SUICIDE PREVENTION AT THE INTERSECTION OF HEALTH EDUCATION, SOCIAL EMOTIONAL LEARNING, AND MENTAL HEALTH LITERACY IN ELEMENTARY EDUCATION

by

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DISSERTATION ABSTRACT

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Title: Suicide Prevention at the Intersection of Mental Health Literacy and Social Emotional Learning in Elementary Education

The rates of death by suicide and the prevalence of mental health conditions in children and youth are a world-wide crisis. Education and school health promotion have a key role in supporting children, however initiatives and interventions are siloed and provide supports to only a few students. In this qualitative study with quantitative components, I used a sequential exploratory research design in a three-phase process to explore how promoting a universal approach to mental health literacy (MHL) and social emotional learning (SEL) in the context of health education can bridge the suicide prevention gap that exists in elementary education. Phase one included an artifact analysis of state and district-level data addressing health education, SEL, and MHL. In phase two, I presented the findings from my artifact analysis to a district-level team. They were then asked to provide feedback on adaptations to a district revision of CDC's Elementary School Health Index (SHI) to better support district and school-level goals (CDC, 2017). The data were collected and shared with the participants through a focus group in phase three, where they continued revising in a collaborative format. The process of adapting the SHI provided insight into how educators perceive the constructs in this study. I selected a purposeful sampling of district-level staff to participate in the survey and focus group. District-level staff were chosen based on their expertise and experience with SEL, mental health, health education,

and/or intimate knowledge of student needs. All 20 participants held leadership or support positions in the district. Participants were female and four racial/ethnic groups were represented. The findings highlight the multidimensional nature of these topics. There was a general consensus that health education, MHL, and SEL can and should be aligned, but there are many factors to consider along the way to alignment. Participants spoke about professional development, accountability, equity, access, cultural responsiveness, collaboration, responsibility, roles, implementation, systems, and more. Implications for practice and suggestions for future research are discussed.

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"I love you to the moon and back and all around the space." – Stinkerbell

I also share this dedication with my beautiful and vibrant friend, Stacy. You impacted my life in multiple ways and I know you would have liked this project. You are missed.

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ABBREVIATIONS

Abbreviation - Meaning

ASCA - American School Counselor Association

CASEL – Collaborative for Academic, Social, and Emotional Learning

CBHSQ – Center for Behavioral Health Statistics and Quality

CDC – Center for Disease Control and Prevention

CHRR – County Health Rankings and Roadmaps

COSA – Counselor on Special Assignment

MHA – Mental Health America

MHL – Mental Health Literacy

MTSS – Multi-tiered System of Support

NASW – National Association of Social Workers

NCSMH – National Center for School Mental Health

NHES – National Health Education Standards

OHA – Oregon Health Authority

PNWSD – Pacific Northwest School District (pseudonym)

SEL – Social Emotional Learning

SHI – School Health Index

SHS – School Health Survey

TOSA – Teacher on Special Assignment

WHO – World Health Organization

WSCC – Whole School, Whole Community, Whole Child Framework

CHAPTER I

INTRODUCTION

Death by suicide is a significant public health crisis in the United States and worldwide (WHO, 2014). According to the Centers for Disease Control (CDC), in 2021 the number of deaths by suicide in the United States was 47,646, a 4% increase from 2020 (*n* = 45,979; Curtin et al., 2022). This equates to 1 suicide every 11 minutes (CDC, 2022a). Overall deaths by suicide have increased 35% since 1999, with a 5% decline between 2018 and 2020 (Curtin et al., 2022). The trend continues across the childhood and young adult age groups. In 2020, death by suicide was the 3rd leading cause of death for young adults between the ages of 20-24, and the cause of 18.6% of all deaths (*n* = 3,846, CDC, 2022b). The same grim reality applies to high school students between the ages of 15-19, where suicide was the cause of 20.4% (*n* = 2,216) of all deaths (see Figure 1). Suicide was the 2nd leading cause of death (*n* = 581; 21.9%) for late elementary and middle school students between the ages of 10-14 (see Figure 2). Very few deaths are classified as death by suicide for children under the age of ten due to difficulty in determining suicide intent for young children (Curtin et al., 2022). However, it is important to note that death by suicide is cited as the 10th leading cause of death for children in early elementary school between the ages of 5-9 (*n* = 20, 1.2%; see Figure 3; CDC, 2022b). Death by suicide is rare for this age group, but not unheard of.

Although children and young adults have overall lower rates of death by suicide, in 2020 they had higher rates of self-harm leading to emergency department visits compared to older age groups (CDC, 2022c). According to the 2019 Youth Risk Behavior Survey, in a 12-month period, 2.5% of high school students made a suicide attempt requiring medical treatment, 8.9% attempted suicide, 15.7% made a suicide plan, 18.8% (1 in 5) seriously considered attempting

Figure 1

Top 10 Leading Causes of Death for 15-19 Year Olds, United States, 2020

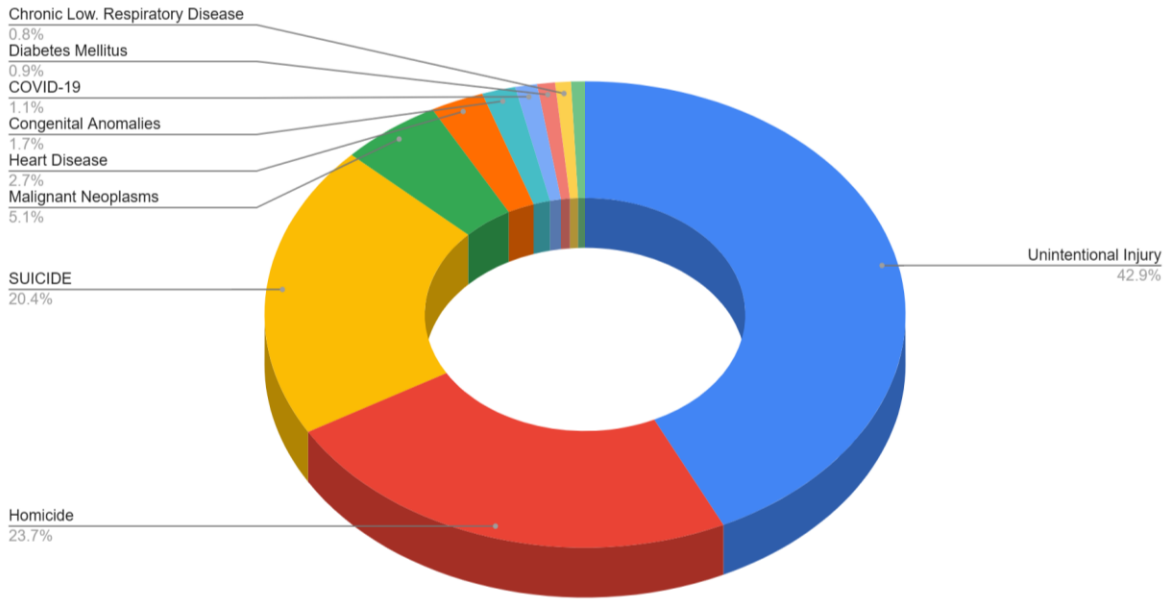


Figure 2

Top 10 Leading Causes of Death for 10-14 Year Olds, United States, 2020

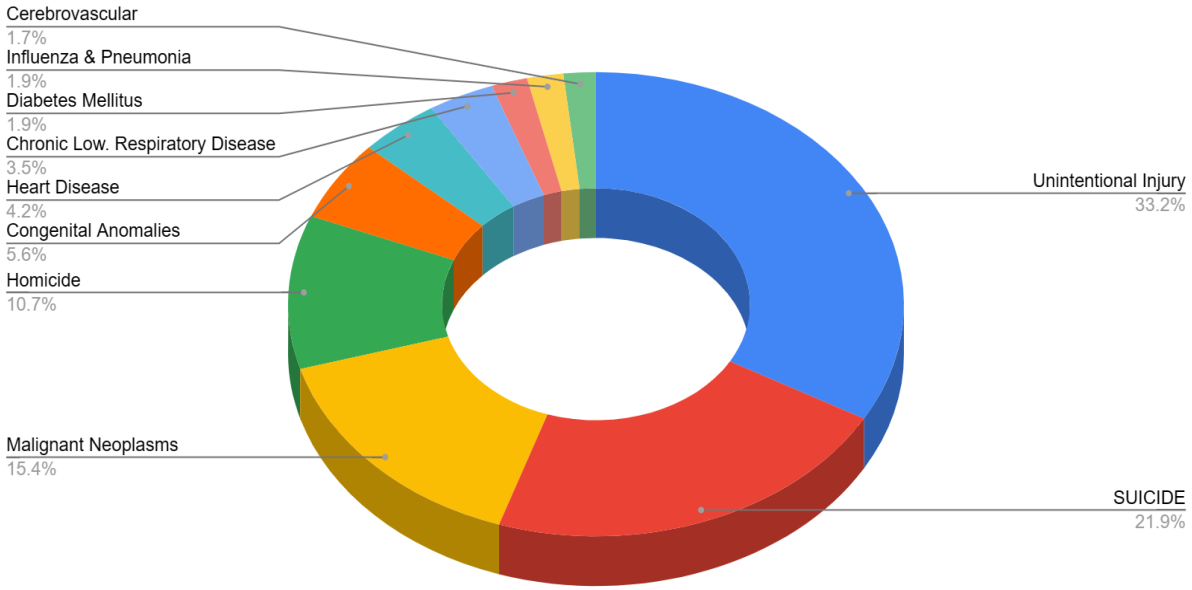
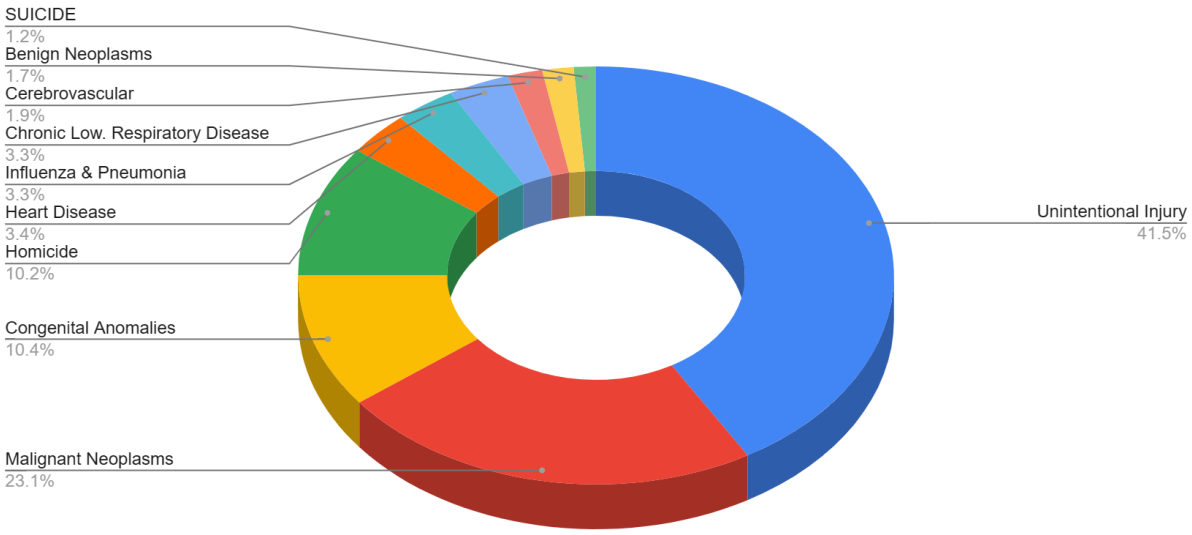


Figure 3

Top 10 Leading Causes of Death for 5-9 Year Olds, United States, 2020



suicide, and 36.7% (1 in 3) reported feeling sad or hopeless (CDC, 2020b). To help put these numbers in context: In a high school of 1,500 students, the above statistics equate to approximately 37 students who made a suicide attempt requiring medical treatment, 133 students who attempted suicide, 235 students who made a suicide plan, 282 students who have seriously considered attempting suicide, and 550 students who reported feeling sad or hopeless in a 12-month period.

In the United States there has been a consistent increase in these numbers over the past 10 years. However, the United States is not the only country with concerning data. According to a study conducted in 17 European countries, 10.5% of children 15-16 years of age reported a suicide attempt (Kokkevi et al., 2012). Because suicide is a sensitive issue, and even illegal in some countries, it is likely that these numbers are under-reported (WHO, 2014). Child and youth suicide is a worldwide public health crisis (Curtin, 2020), and yet suicide and suicidal behavior are only the tip of the iceberg.

Mental Health Conditions in Childhood

Below the surface of suicide, below the act of ending one's life, below the attempts, below the thoughts of suicide, there is a complex story of pain and suffering. Kosic (2018) paraphrases the words of Kalmar (2013) when she writes,

> Suicide is a complex multi-layered public health problem with protective and risk factors operating across many levels of interaction: the physical or biological-somatic level (i.e., health, healthy lifestyle); the psychological (i.e., mental health, self-confidence and ability to cope with challenges); the cultural and overall political, economic, environmental level; the social level of relationships with others in wider communities; and the spiritual level. (p. 1)

It is difficult and maybe impossible to pinpoint a definitive cause of suicide, but the strongest risk factor for developing suicidal thoughts and behaviors is an unrecognized and untreated mental health condition (Kalmar, 2013).

The Mental Health Atlas 2020 defines mental health conditions as a wide range of challenges that negatively impact a person's relationships, behaviors, thoughts, and/or emotions (WHO, 2021b). These challenges have a variety of symptoms and tend to fall within the realm of mental, neurological and substance use disorders. A mental disorder or mental illness is a diagnosable condition that substantially interferes with or limits one or more major life activities (CBHSQ, 2020), such as caring for oneself, working, concentrating, performing manual tasks, and learning (ADA National Network, n.d.). Many mental health conditions and their corresponding symptoms are recognized by the mental health community and defined in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) and the International Classification of Diseases (ICD; MHA, 2022a). Individuals who die by suicide

commonly experience symptoms associated with mental health conditions, even when the signs and symptoms are difficult to recognize and they have not received a formal diagnosis. Throughout this paper, I will use the term *mental health conditions* to include those individuals who have not received a diagnosis of a mental health disorder. I will use the term *mental disorder* only when speaking directly about a disorder listed in the DSM.

Multiple sources report that mental disorders affect 10-20% of school children worldwide (Erskine et al., 2015; Hoover et al., 2019; Kieling et al., 2011). Millions of children across the United States attend school with mental health conditions threatening their sense of well-being and educational outcomes (Hoover et al., 2019). Between 2016-2019, the most prevalent mental health conditions and disorders reported among children 3-17 years of age were attention-deficit/hyperactivity disorder (ADHD, 9.8%), anxiety (9.4%), behavioral or conduct problems (8.9%), and depression (4.4%; Bisko et al., 2022). Additionally, eating disorders and substance abuse disorders are concerning mental health conditions in children and may be associated with a higher risk of death by suicide. In 2018-2019, Bisko et al. (2022) reported that among children 12-17 years, 4.1% had a substance use disorder, 3.2% had an illicit drug use disorder, and 1.6% had an alcohol use disorder. It is suspected that 1 out of every 5 children suffers from at least one diagnosable mental health condition each year (Patel et al., 2007). In a classroom of 28 students, this would translate to approximately five students who have a mental health condition. Not only are mental health conditions prevalent in childhood, but many mental disorders found in adulthood began to manifest in childhood (Kieling et al., 2011). According to Kessler et al. (2005), half of all chronic mental health disorders start prior to 14 years of age and three-quarters prior to 24 years of age. For anxiety disorders it's even earlier—7 years of age (Kessler et al., 2005).

Mental health conditions commonly co-occur, making life and treatment more complicated for children and families. Ghandour et al. (2018) states that 73.8% of children with depression also experience anxiety and 47.2% experience behavioral and conduct problems; 32.3% with anxiety experience depression and 37.9% behavioral and conduct problems; while 36.6% with behavioral and conduct problems experience anxiety and 20.3% depression. The co-occurrence of depression and anxiety with behavioral and conduct problems in children deserves further examination. Depression and anxiety are often associated with internalizing behaviors, such as complaining of tummy aches, consistent worry, social withdrawal, and fearfulness (Hansen & Jordan, 2020). In contrast, behavioral and conduct problems, such as ADHD, oppositional defiant disorder (ODD), and conduct disorders (CD) are commonly associated with externalizing behaviors. For example, externalizing behaviors may include aggression or violence towards others or self, persistent lying, hyperactive and disruptive behavior, and even substance abuse (Kauten & Barry, 2020). To receive a medical diagnosis, a child must display a set of symptoms, and these symptoms or behaviors may present as internalizing or externalizing. The presenting symptoms determine how a child is approached in the educational and medical system.

As an elementary school counselor for 16 years, I have witnessed mental health conditions manifest in a variety of ways, and the consequences are significant. Children with internalizing behaviors may be overlooked, as they may appear to be compliant or fastidious students. They may fade into the background, not wanting or caring to be seen. This type of behavior can look like daydreaming or “zoning out.” On the other hand, children with externalizing behaviors are often sent to the principal's office for rowdy behaviors that distract, disrupt, and sometimes harm others. Children, especially those who are struggling with a mental

health condition, have not yet developed or cannot access the skills necessary to express what and how they are feeling. They communicate through their behavior, but the adults in their lives might misinterpret these behaviors. Refusing to leave the house before school feels like willful and defiant behavior, but it might be social anxiety. A young child likely does not yet have the skills to say, “My tummy hurts, and my heart is racing. I think I’m feeling anxious about going to school.” Instead, they throw a fit and make everyone late. A child’s behavior is like an iceberg. We only see the tip of the iceberg above the water, and we miss the vast majority of the iceberg below the surface. In my early years as a school counselor I would make quick assessments of what I thought was really going on with a student. I would take the little information I had and form a conclusion. I was frequently frustrated that my solutions did not lead to positive results. The student would continue to struggle and at times, it felt like we, the educators, were making things worse.

