. Understanding and taking heed of such behavior can support those affected in addressing the issue of stigma, prejudice, and discrimination. Like many stigmas, the view of people with mental illness stems mostly from ignorance or lack of knowledge, fear, and media perception. Researchers have identified three major types of stigmas; Institutional stigma, Self-stigma, and Public stigma. Institutional stigma is defined as a systemic idea that

involves several governmental policies as well as private organizations (American Psychiatric Association [APA], 2021). They are known for limiting opportunities for people with mental illness, intentionally or unintentionally. Self-stigma refers to unfavorable and negative ideals, thoughts, perceptions, and attitudes, including but not limited to the shame, that a number of people who suffer from mental illness feel about themselves (APA, 2019). Public stigma, the opposite of self-stigma refers to the unfavorable and negative ideals, thoughts, perceptions, and attitudes that people who suffer from mental illness have to deal with, including but not limited to discrimination, from others. The American Psychiatric Association (2019) stated that stigma against the mentally ill not only affects those individuals but also their loved ones (APA, 2019).

Types of Stigma

Table 2

Types of Stigma

	Public	Self	Institutional
Stereotypes & Prejudices	People with mental illness are dangerous, incompetent, to blame for their disorder, unpredictable	I am dangerous, incompetent, to blame	Stereotypes are embodied in-laws and other institutions
Discrimination	Therefore, employers may not hire them, landlords may not rent to them, the health care system may offer a lower standard of care	These thoughts lead to lowered self-esteem and self-efficacy: "Why try? Someone like me is not worthy of good health."	Intended and unintended loss of opportunity

Note: Source. Corrigan et al. (2016).

The visual in Table 2 depicts the various stereotypes, prejudices, and discrimination of each type of stigma (APA, 2019).

Research also showed that there are many harmful effects of stigma discrimination. It was found that they both can perpetuate and worsen existing symptoms and reduce the likelihood and probability of people with mental illness, receiving treatment. Self-stigma specifically, leads to adverse effects on recovery among those diagnosed with severe mental illnesses.

Effects can include:

- Reduced hope
- Lower self-esteem
- Increased psychiatric symptoms
- Difficulties with social relationships
- Reduced likelihood of staying with treatment
- More difficulties at work

Some of the other harmful effects of stigma can include:

- Reluctance to seek help or treatment and less likely to stay with treatment
- Social isolation
- Lack of understanding by family, friends, coworkers, or others
- Fewer opportunities for work, school, or social activities or trouble finding housing
- Bullying, physical violence, or harassment
- Health insurance that doesn’t adequately cover your mental illness treatment

- The belief that you'll never succeed at certain challenges or that you cannot improve your situation. (Mayo Clinic, 2017)

Wong (2019) conducted a research pilot study on the evaluation of a mental health course for stigma reduction (Table 3)

Table 3

Pre-to-Post Response on Knowledge About Mental Illness

Item/statement	Pre-test Response (%)	Post-test Response (%)	**2 *X***
1. Most people with mental health problems want to have paid employment (true)	100	98	2.02
2. If a friend had a mental health problem, I know what advice to give them to get professional help (true)	44.9	75.5	**19.19****
3. Medication can be an effective treatment for people with mental health problems (true)	67.3	83.7	**7.81****
4. Psychotherapy (e.g. talking therapy or counseling) can be an effective treatment for people with mental health problems (true)	95.9	98.0	.69
5. People with severe mental health problems can fully recover (true)	65.3	85.7	**11.92****
6. Most people with mental health problems go to a healthcare professional to get help (false)	81.79.6	.13	

Note. N = 49.
*Statistically significant p< .05 as indicated in bold
**Statistically significant p< .001as indicated in bold

The study looked closely at the efficacy of a mental health course for undergraduate students in Hong Kong. The premise was to enhance mental health literacy and mitigate the stigma against people who suffered from mental illness. Prior to the study, a pre-and post-test was administered to examine three key factors: students' attitude toward people with mental illness, their knowledge of mental health, and their intended behaviors Wong (2019).

The researchers' findings showed that students who benefited from the study and teaching the course on the evaluation of mental health, as a universal strategy to curb the perpetuation stigma, proved effective in the reduction of it, especially for those students who were apprehensive about seeking help, as they were sometimes overlooked (Wong, 2019).

COVID-19 Pandemic

How has the Coronavirus impacted the education system? There are three major ways that this has happened. The impact of the COVID-19 pandemic has adversely affected children's nutritional health, academics, and achievement gap. Schools are charged with far more than educating students ensuring they are academically prepared for a global society. They are also responsible for providing support to students and their families, in order to meet their basic needs; food, shelter, social and emotional support, transportation, etc.

Among other situations, once the pandemic hit, schools were charged with creating innovative ways to keep students fed as the world had to hard pivot to virtual learning. Students' nutritional health had been severely compromised. In many instances, the meals provided by the schools were the only ones they received. They were consistent

and fluid (Anderson, 2020). The author also contended that students who came from impoverished areas in their communities suffered most, as they encountered more financial barriers than their counterparts.

School districts had to think outside of the box to ensure that students were still being fed nutritious meals; some schools used buses to deliver food, while others set up on-site food pantries. And even though these temporary solutions served their purpose, schools provided students and families with the stability that they were used to and what they needed (Anderson, 2020). There was a universal consensus among schools across the globe that having to shift from traditional learning to virtual learning suddenly, impacted student achievement.

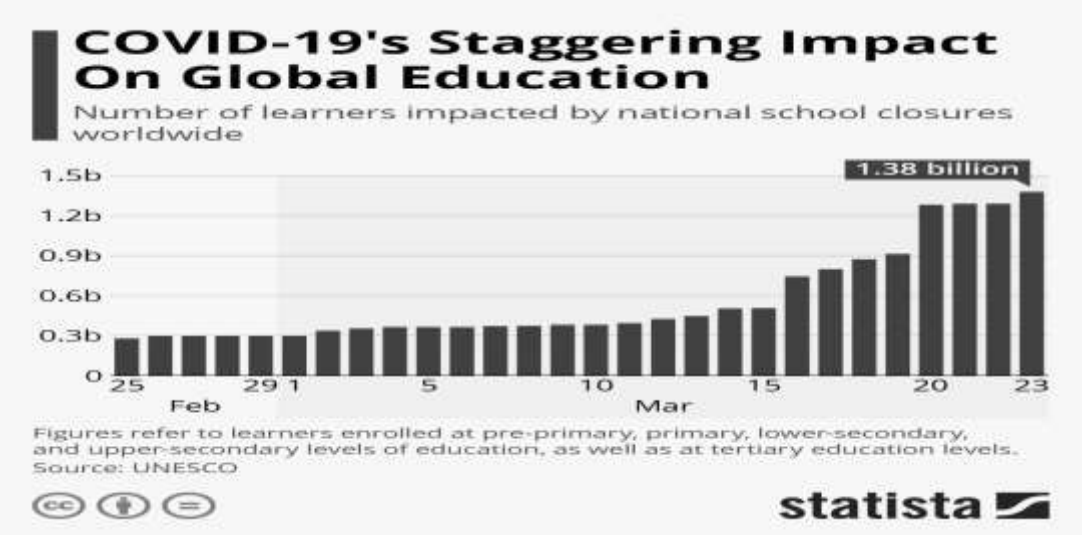
Schools had to quickly change the way they taught students and communicated with families, while still remaining in compliance with the Department of Elementary and Secondary Education (DESE) and alignment with state and federal curricula. Underserved communities and populations were hit hardest, because they did not have access to adequate technology needed in order to be successful; so, schools provided internet connections, WiFI, hotspots, and connections with local technology businesses to ensure that all students had equal access to success (Anderson, 2020).

Children from impoverished communities, those of color, not only depended on schools for technology but for meeting their basic needs (Maxouris & Yu, 2020). Rothstein (2020) contended that socioeconomics played a major role in students' levels of academic success; students of African American and or Hispanic descent oftentimes showed a regression in their academics, severely widening the achievement gap in

comparison to their Caucasian counterparts who were in the upper-class socioeconomic class (Rothstein, 2020).

Figure 4

Learners Enrolled at Pre-Primary, Primary, Lower-Secondary, and Upper-Secondary Levels of Education, and Tertiary Education Levels



Note: Source: UNESCO (2020).

COVID 19 Pandemic Effects

When the pandemic began in March 2020, it affected the nation in more ways than one. The mental impact of COVID 19 still impacts society, as people try to pick up the pieces of its destruction. By reducing the stigma and providing the necessary provisions of mental health services, the challenges associated with the pandemic may lessen. Social stigma has impacted the world worse than one could have imagined. One of the main causes of social stigma, as it relates to COVID 19 is fear and anxiety about the disease, essentially the unknown. Harmful effects derive from these social stigmas resulting in people hiding their disease if they are infected, and their contacts or travel history. This may delay or deter people from practicing healthy and safe behaviors.

Sathyanath (2020) describes three key mental health impacts of COVID 19. The first is the impact on the patients who already possess pre-existing mental illnesses. Higher susceptibility to stress is to be expected in people with pre-existing mental illnesses. They tend to be impacted by the emotional responses that the COVID 19 pandemic brings, resulting in relapses (Sathyanath, 2020).

There is also an impact on the general public. There are several factors that affected the general public during its lockdown period, due to the COVID 19 pandemic. They ranged from financial insecurity, inadequate essential supplies, loss of typical routine, frustration, and boredom (Agoratus, 2021). Persons who have been quarantined and isolated due to COVID 19 have also been impacted. Studies have shown that people who experienced longer isolation and quarantine time had poorer mental health, specifically named anger, avoidance behaviors, and post-traumatic stress (Agoratus, 2021).

Public health responses are crucial in alleviating some of the pressures of dealing with the mental health fallout of the pandemic. Effective communication is necessary to reduce or avoid stigma. Fostering an environment to discuss the pandemic transparently and effectively is imperative as it builds trust and honesty (Sathyanath, 2020). Unbeknownst to some, the media plays a substantial role in how people's perceptions are shaped. Fear-mongering and sensationalizing headlines are known to result in stigma. However, when the opposite occurs, it yields a more positive result, such as engaging influences to ensure community engagement, amplifying positive voices, sharing success stories, or honoring the frontline workers (Sathyanath, 2020). All of the aforementioned support stigma reduction and mental health in public health responses.

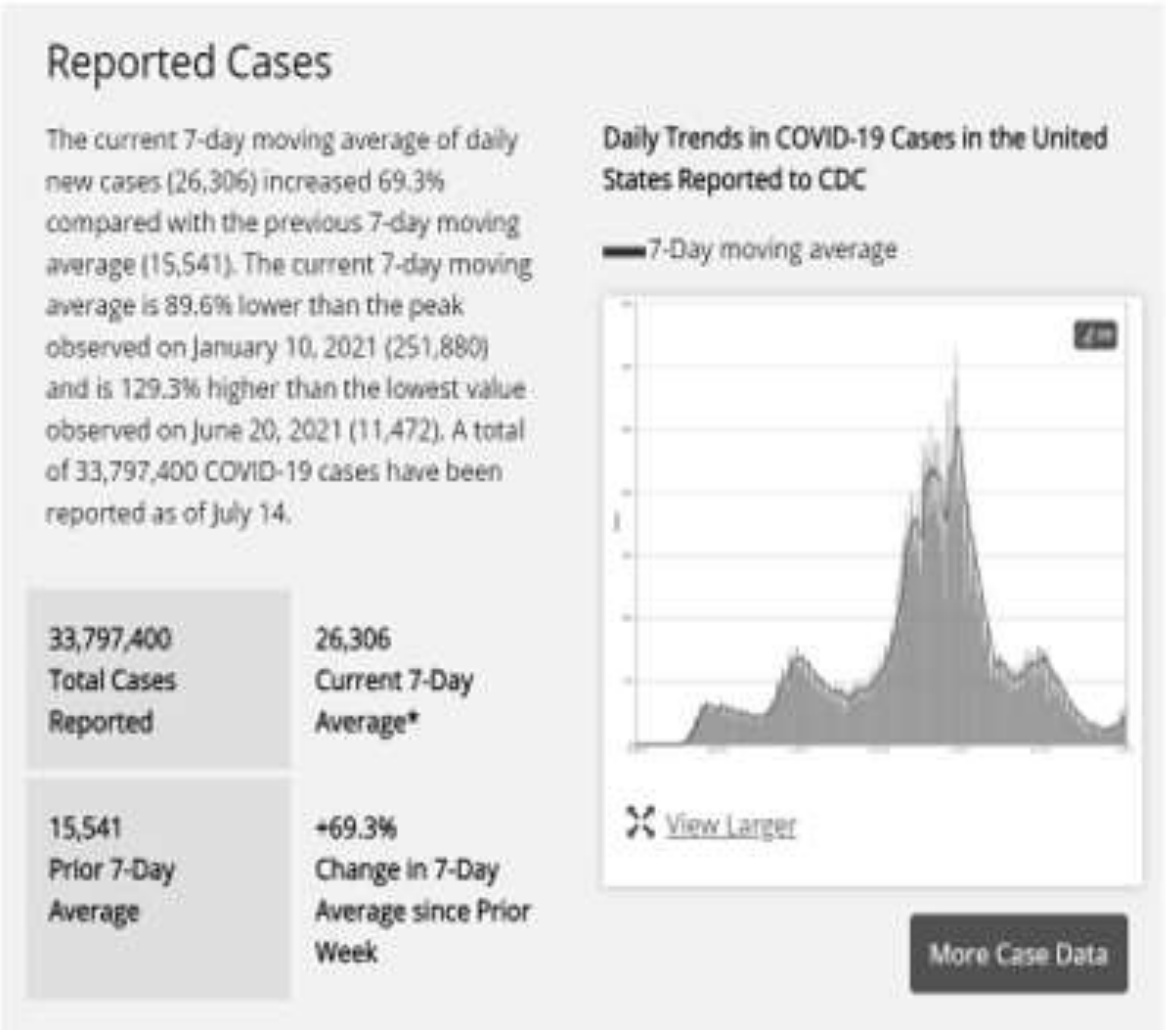
Psychological considerations have been made during the COVID 19 outbreak that has aided in stigma reduction. A guide was created by the World Health Organization (WHO, 2020) addressing and attempting to prevent social stigma. Also, they suggested separating a COVID patient's disease from the patient by paraphrasing a person's case as 'a person who has been affected by the disease.' School-aged children have drastically been impacted by the pandemic. By providing families, schools, and the communities with tips and strategies on how to cope with the anxiety and stress associated with COVID 19 during its lockdown period, the well-being and mental health of youth is crucial (Sathyanath, 2020).

The mental health effects of school closures during COVID 19 made matters worse, as it impacted and disrupted the entire educational system. Students' daily systems and routines were altered drastically and abruptly, resulting in an array of feelings and emotions, not conducive to positive mental health and well-being. According to UNESCO (2020), in April 2020, nationwide, schools suspended services in over 188 countries. Approximately 1. 5 billion youth were without education. For students who already experienced mental illness, this fallout resulted in students who typically received treatments and resources from the schools not having access to the support they needed. This included face-to-face support and peer support (Lee, 2020). Even though online and phone supports and resources were available, accessing help remained a challenge for some children. Schools were known for creating systems and procedures that fostered consistency and a positive atmosphere (Lee, 2020). These routines were crucial when supporting students with mental illness, as they are used sometimes as coping

mechanisms. Some students even relapsed as that the anchor that they had grown accustomed to had disappeared (Lee, 2020).

