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Creating Effective Mental Health Programs in Rural Middle Schools: A Case Study of Challenges, Policy and Programming

Katelyn Kempf

Bucknell University, knk005@bucknell.edu

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**CREATING EFFECTIVE MENTAL HEALTH PROGRAMS IN RURAL MIDDLE
SCHOOLS: A CASE STUDY OF CHALLENGES, POLICY AND PROGRAMMING**

by

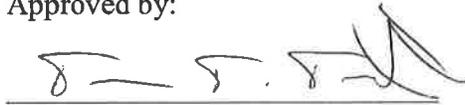
Katelyn Nicole Kempf

A Proposal Submitted to the Bucknell University Honors Council

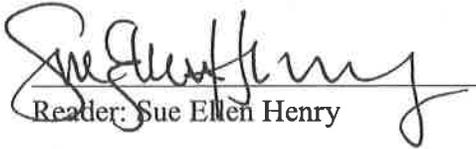
For Honors in The Department of Education

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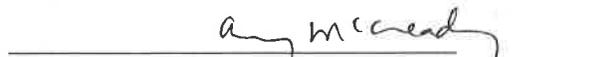
Approved by:



Adviser: Douglas Dexter



Reader: Sue Ellen Henry



Honors Council Representative: Amy McCready

Education Department Chair: Lori A. Smolleck

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Abstract

Using a case study approach, this study investigated the current status of mental health programs and resources within a specific middle school in Eastern Rural Pennsylvania. Interviews were conducted with a school counselor, principal, teacher, social worker and mental health liaison in order to uncover the perceived strengths and weaknesses of mental health resources at this school, and the perceived barriers to providing mental healthcare. Data analysis revealed that the main barriers included parental involvement, parental follow-through, transportation and funding. Further questions were identified for future research within this school in order to create specific recommendations for improvement. Additionally, a case study scenario was created using the findings of this research to contribute to professional development for current in-service school staff members, and for future school staff members in training programs.

Chapter 1

Introduction

Discussion and controversy over the current status of mental health in America has been spurred by pivotal societal events over the last twenty years. In 1999, Eric Harris, aged 18, and Dylan Klebold, aged 17, killed thirteen students and wounded more than 20 others in a school shooting and bombing at their high school in Columbine, Colorado before taking their own lives. The media used this school massacre to shed light into issues regarding mental health and adolescent bullying; endless amounts of news articles blamed the actions of Harris and Klebold on the fact that they were both bullied at their high school (Langman, 2009). Klebold's mother, Sue, also accounted her son's actions on his mental health. She stated, if I had recognized that Dylan was experiencing some real mental distress, he would not have been there. He would have gotten help. I wish I had known then what I know now: that it was possible for everything to seem fine with him when it was not, and that behaviors I mistook as normal for a moody teenager were actually subtle signs of psychological deterioration (Almasy, 2016).

The Columbine massacre is often viewed as the first of the seemingly endless school violence issues leading to discussion about the status of mental health in our society. There have been over 200 school shootings between 1999-2018 (Roberts, 2018), and this increase of school violence has led to discussion over how our society treats mental health disorders, bullying, violence and suicide (Langman, 2009).

However, it has been argued that society's focus on mental health in response to school violence has been used as a way of avoiding other issues that lead to violence (Geher, 2018). The ways in which mental health is portrayed in the media after incidents of school violence have only increased mental health stigma rather than encourage discussion and policymaking to address societal mental health needs (Geher). America's current president, Donald Trump, blamed mental

health as the sole purpose for the Parkland school shooting that occurred in January 2018 (Rogers, 2018). Trump explained his view that this shooting “isn’t a guns situation”, and identified it as “a mental health problem at the highest level” (Rogers).

The increase in school violence our society has experienced within recent years is not the only cause for discussion and debate surrounding mental health today. The way mental health is typically portrayed in the media perpetuates stigmatized beliefs that those who are mentally ill are “incompetent, dangerous, slovenly and undeserving,” and these beliefs create a separation between “them and us” (Fawcett, 2015). For example, there are haunted house attractions throughout the United States during Halloween season that highlight mental health asylums as terrifying (Koennemann, 2016). One attraction in particular, the Brighton Asylum haunted house in New Jersey, takes place at a mental health asylum that housed patients during the 1940s. The Brighton Asylum haunted house purports to transport visitors back to the time “when deranged psychopaths wandered the halls” (Koennemann). Similarly, a pop-culture song entitled “Out of My Mind” was released in 2012 by famous rappers B.o.B and Nicki Minaj, which highlighted many of society’s stigmatized beliefs regarding mental health. The lyrics identify patients who struggle with bipolar disorder as “psychotic with no remedy” and “needing medication and electroconvulsive therapy.”

However, despite the media’s influence in perpetuating mental health stigmas, there has also been an increase in recent years of screenwriters who attempt to portray more humanized characterizations of individuals with mental illness – for example, actors in the Showtime series “Homeland” and the film “Silver Linings Playbook” portray characters with bipolar disorder who struggle at some points, but ultimately function well in society. Likewise, in the film “A Beautiful Mind,” the struggles and triumphs of an individual with schizophrenia are explored (Fawcett,

2015). Similarly, adolescent films such as “The Art of Getting By” and “It’s Kind of a Funny Story” help to normalize mental health disorders by portraying teenaged characters who struggle as relatable (Clabough, 2010).

It is evident that in today’s society, citizens are exposed to both positive and negative opinions and views of mental health disorders. Adolescents and children who have access to media are exposed to these views of mental health from very young ages; even Disney movies, considered to be timeless for children and thus impacting several generations of children, often portray mentally ill characters as “lunatics” and “crazy” (Lawson & Fouts, 2004). Exposure to this type of portrayal “falsely shows children that mentally ill individuals are dangerous, and need to be removed from society” (Lawson & Fouts).

Children and adolescents who have access to social media also are exposed to the trend of idealizing mental health disorders. Social media platforms such as Tumblr and Instagram provide teenagers the opportunity to see glorified photos of adolescents with self-harm scars on their wrists as “beautiful, mysterious and haunted” (Bine, 2013). These types of posts impact the way teenagers view mental health disorders; self-harm, suicide, depression and self-loathing are portrayed as romantic and deep (Bine). These views reveal the lack of understanding amongst teenagers regarding what it means to have a diagnosed mental health disorder (Bine). Depression, for example, has become such an overused term in society today that it has lost its meaning:

People use the word ‘depression’ if they can’t find their keys, or if they’ve had a fight with their mother or father, or if they’ve had an argument with their boyfriend or girlfriend, if they didn’t make the school team or didn’t do well on an exam. When we use the word ‘depression’ for every negative emotional state, the word loses its meaning (Bine).

Because adolescents lack a comprehensive understanding regarding mental health disorders, it becomes imperative for schools to educate their students about these topics and provide resources for students who truly are struggling. The school setting may be the only

environment where adolescents can receive extensive and appropriate education on mental health (Bine, 2013).

This is especially important as mental health disorders are increasingly prevalent amongst adolescents in America. Today, one in five adolescents shows signs of significant emotional distress, with nearly 10% having symptoms that impair daily functioning (Knopf, Park, & Mulye, 2008). While so many adolescents show signs of emotional distress, treatments and resources are lacking nationwide. Research shows that “nearly 80% of youth ages 6-17 who are in need of mental health care do not receive services within the preceding 12 months, with rates approaching 90% for uninsured families” (Kataoka, Zhang, & Wells, 2002). It is particularly important to diagnose adolescent mental health disorders, as youths who are not properly diagnosed and treated are more likely to have significant health issues in adulthood, and have difficulty functioning in society (Wu et al., 2006).

It is also important to diagnose and treat adolescent mental health disorders in order to prevent suicide. Suicide is the third leading cause of death for 15- to 24-year olds (American Academy of Pediatrics), and more adolescents die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined (The Jason Foundation). From 2007 to 2015, the rate of suicide amongst adolescent girls aged 15-19 doubled, and during this same time period, the rate amongst adolescent boys increased by 30% (Holmes, 2017). Suicide continues to be a growing health concern today amongst youths in America (Holmes).

According to the United States Department of Health and Human Services, the top three most common mental health disorders amongst adolescents are anxiety, depression, and eating disorders (HHS, 2018). Nonsuicidal self-harm has also been found to be common amongst

adolescents (Wood, 2009), and is typically used as a coping mechanism for adolescents struggling with depression (Peterson et al., 2008). Statistics support the claim that currently, one-third to one-half of United States adolescents has engaged in some type of nonsuicidal self injury, and cutting and burning are the most common forms of nonsuicidal self harm (Peterson et al., 2008). Research has found the first signs of youth mental health disorders such as depression and anxiety often emerge in the school environment, exemplified through academic difficulties and disciplinary issues (Richardson, 2012).

In response to the rise of mental health disorders amongst youths, it is essential for schools to have mental health support services available to students who are struggling, and common resources include school psychologists, school counselors, and social workers (Richardson, 2012). Mental health awareness programs are another important resource to incorporate into schools; programs typically include mental health education and courses with an intention of providing students, teachers, parents and school-community members with information regarding mental health disorders and diagnoses (Esters, Cooker, & Ittenbach, 1998). Mental health programs can provide adolescents with information regarding different types of disorders, early-warning signs, and resources for seeking help.

As beneficial as mental health programs are for students, schools can only provide these initiatives if available funding exists. Approximately 50% of US middle and high schools have any mental health counseling services available onsite and approximately 11% have mental health counseling, physical examinations, and substance abuse counseling available on-site (Slade, 2003). Schools with the most funding for mental health priorities are typically large, high-achieving suburban schools (Wright, 2012). Suburban areas refer to mainly low population residential areas often located on the outskirts of a city (Libaw, 2013). Schools in urban areas, i.e

settlements with very high populations such as cities (Libaw), encounter difficulties with funding for providing mental health resources for their students, however have the advantage of an abundance of public transportation opportunities to access to outside providers in the city (Slade). Schools in rural areas, i.e. countryside and farmland settlements located far away from crowded communities (Libaw), experience tremendous barriers in both providing funding for mental health purposes *and* access to outside providers. This is why it is particularly important to conduct an examination of rural schools. The lack of funding and access for students in rural schools could create a large barrier to understanding and treating mental health issues.