The consequences of repeated misinterpretation of a child’s behavior and attempts at communication lead to untreated and mismanaged mental health conditions, including misdiagnoses and overdiagnosis. Over time, this can have an adverse impact on child development, quality of life, health outcomes, educational and occupational opportunities, as well as negative implications on social, emotional, cognitive, and academic milestones (Ghandour et al., 2019; Kosic, 2018). As children with inadequately treated mental health conditions grow into adulthood, the possibility for unemployment, incarceration, and homelessness increases (Hymel, 2017), as well as the risk of suicidal behavior (Kosic, 2018). As a nation and local community, it is important to prioritize childhood mental health as early as possible.

Determinants of Health

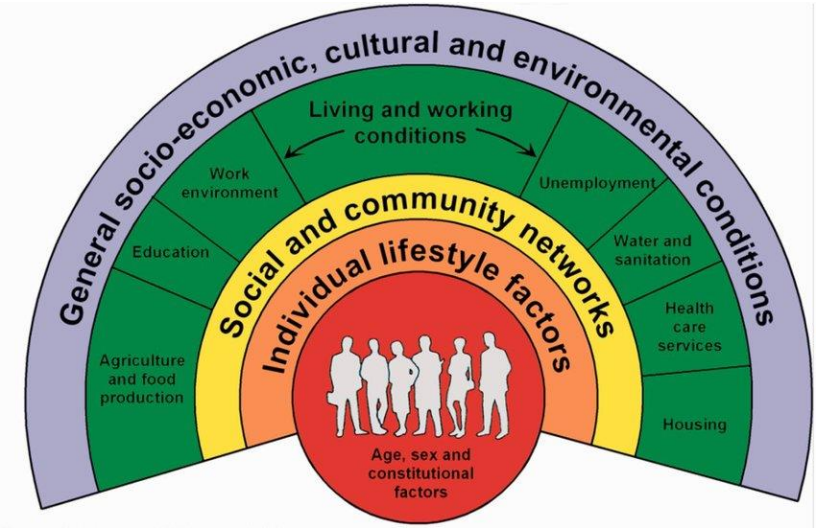
The societal consequences of suicide and mental health conditions are immense (Stone et al., 2017). Due to the high prevalence rates of mental health conditions and death by suicide, it is likely that most people in society have close contact with someone who is struggling from a mild to severe mental health condition (Sisask et al., 2014; Stone et al., 2017). As a result of their prevalence, mental health conditions pose a tremendous economic cost to society (Greenberg et al., 2001). It is estimated that the United States spends $247 billion on treatment and management of childhood mental health conditions each year (CDC, 2020a). When disheartening statistics are combined with large sums of fiscal spending, the people and policymakers want answers. The dominant culture in the United States prefers to move quickly towards solutions; there is a desire to get busy fixing the problem. Unfortunately, there are no easy answers in the mental health field. The conditions influencing health and development are complex, multifaceted, and interactive (WHO, 2021a). It is improbable for there to be one cause or risk factor leading to a mental health condition or death by suicide (Greenberg et al., 2001; Kalmar, 2013; Kosic, 2018). However, it is possible and important to discuss perceived individual and societal determinants of health as they relate to childhood mental health conditions in order to move towards improved outcomes.

Societal conditions, or social determinants of health, are often out of the control of individuals and groups. Social determinants of health are defined as “the social, cultural, political, economic, and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life” (WHO, 2021a, p. 32). Dahlgren and Whitehead (1991) developed the social determinants of health model over three decades ago, and the model holds true today (see

Figure 4). Individual factors play a lesser role in health outcomes than a person's living and working conditions. A child's neighborhood, family income, access to health care, and exposure to trauma can predict or determine their health outcomes.

Figure 4

Social Determinants of Health



Note: Figure comes from Dahlgren & Whitehead, 1991

Recently, an additional social determinant of health has been suggested: information and communication technologies (Rice & Sara, 2019). Over the past 30 years, technology has changed the way we experience the world. The current generations of students, Generation Z (those born between 1996 and 2010) and Generation Alpha (those born after 2010), do not know life without information at their fingertips and media at every turn. In fact, the COVID-19 pandemic fast tracked the use of technology in the classroom, leading students to use technology at school as well as at home. Like many determinants of health, access to and the ability to navigate technology can be a health asset or a health risk factor (Thabrew & Gega, 2023).

Some of the factors impacting health outcomes are unchangeable, such as age, place of birth, and genetics. Many other factors are modifiable to various degrees and under certain circumstances. However, in the dominant culture it is common to value individualism, objectivity, competition, and meritocracy (Chamberlain, 2005; Patton Davis & Museus, 2019). These ideologies perpetuate the idea that those who are healthy and successful must have worked the hardest, earned their place, and possess the most innate potential (Dudley-Marling, 2015). Healthism is an example of these ideologies in practice. It is the idea that a person's health is entirely their responsibility or the responsibility of the immediate family (Crawford, 1980). In the case of childhood mental health, healthism leads to the labeling of children as lazy, unmotivated, manipulative, attention seeking, and troublemakers. Parents and caregivers are labeled as uncaring, permissive, and dysfunctional. This viewpoint places the blame for poor health on the individual and family unit, while ignoring the numerous barriers to maintaining positive mental health and accessing mental health supports, such as discrimination, stigmatization, trauma, poor health literacy, and ineffective and inadequate access to mental health supports. Many, if not all barriers, are influenced by the conditions of society.

Based on numerous sources of data, the University of Wisconsin Population Health Institute finds only 30% of health outcomes are related to individual health behaviors (CHRR, 2022). The other 70% are related to physical environment (10%), clinical care (20%), and social and economic factors (40%). When the focus is on the individual and their perceived risk factors, the probability of biased and deficit-oriented policy decisions increases (Kosic, 2018). Children are seen as risk factors (i.e., at risk youth), rather than as *having* risk factors. This mindset identifies children as a laundry list of problems (Katsarou et al., 2010). Personal, community, and cultural assets are ignored. Children are not seen as dynamic human beings with strengths

and weaknesses, risk factors and protective factors, interwoven in and with societal and cultural influences. The problem with focusing solely on the individual is that it ignores the political, economic, and social factors that play a significant role in poor health outcomes and distract from legitimate solutions to health problems (Crawford, 1980). How do we change systems and structures, rather than focusing on changing individuals? The educational system has attempted many solutions over the years to improve health outcomes for children with mixed results. In the next section, I will discuss the opportunities and challenges education faces in supporting childhood mental health and preventing suicide.

The Role of Education

The educational system is one of many societal factors to play a vital role in a child's health and developmental outcomes. Research suggests a strong link between learning and health (Basch, 2010; CDC, 2015b). Healthy students tend to perform better academically, whereas students with poor health struggle academically (Basch, 2010). According to the CDC, healthy students have higher levels of achievement and cognitive skills and more positive school behavior and attitudes (CDC, 2015a). Johnsson Chiang et al. (2017) cited several recurring connections between health and academics. When a student's basic health needs are met, they are able to attain higher levels of academic achievement. Access to dental, mental, and physical health care positively impacts achievement, behavior, and attendance. The emphasis on fostering a positive social emotional school climate can reduce stress, improve attitudes toward self and others, and increase academic achievement.

The connection between health and learning follows predictable patterns based on the inequities in education (Kozol, 1991), which mirror inequities found across society (i.e., employment, housing, health care). School funding and resources are not distributed equitably

across states, districts, or schools. Gorski (2011) states, “Schools are microcosms of the larger society” (p. 157) and thus can be contributors to poor health outcomes or places of health promotion. Schools must be intentional and focused on their efforts in order to improve health outcomes. Health promotion, as defined by the WHO (2021), empowers people to take ownership and control over their health. It strengthens the skills of individuals, while at the same time taking action for social, political, environmental, and economic change. Health promotion is a practice in the concept of “both…and” rather than “either…or” thinking. Schools must focus on building essential skills in children *and* address the numerous barriers to health outcomes, for some of which the school is a contributor (i.e., limited physical activity, unhealthy cafeteria food options, poor school climate). Education has unique opportunities for health promotion that may escape other societal systems. The amount of time spent in school, the ability to intervene early, the important role of teachers, the social context, and a continuum of supports are just a few of the aspects that make education a conducive setting for mental health promotion and suicide prevention.

One of the ways schools are considered an opportune context is the consistent and longitudinal connection to children and families (Ford, 2018). For example, children attend school from three to five years of age (preschool and kindergarten) through 18 years of age (12th grade). These are 13-15 of the most formative years of an individual’s life (Toth et al., 2018). Sometimes children spend more time at school than they do with members of their own families. In contrast, a child may only see a mental health therapist for an hour a couple times a month or their physician once a year for an annual checkup or when sick.

Schools have the ability to implement proactive measures as early as three to five years old. Ongoing health promotion, prevention, and intervention in preschool and early elementary

years can build foundational skills and foster protective factors, encouraging positive mental health and mediating ill health (Greenberg et al., 2001). Childhood is a critical time to develop good mental health and practice mental health skills (Sisask et al., 2014). The consequence of waiting for a child to display symptoms of a mental health condition and be identified as needing a mental health care referral is that they may have limited tools to cope with their distress and they may needlessly struggle for years without support. Education is one of the few systems that can intervene early in life.

An important player in early intervention is the teacher. Teachers have the unique opportunity of engaging with a group of students in a variety of settings throughout the day. Their role makes them a perfect frontline support as they have frequent and regular interactions with children (Sisask et al., 2014). They may be one of the first individuals to notice signs and symptoms of mental distress or a developing mental health condition. It is not an expectation, nor is it appropriate for teachers to diagnose or treat mental health conditions, but it is essential that they have the skills to identify and refer students to the necessary supports (Hymel, 2017).

In addition, schools are not simply a setting for learning academics. They are social contexts where children develop and practice their social emotional skills (Crosnoe et al., 2012). They form friendships, have conflicts, and navigate the complicated landscape of relationships each day they walk through the school doors. The influence of peers grows more significant as a child ages, and these relationships play a role in health behaviors, particularly drug and alcohol use (Crosnoe et al., 2012). Peer conflict, exclusion, and bullying can also impact a child's mental health. Educators want to believe that schools are a safe place for students, but they can also be a place of stress and turmoil for children.

Finally, due to the amount of time children spend in schools during their educational career, educators, in partnership with community agencies, have the opportunity to provide a continuum of support to a large population of children (Hoover et al., 2019). This continuum is often referred to as a multi-tiered system of support (MTSS) and follows a three-tiered model (Robinson et al., 2018). Tier one support is delivered using a universal approach and is provided to the whole student body, a grade level, and/or a classroom, regardless of need (NCSMH, 2020). This may include health education taught at each grade level; school-wide campaigns to improve attendance; social emotional learning programs; free breakfast for all; and vision, hearing, and dental screenings. Tier one lays the foundation for tier two and three support. Tier two support is delivered in a way identified as a selective approach and is provided to students who display some risk factors. Small group interventions facilitated by the school counselor fall under tier two supports. Tier three, or an indicated approach, is necessary for children displaying high risk behaviors and needing individual intervention, such as a suicide screening or a community agency referral. The National Center for School Mental Health (NCSMH, 2020) believe schools have an opportunity and an obligation to prioritize mental health promotion and provide the following services and supports using a universal approach: enhance school climate, increase staff wellness, promote positive behavior, improve mental health literacy, and facilitate social emotional learning.

The Current Study

The purpose of this study is to explore an upstream approach to suicide prevention and mental health promotion in elementary education. The term “upstream approach” is often used in relation to suicide prevention. It refers to the idea of looking upstream to determine causes and solutions to suicide and mental health conditions, rather than focusing on the problem

downstream. To set the stage, I have discussed rates of suicide and mental health conditions in childhood. I then explored the determinants of health and the role of education in health promotion. In my literature synthesis, I will discuss suicide prevention in schools; introduce the Whole School, Whole Child, Whole Community (WSCC) framework; and highlight the components related to mental health. Then, I will dive into social emotional learning (SEL) and mental health literacy (MHL) as the bridge from standard health education to suicide prevention and health promotion. Finally, I will introduce my study exploring the intersection of health education, MHL, and SEL in one state and school district.

CHAPTER II

LITERATURE SYNTHESIS

I conducted a literature review using electronic databases and search terms, in a variety of combinations, describing health education, SEL, MHL, school mental health, health promotion, and suicide prevention, particularly in elementary education. The Boolean operators "and" and "or" were used to limit or expand searches as needed. My initial search focused on terms found in abstracts. As I reviewed abstracts, article introductions, and literature reviews, I was often drawn to author citations that referenced articles of interest. If an article proved particularly relevant, I would explore additional articles by the same author. In these cases, I would search for a citation, reference, or author name in Google Scholar or in my university's library journal database. The following literature review begins with a brief overview of suicide prevention in schools, a discussion of the WSCC framework, and finally, literature relevant to MHL and SEL.

Suicide Prevention in Schools

As previously stated, the influences and causes of suicide and mental health conditions are complex, multifaceted, and interactive (Greenberg et al., 2001; Kalmar, 2013; Kosic, 2018; WHO, 2021a). Though the impact of suicide and prolonged mental health conditions is immense, there is hope. Suicide is preventable, as evidenced by many of the policies, programs, and practices currently in place (Stone et al., 2017). However, truly effective interventions are not achieved through the use of one program or curriculum. Suicide prevention evaluates the level of risk and protective factors in the community, identifies and prevents risk factors, and promotes protective factors at multiple levels (Kosic, 2018). It also recognizes the interactive layers from individual, family, culture, community, and society (Stone et al., 2017). Possible risk factors for suicide include: bullying and harassment, relational conflicts, substance use, isolation,

discrimination, mental health conditions, and the lack of access to health care, particularly mental health care (Kosic, 2018). Conversely, protective factors include: strong and supportive relationships with peers and adults, a safe and supportive school environment, the availability and ease of access to quality health care, opportunities to contribute to the community, and the development of life skills (Kosic, 2018; Stone et al., 2017).

Suicide prevention in schools currently focuses on screening students for risk factors, training staff to identify and refer students in need, and encouraging students to self-refer through education and screenings (Wyman et al., 2010). Relying solely on screenings, identification, and referrals does not account for the complexities of suicide prevention. According to *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* published by the CDC, promising practices in suicide prevention include: "strengthening economic supports; strengthening access and delivery of suicide care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at risk; and lessening harms and preventing future risk" (Stone et al., 2017, p. 7).

It is also recommended that suicide prevention follow an MTSS model with universal support delivered to the entire student body, selective support offered to groups at risk, and indicated support accessible to those displaying suicidal behavior (Robinson et al., 2018). Examples of universal supports are the delivery of skills-based education and providing opportunities for skill practice. The skills that support suicide prevention include: emotional regulation, problem solving, communication, assertiveness, and critical thinking (Kosic, 2018; Stone et al., 2017). Fostering skill development in school provides students with a toolbox they can carry with them for the rest of their lives. They can access their toolbox when they face big

and small challenges, stressors, and adversity (Stone et al., 2017). Models, such as the Whole School, Whole Community, Whole Child (WSCC) framework can be used as a whole-school approach that provides a structure for skills-based education to support suicide prevention.

Whole School, Whole Community, Whole Child

As I researched childhood mental health and suicide prevention in the school setting, many articles referenced the WSCC framework as a foundation for quality school health initiatives and comprehensive school mental health systems (Hoover et al., 2019; Videto & Dake, 2019). Frameworks and models are helpful tools that lay the groundwork, ultimately driving action (Dusenbury et al., 2020). The ASCD and the CDC conducted a joint study reviewing school and community factors that led to the types of environments that fostered a child's physical, social, and mental health (ASCD & CDC, 2014; Cardina & Fegley, 2016). The study resulted in an update and expansion of the Coordinated School Health model, utilized by the CDC for the past several decades (ASCD & CDC, 2014). The WSCC framework has 10 components that are firmly situated in a collaborative and integrated approach with the child at the center (see Figure 5; Lewallen et al., 2015). The framework builds off Bronfenbrenner's (1977) ecological systems model, which identifies the context in which a child lives, learns, and plays as a critical factor in healthy development. Bronfenbrenner recognized that interventions focused only on changing individual behavior were necessary but insufficient. A sustainable health promotion model must address interpersonal, environmental, and social change (Hoover et al., 2019).

Prior to the WSCC and during the implementation of the Common Core State Standards initiative, school districts shifted resources away from health promotion, health services, health education, including mental health supports, due to budgetary cuts (Moyer et al., 2016); and

Figure 5

The Whole School, Whole Community, Whole Child Framework

Note: (ASCD & CDC, 2014, p. 7)

prioritized reading and math instruction, at the expense of other subject areas (Videto & Dake, 2019). The objective of most national initiatives is to increase student achievement, yet Basch (2010) drew attention to health being the key to closing the achievement gap. He stated that it didn't matter what kind of accountability measures were put in place or how well qualified teachers were if students were not healthy and able to attend to learning. The WSCC framework

provides a guide for schools to refocus on health initiatives (Moyer et al., 2016). It is important to note, however, that there is very little research evaluating the effectiveness of the WSCC framework (Willgerodt et al., 2021). This may be due to schools viewing the framework as a tool or resource, rather than a prescriptive intervention. Implementation and practice can present very differently depending on context and available resources. Although the WSCC does not directly address suicide prevention, it does follow many of the promising practices mentioned in the section above. The WSCC components most closely related to the concepts in this study include Counseling, Psychological, and Social Services; Social and Emotional Climate; and Health Education. I will discuss each in the following sections.

