

ABSTRACT

Title of Dissertation: AN EVALUATION OF YOUTH MENTAL HEALTH FIRST AID TRAINING FOR AMERICORPS CLASSROOM EDUCATORS

Ana-Sophia Ross, Doctor of Philosophy, 2021

Dissertation directed by: Associate Professor, Cixin Wang, and Counseling, Higher Education, and Special Education

The prevalence and severity of adolescent mental health concerns is clear. Half of youth experience a trauma/adverse event, thus significantly increasing their risk of developing mental illness. Further, suicide recently became the second leading cause of death among young people. Unfortunately, most youth do not get the mental health services they need. Schools, however, are the most likely place to provide formal or informal mental health care. Classroom educators, in particular, are most likely to be the one to refer/recommend students to formal school mental health services and they also provide informal mental health help. Despite their key role, they often feel underprepared to recognize concerning symptoms in youth and to support school mental health efforts. This mixed-methods study explored the impact of training 106 City Year AmeriCorps members in Dade County (Miami, Florida) using the Youth Mental Health First Aid (YMHFA) program. Quantitative data were collected at three points (pre, post, and two months after training) to examine whether YMHFA training

equipped corps members with tools to support students' mental health. Overall, training was associated with short-term improvements in mental health literacy, confidence and intentions to engage in providing mental health first aid behaviors, and knowledge of school based mental health providers. Notably, participants self-reported greater engagement in mental health helping behaviors in the two months after training than in the two months before training. No improvement in mental health stigma was observed, and some short-term improvements (i.e., mental health literacy, intentions to help) were not sustained at follow-up. Qualitative data generally supported quantitative findings and suggested that the YMHFA program is well-suited for classroom educators. However, the program has room to grow in ensuring it helps educators support culturally and linguistically diverse students' mental health.

AN EVALUATION OF YOUTH MENTAL HEALTH FIRST AID TRAINING
FOR AMERICORPS CLASSROOM EDUCATORS

by

Ana-Sophia Ross

Dissertation submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
2021

Advisory Committee:

Associate Professor Cixin Wang, Chair

Associate Professor Melinda Martin-Beltran, Dean's Representative

Assistant Professor Kelli Cummings

Assistant Professor Yang Liu

Associate Clinical Professor Natasha Mitchell

© Copyright by
Ana-Sophia Ross
2021

Dedication

To my dad. You didn't get to see the end of the journey, but you supported me at every step. I wouldn't be where I am without you. Every time I told you I couldn't do it, you made sure I knew I could. Your love and support will always be with me, and I could not be more grateful.

Acknowledgements

I am tremendously thankful for the many people who helped me along my doctoral journey. First and foremost, I thank Dr. Cixin Wang who did so much more than serve as a mentor. Dr. Wang has been instrumental in my development as an emerging psychologist through her innovative and caring teaching, supervision, and mentorship style. Dr. Wang encouraged me when I needed an extra push and was patient and supportive when the road became tough. I also thank my committee members Drs. Melinda Martin-Beltrán, Kelli Cummings, Yang Liu, and Natasha Mitchell for their expertise and thoughtful feedback.

To all of the City Year Miami AmeriCorps members and staff, thank you. Your generosity is deeply appreciated. I have the utmost respect for the work you do and sincere appreciation for your participation in this research. This project would not have been possible without you. I am humbled to have learned from you and your stories. Thank you, in particular, to Amore Rodriguez with City Year Miami for your coordination. Thank you also to Demian Laudisio and Tom Felischmann with the Jewish Counsel for Youth Services of South Florida for your collaboration and generosity.

Thank you to my family. Your unwavering support means more than I can put into words. To my dad, who passed away four months before I defended my dissertation, I love you so much and wish you could have seen this to fruition. You believed in me, often more than I believed in myself. Your belief in me and love for me propelled me to where I am. Thank you, mom, for being my role-model and always picking up your phone. You were a refreshing and familiar voice after a long

day. To my husband Brian, who basically earned 25% of this degree himself. Thank you for all your edits, for listening to each practice presentation, and managing 99% of the household responsibilities so I could focus on school. Thank you also to my cohort mates who have become some of my closest and dearest friends. This journey has been so special because of each one of you.

Table of Contents

Dedication	ii
Acknowledgements	iii
Table of Contents	v
Chapter 1: Introduction	1
Statement of the Problem	5
Guiding Theories	6
Theory of Planned Behavior	7
Mental Health Literacy	9
Quantitative Research Questions	11
Qualitative Research Questions	12
Chapter 2: Literature Review	14
Youth and Mental Health	14
Schools and Mental Health	15
Classroom Educators and School Mental Health	18
AmeriCorps Members as Classroom Educators	22
Factors that Impact Teachers Helping Youth with Mental Health Difficulties ..	25
A Brief Introduction to Culture and Education	33
Youth Mental Health First Aid	37
Chapter 3: Method	41
Participants	41
Author Standpoint	41
Procedures	42
Measures	44
Demographics, School Role, and Mental Health Experience	44
Mental Health Literacy	45
Intentions to Engage in Mental Health First Aid Behaviors	45
Engagement in Mental Health First Aid Helping Behaviors	46
Confidence in Providing Mental Health First Aid	47
Mental Health Stigma	47
Utility of the Youth Mental Health First Aid Program	48
Knowledge of School-Based Mental Health Providers and Resources	48
Open-Ended Questions for Qualitative Data	49
Data Analysis	49
Chapter 4: Quantitative Results	53
Quantitative Research Questions	53
Mental Health Stigma	53
Mental Health Literacy	54
Confidence in Providing Mental Health First Aid	55
Intentions to Engage in Mental Health First Aid Behaviors	55
Knowledge of School-Based Mental Health Providers and Resources	56
Engagement in Mental Health First Aid Helping Behaviors	57
Utility of the Youth Mental Health First Aid Program	57
Chapter 5: Qualitative Results	58

Qualitative Research Questions and Overview of Results	58
AmeriCorps Members' Perception of Benefits and Utility of Youth Mental Health First Aid	60
Knowledge and Skills to Respond	60
Awareness about Youth Mental Health	61
Recognition of Signs and Symptoms of Mental Illness.....	62
Course Content Delivered in Digestible Manner.....	62
AmeriCorps Members' Perceptions of Youth Mental Health First Aid to Meet the Needs of Culturally and Linguistically Diverse Students.....	62
Attitudes about Mental Health and Subsequent Actions Differ by Culture.....	63
Course Content and Delivery of the Youth Mental Health First Aid Training Program.....	64
Implicit Assumption that First Aider and Youth Speak Common Language.....	65
Challenges of the Program Not Explicit to Culture.....	65
Relevant and Versatile Action Plan	66
Mental Health Awareness and Stigma Related to Culture.....	66
Benefits of the Program not Explicitly Specific to Culture	66
Chapter 6: Discussion	67
Implications for Practice and Research.....	73
Schools/School Psychologists.....	73
AmeriCorps Programs	76
Youth Mental Health First Aid	78
Research/Future Directions.....	80
Limitations	83
Conclusion	85
Appendices.....	87
Appendix A: Data Collection Plan	87
Appendix B: Demographic Questionnaire.....	88
Appendix C: Mental Health Literacy.....	90
Appendix D: Intentions to Engage in Mental Health First Aid Behaviors and Scoring Rules	94
Appendix E: Engagement in Mental Health First Aid Helping Behaviors.....	96
Appendix F: Confidence in Providing Mental Health First Aid.....	97
Appendix G: Mental Health Stigma	98
Appendix H: Utility of the Youth Mental Health First Aid Program.....	99
Appendix I: School Mental Health Resources Scoring Guide.....	100
Appendix J: Open-Ended Questions.....	101
Tables.....	102
Table 1 Participant Demographics.....	102
Table 2 Teaching Characteristics.....	104
Table 3 Descriptive Statistics of Outcome Variables and Repeated Measure ANOVAs Assessing Change in Variables Over Time	105
Table 4 Descriptive Statistics for Engagement in MHFA Behaviors and Paired- Sample T-Tests Assessing Change Over Time.....	106
Table 5 Frequency of Acceptability Scale Responses	107

Table 6 Themes and Subthemes: AmeriCorps Members' Perception of Role-Specific Benefits of YMHFA	108
Table 7 Themes and Subthemes: AmeriCorps Members' Perception of YMHFA to Meet the Needs of Culturally and Linguistically Diverse Students.....	109
Figures.....	110
Figure 1 Participants' Involvement in Study	110
References.....	111

Chapter 1: Introduction

Up to fifty percent of youth experience a mental illness during childhood, with 20% suffering severe impairment (Merikangas, He, Brody, et al., 2010; Merikangas, He, Burstein, et al., 2010). Mental illnesses have severe consequences such as peer difficulty, truancy, poor academic achievement/dropout, and greater mortality (Druss et al., 2011; Egger et al., 2003; Gardner & Gerdes, 2015; Porche et al., 2011).

Alarmingly, suicide recently became the second leading cause of death among young people in the United States (Center for Disease Control and Prevention, 2017).

Difficulties associated with mental illness persist into adulthood and youth who experience mental illness are more likely to have marital instability, lower earnings, and worse psychological health (Goodman et al., 2011). Despite these concerning outcomes, only one third of youth in need of mental health treatment receive services (Merikangas et al., 2011). Even among those who do receive treatment, services are typically delayed at least nine years (ten Have et al., 2013). Taken together, youth mental health problems represent a major public health concern and there is a need for a greater emphasis on improving help-seeking as well as high-quality informal support.

Schools represent a critical place for efforts to enhance mental health access. Since all students attend school, schools have a unique opportunity to identify, reach, and support students with mental health needs. In fact, schools are the most common place for youth to access formal mental health services (Lyon et al., 2013), perhaps because they bypass many of the barriers families experience accessing community-

based care. For example, major barriers to community but not school-based care include long travel times, lack of financial means, and/or difficulty arranging transportation (Cauce et al., 2002). Compared to White students, racially and ethnically diverse students experience disproportionate barriers to community-based care (Cauce et al., 2002) and are more likely to have greater unmet mental health needs (Kataoka et al., 2002). This signifies an even greater need for school-based services because racially and ethnically diverse students and/or low-income students may receive school-based services at equivalent rates as other demographic groups (Lyon et al., 2013).

Not only are schools most likely to support students' mental health needs, they also provide services that are of similar effectiveness to non-school based services. A meta-analysis evaluating depression and anxiety treatments implemented in schools found schools to be as effective in delivering these interventions as other settings (Mychailyszyn et al., 2012). Students who receive school-based services are also likely to improve in their academics (Bruns et al., 2004). School-based mental health services are most likely to be facilitated by classroom educators who informally support students' mental health needs as well as initiate formal school-based services (Miller et al., 2015; Rickwood et al., 2007; Splett et al., 2018).

Although youth are able to self-refer for school-based services, they are unlikely to initiate formal treatment (Rickwood et al., 2007). Instead, youth are most likely to talk about their mental health experiences informally to friends and other adults such as school-based professionals (Colognori et al., 2012; Rickwood et al., 2007). Classroom educators, who are on the frontlines, are the most likely to

encounter students with mental health concerns because they are well-positioned to talk with students about their well-being and over-hear concerning conversations between friends. Classroom educators provide informal sources of support to promote mental health such as offering emotional support, teaching problem solving strategies, and implementing classroom-based interventions (Ross, 2019). In addition, educators can promote a positive school climate for students with mental illness which is beneficial since positive school climate promotes students' wellbeing (Ruus et al., 2007). Through formal (e.g., mental health curriculums delivered by teachers) and informal mechanisms, educators teach students mental health self-help strategies and enhance classroom and school efforts to promote student mental health (Kutcher et al., 2015; Ross, 2019). In addition, educators spend significant amounts of time with students each day, enabling them to provide mental health surveillance and recognize concerning changes in students' mood, behaviors, academics, and peer-relations. As a result, classroom educators provide basic mental health triage, and refer students to more specialized and formal treatment that is delivered by school mental health providers (Colognori et al., 2012; Rickwood et al., 2007; Splett et al., 2018). Teachers' role in mental health referrals is emphasized by data showing that the majority of students who receive school-based mental health services are initially referred to such services by teachers (Bruns et al., 2004; Dever et al., 2015). As a result, teachers are widely considered "gatekeepers" to accessing school based mental health support (Miller et al., 2015; Rickwood et al., 2007; Splett et al., 2018). Despite classroom educators' prominent role in providing both informal and formal sources of mental health support to students, educators indicate a lack of knowledge about

mental health and in their confidence in knowing how to support their students' mental health needs (Jorm et al., 2010; Rothi et al., 2008; Walter et al., 2006). They wish for more training to address these gaps (Moor et al., 2007), which could enable earlier treatment and strengthen their role in providing informal support.

Mental Health First Aid (MHFA), a program originally developed to train Australian lay people in basic mental health knowledge and to promote help-seeking, was recently transported to the United States where it has become more popular in recent years (Haggerty et al., 2019). Across the United States, 1.6 million people have received the eight-hour training in MHFA USA (*ALGEE-Ometer*, 2019). Since its inception, variants of the original training have been developed to better meet specific populations' needs. For example, Youth Mental Health First Aid (YMHFHA) is delivered to adults to enhance their ability to provide emotional support to youth, teach youth self-help strategies and to recognize, encourage and arrange formal mental health treatment for youth. Some school districts are training their entire staff in YMHFHA (*M-DCPS Creates Department of Mental Health*, 2018; Press Release Desk, 2019). Despite its prominence, limited research has evaluated the training. In fact, only four studies have assessed the USA version of YMHFHA in general, and only one study has been conducted exclusively with teachers (Gryglewicz et al., 2018). So far, research has demonstrated that YMHFHA improves trainees' mental health knowledge, attitudes about helping behaviors, and confidence in aiding youth needing support (Hadlaczky et al., 2014; Jorm et al., 2010; Kelly et al., 2011). However, its effects on reducing mental health stigma have been mixed (Haggerty et al., 2019; Hart et al., 2016; Svensson & Hansson, 2014), and its impact on actual

helping behaviors are not well understood. Further, scholars have not explicitly studied whether the program meets the needs of diverse youth. Although initial results are encouraging, additional research is warranted given the somewhat mixed results, lack of research on the program's cultural sustainability, and limited information about how it enhances classroom educators' ability to support students' mental health. Further, nontraditional classroom educators (e.g., AmeriCorps members, paraprofessionals, interventionists) are a substantially understudied population. No study has evaluated the effect of training nontraditional classroom educators in youth mental health. This is notable since nontraditional classroom educators have distinct backgrounds and roles compared to teachers but forge close one-on-one relationships with students and are uniquely positioned to promote students' mental health.

Statement of the Problem

Mental health concerns in young people represent a public health crisis, as evidenced by suicide becoming the second leading cause of death for young people, and 50% of youth experiencing a mental illness at some point during childhood. Schools and teachers are key to supporting youth mental health. Schools represent the most likely setting for youth to receive mental health services (Lyon et al., 2013) and classroom educators informally support students' mental health, implement formal interventions designed to enhance mental health, and refer students to formal school-based mental health services. (Dever et al., 2015). Despite this role, educators report a lack of confidence in their ability to support youth with mental health needs (Moor et al., 2007), little awareness about effective mental health interventions (Sciutto et al.,

2000), and limited knowledge about mental health in general (Moor et al., 2007). Most classroom educators acknowledge and accept their role in school mental health (e.g., referring for specialized services, offering informal support, teaching self-help strategies, delivering mental health curricula) (Reinke et al., 2011), although they feel unequipped to meet their students' needs. Youth Mental Health First Aid has emerged as a viable training program to educate adults on how to better support youth mental health. Despite the rising popularity of the program, limited research has investigated the value of training classroom educators in YMHFA. Additionally, AmeriCorps members, who are often classroom educators who work with some of the country's most under-served youth, are severely underrepresented in the education literature. Because of the prevalence and severity of youth mental health concerns, as well as educators' need and desire for more training, this research project aims to determine whether training in YMHFA is effective, relevant, and appropriate for AmeriCorps members who serve in classrooms in high-need areas. It also intends to contribute to the literature by using a mixed-methods design, specifically The Embedded Design (Creswell et al., 2003) to understand participants' perception regarding the challenges and benefits of using this program to meet the needs of culturally and linguistically diverse students.

Guiding Theories

This research is guided by the Theory of Planned Behavior (TPB) as well as mental health literacy. Mental health literacy is at the foundation of YMHFA's development.

Theory of Planned Behavior

Theorists have proposed various models to explain people's behavior. One of the most prominent and empirically supported is the Theory of Planned Behavior (TPB; Ajzen, 1985) which suggests that attitudes, subjective norms, and perceived behavioral control contribute towards one's intentions to engage in a behavior. Actual engagement in the behavior is impacted by both intentions and perceived behavioral control.

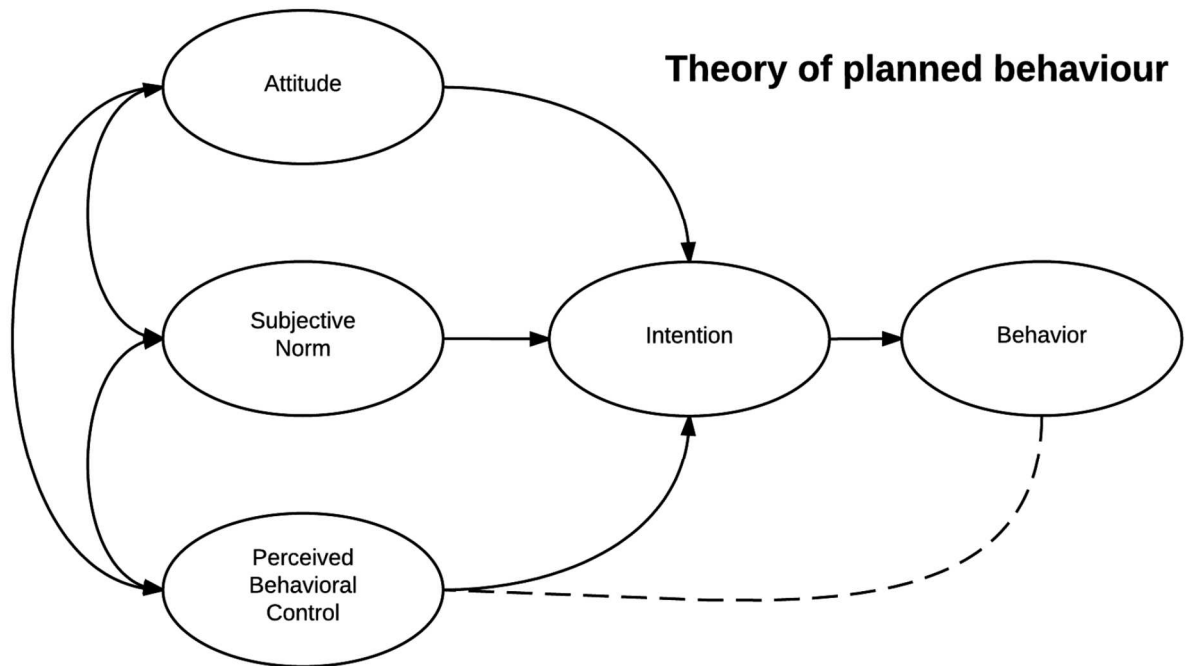


Figure 1. The Theory of Planned Behavior model.

The TPB model has been proposed to explain behaviors related to health (Godin & Kok, 1996) as well as mental health help-seeking (Smith et al., 2008). Meta-analyses find that the theory explains nearly 30% of the variance in behavior and almost 40% of the variance in intentions (Armitage & Conner, 2001).

With regards to mental health help-seeking and engagement in behaviors that promote mental health, the TPB is particularly relevant since it considers one's attitudes to be a prominent contributor towards engagement in a behavior. This is important since studies have demonstrated the importance of mental health stigma in mental health help-seeking (Vogel et al., 2006). Lower self-stigma is consistently related to greater intentions to seek help, and possibly even more so than psychological distress (Vogel et al., 2006). The application of the TPB to mental health has predominantly focused on adults' help-seeking behaviors for themselves. However, recent scholarship has utilized the theory, or extremely similar variants of the theory, to examine teachers' and other adults' engagement in behaviors that encourage help-seeking for adolescents (Banh et al., 2019; Gryglewicz et al., 2018). For example, a recent evaluation of the Youth Mental Health First Aid course for teachers utilized the TPB when they developed their measures to assess the course (Gryglewicz et al., 2018). They found that the course decreased teachers' negative attitudes about mental illness, increased their confidence in supporting youth with mental health needs, and increased the intentions of helping youth (Gryglewicz et al., 2018).

As Gryglewicz and colleagues' (2018) study suggests, the TPB can be utilized to explain how YMHFA evokes behavior change in its trainees, and therefore may contribute to improved mental health among youth. YMHFA equips trainees with an easy-to-remember mnemonic (ALGEE: **A**ssess for risk of suicide or harm; **L**isten nonjudgmentally; **G**ive reassurance; **E**ncourage self-help; **E**ncourage professional help) that serves to enhance their self-efficacy in supporting youth mental health

needs, thus giving them more perceived control over help-seeking behaviors. The course teaches ALGEE after educating trainees about prevalence rates of disorders as well as the signs and symptoms of common childhood mental illnesses (Jorm et al., 2010). Trainees are taught to apply this new knowledge when implementing the YMHFA first aid action plan. Additionally, improved knowledge about mental health is associated with more favorable mental health attitudes towards help-seeking (Jorm et al., 2010) and may also empower trainees with the control to implement first aid behaviors. YMHFA training is also expected to reduce aspects of mental health stigma (Hart et al., 2018; Jorm et al., 2010), which is an important component of the TPB (e.g., attitude). YMHFA emphasizes teaching appropriate sources of professional and self-help which leads trainees to have an enhanced understanding of appropriate help-seeking behaviors (Hadlaczky et al., 2014), which in turn leads to refined norms (component of TPB) around appropriate help-seeking behaviors. Taken together, a study of YMHFA should consider the TPB due to its strong empirical support and relevance to YMHFA.