This thesis focuses on exploring the ways in which societal challenges impact a specific rural Eastern Pennsylvania middle school's ability to provide mental health programs for their students. This thesis will first explore the unique barriers that literature identified rural middle schools to encounter when providing mental health programs for their students. Then, this study will employ qualitative case study research methods to interview school staff members at the chosen middle school and uncover the perceived challenges and successes that these rural professionals face when helping their students.

Chapter 2

Review of Literature

There is a lack of extant research regarding the mental health of rural students. The limited literature in existence typically does not give an extensive overview of the issues that rural schools face when providing students with mental health programs, nor provides comprehensive policy recommendations for rural schools that are struggling. Furthermore, the limited literature is lacking a theoretical framework which may offer deeper explanation of reported results. The literature that does exist regarding mental health in rural schools focuses primarily on the deficits of the schools, and does not tend to address assets in rural areas. The following section outlines the extant literature regarding mental health and rural schools, however, it is important to note the validity in some of this literature seems questionable as a result of small sample sizes, extensive limitations, and over-exaggerated conclusions.

An examination of the limited literature surrounding mental health and rural schools reveals challenges that will be explored further in this thesis. These challenges centered around mental health stigma, e.g. prejudicial attitudes and discriminating behaviors directed towards individuals with mental health disorders (Davey, 2013); teacher, counselor, and administrator education regarding mental health disorders amongst their students; collaboration amongst teachers, counselors, administrators and parents in order to work together to provide student mental health resources; transportation; and financial and regulatory barriers to providing students with necessary mental healthcare.

Mental Health Stigma

Mental health stigma is a barrier rural areas face in implementing mental health resources and programs in schools. Mental health stigma can be evidenced through fear, rejection,

avoidance, prejudice and discrimination against people who have psychiatric disorders (D’Cunha, 2014). Rural adolescents have been found to have significantly higher mental health disorder and suicide rates than their urban counterparts (Gustafson, Preston, & Hudson, 2009), however students in rural areas are unlikely to seek mental health care due to “fear of prejudice or community rejection”. This is largely due to the rural expectation of prioritizing behaviors of autonomy and self-help, and therefore the act of seeking mental health resources is stigmatized as dependent and weak (Esters, Cooker, & Ittenbach, 1998).

Rural environments are typically very small communities, where everybody knows one another and privacy is difficult to guarantee; hence, rural citizens tend to withhold from going to a psychiatrist or psychologists’ office out of fear that “everyone would recognize their truck” (Nelson et al., 2007). Stigma therefore exemplifies itself in terms of where community and family members encourage adolescents to seek help in rural areas. African American adolescents in Georgia, in particular, were found to face extremely significant barriers to professional mental health care, largely due to a lack of community support and parent expectations (Murry et al., 2011). Researchers used a mixed-methods approach to examine the help-seeking behaviors and mental health perceptions of African American mothers in Georgia. A quantitative survey was given to 163 rural African American mothers, and a subsample of 21 of these mothers with adolescent children with diagnosed disorders of attention deficit disorder and depression also participated in qualitative interviews. Most of the mothers in the entire sample identified their confidence in mental health care providers to provide support for adolescents, however still preferred to encourage their own children to seek help from informal sources, such as family, church and schools (Murry et al.). The majority of these mothers reported community stigma toward children with mental health disorders and their families as the main reason for a

preference in informal sources of support (Murry et al.). This study's large sample size, mixed methods format, and evaluation of research findings make this a high-quality and reliable study.

The fear of being stigmatized as the parent of a child with mental health struggles does line up with the research regarding community stigma; the families of children and adolescents with mental health disorders have been found to be more likely to face stigma from community members about their parenting skills (Corrigan and Miller, 2004), which contributes to parental self-stigma and self-blame about their child's problems (Moses, 2010). Parental self-stigma and self-blame for their child's mental health disorders then impacts the parenting of the child and the resources a parent is willing to seek for their child (Eaton et al., 2016).

Self-stigma is also present amongst rural children, adolescents and adults who struggle with mental health disorders. Self-stigma amongst rural citizens who have mental health illnesses "consists of internalized public stigma that leads to reductions in self-esteem and self-efficacy" (Larson, Corrigan, & Cothran, 2012). Self-stigma and low self-esteem amongst rural children, adolescents and adults with mental health disorders impedes self-seeking behavior (Clement, Graham, & Evans-Lacko, 2015), and therefore contributes to "the large number of rural adults currently suffering from untreated psychiatric illnesses" (Stewart, Jameson, & Curtin, 2015). Self-stigma can cause negative outcomes for sufferers (McGee, 2007), including worsening chronic psychiatric disorders and suicide (NAMI).

Mental health awareness programs have been created in rural areas with a goal of combating mental health stereotypes held by students. Researchers evaluated the impact of a mental health awareness program for 40 students aged 13-17 in a rural school in Mississippi with an intention of positively impacting student perceptions regarding mental health help-seeking behaviors (Esters, Cooker, & Ittenbach, 1998). Students took a test evaluating mental health

stigmatized beliefs immediately before completing the 270 minute program, immediately after completing the program, and again 12 weeks after completing the program. The researchers found that the students opinions about self-seeking behaviors became more favorable, and that thoughts about mental illness became “more like those of mental health professionals” (Esters, Cooker, & Ittenbach) after completing the program. The results of this research seem vague and overstated given the short duration of the program.

Similarly, researchers explored the impact of an educational intervention program called *The Science of Mental Health* curriculum, designed by the National Institute of Health Office of Science Education (Watson et al., 2004). *The Science of Mental Health* curriculum has two primary goals: to help students understand that mental illness has a biological basis and can be diagnosed and effectively treated, and to increase students' awareness and understanding of the biological, psychological, and social aspects of mental illness (Watson et al.). Researchers explored the impact of this 8-session long educational intervention program on stigma-related attitudes amongst 1,566 students in middle school grades 6-8 from 16 states. In a Pre-Post test format, students were asked to mark statements regarding stereotypes of mental health as true, false, or not sure. The initial pre-test results identified that students did not hold strong negative views of mental health disorders at a baseline, and the most common stereotype that students did hold is that people with mental health disorders are dangerous. The curriculum held small but significant changes in post-test results, as it was most effective in reducing negative attitudes amongst those with the most stigmatizing beliefs at baseline (Watson et al.).

Researchers in Nigeria also implemented a short-term program which consisted of a three-hour mental health awareness session for 154 secondary students (Bella-Awusah et al., 2014). The program was intended to increase mental health literacy and decrease negative perceptions

about mental health. The researchers discovered that there was an increase in the mental health literacy and knowledge of students after this short intervention, however there was not a significant increase in attitude changes. However, the findings of this research in Nigeria may not be indicative of what these results would like in the United States. Approximately 6% of Nigeria's population suffers from disorders, in comparison to the 18.5% of Americans that struggle with mental health disorders in any given year (Walton, 2011). Additionally, differences in culture, society, and government limit the generalizability of the results to the United States.

Although research in this field has focused on the ways in which stigma creates challenges for rural schools when providing mental health resources for their students, there is a lack of research that goes into extensive depth evaluating this issue, and not all studies regarding stigma can be applied as general themes due to small sample sizes or overstatements of findings.

Teacher, Counselor and Administrator Education

School professionals including teachers, counselors and administrators “often lack basic specific evidence-based knowledge and skills to identify and intervene with students at risk for mental illness” (Koller & Bertel, 2006), and therefore there is an urgent need to prepare all school-based personnel to understand adolescent mental health disorders. The following sections review the current status of mental health training and education for rural teachers, counselors and administrators.

A. Teacher Education

Teachers play an extremely important role in supporting students who struggle with emotional distress, however are unable to do so without an education and background about adolescent mental health disorders, warning signs and intervention strategies. Research has found that teacher candidates across America today generally receive “little, if any, mental health

training” (Kratt, 2017). Mental health education and training for teachers is particularly important because educators are typically the first people in the school to notice student problems, and are responsible for directing students to available resources (Nichols et al.).

Rural adolescents have been found to have significantly higher mental health disorder and suicide rates than their urban counterparts (Gustafson, Preston, & Hudson, 2009). This is largely due to the many challenges that come with living in rural areas, such as coming from families of poverty and struggling with family and community members who struggle with drug addiction (Hazlett, 2018). The most important first step in supporting the emotional well-being of rural students, then, is to prioritize educating teachers about students’ mental health needs and intervention methods (Nichols et al.).

However, teachers globally have reported a lack of experience and training for supporting children’s mental health needs in schools, and therefore tend to view school psychologists as having the primary role in mental health service delivery (Reinke et al., 2011). Teachers have reported that this lack of mental health training hinders their confidence and ability to identify and help students with mental health disorders (Baker, 2014). Researcher Loren F. Ditmar emphasized the importance of teacher education for the purpose of improving teacher self-efficacy; “if teachers have confidence in their knowledge and abilities to work effectively within an environment inclusive of students with major mental health challenges, their personal efficacy will positively impact their success within the classroom” (2014).

Teacher training models have been proposed and researched in order to increase teacher confidence when supporting the mental health needs of their students. One training model mentioned in research for current teachers is the “single shot classroom based workshop” (Lyon et al., 2011), which “relies heavily on didactic presentation of information and may or may not be

coupled with interactive strategies, such as modeling and role plays” (Lyon et al.). This model tends to be short-term, lasting somewhere between a few hours to a few days, and can lead to increases in provider knowledge (Fixsen et al., 2005). However, this model faces limitations in terms of being able to produce consistent behavioral change (Lyon et al.).