Figure 5

Daily Trends in COVID-19 Cases in the United States Reported to CDC



Note: Source, UNESCO (2020)

While the world anticipated getting back to "normal", for those students who suffered from depression, those students would have a harder time adjusting when the pandemic was over. Autistic children and others with special education needs were also at risk. Their effects consisted of short-temper and frustration with the disruption of their

daily routines (Lee 2020). Any break in routine, especially during the COVID pandemic had a greater risk of halting a child with mental illness progress, causing relapses, and/or missed opportunities for those children to develop essential skills. During this unprecedented time of stress, for some, the social distancing guidelines put in place resulted in social isolation. It is imperative that society continues to support students with mental illness and their families (Lee, 2020).

Barriers

There are several barriers to reaching the future state, especially for students who are considered at higher risk. These barriers include but are not limited to access to services, financial obstacles, the notion that the symptoms will simply go away on their own, the sense that the treatment will not be effective, and the stigma regarding mental health. There are barriers specific to those of minority youth that include systemic factors, population barriers, socioeconomic differences, inadequate health education, mental health stigma, lack of advocacy, lower quality skills, and deficits in culturally informed care (M. Pendleton, personal communication, January 3, 2020).

While interviewing the coordinator of social services and workers from an urban school district, we discussed these barriers in-depth and how there could be additional issues for teachers who teach students with mental health needs, that need to be addressed before we, as a district could even begin to tackle the bigger issue. These issues fell into five main buckets, time for school-based staff, time for children and their families, the stigma of mental illness, the role of the school community and its role and responsibility in supporting students who suffer from mental illness (M. Marietta, personal communication, June 2019).

The following questions were those questions determined to be ones that staff and families were likely to ask and or have concerns about, in order to provide the best possible solutions and most effective supports for students who suffer from mental illness:

1. **Time for school-based staff:** When will staff receive training? Training is essential. Without it, stakeholders feel inept or inadequate in their roles to assist children with mental illness. When will staff, families, and community partners meet to identify triggers and interventions? In order for there to be productivity, both ideas of triggers and interventions must be addressed. The trigger in mental health is that thing that affects the emotional state, often significantly, by causing extreme to overwhelm or distress. The interventions are developed when the individual and professional work together to set goals and strategies for achieving them using the interaction of thought, feeling, and behavior. It may be used to treat a range of problems, including depression and anxiety, and more complex disorders such as psychosis. How can they squeeze in one more thing? As an educator, classroom teachers are already inundated and overwhelmed with being the primary source and resources for every student and the needs in the classroom. The idea of having to do more than what has already been asked to do adds more pressure, stress, and anxiety. This leads to the next question; How much longer can they perform their role while having to balance the demands of meeting the student's needs? The integrity of the program or system has the potential to be compromised due to the extreme level of multitasking that educators and their families are required to do. When we will see an improvement (Personal Notes, Payton, 2020)? Education is a results-oriented business, especially when it comes to high-stakes testing. As with any research,

study, or assessment, the need for speedy accurate results is crucial.

2. **Time for the child and the family:** When will they be able to receive community-based services (waitlists)? As with any major educational decision, all stakeholders must be kept abreast of and participate in the decision-making process. Involving the community is one way to do it. Services must be provided in order for families and other partners to feel they have a choice and voice in matters (Marietta, 2019). The results do not always come as swiftly as wanted, so being prepared for abundance is key. If the demand is higher than anticipated for receiving community-based services, some form of waiting list must be considered. When will we go to future appointments? When we will see an improvement? Timing and timelines are everything. And as stated before, the need for swift results and improvement is what's important to stakeholders (Personal Notes, Payton, 2019).

3. **Stigma:** The idea of "mental illness" is not necessarily believed in. Educating staff, children, and families about mental health and how it impacts a child's ability to function in the school environment is a critical component. Reducing the stigma surrounding mental health in schools is important to both the students in your classroom, but also, the wider school community. There is still a belief among some people in communities that mental illnesses such as depression and anxiety are signs of weakness. Until the broader community has a better understanding of this social issue, there will always be a stigma attached. The key to mitigating or at least reducing the stigma attached to mental illness is education (M. Marietta, personal communication, June 2019).

4. **Roles and responsibilities:** Not all school-based staff believe that addressing a

student's mental health needs is part of their role. The old saying, "It takes a village," has been the mantra that educators and families have embodied for years. However, lately in education, it seems as if most of the responsibilities have fallen more and more on the schools to address mental health and wellbeing in education, taking the accountability away from families, the first teachers of their children.

5. **Skillset:** Not all staff, families or other stakeholders will feel equipped to provide appropriate interventions. Teachers and school leaders feel that public schools lack time, funding, and other resources to effectively address the needs of mental health in schools (Fulks et al., 2019, para. 3). Even the more experienced educators. Even though some schools have made progress in integrating mental health practices from training and professional developments, schools are still challenged when it comes to increasing teachers' ability to identify and address student mental health needs (Marrietta, 2020).

Thompson et al., (2004) categorized the barriers to mental health services into three buckets, knowledge-based barriers, structural barriers, and attitudinal barriers. When we think of knowledge-based barriers, we tend to think of peoples' lack of understanding about the illness, their inability to recognize symptoms, and their not being aware of services that are available for those who suffer from mental health issues. Structural barriers include a lack of transportation and financial costs for those people and their families. Attitudinal barriers are those that deal with attitudes of people and possibly revealing personal information about themselves or stigma-related concerns, embarrassment, and or fears, (Clement et al., 2015).

Pipeline to Prison

Research suggested a direct correlation between mental health, education, and juvenile justice as it relates to the School-to Prison-Pipeline (STPP) and the fact that health care providers, especially in schools, play a pivotal role. “Approximately 22% of children (under 18 years of age) in the general U.S. population have psychiatric disorders, as compared to approximately 70% of justice-involved children” (Cocozza & Shufelt, 2006, p. 5). Not only do mental health challenges vary by age, but also by stage of human development. Children in the range of age 4 to 10 experience disruptive behaviors that are often diagnosed as oppositional defiant disorder (ODD), attention deficit hyperactivity disorder (ADHD), and anxiety disorders, psychoses, depression, and disordered eating (McCarter, 2019). In 2016, the Center for Disease Control and Prevention estimated that 17.4% of U.S. children in the age range of two through eight were diagnosed with a developmental, mental, or behavioral disorder (McCarter, 2019). As staggering as the data is, what is even more astonishing is the fact that youth of color are even less likely to receive services for the aforementioned disorder, in comparison to their white counterparts. For these students, there is a multitude of concerns that correlate with other aspects of their lives, such as increased risks of suicide, lower academic achievement, and increased school discipline. This group of students is also likely to experience increased substance abuse, as well as increased risky sexual behavior. Unfortunately, the majority of these students do not receive services. However, approximately 70% of the ones who do, ascertain them at school (DeSocio & Hootman, 2016). Research states that children with mental health challenges whose behaviors are deemed inappropriate are likely to enter the STPP (McCarter, 2017). There is an

overcompensation of these students in the justice system that include but are not limited to boys, racial/ethnic minorities, children of poverty, gender-expansive students, LGBTQ, students whose primary language is not English, and children with disabilities (Beck et al., 2017).

Early identification, community-based services, and systems of care, all aid in the support of children who suffer from mental health issues. Once a child has been identified as one with a mental illness, effective treatment is essential. Treatments, such as Cognitive-Behavior Therapy, Functional Family Therapy, Multisystemic therapy, and a variety of substance-abuse interventions, not only reduce further delinquency and negative outcomes but also improve the symptom management and quality of life for those children. Some community-based health services that are intended to support children oftentimes worsen their symptoms and intensify their psychological disorder (National Conference of State Legislatures, 2011), With the use of assessment of long-term benefits, as well as cost-benefit analysis, community-based alternatives were found to be more successful with the rehabilitation of children, including those who were prone to committing more violent offenses (Juvenile Justice Information Exchange, 2016).

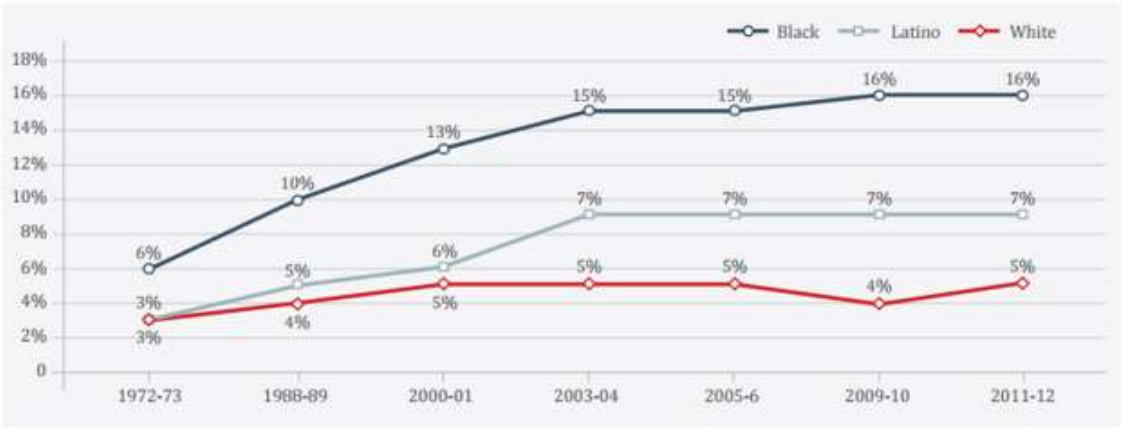
As it relates to mental health courts, they tended to only focus on the punishment instead of the root cause of the problem, which leaves the core issues untreated. Juvenile Mental Health Courts utilize an approach that is trauma-informed and multi-disciplinary. It provides support to families from the community that focuses on assistance with health services for the children instead of detaining or incarcerating them. This support includes treatment for the entire family unit (Burris, 2011). Research shows that there are several effective mental health interventions that JMHCs provide, using behavioral, social,

psychological, educational, and familial clinical assessments to treat the underlying triggers of delinquent behaviors of juveniles (Behnken, Arrendondo, & Packman, 2009).

Not only were there disparities as it related to the barriers that ethnic and minority individuals faced. There was also an unbalanced and racial disparity for those minorities with substance abuse issues and mental illness. The treatment was significantly different within the justice system. The parolees faced barriers in treatment. Once again, the issue of the supporters being competent or able to provide adequate help to these individuals was also a concern. This was directly related to the success or failure of the parolee (Thompson et al., 2016). In this study, it was found that there are significant disparities and racial gaps in the type, amount, and quality received. Caucasian inmates were more likely to receive treatment for mental health and or substance abuse in comparison to their minority counterparts (Bureau of Justice Statistics, 2002, Thompson et al., 2016).

Figure 6

Suspension Rates Over Time By Race/Ethnicity, K-12



Note: Source, U.S. Department of Education, Office for Civil Rights (2020)

School Counselors and Social Workers

As previously mentioned, children who do receive services or support for their

illnesses, do so at school and mostly from the school counselor. However, school social workers play an integral role in the success of these children, as well and the use of specific strategies used to reduce the impact of the STPP.

There are several factors that contribute to the STPP. They include but are not limited to school-based offenses, Zero Tolerance Policies, high-stakes testing, exclusionary discipline, race and ethnicity, sex, sexual orientation, socioeconomic status, disability and mental health, school climate, and safety resource officers. McCarter (2017, 2019) defines school-based offenses as those incidents that occur on school property including buses. They arrange in a variety of codes that include severity, frequency, location, etc. Some states require mandatory reporting, based on the severity of the infraction.

Next, what's known as zero-tolerance policies, also tend to contribute to the STPP. These policies are put in place by school districts and in student code of conduct handbooks. In these policies, the consequences have already been predetermined. Most often, the consequences are punitive rather than restorative. They do not take into account the offense's severity, any mitigating circumstances, or the context of the situation (McCarter, 2019).

High-stakes testing is another factor that attributes to the school-to-prison pipeline. This refers to the mandatory state-wide assessments that each state is required to administer to students. Oftentimes, these tests are tied to rewards and or consequences in schools (McCarter, 2019). They are directly connected to a school's or district's accountability. High-stakes testing tends to alienate students. They become disengaged, which results in behavior problems.

The definition of "educational success" was narrowed by The No Child Left Behind Act (NCLB). Under-performing students were removed from testing because they lowered the scores and weakened the curriculum by creating the need for more focus on test preparation (Amrein & Berliner, 2002). Exclusionary discipline was defined by Losen (2011) as any discipline strategy that excludes students from actual regular instruction. These strategies included but were not limited to In-School Suspensions (ISS,) Out-Of-School Suspensions (OSS), and expulsion. When students are out of the classroom, no instruction takes place. This type of situation or circumstance can lead to multiple adverse scenarios; increased dropout rates, violent behavior or even suicide (Losen, 2011). The STPP is also perpetuated by race and ethnicity. Although they vary in classification, more minority students and students of color are disproportionately represented as it relates to schools' discipline data and statistics. This includes but is not limited to suspensions, discretionary violations, and disciplinary actions (Losen, 2011). African American data were higher in each category than their white and or Asian counterparts.

Skiba et al. (2002) referred to students' biological sex as operationalized male or female. Their research showed that boys were more likely to receive disciplinary actions than girls. This included In-School Suspension, Out-Of-School Suspension, and expulsion (Fabelo et al., 2011). As it relates to a child's sexual orientation and identity, a recent study conducted by Kosciw et al. (2012), suggests that lesbians, gays, bisexual, transgender, and queer (LGBTQ) and students who were gender nonconforming, were also overrepresented in suspension and expulsions in comparison to their non-LGBTQ peers. Despite exhibiting any high volume of behavioral issues and not more academic

growth, or illegal activity, sexual orientation and identity affect a student's likelihood of having to deal with disciplinary actions from school and subsequent contact with the justice system.

For decades, socioeconomic status (SES) has played a significant role in STPP. The data represent that those students who receive free or reduced-price meals at school are at a greater risk of being suspended than their more affluent peers. However, in comparison to race and gender, the effects of SES are less vigorous (Skiba et al., 2002).

Students who have been diagnosed with a disability or mental health are more likely to fall into the STPP category. These students are at greater risk of the school-based punishment, exclusionary discipline previously mentioned. Skiba et al. (2016) discovered that students with disabilities were suspended twice as much and were 75% more likely to be expelled in comparison to their non-disabled peers.

> Students with emotional disabilities were over 10 times more likely to be removed from school than students with other types of disabilities, and Black students with disabilities were approximately three times more likely to be removed from school than other students with disabilities (Skiba et al., 2016, p. 1).

Education Digest (2014) defines school climate, which is another factor that affects if a student will fall between the cracks in the STPP, as the organizational factors that contribute to and affect a school's morale, including its leadership, discipline, academics, and students and their families' interactions with the community.