Mental Health Literacy

When initially introduced, mental health literacy (MHL) was defined as the “knowledge and beliefs about mental disorders which aid their recognition, management, or prevention” (p. 182). Jorm and colleagues (1997) originally coined MHL in an effort to assist the general public in supporting and promoting mental health, given their lack of mental health specialization. Eventually, Jorm (2012) expanded the original definition, acknowledging that MHL is comprised of five

components: (a) knowledge pertaining to the prevention of mental illness, (b) ability to identify a disorder developing, (c) awareness of appropriate help (i.e., effective treatments and providers) (d) awareness of appropriate self-help strategies, and (e) ability to implement first aid skills to support someone experiencing mental health concerns or a mental health crisis. Kutcher, Wei, and Coniglio (2016) expanded this five-component construct, emphasizing that MHL also includes mental health stigma and information about positive mental health. Typically, individual components of MHL are evaluated in isolation, although limited literature exploring MHL from a holistic perspective has found higher MHL to be associated with more experience with mental health, greater intentions of help-seeking, and more actual help-seeking (Jung et al., 2016; O'Connor & Casey, 2015). Perhaps through increasing MHL, individuals become more likely to improve their mental health through engagement in behaviors that promote mental health.

As indicated earlier, the development of YMHFA was guided by MHL. The training starts by introducing trainees to general information about mental health such as prevalence rates, signs and symptoms, and risk and protective factors of common childhood disorders. The remainder of the training features an easy-to-remember mnemonic as discussed earlier (ALGEE: **A**ssess for risk of suicide or harm; **L**isten nonjudgmentally; **G**ive reassurance; **E**ncourage self-help; **E**ncourage professional help). For example, when the course covers the final two parts of ALGEE (encouraging self-help and professional help), trainees learn about appropriate types of self-help as well as people and treatments that constitute appropriate professional help for mental health concerns. Taken together, the theory of planned behavior and

mental health literacy serve as complementary theories/constructs that guide rationale for why YMHFA likely serves as an effective training program in enhancing AmeriCorps members' ability to support student mental health.

Quantitative Research Questions

1. Does Youth Mental Health First Aid reduce AmeriCorps education members' mental health stigma and improve their mental health literacy, confidence in helping behaviors, intentions to engage in mental health first aid behaviors, (Assess for risk of suicide or harm, Listen nonjudgmentally, Give reassurance, Encourage professional help, Encourage self-help strategies), and knowledge of school-based mental health providers and resources?

It is hypothesized that participation in YMHFA will decrease participants' stigma and improve participants' mental health literacy, confidence in helping behaviors, intentions to engage in mental health first aid behaviors, and knowledge of school-based mental health providers and resources. Most of these constructs have been improved following participation in YMHFA training and many have been evaluated in a study with teachers (Gryglewicz et al., 2018; Hadlaczky et al., 2014; Jorm et al., 2010). Although no research has looked specifically at knowledge of school-based mental health providers, other research has found trainees to be more aware of appropriate forms of professional help following participation in YMHFA training (Hart et al., 2016; Jorm et al., 2010).

2. If YMHFA is effective in reducing participants' stigma and increasing participants' mental health literacy, confidence in helping behaviors, intentions to engage in mental health first aid behaviors, and knowledge of school-based mental health providers and resources, are these benefits sustained two months later?

Previous longitudinal studies regarding the efficacy of YMHFA have found benefits of the training to be maintained (Haggerty et al., 2019; Rose et al., 2019). Therefore, it is expected that benefits acquired through participation of YMHFA will be sustained.

3. Do participants report engaging in more mental health first aid behaviors (Assess for risk of suicide or harm, Listen nonjudgmentally, Give reassurance, Encourage professional help, Encourage self-help strategies) in the two months after the training than in the two months before the training?

It is expected that classroom educators will engage in more MHFA behaviors after the training versus before. Hadlaczky et al. (2014) found that participants engaged in more helping behaviors after training.

Qualitative Research Questions

1. What are AmeriCorps members' perceptions of the benefits and utility of the YMHFA program?

2. What are the challenges and benefits of using this program to meet the needs of culturally and linguistically diverse students?

Chapter 2: Literature Review

Youth and Mental Health

Half of youth experience a mental illness at some point during adolescence, and 20% of youth are expected to experience one that causes severe impairment (Merikangas, He, Burstein, et al., 2010). Depression is particularly prevalent, with more than 10% of youth between 12 and 17 experiencing a major depressive episode in the last year (Merikangas, He, Burstein, et al., 2010). Further underscoring the magnitude of youth mental health concerns, suicide recently became the second leading cause of death among young people (Center for Disease Control and Prevention, 2017). Unfortunately, despite this sobering information, just one in three youth who meet criteria for a mental health disorder receive the mental health services they need (Merikangas et al., 2011; Merikangas, He, Brody, et al., 2010). Of those who do receive mental health services, the delay in treatment is typically about ten years, although it often extends longer (ten Have et al., 2013; Wang et al., 2005).

The delay or lack of treatment is consequential. Mental illness is associated with poor short and long-term outcomes such as higher rates of school dropout and peer difficulty as well as decreased quality of life (Druss et al., 2011; El-Badri & Mellso, 2007; Gardner & Gerdes, 2015; O'Connell et al., 2009; Porche et al., 2011). Negative outcomes are exacerbated when people spend more time untreated (O'Connell et al., 2009). The economic cost of mental illness to society is also large; spending on treatment related to mental illness tripled from the late 1980s until the early 2000s, and reached 100 billion dollars in 2003 (Mark et al., 2007). This number is substantial and does not even account for the indirect costs of mental illness, which

are estimated to be equal or greater than the direct costs (World Health Organization, 2003). Mental health prevention and even early intervention is hypothesized to reduce the economic costs of mental illness (Knapp et al., 2011).

In conclusion, the extant literature on youth mental health indicates that mental illnesses are highly prevalent in childhood, largely go untreated, and have severe consequences to both individuals and the greater society. In order to improve outcomes among youth experiencing mental health concerns, and to reduce the societal burden of mental illness, efforts must focus on increasing access to mental health treatment and support.

Schools and Mental Health

Schools have emerged as prominent settings for youth to receive mental health supports, a phenomenon at least partially driven by legislation but also reflective of youths contact with school systems. The President's New Freedom Commission on Mental Health (2003) noted schools as locations for mental health treatment and emphasized their potential to increase access to high quality mental health care. Since all students attend school, schools are an accessible place in which students with mental health needs can be identified and linked with services. In fact, schools are the most likely place for students to receive mental health services. For depression, students are 33% more likely to receive school-based services than specialty mental health services and four times more likely to receive school-based services than primary care services (Lyon et al., 2013). While some scholars have expressed concern about transporting interventions from clinics to schools, a meta-analysis found no difference in the effectiveness of depression and anxiety

interventions implemented in schools; additionally, there was no significant difference in outcome if a school-based provider versus a researcher implemented the intervention (Mychailyszyn et al., 2012). Though specialized treatments for mental illness are successfully implemented in schools and associated with improved mental health, attendance, and academic outcomes (Wade et al., 2008; Walker et al., 2010), they are not lauded for sustainability (Mychailyszyn et al., 2012). More sustainable approaches typically utilize teachers, who are on the frontlines, to implement prevention efforts and promote well-being (Cohen, 2006; Dix et al., 2012; Mychailyszyn et al., 2012). Taken together, schools are well-positioned to successfully address and reduce mental health concerns as well institute large-scale prevention efforts.

Although many students with mental health needs do not receive the services they need, racially/ethnically diverse students and/or low-income youth are even less likely than their White and/or affluent peers to receive mental health services (Cauce et al., 2002). Racially and ethnically diverse students are often disproportionately affected by providers' inflexible hours, transportation challenges, and lack of culturally competent providers (Cauce et al., 2002). Further, racially and ethnically diverse students are more likely to experience discrimination, poverty, and neighborhood violence (Evans & Kim, 2013; Milner & Laughter, 2015; Peterson & Krivo, 2009) resulting in more stress and mental health related difficulties. Increasing access to mental health services is critical. Schools, however, may offset some of the barriers that disproportionately affect youth of color. Typically, research on service utilization rates does not consider schools as a service setting. Lyon et al. (2013),

however, included schools in their service utilization study and found fewer youth with unmet needs in general. They also found evidence suggesting that racially/ethnically diverse and/or low-income students with depressive symptoms are equally as likely as their White and/or affluent peers to receive school-based services. This could suggest that barriers that disproportionately affect students of color in the community sphere may not be as prominent in schools. It is worth noting, however, that Lyon et al.'s (2013) study did not report on quality of mental health services received and reported significantly more missing data for students from diverse or low SES groups. Therefore, it remains uncertain whether schools are more likely to provide equitable mental health services to students of color than other settings. In fact, other work has found that mental health referral rates vary disproportionately based on student race (Guo et al., 2014). More specifically, Guo and colleagues (2014) found that teachers were more likely to refer Latino students than Asian students for SBMHS, even when controlling for externalizing symptoms, academic performance, and impairment. Taken together, it remains likely that racial and ethnic differences in referrals and service utilization persist in schools. However, some differences in service utilization rates may be less profound in schools versus the community because SBMHS reduce some of the barriers for seeking help (i.e., transportation challenges, high cost, long wait times, and limited hours).

Schools have established themselves as the most likely place for students with mental health needs to receive services (Burns et al., 1995). They are effective in delivering prevention programs that encourage well-being and reduce mental health concerns (Cook et al., 2015); they reduce symptoms of mental illness (Mychailyszyn

et al., 2012), improve academic outcomes among those with mental health concerns (Bruns et al., 2004), and possibly reduce barriers to services that disproportionately affect students of color and/or students with fewer financial means (Lyon et al., 2013). Before students can receive mental health services in the school, they must be identified and recommended for supports. Although parents can request evaluations, and students can self-refer for mental health services, the most likely route for students to receive assistance is through a teacher's mental health referral. Teachers also play a prominent role in promoting school mental health, especially among students not receiving specialized care.

Classroom Educators and School Mental Health

In the school setting, classroom educators are instrumental in promoting mental health among students and in implementing prevention and intervention efforts because they are “in a natural position to carry out informal surveillance, detection, and assistance for those in need” (Cross et al., 2007). Classroom educators forge close relationships with students and are uniquely situated to observe changes in academics, social relationships, behavior, mood, and overall functioning. Therefore, I start by reviewing the existing scholarship on classroom educators' role in school mental health. Much of the literature about classroom educators and mental health focuses on traditional classroom teachers, which is therefore what I reference most often. However, since this study focuses on a unique subset of classroom educators (AmeriCorps members) who have different backgrounds and classroom roles than teachers, I also integrate information about other types of classroom educators. Then, I describe the role and background of AmeriCorps members more specifically.

Traditionally, teachers' role in school mental health has been to serve as "gatekeepers" for mental health services (Miller et al., 2015; Rickwood, Deane, & Wilson, 2007; Splett et al., 2018, Williams, Horvath, Wei, Van Dorn, & Jonson-Reid, 2007). In the school setting, teachers are the most likely reason for a student to have obtained specialty mental health services (Bruns et al., 2004; Dever et al., 2015); greater than 50% of teachers are estimated to have made a referral for emotional or behavioral problems compared to around 30% of non-teachers (Bruns et al., 2004). Teachers act as gatekeepers by completing questionnaires/screeners that flag students with elevated risk and by directly referring students to school mental health providers after recognizing concerning symptoms. Efforts to enhance teachers' capacity to facilitate formal treatment and recommend appropriate services has resulted in mental health training for teachers (Cunningham & Suldo, 2014; Gryglewicz et al., 2018). In schools, teachers are the most likely professional to refer students to formal school-based mental health services.

Over the last two decades, paradigm shifts caused by the emergence of multi-tiered systems of support (MTSS; e.g., PBIS and RTI) have extended teachers' role in school mental health prevention efforts. Universal prevention efforts delivered as components of MTSS models are typically led by teachers. These efforts often include social emotional curricula implemented by teachers in the general education setting (Arora et al., 2019). Social-emotional curricula led by teachers promote student mental health (Cook et al., 2015) and mitigate the risk of developing mental health difficulties (Corrieri et al., 2014). For example, Positive Action, a social-emotional learning (SEL) program led by teachers was found to reduce future

depressive and anxiety symptoms among low-income urban youth (Lewis et al., 2013). Teachers also implement prevention programs that directly instruct students on mental health. The Mental Health and High School Curriculum Guide, for example, is taught by general education teachers and related to improvements in students' attitudes towards mental illness and mental health knowledge (Kutcher, Wei, & Morgan, 2015). However, teachers' involvement in efforts specifically teaching mental health (e.g., the Mental Health and High School Curriculum Guide) tend to be less common than their involvement implementing social emotional curricula, which often touch on mental health though they are not typically as explicit.

Teachers and paraprofessionals have a notable role in delivering mental health interventions; Wilson, Lipsey, and Derzon (2003) argue that most successful interventions include teachers. This makes sense since teachers are active in 40% of interventions and the sole implementer in 20% (Franklin et al., 2012). Similarly, one of the primary responsibilities of paraprofessionals (another type of classroom educator) is to implement individual and group behavioral interventions for students with disabilities (Reddy, 2019). Sometimes both teachers and paraprofessionals' roles include implementing mental health interventions independent of other school professionals (e.g., Daily Report Cards), while at other times they partner with specialty mental health providers. For example, teachers are sometimes integrated into student counseling sessions with school mental health experts (Berzin et al., 2011). In certain circumstances, teachers may be equally as effective as specialty mental health providers when implementing interventions (Franklin et al., 2012). Franklin et al. (2012) made this assertion after comparing effect sizes of teacher-led

interventions to effect sizes of specialty provider-led interventions; they found no differences in effect size based on provider. However, comparisons were not made using identical interventions, so while teachers are not specialty providers, they likely are able to deliver certain interventions that are within their scope of practice. Taken together, there is substantial evidence indicating the value of utilizing teachers and paraprofessionals in school mental health.

In addition to teachers' roles in formal school mental health efforts, classroom educators also provide informal services (Ross, 2019) until specialized help becomes available or is needed. Teachers are positioned to build strong one-on-one relationships with students which may help students feel more comfortable disclosing mental health concerns (Buchholz et al., 2015). Further, classroom educators informally support students' emotional well-being through the teaching of mental health problem solving and self-help techniques (Ross, 2019).

Teachers' informal and formal involvement in school mental health spans the gamut from prevention to intervention services. While teachers are most commonly considered when addressing classroom educators' role in school mental health, nontraditional classroom educators have a prominent part in educating a substantial portion of America's youth, yet they are severely understudied. Therefore, in order to familiarize the reader with the specific type of classroom educator to be studied, I provide an overview of who AmeriCorps members are and what role they serve in education.

AmeriCorps Members as Classroom Educators

Since 1994, over one-million adults have committed to a year of national service through AmeriCorps (*National Service Strengthens Education*, 2017). They have served at fifty-thousand sites, many of which are in education, and have supported millions of school-aged youth, many of whom live in vulnerable, high-need communities (*National Service Strengthens Education*, 2017). In fact, one in four low-performing schools receives support from AmeriCorps members, typically through teaching, tutoring, or general programming (*National Service Strengthens Education*, 2017). While the Corporation for National and Community Service's (CNCS) budget supports a variety of sectors, more than 50% is devoted to education related issues (*National Service Strengthens Education*, 2017). A Columbia University study highlighted the return on investment in AmeriCorps programs, arguing that for every one-dollar spent on AmeriCorps education programming, there is a future four-dollar savings (Belfield, 2013). One particular AmeriCorps program called City Year has saved the government an estimated seven million dollars (Sum et al., 2009). In addition, schools with City Year corps members are two times more likely than similar schools without City Year to improve their English state assessments scores, and three times more likely to improve their math state assessments scores (*Annual Report | City Year*, 2018).

In addition to AmeriCorps members' presence in high-need communities, participation in AmeriCorps programs acts as a pipeline to careers in education (*National Service Strengthens Education*, 2017); half of AmeriCorps alumni in City Year work in education and 16% work as teachers (*Annual Report | City Year*, 2018).

Additionally, a corps member who stays in education following service with AmeriCorps is more likely to be a person of color than the average American teacher. This suggests that AmeriCorps programs facilitate greater representation of people of color within education (*Annual Report | City Year, 2018*). The teacher pipeline AmeriCorps has created is also notable because high-need areas face severe teacher shortages and are left unable to fill teaching positions (Howard, 2003). AmeriCorps members are younger than the average educator; to be eligible for AmeriCorps National Civilian Community Corps, one must have completed high school and be between the ages of 18 and 26. Most frequently, AmeriCorps members are post-college graduates or have some higher education experience. Despite many corps members possessing a bachelor's degree, many do not receive extensive training in education or a mental health related field prior to service with AmeriCorps. Thus, although corps members often continue their career into education, and serve in settings similar or identical to traditional teachers, they typically do not have the four-years of training on child development and education as do traditional teachers. Additionally, although AmeriCorps members tend to be more diverse than the general teaching population, almost half are White (Cooperation for National and Community Service, 2018) despite being most likely to work in communities that are predominantly communities of color. Therefore, AmeriCorps members are not only new to education but also often unfamiliar with the communities in which they serve. This has emerged as a criticism of AmeriCorps programs. White corps members, in particular, are often drawn to national service to “make a difference” or to “give back.” Underneath the feel-good phrase is often a veiled or implicit desire to “save”

the youth (typically students of color) that they will work with. Teju Cole coined this phenomenon ‘White Saviorism,’ and it is marked by White people’s desire to “help” people of color coupled with a lack of understanding of White privilege and the oppressive systems in which White people maintain (Cole, 2012). Therefore, White people’s participation in AmeriCorps necessitates a critical understanding of White identity and engagement in the promotion of culturally responsive pedagogy (see section A Brief Introduction to Culture and Education for brief discussion). Thus, it is important to understand the professional and cultural background of AmeriCorps members working in education. This goes beyond the scope of the current study so this review provides a brief overview, although future work should address this more specifically.

While many subsidiaries of AmeriCorps focus on education, City Year is one that places thousands of young adults in inner-city schools across 29 U.S. cities each year. Corps members work in Title 1 schools and ninety percent of the students that City Year serves are students of color and/or eligible for Free and Reduced Meals (*Annual Report | City Year, 2018*). City Year’s main mission is to reduce the dropout crisis, disrupt the school-to-prison pipeline, promote life-long learning, and mitigate the systemic injustices that disproportionately affect students of color and/or children who live in neighborhoods of concentrated poverty. Unfortunately, youth living in areas of concentrated poverty are 22% less likely to complete high school (*Annual Report | City Year, 2018*).

City Year corps members partner full-time with classroom teachers to provide whole-class support, and they also lead small-group interventions for children

identified as having underdeveloped proficiency in English Language Arts or Math. Corps members provide small-group attendance supports and behavioral interventions for children requiring additional services. Corps members tend to be younger than classroom teachers, allowing them to forge near-peer relationships with students, often leading to stronger bonds. Corps members' role in providing whole-class support allows them to step out of the classroom and address crises while teachers continue delivering whole-class instruction. Since they also provide small-group and one-on-one interventions to students struggling with reading, math, attendance, or behavior, they are likely to become aware of students' mental health needs. Thus, in addition to corps members' ability to develop near-peer relationships with students due to their younger age, corps members are often uniquely positioned to recognize and address mental health crises in students. Therefore, it is essential to understand the factors that facilitate and hinder corps members' ability to support students' mental health needs. Since nontraditional educators like corps members are understudied in the literature, and teachers most closely resemble corps members, the upcoming review focuses on factors that impact teachers' role in school mental health.

Factors that Impact Teachers Helping Youth with Mental Health Difficulties

It is important to understand factors contributing to classroom educators' ability to fulfill their role in school mental health. Therefore, in this section, I review facets scholars have identified as contributors to how classroom educators fulfill their role within the school mental health context. First of all, classroom educators need a stronger command of mental health knowledge. This is necessary for functioning as

gatekeepers as well as for implementers of prevention, promotion, and intervention programs. However, there is a need to address more than merely teachers' mental health knowledge. Jorm and colleagues proposed mental health literacy (MHL) to expand conceptualizations of the factors promoting mental health. When initially introduced, MHL was defined as the "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" (p. 182). Kutcher, Wei, and Coniglio (2016) noted that MHL also includes "understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy (knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management capabilities" (p.155). Limited literature looks at mental health literacy as a comprehensive construct, instead focusing on individual components of MHL. Therefore, I discuss aspects of MHL one-by-one that are likely to impact educators' roles in school mental health.

Attitudes towards mental health treatment. By and large, teachers believe in mental health treatment for students. They acknowledge and accept schools as a place for mental health treatment (Walter et al., 2006) and are more likely than school-based mental health providers to believe schools have a responsibility to provide certain types of mental health treatment (Rothì et al., 2008). Teachers with prior exposure or experience in childhood mental health acknowledge the value of treatment and support teachers' engagement in behaviors that promote help-seeking (Ford & Nikapota, 2000); teachers believe it is essential they know where to refer a student with mental health problems (Rothì et al., 2008). Positive attitudes towards

treatment are also likely to be impacted by teachers' perception of a problem (Rothì et al., 2008). When teachers perceive a problem, they are more likely to possess positive attitudes about help, and more likely to engage in behaviors that support help-seeking. Unfortunately, teachers believe that most students with mental health difficulties are overlooked and not referred for treatment (Rothì et al., 2008). This suspicion is supported by evidence that teachers perceive depression as less problematic/serious, than school mental health providers (Repie, 2005). Further, teachers are more likely to believe students with externalizing problems are in need of help than are students with internalizing difficulties (Williams et al., 2007). Unfortunately, when teachers do not perceive a problem, they are less likely to personally help the student in need and refer them to SBMHS. Teachers' misperceptions about the severity of depression and overlooked symptoms of internalizing disorders are likely impacted by teachers' mental health knowledge. Therefore, I next provide an overview of teachers' knowledge about mental health.