Counseling, Psychological, and Social Services

The Counseling, Psychological, and Social Services component is the primary driver of mental health support in the WSCC framework. It relies on school counselors, school psychologists, and school social workers to identify, assess, refer, and deliver mental, behavioral, and social-emotional health services (CDC, 2021a). Services may include individual counseling, peer small groups, psycho-educational evaluations, and referrals to social services. These specialists can provide consultation and professional development to school staff. The differences in training and school responsibilities between the three disciplines is vast. For example, school psychologists are trained to provide formal psycho-educational evaluations and diagnose mental health conditions, whereas school counselors, in general, do not have this training. In fact, the American School Counselor Association's (ASCA) *School Counselor Professional Standards & Competencies* document (2019) mentions mental health only twice in the context of understanding the differences between school counseling and various mental health fields and making referrals to appropriate school and community resources. School

counselors encourage a “healthy balance of mental, social/emotional and physical well-being,” as well as “provide culturally sustaining instruction, appraisal and advisement, and counseling to help all students demonstrate: learning strategies, self-management skills, and social skills” (ASCA, 2021).

The recommended ratio of school psychologists is 500:1, yet the national average is 1127:1 (NASP, 2023). The recommended ratio for school counselors is 250:1, and the national average is 408:1 (ASCA, 2023). The recommended ratio for school social workers is 250:1 (NASW, 2012). I wasn’t able to find current data for school social workers, but from my own experience the ratio is worse than the ratio of students to school counselors. It is important to keep in mind that these are averages and that there are many schools and districts with high needs and ratios that are even more disproportionate. The ratios also do not reflect when one of these roles works across multiple school buildings. As I have illustrated before, mental health conditions impact a large number of students. One school counselor in a school building of 400+ students is not capable of providing adequate mental health support in all three tiers of the MTSS model, and multiple mental health specialists in a school building are relatively rare at the elementary school level.

The school counselor is likely the primary, if not the only, resource for mental health support and suicide screenings in the building. In one study, two-thirds of school counselors report conducting multiple suicide screenings each month, a tier three support (Gallo, 2018). However, school counselors are reporting that they feel inadequately trained to recognize and assess young children at risk for suicide (Gallo, 2018). If this is truly the case, is it not reasonable to rely solely on school counselors to provide all of the mental health support and services in the school building. The Counseling, Psychological, and Social Services component is essential, but

may not be able to provide universal support to the vast majority of students. I will explore more about mental health in particular in the Mental Health Literacy section of this paper.

Social and Emotional Climate

The Social and Emotional Climate component focuses primarily on the learning environment and the educational experience of students (CDC, 2021a). According to Townsend et al. (2017), there is minimal research on the connection between school climate and mental health, so they conducted a study to find whether school climate had an impact on depression literacy and mental health education. They found that positive school climate was associated with greater depression literacy and lower levels of mental health stigma. Their article discussed the relationship between school climate and the implementation of multiple types of health education (i.e., illness prevention, and drug and alcohol education). They also discuss how poor school climate negatively impacts peer to peer and student to teacher interactions, which, in turn, decreases a student's overall connection to school and positive relationships, increasing the risk of depression and suicide (Townsend et al., 2017). The lack of a positive school climate creates an environment ripe for stigmatization, bullying, and harassment. When students are afraid, they are less likely to seek help. In addition to the impact of school climate on students, teachers show an increase in confidence to support the mental health of students when they report greater psychological wellness and higher satisfaction in the school climate (Sisask et al., 2014).

The WSCC does not directly address SEL; however, many schools and districts consider SEL a strategy in their school climate and culture approach. They recognize that educating the whole child is more than acquiring skills and knowledge or developing character and positive behavior; it is all of these (ASCD & CDC, 2014). I will explore more on this topic and how it relates to mental health in the Social Emotional Learning section of this paper.

Health Education

The CDC states that the purpose of comprehensive health education is to help pre-K through 12th grade students acquire the knowledge, attitudes, and skills they need to make health-promoting decisions, achieve health literacy, adopt health-enhancing behaviors, and promote the health of others (CDC, 2021a). One of the few components in the WSCC framework that directly provides skill-building at the tier one universal support level is health education (Cardina & James, 2018). Health education addresses a variety of topics, for example, safety and injury prevention, drug and alcohol use, healthy eating and nutrition, mental and emotional health, and violence prevention. The WHO expands the possibilities by stating that discussing the determinants of health and participating in life skill activities, such as navigating the healthcare system, can be examples of health education (WHO, 2021a). Previous models of health education focused primarily on encouraging students to avoid risky behavior because it was believed that students did not yet have the cognitive ability to make complex life decisions (Babinski et al., 2018). The Just Say No campaign is an example of health education in the 80s and 90s. However, current models of health education focus more on developing healthy habits and building life-skills that students can carry into adulthood. The National Health Education Standards (NHES) provide a baseline for health education with a primary focus on seven skill-based standards and one content-based standard addressing functional knowledge to lay the foundation for skill development (Videto & Dake, 2019). The natural setting for skills-based education is within the context of health education.

However, research indicates that there are multiple challenges to health education. There is limited evidence regarding the quality of health education across the United States (Videto & Dake, 2019). It is believed that some health content is being addressed, but not in a skills-based

format. Teachers report that there is not enough dedicated time in the school day or adequate resources to address health education (Toth et al., 2018). The same article goes on to say that at times only a crisis-response approach to health education is taking place. This approach focuses only on a few health topics, such as alcohol and drug prevention. Comprehensive health education includes physical, social, and mental health (Šouláková et al., 2019). Health does not exist apart from mental health, and yet school programs promoting mental health compared to physical health are rare. One of the objectives in Healthy People 2020 (CDC, 2021b) tracked elementary schools that required health education instruction that met national standards. The baseline was 7.5% in 2006, and it decreased to 1.7% in 2014. The absence of a dedicated, comprehensive, skill-based, health education program may cause students to enter the world unprepared to face the challenges ahead (Bice et al., 2020).

A primary component and measurable outcome of health education is health literacy. It includes personal health knowledge and competencies leading to the ability to access, understand, and use information to promote and maintain health (WHO, 2021a). It is considered a personal asset and protective factor (Kutcher et al., 2016a). Without health literacy, individuals are less confident to make critical and informed decisions about their health. Conversely, with a strong foundation of health literacy, they are empowered to take action to address determinants of health. However, in 2003, the last reported national data on adult health literacy, it was documented that only 12% of adults in the United States were proficient resulting in a significant monetary cost to society (Videto & Dake, 2019). An individual's level of health literacy is considered a stronger predictor of health status than other social determinants of health (WHO, 2013).

Videto and Dake (2019) provide three recommendations for states and school districts to

improve health education and positively impact student health outcomes. First, schools need to make comprehensive, skills-based health education the new norm. Second, the case must be made that health education leads to increased health literacy. And finally, quality school health education needs to be operationally defined and include physical, social, and mental health components (Šouláková et al., 2019).

The Intersection of Mental Health Literacy and Social Emotional Learning

Students will face a variety of experiences in and out of school that will challenge their social, mental, physical, and academic skills. This study will explore how the intersection of SEL and MHL, in the context of health education, can promote the skills necessary for students to cope with a variety of challenges. The combination of social, mental, and physical health education in schools can be used as a protective factor against the onset and severity of mental illness and overall distress in students from kindergarten to 12th grade, and ultimately prevent suicide. There is a small, but growing consensus that MHL and SEL have a symbiotic relationship (Greenberg et al., 2001; Hymel, 2017; Weare, 2010). Both SEL and MHL are skills-based, as is health education. They are also universal prevention that is provided to all students regardless of need. When SEL is implemented with intentionality and integrated into core content for all students, it can improve academics, decrease negative behaviors, and improve the overall climate and culture of a school (Durlak et al., 2011). However, SEL alone rarely bridges the gap of suicide prevention. MHL provides necessary mental health skills that lead to management and treatment of mental health conditions.

Mental Health Literacy

Before the COVID-19 pandemic, there was a growing interest in school mental health (Kutcher et al., 2015), and since the pandemic the need has escalated (Ryan, 2020; Sparks,

2021). Schools are desperate for help, as they see students struggle with their mental health. Kutcher et al. (2016b) believe MHL is foundational to all school mental health models. At its root, MHL is about the prevention and intervention of mental health conditions and suicide (Coles et al., 2016; Ryan, 2020). MHL was born out of the concept of health literacy and is defined as

> understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy (knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management capabilities). (Kutcher et al., 2016a, p. 155)

It is important that MHL be taught in the context of everyday life, applied in a developmentally appropriate manner, and delivered as content that is integrated in the existing school structure (Kutcher et al., 2016a). The promotion of mental health is most effective when introduced at an early age (Kosic, 2018). A universal approach is best suited for MHL, rather than focusing only on those students who demonstrate a current need (Hymel, 2017). MHL is more than sharing information about mental health disorders, it is “an empowerment competency” that enables individuals to engage in their own health care (Kutcher et al., 2016b, p. 161). The perceptions around mental health have shifted considerably over the past few decades (Weare, 2010). Instead of focusing solely on mental disorders, there is now a greater emphasis on maintaining positive mental health, regardless of the presence of a mental health condition (Hymel, 2017). Currently, it is believed that students have minimal understanding of mental health and mental disorders (Ryan, 2020), and teachers feel their own MHL is inadequate to address the mental health needs in their classrooms (Iizuka et al., 2015).

A significant amount of research has been conducted on MHL in the school setting in Canada and Australia (Jorm, 2011; Kutcher et al., 2016a;), but it appears to be a fairly new concept in the United States. A quick search of the term mental health literacy in article abstracts in the ERIC Database displayed 118 articles: 21 based in Canada, 15 in Australia, 52 referenced a foreign country, while only three were based in the United States.

Social Emotional Learning

The Collaborative for Academic, Social, and Emotional Learning (CASEL, 2022) defines SEL as,

> an integral part of education and human development. SEL is the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions.

The CASEL SEL core competencies include self-awareness, self-management, responsible decision-making, relationship skills, and social awareness. The definition has recently expanded to include what is called Transformative SEL (Jagers et al., 2019). The intention behind this change is rooted in justice-oriented citizenship and educational equity. SEL programs are ideal settings to address issues of identity, culture, belonging, agency, and engagement. Unfortunately, when SEL is not elevated to this level, it can be watered down and used as a blanket term for behavior management (Wood, 2020).

Kourmousia et al. (2015) found numerous research articles reporting positive outcomes related to SEL programs, such as preventing mental health problems and drug and alcohol use; enhancing self-esteem, emotion management, and problem solving; maintaining healthy

relationships; and reducing violent behavior. A longitudinal study showed positive outcomes from an elementary school SEL program 12 to 15 years later, including reduced social phobia and suicidal thoughts (Hawkins et al., 2005; Hymel, 2017). As of 2022, the WHO has included the development of social emotional learning in their recommendations to countries around the world to prevent suicide. Figure 6 illustrates *how* SEL can be implemented in schools and districts, as well as the *what* and *where* of the SEL competencies. The *why* column displays short-, intermediate-, and long-term student outcomes, including improved mental health.

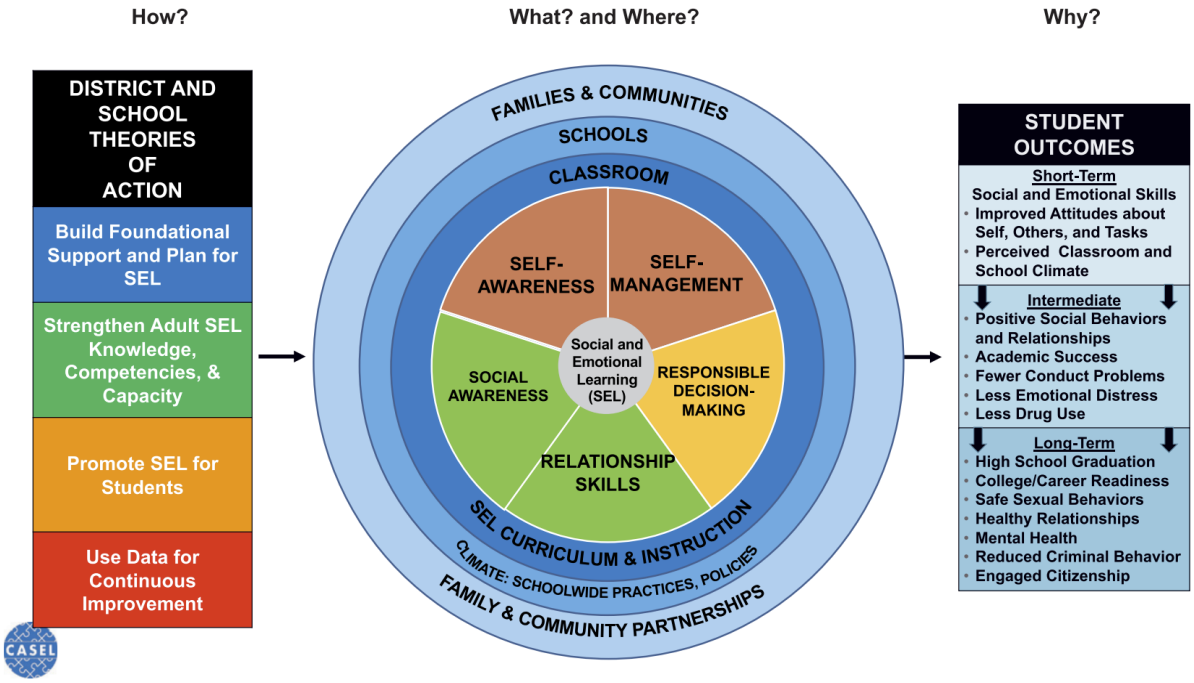
SEL is a central component of teaching and learning (Durlak et al., 2011). Students do not learn in isolation. They learn through group work with peers, connections with teachers, and support from their family. Each of these connections requires navigation. Additionally, a student's emotions can encourage a fascination in an academic subject or can hinder creative thinking and perseverance. Learning cannot happen without attention to SEL.

Durlak at al. (2011) wanted to know whether SEL interventions that focused on the entire student body would improve positive student outcomes and prevent future problems from occurring. He and his colleagues conducted a meta-analysis of 213 school-based SEL interventions in the K-12 school setting. They found that the SEL interventions reviewed had significant positive effects on social-emotional competencies as well as behaviors. Students with strong social-emotional skills appear to fare better over time and into adulthood, as opposed to those with lagging skills (Domitrovich et al., 2010). Domitrovich et al. (2010) writes, "We focus on social-emotional competence because of the empirical evidence that it is an individual characteristic that is critical for healthy development and for counteracting the negative effects of exposure to risk" (p. 409). Focusing on SEL as prevention and a universal intervention for the entire student body has the potential of making a much greater impact on long term outcomes for students than a targeted

approach. Knight et al. (2019) view SEL as an upstream prevention program in which students build skills that help them to navigate social and emotional challenges later in life. It is recommended that this work be situated in a comprehensive public health approach (Domitrovich et al., 2010; Greenberg et al., 2017).

Figure 6

Framework for Systemic School and District SEL



Note. (Jagers et al., 2019, p. 165)

Health Education in Ontario, Canada

The Ontario Ministry of Education (2019) provides an excellent example of situating SEL and MHL in the context of health education. Figure 7 is an illustration borrowed from the first through eighth grade curriculum. It shows how SEL is embedded throughout all four health

and physical education strands. MHL is a subtopic in the Healthy Living strand; however, mental health is called out as something that is interwoven throughout all the topics and part of the learning across the entire curriculum. The Healthy Living strand has three topics: understanding health concepts, making healthy choices, and making connections for healthy living. Under each of these topics are different subtopics related to MHL at each grade level:

- first grade addresses mental health and overall health, and thoughts, emotions, and actions;
- second grade addresses body and brain - responses and feelings, and knowing when to seek help;
- third grade addresses brain stress response system, and external factors that contribute to stressful feelings;
- fourth grade addresses healthy choices to support mental health, and stress management (cognitive, behavioral);
- fifth grade addresses how to help others, when to seek help, and stigma awareness; and
- sixth grade addressed seeking help - professional helpers, and connecting thoughts, emotions, and actions.

Though the curriculum does not specifically address suicide, it does acknowledge that the integration of SEL and MHL may provoke questions and discussion about suicide. They recommend the topic of suicide be "approached through structured, developmentally appropriate, adult-led instruction" (Ontario Ministry of Education, 2019, p. 41). When discussing suicide it is also important to collaborate with the school's mental health staff, as well as incorporate stories of hope and how to seek help. Under *Roles and Responsibilities in Health and Physical*

Education, teachers are reminded that their first priority is to do no harm. They are to foster a classroom environment that is emotionally and physically safe for students to learn and grow. Health topics can often bring up challenging subject matter and students may disclose personal information, in which the teacher must show care and professional responsibility. It is important to follow the established systems for confidentiality and risk assessment, such as suicide screenings. Critical to student success is establishing an atmosphere in which all students feel they are safe, accepted, and belong, especially in regards to how they identify (i.e., body shape and size, ability, gender, sexual orientation, ethnicity, race, or religion).