The last factors discussed that contributed to the STPP are the use and presence of Safety Resources Officers (SROs) in schools. These people have typically sworn police officers employed by local police departments. They are stationed within the schools

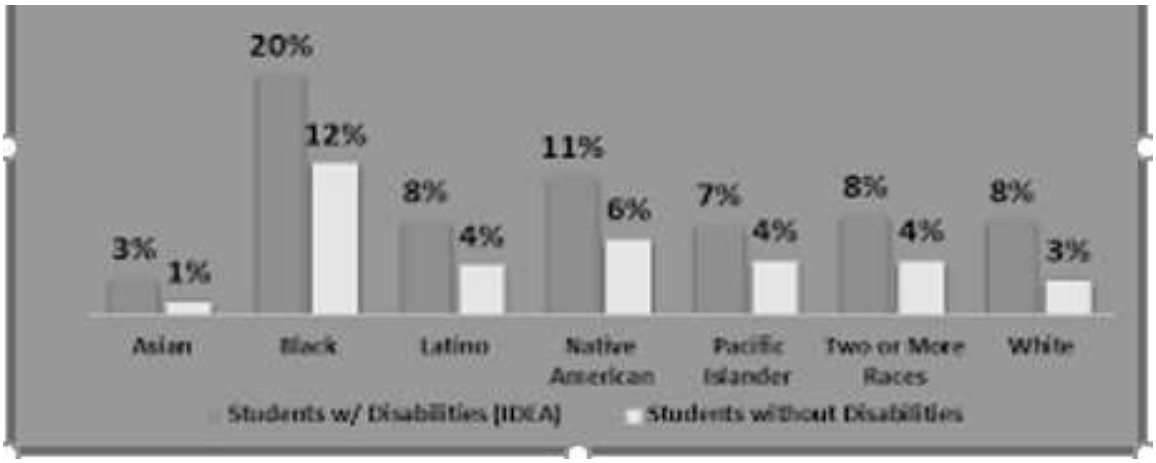
fully dressed in their uniform, weapon, and badge. Their presence alone sends a negative message to students because most of the officers come with preconceived notions and views that school discipline should be looked at from a law enforcement standpoint. Schools with an SRO had approximately five times the rate of arrests for disorderly conduct, in comparison to those schools that did not have an SRO (McCarter, 2017).

The school's social worker plays an integral role in addressing the STPP. They are trained professionals who come with a wealth of knowledge and strategies to assist with dismantling the cycle of the STPP. In providing an atmosphere for all students to thrive academically, socially, and emotionally, school social workers are essential. They are highly trained and skilled in the areas of but not limited to psychology, trauma, mental health, child welfare, race, ethnicity, and culture, gender identity and sexual orientation, families, and communities (McCarter, 2017).

Race Matters for Juvenile Justice (RMJJ) has identified four steps that all social workers can take to address the STPP. The first is to facilitate continued education and re-enrollment for students returning from out-of-school placements. Next, improve data collection, analysis, and dissemination. Then, use positive, appropriate, and graduated school discipline sanctions. Lastly, provide a race analysis, courageous conversations, and professional development opportunities to collaboratively strengthen the school climate (McCarter, 2017).

Figure 7

2013-14 U.S. Public School Students Suspended Once or More by Race, Ethnicity and Disability Status



Note Source: Greenlining.org

Social and Emotional Learning (SEL)

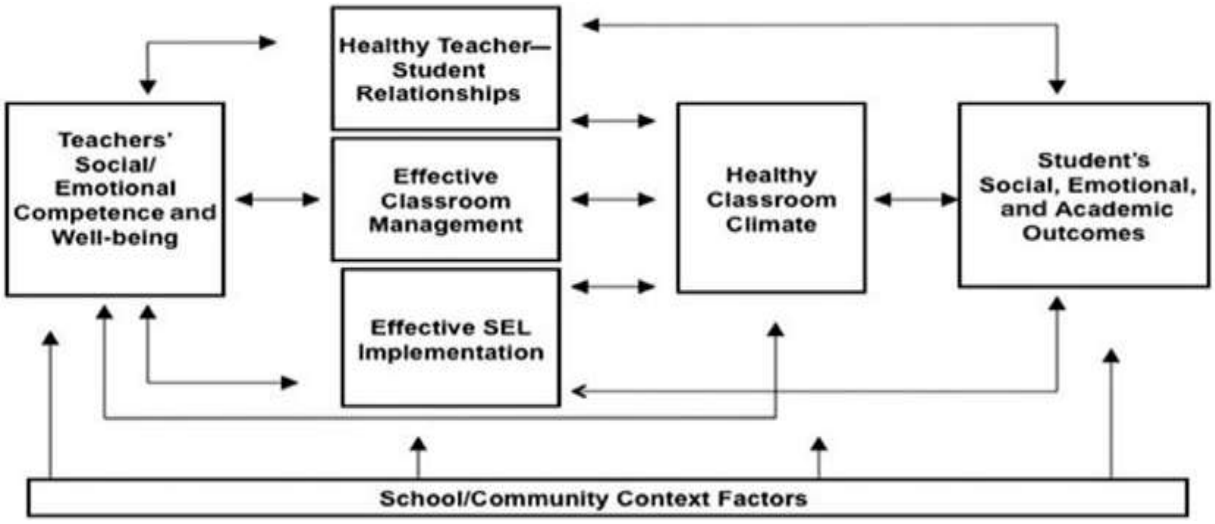
Social and emotional learning (SEL) is an integral part of education and human development. Schools across the globe have been charged with providing more than basic reading, writing, and arithmetic. Before authentic learning occurs, students' social and emotional needs must be met. In order for students to get what they need, educators must also feel supported. Joyce (2018) contended that there is a direct correlation between teachers' relationships and depressive symptoms of students. If the teacher provided strong support, then students would exhibit fewer depressive students.

A study was conducted, titled the National Longitudinal Study of Adolescent to Adult Health. The study looked at the connectedness of schools and the support that teachers provided to students and adolescents' depressive symptoms (Joyce, 2018). It was concluded that there is a multitude of mental health issues that plague students, depression being a major issue, as it adversely affects the health and mental well-being of

a child. Social workers in the school play a critical role in building relationships with students that shape who they are in society. When the relationship was positive between the student and teacher, it yielded fewer depressive symptoms in the student. The support of the social worker heavily impacts the outcome, as well as the promotion of a myriad of research-based strategies that continue to enhance the relationship and connectedness to students (Joyce, 2018).

Figure 8

The Prosocial Classroom Model



Note: Source, *Frontiers in Education* (2011)

Barriers

Mental illness does not discriminate. It affects people of all walks of life, not just minorities or people who come from impoverished communities, various ages, and even school-age students. With this illness, also come barriers that these people are faced with as it relates to treatment. This global issue has also had an effect on the transgender and gender-nonconforming population and the barriers they have been faced with, as well.

During a study conducted by Snow et al. (2019), it was contended that transgender and gender-nonconforming (TGNC) individuals experienced similar barriers to mental health care as those who were of African American descent, impoverished, and women, etc. One of the key barriers discussed in the study consisted of those that were closely related to not having access to quality therapeutic services and/or interventions (Snow et al., 2019). TGNC individuals had personal concerns that they would be stereotyped, which caused them not to want to seek the necessary mental health support they needed. There was also a concern with the competency levels of the mental health care providers. TGNC individuals did not feel that they were not only unknowledgeable but that TGNC individuals felt that the workers were supportive of their needs. And lastly, there were factors surrounding the affordability of mental health care expenses. The aforementioned concerns played an integral role in TGNC not receiving the support needed to address and protect their mental well-being.

Similar to prison-to-pipeline data, there was a disproportionately high rate of mental health issues in the TGNC population (Borkting, 2013); and the rate of suicide attempts raises grave concern (Haas et al., 2014). The barriers that TGNC people face are not surprising to the American Psychological Association, (2015), as they felt that this particular community of people faced challenges, such as these historically, as back then, therapists played a role that was controversial (Edwards-Leeper et al., 2016). Similar to other classifications and populations, TGNC individuals too experienced anxiety and depression (Meier & Abuski, 2013).

To address and attempt to overcome the barriers that low-income depressed women felt they faced as it related to the type of support they felt they needed from

healthcare professionals, a study was conducted by DeCou and Vidair (2017). Barriers for mothers who suffer from depression and who fall in the low-income socioeconomic status are faced with barriers, as it relates to mental health care and treatment. Mental health concerns have been made public for quite some time, more so now, than before.

Oftentimes depression and other symptoms from a mother can adversely affect her child or children (Goodman, 2007). Biederman et al. (2001) and Hammen and Brennan (2003) contended that children, whose mothers suffered depression, were highly likely, more than their counterparts whose mothers did not suffer depression, would have some psychiatric disorders, as well as functional impairments. Populations who were at higher risk included those who had children and fell in the low-income category (Biederman et al., 2001; Hammen & Brennan 2003).

Children whose mothers suffered from depression also experienced worse psychological treatment and more problems in their adulthood (Garber et al., 2009; Owens 2003). Very similarly to the different groups or populations discussed, low-income depressed mothers too experienced levels of depression at a high rate (Weissman et al., 2016). The barriers associated with treatment for women in this situation included cost, which was one of the barriers that individuals stated in the TGNC population. If the support needed was not affordable for them then it was almost impossible for them to receive the services needed to address their mental well-being.

Transportation was also identified as a barrier for low-income women who suffered from depression. If the women were not able to get to sessions or appointments, then as stated previously, it makes it less likely that they would receive treatment. The final barrier discussed was that of childcare (Avidrez & Azocr 1999; Mohr, 2006).

Aside from the obvious and more tangible barriers, low-income women who suffered from depression also experienced psychological barriers such as stigma, which was referenced within this text. Depending on the era, upbringing, or socioeconomic status, recognizing depression as an actual illness was also a barrier, including the mistrust of the educational system, as previously mentioned regarding the TGNC population (Alvidrez & Azocar 1999; Nadeem, 2007).

Prescribing medication as a treatment prior to truly assessing the needs of the patient or respecting the views or stance of a patient who suffers from mental health issues was also a barrier when low-income, ethnic minority mothers who suffered from postpartum depression, were interviewed. The idea of receiving the necessary treatment to support these women was rejected, due to negative past experiences with the "medicine first" mentality (Anderson, 2006).

During a study researched by Dr. Regina Miranda in 2015, she and her team discovered an evident disparity between racial-ethnic minorities and white young adults at a college counseling center. It was found that students who were of an ethnic minority were more likely than their white counterparts, to not seek treatment for mental health illnesses. Some of the barriers that hindered the process of receiving the support they needed consisted of those students thinking that they could handle the issues on their own, without medical treatment. Another barrier was the factor of time, which is synonymous throughout the various groups of people faced with the barriers of getting the treatment they needed. Some of these young people did not think that the treatment would be of any help if they had received it. Concerns about how others may view or perceive an individual were also a barrier to treatment. The ethnic minority students felt

that they would be looked at with a negative opinion about them. Lastly, locating where adequate treatment could be acquired was also a barrier that was reported (Miranda et al., 2015).

Prevention and supports for children are the key benefits to success. Incorporating school-based mental health services in schools has been proven to be effective in prior literature and research. The data show that for every five children, one of them has a diagnosable mental health disorder. Unfortunately, out of those children, 70% do not receive the treatment and support they need to be successful and productive citizens. Because of this significant gap, children suffer socially and emotionally, as well as academically. The support of all stakeholders is essential in the success of the child; including the family, school, and other community partners. Even when families attempt to support in bridging the gap, they are met with barriers that hinder them from helping their children to the fullest of their capabilities (Vulpen et al., 2018).

This research study showed that parents were in full support of what the schools were able to offer them and their children while addressing the needs of those students who suffer from mental illness. The most significant challenges and barriers they identified were synonymous with most of the barriers mentioned throughout the text are that of anxiety and depression. Since this study was conducted and shortly thereafter, the world experienced the COVID-19 pandemic. Bullying was also a challenge for parents, as these were at the top of the list of concerns.

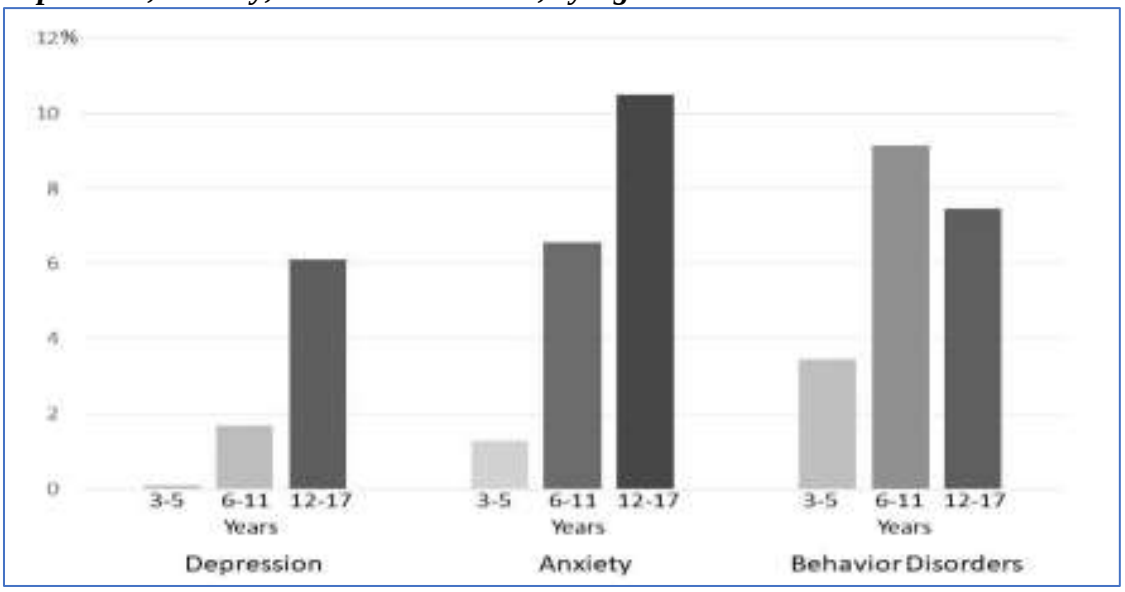
Mental illness is not an issue or concern for adults only. Families felt that people were not aware or understanding that mental illness happens in children as well, at the school level, so they felt a lack of parental support. The key factor that placed students at

high risks was the lack of school programs that supported those students (Vulpen et al., 2018).

School-based mental health programs have been implemented across the globe. Based on the research, effectiveness has had a positive and upward trend. Early intervention is the key. It is critical that children are immediately and accurately identified so that treatments are properly administered. School-based mental health benefits the student's social and emotional well-being. However, every possible solution comes with its own set of barriers. Service access was the number one barrier for families (Vulpen et al., 2018). However, some additional barriers included but were not limited to limited access for those families who live in rural areas. There seems to be a shortage of healthcare providers in the mental health profession in these areas. They are at great risk of having both financial and insurance hardships and well-limited community resources (Robinson, 2017).

Figure 9

Depression, Anxiety, Behavior Disorders, by Age



Note: Source, Centers for Disease Control and Prevention (2016)

When it comes to effectively supporting students with mental illness in schools, one must remember to be empathetic and compassionate. These specific character traits will not only promote a positive atmosphere and environment but will also assist with the promotion of positive mental health and well-being. Research states that saying that you are fine when you are not, is unhealthy (Mental Health for Educators, 2021). When these feelings are kept locked away inside, it causes social, emotional, behavioral, and even psychological adverse effects. In order for this concept to matriculate from the school system to its educators, administrators must practice empathy and compassion to their teachers, modeling the expectations for them when it comes to their students. Showing empathy in the workplace is easier said than done for several reasons, as educators may refrain from showing their authentic selves in the workplace.