There is an overall lack of research today giving insight into the mental health training United States teacher candidates receive during their undergraduate education in American college programs. The majority of extant research regarding the development of mental health literacy for teacher candidates was done by Jorm et al. in Australia (2010). These researchers created a Youth Mental Health First Aid course that trains teachers to apply an action plan when faced with a student struggling with a mental health issue (Jorm et al.). Within the last few years, researchers in Canada have also begun to prioritize creating a mental health curriculum for teacher education programs. Rodger et al. (2014) recommends for faculties of education across Canada to “increase the number of mental health-specific courses offered and make these courses mandatory for all teacher education students” (Rodger et al.). The researchers designed a comprehensive teacher education curriculum that trains candidates to work with many different students, including those whose parents have divorced, who have same-sex parents, who have parents struggling with substance abuse, and children who are new to Canada (Rodger et al.).

Similarly, Canadian researchers Whitley, Smith, and Vaillancourt (2013) proposed a curriculum that not only prioritizes the mental health literacy of future teachers, but also of current in-service teachers. These researchers argue that single-shot workshops are not sufficient in producing consistent change in classroom settings, and ongoing training efforts must be prioritized for teachers.

While the literature by Australian and Canadian researchers sheds light into the types of mental health teacher-training programs that can be productive, there is an overall lack of research addressing these programs in the United States. Research within the United States must prioritize the evaluation of mental health teacher-training programs in order to gain insight into the strengths and weaknesses of existing programs, and to then help provide rural teachers with the necessary training and support that they need to help their students who encounter additional struggles in everyday life.

B. Counselor Education

The role of school counselors has changed drastically within recent years in response to the changing climate of America's mental health. In the past, the role of school counselors was primarily vocational (O'Bannon, 2005). However, school counselors today must balance students' academic, career, and education planning, and their personal, emotional and social needs, while also being responsible for a greater amount of administrative tasks (Paterson, 2004).

In order for school counselors to address the mental health needs of their students, it is "imperative that counselor educators are structuring the professional identity development of counselors-in-training through guided learning experiences with a focus on demonstrated effectiveness" (Brott, 2006). In order to create effective school counselors, counseling faculty members must create courses that include values and tools for counseling effectiveness (Brott).

A learn by doing approach must provide counselors-in-training with the knowledge, skills and application for being an effective school counselor in order for a training degree program to be considered accountable (Brott, 2006). The Council for Accreditation of Counseling and Related Educational Programs, CACREP, outlines standards that are used as a framework for effective school counseling degree programs; the standards for school counseling programs

“require students to have curricular experiences and demonstrated knowledge and skills in the methods to plan, develop, implement, monitor, and evaluate a comprehensive developmental school counseling program” (Brott). Within these programs, counselor-in-training students must participate in practicum and internship experiences that focus on demonstrating one’s school counseling effectiveness (CACREP, 2016).

In-service school counselors hold a large influence and responsibility in creating educational mental health training programs for teachers, administrators, parents and students (Debose, 2008). School counselors must provide suicide intervention regularly, as suicide is the third leading cause of death for children and adolescents ages 10-19 years old (Hamilton et al., 2007). With suicide ideation becoming an issue that schools see on a regular basis, school counselors are responsible for providing school staff and students with trainings regarding suicide prevention and awareness (Gibbons & Studer, 2011). Legal implications also exist for school counselors when handling situations of suicide; “if schools fail to establish prevention programs, and personnel do not respond appropriately to suicide situations, litigation could be the end result” (Gibbons & Studer).

However, not all schools provide school staff training on suicide awareness, and there is a great disparity in the types of mental health programs that schools within America offer (Keller et al., 2009). In some schools, staff members do not believe that suicide awareness training is necessary; elementary school counselors, for example, have reported their beliefs that suicide prevention training is not relevant for this age group, because the children are too young and administrators would not support this training (Gibbons & Studer, 2011). Research shows, however, that suicidal thoughts and attempts do begin as early as during elementary school (Hamilton et al., 2007). Additionally, suicide rates have been found to be highest in Western

America, in rural areas of Montana, Alaska and Wyoming, averaging approximately 25 deaths per 100,000 people (Maciag, 2018). Suicide prevention education for staff within these schools is particularly relevant given these statistics. However, school counselors have reported school environments all over the United States are primarily focused on academic achievement and test scores, and therefore trainings regarding the emotional wellbeing of students is often overlooked as a priority (Gibbons & Studer).

Additionally, rural schools in particular often do not have the resources necessary for creating a full mental health counseling program for staff and community members, and school counselors in these areas are therefore often re-assigned to unrelated tasks such as clerical and disciplinary duties (Monteiro-Leitner et al., 2006). This sheds light to the fact that school counselors in rural areas are often not spending as much time as they view they should be on working directly with students, teachers and parents for mental health intervention, because the schools in which they work do not have the resources necessary for them to do so (Monteiro-Leitner et al.). Due to limited available resources and training opportunities, mental health is not often considered a priority by school staff members, and thus school counselors in rural schools face difficulties when attempting to provide necessary resources for their students.

C. Administrator Education

There is also an overall lack of research regarding the mental health training school administrator candidates receive throughout their degree programs. Research regarding the mental health literacy of school administrators primarily focuses on the educational initiatives that these staff members prioritize bringing into their schools, and initiatives that they should be bringing, once they are in-service administrators.

In-service principals have acknowledged that school counselors should be spending more time counseling students and training staff members about mental health interventions, however the demands of schools often require counselors to spend the majority of their time testing students for special education placement, and participating in overall administrative tasks (Monteiro-Leitner et al., 2006).

There are certainly discrepancies in how administrators view the work that mental health professionals should be doing in schools, versus how school counselors view this work. In a study that compared counselors, counselors-in training, and administrators points of view regarding how much time counselors should dedicate to certain tasks, principals responded that counselors should spend 12.3 hours per week on individual and group counseling students, whereas counselors and counselors-in-training responded that they should be spending 18.5 hours per week (Monteiro-Leitner et al., 2006). Principals responded that counselors should be spending 4.3 hours per week working on Individualized Educational Plans (IEPs) for students with special education needs, whereas counselors and counselors-in-training reported no hours at all (Monteiro-Leitner et al.). Though administrators acknowledge the importance of mental health prevention programs, administrators often do not consider these programs a main priority (Gibbons & Studer, 2011). There are multiple reasons administrators do not focus on these programming initiatives: “concerns about public reaction, lack of knowledge about suicide statistics, and fear that training may shift attention away from core academics” (Gibbons & Studer) all account for the lack of administrator support for interventions.

Researcher Pluymert created surveys for 175 administrators within 35 states including districts urban, suburban and rural settings in order to understand opinions regarding many mental health questions (2000). Administrators’ opinions regarding the relationship between students’

mental health needs and students' ability to be successful in school, the extent to which schools are responsible to provide mental health services, the efficacy of mental health programs in school settings and the efficacy of school psychological services were explored in this study (Pluymert). Overall, administrators reported a strong positive relationship between student mental health needs and school success, although they did not appear to feel as strongly that schools should provide mental health services to address student mental health needs (Pluymert). Administrators in this study were overall in high support of providing educational training programs regarding mental health, and were in low support of providing individual mental health evaluations within the school (Pluymert).

There is an overall lack of extensive literature regarding the types of training that administrator-candidates receive regarding mental health, and administrator opinions of their role in providing mental healthcare to their students in both rural and non-rural areas throughout the United States.

Collaboration

Collaboration amongst teachers, school counselors, administrators and parents is necessary in order to successfully provide students with the mental health resources they need within a school setting. With mental health disorders on the rise within schools, a collaborative level of care is necessary for creating training and identification education for school staff (Davis et al., 2006). The effect of mental health disorders on academic success also highlights the importance of collaboration between educators and specialized support personnel; “collaboration between educators and school-based mental health personnel like school counselors and school psychologists is critical in ensuring that students are receiving social-emotional support to benefit their learning” (Nichols, 2017).

However, collaboration can be difficult to achieve, especially in rural schools, due to concerns about overstepping professional "turf," lack of knowledge and training about the skills each professional has to contribute, and limited resources (Choi et al., 2008). A lack of mental health resources in rural schools sometimes requires school staff members to refer students to outside therapists who do have the abilities to help students, which makes collaboration difficult to achieve within the school setting (Nichols, 2017). Additionally, school counselors and school psychologists within rural schools may work in multiple schools at once, which makes collaboration with teachers, administrators, parents and students a challenge as the counselors are balancing many different school environments (Nichols).

Thirty-three school counselors at twenty administrators participated employed in middle and high school settings in the Midwest region participated in surveys to uncover their perceptions on the roles and responsibilities of school counselors and the scope of school counselor training in order to assure school staff collaboration (Brown, Dahlbeck, & Sparkman-Barnes, 2006). Responses were organized in multiple categories: 1) school counselor role definition and clarification, 2) increased opportunity for dialogue, 3) information on referral procedures, 4) elimination of turf war issues (Brown et al.). Turf war issues are considered especially important to address; counselors must give up turf issues and accept that multiple sources of support are necessary in order to provide students with the best mental health resources possible. Increased opportunities for dialogues regarding clarification of the roles of multiple school staff positions and information on referral procedures were also emphasized as necessary for creating collaboration amongst multiple school-professionals in order to create a plan to best help students who are struggling (Brown et al.). Despite this study's relatively small sample size, it was effective in providing insight into the areas that current school counselors and

administrators perceive need to be addressed in order to reach collaboration, especially because there is not an abundance of existing literature in the field that explores this topic.

Transportation

Transportation is a frequently mentioned barrier in the literature regarding mental health in rural areas, however is only briefly expanded upon. Because the majority of rural areas are large farmlands, these environments lack public transit options that are readily available in urban and suburban areas (Thomhave, 2017). Rural residents therefore must rely on their own personal vehicles to travel to everyday locations such as mental healthcare appointments. However, rural citizens struggling with poverty cannot afford personal cars, have illnesses that impede their ability to drive, or are elderly and unable to drive (Thomhave). Transportation is addressed as a barrier that rural areas encounter, however is typically not deemed as a top issue (Kelleher et al., 1992).