Knowledge of mental health symptoms. Although teachers acknowledge a role in promoting students' well-being/mental health (Roeser & Midgley, 1997; Rothì et al., 2008), they recognize their limited mental health knowledge (Walter et al., 2006). They do not receive mental health training in pre-service programs (Koller et al., 2004) and call on local education agencies to fill the gaps through on-the-job training (Rothì et al., 2008). Further, paraprofessionals tend to have lower levels of education than teachers, and also receive little to no on-the-job training or supervision (Reddy, 2019). Highlighting the impact of classroom educators' limited mental health knowledge, inner-city teachers list a lack of mental health knowledge and limited

training as the number one barrier obstructing them from being able to fulfill their role (Walter et al., 2006).

Researchers have also investigated teachers' actual mental health knowledge (as opposed to their perception of knowledge). Scholars primarily take one of three approaches to determine teachers' actual mental health knowledge. The most common method involves asking teachers to respond to vignettes depicting students with mental illness. Another approach assesses teachers' performance on mental health questionnaires. The only in-vivo technique for assessing mental health knowledge compares teachers' ability to identify mental health symptoms in students in comparison to students' self-report of their symptoms.

Vignettes depicting people with mental illness are widely used across the literature. They are written to emphasize common symptoms associated with a given disorder (Jorm et al., 2007). Scholars use vignettes to determine whether individuals recognize disorders and accurately perceive varying levels of distress. By and large, these studies suggest that teachers recognize clinical problems and make appropriate distinctions between levels of distress (Loades & Mastroyannopoulou, 2010; Percy et al., 1993). However, gender differences emerge; teachers have greater difficulty identifying behavioral disorders in girls and separation anxiety in boys than they do in identifying behavioral disorders in boys and separation anxiety in girls, respectively (Loades & Mastroyannopoulou, 2010). Percy et al. (1993)'s vignette study also inquired about real-life students resembling characters depicted in the vignettes. Teachers claimed they would be less inclined to write a mental health referral for real-life students with more severe internalizing problems than they would be to write

mental health referrals for students with fewer internalizing concerns. This may suggest that teachers struggle to transfer knowledge from vignettes to real-life; alternatively, real-life students with severe internalizing symptoms may be more withdrawn and therefore more easily overlooked by teachers. Taken together, vignette studies indicate that teachers may have a basic knowledge of the signs and symptoms of mental illness, though they likely lack a deeper and more nuanced understanding that could directly impact whether students receive access to school mental health care.

Teachers' knowledge is also assessed through questionnaires. One group of scholars used a mental health knowledge measure to compare veteran teachers' knowledge to less-experienced teachers' knowledge. Overall, teachers averaged a 65% on the knowledge measure, indicating substantial gaps (Walter et al., 2006). Scores were lower among teachers with less experience and less education, underscoring the importance of professional development initiatives for new teachers. When mental health knowledge instruments are administered to assess training effects, trainees typically score in the 50% range before training and improve their scores on post-tests (Jorm et al., 2010). Knowledge measures indicate that teachers do not have adequate mental health knowledge, although they are often used to demonstrate the benefits of trainings.

Little scholarship has investigated the application of mental health knowledge to real-life scenarios. Cunningham and Suldo (2010) conducted one of the first evaluations in the United States and asked teachers to identify students suspected of experiencing mental health problems. Students were given self-report screens for

depression and anxiety, and students with elevated scores completed a clinical interview. Unfortunately, only 50% of students with depression and 41% with anxiety were identified by teachers. A similar study in Australia found that among 361 students recruited for a treatment using teacher nomination and/or student self-report, only 33 were flagged by both a teacher and their score on the self-report screen (Dadds et al., 1997). Discrepancies between students flagged by teachers and their scores on self-report screeners likely indicates limited mental health knowledge.

Teachers' mental health knowledge assessed through vignettes, questionnaires, and in real-life scenarios aligns with their perception of their knowledge; teachers' mental health knowledge is limited, they are aware of it, and they desire more training to fill the gaps.

Stigma and mental disorders. Stigma, in relation to mental illness, has been defined as “a collection of negative attitudes, beliefs, thoughts, and behaviors that influences the individual, or the general public, to fear, reject, avoid, be prejudiced, and discriminate against people with mental disorders” (Gary, 2005, p. 980). Stigma takes many forms and is a major predictor of help-seeking (Clement et al., 2015). Self-stigma, or internalized stigma, refers to one's internalization of the public's negative attitudes about mental illness (Clement et al., 2015); perceived stigma reflects one's thoughts about other people's negative attitudes towards those with mental health concerns.

The relationship between teachers' stigma and student mental health is not well understood. However, evidence suggests teachers' stigma impacts student mental health or at least their help-seeking. Self-stigma is a significant barrier to help-

seeking behaviors (Vogel, Wade, & Haake, 2006), but in adolescence, youth are more likely to get referred for services by an adult than to self-refer (Dever et al., 2015). One reason youth may abstain from self-referring could be due to perceived stigma (Chandra & Minkovitz, 2006), which is why classrooms have been noted as ideal settings to introduce stigma reduction interventions (Meldrum et al., 2009). When youth perceive teachers and other school personnel to have low mental health stigma, youth may be more inclined to disclose mental health difficulties, setting them on a trajectory for earlier treatment and greater service utilization. Alternatively, teachers' perceived stigma may also impact teachers' engagement in behaviors that promote help-seeking for their students. For example, some teachers may not seek help for students they are concerned about because of fear that students will become stigmatized when labeled with a mental illness (Rothì et al., 2008). This could reduce the chance that teachers seek help for students they are concerned about.

Unfortunately, students with a diagnosed mental illness view school as a complicated place with regards to stigma (Chandra & Minkovitz, 2007). Some students encounter supportive teachers who encourage help-seeking, while others find teachers' comments to exacerbate mental health stigma (Chandra & Minkovitz, 2007; Moses, 2010). This complicated phenomenon is also noted by teachers who acknowledge that teachers sometimes use language that stigmatizes youth mental illness (Rothì et al., 2008). Taken together, teachers' attitudes about mental health, or at least what they project, appears to have the potential to facilitate treatment. Assessing and reducing teachers' stigma towards mental illness is an important component in the promotion of school mental health efforts.

Self-efficacy around supporting students' mental health. Research has shown that teachers perceive a lack of confidence and self-efficacy in supporting students' mental health. They are insecure about their ability to talk with students about mental health problems (Jorm et al., 2010) and they feel unable to manage students' mental health needs in the classroom (Walter et al., 2006). For example, on a scale from one (not at all confident) to three (very confident), 119 teachers from urban schools averaged a 1.82 when describing their confidence in managing students' mental health problems in the classroom (Walter et al., 2006). Also, they feel helpless in implementing strategies that do not punish or discipline students for mental health difficulties (Rothì et al., 2008). Unfortunately, this substantial lack of confidence has impactful consequences. When teachers have lower self-efficacy, they perceive their role in supporting students' mental health to be more burdensome (Roeser & Midgley, 1997) and they are less willing to implement interventions (Han & Weiss, 2005). Teachers from urban areas are most likely to bear the brunt of low self-efficacy, as they are also most likely to feel overburdened by student mental health problems (Roeser & Midgley, 1997).

Despite the discouraging information about teachers' lack of confidence in supporting students' mental health, encouraging scholarship exists on benefits obtained through mental health professional development trainings. Training increases teachers' confidence in helping their students. For example, it equips teachers with the confidence to recognize a students' suicidal verbalizations, take them seriously, and then refer them to appropriate services (Davidson, 1999). Further, when teachers have more self-efficacy, they are more likely to view supporting

students' mental health as part of their role (Roeser & Midgley, 1997). Taken together, across MHL domains, there is substantial evidence that suggests teachers require, want, and can benefit from mental health training.

A Brief Introduction to Culture and Education

Youth of color, and particularly Black students, are disproportionately represented in office disciplinary referrals, disciplinary/exclusionary practices, and special education under the classification category of emotional disability (Skiba et al., 2011). These disproportionate exclusionary practices have grave implications for the school-to-prison pipeline as well as academic outcomes (i.e., known as the academic achievement gap) (Annamma et al., 2014; Skiba et al., 2014). Some have postulated that disproportionality and the achievement gap can be remedied, at least in part, by reducing teacher bias and moving away from harsh behavior management practices and towards greater utilization of mental health resources versus special education. Therefore, investing in mental health and implicit bias training for teachers and mental health programming for students, combined with a divestment in punitive approaches is hypothesized to disrupt the school-to-prison pipeline. In fact, some work suggests that office disciplinary referrals (ODRs) are reduced after educators complete a program aimed at improving relationships between teachers and students of color (Gregory et al., 2015). At the same time, scholars acknowledge that efforts such as implicit bias trainings, adoption of PBIS, and expansion of mental health programming are more frequently pursued than systems level interventions at the national level that explicitly address racism (i.e., government policies) (Anyon et al., 2018). Efforts that neglect the systems level efforts fall short in addressing the systemic racism and other forms of oppression that are at the foundation of the achievement gap. Thus, it is worth noting that

efforts focusing solely on individual efforts (i.e., a school adopting PBIS or training their teachers to refer students for mental health services instead of for disciplinary action) are insufficient and can be used to distract from the systems level forces of oppression and racism that maintain the status quo of disproportionate representation (Sleeter, 2012). Sleeter (2012) emphasizes that “substituting cultural for political analysis involves maintaining silence about the conditions of racism and other forms of oppression that underlie achievement gaps and alienation from school, assuming that attending to culture alone will bring about equity (p. 571).” Studies within education support this assertion that adoption of PBIS programs do not reduce disproportionate representation of students of color in exclusionary practices, for example (Vincent et al., 2015), possibly because PBIS does not directly address racism within the school system. These findings indicate that expansion of school mental health, contraction of punitive practices, and greater anti-bias efforts are necessary, but these cannot be touted as the fix-all to addressing disproportionality in schools. Systems level issues related to systematic oppression (i.e., less funding and less experienced teachers being concentrated in racially segregated urban areas) must be addressed simultaneously. Lewis and colleagues (2008) note that disparities are a result of a “web of interrelated impediments”— ideologies, practices, and policies—“that are actively and passively undermining widespread academic excellence among African Americans attending urban schools (p. 148)”.

While systems-level interventions that target racist policies and practices are necessary, this study focuses on an intervention designed to help adults (i.e., classroom educators) support youth mental health among a diverse sample of educators as well as youth they serve. Youth mental health difficulties are real,

serious, and affect all students. Training educators in youth mental health is important and desired, but it is imperative these professional development efforts include discussions about race and culture. For example, adults (educators, in this case) who celebrate culture and multilingualism in their work build protective factors in youth that support mental well-being (Brown, 2008). On the other hand, racism and discrimination are linked to depressive symptoms. Thus, ignoring the impact oppression has on mental health is misguided (Anyon et al., 2018). Gloria Ladson Billings (1995) coined the term culturally relevant pedagogy to represent the “ability to develop students academically, a willingness to nurture and support cultural competence, and the development of a sociopolitical or critical consciousness” (p. 481). She conceptualized the term to be comprised of three dimensions, which other scholars have coined the institutional, personal, and instructional domains (Richards et al., 2007). Richards and colleagues (2007) stated that the personal dimension refers to the cognitive and emotional processes that teachers engage in with their students when aspiring to be culturally competent. It is necessary for educators to acknowledge their own attitudes and beliefs about themselves and others to begin to do the work of confronting their biases (Villegas & Lucas, 2002). Recently, the term culturally sustaining pedagogy has emerged as the 2.0 version to culturally relevant pedagogy. Paris and Alim (2014) acknowledge that culturally sustaining pedagogy (CSP) “has as its explicit goal supporting multilingualism and multiculturalism in practice and perspective for students and teachers. CSP seeks to perpetuate and foster—to sustain—linguistic, literate, and cultural pluralism as part of the democratic project of schooling and as a needed response to demographic and social change”

(Paris & Alim, 2014, p. 88). CSP therefore is a means through which to recognize, support, and sustain the culture of students of color. Thus, culturally sustaining pedagogy is important when teaching math, but it is also important within the realm of mental health.

Scholars and professional organizations have emphasized the need for greater attention devoted to cultural competence and multiculturalism within the field of psychology. More specifically, the American Psychological Association (APA, 2017) calls on psychologists to use an ecological approach that acknowledges the dynamic nature of identity, the social structures and relationships through which identity and attitudes/beliefs are formed, and more. These guidelines expect psychologists to understand issues of power, privilege, and oppression and to engage in efforts that combat these harmful systems. Individual psychologists, researchers, and policies have a role in propelling the field towards providing culturally competent care. At the individual level, psychologists should focus on self-awareness and consider the ways in which their biases, privileges, values, and beliefs impact their practice. Soto and colleagues (2018) emphasize the need for therapists to strive for cultural competence and assert that cultural competence is comprised of cultural awareness, cultural knowledge, and cultural skills. Soto and colleagues (2018) define these terms, stating that:

cultural awareness refers to therapists' ability to recognize the cultural background of themselves and their clients, including assumptions and biases that influence the process of psychotherapy with diverse clientele. Cultural knowledge refers to therapists' understanding of specific cultural groups, their norms, and unique experience...as well as the ways in which historical forms of oppression continue to impact the assumptions of psychotherapy. Finally, cultural skills refer to therapists' "ability to actively engage diverse clientele and to modify assessment or treatment methods to better match the cultural needs of clients (p. 1908).

With regards to policies, professional organizations and psychologists should emphasize organizational change practices in the development and lobbying of policies that are culturally informed and address the long history of oppression and harm that has been done to communities of color. From a research perspective, APA calls for research that centers culture and ethics. Thus far, research indicates that adapting interventions to the population they serve can be effective and appropriate (Castro-Olivo & Merrell, 2012) but more work is necessary. The field requires continued emphasis on identifying whether a mental health intervention is culturally responsive and what it means for it to be culturally responsive (Castro-Olivo, 2017). This study seeks to understand the ways in which Youth Mental Health First Aid, the intervention being studied, does and does not meet the needs of culturally and linguistically diverse youth.

Youth Mental Health First Aid

Approximately two decades ago, Anthony Jorm and Betty Kitchener developed a Mental Health First Aid course in Australia. The course was intended to educate, spread awareness, and equip the public with tools to address everyday mental health concerns that they encountered. Since the initial development of the course, Mental Health First Aid (MHFA) has been transported to the United States where 1.6 million have been trained thus far (*ALGEE-Ometer*, 2019). Various versions of the course have been created and devote specialized attention to either youth or adults. For example, adults in America can receive Mental Health First Aid certification to support other adults, or they can receive certification in Youth Mental Health First Aid to support youth. A new program is being evaluated to train youth to assist other youth in the U.S. (Teen MHFA). Educators, who work extensively with

youth, are strong candidates for Youth Mental Health First Aid (YMHFA) training because they indicate inadequate preparation to address student mental health concerns. At the time of the study, the USA version of YMHFA was 8-hours and designed specifically for adults who work frequently with children; training equips adults to recognize and intervene in early mental health problems or to provide emergency aid during crisis situations until professional help arrives or is acquired. Before YMHFA became publicly available, it underwent preliminary evaluation and has continued to be studied since. Therefore, I will review what is known about the effects of YMHFA as well as highlight areas in which more evaluation is necessary, specifically pertaining to how YMHFA impacts classroom educators.

Classroom educators are interested in better meeting their students' mental health needs (Reinke et al., 2011) and many school systems in the United States are turning to YMHFA to assist educators in supporting their students' mental health (*M-DCPS Creates Department of Mental Health*, 2018; Press Release Desk, 2019). Despite the rising prevalence of YMHFA in schools, to my knowledge, only one study has evaluated the effects of training educators in the USA version of YMHFA (Gryglewicz et al., 2018). Further, only one other study evaluating the effects of training teachers in YMHFA has been conducted, and it was done in Australia using the Australian version of YMHFA (Jorm et al., 2010). Therefore, this review focuses on the effects of YMHFA in general while emphasizing studies of YMHFA conducted with educators.

Evaluations of the USA version of YMHFA show that the program is generally effective across a range of constructs, although its effect on stigma remains

unknown. Results have been unclear (Haggerty et al., 2019; Hart et al., 2016; Svensson & Hansson, 2014) but since stigma is an important component of actual help-seeking, understanding whether it is impacted by YMHFA training is essential. Other research on YMHFA, however, suggests that training improves trainees' mental health literacy, attitudes about helping behaviors, and confidence in providing assistance to youth needing help (Hadlaczky et al., 2014; Jorm et al., 2010; Kelly et al., 2007). Despite these positive outcomes, improvements in mental health literacy appear limited among those with prior mental health training experience (Haggerty et al., 2019). For example, specialty mental health providers did not improve their mental health literacy. This may be due ceiling effects since those with prior training already have high MHL, and there is limited room for improvement. No research has evaluated whether this extends to classroom educators who may have received some mental health training. Training also equips participants with greater comfort and confidence in providing assistance; trainees learn an easy-to-remember acronym to apply when helping. However, limited research, and none in the United States, has evaluated whether YMHFA training leads to actual changes in behavior. In Australia, Kelly et al. (2011) found that participants who completed YMHFA training were more likely to report engaging in helping behaviors. Another study conducted in Australia determined that teachers who received training were more likely to endorse school policies that advance dialogue pertaining to mental health and support youth with mental health difficulties (Jorm et al., 2010). While these findings are encouraging, only one study has been conducted with classroom educators in the United States using the YMHFA training course. Post-training, teachers experienced

greater mental health literacy, higher self-efficacy in providing assistance, and expressed more intentions of helping a youth with a mental health difficulty (Gryglewicz et al., 2018).

Taken together, the literature on the application of the USA version of YMHFA is insufficient in general and also as it pertains to the benefits afforded to classroom educators. Few studies have conducted follow-ups, leaving uncertainty in whether benefits acquired from the training are maintained. Additionally, no research in the USA has evaluated whether YMHFA helps educators support their students' mental health needs. More specifically, questions regarding whether YMHFA supports teachers in meeting diverse students' mental health needs remain unanswered. Despite the rising prevalence of YMHFA, additional scholarship is necessary to determine its appropriateness and benefits afforded to educators.

Chapter 3: Method

Participants

Participants were 106 City Year Miami AmeriCorps members who served during the 2019-2020 academic year. Participants were predominantly women (79%, 15% men, 5% unknown, and 0.9% nonbinary), whose average age was 22 (SD = 1.9). Fifty-nine percent of participants identified as Black or African American, 21% as Latinx, 6% White, 4% Asian, 3% multiracial and/or multiethnic, and 5% unknown. All participants were high school/GED graduates and most participants had completed a bachelor's degree (57%). Participants were most likely to have completed a degree in the Liberal Arts (22%) or Psychology (16%).

All participants were working in a Title I Miami public school at the time of the study. Sixty percent were placed in a high school and 30% were placed in a middle school. About half taught English Language Arts, 40% taught Math, and another 10% did not report. See tables 1 and 2 for demographic information. All City Year Miami corps members were required to participate in the Youth Mental Health First Aid training, although participation in the research study was optional and could be withdrawn at any point (See figure 2 regarding retention). Participants were incentivized to participate in the study using entries into a raffle to win a \$20 gift card. Participants also received a \$5 gift card for completing the follow-up survey.

Author Standpoint

My passion for this topic comes, in part, from my prior experience as an AmeriCorps member with the organization involved in the study. My interest is also derived from a desire for schools to better meet the mental health needs of children,

particularly for those who are likely to experience greater barriers accessing mental health services within the community. I identify as a White, cisgender, straight woman and was raised in a predominantly White suburban, college town in the mid-Atlantic region. These aspects of my identity likely contributed to how I conceptualized the data. Notably, the majority of participants came from different cultural, racial, and ethnic backgrounds than my own. To reduce bias in the current study, experts in qualitative research design helped brainstorm questions for participants. Data were coded and themes generated by two coders (myself and another PhD student who is a White woman). To offer a different cultural perspective, two PhD level Asian American women also reviewed the data and offered insight into codes and themes. Finally, I attempted to triangulate the qualitative data and quantitative data.

Procedures

The Youth Mental Health First Aid course was delivered five times over a one-week span in October. Each class contained at least twelve people and no more than thirty. All courses were delivered by one or two certified YMHFA instructors. One instructor regularly delivers mental health training in Miami Dade County, Florida, and the other two instructors are advanced doctoral students in school psychology who conducted training as part of this dissertation. All five of the training cohorts received the eight-hour course over a one-day span. Participants were provided mental health resources and opportunities to talk with a trained instructor during or after the training.

All instructors closely followed the instructor manual and PowerPoint during delivery of the training. YMHFA training is structured such that the program splits the course into two components—the first four hours focus on information related to mental health and wellbeing, typical child development versus developmental psychopathology, signs and symptoms associated with mental illness, and risk and protective factors. The second half (four hours) of the training focuses largely on the ALGEE action plan. Activities are built in throughout the course to promote engagement and discussion. Case vignettes are used to discuss and practice skills. These vignettes gradually become more complex as participants learn more material throughout the course. Participants are given opportunities to practice using the ALGEE plan. Role plays and group discussions are used regularly.

As noted above, instructors closely adhered to the YMHFA manual and slides to ensure the intervention was delivered as intended. Although the training program is standardized, there are opportunities to tailor the course slightly. One of the instructors was a prior AmeriCorps member and familiar with the AmeriCorps culture and student population. Given the diverse population of the corps, and the diversity of the students they serve, the doctoral student instructors (who trained three of the five cohorts) incorporated information from YMHFA's guide on training diverse populations. For example, participants were given information on protective factors related to culture (i.e., strong cultural identity as a buffer, impact of educators valuing multilingualism/multiculturalism) and they were encouraged to investigate and consider how treatment may be impacted by culture (i.e., religious leaders may be highly respected and deemed essential in supporting mental health). Further, they also

received information about how immigration can be related to stress or trauma for a variety of reasons (i.e., immigration journey, acculturative stress, immigration status). Unfortunately, it is unknown whether the other instructor also integrated information from this guide into the two trainings he provided. The National Council for Behavior Health did not provide instructors with any formal fidelity checklists to assess whether instructors delivered the course material with integrity to the intervention. Although we did not use any fidelity checklists, two instructors were careful to ensure we followed the training manual and slides correctly.