Harrison Berg and Oppong (2020) define two main reasons why educators are hesitant to discuss their feelings. They fear that they would be perceived as unprofessional and that no one would care. Educators may feel that students' needs supersede their own, resulting in apprehension. Three key strategies have been developed to ensure that educators are heard, seen, valued, and supported; seek and receive empathy, invite opportunities for empathy and listen with empathy. While seeking and receiving empathy, leaders need to be aware of the impact and influence they have on the perceptions of their staff. It is their responsibility to create an atmosphere that is "safe" for staff to be vulnerable. It builds a more positive culture promoting positive mental well-being. Once empathy has been established, it is also important for the leader to follow up with the staff with whom they have made connections. Listening with empathy takes practice. It is an acquired skill. When you know that your voice will be heard, it

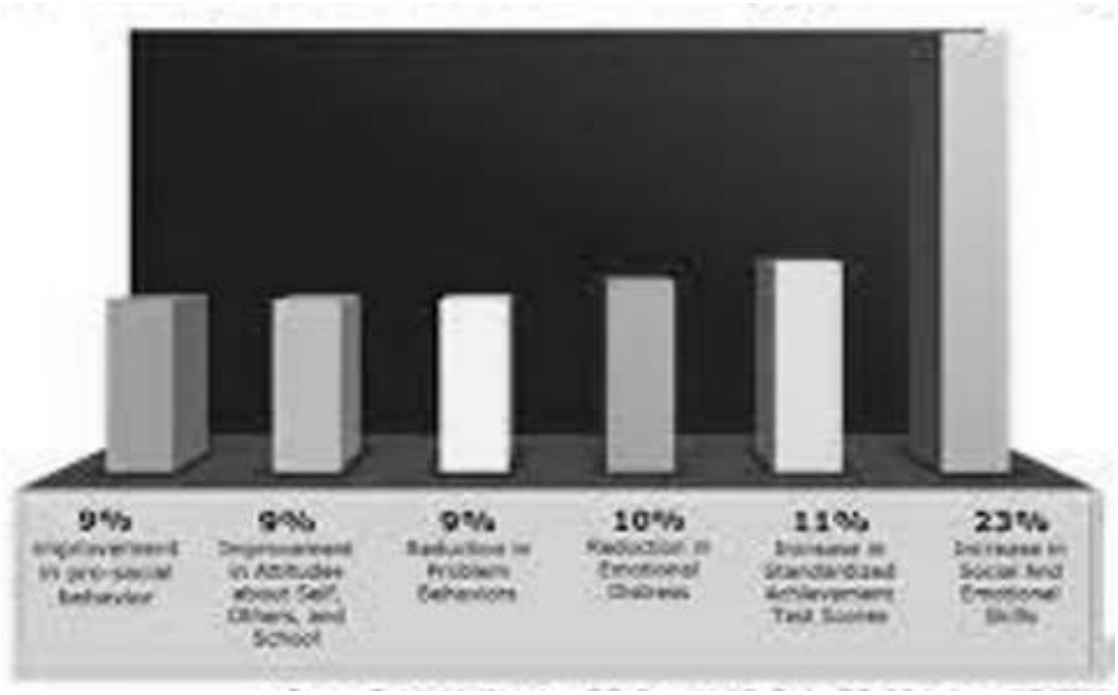
fosters a sense of security and continues to maintain positive mental health as an educator. While allowing for deeper meaning and understanding, leaders must create routines. For educators to feel validated and valued, the leader or listener must show genuine interest. In taking a proactive role, educators need to create empathetic interactions with their staff and students before a situation arises and leads to burnout (Harrison Berg & Oppong, 2020).

As schools prepare to begin the new school year, educators anticipate the mental health needs of students will be great. Teachers will be required to meet those needs. The lack of social-emotional, bullying, and suicidal ideation, all are likely to re-emerge. Social-Emotional Learning, training, and rules are of the utmost importance, especially with schools opening back up in the fall. When students were left quarantined for nearly two years, they were left feeling isolated and expressing the need for socialization. The world, but students especially, was out of practice when it came to engaging with the peers. As it relates to Social-Emotional Learning, for humans to connect and make sense of the world, they must be connected in some way, in order to yield positive mental well-being. The COVID-19 pandemic has left students feeling uncertain about how to act. It is likely that they are experiencing more depression, anxiety, fear and trauma because of it. Schools are seeing an increase in bullying. Equally important, is the need for educators to be trained to support students who may suffer from mental illness and even the ones who do not. Teachers are inundated with all the responsibilities they have. At times they sometimes feel unequipped and uncomfortable when situations arise with students who suffer from mental illness. It is the teacher's job to foster a positive and safe classroom learning environment that is conducive to the academic, social and emotional success and

well-being of all children. When the teacher feels untrained, this cannot be accomplished if the students feel unsafe or embarrassed in a space that is supposed to promote the exact opposite.

Figure 10

Data Trends for Students Who Participate in SEL Programming



Note: Source: Child Development (2011)

With the start of the upcoming 2021-2022 school year fast approaching, it is going to be crucial that schools find out how they are going to respond to the behavioral challenges they will experience and that are sure to arise. By taking a proactive approach, schools need to plan now to ensure the best possible outcome by putting positive supports in place, opposed to using punitive actions later. When students come to us educators, they will not all need the same support. The NJ Department of Education uses a three-tiered approach to supporting students with special needs and mental health post-COVID.

The development of an array of interventions is used, based on the intensity of the students' individual needs. The first is Tier 1 or Primary Prevention. This tier focuses on strategies to support all students. For small groups, Secondary Supports are used. The final tier, Tier 3 or Tertiary, offers intensive interventions (Keelan, 2020).

The American Academy of Pediatrics (AAP, 2020) notes that policies that schools have put in place should support the over health and well-being of the child and their stakeholders; their families and communities, while assisting educators by providing them with safe working conditions and an environment that is conducive to the academic, social, and emotional well-being of the students. The AAP (2020) also recommends that for students who already experience mental health issues, special considerations should be considered if the student has pre-existing issues, such as anxiety, depression, and any other mental health condition. Students who have previously been exposed to a history of loss or trauma may be more sensitive to disruptions in routine and caregivers. The COVID-19 pandemic had a negatively drastic effect on these children, for those aforementioned reasons. Those students who faced other challenges, such as poverty, transiency, food insecurity, and racial inequities would benefit from the additional support and assistance, hence the urgency to address the social-emotional learning and mental needs of children.

Before schools begin to implement their reentry plan for students, the NASP (2020) suggests the following considerations should be adhered to: embed social-emotional learning into core academic subjects, develop strategies for students, parents, and staff, hold classroom meetings with school mental health to discuss impact as a group, have a referral system for targeted support, identify high-risk students, such as

those with pre-existing mental health and experiences of loss, conduct universal social/emotional screenings and establish periodic informal check-ins with school mental health professionals. Society has been negatively impacted by the pandemic (Agoratus, 2021). Putting social and emotional health supports in place in schools will be crucial for the success of children's academic progress. Being proactive, instead of reactive, will promote positive behaviors, which will yield and ensure success for all students (Agoratus, 2021).

It is all connected. It is imperative that teachers' SEL is balanced and taken care of in order to provide students with the supports they need and to also model how to cope when they are feeling stressed, thus providing students with the tools necessary to have a healthy mental well-being. Highly stressful situations typically yield symptoms of anxiety and depression. For some, in education, it can lead to burnout. A study was done that showed the relationship between stress, burnout, and mental health among teachers of color. Research documents showed that, as educators know, teaching in K-12 schools is stressful. In 2020, Herman et al. found that 94% of middle school teachers reported elevated levels of stress. It is a fact that all teachers experience stress at some point in their educational careers. However, minority educators oftentimes experience unique stressors. In many situations, minority teachers take on multiple responsibilities and additional duties in efforts to support students who have similar cultural backgrounds (Herman et al., 2020). In doing so, there also comes a level of stress. For example, Black Lives Matter; not only did teachers feel the obligation to educate their peers; but, they also had to make time to deal with their own personal issues. The stressors of minority teachers tended to be complex and multilayered. Stress increases a person's susceptibility

to both physical and emotional illness and oftentimes is directly related to how we interpret, process, or internalize the stressor (Herman et al., 2020).

There are several consequences of chronic stress at work. Burnout is only one. Along with burnout comes a reduced sense of work, emotional exhaustion, negative attitudes and feelings toward work, feeling overwhelmed, and depersonalization. Fortunately, there are steps administrators can take to mitigate the adverse effects of stress while promoting social and emotional well-being for all (Cormier et al., 2021).

Teacher Training

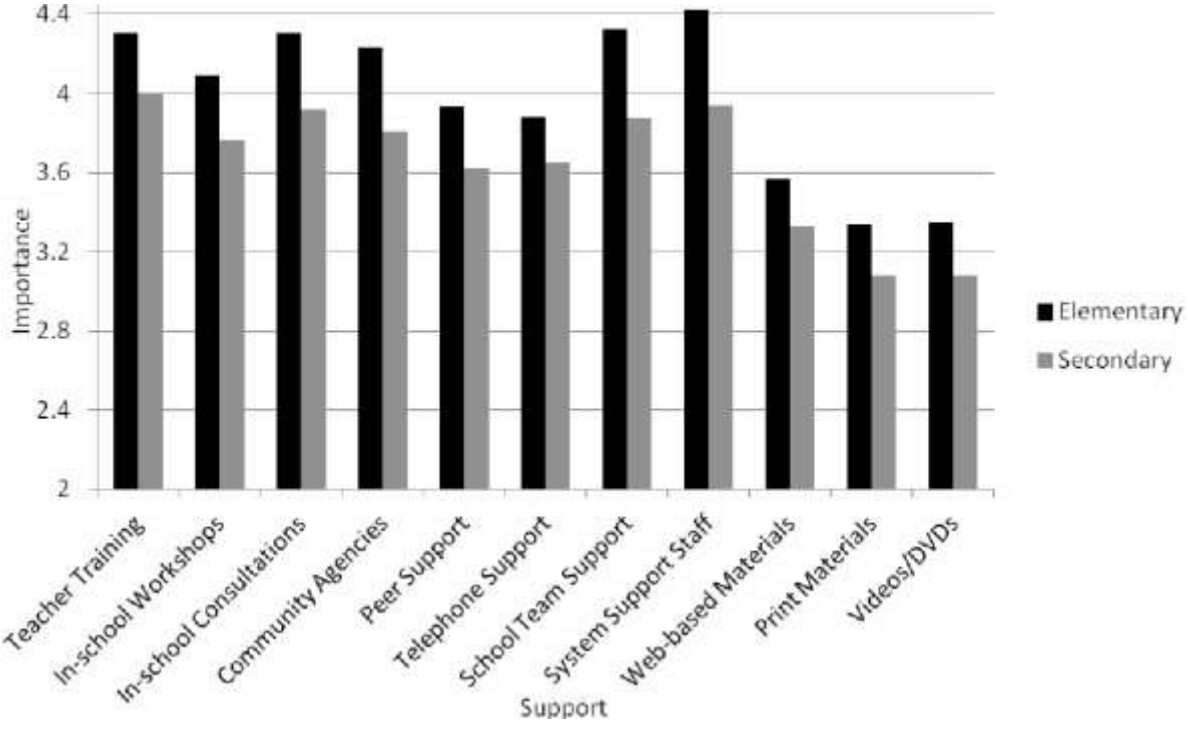
When considering "good fits" in certain districts, like urban areas, educators often tend to look at whether or not they have what it takes to support and provide students with what they need. They often lack teacher efficacy; therefore, leading to a lack of student efficacy. As it relates to mental illness, teachers come into the field of education stressed and anxious, because they already feel like they are at a disadvantage because of the lack of training they have received. They feel that there should be some pre-service training in the area of mental health; research behind the issue and ways they can best support and service school-aged students who suffer from mental health issues in schools.

The number one priority in every classroom is to meet the needs of each individual student in the regular educational setting, but most teachers feel they are not adequately equipped to do so. When students suffer from mental illness, this quickly changes the dynamic of the situation, causing a drastic paradigm shift in the classroom for everyone impacted (Atkins & Rodgers, 2016). Atkins and Rodgers (2016) conducted a study in Canada that examined the results of a mental health online course for educators that was centered around five key learning objectives and to examine the impact of

research on the pre-service teacher's education of students (Atkins & Rodgers, 2016). In a given year, one-fifth of youth who attended school experienced a substance abuse problem or mental illness (Adelman & Taylor, 2000).

Figure 11

Elementary versus Secondary Teachers' Mean Rankings of Importance of Mental Health Supports



Note Source: Semanticscholar.org (2021).

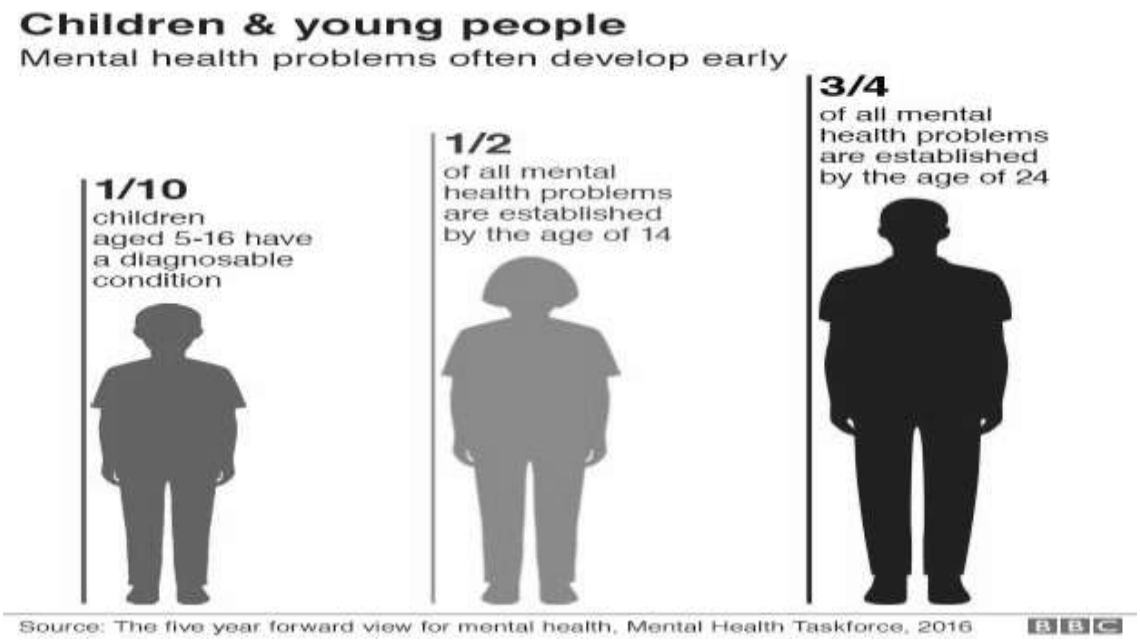
Beginning in childhood, most mental illnesses occur (Kessler et al., 2005). Not only was the mental illness of students a concern, but also the mental health of teachers. Research conducted showed that 12% of novice teachers, unfortunately, leave the teaching profession completely, prior to finishing their first full year in the educational system. After the third year, the percentage more than doubled at 28%. In the fifth year,

more than 41% of new teachers, prior to reaching their tenure, left the teaching profession.

Nearly half the new teachers who graduated, applied, got hired, and taught, then resigned, due to the mental health problems they witnessed in children and/or that they suffered themselves as a result of working with students who suffered from mental health issues. Equipping teachers with the knowledge early on would eliminate such mass exodus and turnover rate in the education profession (Ingersoll et al., 2014).

Figure 12

Development Stages of Mental Health Problems



Social-Emotional Learning

Supporting and protecting children's social and emotional wellbeing is crucial to their success in life as adults; academic, social, professional, and personal successes all shape who people end up being. Traumas and stressors in youths' lives affect how they

function physically, mentally, and emotionally, as well as psychologically. One of the many stressors that young children are faced with globally is divorce and how it affects children of different ages and ethnic groups. A study conducted by Dagdas et al. (2018) and his team examined the effects of parental divorce in children of diverse backgrounds and how it affected those children in various aspects of their lives, including their relationships with others and educational experiences, especially those students with special needs. Family support systems and structures in place to support children are essential to children's social and emotional well-being (SEL) This enables them to grow and develop into and function as healthy human beings in society (Amato et al., 1996).