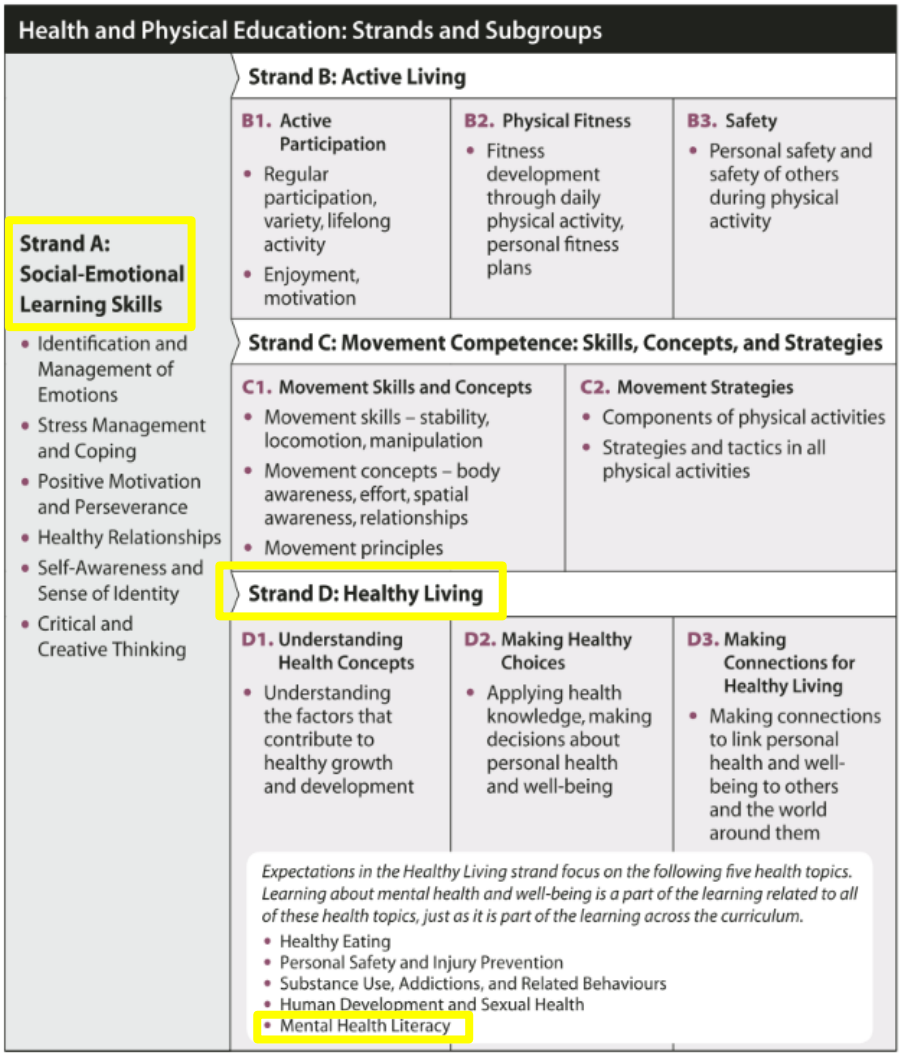
The Ontario health and physical education curriculum promotes experiential learning, fosters community building, offers developmentally appropriate content, and provides an inclusive orientation (Ryan, 2020). It is expected that students and educators will continue to learn and develop health promoting skills as they move through the curriculum year after year. The goal is for Ontario students to develop the skills needed to grow into active, healthy, and socially responsible citizens (Ontario Ministry of Education, 2019).

Context of Study

Mental Health America provides state rankings on the state of mental health in America (MHA, 2022b). If a state or federal district ranks between 39-51, it has a high prevalence of mental illness and lower rates of access to care. Among youth aged 12 to 17 years old, Oregon ranked 45 out of 51 states and federal districts in 2022. In 2019, Oregon's youth suicide rate was ranked 11th in the nation, with higher rates of suicide than most other states (OHA, 2020). In response to repeated years of alarming statistics, Oregon passed Senate Bill 52 (i.e., Adi's Act), requiring school districts to develop a suicide prevention, intervention, and postvention plan for students in kindergarten through 12th grade (Adi's Act, 2019).

Figure 7

The Ontario Curriculum Grades 1-8: Health and Physical Education



Note: Highlighted boxes were added. (Ontario Ministry of Education, 2019, p. 24)

Thankfully, Oregon school districts were already underway with their suicide prevention efforts before the COVID-19 pandemic. During this education crisis, the Oregon legislature passed House Bill 2166 addressing SEL standards kindergarten through 12th grade (H.B. 2166,

2021). The bill declares an educational emergency and calls for equitable systems that consider the whole child. A whole child approach ensures the social, emotional, and mental health needs of a child are addressed. However, this must be done with racial equity, trauma-informed care, and a strength-based approach at the center. This can be done within an MTSS model. It is explicitly stated in the bill that SEL is a key factor in an integrated model of mental and emotional health, and an equitable system of SEL can contribute to overall health promotion. By September 2023, the Oregon Department of Education (ODE) will adopt SEL standards and a state-wide framework. Oregon school districts are expected to implement these standards by July 2024. The updated health education standards will also be available prior to the 2023-2024 school year.

It has been two and half years since schools went to distance learning in March 2020. During the pandemic, students were forced to attend school virtually, then transition to hybrid schooling, and finally social distancing and masking. Many educators hoped the 2021-2022 school year would offer some relief, but in some aspects, it was even harder. Students are more anxious than ever, and school staff are overwhelmed. Adi's Act and House Bill 2166 are timely and relevant to the Pacific Northwest School District (PNWSD) in which this study takes place.

My study addressed the following research questions in the context of elementary education:

RQ1. How, and to what extent, are health education, social emotional learning, and mental health literacy present and where do they align, if at all?

RQ2. What are educator perceptions of the challenges, opportunities, and potential alignment of health education, social emotional learning, and mental health literacy?

RQ3. What solutions do educators provide to meet the mental health needs of elementary school children?

CHAPTER III

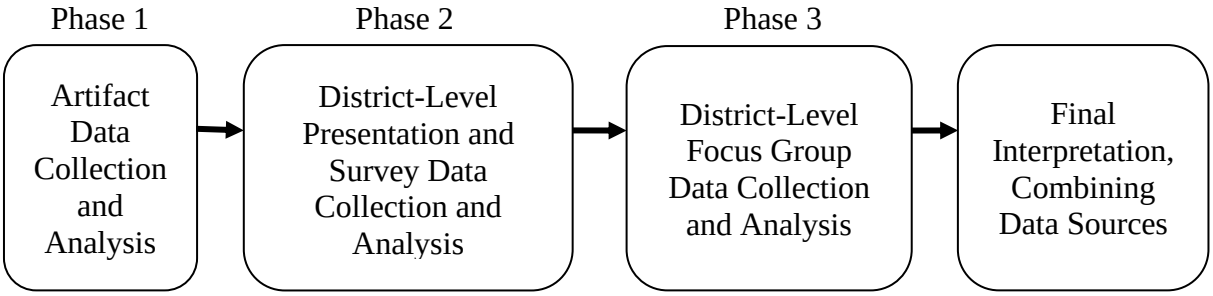
METHOD

For this qualitative study with quantitative components, I used a sequential exploratory research design in a three-phase process (see Figure 8; Creswell, 2003). Qualitative research is about "exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (Creswell & Creswell, 2018, p. 41). The problem or the context in this study is health education, SEL, and MHL at the elementary school level as an avenue for improving overall health in children and preventing suicide. I explored how educators perceived the relationship between these constructs, as well as the benefits and challenges to bringing these constructs together. Their understanding of these constructs influences the decisions they make, ultimately impacting outcomes.

Phase one included an artifact analysis of state and district-level data addressing health education, SEL, and MHL. In phase two, I presented the findings from my artifact analysis to a district-level team. They were then asked to provide feedback on adaptations to a district revision of CDC's Elementary School Health Index (SHI) to better support district and school-level goals (CDC, 2017). This was completed through a Google Form. The data were collected and shared with the participants through a focus group in phase three, where they continued revising in a collaborative format. The process of adapting the SHI provided me insight into how educators perceive the constructs in this study. Each phase of this study built on the next phase, resulting in method triangulation (Mathison, 1988). Collecting a variety of data types can offer a deeper understanding of a particular issue as compared to using one source of data alone (Creswell & Creswell, 2018).

Figure 8

Sequential Exploratory Design



Setting

The study took place in a large PK-12 school district in the Pacific Northwest. Throughout the study, I refer to the district as Pacific Northwest School District (PNWSD). The district educates a diverse population of over 20,000 students in 32 traditional schools and 4 alternative schools. Approximately, 42% of the students identify as White, 40% as Hispanic, 7% as Multi-racial, 7% as Asian, 2% as Black, and less than 1% as American Indian/Alaskan Native and Pacific Islander. Students who speak a language other than English at home represent 28% of the population, and 102 countries of origin are represented throughout the district. A Spanish dual-language program is housed at 43% of the district's schools, and 30% of the elementary schools are Title I. The district is committed to prioritizing student strengths and assets, especially in the areas of diversity, cultural representation, and multilingualism. The equity department and the department that oversees curriculum, instruction, and assessment collaborate on SEL, mental health, and health education efforts in the district. I am an employee in PNWSD, currently supporting health education implementation preschool through 12th grade.

District Approval and Human Subjects Approval

I received permission to conduct my study from the University of Oregon's Institutional Review Board (IRB) Office, as well as the school district where the study was conducted. All participants completed informed consent forms prior to participating in the study.

Phase 1 - Artifact Collection and Analysis

The first phase began with gathering artifacts and analyzing their connection and alignment to health education, SEL, and MHL. I started by requesting extant data from the PNWSD. I then compared and analyzed the skills associated with each construct. Finally, I analyzed the curricula currently in use to teach health education, SEL, and suicide prevention.

Extant Data

Recently, PNWSD administered a number of surveys to students and staff in the usual course of school district activities. The extant data were de-identified, analyzed, and summarized by the district. I requested and was granted a summary of the de-identified data. Each of the surveys is listed below with a brief description and the available demographics.

Oregon Student Health Survey. In the fall of 2022, all 6th, 8th, and 11th graders across the district were given the opportunity to complete the Oregon Student Health Survey (SHS). The Oregon SHS asks students 68 questions about school climate and culture, mental and behavioral health, as well as student health and safety. I used the six questions most closely related to mental health in this study. The data collected from this survey lay the foundation for why this study is important. The Oregon SHS is administered in even-numbered years through a collaborative effort between the Oregon Health Authority and the Oregon Department of Education (OHA, n.d.)

The survey is voluntary and completely anonymous. For the purposes of this study, I requested and was given a summary of the 6th grade data related to mental health. The data are considered preliminary, as they were released by request prior to the final data clean-up. The final report will be released to the district in late spring.

All 6th graders in the district were given the opportunity to take the survey and there was a completion rate of 84% (n = 1,135). Approximately, 37% of the students responding to the survey identified as White, 30% as Hispanic or Latino/a/x, 10% as Asian, 7% as Asian, 5% as Black, 4% as American Indian or Alaskan Native, 2% as Native Hawaiian or Pacific Islander, 1% as Middle Eastern, and less than 1% as North African. A number of students said "something else fits better" (12%), they were not sure (10%), or they preferred not to answer (6%). Students were asked what language(s) they spoke at home and 90% said English, 33% said Spanish, and less than 2% said Vietnamese. Students were asked to share their gender identity: 46% indicated boy/man, 44% girl/woman, 3% nonbinary, and less than 2% indicated demigirl/demiboy or gender fluid. Some students (3%) preferred not to answer. Transgender students represented 2% of the sample. Students were asked to share their sexual orientation: 54% indicated straight, 10% bisexual, 5% pansexual, 4% lesbian or gay, 3% asexual or aromantic, 11% preferred not to answer, and 8% were not sure of their sexual orientation.

Suicide Screenings. The PNWSD has a detailed suicide prevention plan that includes screening students when there is a potential risk for suicide. Often these screeners are completed by a school counselor. Sometimes reports come from teachers or peers; at other times they are self-reported. The screener asks the student about suicidal intent and assesses the level of risk. These data are important to show the proportion of suicide screenings in elementary versus secondary school. I requested and was granted a summary of the total suicide screeners in

Kindergarten-6th grade and 7th - 12th grade for the past 10 years in the district. I received de-identified data as far back as the 2013-2014 school year. Data from the 2022-2023 school year were not included as it would only represent mid-year data.

Mental Health Literacy Survey. In the 2021-2022 school year, a PNWSD school counselor developed a mental health literacy survey and administered it to a sample of 58 sixth graders at one elementary school. Although the survey was not research-based, it was included in this study to provide a snapshot of student MHL at the end of their elementary experience. In many school districts, 6th graders are considered middle schoolers. Therefore, I wondered if 6th graders had acquired MHL skills prior to transitioning to middle school, a place where emotions can be overwhelming, relationships complicated, and hormones confusing.

Figure 9

Mental Health Literacy Survey Questions

1. What is mental health?
2. How does someone maintain good mental health?
3. Name and describe a mental disorder? You can name more than one.
4. How does someone treat a mental disorder?
5. When would someone need to seek help for their mental health?
6. How would someone seek help for their mental health?
7. Are mental disorders common or rare? Explain.
8. Is it normal to have a mental disorder? Explain.
9. Where have you learned about mental health and mental illness? Family, social media, school…?

The survey contained nine open-ended questions and was administered prior to the annual suicide prevention lessons (see Figure 9). Students were not required to provide detailed descriptions. Simple answers were accepted. The only demographic data collected was gender, in

which students self-selected their response: 48.3% female, 39.7% male, 8.6% chose not to respond, and 3.4% non-binary. The school counselor collected and analyzed the data. Student responses were coded and organized into themes. Each theme included a frequency count for how often the theme appeared in student responses. I was given a summary of the most frequent themes for each question.

Health Education Adoption Survey. As part of the PNWSD health curriculum adoption, staff were surveyed in February 2022. They were asked questions related to their professional health curriculum needs and their students' health needs. All elementary principals were sent the survey, and it was their responsibility to share the survey with their staff. A total of 210 staff members across all district elementary schools completed the survey, with nearly 80% of respondents classroom teachers. The remaining respondents were primarily building specialists, such as school counselors and English language specialists.

Staff were asked to answer five multiple-choice questions and one open-ended question. A district employee collected and analyzed the data. I was given a de-identified summary of the responses and demographics. I chose to include three of the five multiple choice questions in this study because responses demonstrate a connection between health education, SEL, and mental health (see Figure 10).

Social Emotional Learning Educator Survey. In March 2022, a survey was developed by district office staff to evaluate staff understanding of SEL. The survey was shared with staff across the district via email and in a virtual meeting with school building culture and climate leaders. In both venues the survey was administered using a Google Form. A total of 223 staff members participated in the survey. The vast majority of participants (69.5%) were from elementary schools and many were elementary classroom teachers (44.8%). The remaining

respondents were primarily building specialists (22.4%), such as special education teachers, school counselors, coaches, and English language specialists. Building administrators made up 5.7% of the respondents. Staff were asked to answer three open-ended questions and one multiple-choice question. A district employee collected and analyzed the data. I was given a de-identified summary of the responses and demographics. I chose to include the three open-ended questions in this study (see Figure 11) because they provide a snapshot of the current state of SEL in the district.

Figure 10

Health Education Adoption Survey Questions

What are your hopes & dreams for health education? Choose all that apply.	**As we look at core resources and supplemental resources, what are the three highest priority needs for your students?** Choose all that apply.	**Which topics or standards do you find particularly unprepared to teach and may require additional professional development support in the future?** Choose all that apply.
● Supplemental resources. ● Plug and play. Ready to go lessons. ● Engaging and relevant materials. ● Ease of use. Not a lot of required PD. ● Developmentally appropriate. ● Family connections. ● Integrating SEL with Health ● Other	● Affirming identities and anti-oppression ● Wellness and health promotion ● Alcohol, tobacco, and other drug use prevention ● Social Emotional Learning ● Mental health ● Healthy relationships and violence prevention ● Growth and development ● Sexual health promotion ● Nutrition and physical activity ● Analyzing influences ● Accessing information ● Interpersonal communication ● Decision-making ● Goal-setting ● Self-management ● Advocacy	● Affirming identities and anti-oppression ● Wellness and health promotion ● Alcohol, tobacco, and other drug use prevention ● Social Emotional Learning ● Mental health ● Healthy relationships and violence prevention ● Growth and development ● Sexual health promotion ● Nutrition and physical activity ● Analyzing influences ● Accessing information ● Interpersonal communication ● Decision-making ● Goal-setting ● Self-management ● Advocacy

Figure 11

Social Emotional Learning Educator Survey Questions

1. Why is Social Emotional Learning important?
2. Provide a definition for SEL.
3. If your building has a SEL action plan, please provide a brief description of what is currently in place and any next steps.

Skill Alignment

After gathering the data above, I analyzed the alignment between the skill definitions for the NHES, SEL competencies, and MHL skills. The NHES was developed by a coalition in 1995 and was revised in 2007 (JCNHES, 2007). SHAPE America has recently obtained the copyright and is creating a task force to revise and update the standards (see Figure 12). Each standard includes sub standards for multiple grade bands (i.e., K-2, 3-5, 6-8, and 9-12). I referred to the sub standards for the elementary grade bands (K-2 and 3-5) when comparing NHES with SEL and MHL.