Prior to the start of the training, and immediately after, participants completed an electronic or paper copy of the survey containing relevant measures for each data collection point. Two months following the training, participants were emailed an electronic copy of the follow-up survey. Follow-up responses were accepted and included in the analyses until four months after the training.

Measures

Data collected at each time point are referenced in Appendix A. Complete copies of each measure are found in Appendices A through J.

Demographics, School Role, and Mental Health Experience

At pre-test, participants responded to general demographic questions related to their age, gender, race/ethnicity, and education. Questions also addressed corps members' experience with mental illness, psychology pedagogy, and mental health training. Participants were asked to report on their prior and current role working in a school. See Appendix B for full questionnaire.

Mental Health Literacy

The mental health literacy scale (O'Connor & Casey, 2015; Appendix C) is a 35-item integrative measure that assesses facets of mental health (ability to identify disorders, knowledge of risk factors and causes of disorders, knowledge about how to seek mental health information, knowledge about treatments, knowledge about professional help, attitudes that enhance help-seeking, and disorder recognition) using a univariate structure. A systematic review evaluating tools to assess mental health knowledge rated this scale as “ideal” given its internal consistency and content validity (Wei et al., 2016). This scale has been used in research across age groups, and in research conducted in the United States and abroad. It is unclear whether the scale has been used in the US with diverse populations. All items on the scale are answered using either a 4-point or 5-point Likert scale. Item scores are typically summed to represent one’s MHL score; higher scores indicate greater MHL. The overall Cronbach’s Alpha for the scale from previous research was 0.87. For the current study, the scale was administered at all time points. Cronbach’s alpha across time points was excellent – pretest $\alpha = 0.90$ (95% CI = [0.88, 0.93]), post-test $\alpha = 0.91$ (95% CI = [0.87, 0.93]), follow-up $\alpha = 0.91$ (95% CI = [0.89, 0.94]).

Intentions to Engage in Mental Health First Aid Behaviors

Participants’ intentions to engage in first aid behaviors were measured using responses to two open-ended questions (Kelly et al., 2011; Appendix D). Participants were given two vignettes, each depicting a child experiencing a mental health difficulty. Participants’ responses were coded using a checklist that scores each ALGEE action step on a 0-2 scale, such that participants could earn up to 10 points

for each open-ended question. For a vague or superficial response touching on one ALGEE action step, participants earned one point (e.g., “I would talk to them” would be scored 1 point for A). Two points were earned for each ALGEE step mentioned in detail. The response “I would talk to them and assess for suicide and I would listen nonjudgmentally” would receive two points for A and two points for L for a total of four points. This measure was originally used to assess YMHFA in Australia and was thus validated on a sample of Australian adults. In the current study, the scale was administered at pre-test, post-test, and follow-up. Two coders coded 20% of responses and since interrater reliability was sufficient (85.2%), one coder coded the remaining data independently (see Appendix D for scoring guide).

Engagement in Mental Health First Aid Helping Behaviors

Actual behaviors were assessed at pre-test and follow-up using an adapted version of Kelly et al.’s (2011) measure for assessing MHFA behaviors (Appendix E). The original measure uses a 4-point Likert scale for the question “how often have you talked to a young person about their mental health problem” over the last six months. Subsequent questions ask the participant to check which of nine behaviors they engaged in. For the purposes of this study, each behavior was transformed to be on a 4-point Likert scale, representing how often participants engaged in each behavior. Participants were given the option to type in any additional helping behaviors they engaged in during the last two months. Higher scores on the measure reflect greater self-reported engagement in mental health first aid behaviors. Internal consistency within the current sample was good – $\alpha = 0.90$ (95% CI = [0.88, 0.93]) at pre-test and $\alpha = 0.88$ (95% CI = [0.85, 0.91]) at follow-up.

Confidence in Providing Mental Health First Aid

Confidence in helping behaviors was assessed at pre-test, post-test, and follow-up using Haggerty et al.'s (2019) five-item measure validated on a sample of US middle-aged, predominantly White adults (Appendix F). The original scale used a five-point Likert scale (Strongly disagree to Strongly agree), although this study removed the midpoint and used a four-point Likert scale. Items were developed to match participants' comfort with each component of the YMHFA training plan (e.g., "I feel comfortable in helping school-aged youth feel reassured that supports are available when they are experiencing mental health problems.") Higher scores indicate greater confidence in helping. A CFA conducted by Haggerty and colleagues (2019) supported a one-factor structure and the Cronbach's Alpha for the scale in their study was 0.91. Within the current sample, Cronbach's alpha = 0.87 (95% CI = [0.83, 0.91]) at pre-test, 0.93 (95% CI = [0.91, 0.95]) at post-test, and 0.91 (95% CI = [0.88, 0.94]) at follow-up.

Mental Health Stigma

The eight items (Appendix G; Turner, 2012) comprising the stigma scale of the Parental Attitudes Toward Psychological Services Inventory (PATPSI) were adapted for the purposes of this study and were administered at pre-test, post-test, and follow-up. Items were adapted to reflect participants' own stigmatizing beliefs, rather than their child's (e.g., instead of "Had my child..." the item will be edited to say "Had I..."). The seven-item measure uses a five-point Likert scale. The stigma scale of the PATPSI was selected over extant personal stigma measures because of its

strong empirical support, which was demonstrated by rigorous validation efforts, albeit on a population of parents. Higher scores indicate greater mental health stigma. Cronbach's Alpha for the scale in Turner's study was 0.89. In the present study, internal reliability was good – $\alpha = 0.89$ (95% CI = [0.85, 0.92]) at pre-test, $\alpha = 0.87$ (95% CI = [0.83, 0.91]) at post-test, and $\alpha = 0.92$ (95% CI = [0.90, 0.94]) at follow-up.

Utility of the Youth Mental Health First Aid Program

This five-item measure (Fabrizio, Lam, Hirschmann, & Stewart, 2013; Appendix H) was originally developed to evaluate the effect of a parenting intervention in Hong Kong. Each item is rated on a 1-5 (Strongly Disagree to Strongly Agree) Likert scale. Higher scores indicate greater satisfaction with the program. In order to better match the anchors, items were tweaked to correspond more appropriately to the scale's anchors. For example, "How much did you like this program" was transformed to "I like this program." The measure was administered to participants at post-test. Higher scores indicate greater acceptability of the program. Cronbach's alpha for the scale in the present study was excellent ($\alpha = 0.97$; 95% CI = [0.96, 0.98]).

Knowledge of School-Based Mental Health Providers and Resources

Participants were asked to respond to an open-ended question ("What mental health services are available at your school and/or who are the people that provide mental health services? List all that you can think of.") about who and which mental health providers they are aware of within their school. A list of school mental health

resources was created and used as a scoring guide (Appendix I) for participants' responses to the open-ended question about school resources. Using the scoring guide, the number of resources each participant listed at each time point was tallied and totaled by a reliable scorer. Higher scores indicate knowledge of greater mental health resources. Two coders coded 20% of participants' data that was randomly selected. The coders had 97.2% reliability. Due to the high degree of reliability, one coder independently coded the remainder of the data.

Open-Ended Questions for Qualitative Data

Participants were asked to respond to two open-ended questions designed to tap into participants' perceptions of training utility for classroom educators as well as the cultural sustainability of the program. See Appendix J

Data Analysis

Data were cleaned prior to analyses. Five participants submitted a survey but did not complete the training, so their surveys were removed from analyses. Survey responses were also screened for duplicate and/or aberrant responses. If a participant submitted more than one survey for a given time point, the more complete survey was used in analyses. If a participant submitted equally complete surveys, the most recent one was used. In total, 41 duplicate entries were discarded. Aberrant responses were identified using a two-step screening process. Surveys completed in under 800 seconds were flagged, as were surveys with unexpectedly low variability (determined by having a SD of less than 0.60 within responses on the MHL scale before items were reverse coded). Using these methods, 30 survey responses were flagged. The

researcher then looked at all flagged responses for indications of invalid response style. Ultimately, 16 responses (four at pre-test, four at post-test, eight at follow-up) were determined to be invalid and were removed from analyses. Participants' responses that did not answer the qualitative question (e.g., answers such as "NA", "No") were removed from qualitative analyses. Quantitative analyses relied upon scale data in which scale scores typically are derived by summing all item scores. In the present study, however, participants were permitted to skip individual items. Therefore, it was determined that scale scores would be calculated by averaging all completed items for a given measure. As a result, each scale score reflects the scale's average item score. Items on the MHL scale were re-scaled to be on a 1-point scale since some items used a 4-point Likert scale (re-scale values = 0.25, 0.50, 0.75, 1) and others used a 5 point Likert scale (re-scale values = 0.20, 0.40, 0.60, 0.80, 1.00).

In order to answer quantitative questions one and two, a series of repeated measure ANOVAs were conducted using pre, post, and follow-up data for stigma, overall MHL, confidence in providing MHFA behaviors, intentions to engage in MHFA behaviors, and knowledge of school mental health providers and resources. Power analyses were conducted through G*Power, which revealed that 75 participants were needed to detect a small effect size (partial $\eta^2 = 0.03$), using a p-value of 0.05 and power of 0.80. The LME4 package in R was utilized for RM-ANOVA analyses and post-hoc Tukey contrasts with Bonferroni corrected p-values were run using the glht package in R. Due to the nested structure of the data (participants were trained in groups), a multi-level model including training group (in addition to time) as a predictor was compared to the multi-level model that only

included time as a predictor. The multi-level model including training group as a predictor explained no additional variance in dependent variables. Thus, RM-ANOVA were used for all analyses. Mauchly's Test was used to check the assumption of sphericity. The Greenhouse-Geisser corrected statistic is reported in instances when the model violated the assumption of sphericity. The RStatix package in R was used for analyses in which the assumption of sphericity was violated. A paired sample t-test was used to answer question three – whether participants engaged in more MHFA behaviors in the two months after training than in the two-months before training.

Qualitative data for this mixed methods study were obtained from responses to two questions posed to participants at post-test:

- 1) How do you think this program prepares you, or doesn't prepare you, to work with students at your school?
- 2) What are the challenges and benefits of using this program to meet the needs of culturally and linguistically diverse students?

Participants' responses were analyzed in Microsoft Excel using an inductive content analysis approach, where coding categories are derived directly from the text data (Hsieh & Shannon, 2005). Content analysis represents an “objective, systematic and quantitative description of the manifest content of communication” (Berelson, 1952, p. 18) and is appropriate for exploratory studies given its simple reporting of common issues mentioned in the data (Green & Thorogood, 2004). First, participant responses were extracted into an Excel sheet. To gain familiarity with the data, two researchers (ASR and KS) read the responses and conducted a line-by-line analysis, applying a paraphrase or label (i.e. code) as appropriate. This step was done

individually to ensure independent understanding. The two researchers then shared their impressions and initial codes, which became the foundation for the codebook. The codebook included descriptions of codes/labels and exemplars of each. Next, data from 5% of the participants were randomly selected for initial coding. The researchers coded this sample independently. Any coding discrepancies were resolved through discussion and codes/labels were further refined. During this refinement process, codes were combined into initial groupings (i.e. themes) until no new or relevant information could be derived from the data. At this point, two doctoral level researchers were consulted and reviewed the data and helped refine/name themes. Once themes were more finalized, the coders coded an additional 20% of the data. Reliability of the coders was calculated using Campbell, Quincy, Osserman, and Pedersen's (2013) method and was 85% for Q1 and 82% for Q2 indicating strong agreement. One researcher (ASR) coded the remainder of the responses. Qualitative results from Q1 were triangulated with quantitative results from various quantitative measures (e.g., utility measure, MHL scale, SBMH Resources).

Chapter 4: Quantitative Results

Quantitative Research Questions

- 1) Does Youth Mental Health First Aid reduce AmeriCorps education members' mental health stigma and improve their mental health literacy, confidence in helping behaviors, intentions to engage in mental health first aid behaviors, and knowledge of school-based mental health providers and resources?
- 2) If participants have reductions in stigma and increases in mental health literacy, confidence in helping behaviors, intentions to engage in mental health first aid behaviors, and knowledge of school-based mental health providers and resources immediately after the training, are these benefits sustained two months later?
- 3) Do participants report engaging in more mental health first aid behaviors (Assess for risk of suicide or harm, Listen nonjudgmentally, Give reassurance, Encourage professional help, Encourage self-help strategies) in the two months after the training than in the two months before the training?

Over 95% (n = 101) of participants completed post-test, and around 60% completed follow-up (n = 67). Overall, findings generally supported the hypotheses, although not every construct changed significantly ($p < 0.05$) at each time point. A summary of findings is included in Table 3.

Mental Health Stigma

The RM-ANOVA including time as a predictor revealed no significant difference than the null model in its ability to predict mental health stigma ($\chi^2(2) = 3.76, p = 0.15$). This means

there was no observed difference in stigma between any two time points. In other words, mental health stigma, which was low at pre-test in this sample (mean = 1.67 out of a possible 5 points), did not significantly change from baseline during the training or at follow-up.

Mental Health Literacy

Since other scholars have used the MHL scale and report sum scores for the scale score (versus average item score), I used a sum score for this measure so I could compare MHL scores of this study to MHL scores from other scholars' work. Since participants in this study could skip individual items on a scale, I had to deal with missing item-level data before calculating a sum score. Imputation was completed such that I calculated each participant's average response to four-point items and average response to five-point items. Each participant's average four-point response was imputed into four-point items they skipped. Similarly, each participant's average five-point response was imputed into any five-point items they skipped. Notably, this method did not involve re-scaling the data. All items were then summed. Average MHL score before intervention was 127.93 ($SD = 15.23$), immediately after it was 131.77 ($SD = 13.87$) and two months later it was 128.90 ($SD = 16.27$).

The RM-ANOVA including time as a predictor significantly outperformed the null model ($\chi^2(2) = 15.59, p < 0.001$) in predicting MHL scores. This means there were differences in mental health literacy over the three time points. Post-hoc analyses were conducted using Tukey Contrasts with Bonferonni-adjusted p-values. Mean MHL scores significantly increased from pre-test to post-test ($M_{diff} = 3.95, p < 0.01, \text{Cohen's } d = 0.43$) and significantly decreased from post-test to follow-up ($M_{diff} = -4.46, p < 0.001, \text{Cohen's } d = 0.41$). There was no significant difference in mean MHL scores between pre-test and follow-up ($M_{diff} = -0.52, p = 1.00$). This

suggests that participants' MHL increased during training, but the benefits were not sustained at follow-up (two to four months after the training).

Confidence in Providing Mental Health First Aid

Since the assumption of sphericity was violated, the Greenhouse-Geisser corrected statistic is provided. There was a significant change in mean confidence in providing MHFA across time points ($F(1.76, 94.79) = 15.33$, $G_{ge} = 0.88$, $p < 0.001$). This means there were differences in confidence in providing MHFA over the three time points. Tukey Contrasts with Bonferonni-adjusted p-values indicated a significant increase in mean confidence scores from pre-test to post-test ($M_{diff} = 0.38$, $p < 0.001$, Cohen's $d = 0.60$) and from pre-test to follow-up ($M_{diff} = 0.31$, $p < 0.01$, Cohen's $d = 0.39$). There was no difference from post-test to follow-up ($M_{diff} = -0.07$, $p = 1.00$). Taken together, these findings suggest that participants became more confident engaging in mental health first aid behaviors after training, and maintained this confidence two to four months later.

Intentions to Engage in Mental Health First Aid Behaviors

Participants' intentions to engage in mental health first aid behaviors was represented by two distinct total scores earned for a response to vignettes depicting students with mental illness. One total score represents participants' intentions to engage in appropriate helping behaviors for a child with schizophrenia. The other total score represents participants' intentions to engage in appropriate helping behaviors for a child with depression.

The RM-ANOVA that included time as a predictor of intentions to help a child with depression significantly outperformed the null model ($\chi^2(2) = 18.80$, $p < 0.001$). This means there were differences in intentions to engage in MHFA behaviors for a child with depressive

symptoms over the three time points. Post-hoc analyses revealed a significant increase in mean intentions scores between pre-test to post-test ($M_{\text{diff}} = 0.77, p = < 0.001, \text{Cohen's } d = 0.44$). Unfortunately, it seems this was not maintained and since there was a near significant decrease from post-test to follow-up ($M_{\text{diff}} = -0.51, p = 0.05, \text{Cohen's } d = 0.54$). There was no significant difference between pre-test and follow-up ($M_{\text{diff}} = 0.26, p = 0.64$). These analyses reflect change in overall intentions to help a child with depressive symptoms.

The RM-ANOVA including time as a predictor significantly outperformed the null model ($\chi^2(2) = 31.98, p < 0.001$), indicating that participants' intentions to engage in MHFA behaviors to help a child with symptoms of schizophrenia significantly changed over time. Participants were significantly more likely to engage in more MHFA behaviors immediately after the training than they were before the training ($M_{\text{diff}} = 0.91, p < 0.001, \text{Cohen's } d = 0.63$), but unfortunately their intentions to help a child dropped significantly between post-test and follow-up ($M_{\text{diff}} = -0.48, p = 0.03, \text{Cohen's } d = 0.42$). Despite this drop, participants were possibly still more likely to have greater intentions of helping a child with schizophrenia at follow-up than they were before the training since there was an approaching significant change in score ($M_{\text{diff}} = 0.43, p = 0.05, \text{Cohen's } d = 0.40$).

Knowledge of School-Based Mental Health Providers and Resources

At pre-test, just 23% of participants were able to list two or more mental health providers at school. At post-test, nearly half of participants (48%) could list at least two mental health providers at school. The average increase in knowledge of SBMH providers and resources was significant, such that the RM-ANOVA that included time as a predictor significantly outperformed the null model ($\chi^2(2) = 19.51, p < 0.001$) in predicting knowledge of SBMH providers and resources. Post-hoc analyses showed that participants were able to name more

SBMH providers and resources after the training than they were before the training ($M_{diff} = 0.55$, $p < 0.001$, Cohen's $d = 0.57$). This improvement was maintained at follow-up, such that there was no difference in scores between post-test and follow-up ($M_{diff} = -0.08$, $p = 1.00$). Therefore, participants were able to name significantly more providers at follow-up than they were at pre-test ($M_{diff} = 0.47$, $p < 0.01$, Cohen's $d = 0.41$).

Engagement in Mental Health First Aid Helping Behaviors

Fifty-eight participants completed the pre-test and follow-up measure assessing participants' perception of their engagement in MHFA actions. A paired sample t-test was used to assess whether participants self-reported greater engagement in MHFA actions in the two-to-four months after training ($M_{MHFA} = 2.46$, $SD = 0.65$) than they did in the two months before training ($M_{MHFA} = 2.03$, $SD = 0.73$). The average increase was significant ($M_{diff} = 0.37$, $t = 4.10$, $p < 0.001$) and carries a moderate effect size $d = 0.54$. Table 4 includes paired sample t-test data aggregated by each MHFA behavior.

Utility of the Youth Mental Health First Aid Program

Overall, the YMHFA program was well-received. On the acceptability scale, participants' average item score was a 3.65 out of a possible 4 points. All but four participants agreed or strongly agreed with every item on the acceptability scale (Table 5).

Chapter 5: Qualitative Results

Qualitative Research Questions and Overview of Results

- 1) What are AmeriCorps members' perceptions of the benefits and utility of the YMHFA program?
- 2) What are the challenges and benefits of using this program to meet the needs of culturally and linguistically diverse students?

Ninety-nine participants responded to at least one of the two open-ended questions included in the post-test survey. One question (“How do you think this program prepares you, or doesn't prepare you, to work with students at your school”) was used to assess whether participants found the training and YMHFA program to be beneficial in their role as classroom educators. The other question (“What are the challenges and benefits of using this program to meet the needs of culturally and linguistically diverse students”) was used to assess participants' perception of whether the training was helpful to them in working with culturally and linguistically diverse students.

Ninety-nine participants responded to the open-ended question addressing participants' perception of the YMHFA program's relevance to their role as classroom educators. Four themes and three sub-themes emerged from responses. Participants thought the training was relevant to their role as classroom educators because it provided them with 1) knowledge and skills to respond and help a student experiencing a mental health difficulty, 2) greater awareness about youth mental health, 3) knowledge and ability to recognize concerning mental health signs and symptoms, and 4) relevant scenarios and practical examples, which made the course information relevant and digestible. Nearly all participants touched on why the program was helpful; only one participant mentioned an area in which the program could be enhanced. Table 6 highlights

exemplar quotes and the percentage of participants who endorsed each theme. Percentages were calculated using data only from participants who responded to the question.

Eighty-eight participants responded to the open-ended question addressing participants' perception of the YMHFA program as being a helpful and appropriate program for work with diverse students. Three themes and four sub-themes emerged regarding ways in which participants thought the program fell short in helping them meet the needs of culturally and linguistically diverse students. Participants noted that 1) attitudes about mental health and subsequent actions differ by culture, which can be barriers in providing YMHFA. Participants also mentioned challenges associated with 2) the course content and delivery of the YMHFA training program, and 3) the implicit assumption that the first aider and youth speak a common language (i.e., both first aider and student speak English, or both speak Spanish). Two themes emerged reflecting ways in which participants perceived the program to be beneficial for culturally and linguistically diverse students. Participants noted that the program 1) provides first aiders with skills and an action plan that can be used with diverse students, and 2) raises mental health awareness related to culture and reduces culture-related stigma. Additionally, several participants provided responses that appeared to reflect general benefits and challenges of using YMHFA, and not be specific to work with culturally and linguistically diverse youth. These are also listed in more detail below. Table 7 highlights the percentage of participants who endorsed each theme. Only participants who responded to the question are captured in the percentages listed (n = 88).