With an ever-changing society, a multitude of children live in several different family structures and cohabitate differently for several reasons; death of a parent, foster parenting, adoption, and same-sex parenting, as well as divorce. The aforementioned study focused on the outcomes for children, as it relates to their development. Research shows that nearly 50% of married couples eventually divorce, as it is a dramatic and adverse change to a family's structure traditionally, which did not become common until the recent decades (Amato et al., 1996).

During crucial years of a child, early years adolescents, to youth, to young adulthood, divorce has long-lasting effects on individuals. These effects include but are not limited to, academic, physical, emotional, social, and psychological behavioral areas of a child's life (Cherlin, 2010). It was found that the impact of divorce on children varied, based on the structure of the home that included ethnicity or race. The study showed that children from homes with two parents showed a higher quality of life than those of African American and white children. Be that as it may, those African American

children in the single-family household dynamic experienced more issues with adjusting, opposed to their counterparts.

Between the ages of five and 11, those African American children experienced more socioemotional issues. By the time those children reached age 11, they would have already experienced an intolerable level of stress in their life's events, which was linked directly to students at 13 being depressed (Natsuaki et al., 2007). Hence, African American children would face more long-term challenges, because they were exposed to traumatic events that disrupted the family structure, which caused illnesses that were chronic; i.e., parental death or domestic violence, to name a few. As it relates to a child's social and emotional well-being, certain factors play a significant role in how a child is adversely affected by divorce.

During the growth period of a chil''s development, there are risk factors, such as poverty, mental health problems, absenteeism on the father's part, marital issues, domestic violence, or alcohol abuse (Umberson, 2014). Divorce can also have long-term effects on children's physical health. When children are psychologically traumatized, if not properly addressed with treatment, it can manifest physically, resulting in eating disorders, along with a plethora of mental issues that tend to arise in schools. These mental issues include but are not limited to depression, aggressive behaviors, anxiety, and attention issues (Cherlin, 2010).

Although various forms of cohabitation have become more common, the fact still remains that divorce still hinders interpersonal relationships which stem from families in low-income, single-parent households who fall into the low socioeconomic status (Barrett & Turner, 2005). The scenario of children growing up with no contact from either parent

after divorce tends to experience more educational and economic hardship. This affects a child's or youth's total image of one's self, self-esteem, and worth, and efficacy. It hinders a child's ability to cope with the day-to-day stressors of life and effectively communicate with others (Storksen, 2005).

Parental divorce and the connection between parent-child relationships is an essential factor that tends to play a dramatic role in a child's development and social and emotional well-being. This was established by research years ago. It links a relationship that is or has been declining to eventual and ultimate divorce, especially if there has been negative communication between the two spouses. All of which affects how a child performs in school (Sobolewski & Amato, 2007).

When couples are stressed, it gravely affects the communication not only between the spouses but also between a parent and a child. This could be looked at as a cycle of neglect; parents tend to neglect the child's needs during trying times with the spouse, which can lead to other problems in the household structure. The child may then begin exhibiting behaviors that are problematic. Oftentimes, these behaviors arise at school. This too affects the parent's relationship negatively. Within parenting relationships, some studies have shown some inequities in race or ethnicity and gender.

During times of hardship in a family structure that is potentially headed for divorce, research showed that the relationship between the opposite-sex parent may be stronger than the relationship between the child and the same parent (Booth & Amato, 1994). A study conducted by Kalmijin (2016) showed that after there has been marital conflict in the home, female children tend to have a more difficult time with symptoms of depression when the relationship with the father is poor (Kalmijin, 2016). After divorce,

if there are not any conflicts amongst the spouses, boy'' social and emotional well-being tend to benefit most from having more frequent contact. In contrast, for girls, it was the quality of the contact that benefited them mostly socially and emotionally (Riggio, 2004).

When taking factors into consideration, the culture of the family must be included. It has already been researched and established that when children are exposed to divorce, it affects their interpersonal relationships. In addition, children's future relationships are in jeopardy, as well. The results vary from family to family based on their cultural, race, or ethnic backgrounds (Lansford, 2009). This is often the case in schools in urban school districts. Divorce has traumatic effects on children and their educational experiences. It has been proven all over the world that the fallout after a divorce, for a child can adversely impact their academic achievement. Some researchers have even stated that divorce could also negatively affect them once they attend college, their attendance in school as well as their graduation; there's a generational impact (Fagan & Churchill, 2021).

There are many factors that negatively impact children's grades during a divorce. According to Fomby and Cherlin, 2007, these circumstances contribute to the decline in students' academic growth and overall performance; having to transition back and forth from one parent to the other, place tremendous stress and anxiety on a child. These living arrangements are not common for the child and take time to get acclimated. Some children never do. In school, grades suffer due to students' inappropriate behaviors. They tend to act out as a way of expressing their feelings of anger, anxiety, and stress. Their attitudes and values towards learning often decline as a result of post-divorce situations. If a child moves into a situation where there's a new step-parent, the dynamic of that

relationship shifts even more significantly for the worse (Fomby & Cherlin, 2007). There have also been studies done to show the differences between genders, as it relates to children of divorced parents and their educational outcomes.

Boys are more negatively affected by divorce, more specifically, toddler boys' cognitive development is adversely impacted. Girls, however, suffer more with their emotional development (Lee & Kushner, 2008). Interestingly enough, when examining the results of a child's race, it was claimed in one study that the impact of divorce on African American girls was more significant, in contrast, other studies found that White girls were no more or less impacted (Amato & Keith, 1991).

The impact of divorce on America's grades was also examined. Black students did not see a significant drop in grades, due to the additional support systems in place. However, their performance was affected by the challenges of their socioeconomic status. Emotional challenges were more difficult for White students' achievement, as a result of divorce (Smith, 1997). Sun & Li, 2007 studied the effects of divorce in Hispanic Americans and discovered that in comparison to Whites, who had experienced the largest impact, they were least affected in several educational areas such as math and reading scores, academic readiness, homework completion, and educational aspirations.

The ethnic groups that experienced the second-largest impact were African Americans and Asian Americans (Ryan, 2015). When examining the effects on children and how it impacts their social and emotional well-being, one must take a look at divorce and how it impacts those students who suffer from mental illness and have special needs. In turn, families of children with special needs also tend to impact spouses who are struggling to keep their marital union together. Oftentimes, this leads to divorce. For

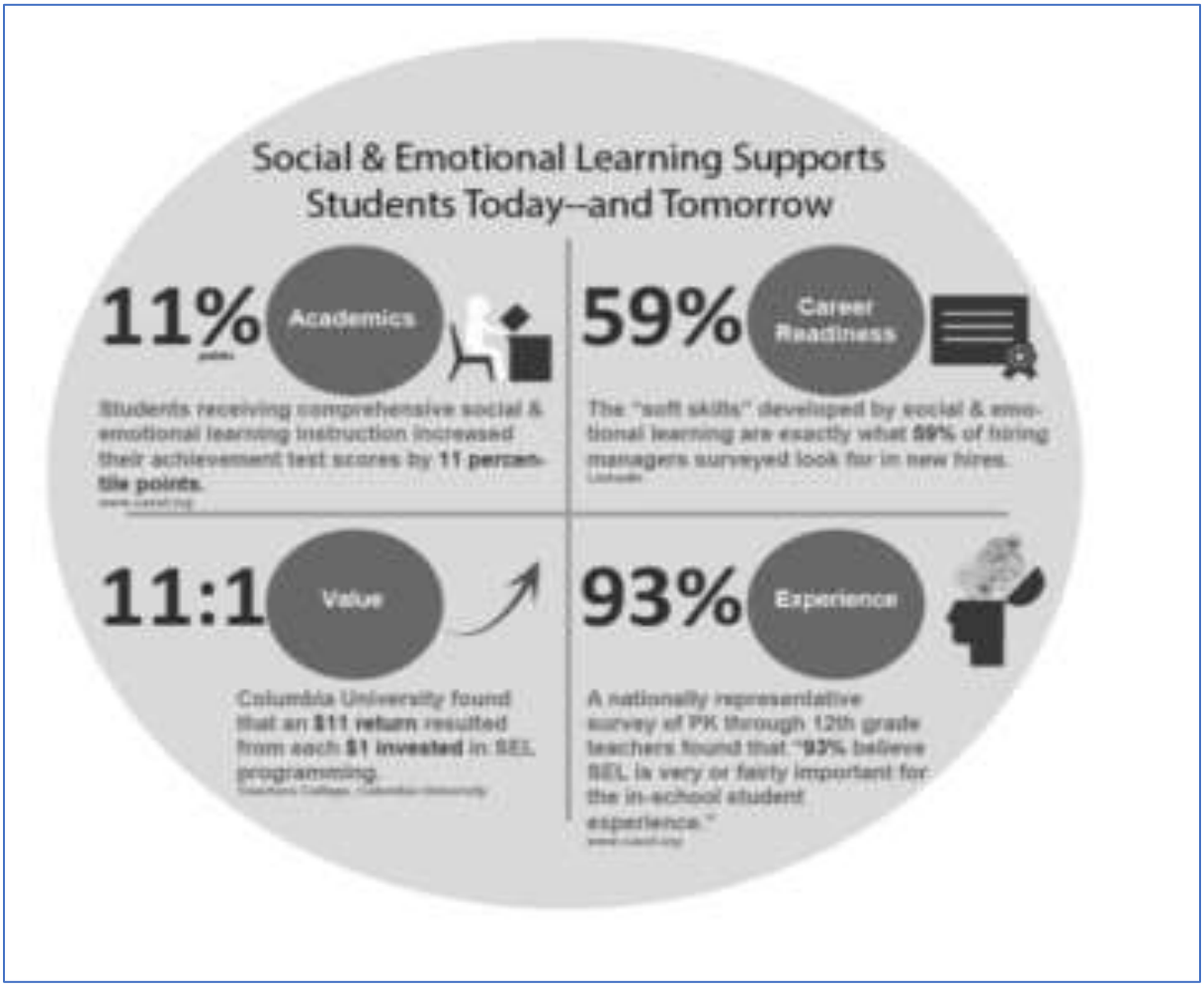
example, there has been literature that showed that parents who had children who suffered from autism were more likely to divorce in comparison to those of children who did not suffer from a mental illness. This was due to the fact that there were no challenges, such as conflict, additional pressures, parental stress, or anxiety (Freedman, 2012).

Similarly, to students who suffered from Attention Deficit Hyperactive Disorder (ADHD), parent stress was higher in comparison to their counterparts of parents who did not have children who suffered from a mental illness. These students react to divorce in many ways, as they tend to suffer more adverse effects compared to their peers who are not challenged with a mental health illness. Some of the outcomes include but are not limited to aggression, difficulties with social and academic skills, a sense of hopelessness, self-harm and suicidal tendencies, a desire to run away, and emotional outbursts.

All of the aforementioned reactions are directly linked to the results of divorce. The last group of students who are diverse and are impacted by divorce is those students who fall under the gifted category. Kraynak intended that students who were gifted who lived in a two-parent home were more successful than gifted students who had only one parent in the household. Both groups of students were still successful, but the latter was sole because of their giftedness and their ability. Prevention and early detection are the keys (as cited in Ryan, 2015).

Figure 13

Social & Emotional Learning Supports



Note Source: Wisconsin School Counseling Association (2019)

Stigma

There were several reasons why people who suffered from mental illness did not choose to receive treatment. One main reason is the stigma associated with mental illness. Qahar et al. (2020) conducted a study about the Pakistan culture that examined the attitudes of the patients who dealt with mental illness towards receiving support and treatment from medical professionals, such as psychologists/psychiatrists in comparison

to receiving treatment and help from other avenues, including faith healing practices. The people of Pakistan are associated with various backgrounds and cultures and prefer different methods, as it relates to healing practices. The preference of their healing practices depends heavily on their belief in their own culture or background (Qahar et al., 2020).

When it comes to deciding whether to solicit support from medical professions for the treatment of mental illness, the options typically are a psychologist versus a psychiatrist. The work done by both professionals is very similar in nature. However, in the public eye, because of the age-old stigma, they prefer one over the other, psychologists. When it comes to the treatment of depression, psychologists are more recommended than psychiatrists.

Times are continuing to change but the gap in preference is still prevalent. In Pakistan, they prefer not to seek help from either a psychologist or psychiatrist. In fact, they prefer the support of spiritual healers. In the public eye, psychiatrists are viewed as being impersonal while psychologists actually listen to people's problems and do not opt to prescribe medicine as the first form of treatment. Psychiatrists were considered to have a lack of empathy and compassion for their patients did not communicate effectively.

Social media and the public eye play a substantial role in how the world is viewed. Some decisions are based on these systems as well as a group's religious background and belief system and their culture. There are several factors that play a role in people's perceptions of medical professionals. Children who are unhappy in their childhood, go through a divorce or other transitions and adjustments within their family unit, household, or structure, or are not supported social, tend to have psychological

developmental issues. If the aforementioned factors are addressed early on in a child's life there is a significant chance that mental health illness can be prevented (Qahar et al., 2020).

There has been a stigma and taboo on mental health for decades. The New Dictionary of Christian Ethics and Pastoral Theology defines taboo as "A powerful prohibition, cultural or individualistic, leading to strict avoidance of the forbidden act, object, person or place" (Ommen, 2019, p. 206). Some cultures have set societal norms that frown upon certain issues, such as mental health; they call it taboo. Oftentimes, when spoken of, they are considered topics that were cursed or too sacred to discuss. Hence, they felt that if you did not suffer from mental illness, then you should not discuss it.

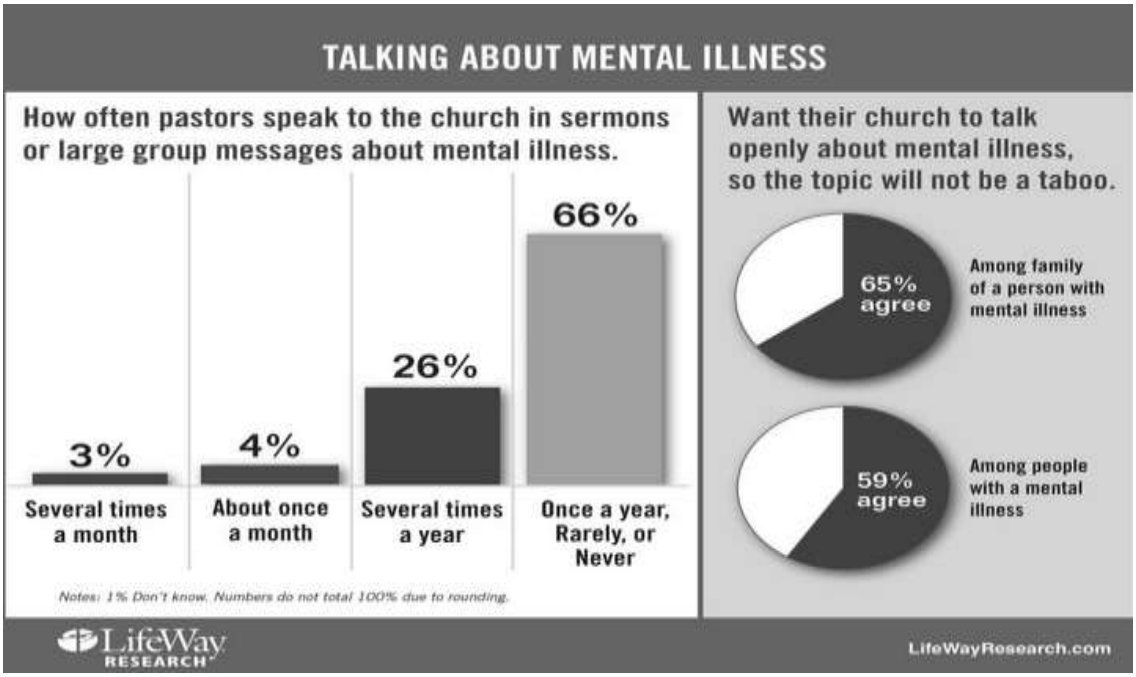
The idea of taboo has been based on societal views, a group's culture, or religious beliefs (Ommen, 2019). Taboo and mental health; Millions of people suffer from mental illness across the world. According to MacIntyre, these people reported that those closest to them, family and friends do not understand them or their mental illness or even know how to respond to them (as cited by Ommen, 2019). This also holds true to the professional world. Medical professionals tend to use naming to describe people who suffer from mental illness because they do not understand them either. Because these people are misunderstood, they become stigmatized by society, and unfortunately by the ones who love them and also by the ones who are supposed to support and treat them. This is part of the reason society looks at them the way they do and why mental health issues are considered taboo (Ommen, 2019).