The SEL competencies include self-awareness, self-management, responsible decision-making, relationship skills, and social awareness (CASEL, 2022). I referred to the CASEL definitions and examples available in the interactive CASEL wheel on their website when comparing SEL with NHES and MHL (CASEL, 2023).

The MHL skills are defined by Kutcher et al. (2016a) and include mental health maintenance, mental disorders and their treatments, stigma reduction, and help-seeking. Because these skills were not defined in great detail, I took the liberty of expanding each construct. For the purposes of this study, *mental health maintenance* includes any activity that would promote positive mental health. I separated mental disorders and treatment. I broadened the concept of

mental disorders to include symptom identification and stress awareness, as these topics may be more relatable for elementary school students. *Treatment* includes any discussion around doctors, medication, and therapy. *Stigma reduction* was expanded to include all topics that teach students to accept, encourage, and care for those who may be different than themselves and learning to accept their own differences. These topics can lay the foundation for decreasing mental health stigma. Finally, *help-seeking* was outlined in the greatest detail and I retained the original definition of "knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management capabilities" (Kutcher et al., 2016a, p. 155).

After definitions were finalized, each set of skills was compared with another set of skills. For example, the NHES were compared with each of the SEL competencies and each of the MHL skills. The SEL competencies were also compared with each of the MHL skills. All data were recorded in a spreadsheet with each skill definition from one of the data sources listed in the left column and the skill definitions from another data source listed across the top row. If a skill in the left column aligned with or showed similarities to a skill in the top row, the intersecting cell would be checked. I would then make a note of the word or phrase that supported my conclusion. The analysis revealed where there is and where there is not alignment between the skill sets. It also shows how frequently a skill may align with a different set of skills. For example, how often *self-awareness* aligned with each of the NHES. Findings from these analyses will be shared in the Results chapter.

Figure 12

National Health Education Standards

Standard 1. Students will comprehend concepts related to health promotion and disease prevention to enhance health.
Standard 2. Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.
Standard 3. Students will demonstrate the ability to access valid information and products and services to enhance health.
Standard 4. Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
Standard 5. Students will demonstrate the ability to use decision-making skills to enhance health.
Standard 6. Students will demonstrate the ability to use goal-setting skills to enhance health.
Standard 7. Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.
Standard 8. Students will demonstrate the ability to advocate for personal, family, and community health.

Aligning Classroom Curricula with Skills

The PNWSD uses three curricula in elementary classrooms to teach the skills mentioned above. Health education standards are taught using *The Great Body Shop* (The Children's Health Market, 2023). The 2022-2023 school year was the first year of implementation. *The Great Body Shop* is an evidence-based, comprehensive health education curriculum that aligns with the NHES. Most elementary classrooms have a daily 30-minute content block. This block of time is set aside for science, social studies, and health instruction.

SEL competencies are taught in the majority of elementary classrooms using the *Harmony SEL, Second Edition,* curriculum (Harmony, 2023), which was introduced in 2019 and

systematically implemented during comprehensive distance learning. These lessons are usually taught during morning meeting, a daily 20-minute block set aside to build classroom community.

Sources of Strength (2023) is a curriculum new to the district this year and was brought on board to address suicide prevention in elementary school. The entire program is designed to be an upstream strength-based prevention program that builds upon and grows protective factors in children. PNWSD has school counselors teach two lessons in unit one and one lesson in unit four in 3rd-6th grades as part of the Adi's Act requirements. School counselors have the option of teaching additional lessons if they wish. Classroom teachers in the district are not currently using this curriculum.

Each curriculum addresses the NHES, SEL competencies, and MHL skills to different degrees and I wanted to know how each aligned with the skills. I was given online access to each curriculum. Due to each curricula containing over 100 lessons each, I did not read the entirety of each lesson plan. I focused my attention on the titles, descriptions, and objectives for each lesson. I then proceeded to compare each lesson with the description of each skill. All data were recorded in a spreadsheet with lesson descriptions in the left column and the skills listed across the top row. When a lesson and a skill aligned, I would check the intersecting cell and make a note of the word or phrase that supported my conclusion. In some instances the curriculum developers had completed the work for me. *Harmony SEL* and *Sources of Strength* documented where their lessons aligned to SEL competencies, and *The Great Body Shop* documented where their lessons aligned with the NHES. I reviewed these documents and added alignment where it was missing. Frequency counts were collected for each skill by grade level for each curriculum and a total frequency count for each skill by curriculum.

Sharing the Results of Phase 1 Analysis with District Staff

All data gathered in Phase 1 went through an initial analysis in order to prepare it for a presentation that was shared with the district-level participants in Phase 2. I reviewed the summarized data provided by the district and pulled out the data that would be most relevant to the participants as they worked to adapt the SHI. The purpose of the presentation was to have the participants review the data currently available in the district on student mental health, student mental health literacy, teacher perceptions on health education and social emotional learning, and skill alignment across curricula. I shared the results of my Phase 1 analysis but was careful to avoid providing interpretations in order to allow the participants to form their own professional conclusions about the data. To aid in their interpretation, I offered a visualization of the data represented in an average classroom of 28 students. The presentation was developed in Google Slides (see Appendix B). A more detailed summary of the data is included in the results to illustrate how and to what extent health education, social emotional learning, and mental health literacy are present in the district.

Phase 2 - Presentation and Survey

Participants

In phase two, I selected a purposeful sampling of district-level staff to participate in a focus group (Coyne, 1997). District-level staff members were chosen based on their expertise and experience with SEL, mental health, health education, and/or intimate knowledge of student needs. I recruited participants by first making a list of who fit the criteria above. I then shared my list with district office supervisors to request permission to recruit participants. Slight adjustments were made to the participant list based on supervisor input, and then I sent an email detailing the study to each potential participant. No identifiable information was connected to

participant comments in this study. Participants are identified by a code. Prior to participation, each recruit was given an informed consent form indicating the purpose of the study, the method of data collection, and the process for confidentiality. The participants were given the opportunity to participate in phase one, or both phase one and two. All recruited participants chose to participate in the study. Phase two had 20 participants, while phase three maintained 14 of the same participants. I participated in completing the survey in phase two, as my voice as the health education counselor on special assignment (COSA) is important to this work. My participation remained anonymous to avoid influencing participant dialogue in phase three. I maintained a facilitator role in phase three and did not include myself as a participant.

The 20 participants included the district's mental health specialist social worker on special assignment (SWOSA), health education teacher on special assignment (TOSA), health education COSA, SEL TOSA, equity TOSA, inclusion TOSA, college and career TOSA, universal supports TOSA, mental health in education program manager, school counselor COSA, student support COSA, two drug and alcohol counselors, two elementary school counselor leaders, two elementary digital curriculum TOSAs, a mental health care coordinator, the district's executive director, and the district's equity officer. Participants were asked to indicate whether their job responsibilities addressed any of the concepts addressed in this study. Their responses indicated that 65% address mental health, 60% SEL and equity, 30% health education, and 10% another focus area, such as digital curriculum. The two elementary school counselor leaders, a drug and alcohol counselor, the mental health coordinator, and the executive director did not attend the focus group in phase three due to scheduling conflicts.

During phase three, participants were asked to share the number of years they had been in education, the number of years in their current role, and positions they had held that related to

health education, SEL, or mental health. In terms of their years of experience in education, participants ranged from 5 months to 32 years. The mean number of years was 16, with the majority of participants (n = 10) between 15 to 32 years. The mean number of years in their current position was 1.8, with a maximum of 5 years and a minimum of 5 months. The majority (n = 11) fell between 1 and 2 years. Previous to their current position, participants held positions such as classroom teacher, school counselor, instructional coach, assistant principal, family therapist, behavior specialist, student success coach, and substance abuse prevention specialist. Some of them indicated they had championed one or more of these focus areas through committee work or in college level roles.

At the completion of phase three, participants were sent an optional questionnaire requesting anonymous demographics. Only 11 out of 14 participants completed the questionnaire. All eleven identified as female (100%), five identified as White (45%), three as Latina (27.3%), one as Polynesian/Pacific Islander (9%), and one as African American (9%). Participants used their own terminology to identify their race/ethnicity.

Presentation

Once the consent form was signed, participants were invited to participate in a brief presentation of my artifact analysis (see Appendix C). The presentation laid the foundation for the work ahead. Participants were given the option to watch the live presentation or watch a recording of it. Most participants (n = 15) watched the recording. They confirmed their participation through a Google Form. After watching the presentation they were free to take the SHI survey.

School Health Index Survey

The CDC's *SHI Self-Assessment and Planning Guide* is a self-evaluation and planning tool for schools (CDC, 2017) with both elementary and middle/high school versions. I used the elementary version with some modifications. The SHI is based on the CDC's research-based school health guidelines to improve student health outcomes. The SHI aligns with the WSCC framework (ASCD & CDC, 2014). Each of the 10 WSCC components has a section in the SHI and is broken down into specific questions related to the details of that component. The tool helps districts and schools identify strengths and weaknesses in their school health program and develop an action plan. The components of the SHI relevant to this study include Module 2: *Health Education*, Module 6: *School Counseling, Psychological, and Social Services*, and Module 7: *Social and Emotional Climate*. Each module contains discussion questions, a score card, and planning questions. After each module is completed, the school completes an overall score card and develops a school health action plan.

After participants watched the brief presentation, they were given access to a Google Form containing all the original questions from the modules listed above (see Appendix D). The participants were asked to provide feedback on which questions should be included in the final index. They were given the options of *keep*, *modify*, *discard*, or *unsure* for each question. They were also asked to indicate whether they felt the question was *very important* in addressing district goals. Frequency counts were calculated for each response option. Participants were then given the opportunity to explain their response to each question.

Merriam and Tisdell (2016) use the analogy of "seeing the forest through the trees" to describe data analysis. The "trees" are the particulars or the codes identified in the data. The "forest" is the big picture or the themes discovered in the data. The goal is to go back and forth

from particulars to the big picture. To start the coding process, I read through all responses and used a concept called open coding, which allows me to make note of anything that might be relevant (Merriam & Tisdell, 2016). On my second read through, I was more deliberate about using descriptive, *in vivo*, and concept coding (Saldaña, 2021). In descriptive coding, I chose a word or phrase that described the participant's statement. *In vivo* coding involves creating a code using an exact word or phrase from the participant. When using concept coding, I would assign meaning to the larger concept that the participant was speaking of. Then I grouped codes into themes or categories. I followed this process until I reached data saturation (Merriam & Tisdell, 2016). The survey results and the data analysis process were documented in a spreadsheet. As codes and themes were identified, I used the *sort*, *filter*, and *find* features to discover patterns and calculate frequency counts. I created additional tabs to document each theme and the corresponding excerpts.

In the spirit of qualitative exploratory research, I primarily used inductive coding, the process of having an open mind as I read and interpreted the data (Saldaña, 2021). However, I did keep an eye out for a few deductive codes, concepts I believed would be evident in the data. Aside from the clearly relatable topics in the SHI questions, I watched for additional comments about mental health, social emotional learning, health education, and alignment. In the Results chapter, each theme will be accompanied by frequency counts for the total number of comments related to the theme (*TC*), the number of questions in which the theme appeared (*Q*), and the number of participants who made reference to the theme (*P*).

Phase 3 – Focus Group

In phase three, participants gathered for a focus group to discuss the concepts in this study, review the results of the SHI survey, and continue developing the SHI. The first part of the

focus group involved a whole group discussion about the alignment of SEL, MHL, and health education. I then spent time going into greater detail about the purpose of the SHI, what the final product will look like, and how it will be used. I felt this was necessary to ensure that everyone was on the same page. Next, I divided participants into three multi-disciplinary groups and gave each group a set of questions from the school health index. Questions 1-9 addressed health education (9 questions), Q10-16 counseling services (6 questions), and Q17-26 school climate (9 questions).

Based on the survey data some of the questions appeared a little more straight forward and others a little more nuanced, so I broke up the questions in the following way to provide some balance: group one had Q1-10 (10 questions), group two Q11-18 (7 questions), and group three had Q19-26 (7 questions). Each group included at least one participant who would be considered an expert in the subject of most of the questions. For example, one of the health education specialists was part of the group that reviewed the questions addressing health education. The groups were tasked with reviewing the data from the SHI survey and modifying the questions as needed. Participants had access to a Google Slides presentation that included a different question on each slide, a bar graph displaying the frequency counts for each response option, and a summary of the written responses. The percent of participants indicating each response was included in the bar graph. I popped in and out of the groups to provide assistance, listen to discussions, and take field notes. After 45 minutes, the groups came back together to give a summary of their discussion and suggested questions to the whole group. The purpose of the summary was to ensure that I gathered the main discussion points from each group, as a form of member checking.

I used a focus group protocol (see Appendix E) that included the focus group agenda, questions, and activities. The focus group took place virtually using the Zoom software. It was recorded, and closed captioning was activated to collect verbatim transcription. The transcript was checked against the recording to ensure accuracy.

I followed a similar process in analyzing the focus group data as I had in analyzing the survey. I read through the whole group transcript and each individual subgroup transcript, while using open coding (Merriam & Tisdell, 2016). On my second read through I used descriptive, *in vivo*, and concept coding (Saldaña, 2021). I then grouped codes into themes or categories. I followed this process until I reached data saturation (Merriam & Tisdell, 2016). When participant comments needed clarification, I reached out to participants to give them an opportunity to expand on their thinking. I also had one participant from each group look over my codes to member check my work. I documented the transcript and the data analysis process in a spreadsheet. As codes and themes were identified, I used the *sort*, *filter*, and *find* features to discover patterns and calculate frequency counts. As before, I primarily used inductive coding (Saldaña, 2021), but I did keep an eye out for a few deductive codes, concepts I believed would be evident in the data. In the Results chapter, each theme will be accompanied by frequency counts for the total number of comments related to the theme (*TC*), the number of questions in which the theme appeared (*Q*), and the number of participants who made reference to the theme (*P*).

CHAPTER IV

RESULTS

Phase 1 - Artifact Analysis

Extant Data

Oregon Student Health Survey. The Oregon SHS laid the foundation for why suicide prevention and helping elementary school students build skills to cope with mental health challenges are so important. The preliminary data revealed 13.6% of 6th graders were *bothered by feeling nervous, anxious or on edge* nearly every day for the month prior to taking the survey. In a 6th-grade class of 28 students this translates to approximately four students per class in the PNWSD.

Regarding the past year, students were asked if they felt *so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities*, and 24.2% said yes. In a 6th-grade class of 28 students this translates to approximately seven students per 6th-grade class.

A question about self-harm asked students if they *purposely hurt themselves without wanting to die, such as cutting or burning themselves on purpose* during the past year, and 12.9% said at least one or more times. This translates to approximately four students per 6th-grade class.

Students were asked if they *ever seriously considered attempting suicide* in the past year, and 8.7% said yes. This translates to approximately two students per class who have seriously considered attempting suicide. Of the 8.7% who seriously considered attempting suicide, 32.6%

said they have *actually attempted suicide* one or more times in the past year, and 14.7% said they preferred not to answer the question.

The final question pulled from the Oregon SHS asked students if they had *a physical or mental health care problem or felt stressed/anxious during the school day, who would they go to at their school for help,* and 48.9% said they would go to a *friend/classmate*. Many fewer students indicated they would go to a *teacher* (33%), a *parent/stepparent/guardian* (31.7%), or the *school counselor* (28.9%). Students were able to choose more than one answer for this question and did not indicate the order in which they would reach out to these individuals.

Suicide Screenings. The suicide screening data continues to build on the foundation of why suicide prevention in elementary school is so important. The data goes back as far as the 2013-2014 school year when 73% of screeners came from 7th through 12th grade and 27% came from kindergarten through 6th grade (see Table 1). The percent of suicide screeners by grade

Table 1

Percent of Suicide Screeners by School Year and Grade Band

	K-6	7-12
2013-2014	27	73
2014-2015	21.7	78.3
2015-2016	39.3	60.7
2016-2017	35.9	64.1
2017-2018	31.3	68.8
2018-2019	38.6	61.4
2019-2020	44.3	55.7

Table 1

Percent of Suicide Screeners by School Year and Grade Band (Continued)

	K-6	7-12
2020-2021	36.2	63.8
2021-2022	36	64

band in 2021-2022 shifted to 64% in 7th through 12th grade and 36% from kindergarten through 6th grade. Just in the last five years from the 2021-2022 school year to the 2017-2018 school year, an average of 37.8% of all suicide screenings were conducted with kindergarten through 6th grade students.

Mental Health Literacy Survey. Part of RQ1 asked how, and to what extent is MHL present in the district. One way to answer that question is to assess the MHL of students. The first question asked students: *What is mental health?* Students were not required to provide a detailed definition. Simple answers were accepted. The largest portion of students responded by either admitting to not knowing; wrote a non-descriptive phrase, such as "something about health;" or shared an unrelated statement (37.9%). The remaining students believed that mental health may have something to do with "emotions/feelings" (25.9%), the "health of the mind" (22.4%), or "thoughts" (13.8%). "Wellness/well-being", "physical health", and "brain/head" were mentioned by 10.3% of students. A number of students (13.8%) mentioned a combination of factors in their definition, such as "it includes physical, emotional, and social well being," "mental health is how we think, feel, and act," and "something that controls you emotions, actions, and relationships." In a 6th-grade class of 28 students this translates to approximately 11 students per class who were not able to provide a definition for mental health.