AmeriCorps Members' Perception of Benefits and Utility of Youth Mental Health First Aid

Participants' responses to the first open-ended question demonstrated their perceived value of the program. Four themes emerged regarding participants' perceptions of the benefits and relevance of the YMHFA program.

Knowledge and Skills to Respond

Sixty-four percent (n = 63) of participants stated that the program was beneficial because it equipped them with the skills, knowledge, and awareness of how to respond and support a youth suspected to be experiencing a mental health concern. Three subthemes illustrate discrete areas and situations in which participants' skillset grew. Participants gained the skills to 1) *address a general mental health concern* (n = 44, 44%), 2) *approach a student experiencing a mental health difficulty* (n= 12, 12%), and 3) *support a student experiencing a mental health crisis* (i.e., suicidal ideation, psychosis, self-harm) (n = 7, 7%). One participant's response succinctly summarized the main theme and touched on aspects of the sub-themes. Participant 081 commented:

This program prepared me with the knowledge of how to approach students about certain mental health concerns, how to bring up conversations concerning mental health, and proper resources for students' mental health.

Forty-four participants felt they were better prepared to *address students' general mental health*. Participants felt equipped to respond to mental health concerns and also recognized the scope of their role. One participant shared (participant 231):

I think this program has give[n] me tools to work with students who I have concerns about at my school. Before I just really felt unsure, but now I feel more confident about what I'm going to do.

Others mentioned appreciation for having the ALGEE action plan, an understanding of resources to recommend, and an enhanced awareness of language for discussing mental health related topics.

Participants (n= 12, 12%) gained the knowledge and skills to *approach a student suspected of experiencing a mental health difficulty*. Some commented on learning various strategies such as ensuring the use of sensitive language when broaching the topic of a mental health concern. Participant 811 stated “it gave me key examples and different ways to approach my students when it comes to mental health related issues.”

Youth Mental Health First Aid includes material addressing mental health difficulties ranging in severity from mild impairment to severe crisis. Seven percent (n = 7) appreciated learning the skillset to *support a student experiencing a mental health crisis*. Some whose responses fell into this sub-theme mentioned crises related to suicide or self-harm. Some participants specifically mentioned the ways in which ALGEE can be applied, while others commented on a general awareness of how to use YMHFA skills during crisis. For example, Participant 701 said:

Youth Mental Health First Aid has prepared me to proactively handle student crisis within the school environment and has taught me the proper steps to give them the appropriate services.

Awareness about Youth Mental Health

Twenty percent (n = 20) of participants stated that the program offered general awareness about youth mental health. For example, participant 631 said:

This program helps give insight to student[s] you would have not thought about. It gives context that can help someone open their mindset about mental health and it does not have any biases for age or background.

A few participants also appreciated gaining a better understanding of how children experience/express emotions more generally.

Recognition of Signs and Symptoms of Mental Illness

Fifteen percent (n = 15) of participants appreciated that the program gave them knowledge of common signs and symptoms of mental illness. Many believed they would have a refined ability to recognize concerning signs in students. For example, participant 122 succinctly said that the program “prepares me to look for or recognize possible signs [that] my student may be struggling.”

Course Content Delivered in Digestible Manner

Some participants (n = 10, 10%) thought the program was beneficial because the content was relevant and delivered in a digestible manner using real-life scenarios and practical examples. Participant 201 said “it provided us with the opportunity to work through scenarios related to youth and their mental health. Those scenarios were the most helpful.

AmeriCorps Members’ Perceptions of Youth Mental Health First Aid to Meet the Needs of Culturally and Linguistically Diverse Students

Participants responses were mixed on whether they perceived YMHFA to meet the needs of culturally and linguistically diverse students. Three themes and four sub-themes emerged pertaining to participants’ impressions of limitations of the program as it relates to meeting diverse students’ needs. Overall, 51% of participants (n = 45) listed at least one area in which the program falls short in supporting CLD students. Although the question directly asked for

participants' perception of the course related to meeting diverse students' needs, several participants (27%, n = 24) provided critiques of the program that did not appear specific to work with culturally and linguistically diverse youth. These responses are also summarized below. Two themes emerged regarding participants' positive impressions of the program related to cultural sustainability. More participants (25%, n= 22) responded with positive impressions of the program unrelated to culture, than those (23%, n = 20) who provided responses appearing related to culture. These comments are also covered.

Attitudes about Mental Health and Subsequent Actions Differ by Culture

Forty-two percent (n = 37) of participants mentioned that cultural groups have different attitudes regarding mental health, which can make it hard for YMHFSA to meet every cultural group's needs. More specifically, three sub-themes emerged suggesting that 1) *a one size fits all approach to mental health is inadequate* (n = 16, 18%), 2) *stigma related to culture is a barrier for YMHFSA* (n = 9, 10%), 3) *recognition, beliefs, and interpretations of behaviors vary based on culture which is a barrier for YMHFSA* (n = 9 , 10%).

Almost a fifth of participants acknowledged that a challenge of the program is the *one-size-fits-all approach to MHFA*. Interestingly, almost as many participants commended the ALGEE action plan for having a strong guiding framework that can be applied uniquely such that students' diverse backgrounds and experiences are recognized. Participants' responses touched on this unique conundrum, some noting the strength of a flexible program, while simultaneously acknowledging difficulties with personalization. Participant 341 said:

It is difficult to apply one thing to a big group of diverse individuals. Different people require different strategies of mental [health] first aid and you must apply it to them all in a unique way.

Other participants acknowledged challenges of transferring specific skills (rather than a broader skillset). For example, Participant 131 said “some strategies may not be effective in certain cultural communities.”

Ten percent (n = 9) of participants discussed how culture-related stigma regarding mental health and/or help-seeking can be a barrier to using the ALGEE action plan. Participants described feeling helpless when recommendations for professional mental health services are rejected, perhaps due to culture related stigma. For example, Participant 531 said, “some of these students will turn away the help because of some cultural norms.” Another participant (011) highlighted the challenge of talking about sensitive topics that are stigmatized noting, “suicide and mental illness may be extremely taboo in other cultures, so children and parents may not want to discuss mental health.”

Ten percent (n = 9) of participants commented on how the recognition, beliefs, and interpretation of symptoms/behaviors can depend on culture, thus making YMHFA difficult to use. Participants noted that symptom presentation can differ based on culture, and that some cultures may reject symptoms as being indicative of mental illness. If first aiders lack awareness of these nuances, they may overlook mental health related symptoms or opportunities to discuss symptoms in greater detail. Participant 021 said, “we need to understand that many different kinds of people have different health issues in different ways.” This quote reflects the notion that symptoms of mental illness are expressed differently, sometimes because of culture.

Course Content and Delivery of the Youth Mental Health First Aid Training Program

Eight percent of participants (n = 7) expressed challenges with the actual delivery of the YMHFA training program. Participants’ comments ranged from frustration regarding insensitive language used during the training to perceiving that the course offered inadequate information

related to culture. For example, one participant stated that “the program give[s] insight [in]to the needs, but does not go into further detail on cultures and their perspective on the topic and how it can effect (sic) them.”

Implicit Assumption that First Aider and Youth Speak Common Language

Some participants underscored the program’s assumption that the first aider and youth speak the same language. Participant 582 said “one of the challenges is helping our students who don't speak English, which is my team's first and only language.”

Challenges of the Program Not Explicit to Culture

Thirty percent (n = 26) of participants discussed limitations of the program, but it was unclear whether they intended to represent challenges of using the program with culturally and linguistically diverse youth in particular. Nonetheless, these comments were heterogeneous in nature, and did not fit into discrete sub-themes. A few participants expressed concern about whether the program prepared them to relate to and communicate with students. Other participants expressed concern about encountering unexpected challenges.

Themes listed thus far highlighted areas in which the program can be improved to better support AmeriCorps members providing YMHFA. On the contrary, the themes below indicate areas in which AmeriCorps members perceived YMHFA to be a positive approach to supporting students. Two of the three themes focus specifically on how AmeriCorps members perceived the YMHFA program to be beneficial in helping them work with culturally and linguistically diverse students.

Relevant and Versatile Action Plan

Fourteen percent of participants (n = 12) noted that the ALGEE action plan is a guiding framework that is relevant and easily applied to youth from diverse backgrounds. Participant 991 said, “it allows me to have an inclusive response to every situation. Another (participant 811) commended the program noting, “I think that the program actually recognizes the diversity of students and provides us with a culturally responsive action plan.”

Mental Health Awareness and Stigma Related to Culture

A few participants (7%, n = 6) perceived the program to offer strategies and information to help elucidate the prevalence of mental health difficulties, destigmatize mental illness, and attend to mental health inequities as they relate to culture. Participant 222 said benefits obtained from the program include “educating and raising awareness, [so that] more people can participate in the conversation and strategize together to address mental health and the inequity around it.”

Benefits of the Program not Explicitly Specific to Culture

Twenty-eight percent (n = 25) of participants discussed benefits of the program, but it was unclear if their responses pertained to using the program with culturally and linguistically diverse youth. More specifically, fifteen percent (n = 13) believe the program teaches skills for intervening. Some (7%, n = 6) mentioned obtaining greater awareness about general mental health (ranging from increased awareness of mental health concerns broadly to increased knowledge of specific signs and symptoms).

Chapter 6: Discussion

Findings from the present study suggest potential benefits of training AmeriCorps classroom educators on mental health related issues using the Youth Mental Health First Aid (YMHFA) program. Classroom educators' knowledge of and attitudes towards youth mental health concerns were measured before, immediately after, and between two-to-four months after participation in the eight-hour YMHFA training. Participants also provided qualitative data assessing whether they felt the training appropriate for their role in general, and in working with culturally and linguistically diverse students, more specifically.

Findings from this mixed-methods study generally support the hypotheses, suggesting that training in YMHFA may be responsible for immediate improvements in MHL, confidence in helping behaviors, engagement in helping behaviors, and improved knowledge of school mental health professionals. Mental health stigma did not change after training. Some improvements (confidence in helping behaviors, knowledge of school mental health resources) were sustained several months after training and some were not (mental health literacy, intentions to engage in mental health first aid behaviors), which provides mixed support for the second hypothesis. Additionally, the current investigation utilized qualitative data to understand the strengths and challenges of using the program among a population of educators who work with students from culturally and linguistically diverse backgrounds. In general, findings revealed that the YMHFA program was well-received among classroom educators and that they found the program to be relevant to their role as classroom educators for several reasons. Classroom educators believed training provided them with (1) knowledge/skills to respond, (2) awareness about mental illness, (3) the ability to recognize signs and symptoms of mental illness, and (4) information was delivered in a digestible, easy to understand manner. They also noted that the program prepares

them to support culturally and linguistically diverse students' mental health because it (1) teaches a relevant and versatile action plan that can be applied across diverse populations and (2) offers mental health awareness and strategies to de-stigmatize mental illness as it relates to culture. Nonetheless, participants noted that the YMHFA program can be improved to better meet the needs of culturally and linguistically diverse youth. Participants mentioned barriers in providing YMHFA or limitations of the program because (1) attitudes about mental health and subsequent actions differ by culture (2) the course content and delivery of the YMHFA training program needs improvement related to culture, and (3) the implicit assumption that the first aider and youth speak a common language. Although improvement areas emerged, the overall findings are encouraging since classroom educators play a vital role in supporting youth with mental health difficulties but often lack the training and knowledge to fulfill this role. Programs like YMHFA may improve teachers' capacity to provide informal mental health support and direct students to formal school-based mental health care.

This study on YMHFA generally corroborates findings from other studies on mental health training programs, some of which have used controlled experimental designs (Jorm et al., 2010). Findings from the present investigation are aligned with previous work since MHL improved after training, and participants reported greater confidence in providing mental health support (Gryglewicz et al., 2018; Rose et al., 2019). Interestingly, the average MHL score in this study ($M = 127.98$) was nearly identical to that from O'Connor and Casey's (2015) study ($M = 127.38$) which included a predominantly White, freshman college sample. Unfortunately, to my knowledge, no study has used the MHLS when evaluating the YMHFA program. Therefore, comparisons regarding magnitude of improvement in MHL are not possible. The literature is mixed on whether mental health training leads to decreases in attendees' mental health stigma, a

major predictor of help-seeking behavior (Vogel et al., 2006). This study, like Haggerty et al. (2019), found no relationship between training and participants' level of mental health stigma. However, other scholars have found trainees to have lower stigma after YMHFA participation (Kelly et al., 2011). Within the stigma literature, scholars have identified various types of mental health stigma (i.e., perceived stigma, self-stigma, etc.), and researchers have been inconsistent in the ways in which they measure during evaluations of mental health training programs (Haggerty et al., 2019; Kelly et al., 2007). This could contribute to the mixed findings. Certain types of stigma may be more resistant to change or have floor effects. Another possible explanation for the discrepant findings between studies could be due to differences in population. Younger people (and possibly educators) tend to have lower levels of mental health stigma than the general population (Collins et al., 2014), additionally some studies have been conducted outside of the United States. Therefore, it may be difficult to further decrease stigma among a population of young educators in the United States, since stigma related to mental illness may typically be lower to begin with.

Since YMHFA was designed for any adult who interacts with youth, most inquiries into its efficacy have looked at general outcomes (i.e., mental health literacy) across a general population, and not investigated the training program's application and relevance to specific populations (i.e., classroom educators). This study is the first to investigate YMHFA's relevance to AmeriCorps classroom educators and one of the first to focus on United States educators. A mixed-methods approach was utilized, which included a role-specific quantitative measure (knowledge of school mental health resources) and qualitative questions. Qualitative data revealed that teachers found YMHFA to be helpful because it provided them with greater awareness about youth mental health and increased their ability to recognize student mental

health concerns. Quantitative data indicated that participants had greater knowledge of school mental health resources following participation in the training. Considering previous work has found that teachers cite limited mental health knowledge as the number one barrier to fulfilling their role (Walter et al., 2006), these findings are encouraging and suggest YMHFA may support educators in being more effective gatekeepers to mental health services. Following training, they may have (1) greater knowledge of signs/symptoms of mental illness, (2) enhanced awareness about youth mental health, and (3) improved knowledge of school mental health professionals.

In most cases, evaluations of mental health training programs have not explored whether training leads to actual behavior change among first aiders. An important contribution of the present study is the finding that participants self-reported greater engagement in mental health first aid helping behaviors in the two months after training than they did in the two months before training. Additionally, scores on behavioral intention measures indicated that participants were more likely to have intentions of engaging in appropriate helping behavior after training. However, participants in the present study reported somewhat lower behavioral intentions compared with participants in Kelly et al. (2011)'s study, which was conducted in Australia with lay people who were older and less ethnically diverse than our participants. Qualitative data from the present study touched on the behavioral impact of the YMHFA training for educators' specific role. Notably, the most frequently endorsed theme to emerge from the data was that educators felt the program equipped them with the knowledge and skills to respond to student mental health concerns. Also, some participants indicated that a strength of the program is that the behavioral action plan can be adapted to meet diverse students' needs. Taken together, these findings provide initial support for the idea that mental health training programs may go above and beyond simply changing attitudes and improving mental health knowledge. Participation in

training may also lead to greater engagement in mental health helping behaviors. Since the present study included only self-report data and was not a controlled study, further investigation is necessary to determine whether a causal relation exists between participation in mental health training (such as YMHFAs) and improvements in mental health helping behaviors.

Scholarship has not been able to keep up with YMHFAs' rapid gain in popularity. Limited research has looked at longitudinal impacts associated with training. Among the few existing longitudinal studies, consensus is lacking on whether outcomes are maintained at follow-up (Banh et al., 2019; Haggerty et al., 2019). This study found mixed results at follow-up, which occurred between two to four months after training and had 64% retention. Mental health literacy, perhaps one of the most robust predictors of mental health related behaviors, decreased at follow-up, as did participants' intentions to engage in mental health helping behaviors. Since some outcomes were maintained at follow-up (i.e., confidence in helping and knowledge of school mental health resources), some impacts of the training may be more easily maintained. These findings suggest that booster sessions are necessary for maintaining and supporting progress made during the initial course. Booster sessions may also provide an opportunity to address classroom educators' specific barriers in their role as first aiders. Further, a booster session could include explicit and tailored information specific to the application of YMHFAs in the school setting.

In addition to limited research on the longitudinal impacts of YMHFAs, scholarship is lacking on the applicability of YMHFAs to diverse populations. Most studies of YMHFAs have been conducted on majority-White populations. This study was one of the first in which most participants identified as either Black (59%) and/or Latinx (21%), and all participants reported working in schools in which the majority of students identify as Hispanic and/or Black. As

evidenced in previous paragraphs, findings from the quantitative portion of the study generally align with findings from previous evaluations of YMHFA that have been conducted on predominantly White populations. This study is unique because it used qualitative data to determine participants' perspectives on how the YMHFA program prepares classroom educators to support culturally and linguistically diverse students' mental health needs. While participants commended the program for utilizing an action plan that can be applied to diverse populations, many also noted cultural-related challenges associated with using YMHFA. In particular, almost half of participants noted that attitudes about mental health and subsequent actions differ by culture which can be barriers to providing mental health first aid. YMHFA trainers may benefit from including more explicit examples and role-plays unique to diverse youth. This may help prepare trainees to support culturally and linguistically diverse students' mental health. A few participants in the study also noted that a limitation of the YMHFA program is that it does not provide strategies for situations in which first aiders and youth do not speak a common language. This district has a high immigrant population with over 128 languages spoken in homes in the county (Batista, 2015) and 20% of students are classified as English Language Learners (Shneyderman, 2018). Equipping staff with the skills to either provide mental health first aid or refer to someone else who can is essential since this population is at high risk of trauma and stress (Perreira & Ornelas, 2013). YMHFA may include skills to use with this population, and schools may also benefit from investing in programming that more specifically supports ESL learners' mental health.

Implications for Practice and Research

Schools/School Psychologists

Findings from the current investigation have meaningful implications for school systems and school psychologists. Notably, mental health training for teachers/educators in general (such as YMHFA) appears to be a viable tier I mental health initiative because it provides educators (teachers, para-educators, and support staff at school) with improved mental health literacy and may make trainees more likely to engage in MHFA helping behaviors. School systems and school psychologists should ensure schools invest in mental health programming for staff that 1) fits within school mental health initiatives, 2) is relevant and of high-quality, and 3) is efficient and has the capacity to reduce burden placed on educators.

Programs like YMHFA can fit within larger school-wide initiatives aimed at creating a warm environment for mental health related concerns. During the process of identifying and selecting a mental health training program, stakeholders should consider whether a given program complements other efforts and fits within larger school initiatives. In the district in which this study took place, YMHFA was widely adopted and part of a larger district-wide campaign to improve mental health. City Year AmeriCorps members, teachers, and administrators were all trained in YMHFA (only AmeriCorps members' participated in the present study). Additionally, AmeriCorps managers were trained in Adult Mental Health First Aid to support corps members' mental health. Some districts have collaborated with their PTAs to provide YMHFA training for parents. YMHFA, a versatile program geared towards all adults, allows for a unified approach to supporting mental health. Widespread implementation equips adults with a common language and an action plan to support youth mental health. Recently, MHFA launched a teen version, which could also be harnessed by schools to teach adolescents

MHFA in an age-appropriate manner. The opportunity to engage teachers, administrators, parents, and teens in parallel programming (i.e., by providing MHFA) is an example of how training teachers can fit within larger efforts geared at improving youth mental health.

School psychologists, mental health experts within the school, are integral in the coordination and adoption of mental health initiatives. Unfortunately, they often experience barriers in implementing school-based mental health services, due to relationship challenges with school administrators and teachers (Suldo et al., 2010). Programs like YMHFA may reduce these barriers. Specifically, the current study indicated that teachers have a stronger understanding of school-based mental health providers and services after training. Therefore, teachers may be more aware of and in support of school psychologists' role in school mental health thus reducing barriers frequently referenced by school psychologists. Additionally, school psychologists' knowledge is important in sifting through research to determine whether a program has a sufficient evidence-base (*Who Are School Psychologists*, n.d.), meets a given need, and fits within school-wide mental health initiatives. Other stakeholders (i.e., administration, teachers, students, parents, community members) involved in the decision-making process should also weigh factors such as cost, time commitment, and resources required for adoption. Once a program is adopted, school psychologists continue to be involved with implementation and follow-up. In some instances, they may provide the professional development/training themselves (Suldo et al., 2010), or provide supplemental resources to ensure the training is relevant to the school and the school's needs. For example, school psychologists could develop a resource guide to accompany mental health training. This guide could include a list of school-based mental health professionals, information on the school's referral processes, and self-help strategies teachers can utilize with their students. Another role for school psychologists includes

the development or implementation of follow-up programming. Results from the current study suggest a need for a booster session. Since YMHFA does not include a booster session, school psychologists may develop a booster session for teachers should their school adopt the MHFA program.

Investing in training like YMHFA may also reduce staff workload (mental health professionals, teachers, and administrators) if the program functions as a prevention program and there are streamlined processes in place for students to be referred to second and third tier services. Equipping teachers with the skillset to informally support students with mild difficulties may prevent worsening symptoms, and therefore reduce some of the burden placed on school psychologists since specialized services may not become necessary. This is encouraging since school psychologists typically serve more students than what the National Association of School Psychologists recommends. It is also possible that training in programs like YMHFA may reduce teachers' workload by providing them with skills to facilitate more positive relationships with students. Finally, a goal of the training is to equip attendees with the ability to make distinctions between typical development and signs/symptoms of mental illness. Therefore, teachers who participate in YMHFA should be able to recognize and refer students displaying more intense mental health difficulties to school based mental health providers. School systems can complement this aspect of training by building efficient processes for identifying and referring students in need of specialized mental health services. It is important that trainers clearly communicate the streamlined referral processes when providing YMHFA to educators. This may help educators have a clear understanding of how the training applies to their specific role.