Fear of the unknown is powerful. It is easier to believe what is spoken of or seen in the media, opposed to doing the research to find the truth for themselves. Even if these

people do not do anything that is considered morally wrong, their so-called status in life has already been labeled and tainted. They are then perceived as abnormal and are judged unfairly. Labels last forever, even in schools with diagnoses and Individual Educational Plans. (IEP) This could have a lifelong adverse impact on a child. When this is the only way a person is being seen, they are then stigmatized (Ommen, 2019).

Figure 14

Ways to Address Mental Illness in Your Church



Note: Source, LifeWay Research (2016)

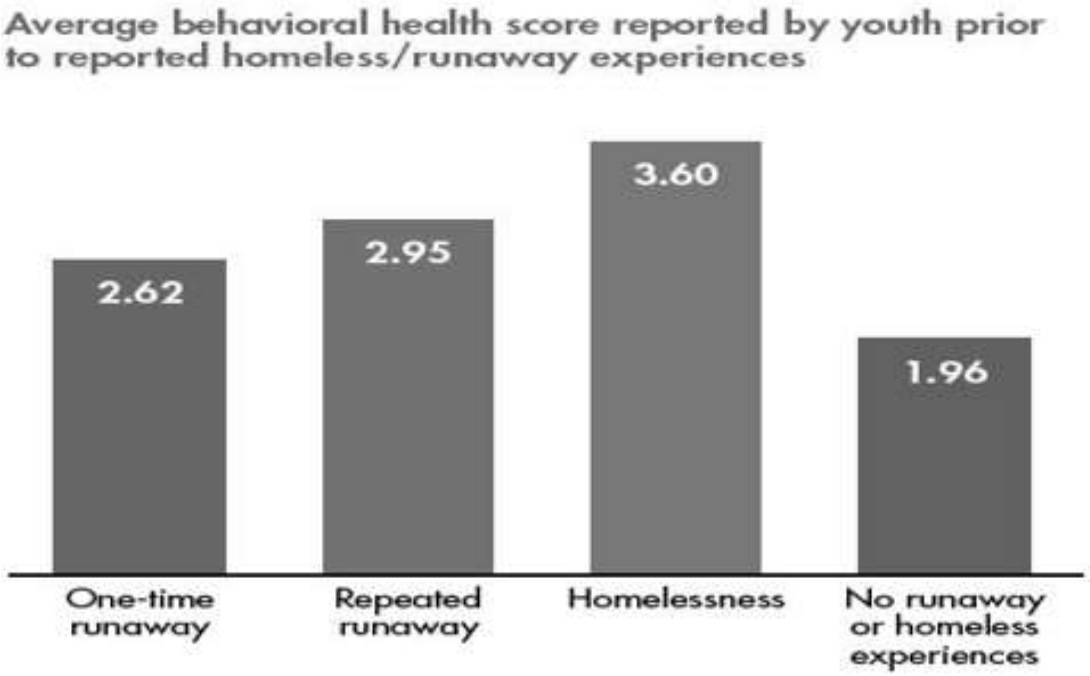
Mental Health Illness and Homelessness

During a study conducted by Armstrong et al. (2018), she contended that homeless students are at a high risk of mental health because of their vulnerability and challenges that they face for not being a safe and suitable living arrangement. Due to the fact that their situation is even more extenuating, their vulnerability is even more pronounced. Homeless students were transient, migrating from location to location very

frequently, putting them at risk. This prevented them from maintaining basic necessities. Being on the streets, homeless students were exposed to traumatic experiences more frequently than those who had stable housing, regularly. If their parents experienced trauma, it was likely that the child did also, or perhaps encountered bouts of depression (Armstrong et al., 2018).

Figure 15

Homeless Children and Youth: Causes and Consequences



Note: Source, NCCP analysis of National Longitudinal Survey of Youth (1997)

It was also contended that students who are homeless, were likely to have suffered some form of abuse in the home and or neighborhood. Either of the aforementioned factors can add to the negative mental health and social and emotional well-being of youth who are homeless (Armstrong et al., 2018). When taking a look at students who were homeless youth in comparison to those students who have housed youth, students

who were homeless were reported to have had classic symptoms of depression, suicidal attempts, and ideation as well as mood disorders (Armstrong et al., 2018).

Schools play a vital role in the success of children on several levels, including homelessness. In schools, students who were homeless were more isolated and exhibited signs of social isolation and rejection from their peers. These students' academic achievement also was poorer than their counterparts. However, if the relationships within the schools were positive, it had a significant effect on the student's social and emotional well-being (Armstrong et al., 2018).

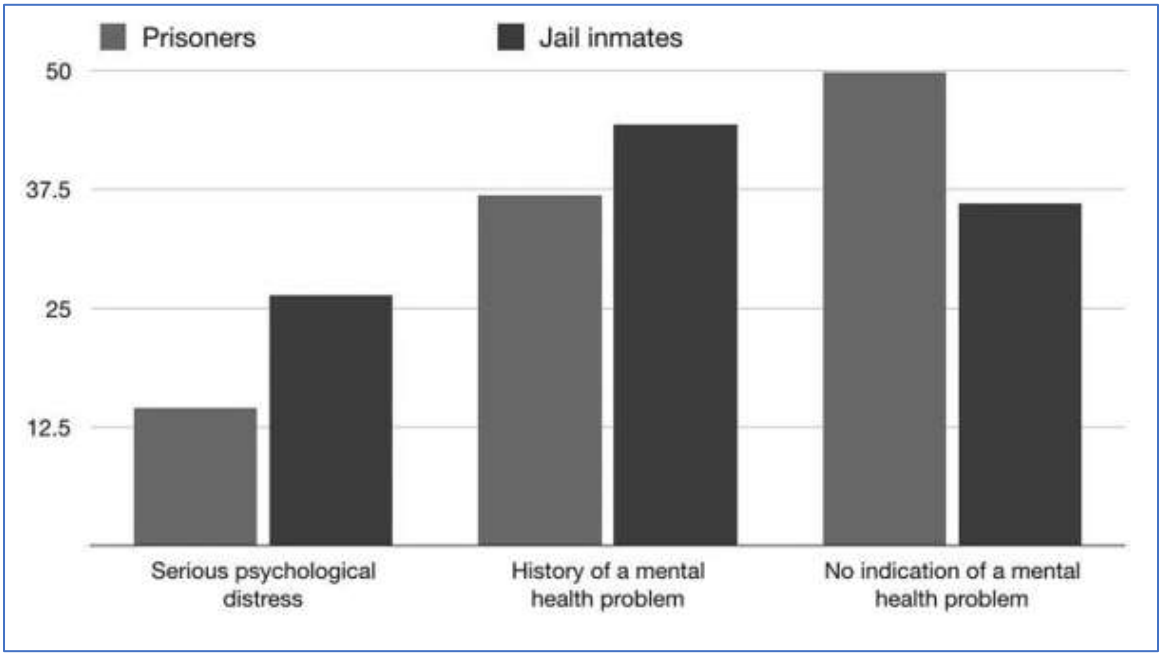
Current State

Research shows that an abundant number of incarcerated prisoners have been diagnosed with some form of mental health illness. They too receive treatment, but what those services entail, has yet to be discovered. Even in the prison system, there are barriers. Some of these risk factors have been mirrored throughout the text, such as lack of resources and competent professionals to issue treatment. In this case, there is inadequate space, housing, and beds for prisoners who suffer from mental illness. Providing adequate and effective post-release services to these inmates is crucial. Without it, they end right back in prison (Blevins & Soderstrom, 2015).

James and Glazer (2006) found that 56% of prisoners of the state suffer from some form of mental health issues. Of those, 15% have psychotic disorders. At the end of 2011, more than 700,000 inmates needed mental health treatment. These treatments ranged from minimal to intensive types.

Figure 16

Mental Health Status of Prisoners and Jail Inmates, by Type of Mental Indicator. 2011-2012



Note: Source, Bureau of Justice Statistics (2012)

Training and Professional Development

According to Fathers (2019), mental health training and professional development have the potential to equip teachers, families, and other community stakeholders with the right tools to support students who are experiencing mental distress. Something as simple as offering a supportive listening ear would be beneficial when children need to talk (Fathers, 2019). It is imperative that schools ensure that schools are well equipped to not only identify but support students and their families by building their capacity to efficiently and effectively address student mental health needs (Fulks et al., 2019).

Children are highly likely to be encouraged or persuaded in the school setting, where the environment is positive. They can thrive and become affected in a conducive

way that is beneficial to their wellbeing and mental health. However, all schools do not provide the same level of support to students. Unfortunately, some schools create the opposite effect desired. These schools feel children with worry, anxiety, and unhappiness also affect their mental well-being. Not only can this hinder their social and emotional state, but their academic progress (O'Reilly et al., 2018). Over the years, schools have been charged with supporting children with everything they need, from food, clothing, and sometimes shelter. They are at the forefront of ensuring that children are afforded a positive environment that promotes positive mental health. This is achieved through the provision of consistent and effective intervention programs that educators and other stakeholders including families and community partners, are privy to (O'Reilly, et al., 2018).

It is imperative that schools and districts take a whole-school approach to promote positive mental health. It allows for essential collaboration amongst all parties involved, the school community, students, families, and staff. As with any approach, they do not come without challenges. Some of the challenges that go along with the whole-school approach include, but are not limited to, the lack of willingness from the staff. There's no buy-in. Also, the clarity and consistency in the vocabulary and terminology is an issue (O'Reilly et al., 2018).

Safety and supervision are crucial. However, with this approach, schools run the risk of not having highly effective or trained staff to carry out the mission of the approach itself. Being able to obtain and sustain engagement with the youth is another concern as it relates to the whole school approach. It is important that this occurs in order to promote positive mental health (O'Reilly et al., 2018).

Chapter Three: Methodology

Introduction: Chapter three will discuss the methodology of the research conducted that will include several components. The first will be a detailed description of the participants who agreed to participate in the study. The site of the research study will also be addressed. The chapter will then dive into the instrumentation used in the study and its research question(s). Chapter Three will examine the study's method, data collection as well as data analysis.

Research Question:

How does teacher, family, and community partner preparedness affect the quality or level of support provided to students with mental illness, as measured by interview questions, survey questions, and focus group responses?

Questions

- When is the most optimal time for stakeholders to receive training to support students with mental illness?
- What are the implications for reducing the stigma surrounding mental health?
- Whose responsibility is it to initiate support for students with mental illness?
- How can adequate and effective training of key stakeholders increase their ability to identify and address students' mental health needs?

According to Fathers (2019), mental health training and professional development have the potential to equip teachers, families, and other community stakeholders with the right tools to support students who are experiencing mental distress. Something as simple as offering a supportive listening ear would be beneficial when children need to talk (Fathers, 2019). It is imperative that schools ensure that schools are well equipped to not

only identify but support students and their families by building their capacity to efficiently and effectively address student mental health needs (Fulks et al., 2019).

Participants, Instrumentation, & Methods

This study took place virtually, using the platform, Zoom. Professional contacts in the field of education as well as members from the Parents As Teachers organization were recruited to participate in the study. The researcher aimed for a minimum of 15 participants and a maximum of 20 participants with varied gender, ages, ethnicity, race, and health status. After the third party made contact with potential participants, 20 total were secured and actually participated in the research study. Educators who serviced classes of students that included the following instructional programs were among the participants; general education, gifted education, and special education qualified to participate in the study.

A voluntary survey, created and administered through *Qualtrics*, which participants could opt out of at any time, was emailed to participants by a third-party requesting participation. Participants who completed the survey were able to indicate interest in the interview and focus group phase through responding to questions on the survey. After sending out the survey link, the third party created a timeline that included beginning and end dates for the participants to complete the survey. Once all surveys were submitted in *Qualtrics*, the third party randomly selected five of the 20 participants to participate in the Focus Group session. They were contacted via email. The email consisted of what a Focus Group was, how it would be used, and its purpose. Once all five selected participants agreed to partake in the Focus Group, the third party emailed the group asking their preferred days of the week to meet and time of day to meet with a

list of potential time frames provided.

A third party then conducted the interviews for those participants who volunteered for the interview phase. The third party also conducted the focus groups for those participants who volunteered for the interview phase, to lessen potential coercion. During this study, there was no compensation for any participant and the process did not involve deception. Qualifications for participation in this study included personnel with professional contacts in various roles within the field of education, such as classroom teachers, student support services, administration, non-certificated staff, and members of the Parents As Teachers organization.

Exclusion criteria included persons, not in the field of education, who were not personal contacts nor members of the Parents As Teachers organization. However, neither age, gender, race or ethnicity, nor language was used as exclusion criteria in this study. The following populations were not enrolled in the study: minors, prisoners, nor vulnerable populations. No one on the research team was in a position of authority over participants. Participants were recruited for the study via email script. A neutral, third-party utilized personal emails of professional colleagues to send the initial invitation and *Qualtrics* survey to potential participants. The research did not involve any of the following; sensitive and identifiable information, physical, pharmacological, or psychological intervention, nor vulnerable populations. Only adult participants were invited to participate in the research study.

Participants received an email from the neutral third party that contained the introductory email script and a link to the study survey. Clicking the link indicated consent to participate, as outlined in the email script. For privacy and confidentiality

measures, there was no collection of personally identifiable information. This included, but was not limited to any data element which singly or in combination could be used to directly identify a participant, nor any code or combination of variables in a data set that might permit indirect identification of a participant. Identification could not be ascertained through any element of the research design, such as timing or location, that may permit the incidental identification of participants. Technological and physical safeguards used to protect data from inappropriate use or disclosure consisted of the use of *Qualtrics* to anonymize data. There will be no identifiers collected. Data will be retained for the required period of three years. Results of the research will be made available through the publication of a dissertation submitted to *ProQuest* by Lindenwood University.

Site

Due to the COVID-19 pandemic and for safety purposes, this study was conducted virtually via Zoom. Zoom is a cloud-based video conferencing tool that lets a person host virtual one-on-one or team meetings easily. With powerful audio, video, and collaboration features, this remote communication tool connected remote team members with each other (Davidson, 2021).

Research Perspective

The research perspective for this study comes from the viewpoint of the participants who were the ones who were directly impacted by educating students with mental illness and their families, the classroom teachers, and members of other educational organizations. These participants would bring their unique perspectives and voices to the study, as each would have encountered a varying degree of experience,

bringing their individual skillset to the table.

List of Survey Questions

Combatting Mental Health in Schools: Are Schools Ready?

Q 1. Please list any trauma-related trainings or professional development you have received that were intended to prepare you for the mental wellness of students in the classroom.

Q 2. Explain why you would or would not consider these trainings useful.