Students were then asked to explain *how someone would maintain good mental health*. Almost a quarter of students mentioned "express feelings" and "maintaining physical health" (23.2%). Students indicated ways to "maintain relationships" as a way to promote good mental health (17.9%). Students also mentioned "specific strategies" unrelated to the themes above, such as "deep breaths," "praying," and "alone time" (26.8%). A full 40% of students did not mention a clear strategy for maintaining positive mental health. Many students were more vague in their ideas, such as "be positive and happy" (23.2%), "take care of yourself" (23.2%), and "stay calm" (14.3%). This translates to approximately 11 students per 6th grade class who were not able to list a strategy for maintaining good mental health.

Students were asked to *name and describe a mental disorder or mental illness* and were encouraged to name more than one. Almost half of students could accurately name at least one mental disorder (46.4%), and 12.5% could list multiple disorders. Only 21.4% of students could provide an adequate definition for the mental disorder they listed. An adequate definition only needed to include a general understanding of the disorder. A simple definition was sufficient. The most common mental disorders mentioned were "depression" (35.7%), "anxiety" (14.3%), and "obsessive compulsive disorder" (8.9%). Conditions that fall under developmental disorders were a common response (35.7%) such as "ADHD" (17.9%), "autism" (7.1%), and "dyslexia" (7.1%). The remaining students thought a mental disorder was a type of disease or sickness (14.3%), such as "cancer". This translates to approximately 13 students per 6th grade class who were able to accurately identify a mental disorder.

Students were asked *how someone treated a mental disorder or mental illness*. Many students suggested "talking to a mental health professional" (34.5%) or simply "talking to someone" (16.4%). Students suggested "taking medication" (14.5%) and "going to the doctor"

(9.1%). Some students provided a vague suggestion, such as “take care of yourself” or “stay calm” (14.5%). This translates to approximately nine students per 6th grade class who believe mental disorders are treated by talking to a mental health professional.

Students were asked *when would someone need to seek help for their mental health*. Not quite a quarter of students indicated that someone should seek help when they “want to hurt themselves” (19.6%). Of these students, 10.7% used the word “suicide” or “suicidal” in their response. Other students said when someone feels “overwhelmed” or “out of control” they should seek help (16.1%). The remaining students said when someone “feels bad” (14.3%), “feels depressed” (10.7%), or their “physical health worsens” (8.9%). This translates to approximately five students per 6th grade class who believe you should get help when you want to hurt yourself.

Students were asked *how someone would seek help for their mental health*. The responses to this question were similar to the treatment question. Students said “talk to someone” or “talk to a mental health professional” (39.3%). A quarter of students indicated “going to a doctor” (25%). This translates to approximately 11 students per 6th grade class who believe you should talk to someone if you need help with your mental health.

Students were asked if *mental disorders were common or rare*. The majority of students indicated that mental disorders were “common” (35.7%). However, almost a quarter of students felt that it “depends” (23.2%), because some mental disorders are common and some are rare. The remaining students felt they were “rare” (14.3%). This translates to approximately 10 students per 6th grade class who believe mental disorders are common.

The last question asked students *where they learned about mental health and mental illness*. The vast majority of students indicated “school” (64.9%). Students also indicated some

kind of "media" (31.6%), "family" (24.6%), a "personal experience or close contact" (8.8%), and "friends" (3.5%). This translates to approximately 18 students per 6th grade class who learned about mental health from school.

Health Education Adoption Survey. Educators were asked *what their hopes and dreams were for health education in the district.* Most educators wanted a curriculum that would be "engaging and relevant" (76%), as well as "developmentally appropriate" (68%). In addition, they wanted a curriculum that would be "plug-and-play" (65%) and "easy to use" (60%). What is particularly relevant for this study is that educators preferred a curriculum that "integrated SEL with health" (58%).

They were then asked *which topics or standards they found particularly unprepared to teach and may require additional professional development support*. At the top of the list was "affirming identities and anti-oppression" (42%); then "mental health" (34%); "sexual health promotion" (34%); "healthy relationships and violence prevention" (24%); and finally, "alcohol, tobacco, and other drug use prevention" (22%).

As the district looked for health education resources, the educators were asked what they viewed as the *three highest priority needs for their students*. They were given a list of health education topic areas and standards. The majority chose "social emotional learning" (51%), a topic area; and then "**s**elf-management" (38%). Unfortunately, self-management was mislabeled. See Limitations for more details. The remaining responses included mostly topic areas: "mental health" (33%), "wellness and health promotion" (28%), "nutrition and physical activity" (27%), "affirming identities and anti-oppression" (25%), and "healthy relationships and violence prevention" (24%). "Interpersonal communication" was the only health standard mentioned (20%).

Social Emotional Learning Educator Survey. Educators were asked: *Why is Social Emotional Learning important?* The themes most frequently referred to by respondents were "self-management" (37.1%), "integral" (31%), "success and future outcomes" (24.8%), and "self-awareness" (24.3%). Three themes were identified by 10%-15% of respondents: "school culture and community" (14.3%), "trauma-informed" (13.3%), and "relationship skills" (11.4%). Respondents used phrases like "handle their emotions," "manage their emotions," "deal with their emotions," and "self-regulation" when referencing self-management. Self-management was a consistent theme throughout the data. When respondents discussed how SEL was *integral* they referred to things like "vital component," "number one priority," and "essential for learning." Respondents felt like SEL was a foundation upon which academics could be built. Respondents viewed SEL as a "basic need" and connected it with "Maslow's hierarchy of needs," stating that "a student's hierarchy of needs need to be met before they can learn." *Success and future outcomes* were referred to when respondents said things like "employment and life satisfaction," "building block for life-long success," and "well adjusted, successful member of society." Respondents saw SEL as a tool for improving the lives of students and helping them reach success in a variety of ways. For *self-awareness*, respondents frequently used phrases like "understand that feelings are normal and important," "understand their emotions," and "recognize their feelings." Emotions or feelings were the primary focus. Some respondents talked about a "richer relationship to self" and "knowing oneself."

Educators were then asked to *provide a definition for SEL*. The most frequent responses involved "self-awareness" (46.2%) and "self-management" (43.3%). This is consistent with themes highlighted in the previous question. The third most frequent response was "relationship skills" (26.7%). Relationship skills was a full 16.7% lower than self-management. All other

themes were less than 19.1%. Respondents frequently used phrases such as “identify emotions,” “understanding how emotions work,” and “explore emotions” to talk about self-awareness. Respondents used phrases like “provides tools and strategies to manage self,” “self-control,” “manage emotions,” and “self-regulation” when referencing self-management. Respondents also referred to r*elationship skills* when they said things like “interpersonal skills,” “get along with others,” “interact with others,” and “navigate and building relationships.”

The final question asked educators to *provide a brief description of what is currently in place and any next steps related to their buildings SEL action plan*. The results include 35.74% of respondents indicating “I’m not sure,” “unaware,” and “not at this time.” Respondents either didn’t know if their building had a plan or they were thinking the question referred to an official document that they were unaware of. The second most frequent theme was “Morning Meeting” or “Advisory” (25.23%) which is a reference to where SEL is most often delivered. The next most common theme was “someone other than respondent is identified as leading the work” (12.38%). Sometimes the “school counselor” or the “student success coach” would be referenced as someone who delivers the lessons or leads small groups. All other themes had less than an 8% response rate. Many of these included curriculum or programs that guide SEL in school buildings. *Harmony SEL* was the most frequent curriculum mentioned (7.61%).

Skill Alignment

NHES and SEL. Each NHES aligns with a minimum of three SEL competencies. “Comprehend Concepts,” “Interpersonal Communication,” and “Goal Setting” aligns with 4 out of 5 (80%) of the SEL competencies. “Analyzing Influences,” “Accessing Information,” “Decision Making,” “Practice Health-Enhancing Behaviors,” and “Advocacy” align with 3 out 5 (60%) of the SEL competencies. Each SEL competency aligns with a minimum of three NHES.

"Self-Awareness" aligns with 8 out of 8 (100%) of the NHES. "Responsible Decision Making" and "Relationship Skills" aligns with 6 out of 8 (75%) of the NHES. "Self-Management" aligns with 4 out of 8 (50%) and "Social Awareness" aligns with 3 out of 8 (37%) of the NHES (see Table 2).

Table 2

Skill Alignment Between NHES and SEL Competencies

National Health Education Standards	Social Emotional Learning Competencies				
	Self-Awareness	Self-Manage-ment	Responsible Decision Making	Relation-ship Skills	Social Awareness
1 - Comprehend Concepts	X	X	X		X
2 - Analyze Influences	X			X	X
3 - Accessing Information	X		X	X	
4 - Interpersonal Communication	X	X	X	X	
5 - Decision Making	X		X	X	
6 - Goal Setting	X	X	X	X	
7 - Practice Health-Enhancing Behaviors	X	X	X		
8 - Advocacy	X			X	X

NHES and MHL. Each NHES aligns with a minimum of one MHL skill. "Accessing Information" and "Decision Making" aligns with 4 out of 5 (80%) of the MHL skills. "Advocacy" aligns with 3 out of 5 (60%) of the MHL skills. "Comprehend Concepts," "Analyze Influences," "Interpersonal Communication," and "Goal Setting" aligns with 2 out of 5 (40%) of

the MHL skills. “Practice Health-Enhancing Behaviors” aligns with 1 out of 5 (20%) or one MHL skill.

Each MHL skill aligns with a minimum of two NHES. Mental Health Maintenance aligns with 8 out of 8 (100%) of the NHES. “Help Seeking” is addressed in 6 out of 8 (75%) of the NHES. “Mental Disorders and Symptoms,” “Treatment,” and “Stigma” were addressed at a lesser degree (2 out of 8, 25%, see Table 3).

Each MHL skill aligns with a minimum of two NHES. Mental Health Maintenance aligns with 8 out of 8 (100%) of the NHES. “Help Seeking” is addressed in 6 out of 8 (75%) of the NHES. “Mental Disorders and Symptoms,” “Treatment,” and “Stigma” were addressed at a lesser degree (2 out of 8, 25%, see Table 3).

MHL and SEL. Each MHL skill aligns with a minimum of one SEL competency. “Mental Health Maintenance” aligns with 5 out of 5 (100%) of the SEL competencies. “Stigma Reduction” and “Help Seeking” aligns with 3 out of 5 (60%), “Mental Disorders and Symptoms” aligns with 2 out of 5 (40%), and “Treatment” aligns with 1 out of 5 (20%) of the SEL competencies.

Each SEL competency aligns with a minimum of two MHL skills. “Responsible Decision Making” aligns with 4 out of 5 (80%) of the MHL skills. “Self-Management” and “Relationship Skills” aligns with 3 out of 5 (60%), and “Self-Awareness” and “Social Awareness” aligns with 2 out of 5 (40%) of the MHL skills (see Table 4).

Table 3

Skill Alignment Between NHES and MHL Skills

National Health Education Standards	Mental Health Literacy Skills				
	Mental Health Maintenance	Mental Disorders and Symptoms	Treatment	Stigma	Help Seeking
1 – Comprehend Concepts	X				X
2 – Analyze Influences	X			X	
3 – Accessing Information	X	X	X		X
4 – Interpersonal Communication	X				X
5 – Decision Making	X	X	X		X
6 – Goal Setting	X				X
7 – Practice Health-Enhancing Behaviors	X				
8 – Advocacy	X			X	X

Table 4

Skill Alignment Between MHL Skills and SEL Competencies

Mental Health Literacy Skills	Social Emotional Learning Competencies				
	Self-Awareness	Self-Management	Responsible Decision Making	Relationship Skills	Social Awareness
Mental Health Maintenance	X	X	X	X	X
Mental Disorders and Symptoms	X	X			
Treatment			X		
Stigma Reduction			X	X	X
Help Seeking		X	X	X	

Aligning Classroom Curricula with Skills

The Great Body Shop. *The Great Body Shop* consists of 10 units per grade level (The Children's Health Market, 2023). Each unit has four lessons, for a total of 40 lessons at each grade. All throughout the curriculum and in each grade level topics such as injury prevention and personal safety; nutrition; functions of the body; growth and development; disease and illness prevention; substance abuse prevention; community health and safety; self-worth, mental and emotional health; environmental and consumer health; and physical fitness are addressed. The publisher provided documentation on where the NHES aligned with each lesson. I continued analysis of the alignment by comparing each lesson with the SEL competencies and the MHL skills at each grade level (see Table 5 and Table 6). Table 10 contains data for all 400 lessons. Tables 7 through 9 demonstrate how frequently a skill is being taught at a particular grade level and curriculum.

Sources of Strength. Sources of Strength (2023) has a separate curriculum for kindergarten, first grade, and second grade, with a combined third through 6th grade curriculum. The kindergarten through second grade curricula each have three units. Unit one is called "Connections and Community;" unit two is "Engaging Our Strengths;" and unit three is "We Can Make a Difference." Each unit has eight lessons, for a total of 24 lessons. The third through 6th grade curriculum has 12 units with two to four lessons each, plus a couple lessons on transitions. The curriculum contains a total of 35 lessons. The publisher provided documentation on where the SEL competencies aligned with each lesson. I continued analysis of the alignment

by comparing each lesson with the NHES and the MHL skills at each grade level (see Table 7). Table 10 contains data for all 107 lessons.

Harmony SEL. Harmony SEL consists of five units per grade or grade band (Harmony, 2023). A grade band is a grouping of two or more grades. Each unit typically has three to five lessons with the exception of unit two in the first two grade bands. The preschool (Pre-K) to kindergarten (K) grade band and the first to second grade band have 22 lessons each. Third grade has 19 lessons, fourth grade has 20 lessons, and the fifth to 6th grade band has 21 lessons. Unit one is called "Diversity & Inclusion;" unit two is "Empathy & Critical Thinking;" unit three is "Communication;" unit four is "Problem Solving;" and unit five is "Peer Relationships." The publisher provided documentation on where the SEL competencies aligned with each lesson. I continued analysis of the alignment by comparing each lesson with the NHES and the MHL skills at each grade level and grade band (see Table 8). Table 9 contains data for all 104 lessons.

Table 5

The Great Body Shop: Frequency Counts of Skills by Grade Level K-2

	Kindergarten		First Grade		Second Grade	
	n	%	*n*	%	*n*	%
SEL Competencies						
Self-Awareness	30	75	30	75	33	83
Self-Management	26	65	22	55	26	65
Responsible Decision Making	23	58	31	78	24	60
Relationship Skills	11	28	19	48	10	25
Social Awareness	13	33	18	45	17	43
Mental Health Literacy						
Mental Health Maintenance	23	58	22	55	19	48
Mental Disorders & Symptoms	1	3	2	5	0	0
Treatment	2	5	7	18	3	8
Stigma Reduction	3	8	7	18	11	28
Help Seeking	6	15	9	23	3	8
National Health Education Standards						
1 – Comprehend Concepts	35	88	36	90	33	83
2 – Analyze Influences	17	43	21	53	14	35
3 – Accessing Information	15	38	18	45	11	28
4 – Interpersonal Communication	14	35	25	63	10	25
5 – Decision Making	19	48	29	73	23	58
6 – Goal Setting	21	53	23	58	14	35
7 – Practice Health-Enhancing Behaviors	33	83	32	80	37	93
8 – Advocacy	18	45	29	73	15	38

Table 6

The Great Body Shop: Frequency Counts of Skills by Grade Level 3-6

	Third Grade		Fourth Grade		Fifth Grade		Sixth Grade	
	n	%	*n*	%	*n*	%	*n*	%
SEL Competencies								
Self-Awareness	32	80	32	80	13	33	10	25
Self-Management	21	53	29	73	19	48	24	60
Responsible Decision Making	31	78	31	78	27	68	27	68
Relationship Skills	14	35	10	25	18	45	11	28
Social Awareness	20	50	15	38	19	48	16	40
Mental Health Literacy								
Mental Health Maintenance	28	70	30	75	16	40	12	30
Mental Disorders & Symptoms	1	3	1	3	2	5	6	15
Treatment	3	8	4	10	6	15	6	15
Stigma Reduction	7	18	3	8	4	10	6	15
Help Seeking	2	5	4	10	7	18	6	15
National Health Education Standards								
1 – Comprehend Concepts	37	93	37	93	35	88	37	93
2 – Analyze Influences	22	55	25	63	27	68	33	83
3 – Accessing Information	8	20	11	28	16	40	16	40
4 – Interpersonal Communication	16	40	24	60	18	45	23	58
5 – Decision Making	35	88	34	85	34	85	35	88
6 – Goal Setting	16	40	17	43	18	45	26	65
7 – Practice Health-Enhancing Behaviors	29	73	34	85	35	88	37	93
8 – Advocacy	32	80	36	90	29	73	31	78

Table 7

Sources of Strength: Frequency Counts of Skills by Grade Level

	Kindergarten		First Grade		Second Grade		3rd-6th Grade	
	n	%	*n*	%	*n*	%	*n*	%
SEL Competencies								
Self-Awareness	18	75	22	92	19	79	26	74
Self-Management	10	42	12	50	8	33	16	46
Responsible Decision Making	12	50	9	38	15	63	12	34
Relationship Skills	14	58	10	42	15	63	16	46
Social Awareness	15	63	16	67	20	83	19	54
Mental Health Literacy								
Mental Health Maintenance	24	100	24	100	24	100	26	74
Mental Disorders & Symptoms	0	0	0	0	0	0	1	3
Treatment	1	4	1	4	2	8	0	0
Stigma Reduction	4	17	2	8	11	46	5	14
Help Seeking	3	13	4	17	1	4	6	17
National Health Education Standards								
1 - Comprehend Concepts	8	33	2	8	2	8	21	60
2 - Analyze Influences	3	13	1	4	4	17	11	31
3 - Accessing Information	0	0	0	0	1	4	3	9
4 - Interpersonal Communication	14	58	14	58	17	71	12	34
5 - Decision Making	8	33	6	25	7	29	23	66
6 - Goal Setting	0	0	0	0	0	0	1	3
7 - Practice Health-Enhancing Behaviors	15	63	13	54	19	79	19	54
8 - Advocacy	3	13	5	21	7	29	8	23