AmeriCorps Programs

This study was piloted in one of City Year's 27 cities. Due to the perceived benefits of YMHFA training, the study gathered the attention of the corporate office, which was considering implementation across more sites. Although this reflects the leadership's perception of potential benefits of the program, organizations should consider various factors before adopting a program to ensure the training adds value and is smoothly implemented.

In the current study, the majority of participants (60%) had no prior mental health training, which highlights the need for programs like City Year to offer mental health training. Although YMHFA is a popular and evidenced based program, it might not be the best fit for all AmeriCorps programs. Programs like YMHFA, Psychological First Aid, and Question, Persuade, and Refer (QPR) are all evidence-based programs addressing mental health related issues. Therefore, when an AmeriCorps program decides to pursue mental health training, the leadership should consider all options and identify a program that fits the organization best. The present study underscores the importance of selecting a program that meets the needs of diverse students. Since the literature typically lacks this evaluation, qualified stakeholders may need to evaluate a program's cultural sustainability. In addition, factors such as time commitment, evidence base, cost, training requirements, training objectives, and existing school district/local programming efforts should be considered. AmeriCorps programs should coordinate and collaborate with school district efforts to implement complementing mental health initiatives. For example, the district in which this AmeriCorps program serves committed to training all of their teachers in YMHFA. This means that school staff and AmeriCorps members were familiar with the ALGEE action plan and able to support one another in implementation. Since cost can be a major barrier to program adoption, creative solutions such as acquiring grant funding and/or

pursuing collaborations between organizations, non-profits, and school districts can be helpful in defraying costs associated with mental health training. For example, the current study was funded through a three-part collaboration between the University of Maryland, AmeriCorps, and a local non-profit committed to supporting community mental health. Finally, timing of mental health training is important. Corps members serve only one year in the school. To reap the full benefits of a training program, it is recommended that corps members participate in the training in their pre-service teaching bootcamp, so they are prepared to support students' mental health immediately upon entering the school.

Participation in AmeriCorps programs is often regarded as highly rewarding, yet difficult and stressful. Notably, over 50% of participants had experience with mental illness. Additionally, retention is a challenge, perhaps because of the stress corps members take on. AmeriCorps programs have committed to enhancing their corps mental health. This was reflected in the AmeriCorps program choosing to also train managers in Adult MHFA with the hope that managers would be able to better support corps members with mental health difficulties. Although the current study focused on how YMHFA training relates to improvements in student mental health, it appears the corps' training may have also positively impacted corps members, even though they participated in YMHFA. City Year leadership believed training gave corps members a place to feel safe disclosing their own mental health struggles, which led to greater empathy and stronger bonds between team members. It is possible that training in YMHFA could lead to positive cultural shifts within the organization, although this would require greater investigation.

In sum, the AmeriCorps program leadership believed that participation in YMHFA provided the corps a meaningful professional development opportunity, helped them support

their students, and may have contributed to a more positive culture shift around mental health issues. Choosing to adopt a mental health training initiative should be done carefully, with specific attention to various factors such as cost, time commitment, and overall goals.

Youth Mental Health First Aid

While the YMHFA program was generally well received by the AmeriCorps organization and attendees, areas for improvement were apparent. Some challenges were apparent before the course was delivered. Qualitative data revealed areas for improvement related to the course content and relevance to diverse populations. Follow-up quantitative data indicated that additional value may be obtained through the incorporation of a booster or refresher course.

YMHFA USA is an eight-hour course that must be taught by certified instructors. Organizations typically collaborate with outside trainers to deliver the course to their employees which means coordinating organization and instructor availability can be difficult. In particular, employees are often unable to give up a full day to participate in the eight-hour YMHFA training. This is especially true for teachers who have limited days devoted to professional development. Since this study was conducted, YMHFA released a hybrid version of the course in which participants can complete part online and the remainder in-person. This may make YMHFA more accessible. Perhaps, educators could complete the online component in small segments in a more flexible timeframe, and then complete the in-person training during professional development. This new model may make YMHFA more accessible, and future research should assess whether model differences impact outcomes.

Participants thought the program has strengths and areas for improvement in meeting the needs of diverse populations. Although 15% of participants noted that the action plan is flexible and can be applied to students from diverse backgrounds, nearly half of participants indicated

that cultural factors related to attitudes about mental health can impede first aiders' ability to help. More specifically, sub-themes emerged showing barriers to providing help include stigma related to culture and diverse symptom presentations. Although instructor materials offer guidance on how to tailor the course to diverse individuals, it would be meaningful to embed greater culture related information into the core course. Participants' qualitative data revealed that YMHFA improvement efforts should focus on expanding course dialogue and instruction related to culture. After leading numerous YMHFA courses, I echo participants' thoughts and argue that the course needs greater emphasis on culture in addition to anti-racist content that acknowledges disparities related to mental health and equips first aiders with skills to contribute to more equitable mental health care. For example, the course would benefit from explicitly acknowledging how both systemic oppression and individual acts of racism can impact mental health and mental health care for people of color. Further, some participants noted that YMHFA relies on the assumption that the first aider and youth speak the same language. First aiders need specific strategies to use when encountering stigma and as well as a skillset to draw upon when a first aider and youth do not speak a common language. Taken together, it is insufficient to have an optional guide containing information related to culture that can be integrated into the core course should an instructor decide to integrate this information. This information needs to be expanded upon and embedded within the core course. Despite these areas for growth, participants appreciated that the activities within the course felt relevant and mirrored real life. YMHFA developers can expand upon this strength and include case examples with more diverse individuals whose mental health difficulties are mitigated or exacerbated by culture-related factors. Including these types of case examples may push trainees to work through similar challenges they may encounter in real life. In conclusion, the course would benefit from more

culture-related content and a greater integration of this information throughout the entirety of the program.

As noted in the general discussion section, participants showed improvements in many constructs assessed after participation in YMHFA. Unfortunately, many of these improvements were not sustained at follow-up. YMHFA is typically delivered through one eight-hour course and covers substantial content. The program may consider including a follow-up booster session that reviews important content. The booster session may feature a structured section and also have a semi-structured component in which first aiders can raise challenges and offer success stories associated with using the ALGEE action plan. Follow-up modules may also be tailored to specific populations. In other words, a refresher course could be developed specifically focusing on educators. This could help teachers learn more about school-specific policies and practices, and may also allow for teacher-specific case examples.

Although results from the study indicate that YMHFA was generally well-received and well-suited for this population of classroom educators, YMHFA developers may consider making improvements to the course. These enhancements would generally improve the quality of the course, support longer-term impacts of the course, and better support diverse populations.

Research/Future Directions

A strength of this study is that it was one of the first to evaluate YMHFA's application to a specific population (AmeriCorps classroom educators) that has received relatively little attention in the literature despite working with millions of youth. Further, it is one of the first to inquire about YMHFA's cultural sustainability and to evaluate YMHFA training among a predominantly Black and Latinx population. These findings revealed the importance of future research assessing the ways in which the program can be improved to better support diverse

trainees and youth they work with. However, the information used to answer the question regarding the challenges and benefits of using this program to meet the needs of culturally and linguistically diverse students was only collected through short answers. Future studies should use interviews and focus groups in order to gather more information about the strengths and challenges of the program, as well as provide specific insight into how the program can be enhanced and made more equitable.

Recently, the National Council for Behavioral Health released an updated version of the training. YMHFA 2.0 is shorter (six hours versus eight) and utilizes a blended model in which participants can opt to complete half of the course electronically thus reducing the in-person time commitment. Activities included in the course were modified. Some aspects were removed such as a moving video series showing a man as he reflected on his childhood experience with bipolar disorder. Future research should not only use RCTs to assess outcomes among those who receive YMHFA versus those in a control group, but they should also be used to assess whether certain YMHFA formats (i.e., virtual, in-person, blended) are more effective than others.

Identifying the best format of YMHFA is important, as is determining whether similar mental health training programs are superior or possibly complement one another. YMHFA, QPR, and Psychological First Aid have all been identified as evidence-based mental health training programs and are used in the school setting. To my knowledge, no study has compared these interventions among the general population, let alone among classroom educators specifically. Knowledge of whether these programs differ in effectiveness may help schools identify which mental health training program to invest in. Similarly, research should evaluate whether certain demographic characteristics (i.e., age, previous mental health training, education

level) impact training outcomes. This information could be used to help schools determine who to train.

Nationwide, there are thousands of eligible YMHFA instructors. Instructors' backgrounds vary; some seek YMHFA trainer certification because of their career as mental health professionals, while others seek certification because of involvement in community organizations even though they have no prior mental health experience. Instructor certification requires that all instructors complete a manualized YMHFA instructor training program regardless of background. Nonetheless, it is possible that trainer features impact the experience of trainees. Future research should investigate whether any trainer characteristics impact trainee outcomes.

Finally, the ultimate goal of training classroom educators in YMHFA is to reduce the impact of students' mental health difficulties, and perhaps prevent these difficulties from emerging. In other words, the goal is that training in YMHFA results in actual behavior change in educators, leading to improved outcomes in student mental health. Despite this goal, inquiries into YMHFA have focused almost exclusively on trainee related outcomes. Future work should look at an amalgam of school-level and student-level outcomes following training educators. RCTs that investigate the trickle-down effects of training educators in the program are warranted (e.g., rates of ODRs, rates of school mental health referrals, school mental health climate). One group of scholars have started this work and evaluated Australia's version of YMHFA collected some student-level data and found that students reported receiving more information about mental health after teachers were trained (Jorm et al., 2010). This work is only preliminary and should be further assessed using the USA version of YMHFA.

Limitations

Although the present study has numerous strengths, it is not without limitations. This study, like other investigations into YMHFA, has a somewhat small-sample size for quantitative analyses, even though power analyses suggested that we had obtained a sufficient sample size to detect change. Even though power analyses were set to 0.80, which is consistent with the thresholds, there is a 20% possibility that with a sample size of 75, I missed the effects I was looking for with regards to changes in stigma. Further, with a larger sample, it may have been possible to look at outcomes in relation to covariates. Further, causal conclusions are not possible due to the lack of randomized control. Confounds exist which threaten the internal validity of the study. For example, most participants were new to the education system (averaging 10 months of classroom education experience). All participants were new to the specific school in which they worked. Therefore, it is possible that improvements in variables are not a result of YMHFA but rather because of general exposure and experience within the school setting. With regards to the qualitative data, it was not possible to follow-up on participants' responses which limits the inferences that can be drawn from brief responses. Small group follow-up interviews would offer richer data and provide greater insight into participants' thoughts regarding the utility and cultural sustainability of the program.

The sample included in this study is unique and understudied. However, it is not reflective of the diverse range of classroom professionals, which means these findings may not generalize to other populations. All participants were enrolled in a specific AmeriCorps program located in a specific region. No participants were lead classroom teachers, and the majority have a different background than that of both the average teacher and paraeducator. Participants in this sample were significantly younger than the average teacher (U.S. Department of Education,

2012) and the sample was more heterogenous with regards to participants' level of education. Participants ranged from having a high school degree to an advanced degree. The plurality held bachelors', albeit across diverse disciplines. Despite threats to generalizability, the unique sample is a strength of the study since scholarship on this population is substantially under-represented.

Although the YMHFA program is a manualized intervention, trainer effects are possible. Three of the courses were taught by two advanced doctoral students in psychology and the other two were taught by a trainer who regularly teaches the class. There is substantial heterogeneity of instructor background, and the training includes many optional exercises/activities, so it is possible such factors may impact what participants gain from the training. Moreover, YMHFA does not have fidelity checks to assess the integrity with which instructors adhered to the program.

Participants were required to enroll in the training as part of their employment with the AmeriCorps program. However, participation in the research study was optional. Many participants willingly participated, and some expressed excitement for the opportunity to contribute to the research base. Nonetheless, some seemed burdened by completing the survey and may not have responded in a valid manner. Despite efforts to remove aberrant responses, it is possible some were overlooked and remained for the analyses. Additionally, some participants left the AmeriCorps program between post-test and follow-up. Few participants who were no longer employed by AmeriCorps completed the follow-up. Nonetheless, those who did may not have had contact with youth, thus reducing their opportunities to utilize the skills, ultimately deflating the relationship between participation in YMHFA and engagement in mental health

first aid behaviors. Notably, there may have been certain characteristics associated with participants who left the program.

Conclusion

This study examined classroom educators' changes in MHL, engagement in MHFA behaviors, MHFA intentions, mental health stigma, and confidence in engaging in MHFA before, immediately after, and two to four months after YMHFA training. Scholars have conducted similar studies within the general population, but limited research has focused on educators. Classroom educators' role in supporting youth mental health is significant. Educators provide informal mental health support and are the most likely adult to facilitate formal school-based care. Of note, youth are most likely to receive mental health care in schools. To the author's knowledge, no studies have been conducted with AmeriCorps members, despite AmeriCorps members educating millions of America's youth. The majority of participants in this study identified as Black and/or Latinx, and work with a similar demographic of students. Qualitative data were used to assess whether YMHFA is a culturally sustaining program that supports educators in providing mental health first aid to a culturally and linguistically diverse population. Qualitative data also investigated participants' perception of whether the YMHFA program is relevant in their role as educators. Participants' responses indicate that they felt the program was helpful and beneficial to them as classroom educators, though they noted areas in which the program can be enhanced to be more appropriate for diverse youth. Some themes emerged indicating areas in which the program is already a good fit for culturally and linguistically diverse youth. In general, quantitative findings suggested that participation in YMHFA is related to improvements in most of the constructs of interest (e.g., MHL, engagement in MHFA behaviors). Unfortunately, some of these improvements were not maintained,

indicating the need for booster courses. Taken together, YMHFA is a viable professional development training program for educators but it is not without limitations.

Appendices

Appendix A: Data Collection Plan

	Pre-test	Post-test	Follow-up
Demographics, School Role, and Mental Health Experience	X		
Mental Health Literacy	X	X	X
Mental Health First Aid Behaviors	X		X
Confidence in Helping Behaviors	X	X	X
Mental Health Stigma	X	X	X
Awareness of School Resources	X	X	X
Acceptability		X	
Intentions of Providing Help	X	X	X

Appendix B: Demographic Questionnaire

1. What is your age? ____
2. How do you identify with regards to gender?
 - a. Woman
 - b. Man
 - c. Transgender
 - d. Non-binary
 - e. Gender fluid
 - f. Gender neutral
 - g. Other: _____
3. What is your race and ethnicity? (Check all that apply)
 - a. Asian
 - b. Black or African American
 - c. Native Hawaiian or Other Pacific Islander
 - d. Native American or Alaska Native
 - e. White
 - f. Hispanic/Latino/Latinx
4. Classroom Experience (years, months)
 - a. _____
5. Current grade(s) you're teaching
 - a. _____
6. Current subject(s) you're teaching
 - a. _____
7. School in which you're teaching:
 - a. _____
8. Highest level of education completed
 - a. High school degree or equivalent
 - b. Associate
 - c. Bachelor's degree
 - d. Advanced degree (e.g., masters or doctoral)
 - e. Other _____
9. If you have completed 2 or more years of higher education (after high school), what is/was your field of study? _____
10. Are you presently taking classes for any of the following?
 - a. No
 - b. Associate's/Trade Degree
 - c. Bachelor's degree
 - d. Master's degree
 - e. Professional/doctorate degree
11. Have you ever done any previous mental health training? (including material covered in college courses and short-term training programs)
 - a. Yes
 - b. No

- c. If yes: Briefly describe your previous mental health training. _____
12. Have you or someone close to you ever been diagnosed with a mental illness? (check all that apply)
- a. Yes, myself
 - b. Yes, a relative
 - c. Yes, a friend
 - d. No
13. Have you or someone close to you ever sought professional help or treatment for a mental illness? (check all that apply)
- a. Yes, myself
 - b. Yes, a relative
 - c. Yes, a friend
 - d. No

Appendix C: Mental Health Literacy

The purpose of these questions is to gain an understanding of your knowledge of various aspects to do with mental health. When responding, we are interested in your degree of knowledge. Therefore when choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely

Unlikely = I think it is unlikely but am not certain

Likely = I think it is likely but am not certain

Very Likely = I am certain that it IS very likely

1

If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have Social Phobia?

Very unlikely Unlikely Likely Very Likely

2

If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry and had physical symptoms such as having tense muscles and feeling fatigued then to what extent do you think it is likely they have Generalized Anxiety Disorder?

Very unlikely Unlikely Likely Very Likely

3

If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep then to what extent do you think it is likely they have Major Depressive Disorder?

Very unlikely Unlikely Likely Very Likely

4

To what extent do you think it is likely that Personality Disorders are a category of mental illness?

Very unlikely Unlikely Likely Very Likely

5

To what extent do you think it is likely that Dysthymia is a disorder?

Very unlikely Unlikely Likely Very Likely

6

To what extent do you think it is likely that the diagnosis of Agoraphobia includes anxiety about situations where escape may be difficult or embarrassing?

Very unlikely Unlikely Likely Very Likely

7

To what extent do you think it is likely that the diagnosis of Bipolar Disorder includes experiencing periods of elevated (i.e., high) and periods of depressed (i.e., low) mood?

Very unlikely Unlikely Likely Very Likely

8

To what extent do you think it is likely that the diagnosis of Drug Dependence includes physical and psychological tolerance of the drug (i.e., require more of the drug to get the same effect)?

Very unlikely Unlikely Likely Very Likely

9

To what extent do you think it is likely that in general in the United States, women are MORE likely to experience a mental illness of any kind compared to men?

Very unlikely Unlikely Likely Very Likely

10

To what extent do you think it is likely that in general, in the United States, men are MORE likely to experience an anxiety disorder compared to women?

Very unlikely Unlikely Likely Very Likely

When choosing your response, consider that:

Very Unhelpful = I am certain that it is NOT helpful

Unhelpful = I think it is unhelpful but am not certain

Helpful = I think it is helpful but am not certain

Very Helpful = I am certain that it IS very helpful

11

To what extent do you think it would be helpful for someone to improve their quality of sleep if they were having difficulties managing their emotions (e.g., becoming very anxious or depressed)?

Very unhelpful Unhelpful Helpful Very helpful

12

To what extent do you think it would be helpful for someone to avoid all activities or situations that made them feel anxious if they were having difficulties managing their emotions?

Very unhelpful Unhelpful Helpful Very Unhelpful

When choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely

Unlikely = I think it is unlikely but am not certain

Likely = I think it is likely but am not certain

Very Likely = I am certain that it IS very likely

13

To what extent do you think it is likely that Cognitive Behavior Therapy (CBT) is a therapy based on challenging negative thoughts and increasing helpful behaviors?

Very unlikely Unlikely Likely Very Likely

14

Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to break confidentiality:

If you are at immediate risk of harm to yourself or others

Very unlikely

Unlikely

Likely

Very Likely

15

Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to break confidentiality:

if your problem is not life-threatening and they want to assist others to better support you

Very unlikely

Unlikely

Likely

Very Likely

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
16. I am confident that I know where to seek information about mental illness					
17. I am confident using the computer or telephone to seek information about mental illness					
18. I am confident attending face to face appointments to seek information about mental illness (e.g., seeing the General Practitioner)					
19. I am confident I have access to resources (e.g., General Practitioner, internet, friends) that I can use to seek information about mental illness					

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
20. People with a mental illness could snap out if it if they wanted					
21. A mental illness is a sign of personal weakness					
22. A mental illness is not a real medical illness					
23. People with a mental illness are dangerous					
24. It is best to avoid people with a mental illness so that you don't develop this problem					
25. If I had a mental illness I would not tell anyone					

26. Seeing a mental health professional means you are not strong enough to manage your own difficulties					
27. If I had a mental illness, I would not seek help from a mental health professional					
28. I believe treatment for a mental illness, provided by a mental health professional, would not be effective					

Please indicate to what extent you agree with the following statements:

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
29. How willing would you be to move next door to someone with a mental illness?					
30. How willing would you be to spend an evening socializing with someone with a mental illness?					
31. How willing would you be to make friends with someone with a mental illness?					
	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
32. How willing would you be to have someone with a mental illness start working closely with you on a job?					
33. How willing would you be to have someone with a mental illness marry into your family?					
34. How willing would you be to vote for a politician if you knew they had suffered a mental illness?					
35. How willing would you be to employ someone if you knew they had a mental illness?					

Appendix D: Intentions to Engage in Mental Health First Aid Behaviors and Scoring Rules

1. Jenny is a 15 year old who has been feeling unusually sad and miserable for the last few weeks. She is tired all the time and has trouble sleeping at night. Jenny doesn't feel like eating and has lost weight. She can't keep her mind on her studies and her marks have dropped. She puts off making any decisions and even day-to-day tasks seem too much for her. Her parents and friends are very concerned about her. Jenny feels she will never be happy again and believes her family would be better off without her. She has been so desperate, she has been thinking of ways to end her life.

Imagine Jenny is a young person you know. You want to help her. What would you do?

2. John is a 15 year old who lives at home with his parents. He has been attending school irregularly over the past year and has recently stopped attending altogether. Over the past six months he has stopped seeing his friends and begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear him walking about in his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbor. They realize he is not taking drugs because he never sees anyone or goes anywhere.

Imagine John is a young person you know. You want to help him. What would you do?

- Scoring is done on a 0-10 point scale. It is based on the ALGEE action plan. The individual score for each aspect of ALGEE is put in a corresponding box. A total score is then calculated.
 - For example: A=0, L=1, G=1, E (professional)=0, E (self)=0, TOTAL=2
- A 10 point answer would look something like this:
 - Assess for risk of suicide and harm
 - Listen non-judgmentally
 - Give reassurance and information
 - Encourage professional help
 - Encourage self-help and other support strategies
- If a participant writes the term “ALGEE” they get a base of 5 points. If they add more detail beyond writing the acronym, they could earn up to an additional one point for each letter (depending on the level of detail).
 - For example, if they say “ALGEE. I would assess for suicide.” That would be 6 points (5 for ALGEE, 1 extra for specifying the A).
- Participants earn 1 point for each part of ALGEE they touch on but do not give enough depth. For example, the following responses would all earn 1 point (each):
 - Assess
 - Talk to the child/listen to the child
 - Empathize (1 point for reassurance)
 - Ask if the child wants professional help
 - Encourage the child to talk to his/her parents
- If they do not touch on any parts of this, they get a score of 0.
 - For example, “This child needs help.”