Q 3. What topics or concepts, if any, were missing from your training sessions?

Q 4. What are areas of concern for which you would like more professional development?

Q 5. How could a professional trainer better prepare you to handle students with mental illness in educational settings?

Q 6. How often would you like the opportunity to attend professional development regarding mental wellness for students in education?

Weekly (4)

Monthly (5)

Once per quarter/semester (6)

Once per academic year (7)

Other (8)

Q 7. Which form of training would you prefer and why? (i.e. virtual, in-person, modules, videos, etc.)

Q 8. What do you consider the most productive times to schedule training and why? Select all that apply.

Weekdays (4)

Weekends (5)

Mornings (6)

Evenings (7)

Non-work days/breaks (8)

Please explain the reason for your choice(s). (9)

Q 9. How do your personal life experiences impact your practices and approach in dealing with students with mental illness?

Q 11. What is your age?

18-24 years (1)

25-34 years (2)

35-44 years (3)

45-54 years (4)

55-64 years (5)

65-74 years (6)

75 years or older (7)

Q 12. What is your ethnicity?

White (1)

Black or African American (6)

Hispanic or Latino (2)

Native American or American Indian (3)

Asian/Pacific Islander (4)

Other (5)

Q 13 What is your highest degree or level of school completed?

Up to 8th grade (1)

Some high school (2)

High school diploma or equivalent (GED) (3)

Trade or vocational training (7)

Some college (4)

Associate degree (5)

Bachelor’s degree (6)

Master’s degree (8)

Professional degree (9)

Doctorate degree (10)

Focus Group Questions

- How do we start or guide conversations about mental health with children?
- What would you say about guiding conversations with kids that you did’’t personally birth, kids that you may not know well? How do you feel you would guide conversations with kids in a school setting?
- Why do you think it’s important for children to learn about mental health?
- What kind of language do we use when w’’re talking about mental health needs; What type of language do you think is necessary to explain that you may go through different things or feel different things or in this case have different abilities?
- How do we help them make sense of whatever might be going on in their mind?

- How can we, meaning whether you're a parent, educator, etc., matter what interaction you have with youth, can we educate parents about mental health?
- Do teachers have enough training or enough capacity or time to address those same issues as a counselor and or social worker? And if they don't how can we get it to them?
- Are there things that teachers or educators can do in those moments in the classroom to mitigate or calm a situation?
- How do you personally promote mental wellness in children, whether it's in the school, community, neighborhood, wherever for children specifically?
- What is it that w''re adding in educational settings to make sure that mental wellness is prioritized?

Qualitative Methods Approach to Synthesize the Data (Framework)

The qualitative Methods Approach to synthesize the data from this research study was the phenomenological approach, as it described the age-old issue of mental illness in education but most importantly, in the classroom setting. The study took a look at if teachers were adequately and effectively trained to cope with all of the secondary trauma and disparity that teaching came with when they were faced with having to integrate children with mental illness in their classroom environment with lack of support. During this study, a combination of surveys and focus groups were utilized, to better understand the meaning participants placed on the topic of mental illness in the classroom. Reliance on the participants' own perspectives provided a variety of perspectives and insight to the topic, as they were able to relate their own experiences as a child and or to their own children.

Summary

Based on the data gathered from the survey and focus groups, it was agreed that teachers were not ready to combat the age-old issue of mental illness in the classroom. Due to several barriers, like lack of access to treatment, to little-to-no teacher training. The data also showed that promoting awareness of mental illness in schools would have a more positive effect on the outcomes that educators need. This would include all stakeholders, families, community partners, etc. Questions were raised on how and where to begin the conversation to support educators and children, with their families about mental illness in schools, despite the stigma that has been placed on the subject. Society plays a major role in prioritizing this issue so that students who suffer from mental illness do not continue to fall through the cracks of the achievement gap and school pipeline-to-prison.

Chapter Four: Analysis

Analysis of Survey Questions

Originally, 20 participants were invited to take part in the research study. However, only 13 out of the 20 actually participated. The survey consisted of 13 open-ended and demographic questions. The nature of the questions and discussions were centered around the growing issues of mental illness in classrooms within society and what was being done, if anything, to support stakeholders who were responsible for the success of students. The survey was designed and completed in *Qualtrics* and ran from August 8, 2021, to August 15, 2021. I noticed trends with participants who not only fell in the same age ranges but there were also variances among races. Participants' backgrounds played a major role in the discussions, as they leaned heavily on their own prior experiences as a child and/or with their own children and families.

#10 – **Age.** Thirteen participants took the survey. There were no participants who fell in the 18 to 24 age range. Two participants were between the ages of 25 and 34. In the age range of 35 to 44, three participants fell into this category. There were five participants in the age range of 45 to 54 and three participants in the age range of 55 to 64. There was a wide range of ages represented among those who participated in the survey. The minimum number of participants was two, and the maximum number of participants was five. The mean was 3.69, with a standard deviation of 0.99. The variance was 0.98. As it relates to the choice count, 0% of participants were in the 18 to 24 years field. And, 15.38 % of participants fell in the 25 to 34 years field. In the 35 to 44 years field, 23.08% fell in this field. Additionally, 38.46% of the participants were in the 45 to

54 years field and 23.08% were in the 55 to 64 years field. None of the participants were in either the 65 to 74 years or 75 years or older fields.

#11 –- **Race/Ethnicity.** Out of the 13 participants, only 12 answered; two selected the choice, White. Ten participants selected the choice Black or African American and one participant chose not to answer. There was a minimum of one with a maximum of six. The mean was 5.17 with a standard deviation of 1.86. The variance was 3.47. There were no participants who fell in the categories of Hispanic or Latino, Native American or American Indian, Asian/Pacific Islander or other. Black or African Americans represented 83.33% of the participants. The representation of race and ethnicity was not evenly balanced.

#12 –- **Highest Degree or Grade Completed.** One participant selected the choice of high school diploma or equivalent (GED). The count for Bachelor's degree consisted of two participants. Five participants completed their master's degree. One participant received a professional degree and three participants received their doctorate degree. Most of the participants fell in the master's degree range while the high school diploma or equivalent (GED) and professional degree included the least number of participants. The minimum number of participants was three and the maximum number of participants was ten. The mean was 7.83 with a standard deviation of 1.95. The variance was 3.81. Neither participant fell into the categories of "up to ^{8t}h grade," "some high school," "some college," "associate degree," or trade or vocational training. Also, 88.33% of participants received a high school diploma or equivalent (GED). Additionally, 16.67% of participants earned their bachelor's degree. Forty-six point six

percent received their master's degree. Eight point thirty-three percent of participants earned a professional degree, while 25.00% of participants earned a doctorate degree.

#13 – **Gender.** There was only one participant who described his gender as male while 11 selected the female answer choice. The minimum was one and the maximum was two. The mean was 1,92 with a standard deviation of 0.28. The variance was 0.08. Eight and thirty-three hundredth percent represents the percentage of participants who were male and 91.67% of participants selected the female answer choice. The following gender categories were not represented: non-binary, transgender, prefer not to say or self-describe.

#6 –- **Frequency to Attend Professional Development.** When asked how often participants would like the opportunity to attend professional development regarding mental wellness in education, the answer choices included weekly, monthly, once per quarter/semester, once per academic year, and other. From the choice, one participant was selected weekly. Three participants chose to have professional development monthly. Five participants chose once per quarter or semester, which was the most popular selection. Two participants were selected to have professional development once per academic school year and only one participant chose the "other" category. The minimum was four and the maximum was eight. The mean was 5.92 with a standard deviation of 1.04. The variance was 1.08. And, 8.33% of participants selected to have professional development weekly while 25% chose monthly. Additionally, 41.67% of participants would rather participate in professional development once per quarter/semester while 16.67% selected once per academic school year. Eight and thirty-three hundredth percent fell in the "other" category.

#8 –- **Most Productive Time to Schedule Training and Why.** When surveyed on what participants considered the most productive times to schedule training and why, the answer choices consisted of the following selections: weekdays, weekends, mornings, evenings, and non-workdays/breaks. Eight participants chose weekdays, while one participant chose weekends. Four participants selected to have the training scheduled in the mornings and two preferred the evenings. Two participants also chose to have training scheduled during non-work days or over breaks. And, 27.59% of participants selected weekdays as their answer choice. Additionally, 3.45% chose weekends, 13.79% picked mornings, and 6.90% chose evenings. Six and nine tenth percent selected to receive training on non-workdays or over breaks.

Participants who chose to have professional development earlier in the day all agreed that if it were earlier during the day, they would be able to have fresher thoughts and be more alert with time to reflect and alter the course as needed. Educators are more likely to give the presenter their full attention as the consensus of the group with the same selection choice. They felt that they would be drained by the evenings that weekends were for their families. Participants who preferred professional development during the contractual day were better because it would allow them to see students in action. The weekends could be very hectic and busy if they attended professional development any other time. This is the time that educators would likely prefer to themselves, to reflect and rejuvenate for the next week. They agreed that people need their weekends for their own mental health. The outlier to the group felt that weekends were the prime time to address these issues because the staff was ready to go and “in the learning zone.” They felt that people were less likely to engage if it was during their personal time, but were in

a “real-life” scenario with students; it would appear more relevant and be more likely to have a more substantial impact.

#7 –- **Which form of training would you prefer and why.** Six of the participants chose in-person training because of the hands-on setting and learning experiences that happen. It also gives the teacher an opportunity to support students who are struggling. Three participants chose virtual training because of its ease of access and comfort and the fact that more people would be able to attend a session. Three participants chose to participate in a variety of training, as some aspects of the training may not require face-to-face. Having multiple methods allowed for the facilitator to address the needs of the audience, depending on his/her levels of understanding of the content. The consensus of this group felt that a variety of formats would be helpful as some staff may be more comfortable using different modes of learning. Utilizing a variety of methods allowed for participants to pace themselves to have more time to digest the material as needed.

#1 –- **List trauma-related training received.** Some participants shared that they received some professional development that was intended to prepare them for the mental wellness of students in the classroom. They included trauma-informed programming and support for social workers and student support services. Participants reflected on their own backgrounds and shared that although the training was limited on the job, they were able to receive support through their academic background with university-level training. Cultural relevance was also a type of training that some of the participants were privy to, as well as trauma-informed teaching. Several participants agreed that they may have experienced some form of training related to trauma, but they did not remember any of

them well enough to make a list. It is my assumption that they may not have been anything of substance. Typically, when true learning occurs, students tend to remember what was taught. At least two participants stated they had never received any trainings or professional development to support them in preparing them to deal with mental illness in the classroom. The training or professional development that was mentioned appeared to be choppy and of no real value or interest to the participants. Several of them could not recall the content of the training. And for the ones who did, they stated that it had been so long ago that they had been trained that they could not remember what was presented. Others stated that any training they participated in always seemed to come at the beginning of a school year, as a back-to-school professional development with no follow-up sessions. There was no ongoing support in place by their company, job, or district.

#2 –- **Explain why you would or would not consider these training useful. T**he consensus from most of the participants in the survey was that they did find the training and professional development were both relevant and useful at the time because they provided tips and strategies that supported not only the teacher, but the students, their families, and the community. The training provided research-based data on how to teach and counsel students who experienced some type of trauma. The strategies were practical and "friendly." The participant'' answers as to why they would or would not consider the training useful mentioned the vitality of all employees having some background in addressing trauma for students because all staff has the potential to make a positive difference in a student's life, as anyone could find themselves in a position to find a student in crisis. Based on the responses, the participants agreed that, due to a large number of students and experiencing mental health issues, the professional development

was useful. One response referenced the demographics of where students tended to experience more trauma than their counterparts. Teaching in Title-One schools, unfortunately, has a greater instance of students suffering from not only trauma but also undiagnosed and untreated trauma. Teachers should know these will affect the behaviors and outcomes for students in the classroom and design instruction around it. Two of the responses were centered around the fact that they felt that the professional development was useful, they were inundated with terminology, and the fact that after the training, and when school begins, they get caught up in the hustle and bustle of things that they do not think any more about the training unless they encounter a situation that prompts them to recall what they learned during training.

#3 –- **What topics or concepts, if any, were missing from the training sessions?** After viewing the responses to this question, I was able to group them into three categories; poverty, how to involve parents, and the pandemic. Although, at least three of the participants stated they could not recall what topics or concepts, if any, were missing from the training sessions, the others were able to provide rich responses. Poverty was a topic that was missing for some of the participants. They all wished they had a stronger background in fully understanding the impact of environmental factors on student development (i.e., impact of poverty as it relates to living conditions, such as homes with lead-based paint). This particular topic goes back decades when the research was conducted in major urban cities, in the homes of the impoverished, and how it affected those families, especially those children.

Parental involvement was also a missing component. Participants would have liked to see more support for families and how they could help support both their

children, as well as the classroom teachers. The question was raised around how to involve parents in seeing and playing activating roles in getting the help their children needed. The COVID-19 pandemic affected us all and resulted in added trauma to children. The concepts missing from training included the people behind the trauma and the impact of one's own biases that are brought into the interactions with children who experience and who are exposed to trauma, coupled with trauma for the teachers after the pandemic. Several literature reviews have been written on how the pandemic has taken its toll on children, but not as much research has been done as it relates to how it affected teachers and what can be done to support them.

#4 –- **What are areas of concern for which you would like more professional development?** The main topics of concern, for which the participants would have liked to receive training, varied based on the need. A participant wanted more professional development on how to communicate to children that have mental issues. Knowing that a child has a mental health issue is one thing, but knowing how to address it is another, even more so, how to communicate with those children. It is far too easy to assume that what works for one, works for all. That is not the case when dealing with students who suffer from mental illness.

Another concern participants felt needed to be addressed is training for specific situations. Many situations can and will arise when dealing with students who suffer from mental illness in the classroom setting. One may never experience the same thing twice. However, being as prepared as you can be with the most typical situation and how to better prepare yourself could prove to be beneficial for the students and the teacher. One concern regarding how to handle trauma in the classroom for students and teachers, post-

pandemic was one that really stood out because at the time of this writing there is still currently the pandemic. How the support will look when it is over is likely to be extremely different from the support offered now. Excessive exposure to trauma and how it impacts students and the suicide risk factor awareness were all concerns. The last common thread was yet again, the parental involvement piece. Parents are more aware of children with mental health issues, now more than ever. They want to be informed and get involved in supporting their children and their children's teachers.

#5 –- **How could a professional trainer better prepare you to handle students with mental illness in educational settings?** There was a consensus of the use of a holistic approach with hands-on application aiding students going through a crisis or mental health issue. The participants preferred real-life experiences with practical solutions while understanding the population and demographics. How to effectively communicate with students who suffer from mental health issues was mentioned again. Trainers who have had personal experiences dealing with children who have suffered from mental issues was an area that participants felt would better prepare them to handle students with mental illness in the educational setting, coupled with observations and follow-up observations of the students in their natural educational setting while providing constructive feedback and support. Two participants stated there is no amount of training that could prepare an educator to deal with the effects of trauma and how to support teachers who deal with students who suffer from mental illness. They felt that it was a situation that teachers would have to deal with at the moment.

9 –- **How do your personal life experiences impact your practices and approach in dealing with students with mental illness?** Some of the participants stated

that using their own experiences with their own children and family members has greatly impacted their practices and approach in dealing with students with mental illness. There may be a family member who experiences what your students do. Therefore, thinking of what has been successful at home, they used those same strategies and practices within the educational setting. The background as a social worker has impacted the practices and approach of one of the participants because the rigorous training and previous experiences that this person has encountered have helped tremendously when dealing with students who suffer from mental illness. Appreciating the student'' mental status as it relates to empathy and compassion for what they may be experiencing was also an interesting approach because when you have been exposed to similar situations, it makes you more receptive to trying a variety of ways to support children.