Table 8

Harmony SEL 2nd Edition: Frequency Counts of Skills by Grade Level

	Pre-K & K		1st & 2nd		3rd		4th		5th & 6th	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
SEL Competencies										
Self-Awareness	7	32	8	36	5	26	5	25	6	29
Self-Management	7	32	5	23	4	21	4	20	3	14
Responsible Decision Making	5	23	6	27	5	26	5	25	7	33
Relationship Skills	14	64	11	50	11	58	13	65	15	71
Social Awareness	11	50	10	45	5	26	7	35	8	38
Mental Health Literacy										
Mental Health Maintenance	13	59	14	64	14	74	15	75	13	62
Mental Disorders & Symptoms	0	0	0	0	0	0	0	0	0	0
Treatment	0	0	0	0	0	0	0	0	0	0
Stigma Reduction	5	23	4	18	2	11	2	10	3	14
Help Seeking	2	9	2	9	0	0	0	0	0	0
National Health Education Standards										
1 - Comprehend Concepts	2	9	4	18	1	5	1	5	2	10
2 - Analyze Influences	0	0	1	5	1	5	1	5	3	14
3 - Accessing Information	0	0	0	0	0	0	0	0	0	0
4 - Interpersonal Communication	11	50	11	50	10	53	11	55	12	57
5 - Decision Making	2	9	1	5	0	0	1	5	1	5
6 - Goal Setting	1	5	1	5	1	5	1	5	1	5
7 - Practice Health-Enhancing Behaviors	4	18	4	18	4	21	3	15	3	14
8 - Advocacy	2	9	2	9	0	0	0	0	0	0

Table 9

Frequency Counts of Skill Alignment with Elementary Classroom Curricula K-6

	Harmony SEL		The Great Body Shop		Sources of Strength	
	n	%	*n*	%	*n*	%
SEL Competencies						
Self-Awareness	31	29.8	180	64.3	85	79.4
Self-Management	23	22.1	167	59.6	46	43.0
Responsible Decision Making	28	26.9	194	69.3	48	44.9
Relationship Skills	64	61.5	93	33.2	55	51.4
Social Awareness	41	39.4	118	42.1	70	65.4
Mental Health Literacy						
Mental Health Maintenance	69	66.3	150	53.6	98	91.6
Mental Disorders & Symptoms	0	0	13	4.6	1	0.9
Treatment	0	0	31	11.1	4	3.7
Stigma Reduction	16	15.4	41	14.6	22	20.6
Help Seeking	4	3.8	37	13.2	14	13.1
National Health Education Standards						
1 - Comprehend Concepts	10	9.6	250	89.3	33	30.8
2 - Analyze Influences	6	5.8	159	56.8	19	17.8
3 - Accessing Information	0	0	95	33.9	4	3.7
4 - Interpersonal Communication	55	52.9	130	46.4	57	53.3
5 - Decision Making	5	4.8	209	74.6	44	41.1
6 - Goal Setting	5	4.8	135	48.2	1	0.9
7 - Practice Health-Enhancing Behaviors	18	17.3	237	84.6	66	61.7
8 - Advocacy	4	3.8	190	67.9	23	21.5

Phase 2 – School Health Index Survey

To Keep or Not to Keep

Participants were asked to choose from *Keep*, *Modify*, *Discard*, *Unsure*, and/or *Very Important* for each question in the survey (see Table 11). Of the 26 questions, 10 were marked as

Very Important by 40% or more of the participants. These questions included topics such as "opportunities to practice skills" (Q4), "culturally appropriate activities and examples" (Q5), "counseling, psychological, and social services provided by a full-time counselor, social worker, and psychologist" (Q10), "health and safety promotion and treatment" (Q11), "collaborate with other school staff members" (Q12), "identify and refer students involved in violence" (Q16), "positive school climate" (Q17), "professional development on meeting diverse needs of students" (Q19), "prevent harassment and bullying" (Q23), and "engaging all students" (Q25).

Of the 26 questions, 10 were marked as *Keep* by 70% or more of the participants. Some of these questions overlapped with questions marked as *Very Important*, such as Q4, Q5, Q17, Q23, and Q25. Additional questions marked as *Keep* included "health education taught in all grades" (Q1), "sequential health education curriculum consistent with standards" (Q2), "establish referral system" (Q14), "aid students during transitions" (Q15), and "school-wide social and emotional learning" (Q21).

Of the 26 questions, seven were marked as *Modify* by 30% or more of the participants. Some of these questions overlapped with questions marked as *Very Important*, such as Q10, Q11, Q12, and Q23. Additional questions marked as *Modify* included "active learning strategies" (Q3), "assignments encourage student interaction with family and community" (Q6), and "identify and track students with emotional, behavioral and mental health needs" (Q13).

Of the 26 questions, six were marked as *Unsure* by 25% or more of the participants. The only question mentioned under a previous category is Q6. Additional questions marked as *Unsure* included "professional development in health education" (Q7), "professional development in delivering curriculum" (Q8), "professional development in classroom management techniques"

(Q9), “community partnerships to promote social and emotional learning for students in school” (Q22), and “prevent school violence” (Q26).

Of the 26 questions, three were chosen by 20% or more of the participants as questions to *Discard*. The question “assignments encourage student interaction with family and community” (Q6) was also included in the *Modify* and *Unsure* categories. Q6 has the lowest scores across the board with nothing above 35%. The question “professional development in classroom management techniques” (Q9) had the highest *Discard* score of 45%. It was also included in the *Unsure* category. Finally, 20% of participants recommended discarding “positive student relationships” (Q18).

Table 10

School Health Index Survey Results

	SHI Questions	Keep		Modify		Discard		Unsure		Very Important	
		n	%	*n*	%	*n*	%	*n*	%	*n*	%
1	Do students receive health education instruction in all grades?	15	79	4	21	1	5	0	0	5	26
2	Do all teachers of health education use age-appropriate health education curriculum materials that are sequential and consistent with state or national standards for health education and the district's requirements for health education?	17	85	1	5	2	10	2	10	4	20
3	Do all teachers of health education use active learning strategies and activities that students find engaging and make learning relevant to their daily lives?	11	55	6	30	1	5	4	20	7	35
4	Do all teachers of health education provide opportunities for students to practice or rehearse the skills needed to maintain and improve their health?	16	80	4	20	1	5	1	5	8	40
5	Do all teachers of health education use a variety of culturally-appropriate activities and examples that reflect the community's cultural diversity?	16	80	4	20	0	0	2	10	13	65
6	Do all teachers of health education use assignments or projects that encourage students to have interactions with family members and community organizations?	6	30	7	35	4	20	5	25	3	15
7	Do all teachers of health education participate at least once a year in professional development in health education?	10	50	4	20	2	10	6	30	3	15
8	Have all teachers of health education received professional development in delivery of the school's health and safety curriculum in the past two years?	9	45	1	5	2	10	9	45	4	20
9	Have all teachers of health education received professional development in classroom management techniques in the past two years?	5	25	2	10	9	45	5	25	0	0
10	Does your school have access to a full-time counselor, social worker, or psychologist for providing counseling, psychological, and social services? Is an adequate number of these staff members provided based on the following recommended ratios? (A list was provided.)	12	60	7	35	2	10	2	10	9	45
11	Does the counseling, psychological, or social services provider promote the emotional, behavioral, and mental health of and provide treatment to students and families in the following ways? (A list was provided.)	13	65	7	35	0	0	2	10	8	40
12	Does the counseling, psychological, or social services provider collaborate with other school staff members to promote student health and safety in at least six of the following ways? (A list was provided.)	13	65	6	30	1	5	1	5	8	40

Table 10

School Health Index Survey Results (Continued)

SHI Questions		Keep		Modify		Discard		Unsure		Very Important	
		n	%	*n*	%	*n*	%	*n*	%	*n*	%
13	Does the counseling, psychological, or social services provider have a system for identifying and tracking students with emotional, behavioral, and mental health needs?	11	55	6	30	2	10	4	20	5	25
14	Does your school implement a systematic approach (including the following components) for referring students, as needed, to appropriate school- or community-based counseling, psychological, and social services? (A list was provided.)	14	70	4	20	0	0	3	15	6	30
15	Does your school aid students during school and life transitions (such as changing schools or changes in family structure) in the following ways? (A list was provided.)	15	75	4	20	1	5	0	0	2	10
16	Does the counseling, psychological, or social services provider have a system for identifying students who have been involved (as a bystander, victim, perpetrator, or some combination of these) in any type of violence (e.g., child abuse, dating violence, sexual assault, bullying or harassment, fighting, suicide and self-harm behaviors) and, if necessary, refer them to the most appropriate school-based or community-based services?	13	65	5	25	1	5	2	10	8	40
17	Does your school foster a positive psychosocial school climate using all of the following practices? (A list was provided.)	14	70	5	25	1	5	1	5	8	40
18	Does your school take steps to foster peer relationships among students in each of the following ways?	13	65	4	20	4	20	0	0	6	30
19	Have all teachers received professional development on meeting the diverse cognitive, emotional, and social needs of children and adolescents in the past two years? (A list was provided.)	12	60	5	25	0	0	4	20	8	40
20	Do teachers at your school collaborate with counseling and psychological services staff to promote social and emotional learning (e.g., providing information to students on developing self-awareness, managing emotions, or maintaining interpersonal relationships; referring students for support services) for students?	12	60	5	25	1	5	2	10	6	30
21	Does your school implement social and emotional learning programs for all students?	17	85	2	10	0	0	1	5	7	35

Table 10

School Health Index Survey Results (Continued)

	SHI Questions	Keep		Modify		Discard		Unsure		Very Important	
		n	%	*n*	%	*n*	%	*n*	%	*n*	%
22	Does your school partner with community organizations to provide students with educational materials and/or resources (e.g., fact sheets on socioemotional well-being, information on community-based counseling services, stress management skill building, depression screenings) to promote social and emotional learning and wellbeing for students in school?	10	50	2	10	2	10	9	45	1	5
23	Has the school established a climate, in each of the following ways that prevents harassment and bullying? (A list was provided.)	15	75	6	30	1	5	0	0	9	45
24	Do staff members actively supervise students, in each of the following ways, everywhere on campus (e.g., classroom, lunchroom, playground, locker room, hallways, bathroom, and school bus)? (A list was provided.)	13	65	2	10	1	5	4	20	2	10
25	Does your school prioritize efforts to engage all students (i.e., diverse students, including but not limited to racial/ethnic minority youth, LGBTQ youth, youth with disabilities, youth with chronic conditions, homeless youth, etc.) in extracurricular school activities to foster student sense of belonging in the following ways? (A list was provided.)	14	70	3	15	1	5	3	15	8	40
26	Does your school take steps to prevent violence, in each of the following ways? (A list was provided.)	13	65	5	25	0	0	5	25	7	35

Participants Explain Their Reasoning

Participants were asked to explain their reasoning for choosing *Keep, Modify*, *Discard, Unsure,* and/or *Very Important* for each question in the survey. A number of themes emerged from the data. Each theme will be accompanied by frequency counts for the total number of comments related to the theme (*TC*), the number of questions in which the theme appeared (*Q*), and the number of participants who made reference to the theme (*P*). The total number of comments on the survey was 381. Question 24, *Active supervision,* had the smallest number of comments (*TC* = 8) and question 13, *positive student relationships*, had the most (*TC* = 18). The total number of questions was 26 and the total number of participants was 20. Excerpts are included as they were written by participants and may include typing errors. Excerpts with brackets were modified for clarity.

Training and Professional Development. Participants frequently made comments related to *training and professional development* (*TC* = 47, 12.3%; *Q* = 10, 38.5%; *P* = 17, 85%). Reasonably, the most frequent comments were attached to question 7, *professional development in health education,* question 8, *professional development in delivering curriculum,* and question 19, *professional development on meeting diverse needs of students*. Comments addressed the frequency of professional development, such as "how realistic 1x a year is" (Participant 3) and "maybe every 2 years" (Participant 17). Participants also discussed how *training and professional development* can provide "accurate information" (Participant 14), "access to new data" (Participant 8), and keep educators "up to date" (Participant 6). According to participants, *training and professional development* needs to be "consistent" (Participant 15) and "continuous" (Participant 19). "Classified [staff]" (Participant 2) and "new staff" (Participant 4)

were identified as two groups that need more training. In response to question 8, where it talks about whether teachers have received professional development in the past 2 years, Participant 12 stated that the question "clearly reflects the standard of training and reflects a sustainability model," but wondered if it was "realistic."

Accountability. Participants frequently used phrases that either directly or indirectly referred to *accountability* (*TC* = 46, 12.1%; *Q* = 16, 61.5%; *P* = 16, 80%). Responses to question 11, *health and safety promotion and treatment*, referred to *accountability* seven times. For example, Participant 9 said,

> "If a school has access, then absolutely we need to ensure that they are promoting emotional, behavioral and mental health… Especially when so many of our students are battling with depression and anxiety."

Responses to question 2, *sequential health education curriculum consistent with standards*, referred to *accountability* six times. For example, Participant 14 stated that "when it comes to delivering messaging to our students about their health we should ensure that the info is vetted and delivered in a consistent way for all students." Responses to question 14, *establish referral system*, referred to *accountability* six times. For example, Participant 14 said, "This is part of how we ensure that students' needs are being addressed and managed." Participant 1 referred to *accountability* 11 times, making comments such as "Accountability[:] all of these systems and procedures are needed for successful implementation." No other participant mentioned it more than four times. The word "ensure" was used 10 times throughout the survey and seven times in relation to *accountability*.

Modification Suggestions. Participants frequently made *modification suggestions* (*TC* = 44, 11.5%; *Q* = 21, 80.8%; *P* = 14, 70%). Frequent suggestions included combining questions, expanding the scope of the question, the need to provide additional examples, or break up the

question into multiple questions. Occasionally a phrase or new terminology was suggested, along with the suggestion to define certain words.

Equity, Access, and Cultural Responsiveness. Throughout the survey participants made references to *equity, access, and cultural responsiveness* (*TC* = 30, 7.9%; *Q* = 15, 57.7%; *P* = 13, 65%). For example, Participant 12 said, "We HAVE to continue to embed our equity work into our content and classrooms." The concept of *bias*, a key concept in equity work, was mentioned eight times. For example, Participant 13 said, "Curriculum often tends to have bias. Additional texts or materials may need to be developed for underserved communities." Participant 14 talks about personal *bias* when they said, "We all carry with us our own personal experience and thoughts about health, and professional development helps us not only provide accurate information but check our biases in this work." The concept of *access*, primarily student's having access to needed support, was mentioned seven times. For example, Participant 13 said, "I would add do they have access to a counselor in their primary language," and Participant 14 said,

> "My experience has proven time and time again that there are countless students who would not access to these necessary services if they weren't offered at school and I consider it critical equity work."

The concept of *cultural responsiveness* was mentioned six times. For example, Participant 19 said in response to question 5, *culturally appropriate activities and examples*, "Definitely a needed question because a student's well-being is connected to culture." The concepts of *marginalization* and *racism* were mentioned twice. Participant 16 was concerned that a tracking system might "perpetuate oppressive and marginalizing treatments, biases, and assumption," and Participant 13 wondered if "racism and bias" would fall under the bullying topic in question 23, *prevent harassment and bullying*.

Students. Throughout the survey, participants discussed *students* in a variety of ways, including *student learning and engagement, student barriers,* and *student wellness.* I included these concepts under the larger theme of *Students* (*TC* = 28, 7.3%; *Q* = 15, 57.7%; *P* = 12, 60%). The concept of *student learning and engagement* was mentioned 10 times. For example, Participant 16 said, "Student engagement is critical to student learning and deepens student understanding of content." Participant 5 elaborates by saying,

> "I find this to be very important because without engaging learning opportunities it feels more like we are 'checking the box' that the material is covered, while our students gain little from the content."

The concept of *student wellbeing* was mentioned seven times. For example, Participant 19 mentioned "student well-being is more than health curriculum." It also includes "peer interactions" (Participant 6) and "harassment and bullying prevention" (Participant 19). The concept of *student barriers* was mentioned five times. Similarly to Participant 19's comment above, Participant 6 states, "Bullying is a HUGE barrier to student health and wellness at school." In response to question 6, *assignments encourage student interaction with family and community,* Participant 15 stated, "This could present a barrier for students who do not feel comfortable talking with an adult at home, [don't] have an adult at home, and/or cannot connect with a community organization."

Responsibility. The idea of *who's responsible* for the concepts mentioned in the questions came up multiple times (*TC* = 19, 5%; *Q* = 13, 50%; *P* = 7, 35%). A variety of individuals and entities were mentioned, such as "this specifically applies to Care Coordinators" (Participant 7), and "[teachers] should be doing this ...are these opportunities even offered by the district/school?" (Participant 10). Participant 9 specifically addressed the important role of teachers and other adults in the building on "the health and wellbeing of our students."

"Classroom-based and school-wide health promotion and prevention does not need to come from the counseling department," Participant 3 pointed out. "It's more important that these things are happening at all - And, ideally, they'd be the product of a diverse group of staff members and other stake holders."