Financial and Regulatory Barriers

Financial and regulatory barriers are often deemed as a large barrier that schools face when providing mental health services to students, however very few studies examine this issue in depth. In the early 1980s, agriculture in America faced its most severe financial crisis since the Great Depression (Murdock et al., 1988). Poverty rates in rural areas were already higher than suburban and urban areas and continued to increase during this crisis (Murdock et al.). The term farm crisis became prominent in referring to the conditions of the high number of agricultural producers being under unusually high levels of financial burden, defined as a debt-to-asset ratio of 40% or higher (Murdock et al.). During the farm crisis, approximately 30% of farm operators had debt-to-asset ratios of above 70% (Ginder, Stone, & Otto, 1985). Today, poverty in rural areas is still a prevalent issue. The recession of 2007 impacted rural workers particularly hard, and

employment growth has remained weak (US Congress, 2017). In 2010, “16.5 percent of rural residents were classified as officially poor” (DeNavas-Walt, Proctor, & Smith, 2011).

According to the National Education Association, “many rural school districts are underfunded and some lack a steady revenue stream”, and therefore in rural schools, there is a lack of available funding to designate for mental health resources (Kelleher, Taylor, & Rickert, 1992). Moreover, rural schools are disadvantaged by size as well as geography. For example, when rural districts apply for grants, the “resulting funds based on number of students are often too small to accomplish the purpose of the award” (NEA).

Rural areas tend to consist of low-income, high-need populations (Cornwell, Hawley, & Romain, 2007), and according to the Health Resources and Service Administration, 61% of areas with a shortage in mental health professionals are rural or partially rural (HRSA). Rural children and adolescents are most likely to be without health insurance, and in areas of poverty, federal funding discriminates against rural areas (Kelleher et al., 1992). With rural areas relying heavily on federal and state funding, it is very difficult to provide students with resources when the financial support is slim (Kelleher et al.). More research must be done exploring the ways in which funds are allocated for mental health resources within rural schools in order to understand the barriers school staff face when supporting their students.

The Opioid Crisis

In result of the many issues challenging rural communities, individuals in these areas are increasingly likely to turn to illegal substances as an escape (Hazlett, 2018). The opioid crisis has put a strain on families where nearly 2.5 million children are being raised by grandparents or extended family because of this struggle in the home (Hazlett). In some rural areas, foster care caseloads are up over 50 percent due to one or both parents battling drug addiction. The opioid

epidemic is also impacting quality of life and economic opportunity in rural America. For many rural counties already operating on slim budgets and struggling to attract new businesses or maintain existing employers, the consequences of this issue are severe (Hazlett). However, there is a lack of research in existence today that connects how the opioid crisis is affecting the mental health of youth in rural America.

Conclusion

The unique challenges rural areas face regarding poverty, substance abuse, joblessness, and family stability directly affect the youth in these communities. Therefore, the need for adolescent mental health resources and programs is even more crucial in rural school districts as this may be the only outlet for understanding and treating mental health issues for these students. School staff such as teachers, administrators and counselors in rural schools are responsible for providing support for students who encounter these significant issues on a regular basis. Therefore, it is particularly important for these school staff members to be trained on adolescent rural issues and on mental health disorders in order to provide necessary support to their students (Nichols et al., 2017).

The top issues explored in extant literature of mental health stigma, education and training of professionals, collaboration, transportation, and funding will be further explored in this thesis. It is important to acknowledge the lack of extant literature regarding mental health in rural schools, and the varying degrees of validity amongst studies. The existing literature focuses primarily on the deficits rural schools face when providing mental health resources to their students, and does not address rural strengths. This thesis will not only delve into the challenges that participants experience, but also the perceived assets that school staff members see in the

explored middle school.

Chapter 3

Purpose of Study

The purpose of this research was to investigate the current status of mental health programs and resources available at a public middle school in rural Eastern Pennsylvania to understand the lived experiences of school professionals and uncover ways in which these professionals face challenges in implementing such resources for grades 6-8. This study is intended to build upon previous research regarding the most productive ways to facilitate mental health care programs and accommodations in middle schools in rural areas that face many social and economic barriers, and examine the ways that educators in these districts can best support students who struggle with suicidal thoughts and/or have mental health disorders such as anxiety and chronic depression.

This research served as the basis for the creation of a case study scenario that can be used to contribute to the professional development of current in-service rural school staff members struggling with providing mental health resources to their students, and of future school staff members in training programs. To that end, this research adds to existent literature by providing insight into the lived experiences of members of a school community in an Eastern Pennsylvania public middle school; this case study scenario can be used to normalize conversation amongst in-service and future school staff members about mental health resources in schools.

This qualitative case study is exploratory in nature, and examines two research questions: 1) How are mental health programs and interventions implemented within a rural middle school in Eastern Pennsylvania, and 2) What challenges do school professionals face in providing these resources? In order to answer these questions, a rural middle school in Eastern Pennsylvania was

On a scale of Advanced, Proficient, Basic and Below Basic on the PSSA, the majority of rural schools in Pennsylvania score an average of Proficient or Basic (Pennsylvania Department of Education, 2018). Therefore, when conducting this study, a rural middle school in Pennsylvania was selected based off of its average score of Proficient in Language Arts, Math and Science. This selection criterion was chosen to serve as an example and a model for rural schools ranked similarly in test scores throughout Pennsylvania.

Theoretical Framework

This case study research is grounded in the theory of the multiple determinants of use, quality, and outcomes recommended by Rost, Fortney, Fischer, and Smith (2002). Rost and her team synthesized literature in the rural mental health services field in order to identify research priorities in this field and create recommendations to improve these priorities. The researchers emphasize the difficulty in creating mental healthcare recommendations for rural public schools without first uncovering evidence of the underlying causes of the difficulties these schools face (Rost et al.). Therefore, the recommendation for future research is to first prioritize uncovering barriers before attempting to design interventions (Rost et al.). The researchers explain that when evaluating barriers to rural care resources,

we encourage investigators to frame the next generation of studies to examine the multiple determinants of service use, quality, and outcomes, placing special emphasis on those determinants that have unique conceptual or empirical importance to rural populations. This shift in focus is needed so that the specific facilitators and barriers to care can be identified to begin designing interventions to improve access to and quality of mental health care in rural areas (Rost et al., p. 242).

Following this framework, I researched how a specific mental health program is implemented in its rural school, its perceived quality from multiple stakeholders, and the perceived outcomes of the programs. The multiple determinants of use, quality and outcomes is a particularly important framework for shaping this research, as it sets a clear outline of steps for

uncovering the barriers that rural areas face when providing mental health care in order to create recommendations.

This theory also guided the design of the interview questions that were created in this study. The experiences of a school administrator, teacher, counselor, social worker and mental health liaison from the chosen school were then uncovered and coded by theme to create a case study scenario for in-service and in-training school staff members. Additionally, this framework was important for the purpose of uncovering the facilitators of mental health care within the chosen school; interviews were framed to explore how resources are implemented in this school, the perceived quality from participants and the perceived outcomes of resources in order to gain insight about who in this school is and is not facilitating and prioritizing mental health care resources.

Methods

This research used a case study design to explore its research questions. The data collection method consisted of semi-structured interviews of key informants. Data analysis methods included transcription of interviews, coding for patterns, synthesis for themes, and theory-triangulation. The following sections outline in depth the research methods that were utilized in this study.

A. Case Study Background

This study utilized a qualitative case study design. A case study can be viewed as a “method of inquiry” (Merriam, 1995), that “stands on its own as a detailed and rich story about a person, organization, event, campaign or program--whatever the focus of the study” (Patton, 2001, p. 259). This type of research is effective in achieving a goal of understanding in depth a specific case: “we take a particular case and come to know it well, not primarily as to how it is

different from others but what it is, what it does” (Stakes, 1995, p. 8). Under the conditions of limited literature regarding mental health in rural schools, a case study can expand upon the issues that have begun to be explored (Yin, 2012). A case study “does not need to be the first of its time” (Patton, p. 275) in order to serve as a valuable addition to its field, as “any exemplar of a phenomenon of interest can be a worthy single-case study” (Patton, p. 275).

Case study research “is more than simply conducting research on a single individual or situation” (Bexter & Jack, 2008). The case study approach can be implemented in both simple and complex situations, and explores the answer to “how” and “why” questions (Bexter & Jack), “while taking into consideration how a phenomenon is influenced by the context within which it is situated” (Bexter & Jack). When looking at case studies where interview questions are the unit of interest for data collection and analysis, “the analysis focuses on analyzing patterns across interview questions, focus group responses, open-ended questionnaire items, or site visit observations” (Patton, 2001, p. 276).

In order to explore a case, key informants “are a prized group...who are essentially knowledgeable about a topic and are willing to share their knowledge. Key informant interviews were developed by ethnographers to help understand cultures other than their own” (Patton, 2001, p. 284). In this research in particular, a case study was an appropriate approach as it provided the framework for gaining insight and an in depth understanding into the lived experiences of a particular group of key informants within a specific school setting. This creates the opportunity to understand the perceived strengths and weaknesses of available school mental health resources from the points of view of the key informants.

I was also able to create a case study scenario for this specific school for future teachers, school counselors and administrators using the recommendations created by the Center For

Enhanced Teaching and Learning (CETL) at the University of New Brunswick, and by Norton in the book *Psychology Applied Learning Scenarios (PALS): A practical introduction to problem-based learning using vignettes for psychology lecturers* (2004).