Additional notes:

- **A:** For assessing, the response can get 1 point if they make any mention of the fact that they are concerned about suicidality, self-harm, or harm of others. However, they must **EXPLICITLY** say that they would ask questions or assess in order to earn 2 points. Need to mention asking questions **AND** self-harm for 2. Just asking questions = 1.
- **L:** Can earn 1 point for anything about talking to the child, asking questions, listening, etc. They must explicitly say that they would listen without judgement to earn 2 points.
- **G:** Need to say give reassurance and information to earn 2 points. In order to earn 1 point for this, the response must either touch on providing reassurance (e.g., saying they would tell the child it will all be okay, that things will get better, etc.) or say they would give the child information. Information is about the mental illness, not about resources, help, etc.
- **E (professional):** If the response says that they would either encourage the child to seek professional help or take the child there directly, it’s 2 points. If they say they would tell the parents or someone else to get professional help, that’s 1 point. If the parent says they would call professional help for ideas, resources, etc. that’s 1 point.
- **E (self-help):** A 2 point response could touch on any form of self-help (e.g., deep breaths, self-talk) or utilizing informal sources of support (e.g., talking to family and friends). However, for 2 points the response must say they would tell the child to use these strategies. If they simply mention that these would be helpful (e.g., the child should talk to her friends) that is only 1 point.

Appendix E: Engagement in Mental Health First Aid Helping Behaviors

1. Over the past 2 months, how many times have you come into contact with a youth who has a mental health concern? _____
2. Over the past 2 months, how many times have you talked to a young person about their mental health problem? _____
3. Over the past two months, how many times have you:
Never Once A few times Many times
Talked with a young person about their mental health problem?
Spent time listening to their problem?
Helped to calm them down?
Talked to them about suicidal thoughts?
Recommended they seek professional help?
Recommended self-help strategies?
Gave them information about their problem?
Gave them information about local services?
Made an appointment for them with services?
Referred them to books or websites about their problem?
4. Did you do anything else? If so, what?

Appendix F: Confidence in Providing Mental Health First Aid

Please rate the degree to which you agree or disagree with each statement below.

	Strongly Disagree				Strongly Agree
1. I feel confident in my ability to ask school-aged youth questions that determine whether they are at risk to physically harm themselves or others.	1	2	3	4	
2. I have the skills necessary to patiently listen and not judge school-aged youth when they talk about their mental health problems.	1	2	3	4	
3. I feel comfortable in helping school-aged youth feel reassured that supports are available when they are experiencing mental health problems.	1	2	3	4	
4. I feel confident in my ability to refer a school-aged youth who is experiencing mental health problems to appropriate school-based and/or community-based resources.	1	2	3	4	
5. I have the knowledge necessary to recommend effective self-help strategies to school aged youth experiencing mental health problems.	1	2	3	4	

Appendix G: Mental Health Stigma

Directions: For each item, indicate whether you strongly disagree, disagree, somewhat disagree, somewhat agree, agree, or strongly agree.

The term “psychological problems” refer to reasons one might visit a professional. Similar terms include: mental health concerns, emotional problems, mental troubles, and personal difficulties. The term “professional” refers to individuals who have been trained to deal with mental health problems (e.g., psychologist, psychiatrist, social workers, and physicians).

1. I would not want others (friends, family, teachers, etc.) to know if I had a psychological or behavior problem.
2. Having been mentally ill carries with it feelings of shame.
3. Important people in my life would think less of me if they were to find out that I had a psychological or behavior problem.
4. I would be uncomfortable seeking professional help for myself because people (friends, family, coworkers, etc.) might find out about it.
5. I would feel uneasy going to a professional because of what some people would think.
6. Had I received treatment for a psychological or behavior problem, I would feel that it should be “kept secret.”
7. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with mental health concerns.

Appendix H: Utility of the Youth Mental Health First Aid Program

1 (Strongly Disagree); 2 (Disagree); 3 (Agree); 4 (Strongly Agree)

1. I liked this program.
2. This program was useful to me.
3. I am satisfied with this program.
4. This program met my expectations.
5. I would recommend this program to my relatives and friends.

Appendix I: School Mental Health Resources Scoring Guide

<p>School Based MH Providers/Resources</p> <p>Art therapy counselors Behavior Interventionist Citrus (Citrus Health Center) Community Outreach Org (w/ mental health focus) Crisis worker Grief Counselor Guidance Counselor HIP Instructor/Therapist/Counselor Interventionist Jackson mental health therapist Life Coach Mental Health Aid Worker Mental Health Group Mental Health Professional/Advisor Mental Wellbeing Counselor Student Mental Health club (Mind and Wellness Club) Nurse Positive Behavior Support Coach/Team Psychiatrist Psychologist School-based mental health clinic School Counselor School Psychologist School Therapist Social Worker Success Coach Therapist Trust Counselor/ Trust for Children</p>	<p>Helpful & School Based but NOT formal mental health:</p> <p>Administration (Principal/Assistant Principal) City Year Mandated Reporter Special Ed teacher Peer organization/Student Group/ Mentorship club (GSA, Girls Power, Gang Alternative) Teacher Title 1 Director</p>
	<p>Not school based but good professional mental health services:</p> <p>911 American Foundation for Suicide Prevention Hospital Outside therapist (unless they come into the school) Hotline NAMI</p>
	<p>Answers that don't fit anywhere (i.e., they may be super vague or they may not be helpful at all). For example, one participant said "website" which is too vague, especially because there are some websites that are outright harmful.</p>

Appendix J: Open-Ended Questions

What mental health services are available at your school and/or who are the people that provide mental health services? List all that you can think of.

How do you think this program prepares you, or doesn't prepare you, to work with students at your school?

What are the challenges and benefits of using this program to meet the needs of culturally and linguistically diverse students?

Tables

Table 1 Participant Demographics

Demographic Characteristics	<i>n (%) (N=106)</i>
Gender	
Woman	84(79)
Man	16(15)
Non-Binary	1(0.9)
Unknown	5(5)
Race/Ethnicity	
Black/African American	63(59)
Hispanic/Latinx	22(21)
White	6(6)
Asian/Asian American	4(4)
Multi-Racial	3(3)
Unknown	5(5)
Highest Degree Earned	
High School/GED degree	29(27)
Associate's degree/Some College	10(9)
Bachelor's degree	60(57)
Professional or doctorate degree	2(2)
Unknown	5(5)
Field of Study Post High School	
Liberal Arts	23(22)
Psychology/Social Work	17(16)
Sciences	10(9)
Education	8(8)
Business	7(7)
Communication	6(6)
General Studies	2(2)
Technology	1(0.9)
Unknown/NA	32(30)
Prior Mental Health Training	
Yes	41(39)
No	60(57)
Unknown	5(5)
Mental Health Diagnosis	
Self	18(17)
Relative	38(36)
Friend	30(28)
None	43(41)
Unknown	4(4)

Mental Health Treatment

Self	23(22)
Relative	35(33)
Friend	30(28)
None	43(41)
Unknown	5(4)

Table 2 Teaching Characteristics

Teaching Characteristics	<i>n (%) (N=106)</i>
Grade Level Taught	
Middle School	31(29)
Junior High	62(58)
Senior High	2(2)
Middle School and Junior High	1(0.9)
Unknown	10(9)
Subject Taught	
ELA/Reading	48(46)
Math	39(37)
ESL	7(7)
Unknown	16(15)

Table 3 Descriptive Statistics of Outcome Variables and Repeated Measure ANOVAs Assessing Change in Variables Over Time

Outcome	Pre-Test			Post-Test			Follow-Up			χ^2 Comparing Null Model to RM-ANOVA Model	Pair-wise Post Hoc	Pair-wise Cohen's <i>d</i>
	Mean	SD	n	Mean	SD	n	Mean	SD	n			
Mental Health Stigma	1.67	1.14	101	1.59	1.05	99	1.85	1.25	65	3.76	N/A	N/A
Mental Health Literacy ^b	127.93	15.23	100	131.77	13.87	100	128.90	16.27	65	15.59***	T1<T2** T2>T3**	0.43 0.41
Confidence in MHFA Skills	3.14	0.69	101	3.50	0.56	99	3.44	0.54	65	^a F(1.76,94.79)=15.33***	T1<T2*** T1<T3**	0.60 0.39
Behav. Intentions – Depression	2.57	1.31	93	3.35	1.65	86	2.94	1.43	51	18.80***	T1<T2*** T2>T3*	0.44 0.54
Behav. Intentions – Schizophrenia	1.49	0.90	92	2.39	1.55	84	1.94	1.17	51	31.98***	T1<T2*** T2>T3*	0.63 0.42
Knowledge of SBMH Providers	1.15	0.59	65	1.69	1.10	65	1.65	1.00	40	19.51***	T1<T2*** T1<T3**	0.57 0.41

^a Because the assumption of sphericity was violated, the Greenhouse Geisser statistic and corrected statistics are used.

^b Mental health literacy score is presented as sum score in order to compare to other studies using this measure. See methods section for more information.

p* < .05. *p* < .01. ****p* < .001

Table 4 Descriptive Statistics for Engagement in MHFA Behaviors and Paired-Sample T-Tests Assessing Change Over Time

Action	Pre-Test			Follow-Up			T-Test Statistics				
	Mean	SD	n	Mean	SD	n	M _{diff}	95% C.I. of M _{diff}	t	df	Cohen's <i>d</i>
Total MHFA Behaviors	2.03	0.73	101	2.46	0.65	62	0.38	[0.19, 0.56]	4.10***	57	0.54
Assessing	2.18	1.07	101	2.71	0.96	62	0.41	[0.14, 0.68]	3.07**	57	0.40
Listening	2.97	1.02	101	3.27	0.63	62	0.17	[- 0.49, 0.15]	1.08	57	NA
Giving Reassurance	2.84	1.01	100	3.11	0.70	62	0.19	[-0.49, 0.11]	1.26	57	NA
Encouraging Professional Help	1.49	0.84	101	1.92	1.03	62	0.47	[0.20, 0.73]	3.56***	57	0.47
Encouraging Self-Help	1.76	1.11	101	2.34	1.02	62	0.52	[0.21, 0.83]	3.56**	57	0.44

* $p < .05$. ** $p < .01$. *** $p < .001$

Table 5 Frequency of Acceptability Scale Responses

Item	Strongly Disagree n(%)	Disagree n(%)	Agree n(%)	Strongly Agree n(%)
Liked the program	1(1)	1(1)	32(32)	66(66)
Found program useful	1(1)	1(1)	26(26)	71(72)
Satisfied with program	1(1)	0(0)	31(32)	66(67)
Program met expectations	1(1)	1(1)	33(34)	63(64)
Would recommend program to family/friends	1(1)	2(2)	26(27)	70(71)

Table 6 Themes and Subthemes: AmeriCorps Members' Perception of Role-Specific

Benefits of YMHFA

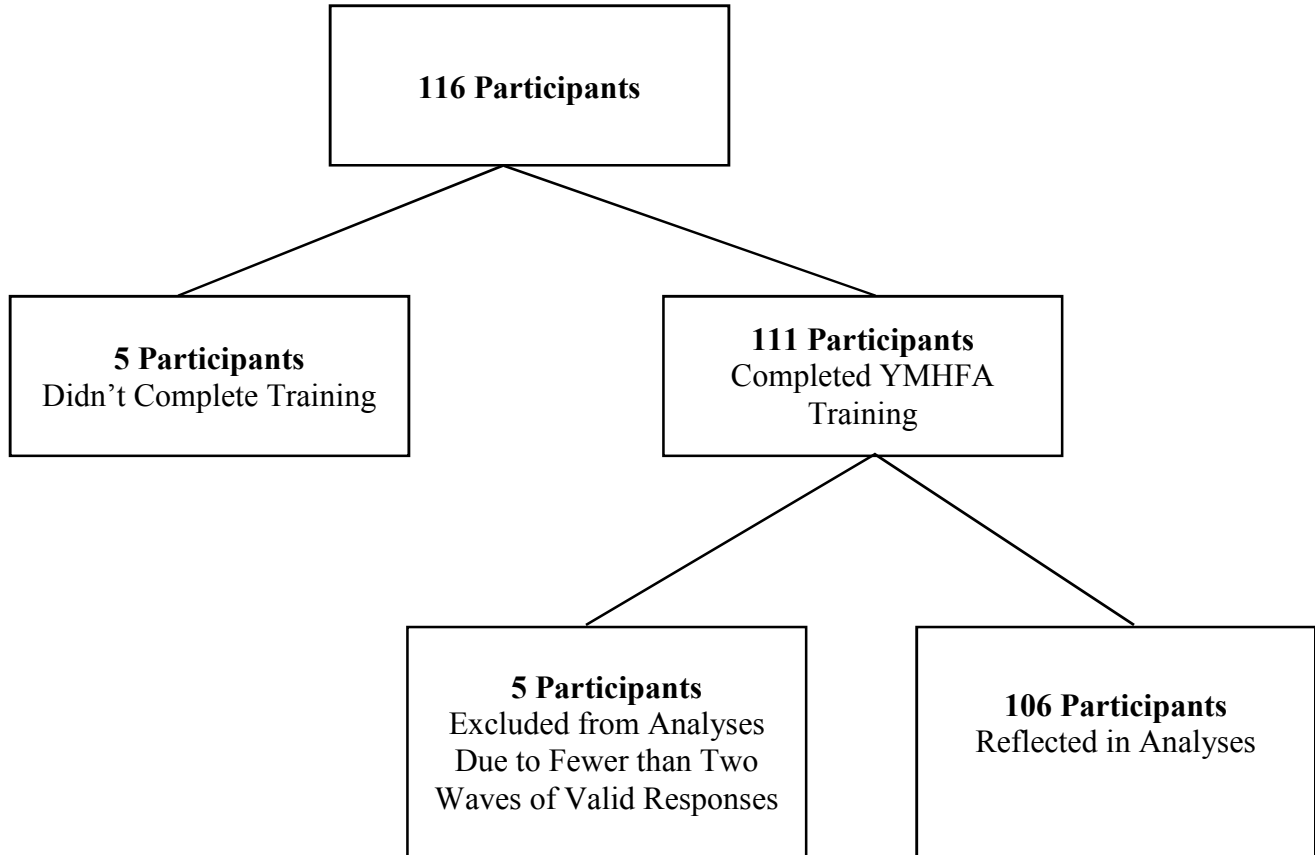
Theme	Endorsed n(%)
Knowledge and Skills to Respond	63(64)
Address a General Mental Health Concern	44(44)
Approach a Student Experiencing a Mental Health Difficulty	12(12)
Support a Student Experiencing a Mental Health Crisis	7(7)
Awareness About Youth Mental Health	20(20)
Recognition of Signs and Symptoms of Mental Illness	15(15)
Course Content Delivered in Digestible Manner	10(10)

Table 7 Themes and Subthemes: AmeriCorps Members' Perception of YMHFA to Meet the Needs of Culturally and Linguistically Diverse Students

Theme	Endorsed n(%)
Negative Perceptions	
Attitudes About Mental Health and Subsequent Actions Differ by Culture	37(42)
One Size Fits All Approach to Mental Health is Inadequate	16(18)
Stigma Related to Culture is a Barrier to YMHFA	9(10)
Recognition, Beliefs, and Interpretations of Behaviors Differ by Culture	6(7)
Course Content and Delivery of the YMHFA Training Program	7(8)
Implicit Assumption that First Aider and Youth Speak Common Language	7(8)
Challenges Not Specific To Culture	26(30)
Positive Perceptions	
Relevant and Versatile Action Plan	12(14)
Mental Health Awareness and Stigma Reduction Related to Culture	6(7)
Benefits Not Specific to Culture	26(30)

Figures

Figure 1 Participants' Involvement in Study



References

- Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In *Action control* (pp. 11–39). Springer.
- ALGEE-ometer*. (2019). Mental Health First Aid.
<https://www.mentalhealthfirstaid.org/algee-ometer/>
- American Psychological Association (2017). Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality. Retrieved from:
<http://www.apa.org/about/policy/multicultural-guidelines.pdf>
- Annamma, S., Morrison, D., & Jackson, D. (2014). Disproportionality fills in the gaps: Connections between achievement, discipline and special education in the school-to-prison pipeline. *Berkeley Review of Education*, 5(1).
- Annual Report | City Year*. (2018). <https://www.cityyear.org/about-us/annual-report>
- Anyon, Y., Lechuga, C., Ortega, D., Downing, B., Greer, E., & Simmons, J. (2018). An exploration of the relationships between student racial background and the school sub-contexts of office discipline referrals: A critical race theory analysis. *Race Ethnicity and Education*, 21(3), 390–406.
- Armitage, C. J., & Conner, M. (2001). Efficacy of the theory of planned behaviour: A meta-analytic review. *British Journal of Social Psychology*, 40(4), 471–499.
- Arora, P. G., Collins, T. A., Dart, E. H., Hernández, S., Fetterman, H., & Doll, B. (2019). Multi-tiered systems of support for school-based mental health: A systematic review of depression interventions. *School Mental Health*.
<https://doi.org/10.1007/s12310-019-09314-4>
- Banh, M. K., Chaikind, J., Robertson, H. A., Troxel, M., Achille, J., Egan, C., & Anthony, B. J. (2019). Evaluation of Mental Health First Aid USA Using the

- Mental Health Beliefs and Literacy Scale. *American Journal of Health Promotion*, 33(2), 237–247. <https://doi.org/10.1177/0890117118784234>
- Batista, A. M. (2015, November 3). *Census: 128 Languages Spoken In South Florida Homes*. <https://www.wlrn.org/post/census-128-languages-spoken-south-florida-homes>
- Belfield, C. (2013). *Center for Benefit-Cost Studies in Education Teachers College, Columbia University*. http://voicesforservice.org/wp-content/uploads/2016/03/Sep19_Econ_Value_National_Service-2.pdf
- Berelson, B. (1952). *Content analysis in communication research*.
- Berzin, S. C., O'Brien, K. H. M., Frey, A., Kelly, M. S., Alvarez, M. E., & Shaffer, G. L. (2011). Meeting the social and behavioral health needs of students: Rethinking the relationship between teachers and school social workers. *Journal of School Health*, 81(8), 493–501.
- Brown, D. L. (2008). African American resiliency: Examining racial socialization and social support as protective factors. *Journal of Black Psychology*, 34(1), 32–48.
- Bruns, E. J., Walrath, C., Glass-Siegel, M., & Weist, M. D. (2004). School-based mental health services in Baltimore: Association with school climate and special education referrals. *Behavior Modification*, 28(4), 491–512.
- Buchholz, B., Aylward, S., McKenzie, S., & Corrigan, P. (2015). Should youth disclose their mental health challenges? Perspectives from students, parents, and school professionals. *Journal of Public Mental Health*, 14(3), 159–168.

- Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M. Z., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*(3), 147–159. <https://doi.org/10.1377/hlthaff.14.3.147>
- Castro-Olivo, S. M. (2017). Introduction to special issue: Culturally responsive school-based mental health interventions. *Contemporary School Psychology, 21*(3), 177–180. <https://doi.org/10.1007/s40688-017-0137-y>
- Castro-Olivo, S. M., & Merrell, K. W. (2012). Validating cultural adaptations of a school-based social-emotional learning programme for use with Latino immigrant adolescents. *Advances in School Mental Health Promotion, 5*(2), 78–92. <https://doi.org/10.1080/1754730X.2012.689193>
- Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology, 70*(1), 44–55. <https://doi.org/10.1037/0022-006X.70.1.44>
- Center for Disease Control and Prevention. (2017). *Leading Causes of Death Reports*. <https://webappa.cdc.gov/sasweb/ncipc/leadcause.html>
- Chandra, A., & Minkovitz, C. S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health, 38*(6), 754.e1-754.e8. <https://doi.org/10.1016/j.jadohealth.2005.08.011>
- Chandra, A., & Minkovitz, C. S. (2007). Factors that influence mental health stigma among 8th grade adolescents. *Journal of Youth and Adolescence, 36*(6), 763–774. <https://doi.org/10.1007/s10964-006-9091-0>

- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*(1), 11–27. <https://doi.org/10.1017/S0033291714000129>
- Cohen, J. (2006). Social, emotional, ethical, and academic education: Creating a climate for learning, participation in democracy, and well-being. *Harvard Educational Review, 76*(2), 201–237.
- Cole, T. (2012, March 21). *The white-savior industrial complex* -. The Atlantic. <https://www.theatlantic.com/international/archive/2012/03/the-white-savior-industrial-complex/254843/>
- Collins, R. L., Roth, E., Cerully, J. L., & Wong, E. C. (2014). Beliefs related to mental illness stigma among California young adults. *Rand Health Quarterly, 4*(3). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5396207/>
- Colognori, D., Esseling, P., Stewart, C., Reiss, P., Lu, F., Case, B., & Warner, C. M. (2012). Self-disclosure and mental health service use in socially anxious adolescents. *School Mental Health, 4*(4), 219–230. <https://doi.org/10.1007/s12310-012-9082-0>
- Cook, C. R., Frye, M., Slemrod, T., Lyon, A. R., Renshaw, T. L., & Zhang, Y. (2015). An integrated approach to universal prevention: Independent and combined effects of PBIS and SEL on youths' mental health. *School Psychology Quarterly : The Official Journal of the Division of School*

Psychology, American Psychological Association, 30(2), 166–183.