Analysis of the Focus Group

The focus group consisted of all females whose ages ranged from 41 years of age to 61 years of age. Four out of the five participants have children of their own. Four out of five of the participants worked or have worked in the field of education or in an educational setting. All participants associated themselves as African American/Black who lived in various cities in the state of Missouri. The Focus Group discussed five major questions with follow-up questions embedded within the discussion. The nature of the questions and discussion was geared toward making stakeholders more aware of the issue of mental illness in schools and how to support students and teachers who are responsible for working with these students. The duration of the focus group was one hour and eighteen minutes.

 # 1 –- How do we start or guide conversations about mental health with children; and how do you feel you guide conversations with kids in a school setting?

The trends noticed during the focus group discussion were varied. The group agreed and discussed that open communication was the key to having or being able to guide conversations about mental health with students in a school setting. They also felt that building relationships would enable them to open up the door to have the initial conversations. If students do not trust you, they are less likely to disclose information to you. Participants drew on their own personal experiences, how they spoke to their family about similar situations, or how conversations were had with them at a point in time regarding mental health. The group also reached a consensus that prevention was the key to supporting students who suffer from mental illness. They felt that districts' and teachers' approaches needed to include culturally responsive pedagogy and relevance to ensure that each child's needs were being addressed and met. The group concurred that it is important to validate a child's feelings and that past beliefs should not make way into the present (i.e., children should be heard and not seen). In fact, students need to feel seen, heard, and supported. Some of the outliers during the discussion included rich conversations around role-playing. One of the participants felt that having a student act out or role-play would benefit from the support given as a guide to facilitating a conversation about mental health with children in the school setting. Assistance from the student support team (SST) could provide a holistic approach that included wrap-around services was a suggestion from one of the participants who was a social worker. Interestingly, a participant viewed the relationship with the student as reciprocal, as not only would the student benefit from the adult but vice versa. Treating students like

humans before children were discussed, because it shows a level of respect that everyone automatically deserves. Lastly, how to address the stigma of mental health issues with children was also a speaking point, as it was considered the ultimate form of communication that included true transparency.

#2 –- **Why do you think it's important for children to learn about mental health and what kind of language do you think is necessary to explain that you may go through different things or feel different things or in this case with different abilities?** During the focus group, participants agreed that child stigma plays a crucial role in why it is important for children to learn about mental health. The stigma can take you back, not to the history of mental illness, but also bring you to its current state. They felt that mental health had not been addressed in a manner that was conducive to the child who struggled. The group discussed the perceptions and preconceived notions around mental illness and the fact that there may be underlying conditions that go along with a child, while a diagnosis goes unnoticed and unaddressed. As it relates to the type of language necessary to explain that students may go through and or have different feelings and possibly have different abilities, participants in the group concurred that using student-friendly language that was consistent across the board would be beneficial. Another trend was that the group felt that getting the input from children, seeing, hearing, and supporting them as opposed to giving in to the stigmas, would provide more effective support for students, as these stigmas are carried out in children's communities, homes, and on the playground.

#3 –- **How can we educate parents about mental health?** Parents have to be receptive to the conversations due to preconceived notions and labeling. It is imperative that the appropriate language is conveyed when speaking to parents about mental health.

Participants felt that relationship building was the crux to everything. If a parent does not have a relationship with the educators, then they are less likely to trust them. Awareness was another way, discussed in the focus group, that parents could be educated on mental health. This participant differed from the rest of the group in the sense that she felt that awareness can come in a variety of forms. Some parents may prefer to be educated about mental health in the school setting or schoolwide. It could even be as simple as a school flyer. Having a curriculum that is specified on how to educate parents with parent family language and practical strategies that could be implemented with ease. All participants agreed that utilizing the school's social worker and counseling team could be beneficial. When they begin to notice a child expressing themselves about having issues at home, they know and feel comfortable with disclosing to school staff about what is happening with them. It was discussed that the student support team could bring families into the schools and make them feel welcome and comfortable with having conversations regarding mental illness. However, one difference was that some of the participants mentioned a concern that some children and their families may not feel that it is OK or appropriate to discuss "family business" with the school or to express true feelings in therapy.

#4 –- **Do teachers have enough training or enough capacity or time to address those same issues? If not, how can we get it to them?** The focus group unanimously agreed that there was enough time to address those issues.

Outlier: One participant, who had been in education, reflected on her experiences as a new educator and how the counselor and social workers were not as visible as they are now. They were typically in their offices behind their desks during the day, or unless it was for an IEP meeting. Some of the participants were able to compare their experiences with their school's or organization's counselor. On one hand, there are student support teams who still sit behind the desk, but there are others who are visible throughout the building, host mediations and sessions with students and even parents. They even push into the classrooms to support teachers and students through observations and suggestions of practical teacher-friendly strategies for support. The consensus was also that teachers have not received ample or adequate training to support students who suffer from mental illness. Novice teachers and or untrained educators send students to the principal's office when they feel the student is out of compliance with the rules in the class. Participants felt that if there was effective training for teachers, they would be better prepared to deal with those types of situations, opposed to a punitive approach. The idea that students be labeled or people giving into the stigma of mental health resurfaced from earlier in the focus group. They mentioned the negativity that goes along with mental illness, the paper trail, and sometimes, the misdiagnosis.

#4 –- **How do you personally promote mental wellness in children?** One participant felt that the approach at which an educator or parent takes to address or promote mental wellness is important; the participant used a more positive and open-ended approach that focused on the positive as opposed to the negative, which yielded a more beneficial result with her own grandchild. She was in tune with her language and the tone that was used supported her efforts. Also, acknowledging that the child may feel

a certain way was deemed as important during the focus group discussion. They felt that acknowledging children, validated what they feel and say, or do not say or do. Children need to feel seen, heard, and supported.

#5 –- **What is it that we're adding in educational settings to make sure that mental wellness is prioritized; what are we adding if mental wellness is the number one priority in every single school?** The trend in these focus group conversations was ongoing professional development, but the caveat was for it to be scaffolded so that eventually there is a guide created for existing educators and new ones to have as a toolkit of resources and strategies. The participant that works in the field as a student support service worker felt that there should be a unit that is specially designed with psychologists, people who are trained to deal with students who are sent out of the classroom but not to the principal's office. They actually go to a place where there is a licensed professional they can talk to and begin really addressing some of the issues on why they behave the way they do.

Summary of the Focus Group

Participants of the Focus Groups were randomly selected from the survey panel of participants. They were able to shed light and various perspectives on the questions posed during the discussion. Participants were given open-ended and thought-provoking questions as they related teacher preparedness in the classroom and supporting students who suffered from mental illness. The discussion encompassed a myriad of sub-topics such as getting other stakeholders involved in the process to support the education system with this issue. The discussion invoked authentic feelings from participants as they reminisce on their own personal experiences as children and or with their own families.

Overall, by having the needed discussion, participants felt that they had value to add to the research study.

Chapter Five: Conclusion

Review of Study

The purpose of this study was to examine general education classroom teacher needs and district-provided professional development concerning trauma and difficult student-oriented situations, to assess the effects on the mental well-being of classroom teachers, at the elementary school level, in urban schools. The goal was to provide recommendations for educators concerning the most effective research-based strategies that support the academic, social, and emotional growth of students who suffer from mental illness. The study consisted of survey questions as well as a focus group. The survey was generated in Qualtrics and administered by a third party. The third party also facilitated the Focus Group. Initially, 20 participants were asked to join the study. However, only 13 actually participated. The research was gathered and conducted through surveys, questionnaires, interviews, and focus groups. The answers to the survey questions and discussion during the focus group invited key stakeholders to join and aid in the process to support the education system with this age-old issue.

Research Question:

How does teacher, family, and community partner preparedness affect the quality or level of support provided to students with mental illness, as measured by interview questions, survey questions, and focus group responses?

Research Sub Questions

- When is the most optimal time for stakeholders to receive training to support students with mental illness?
- What are the implications for reducing the stigma surrounding mental health?

- Whose responsibility is it to initiate support for students with mental illness?
- How can adequate and effective training of key stakeholders increase their ability to identify and address students' mental health needs?

Purpose

The purpose of this study is to examine general education classroom teacher and community needs as it relates to district-provided professional development concerning trauma and difficult student-oriented situations to assess the effects on the mental well-being of classroom teachers, at the elementary school level, in schools. The goal is to provide recommendations for educators and America's families concerning the most effective research-based strategies that support the academic, social, and emotional growth of students who suffer from mental illness.

It is my hope that the results will lead to more professional development and training for teachers and the families of children who suffer from mental illness. The reason why this study is important is there is a gap in the success rate of students at the elementary school level, in urban general education settings, who have teachers who have been effectively trained to support students with mental illness. (Why is this issue being ignored?) The issue of mental health in schools, in the researcher's opinion, has always been a problem and has been around since the beginning of time, even in our homes.

In my home; as a young child, there was a family member who never came around other people or out in public with the rest of the family. He was kept in a room, in the back of the house. Unbeknownst to me then, [he] my uncle suffered from a mental health issue. No one in the family or community talked about it. It was like, "taboo".

However, in its current state, we are not given the option of continuing to ignore the “elephant in the room”. This ever-growing problem has spiraled out of control and the lives of our youth are literally at stake. Unfortunately, schools are witnessing mental illness in students as early as preschool.

The research question addresses how teachers and preparedness affect the quality or level of support provided to students with mental illness, as measured by interview questions, survey questions, and focus group responses. It was my hope that the results would lead to more professional development and training for teachers and the families of children who suffer from mental illness.

Implications for future practice: With this study, not only will students who suffer from mental illness benefit from receiving the supports needed but also, educators would get the training necessary to effectively assist those students. Families too would gain a wealth of knowledge that would boost their skillset and confidence, while working in conjunction with the school system and community partners there to bridge the gap that oftentimes is created.

Implications for future research. There are several benefits to society and my field of study, as it will not only provide essential information, support, and guidance to educators but also to children and their families. The study will go beyond the urban education demographic and will be applicable globally. Stakeholders from all walks of life will benefit from the support of students’ academic, social and emotional growth of students who suffer from mental illness, with or without a clinical diagnosis, and will be used for years to come.

Risks & Limitations

Some of the potential risks related to my research would include, but not be limited to possible coercion, perceived authority, data collection, Hawthorne Effect, self-created test, current pandemic. How will you minimize these risks? The way I plan to minimize the risks of my study would be to keep identities anonymous. The participation would be strictly voluntary with informed consent given. The participants of the study are employees in the same school district as I work. I am currently the supervisor of all participants in the study. There are potential risks with the participants and perceived authority; due to potential adverse effects if the participants choose not to participate in the research study. The participation would be strictly voluntary with informed consent given. The participants would be kept completely anonymous. The research study will also include the support of a third-party person, to eliminate any potential bias.

Limitations: Some of the multifaceted questions could have limited the study or invalidated the data, if the questions were not answered in the manner it was designed to be answered. Initially, the participant pool consisted of 20-25 volunteers but in actuality, only 13 participated, resulting in a low participant rate. Most out of the 20 participants asked to participate, only 2 were male and 1 out of the ones who did participate was Caucasian. The level of experience could have also become a limitation as well as if a participant worked in a school versus, speaking from personal experience as a parent/guardian or other stakeholders.

Risks: Some of the questions required participants to draw on their own personal experiences as it relates to how they dealt with situations that included mental health and how they responded to different situations. They could have felt uncomfortable sharing

personal information. Also, some of the participants may have felt uncomfortable discussing or answering questions about a different race or ethnicity. It could have presented a stressful situation for those participants who may have had a negative or traumatic childhood or upbringing. Other risks, that may have included gender, as there was only 1 male participant, years of service, or race, could have all been risks throughout the study.

Significance of Findings

Confirmation and affirmation, able to help parents and teachers, by starting the conversations about mental illness and how to recognize it. Once it has been accurately diagnosed, it's important that it is treated immediately and correctly. The effective, adequate and ongoing training that educators, families, and all other stakeholders will allow them to support students who suffer from mental illness, ensuring that they are successful academically, socially, and emotionally.

How does the data connect to real-life: Unfortunately, this study was based on the experiences that I've encountered as a building leader. I saw it too often for it not to have been addressed. Several students were products of the pipeline to prison because they suffered from mental illness who received inadequate treatment or no treatment at all. The COVID-19 pandemic only worsened the effects of mental illness in children. They were forced to quarantine and isolated from their friends, families, and schools. For some students, that was the only positive interaction they received.

Advice to educators and participants: I would advise educators to give themselves permission to feel the way they do. If their social and emotional well-being is not adequate then it would be difficult to provide students with what they need. Continue to

seek professional development and training to stay abreast in an ever-changing society and notify the appropriate personnel when they suspect children may need support. Keep the lines of communication open with parents, as they too deserved to be seen, heard, and supported, and utilize the community to support one another, as they make up the stakeholders as well.

Why is it a big deal with what I found: discuss the similarities and differences between the different demographics: From an educational standpoint some of the similarities I noticed between the different demographics of the participants were that they all felt a sense of responsibility to support students but were not certain how. They all agreed that there needed to be more professional development for educators and families, in order to better support students who suffered from mental illness. The differences noticed were individual experiences they encountered personally and or as a child or how they addressed situations in their own families. Gender, race, and ethnicity varied and based on each, depended on the different experiences they had.

Further questions that can be explored:

1. How to better and more successfully cope with mental health during the pandemic, effective resources
2. How to cope with the stigma
3. How to break the generational cycle
4. How do we get families to know that it's ok not to be ok?
5. How can we train students to be self-sufficient when dealing with their own issues?
6. How can we get more youth involved in talking about mental health?

Possible Future Research

Prenatal care, genetics, heredity, lead-based paint, history, There are several benefits to society in my field of study, as it will not only provide essential information, support, and guidance to educators but also to children and their families. The study will go beyond the urban education demographic and will be applicable globally. Stakeholders from all walks of life will benefit from the support of students' academic, social and emotional growth of students who suffer from mental illness, with or without a clinical diagnosis, and will be used for years to come.

Summary of Dissertation

It was interesting to note that before beginning this research study, there was not as much talk or attention to the issue of mental illness and how it affected school-age children. However, since the COVID-19 pandemic, there have been several references to mental illness in schools, in the media. This has been an old-age society problem for decades. That, because of people's perceptions, miseducation, and ignorance, has gone unaddressed for years. The issues are more prevalent than ever, as they have become a grave concern in the educational setting. When asked how this concern will be prioritized, not only in schools but the communities, one Superintendent stated that she would begin looking deeper into how mental illness in students and teachers are being addressed and catering to those needs in a way that is most conducive to their mental well-being. Within weeks, several districts have opted to give schools "mental health days", to take time to take care of their social and emotional state.

In an environment filled with stressors and trauma, school leaders have been charged with more than teaching the basics of reading, writing, and arithmetic. The

accountability has shifted in a direction that requires educators to be the sole provider, in some instances, meeting children's basic needs. (i.e., food, shelter, medical assistance, and support) The collective knowledge and expertise regarding this topic put society in a position to support teachers and children inside and out of the classroom.

When I began this research study, I had the idea that I would change the mindsets of people, to get them to see what I saw as an issue that was worthy of attention. Working in the field of education makes building leaders privy to certain matters with a broader scope. We are in a position to evoke real change, change that makes a difference in children's lives all over the world. I continue to believe that addressing mental illness in schools and supporting educators is an essential component to the health and wellness of students and has the potential to not only close the achievement gap but also the school pipeline- to prison.

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