According to the CETL, case studies are “examples of collaborative teaching techniques that are effective for the deep learning necessary for students to remember and apply concepts after the end of a course” (CETL). Case studies can help future school staff better understand classroom principles by providing the opportunity to see such principles in action (McGuire, 2007, p. iii). Case studies are typically used to apply problem-solving concepts to real-life situations (CETL). Case studies can be well-structured or ill-structured. In well-structured case-studies, “problems and scenarios can be simple or complex or anything in between, but they have an optimal solution and only relevant information is given, and it is usually labeled or otherwise easily identified” (CETL). Contrastingly, in ill-structured case studies, problems and scenarios can also be simple or complex, although they tend to be complex. They have relevant and irrelevant information in them, and part of the student’s job is to decide what is relevant, how it is relevant, and to devise an evidence-based solution to the problem that is appropriate to the context and that can be defended by argumentation that draws upon the student’s knowledge of concepts in the discipline (CETL).

Ill-structured case studies allow for higher levels of student analysis, synthesis and evaluation. Additionally, case studies can either be realistic or authentic; realistic scenarios are hypothetical situations that combine aspects of multiple real-life events, however are typically simplified to be solved easily for beginners. Authentic scenarios, on the other hand, are events that actually occurred in the real world, and are not simplified or idealized. Well-structured scenarios are considered to be low-fidelity, meaning they lack an abundance of details regarding the struggles faced in actual practice. As students become more experienced with case study analysis, they can be given high-fidelity cases, ill-structured cases (CETL).

According to Norton, case studies should build on what students already know, be as authentic as possible, encourage independent learning, enable students to meet learning outcomes, motivate students and adhere to their interests, enable students to understand basic concepts, and help students fill in knowledge gaps (Norton, 2004, p. 6). Once a case study is completed, providing follow-up questions at the end of the scenario “encourages readers to look beneath the surface of classroom events and consider how various concepts and theoretical perspectives might enhance understanding and offer possible strategies and interventions” (McGuire, 2007, p. iii).

Following the recommendations of CETL and Norton, I was able to create a case study for teacher, school counselor and administrator candidates based off of the real world findings of this study. I created an ill-structured, authentic and high-fidelity scenario based upon the perceived experiences of the participants in this study. This case study could be beneficial in undergraduate and graduate education and psychology courses for future school staff members when learning about supporting the mental health needs of students. This case study can be used to normalize conversation about mental health for future school staff members, encourage school staff candidates to apply different principles of educational psychology to this scenario, and consider different courses of action that can provide students with the necessary mental health resources they need. The case study scenario and possible corresponding discussion questions based on this case can be found in Appendix C.

B. Data Collection Methods

Upon choosing the rural middle school in Eastern Pennsylvania for this study, I contacted the counseling office to inquire about interest in involvement in this study. The seventh and eighth grade school counselor informed me about the school’s Student Assistance Committee (SAC), which consists of staff members who are interested in student mental health needs, and

who would be willing to be involved in this research. These key informants would be the most knowledgeable about the mental health programs, resources and interventions available in this school, due to their involvement in SAC. The committee members who agreed to participate in this study were the school principal, the seventh and eighth grade school counselor, a learning support teacher, the district social worker and the district's mental health liaison. Upon selecting these informants, an informed consent form was sent to each interviewee (See Appendix A).

Using a semi-structured interview format, data was collected to uncover the participants' experiences when providing mental health resources to their students. The semi-structured interview format is preferred in this sample as it provides a list of key questions that will help define the areas to be explored, but will also allow me to diverge in order to pursue an idea or response in greater detail (Barribal & While, 1993). Semi-structured interviews allow for further exploration of perceptions and opinions of participants, and allow for the understanding of varying personal and professional backgrounds of participants (Barribal & While). Using the semi-structured interview format, sample lists of questions were created to guide the interviews (See Appendix B), and this list served as a foundation to define the areas that needed to be explored, and allowed for divergence in order to pursue an idea or response in greater detail.

As discussed in the grounded theory section, interview questions were created based on the multiple determinants of use, quality and outcomes recommended by Rost and her team (2002). Following this framework, questions were designed to explore how resources are implemented within the school, the perceived quality from the participants and the perceived outcomes of resources. My questions specifically focused on 1) the current mental health programs and resources available within the school, 2) barriers that staff members face in providing students with necessary resources, 3) perceived strengths and outcomes of programs

and resources, and 4) collaborative work amongst staff members, parents and students. Interviews lasted approximately 20 minutes each, and were conducted over the phone.

C. Data Analysis Methods

Each interview was recorded on my personal computer in a password-locked application. Each interview was then transcribed and saved on my personal computer in a password-locked word document within an hour of completion. After being typed, the interview recordings were deleted to secure the privacy of participants. In each document, interviews were transcribed and coded in order to uncover themes. My thesis advisor did reliability checks on the coding of the transcripts, and we reached 100% agreement.

In qualitative research, coding is considered the critical link between data collection and their explanation of meaning (Charmaz, 2001). A code is considered “a researcher-generated construct that symbolizes or translates data and thus attributes interpreted meaning to each individual datum for later purposes of pattern detection, categorization, assertion or proposition development, theory building, and any other analytic processes” (Saldana, 2009, p. 4). A code can be a word, phrase or paragraph that “symbolically assigns a summative, salient, essence-capturing and/or evocative attribute for a portion of language-based data” (Saldana, p. 4).

Codes are used to create patterns within interviews; a pattern is a “repetitive, regular or consistent occurrence of action/data that occur more than twice” (Saldana, 2009, p. 5). When uncovering patterns through coded data, it is important for a researcher “to understand that you may group things together not just because they are exactly alike or very much alike, but because they might also share something in common--even if, paradoxically, that commonality consists of differences” (Saldana, p. 7). Therefore, if participants share opposing views regarding the same

situation, their differing viewpoints over the situation can still be used to create a pattern (Saldana, p. 7).

In qualitative research, synthesis is the transition from coding to categorizing (Saldana, 2009, p. 8). When synthesizing, qualitative researchers focus not on reducing answers, but on moving toward a consolidated meaning in the forms of categories, themes or concepts. I compared codes and patterns to find similarities and differences between the participants' interview responses, and synthesized these patterns in order to create general themes and categories between the five interviewees' responses (Saldana, p.10).

In order to assure the validity of the themes that I uncovered, I followed qualitative triangulation protocols (Stake, 1995, p. 112) in search of both accuracy and alternative explanations for the data I uncovered. In order to have confirmation that I correctly comprehended the transcriptions, I followed theory triangulation protocol and presented my own observations with my interpretations to my thesis advisor, using pseudonyms to protect the anonymity of the participants (Stake, p. 113). This method of sharing observations with another researcher or expert is "a valuable protocol to discuss alternative interpretations...since no two investigators ever interpret things entirely the same, whenever multiple investigators compare their data, there is some theory triangulation" (Stake, p. 113).

My thesis advisor and I agreed on the meanings I uncovered, and thus the interpretation was triangulated (Stake, 1995, p. 113). Codes and patterns were agreed between my advisor and I to be split into the following themes:

1. Strengths of available resources
2. Most common mental health disorders and student needs
3. Challenges with supporting students

4. School staff training and the referral process

These themes are consistent with the multiple determinants of use, quality and outcomes created by Rost et al. (2002). Within these four themes, an overview of the uses of mental health resources within this school are expanded upon, the perceived quality of these programs are explored, and the outcomes of the programs and challenges are discussed.

Chapter 4

Findings and Discussion

After interviewing the principal, school counselor, learning support teacher, district social worker and district mental health liaison, four overall themes were uncovered and categorized using the recommendations of Rost et al. (2002) into the following: 1) strengths of available resources, 2) challenges with supporting students, 3) most common mental health disorders and student needs, and 4) school staff training and the referral process.

Strengths of available resources

This middle school offers three main mental health programs for its students: an anti-bullying program called Creating a Safe School (CASS), multiple discussion groups called Teen Issues, and the Student Assistance Committee (SAC). CASS focuses on trying to make the school safe and peaceful. The school counselor, John Stevens, gave an overview of CASS:

It's our school's anti-bullying program, focusing on trying to make the school safer and more peaceful. Within CASS, I train approximately seventy 8th graders and 7th graders combined. I train them to deliver an anti-bullying program to all the 6th graders for October during national anti-bullying month. We also made arrangements with a member from the Recreation Center Peer Mediation Center to train all the members about peer mediation. There's multiple sessions of that training, and now we're on session four and we have a core-group of eighteen CASS club members, primarily 7th graders, who are given more specialized skills. We put this program into action so that students, and really anybody in the building, can sign up for it, and CASS club members serve as peer mediators (J. Stevens, personal communication, January 8th, 2018).

CASS is perceived as an effective anti-bullying program within the middle school, and focuses primarily on older students teaching younger students about bullying based of the training that the older students receive. Additionally, the Teen Issues discussion groups are open for all grade levels in the middle school to participate in, and are separated by topics such as "bullying, making friends, improving grades, dealing with stress, resolving conflict, dealing with loss/grief, and anger management" (J. Stevens, personal communication, January 8, 2018).

In addition to CASS and Teen Issues groups, the main mental health program this rural middle school has available for its students is the Student Assistance Committee (SAC). The state of Pennsylvania requires every public school to provide a SAC for their students, to “identify students who may have barriers to their academic success and learning, whether it be drugs/alcohol, mental health, etc.” (Mental health liaison). The SAC at this middle school consists of the principal of the school, the assistant principal, the two school counselors, a learning support teacher, two classroom teachers, the district social worker and the district mental health liaison. The learning support teacher, Nicholas Miller, explained an overview of the Student Assistance Committee:

Basically at this school, we have teachers who have minimal training outside of the depression and suicide awareness mandated trainings that the school offers. And what happens is, we have a group of teachers that meet every Wednesday, along with administration and guidance, in The Student Assistance Committee, and we’re trained for a lot of things like mental health, and there’s also drug use and things involved with that, so there are some of us in the building who have additional training in this area (N. Miller, personal communication, January 9, 2018).

A perceived strength of the SAC, then, is bridging the gap between the resources that the school can and cannot provide. Although not all teachers and administrators in this school receive in-depth mental health training, all staff members receive basic trainings regarding mental health identification, and can then use this knowledge to make referrals for the SAC to evaluate the student given their in-depth training and knowledge.