<https://doi.org/10.1037/spq0000102>

Cooperation for National and Community Service. (2018). *AmeriCorps Members Demographic*. <https://data.nationalservice.gov/National-Service/AmeriCorps-Members-Demographic/2ca3-89j5>

Corrieri, S., Heider, D., Conrad, I., Blume, A., König, H.-H., & Riedel-Heller, S. G. (2014). School-based prevention programs for depression and anxiety in adolescence: A systematic review. *Health Promotion International, 29(3), 427–441*. <https://doi.org/10.1093/heapro/dat001>

Creswell, J. W., Plano Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). Advanced mixed methods research designs. *Handbook of Mixed Methods in Social and Behavioral Research, 209(240), 209–240*.

Cross, W., Matthieu, M. M., Cerel, J., & Knox, K. L. (2007). Proximate outcomes of gatekeeper training for suicide prevention in the workplace. *Suicide and Life-Threatening Behavior, 37(6), 659–670*.

Cunningham, J. M., & Suldo, S. M. (2014). Accuracy of teachers in identifying elementary school students who report at-risk levels of anxiety and depression. *School Mental Health, 6(4), 237–250*.
<https://doi.org/10.1007/s12310-014-9125-9>

Dadds, M. R., Spence, S. H., Holland, D. E., Barrett, P. M., & Laurens, K. R. (1997). Prevention and early intervention for anxiety disorders: A controlled trial. *Journal of Consulting and Clinical Psychology, 65(4), 627–635*.
<https://doi.org/10.1037/0022-006X.65.4.627>

- Davidson, M. W. (1999). Are teachers of children and young adolescents responsive to suicide prevention training modules? Yes. *Death Studies*, 23(1), 61–71.
- Dever, B. V., Dowdy, E., Raines, T. C., & Carnazzo, K. (2015). Stability and change of behavioral and emotional screening scores. *Psychology in the Schools*, 52(6), 618–629. <https://doi.org/10.1002/pits.21825>
- Dix, K. L., Slee, P. T., Lawson, M. J., & Keeves, J. P. (2012). Implementation quality of whole-school mental health promotion and students' academic performance. *Child and Adolescent Mental Health*, 17(1), 45–51. <https://doi.org/10.1111/j.1475-3588.2011.00608.x>
- Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-Year follow up of a nationally representative US survey. *Medical Care*, 49(6), 599–604. JSTOR.
- Egger, H. L., Costello, J. E., & Angold, A. (2003). School refusal and psychiatric disorders: A community study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(7), 797–807. <https://doi.org/10.1097/01.CHI.0000046865.56865.79>
- El-Badri, S., & Mellsop, G. (2007). Stigma and quality of life as experienced by people with mental illness. *Australasian Psychiatry*, 15(3), 195–200.
- Evans, G. W., & Kim, P. (2013). Childhood poverty, chronic stress, self-regulation, and coping. *Child Development Perspectives*, 7(1), 43–48. <https://doi.org/10.1111/cdep.12013>

- Fabrizio, C. S., Lam, T. H., Hirschmann, M. R., & Stewart, S. M. (2013). A brief parenting intervention to enhance the parent–child relationship in Hong Kong: Harmony@ Home. *Journal of Child and Family Studies*, 22(5), 603–613.
- Ford, T., & Nikapota, A. (2000). Teachers' attitudes towards child mental health services. *Psychiatric Bulletin*, 24(12), 457–461.
<https://doi.org/10.1192/pb.24.12.457>
- Franklin, C. G., Kim, J. S., Ryan, T. N., Kelly, M. S., & Montgomery, K. L. (2012). Teacher involvement in school mental health interventions: A systematic review. *Children and Youth Services Review*, 34(5), 973–982.
- Gardner, D. M., & Gerdes, A. C. (2015). A review of peer relationships and friendships in youth with ADHD. *Journal of Attention Disorders*, 19(10), 844–855.
- Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing*, 26(10), 979–999.
- Godin, G., & Kok, G. (1996). The theory of planned behavior: A review of its applications to health-related behaviors. *American Journal of Health Promotion*, 11(2), 87–98.
- Goodman, A., Joyce, R., & Smith, J. P. (2011). The long shadow cast by childhood physical and mental problems on adult life. *Proceedings of the National Academy of Sciences*, 108(15), 6032–6037.
<https://doi.org/10.1073/pnas.1016970108>
- Green, J., & Thorogood, N. (2004). Analysing qualitative data. In *Qualitative Methods for Health Research* (1st ed., pp. 173–200). Sage Publications, Inc.

- Gregory, A., Allen, J. P., Mikami, A. Y., Hafen, C. A., & Pianta, R. C. (2015). The promise of a teacher professional development program in reducing racial disparity in classroom exclusionary discipline. *Closing the School Discipline Gap: Equitable Remedies for Excessive Exclusion*, 168.
- Gryglewicz, K., Childs, K. K., & Soderstrom, M. F. (2018). An evaluation of youth mental health first aid training in school settings. *School Mental Health*, 10(1), 48–60.
- Guo, S., Kataoka, S. H., Bear, L., & Lau, A. S. (2014). Differences in school-based referrals for mental health care: Understanding racial/ethnic disparities between asian american and latino youth. *School Mental Health*, 6(1), 27–39. <https://doi.org/10.1007/s12310-013-9108-2>
- Hadlaczky, G., Hökby, S., Mkrtchian, A., Carli, V., & Wasserman, D. (2014). Mental Health First Aid is an effective public health intervention for improving knowledge, attitudes, and behavior. A meta-analysis. *International Review of Psychiatry*, 26. <https://doi.org/10.3109/09540261.2014.924910>
- Haggerty, D., Carlson, J. S., McNall, M., Lee, K., & Williams, S. (2019). Exploring Youth Mental Health First Aider Training Outcomes by Workforce Affiliation: A Survey of Project AWARE Participants. *School Mental Health*, 11(2), 345–356. <https://doi.org/10.1007/s12310-018-9300-5>
- Han, S. S., & Weiss, B. (2005). Sustainability of teacher implementation of school-based mental health programs. *Journal of Abnormal Child Psychology*, 33(6), 665–679. <https://doi.org/10.1007/s10802-005-7646-2>

- Hart, L. M., Cox, G. R., & Lees, L. (2018). Teaching mental health first aid in the school setting: A novel approach to improving outcomes for common adolescent mental disorders. *Current Opinion in Pediatrics*, 30(4), 478. <https://doi.org/10.1097/MOP.0000000000000639>
- Hart, L. M., Mason, R. J., Kelly, C. M., Cvetkovski, S., & Jorm, A. F. (2016). ‘teen Mental Health First Aid’: A description of the program and an initial evaluation. *International Journal of Mental Health Systems*, 10(1), 3. <https://doi.org/10.1186/s13033-016-0034-1>
- Howard, T. C. (2003). Who receives the short end of the shortage? Implications of the U.S. teacher shortage on urban schools. *Journal of Curriculum and Supervision*, 18(2), 142–160.
- Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277–1288.
- Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *The American Psychologist*, 67(3), 231–243. <https://doi.org/10.1037/a0025957>
- Jorm, A. F., Kitchener, B. A., Sawyer, M. G., Scales, H., & Cvetkovski, S. (2010). Mental health first aid training for high school teachers: A cluster randomized trial. *BMC Psychiatry*, 10. <https://doi.org/10.1186/1471-244X-10-51>
- Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). Mental health literacy: A survey of the public’s ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *The Medical Journal of Australia*, 166(4), 182.

- Jorm, A. F., Wright, A., & Morgan, A. J. (2007). Beliefs about appropriate first aid for young people with mental disorders: Findings from an Australian national survey of youth and parents. *Early Intervention in Psychiatry, 1*(1), 61–70. <https://doi.org/10.1111/j.1751-7893.2007.00012.x>
- Jung, H., von Sternberg, K., & Davis, K. (2016). Expanding a measure of mental health literacy: Development and validation of a multicomponent mental health literacy measure. *Psychiatry Research, 243*, 278–286. <https://doi.org/10.1016/j.psychres.2016.06.034>
- Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*(9), 1548–1555. <https://doi.org/10.1176/appi.ajp.159.9.1548>
- Kelly, C. M., Jorm, A. F., & Wright, A. (2007). Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Medical Journal of Australia, 187*(7).
- Kelly, C. M., Mithen, J. M., Fischer, J. A., Kitchener, B. A., Jorm, A. F., Lowe, A., & Scanlan, C. (2011). Youth mental health first aid: A description of the program and an initial evaluation. *International Journal of Mental Health Systems, 5*(1), 4. <https://doi.org/10.1186/1752-4458-5-4>
- Knapp, M., McDaid, D., & Parsonage, M. (2011). *Mental health promotion and mental illness prevention: The economic case*.
- Koller, J. R., Osterlind, S. J., Paris, K., & Weston, K. J. (2004). Differences between novice and expert teachers' undergraduate preparation and ratings of

importance in the area of children's mental health. *International Journal of Mental Health Promotion*, 6(2), 40–45.

<https://doi.org/10.1080/14623730.2004.9721930>

Kutcher, S., Wei, Y., & Coniglio, C. (2016). Mental health literacy: Past, present, and future. *Canadian Journal of Psychiatry*, 61(3), 154–158.

Kutcher, S., Wei, Y., & Morgan, C. (2015). Successful application of a Canadian mental health curriculum resource by usual classroom teachers in significantly and sustainably improving student mental health literacy. *The Canadian Journal of Psychiatry*, 60(12), 580–586.

Lewis, C. W., James, M., Hancock, S., & Hill-Jackson, V. (2008). Framing African American students' success and failure in urban settings: A typology for change. *Urban Education*, 43(2), 127–153.

Loades, M. E., & Mastroyannopoulou, K. (2010). Teachers' recognition of children's mental health problems. *Child and Adolescent Mental Health*, 15(3), 150–156.

Lyon, A. R., Ludwig, K. A., Stoep, A. V., Gudmundsen, G., & McCauley, E. (2013). Patterns and predictors of mental healthcare utilization in schools and other service sectors among adolescents at risk for depression. *School Mental Health*, 5(3), 155–165. <https://doi.org/10.1007/s12310-012-9097-6>

Mark, T. L., Levit, K. R., Buck, J. A., Coffey, R. M., & Vandivort-Warren, R. (2007). Mental health treatment expenditure trends, 1986–2003. *Psychiatric Services*, 58(8), 1041–1048.

M-DCPS Creates Department of Mental Health. (2018, August 17).

<https://news.dadeschools.net/cmnc/new/28795>

- Meldrum, L., Venn, D., & Kutcher, S. (2009). Mental health in schools: How teachers have the power to make a difference. *Health & Learning Magazine*, 8, 3–5.
- Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the national comorbidity study-adolescent supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(10), 980–989.
<https://doi.org/10.1016/j.jaac.2010.05.017>
- Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S., & Olfson, M. (2011). Service Utilization for Lifetime Mental Disorders in U.S. Adolescents: Results of the National Comorbidity Survey–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, 50(1), 32–45.
<https://doi.org/10.1016/j.jaac.2010.10.006>
- Merikangas, K. R., He, J.-P., Brody, D., Fisher, P. W., Bourdon, K., & Koretz, D. S. (2010). Prevalence and treatment of mental disorders among US children in the 2001–2004 NHANES. *Pediatrics*, 125(1), 75–81.
<https://doi.org/10.1542/peds.2008-2598>
- Miller, F. G., Cohen, D., Chafouleas, S. M., Riley-Tillman, T. C., Welsh, M. E., & Fabiano, G. A. (2015). A comparison of measures to screen for social, emotional, and behavioral risk. *School Psychology Quarterly*, 30(2), 184–196.
<https://doi.org/10.1037/spq0000085>

- Milner, H. R., & Laughter, J. C. (2015). But good intentions are not enough: Preparing teachers to center race and poverty. *The Urban Review*, 47(2), 341–363. <https://doi.org/10.1007/s11256-014-0295-4>
- Moor, S., Ann, M., Hester, M., Elisabeth, W. J., Robert, E., Robert, W., & Caroline, B. (2007). Improving the recognition of depression in adolescence: Can we teach the teachers? *Journal of Adolescence*, 30(1), 81–95. <https://doi.org/10.1016/j.adolescence.2005.12.001>
- Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social Science & Medicine*, 70(7), 985–993.
- Mychailyszyn, M. P., Brodman, D. M., Read, Kendra L., & Kendall, P. C. (2012). Cognitive-behavioral school-based interventions for anxious and depressed youth: A meta-analysis of outcomes. *Clinical Psychology: Science and Practice*, 19(2), 129–153. <https://doi.org/10.1111/j.1468-2850.2012.01279.x>
- National Service Strengthens Education*. (2017). Center for National and Community Service. <https://www.nationalservice.gov/sites/default/files/documents/EducationSupport.pdf>
- O’Connell, M. E., Boat, T., & Warner, K. E. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities* (Vol. 7). Washington, DC: National Academies Press.

- O'Connor, M., & Casey, L. (2015). The Mental Health Literacy Scale (MHLS): A new scale-based measure of mental health literacy. *Psychiatry Research*, 229(1), 511–516. <https://doi.org/10.1016/j.psychres.2015.05.064>
- Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41(6), 731–738.
- Paris, D., & Alim, H. S. (2014). What are we seeking to sustain through culturally sustaining pedagogy? A loving critique forward. *Harvard Educational Review*, 84(1), 85–100.
- Pearcy, M. T., Clopton, J. R., & Pope, A. W. (1993). Influences on teacher referral of children to mental health services: Gender, severity, and internalizing versus externalizing problems. *Journal of Emotional and Behavioral Disorders*, 1(3), 165–169.
- Perreira, K. M., & Ornelas, I. (2013). Painful passages: Traumatic experiences and post-traumatic stress among immigrant Latino adolescents and their primary caregivers. *The International Migration Review*, 47(4).
<https://doi.org/10.1111/imre.12050>
- Peterson, R. D., & Krivo, L. J. (2009). Segregated spatial locations, race-ethnic composition, and neighborhood violent crime. *The ANNALS of the American Academy of Political and Social Science*, 623(1), 93–107.
<https://doi.org/10.1177/0002716208330490>

- Porche, M. V., Fortuna, L. R., Lin, J., & Alegria, M. (2011). Childhood Trauma and Psychiatric Disorders as Correlates of School Dropout in a National Sample of Young Adults: Childhood Trauma and School Dropout. *Child Development*, 82(3), 982–998. <https://doi.org/10.1111/j.1467-8624.2010.01534.x>
- Press Release Desk, N. P. (2019, April 26). *Mental Health First Aid Training Coming to McHenry County School*. Algonquin-Lake In The Hills, IL Patch. <https://patch.com/illinois/algonquin/mental-health-first-aid-training-coming-mchenry-county-school>
- Reddy, L. (2019). *Paraprofessionals the Unspoken and Understudied Heroes of Students with Externalizing Behavior Disorders*. American Psychological Association, Chicago.
- Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting Children’s Mental Health in Schools: Teacher Perceptions of Needs, Roles, and Barriers. *School Psychology Quarterly*, 26(1), 1–13.
- Repie, M. S. (2005). A school mental health issues survey from the perspective of regular and special education teachers, school counselors, and school psychologists. *Education & Treatment of Children*, 28(3), 279.
- Richards, H. V., Brown, A. F., & Forde, T. B. (2007). Addressing diversity in schools: Culturally responsive pedagogy. *Teaching Exceptional Children*, 39(3), 64–68.
- Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems? *Medical Journal of Australia*, 187(7), S35.

- Roeser, R. W., & Midgley, C. (1997). Teachers' views of issues involving students' mental health. *The Elementary School Journal*, 98(2), 115–133.
- Rose, T., Leitch, J., Collins, K. S., Frey, J. J., & Osteen, P. J. (2019). Effectiveness of youth mental health first aid USA for social work students. *Research on Social Work Practice*, 29(3), 291–302.
- Ross, A.-S. M. (2019). *Understanding secondary educators' knowledge of mental health and their perceptions of their role in addressing student mental health*. University of Maryland.
- Rothì, D. M., Leavey, G., & Best, R. (2008). On the front-line: Teachers as active observers of pupils' mental health. *Teaching and Teacher Education*, 24(5), 1217–1231.
- Ruus, V.-R., Veisson, M., Leino, M., Ots, L., Pallas, L., Sarv, E.-S., & Veisson, A. (2007). Students' well-being, coping, academic success, and school climate. *Social Behavior and Personality: An International Journal*, 35(7), 919–936.
- Sciutto, M. J., Terjesen, M. D., & Frank, A. S. B. (2000). Teachers' knowledge and misperceptions of attention-deficit/hyperactivity disorder. *Psychology in the Schools*, 37(2), 115–122.
- Shneyderman, A. (2018). *English Language Learners and their Academic and English Language Acquisition Progress: 2017-2018* (p. 20). Miami Dade County Public Schools.
- Skiba, R. J., Arredondo, M. I., & Williams, N. T. (2014). More than a metaphor: The contribution of exclusionary discipline to a school-to-prison pipeline. *Equity & Excellence in Education*, 47(4), 546–564.

- Skiba, R. J., Horner, R. H., Chung, C.-G., Rausch, M. K., May, S. L., & Tobin, T. (2011). Race is not neutral: A national investigation of African American and Latino disproportionality in school discipline. *School Psychology Review*, *40*(1), 85–107.
- Sleeter, C. E. (2012). Confronting the marginalization of culturally responsive pedagogy. *Urban Education*, *47*(3), 562–584.
- Smith, J. P., Tran, G. Q., & Thompson, R. D. (2008). Can the theory of planned behavior help explain men's psychological help-seeking? Evidence for a mediation effect and clinical implications. *Psychology of Men & Masculinity*, *9*(3), 179–192. <https://doi.org/10.1037/a0012158>
- Soto, A., Smith, T. B., Griner, D., Rodriguez, M. D., Bernal, G. (2018). Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews. *Journal of Clinical Psychology*, *74*, 1907-1923. Doi 10.1002/jclp.22679
- Splett, J. W., Garzona, M., Gibson, N., Wojtalewicz, D., Raborn, A., & Reinke, W. M. (2018). Teacher recognition, concern, and referral of children's internalizing and externalizing behavior problems. *School Mental Health*. <https://doi.org/10.1007/s12310-018-09303-z>
- Suldo, S. M., Friedrich, A., & Michalowski, J. (2010). Personal and systems-level factors that limit and facilitate school psychologists' involvement in school-based mental health services. *Psychology in the Schools*, *47*(4), 354–373.

- Sum, A., Khatiwada, I., McLaughlin, J., & Palma, S. (2009). The consequences of dropping out of high school. *Center for Labor Market Studies Publications*, 23.
- Svensson, B., & Hansson, L. (2014). Effectiveness of Mental Health First Aid Training in Sweden. A randomized controlled trial with a six-month and two-year follow-up. *PLOS ONE*, 9(6), e100911.
<https://doi.org/10.1371/journal.pone.0100911>
- ten Have, M., de Graaf, R., van Dorsselaer, S., & Beekman, A. (2013). Lifetime treatment contact and delay in treatment seeking after first onset of a mental disorder. *Psychiatric Services*, 64(10), 981–989.
<https://doi.org/10.1176/appi.ps.201200454>
- Turner, E. A. (2012). The parental attitudes toward psychological services inventory: Adaptation and development of an attitude scale. *Community Mental Health Journal*, 48(4), 436–449. <https://doi.org/10.1007/s10597-011-9432-7>
- U.S. Department of Education. (2012). *Public School Teacher Data File*. National Center for Education Statistics, Schools and Staffing Survey (SASS).
https://nces.ed.gov/surveys/sass/tables/sass1112_2013314_t1s_002.asp
- Villegas, A. M., & Lucas, T. (2002). Preparing culturally responsive teachers: Rethinking the curriculum. *Journal of Teacher Education*, 53(1), 20–32.
- Vincent, C. G., Sprague, J. R., Pavel, M., Tobin, T. J., & Gau, J. M. (2015). Effectiveness of schoolwide positive behavior interventions and supports in reducing racially inequitable disciplinary exclusion. *Closing the School Discipline Gap: Equitable Remedies for Excessive Exclusion*, 207–221.

- Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, 10–1037.
- Wade, T. J., Mansour, M. E., Line, K., Huentelman, T., & Keller, K. N. (2008). Improvements in health-related quality of life among school-based health center users in elementary and middle school. *Ambulatory Pediatrics*, 8(4), 241–249. <https://doi.org/10.1016/j.ambp.2008.02.004>
- Walker, S. C., Kerns, S. E. U., Lyon, A. R., Bruns, E. J., & Cosgrove, T. J. (2010). Impact of school-based health center use on academic outcomes. *Journal of Adolescent Health*, 46(3), 251–257. <https://doi.org/10.1016/j.jadohealth.2009.07.002>
- Walter, H. J., Gouze, K., & Lim, K. G. (2006). Teachers' beliefs about mental health needs in inner city elementary schools. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(1), 61–68. <https://doi.org/10.1097/01.chi.0000187243.17824.6c>
- Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 603–613.
- Wei, Y., McGrath, P. J., Hayden, J., & Kutcher, S. (2016). Measurement properties of tools measuring mental health knowledge: A systematic review. *BMC Psychiatry*, 16(1), 297.

Who Are School Psychologists. (n.d.). National Association of School Psychologists (NASP). Retrieved June 19, 2020, from <https://www.nasponline.org/about-school-psychology/who-are-school-psychologists>

Williams, J. H., Horvath, V. E., Wei, H.-S., Dorn, R. A. V., & Jonson-Reid, M. (2007). Teachers' perspectives of children's mental health service needs in urban elementary schools. *Children and Schools, 29*(2), 95–107.
<https://doi.org/10.1093/cs/29.2.95>

Wilson, S. J., Lipsey, M. W., & Derzon, J. H. (2003). The effects of school-based intervention programs on aggressive behavior: A meta-analysis. *Journal of Consulting and Clinical Psychology, 71*(1), 136.

World Health Organization. (2003). *Investing in mental health.*
<https://apps.who.int/iris/bitstream/handle/10665/42823/9241562579.pdf>