When a student is referred to the SAC, the district’s mental health liaison, Lily Robertson, can then perform an initial screening on the student:

So one of the interventions that can be used if a student is referred to SAC is a screening can be done on the student, and that’s my role, I complete the screenings on students. The screening is a tool that consists of basically asking them questions about family, friends, what they like to do for fun, some mental health questions, questions about coping, some drug/alcohol related questions, and it’s basically gathering information, having a conversation with the student, to see if they identify anything on their own that they feel they struggle with or need help with that is possibly a

barrier to their learning. So if something is identified, then we look at what we can do to get them services, whether it's going to a support group at school, whether it's guidance just checking in with them, whether it's me just checking in with them, or if we need to arrange them with outside services, so that's kind of my role, I'm a link between school, outside and home to help with those services if found necessary (L. Robertson, personal communication, January 9, 2018).

The primary perceived strengths of the SAC, as mentioned by the interviewees, include its ability to serve as a point of referral for professionals in the school who do not have in-depth training, and its ability to provide an initial screening process in order to uncover what services a student can best benefit from.

The perceived strengths of these programs match with much of the research that has evaluated mental health programs in rural areas. While this school is unable to provide training to all staff members and only has one staff member who can provide mental health screenings, the school does prioritize making use of the resources it does have in order to provide necessary resources for students and faculty members (Davis et al., 2006).

Most Common Mental Health Disorders and Student Needs

The most common mental health issues that the SAC see are anxiety, depression, stress, and nonsuicidal self-harm. Despite the abundance of literature regarding suicide as a top problem amongst rural adolescents, the participants in this study did not perceive suicide as being a relevant issue in their school. This does not align with previous research that emphasizes suicide as a top issue in rural middle schools.

Self-cutting is the most common form of nonsuicidal self-harm that SAC members see in this middle school. The members of the SAC perceive anxiety, depression, stress and nonsuicidal self-harm to be quite common for adolescents throughout the country, and do not view these issues as unique to this particular school.

The mental health disorders that the SAC members view as most common do parallel to the top mental health disorders that research has found to be most common amongst adolescents throughout the United States. According to the United States Department of Health and Human Services, the three most common mental health disorders amongst adolescents are anxiety, depression, and eating disorders (HHS, 2018). Nonsuicidal self-harm has also been found to be common amongst adolescents (Wood, 2009), and is typically used as a coping mechanism for adolescents struggling with depression (Peterson et al., 2008). Statistics show that currently, one-half to one-third of United States adolescents have engaged in some type of nonsuicidal self injury, and cutting and burning are the most common forms of nonsuicidal self harm (Peterson et al., 2008).

In terms of student needs, some interviewees noted a rise in the urgency for mental health resources in the middle school within the past five years. The school counselor explained, “we’ve been seeing more and more mental health needs coming through our student assistance program directly” (J. Stevens, personal communication, January 8, 2018), and similarly, the principal noted that “our students mental health needs are outweighing what we can provide them, and it’s getting worse and worse every year” (J. Adams, personal communication, January 9, 2018).

However, the school social worker’s opinion differed from those of the school counselor and principal. The social worker did not view the needs of middle schoolers to have changed or increased in recent years. Rather, the social worker explained, “I think it’s always been the same issues within the middle school setting” (M. Brennen, personal communication, January 8, 2018). Similarly, the district mental health liaison explained that “across multiple districts, at the middle school level the needs are very common and haven’t seemed to change. Self-harming, cutting,

depression, anxiety, and coping are the top issues, and they've all been fairly consistent within the last few years" (L. Robertson, personal communication, January 9, 2018).

Research validates both sides of the argument regarding if there has been a rise in a need of mental health resources amongst rural middle schoolers. On the one hand, research has emphasized that rates of mental health disorders are increasing amongst adolescents, and therefore there is a higher need now than in the past to provide help to more students (Richardson, 2012). However, research has also shown that the list of top mental health issues amongst adolescents have remained consistent within recent years (HHS, 2018), and therefore the social worker and mental health liaison are supported in their perceptions that the issues tend to overlap within the cases that come to their attention.

Interviewees agreed, however, that one notable change that has occurred is an increase in awareness surrounding mental health needs of students. The social worker addressed that mental health awareness has definitely been on the rise in the middle school, and the learning support teacher explained, "there is a noticeable difference in mental health awareness. The awareness is definitely here more so than in past years". Similarly, the school counselor addressed the increase in awareness about the Student Assistance Committee: "we talk about the committee to students, so that students can be more aware about what we do. We have been making students more aware of what appropriate referrals are". Interviewees agreed that there has been an overall increase in both general awareness of student mental health, and in students' knowledge of the SAC.

The key informants' perception of an increase in mental health awareness in this middle school parallels to the research regarding mental health programs in rural middle schools. Research has identified that having mental health programs in place in middle schools increases student and staff awareness of such issues (American Psychiatric Association, 2017). Mental

health programs have been found to be an important tool for increasing mental health awareness amongst students, teachers and parents (Esters et al., 1998).

Challenges with Supporting Students

While the CASS program, Teen Issue discussion groups, and SAC have perceived strengths, participants also explained perceived challenges with the programs this middle school has to offer. Although the SAC is able to perform screenings for students who may be struggling, the committee cannot give students treatment, which requires parents to find outside resources for follow-up. The school principal explained his view that “the biggest thing is just trying to get students help outside of here, because we don’t have the staff or the means to support them here”. Currently, there is no set list of outside services for referral. When uncovering the reasons for why the school does not have the means to support the mental health needs of the students, multiple barriers were identified: parental involvement, parental follow-through, funding and transportation.

1. Parental involvement

Research has identified community mental health stigma as a top barrier that rural public schools face when providing mental health resources (Nichols, 2017). This finding is consistent with the opinions of the key informants in this study, especially when they spoke about parental involvement.

Parental involvement was a widely mentioned barrier by Student Assistance Committee members. When the SAC receives a referral for a specific student, they cannot have the mental health liaison provide an initial screening with the student until she receives parental consent.

The process of gaining parental consent was one of the most mentioned barriers:

The SAC team has to get parental permission before doing an evaluation, and getting parental permission can be an issue where the parents don’t see an issue with it and think it’s just a phase,

and they don't want to accept it or don't believe in mental health disorders. Or sometimes too, a child's mental health concerns can be an underlying condition of what's going on in the home, so parents become more resistant because they're afraid it's going to show something that's going on outside of the classroom, so that's a big part of it (N. Miller, personal communication, January 9, 2018).

The school counselor and mental health liaison both addressed the issue of parental involvement as well. The school counselor explained, "We have fantastic parents in the school district, but we can't move forward with SAC services without parent permission and this can sometimes be a huge issue" (J. Stevens, personal communication, January 8, 2018). Similarly, the mental health liaison touched upon the difficulty of gaining parental involvement and support, and explained that parents often just do not agree that their child needs a screening, and this may connect to stigmatized beliefs about mental health (L. Robertson, personal communication, January 9, 2018).

The difficulty in parental involvement identified by the participants goes hand in hand with the literature regarding parental stigma of mental health issues in rural areas. The extant literature emphasizes how rural parents encourage students to seek familial or church support rather than the support of outside professional providers (Murry, 2011), and parental stigma impacts the resources a parent is willing to provide for their child (Eaton et al., 2016). The idea of parents being in denial about their child's mental health or believe their child is going through a short-lived phase in this school parallels directly to the literature explaining how rural parents typically make excuses and avoid professional mental health help for their children (Eaton et al).

2. Parental Follow-Through

The mental health liaison continued to expand upon the barrier of parental involvement, and addressed the issue of parental follow-through:

There are times when parents sign off and agree for their child to have a screening, and then I meet with their child and reach back out to the parent to discuss options and offer them assistance

to help link their child up with services, but I just don't hear back from the parent. That's another barrier, parent follow-through after a screening is completed (L. Robertson, personal communication, January 9, 2018).

When parental follow-through is an issue, there is little that the Student Assistance Committee can do besides continue to reach out to the parents and see if they hear back. The student support teacher also mentioned the barrier of follow-through, and expanded upon the issue:

Another barrier would be follow through. A lot of agencies require medical assistance or health insurance of some kind if giving someone extensive services, and a lot of parents, they come from a dysfunctional household, with a lack of medical assistance, and that's always a barrier of the process. Insurance can be an issue, will insurance cover it or not, that becomes a waiting game. There's a whole slew of issues we've dealt with in the past when trying to follow-through and get students hooked up with the services more than what we're providing them (N. Miller, personal communication, January 9, 2018).

Whether parents choose not to follow-through, or are unable to follow-through due to financial issues, parental involvement and follow-through are significant barriers that the committee members face when trying to help support the needs of their students. The issue of parental follow-through is one that was not highlighted in existent literature regarding barriers that rural public schools face when providing mental health resources to their students; the main barriers mentioned in literature regard stigma, school staff training, collaboration and funding (Kelleher et al., 1992). The perceived barrier of parental follow-through uncovered in this study is one that adds to the literature regarding parental stigma.

3. Transportation

Transportation was another briefly mentioned barrier that was addressed when discussing parental follow-through. In addition to the influences of parental stigma or insurance issues contributing to follow-through issues, transportation can prevent parents from providing outside mental health resources for their children: "because we're in a rural area, another barrier to

follow-through is sometimes transportation, getting people to and from mental health services if needed is a very common barrier around here” (L. Robertson, personal communication, January 9, 2018).

The way in which transportation was brought up in this study directly parallels to the way transportation is explained in existent literature. Transportation was mentioned by participants in this study, however was talked about very briefly and was explained more so as an afterthought. This is exactly how transportation is conveyed in literature; transportation is typically mentioned as a barrier to providing mental health resources in rural schools, however is not deemed one of the top issues (Kelleher et al., 1992)

4. Funding

Funding was perceived as the largest barrier to providing students necessary mental health resources in the eyes of all five interviewees. When talking about the issues that the school faces with funding, the school counselor explained:

So basically a few years ago there was no funding left for the Student Assistance Committee, and as far as I know there’s currently no funding available for it as well, so we have to be creative and attend more free-like trainings that come up, but that doesn’t happen often. And for example, we have other staff members who have had interest in joining the Student Assistance Committee, but due to lack of funding we just don’t have enough money to train any new members (J. Stevens, personal communication, January 8, 2018).

Funding causes many issues for the SAC in terms of limiting the resources that they can provide, and the opportunities for expansion. When evaluating the issues that the school faces when trying to expand mental health resources, the school social worker, Megan Brennen, said “funding is always, always the problem, there’s just not enough funds” (M. Brennen, personal communication, January 8, 2018). Similarly, the school principal views funding as the primary barrier that this school encounters:

Ideally, we as a district would hire a mental health professional specifically to help students and support them in house rather than send them away to facilities that have the resources, but until we have funding we can't have that...I just feel like I'm running into walls constantly trying to get support because nobody wants to flip the bill, it's always about money and who is going to pay for it (J. Adams, personal communication, January 9, 2018).

All of the interviewees agreed that the mental health needs of students in this middle school far outweigh the resources available, and primarily blame funding for this gap. Although funding is deemed as a barrier in the existing literature in this field, there is an overall lack of research that focuses primarily on how funding impacts the mental health resources that rural public schools can provide to their students. Research does acknowledge that rural public schools tend to be underfunded and struggle to allocate funds for mental health resources (Kelleher et al., 1992), however it is difficult to find extensive studies that explore the issue of allocating funds for resources in low-income areas. While there is an abundance of literature currently existing regarding the barrier of stigma, little exists regarding funding, despite it being noted as the perceived most prevalent challenge in this study.

School staff Training and the Referral Process

Interviewees highlighted both the perceived positive and negative aspects of current school staff training regarding mental health disorders and student needs. The learning support teacher provided a detailed overview of the training school staff members at this school receive: Basically what happens is, even if my colleagues down the hallway only have the basic training and signs of mental illnesses but don't have that specific training that the committee gets, what they do is they make a referral to our committee. So they're aware of the signs but may not have the extensive training to deal with the problem, but they use their knowledge of the signs and can make a referral and it goes to our committee, and then we talk about if it's going to be evaluated or not. So the training is really between generalized state-mandated training, and then you have the committee members who are trained specifically in this area (N. Miller, personal communication, January 9, 2018).

Due to funding, this school is unable to provide all school staff members mental health training. The difficulty this school faces in providing training to all teachers and staff-members parallels to the research regarding the current status of school staff member mental health training. Teachers globally have reported a lack of training for supporting children's mental health needs in schools (Reinke et al., 2011). Therefore, the SAC serves as a bridge between teachers who are and are not fully trained. Teachers and administrators who are not in the committee receive information from the SAC about what the committee does, and signs to look for amongst students in order to make referrals to the committee.

The learning support teacher discussed the types of signs that teachers receive training to look out for, and the signs he believes are most telling that a student may be struggling:

In terms of students with emotional disturbances, it's looking out for a lot of outbursts, physical aggression, verbal aggression, and basically if a student has these kinds of things you can see it the minute they come into school in the morning. Whether they're not medicated, whether something happened the night before at home or in the morning, they wear a lot in their facial expressions and their body language, so you can tell they're off the minute they step through the door. In terms of any general student, withdraw can be an issue if it's something with depression, and looking at participation--if they used to participate a lot and now they're just sitting there. We do get a lot of cries for help, students incorporate that into written pieces, or they'll say something and lash out verbally about suicide. There's a lot of signs when a student is off. Also physical appearance, if students are coming in that are usually clean that aren't showering or combing their hair, it can be a whole mess of things that can tip us off that something else is going on here (N. Miller, personal communication, January 9, 2018).

In addition to the telling signs of changes in outbursts, facial expressions, withdraw and physical appearances, the mental health liaison and social worker noted the appearance of scars or bruising as additional signs of self-harm or abuse.

The committee members also prioritize training students about the committee's purpose and about making appropriate referrals. The school counselor explained:

I will do a presentation to all the 8th graders and 7th graders, and the other school counselor is in charge of the 6th graders. So, we push these presentations into classrooms in order to make everyone aware of the Student Assistance Committee, how it works, how students can make referrals. We have Student Assistance Committee mailboxes located in different locations of the building, such as the nurse's office, guidance office, main office and the library. And anyone can make a referral so we encourage students to be aware and make referrals as well. This year we're up to 35 referrals and it's only February, and last year we had a total of 47, so I think this year we're more active. We try to make students aware of what are appropriate referrals, so we talk about that as a committee. Unfortunately we haven't had a lot of staff meetings recently, but when we have opportunities we will talk to the entire staff about the Student Assistance Committee (J. Stevens, personal communication, January 8, 2018).

Providing educational presentations and sessions for students has been proven to be successful for raising mental health awareness and combating stigmatized beliefs (Bella-Awusah et al., 2014). The referral process at this school, therefore, is perceived as an effective and simple way of setting students up with the committee. By providing presentations to staff members and students throughout the school year, the committee prepares the school community about mental health signs to look out for, and staff members and students can fill out a form in a Student Assistance Committee mailbox to make a referral for a student who may need assistance.

Limitations To This Thesis

This case study research had several limitations. The first was the small sample size; this study examined only one school in rural Eastern Pennsylvania, and therefore the results cannot be generalized to all rural schools in Pennsylvania. This sample provided insight into the lived realities of members in this specific school-community, however, in order to gain a comprehensive explanation of how mental health programs are implemented into rural middle schools in Eastern Pennsylvania, a larger sample of schools would be required to study.

Another limitation in this study was that not all members of the current Student Assistance Committee at this school agreed to participate in this study. There are currently eleven members of the Student Assistance Committee, and only five volunteered to participate in this study. The

views of the other six committee members could have given further insight into the points of agreement and disagreement that the participants reported.

An additional limitation was the backgrounds of the key informants; all of the interviewees were members of the Student Assistance Committee, and therefore held an existent interest in student mental health and were given extensive mental health training prior to participation in this study. The results may have varied if the participants included non-committee staff members who were less trained and educated about mental health, and who did not hold an inherent interest in mental health. Similarly, this study did not include the perspectives of parents. The school staff members in this study discussed their views of parents and families, however the perspective of parents about the school were not included. The participation of parents in this study could have led to the comparison between the ways in which members view parents, and the ways in which parents view the school.

From a methodology standpoint, this research was limited by the data collection method. The method consisted only of semi-structured interviews, rather than incorporating multiple methods such as interviews, observations and focus groups together. Having multiple data collection methods would have allowed for a more extensive understanding of the lived realities of the participants.

Chapter 5

Conclusions and Implications

The findings of this study uncovered the need for an increase in mental health training and education for all school staff members at this rural middle school in Eastern Pennsylvania, and highlighted the committee members' desire for more funding designated for mental health resources. Despite previous research that deems suicide as a top issue in rural public middle schools, the participants in this rural school do not encounter regular issues of suicide. The findings of this study raise more questions for investigation within this school:

1. How does the funding that the school currently receives for mental health resources compare to the funding the school receives for other programs, such as sports teams or other after-school activities?
2. If a parent does not follow-through after a screening but the committee has reason to believe that the child is a potential harm to themselves or others, what steps does the committee take in trying to reach the parent?
3. If a student has visible self-injuries, and their parents still say no to a screening, what are the next steps in assuring that the student receives necessary help?

Answering these questions will allow for the creation of specific recommendations for the Student Assistance Committee to best support the mental health needs of their students and begin to overcome the perceived barriers and challenges.

Implications for Practice and Research

This study uncovered that one limitation to school staff training is funding; this school was unable to provide mental health training to all of its staff members due to the funding of training programs. The difficulty in providing training for in-service staff members highlights the

importance for school staff training programs to incorporate mental health awareness training into the curriculum so that teachers, administrators and support-staff candidates alike are trained on the needs of students before earning their degrees to practice.

While the findings of this research cannot be generalized to all rural schools, the creation of the case study scenario can be used for the purpose of professional development within similar schools. This school shares consistent features of rural schools generally; the challenges that this school faces are similar to existent literature that outlines challenges of rural schools generally, such as parental involvement, funding and school staff-training issues. The case study scenario created through this research can be used for both school staff training programs, and in-service professional development programs. The case study, along with the follow-up questions (see Appendix C), can be used to introduce the topic of mental health in classrooms, and encourage school staff candidates to begin thinking of the ways they can best help their students, even if facing limited school resources.

This research adds to extant literature regarding the barriers and strengths that rural schools face in providing mental health resources and programs to their students. In addition to the need for further questions within this school in particular, this research also gives insight into questions for future research in general regarding providing mental health for rural students nationwide:

1. What is the link between funding/socioeconomic status of a school district and its approach and prioritization of mental health programs?
2. Is mental health training prioritized during school staff candidacy programs, and what does mental health education look like in these programs?

3. How do rural school-staff members in similarly rural Pennsylvania public schools view the role of suicide in their schools?

4. How is the opioid crisis that rural areas are experiencing today contributing to mental health issues amongst rural adolescents?

While funding was the issue that interviewees reported struggling with the most in this particular study, little research currently exists today outlining the ways that funding is currently prioritized in schools for mental health purposes. More research must investigate the link between socioeconomic status of a school district and its approach to mental health resources and programs. Additionally, in order to make recommendations for school districts who struggle with receiving funding for mental health purposes, more research must be done regarding how funding is allocated within school districts, and what programs are receiving the most money.

Similarly, little research has been done regarding the training school staff candidates receive during their undergraduate and graduate-level programs. Current literature has addressed teacher-candidates often only take one child psychology course as part of their curriculum (Reinke et al., 2011), however does not give a full overview of what school staff candidate programs look like, and what courses are prioritized over mental health trainings.

Although research addresses the need for school staff members to be trained about mental health disorders, there is a lack of focus on how to change the curriculum for school staff candidates. Similarly, when asked about training, the participants of this study solely focused on trainings they have received since being in-practice, and did not at all address mental health education during their candidacy programs. In order to best support the needs of students, research must prioritize learning more about the background school staff candidates receive regarding mental health knowledge, in order to create recommendations for improving courses.

Additionally, the findings of this research actually contrasted previous literature deeming suicide as a top issue in American rural middle schools. The participants in this study explained that suicide is not a typical issue that they encounter amongst their students, and therefore suicide prevention training is not prioritized in this school. Future research must explore how issues of suicide are present in similar Pennsylvania middle schools to understand the extent to which suicide is a rural problem in these areas.

Research also emphasizes the severity of the opioid crisis in rural areas, however there is no research relating this issue to the mental health of rural adolescents. The opioid crisis has put a strain on families where nearly 2.5 million children are being raised by grandparents or extended family because of this struggle in the home (Hazlett, 2018). Future research must be done to investigate the connection that this issue has to adolescent mental health disorders in rural environments.

The findings of this study provide insight into the lived realities of the members of a Student Assistance Committee in a particular rural middle school in Eastern Pennsylvania. The perceived barriers and strengths that these participants shared raise more questions for research in order to best support school staff members in providing mental health resources for their students.

Appendix B

Sample Interview Questions

A. Questions for Principal:

1. As an administrator, how do you view your role in assuring that the mental health needs of students are being met in your school?
2. Can you give me an overview of the current mental health initiatives/programs at this middle school and how they were formed?
 1. What was happening before these were created?
 2. What did the process entail of forming the current programs?
2. Can you give me an overview of both the successes you have faced when implementing mental health programs/initiatives/education in this school, and the challenges you have faced?
3. In your opinion, what can make these programs stronger going forward?/Any changes you foresee?
4. Are you getting support beyond the district, i.e support from IU, from the state?

B. Questions for Teacher:

1. What training, if any, have teachers at this school gone through regarding mental health disorders and making referrals for your students?
2. What kinds of barriers, if any, have you faced when referring a student in your classroom for mental healthcare support?
 1. Is parental acceptance a barrier? What does communication process look like with parents when it comes to mental health concerns?
2. How often do mental health concerns come to your attention in your classroom?

3. What are the warning signs you look for in students who may be struggling/how do you know?
1. Are you getting support beyond the district, i.e support from IU, from the state?

C. Questions for School Counselor:

1. What would you say are the biggest challenges, if any, that you face in providing students with necessary mental health resources at this school?
1. What are the biggest successes in providing students with these resources?
2. What mental health disorders have you found to be the most prevalent amongst your students?
3. Were you working at this school during the development of these programs? What sorts of supports were received/how were the programs created?
4. What continued supports do you receive for mental health resources? Does mental health seem like a priority of the district?
5. Are you getting support beyond the district, i.e support from IU, from the state?

D. Questions for Mental Health Liaison:

1. Can you give me an overview of your role as the district's mental health liaison?
2. What kinds of mental health concerns do you address regularly in the district?
3. Is your type of position typical in rural school districts in Pennsylvania/is this a statewide initiative, or is this something that Selinsgrove has spearheaded themselves?
4. If you've had similar positions in the past, how did they compare to the work you do now in Selinsgrove?
5. Are you getting support beyond the district, i.e support from IU, from the state?

E. Questions for Social Worker:

1. Can you give me an overview of your role as the district's social worker?
2. What kinds of mental health concerns do you address regularly in the district?
3. What kind of work do you do with teachers, counselors, students and administrators?
4. Have you seen an increase in mental health cases in middle school setting in the past five years?
5. Are you getting support beyond the district, i.e support from IU, from the state?

Appendix C

The Student Assistance Committee - A Case Study

Mr. Stevens is a school counselor at Rivers Middle School in rural Pennsylvania, which holds 680 total students in grades 6-8. This town in rural Pennsylvania has approximately 5,000 residents, a 15.7% poverty rate, and a median household income of \$38,000. Mr. Stevens' job as a school counselor in this area of rural PA consists of working with students daily, providing individual and group counseling to students in need, and working with his fellow school staff members in the Student Assistance Committee. The state of Pennsylvania requires every public school to have a Student Assistance Program that address mental health concerns, so the school created a Student Assistance Committee, consisting of teachers, administrators, counselors, social workers, and a mental health liaison within Rivers Middle School who meet weekly to discuss referrals made within the school-community of students who may need mental health assistance. The members of the Student Assistance Committee receive extensive training on mental health disorders and warning signs amongst adolescents.

Mr. Stevens and the rest of the committee members are unable to provide treatment services to students, however the committee can provide mental health screenings with parental permission and can then determine if a student may need follow-up services from an outside resource. It can be difficult, however, to provide students with any types of services at all: sometimes parents decline the committee's request to provide initial mental health screenings for their child, and the committee is left without other options for moving forward with evaluating the child. Frequently, parents will say that they do not see an issue in their child's behavior, that their child's behavior is just a phase, or that they do not believe in mental health disorders. Other times, a parent may agree for initial screenings, but fail to reply to information regarding follow-

up services. This leaves Mr. Stevens and the rest of the committee with limited options, because they cannot help students without parental consent.

Committee members also tend to face challenges with particular students when trying to provide support. If students are fourteen-years-old or above, they can refuse consent to treatment. In this case, the committee is again left with no options in moving forward to help the adolescent, because they cannot make the student seek treatment.

Although the school has done a successful job at offering mental health resources for students, such as creating an anti-bullying program and teen issue discussion groups, Mr. Stevens and the rest of the committee members are often left frustrated at the lack of funding available for mental health purposes at Rivers Middle School. The school has no funding for their Student Assistance Committee, and thus must seek out free trainings when they arise, however this does not occur often. There are many additional teachers and administrators at Rivers Middle School who have expressed interest in becoming involved in the committee, however they are told they cannot join because the committee simply cannot afford to train any new members. As much as the committee would like to expand, the school does not have the funding available to do so. Committee member and principal of Rivers Middle School, Mr. Adams, is also disappointed by the lack of resources that the school has to offer when addressing mental health needs. Mr. Adams believes that the mental health needs of students in the school outweighs the available resources, and hopes to someday be able to offer more mental health support opportunities within the school so that students do not need to rely on outside resources. Mr. Adams has had many teachers come to him frustrated after not being able to help struggling students, however, he does not know how to help the teachers during these situations.

Mr. Adams is particularly upset about the way a situation was handled with a 6th grade student at the school. The student, a 12-year-old girl named Sandy, has been struggling with depression for about a year, and her parents have been reaching out to Mr. Adams constantly to seek his help within the school. Sandy has been to multiple short-term resources, however is discharged after only five days with little improvement. Mr. Adams knows that Sandy needs one-on-one professional counseling, however the school is unable to provide her the support that she needs. Mr. Adams is dejected and worried about Sandy, among other students in similar situations, however he does not know what he can do to help these students.

Possible Case Study Discussion Questions

A. Questions for teachers and teacher candidates:

- 1) You are Sandy's teacher and see her daily in your classroom. Sandy's parents reached out to you after she was released from a facility after five days with no help. What could you do to try to help Sandy?
- 2) You notice that one of your students, Jeremy, has scars on his wrists. Upon writing a referral to the Student Assistance Committee for Jeremy, the committee reaches out to his parents for permission to complete a mental health screening. Jeremy's parents say that their child's behavior is just a phase. What could you do to help Jeremy?
- 3) After the completion of a screening, the school mental health liaison determined that one of the students in your classroom, Isabelle, is struggling with depression. Isabelle's parents do not believe that Isabelle has depression, and told the Student Assistance Committee to stop contacting them. How could you handle this situation in order to help Isabelle?
- 4) One of your students, Nick, has confided in you that he struggles with anxiety attacks. You submit a referral to the Student Assistance Committee, You submit a referral to the Student

Assistance Committee, and after completing a screening the committee advises that Nick seek professional treatment. Nick is fourteen years old and refuses to consent to treatment. How could you address this situation with Nick in order to provide him help?

B. Questions for school counselors and school counselor candidates:

1) You are Sandy's school counselor. Sandy's parents have reached out to you asking for help after she was released from a facility after five days with no help. What could you do to help Sandy?

2) You are Jeremy's school counselor. Jeremy's teacher, who is not a Student Assistance Committee member, comes to you concerned after realizing that Jeremy has scars on his wrists. You write a referral to the Student Assistance Committee for Jeremy, and the committee reaches out to his parents for permission to complete a mental health screening. Jeremy's parents say that their child's behavior is just a phase. What could you do to help Jeremy?

3) After the completion of a screening, the school mental health liaison determined that one of the students in eighth, Isabelle, is struggling with depression. Isabelle's parents do not believe that Isabelle has depression, and told the Student Assistance Committee to stop contacting them. How could you handle this situation in order to help Isabelle?

4) A sixth grade student, Nick, came to your office and confided in you that he struggles with anxiety attacks. You submit a referral to the Student Assistance Committee, and after completing a screening the committee advises that Nick seek professional treatment. Nick is fourteen years old and refuses to consent to treatment. How could you address this situation with Nick in order to provide him help?

C. Questions for administrators and administrator candidates:

1) You are Sandy's principal. Sandy's parents reached out to you after she was released

from a facility after five days with no help. What could you do to try to help Sandy?

2) One of the teachers at your school, Mr. Smith, comes to you concerned about his student Jeremy. Mr. Smith explained that Jeremy's parents are not allowing the Student Assistance Committee to complete a screening on Jeremy, because they believe his behavior is just a phase. Mr. Smith is worried for the student and does not know what to do. What could you do to help Mr. Smith and Jeremy?

3) You have multiple teachers come to you expressing interest in joining the Student Assistance Committee, however your school currently does not have the funding available to provide any more teachers with mental health training. What could you do to help the teachers looking to get involved?

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