Instrumentation. Throughout the survey, there were a variety of comments related to how school teams would answer the questions in the final version of the survey; in other words, how would the questions be *measured*. There were also comments about whether a question aligned with the *survey purpose*. I included both of these concepts under the theme of *instrumentation* (*TC* = 17, 4.5%; *Q* = 11, 42.3%; *P* = 9, 45%). Comments related to *measurement* included, "give teachers a breakdown of options" (Participant 7) and "break this apart so each option can be checked separately" (Participant 8). Participant 3 stated in response to question 3, *active learning strategies,*

> "While I think that it's very important to make health education engaging and relevant to students' daily lives, I'm unsure how we'd measure something like this. Measurement would need to include indicators of what qualifies as active learning strategies and what does not, how many active learning strategies would need to be used per year to qualify as 'using' them (and is this self-reported?), *and* how many teachers in a building are using them. That's a lot of 'moving parts.'"

Participants were asked to keep in mind that our final questions should encourage school teams to reflect on their school's health promotion practices, which prompted some participants to comment on the *survey's purpose*.

In response to question 10, *counseling, psychological, and social services provided by a full-time counselor, social worker, and psychologist,* Participant 9 said,

> "I marked discard because maybe this question is more for [administration]? How would a [school] team develop a goal for improvement off of the results of this question? Other than advocating for the need to have access to [these] services/individuals. I don't think this evaluates the school's health promotion practices."

Systems. Throughout the survey, there were a variety of comments related to *systems* (*TC* = 16, 4.2%; *Q* = 7, 26.9%; *P* = 8, 40%). The most frequent comments were about modifying the question to reflect a building or school level system versus a person or department level system, such as "I think it is enough to just ask about the system as opposed to that being owned by the counselor or another provider" (Participant 12). General comments related to the benefit of systems were used in response to question 15, *aid students during transitions*, when participants stated "All of these systems and procedures are needed for successful implementation" (Participant 1) and "These are positive systems to have in place" (Participant 10). Participant 16 expanded on the benefits of systems by saying,

> "Systems provide a checks and balances approach to referring students so that no one entity is responsible for referral. This would avoid students being subject to the biases, assumptions, and knowledge base of a singular/more individualist referral approach. Multiple systems include multiple perspectives and approaches which increases the capacity to serve. The concern is when systems are so red taped that student[s] cannot be referred/serviced in a timely manner."

District Model. Participants noticed that some of the questions did not reflect the district model or current practices (*TC* = 16, 4.2%; *Q* = 8, 30.8%; *P* = 6, 30%). In multiple questions, Participant 20 stated "take out 'psychological and social services'" and "this is not the model we have." Participant 12 said "take out social worker and psychologist" and suggested adding "success coach, behavior specialists" in order to "reflect current staffing." A couple participants made some additional reflections including "something to clarify [is] that it is asking about psychologists who do counseling - which ours […] typically do not" (Participant 17) and "school counselors in our district don't necessarily 'provide treatment'" (Participant 2).

Mental Health. The concept of *mental health* was mentioned on multiple occasions throughout the survey (*TC* = 16, 4.2%; *Q* = 12, 46.2%; *P* = 7, 35%). Question 11, *health and*

safety promotion and treatment, and question 13, *identify and track students with emotional, behavioral, and mental health needs*, specifically address emotional, behavioral, and *mental health*. However, comments regarding *mental health* did not primarily fall within these questions. Participant 2 contributed seven of the 16 comments, primarily suggesting that questions be reworded to state "mental, social, emotional, and physical health education" and not just health education or social emotional learning. Additional comments related to *mental health* include, "Advocate for more mental health support! Plus, do all staff know what is already offered in their building?" (Participant 10) and "For some students, accessing mental health and social services in the school setting is all they get" (Participant 14). In response to question 4, *opportunities to practice skills,* Participant 5 stated,

> "student engagement is so important, and particularly as it pertains to normalizing physical and mental health, we need to encourage discussion, different points of view and practice in order to prepare students and encourage them to think critically about these topics."

One comment in the survey mentioned suicide:

> "Bullying and harassment have severe implications on mental and emotional health. Schools should prioritize plans to prevent bullying and harassment/ The impact of bullying and harassment on suicide and suicidal ideation must be considered in prioritize these anti-bullying strategies" (Participant 16).

Participant 6 is the only participant who mentioned staff wellness by saying "If staff [are] not mentally healthy, it is difficult if not impossible for them to support the mental health of students."

Social Emotional Learning. The concept of *social emotional learning* was mentioned on multiple occasions throughout the survey (*TC* = 15, 3.9%; *Q* = 8, 30.8%; *P* = 10, 50%). In some instances the participants referred to the SEL competencies directly, such as "social awareness, relationship skills and the awareness [of] other[s]" (Participant 5) and "Many of the answers

reflect the SEL competencies" (Participant 16). Other comments talked about SEL more broadly. Participant 9 implied the SEL competencies of social awareness, relationship skills, and self-awareness in response to question 5, *culturally appropriate activities and examples*, when they said,

> "This question is very important because students need to be able to have discourse around healthy topics and diverse groups so they are able to acknowledge, respect, and appreciate differences. This is important for relationships and interpersonal connections especially around personal values and beliefs that support healthy behaviors and the shaping of group norms that value a healthy lifestyle."

Participant 2 implied the SEL competencies of relationship skills and social awareness in response to question 18, *positive student relationships*, when they said,

> "I think schools would be much healthier places if students were encouraged to socialize and build relationships. This may be a no-brainer for some staff, but for others, following the rules, quiet and compliance, and getting through the content tends to get prioritized over practicing social skills."

Universal Supports. The concept of *universal supports* was mentioned on multiple occasions throughout the survey (*TC* = 13, 3.4%; *Q* = 6, 23.1%; *P* = 8, 40%). Participant 8 stated that *universal supports* are needed for a "positive climate and culture." Participant 16 suggested that "universal structures [should be] in place for all students," and Participant 6 expanded on this by saying "Universal SEL [should] not just [be] in response to student need." *Universal supports* are associated with being *proactive* and *preventative* as highlighted by multiple participants when they mentioned "proactive practices" (Participant 9), "a preventative proactive approach" (Participant 14), "Primary prevention! Yes!" (Participant 3), and "proactively supporting our bystanders" (Participant 6).

Identify and Track. The concepts of *identify* and *track* were mentioned on multiple occasions throughout the survey (*TC* = 13, 3.4%; *Q* = 4, 15.4%; *P* = 10, 50%). Eight comments were connected to question 13, *identify and track students with emotional, behavioral, and mental health needs*. In particular, there were a variety of opinions on the idea of *tracking*, for instance “Do we really want to be 'tracking' students? That term has a lot of baggage” (Participant 2) and “IF the tracking system does not perpetuate oppressive and marginalizing treatments, biases, and assumptions. If the tracking tool is not used to define students in a ‘box’” (Participant 16). Participant 3 felt as if the question used “deficit language.” Participant 12 added even more context to the concerns already stated,

> “I think this gets us into the universal screener territory which we have shied away from as a system in favor of a universal precaution approach. Right now we rely on self-report and family report to specifically link students to support for their trauma.”

There were also comments in support of *identifying* and *tracking* students, such as “Tracking systems are important for case management of any kind” (Participant 14) and “Developing a system for identifying and tracking supports for students is necessary so students don't fall through the cracks” (Participant 19).

School Counselors. The role of the *school counselor* was mentioned on multiple occasions throughout the survey (*TC* = 12, 3.1%; *Q* = 5, 19.2%; *P* = 8, 40%). It was sometimes mentioned in combination with psychological and social services, but the only position that is full-time in each building is a *school counselor*. Several comments shared a concern about some of the questions feeling evaluative of school counselors, such as

> “This feels very targeting and judgmental of a school counselor's role and program (my lens). I got very defensive reading it! I would feel very uncomfortable if I knew that staff members/co-workers were judging/rating/evaluating me or my program. Some of this is not the role of the counselor (I understand other roles are a part of this question as well).” (Participant 7)

A few participants commented on *accountability* for *school counselors*, including "This question helps ensure counselors are doing a comprehensive program," (Participant 17) and it "would be good for school teams to see how their counselors are actually supporting students" (Participant 19). Others talked about how the responsibilities listed in some of questions seemed to fall under school counseling and how that did not seem appropriate, such as "I like the concept of question [13]; I'm not 100% sure I feel like this should ONLY fall on these roles" (Participant 5). and "This reads to me that the counselor is the person primarily responsible for this tracking" (Participant 10). There were several comments that *advocated* for the *school counseling* role, such as

> Let's be honest, almost none of them will be able to say YES to [question 10]. Perhaps it is great data to support the need for more of these roles or to utilize the roles differently within the building to better support this work?" (Participant 5).

Skill Practice. The concept of *skill practice* was mentioned on multiple occasions throughout the survey (*TC* = 11, 2.8%; *Q* = 3, 11.5%; *P* = 11, 55%). The majority of *skill practice* comments were in reference to question 4, *opportunities to practice skills*. The comments listed a number of reasons *skill practice* is important, such as "in order to build true mastery" (Participant 6), "crucial to successfully developing these skills" (Participant 8), "deepens learning" (Participant 16), and "develop[s] muscle memory" (Participant 19). It was mentioned that skill practice was needed in order to "reinforce […], create habits" (Participant 10), and "generalize" (Participant 7) the skills. The complexities of skill practice are referenced here:

> "YES! We want [to] facilitate student connection to family and community resources, and 'accessing information' is one of the health skill standards. Regular connection with families also facilitates transparency around what is happening in the classroom and

> allows families to build on the concepts/skills taught in class in the context of their family values" (Participant 3).

Health Education. The concept of *health education* was mentioned on multiple occasions throughout the survey (*TC* = 11, 2.8%; *Q* = 7, 26.9%; *P* = 6, 30%). *Health education* was specifically addressed in questions 1-9. According to two participants, several of the questions related more to general "instructional strategies and teaching practices" than health education specifically (Participant 20). One participant mentioned on multiple occasions that the questions should read mental, social, emotional, and physical health education" instead of only "health education" to capture more aspects of health education (Participant 2). A couple participants commented on the nuances of *health education*, such as a "best practice in health education is a 'skills-based approach'" (Participant 3) and different "cultures have varied approaches and understandings of health education" (Participant 16). Participant 3 added,

> "Requiring health education isn't enough - We must also ensure that it is of quality. Without this stipulation, it is not uncommon for instruction to basic and repetitive. Students deserve to have instruction that is well-developed and grows with them" (Participant 3).

Counselor and Teacher Collaboration. The concept of *counselor and teacher collaboration* was mentioned on multiple occasions throughout the survey (*TC* = 9, 2.4%; *Q* = 3, 11.5%; *P* = 8, 40%). Question 12, *collaborate with other school staff members*, and question 20, *collaboration to promote social and emotional learning*, specifically addressed collaboration. Participants were in support of "teacher/counselor collaboration" (Participant 3) and believed "Collaboration between the counseling dept and other staff [was] vital to developing systematic approaches to supporting students" (Participant 15). Participant 6 stated that the answer to

question 20 would speak “to the strength and collaborative environment of schools” and added that “we know teacher collaboration has the highest effect size on student learning.” Participant 14 shared their support by saying,

> “The more people we have advocating for and teaming together for students the better and I believe that helping professionals like social workers and counselors have a unique lens and skillset to offer.”

Staff Awareness. The concept that staff were not always aware of systems that were in place in the building was mentioned on multiple occasions throughout the survey (*TC* = 6, 1.6%; *Q* = 4, 15.4%; *P* = 3, 15%). Participant 17 said, “I don't know if our staff would know the answer to this question - a lot of these conversations happen in meetings they aren't aware of,” and “This happens at care team - most our staff doesn't know about the details of it.” In response to question 14, *establish referral system*, Participant 12 said,

> “A lot of what goes on behind the scenes with our care coordination team is not well known to teachers but the first part of this question would really reveal if the system of linking students to supports is well known an accessible to the larger team.”

Student Belonging. The concept of *student belonging* was mentioned on multiple occasions throughout the survey (*TC* = 4, 1%; *Q* = 3, 11.5%; *P* = 3, 15%). Participant 15 stated that “belonging [was] vital to students coming to and engaging in school.” In reference to question 9, *professional development in classroom management techniques*, Participant 12 said,

> “Creating a safe environment in the classroom is going to have a big impact on how these concepts are going to be approached. I would love to see it read ‘have all teachers of health education received PD in building a classroom culture of safety and belonging?’”

Phase 3 – District-Level Focus Group

At the start of the focus group I asked participants several questions. Here are their responses.

Reflecting on the Presentation

To kick off the focus group, I asked participants to reflect on the presentation they watched prior to completing the survey. A couple participants felt like the data "painted a picture" for them and said, "what a narrative this tells us" (Participant 12). Participant 6 shared that the "visual impact of the classroom of 28 really made [the] data meaningful to [them] as a teacher." Other participants mentioned specific data points that stood out to them, such as "school is the place most students hear about mental health" (Participant 19) and how "seeing [the] data for sixth grade brought it home to elementary" (Participant 8). Participant 9 thought the "referrals by care coordinators [was] higher than what [they] imagined" but they were not "surprised by the number of suicide screenings by grade level and that it would be higher in [secondary]." Participant 5 found the "contrast" between where kids are at on the Oregon SHS versus what they knew about MHL interesting. They went on to say, "They're experiencing it at this rate, but they have less knowledge about it than we would like them to have." Participant 3 was curious and wanted to know more about the curriculum data. Finally, in regards to the Mental Health Literacy Survey, Participant 11 wondered "where is my work [in this]?" and what about "mental health literacy in the family units."

Current State of SEL, MHL, and Health Education in the District

Next, I asked participants to tell me about their thoughts regarding the current state of SEL, MHL, and health education in the district. Presently, at the district office there are three departments that span this work (Participant 8). In regards to health education, Participant 3

stated that the district's "ability to deliver high-quality health education is severely limited by the curricula available. It does not feel like curriculum options have kept up with best practices in health education." In the context of mental health literacy, Participant 12 stated, "we have tended to outsource this material to counseling instruction" and high school health education, "but I don't know that there's anything explicit happening around building [in] the literacy piece. It shows up a bit in our suicide prevention work." They went on to say that it "has lived in the counseling realm and it is time to fold it into our core classroom instruction." However, Participant 16 shared that "there's been some resistance and pushback from educational practitioners in classrooms" who "just wanna stay in [their] lane." There is a lack of "teacher confidence and capacity to engage with this content with students" (Participant 12). Participant 6 was "encouraged by the increased discourse around mental health education and suicide prevention" and at the same time they wonder

> "how we can create systems that prepare educators to see themselves as mental health educators in addition to the core content. Similar to the way we are helping teachers understand that they are teachers of language they are also teachers of SEL and Mental Health."

Additionally, Participant 15 mentioned that there is a lack of modeling and leadership in this area. If building administrators are not willing to model this work, how are staff going to buy-in? Another way of gaining buy-in may be to do "more work on integrating MHL and SEL into academic/content work" (Participant 7).

Opportunities and Challenges of Alignment

Then I asked participants to share what they felt were opportunities and challenges of aligning this work. Many opportunities also presented challenges, as will become evident through the participant comments. For example, Participant 9 stated,

> "an obvious opportunity in our district is that we have positions that are very specific to each of these pieces. I mean, that is also a challenge, because I think there's just so much work to be done and there's only one person for each of these positions."

Participant 8 suggested that these three positions "can collaborate and present [their work] to buildings." Participant 5 added that "these roles tend to be 'islands' operating separately when we could probably get farther if we worked together to be more comprehensive." Participant 11 felt that "as a district we are in a good place to align these systems. I think it would be good to have a larger district conversation on how these systems intersect." Participant 8 allowed herself to dream a little and said,

> "It would be amazing to have some sort of a symposium where all 3 departments and all 3 pieces could be in one place for teachers to take advantage of and to see that collaboration, and how it weaves together, and how one curriculum can fold into another, and really give them that language and that confidence to be presenting this in classrooms."

Participant 6 brought future outcomes into the conversation by saying,

> "We know that if students are mentally in crisis they are unable to learn, therefore if we can proactively teach mental health and Social Emotional Learning we can increase academic success as well."

Aligning the work also has the added benefit of allowing "students to see that mental health and SEL aren't just another subject area taught at specific times" (Participant 19).

Some of the specific challenges mentioned included "limited staffing resources, time for collaboration and planning, and professional development" (Participant 12). Other challenges include "not duplicating efforts" (Participant 5), "parent understanding and support is all over [the place]" (Participant 9), and the "understanding of interdisciplinary roles and how to leverage these differences [to better] serve students" (Participant 12). A couple participants mentioned challenges related to teacher "beliefs about how this work should unfold in classrooms," (Participant 16) and

> "educators [who] are unsure or inadequately prepared to be leaders in mental health or social emotional learning as they are in crisis [or] they may never have learned this themselves." (Participant 6)

What Does Alignment Look Like?

To provide additional clarity, I asked participants to describe what they felt alignment looked like. I let them know they could offer practical or innovative ideas. Participants made comments such as a "common language" and improved "pre-service education" (Participant 16); "vertical alignment" and "groups and committees working together" (Participant 19); "having a scope and sequence" (Participant 8); "a clear way of onboarding administrators and new counselors" (Participant 15); and everyone being on "the same team," as well as "clear universal supports [and] supportive interventions" (Participant 3). Participant 6 associated alignment with a teacher's identity saying,

> "I feel like educators having a clear goal of what we're trying to [do], and knowing where [these] resources would come together so they can braid [them together], and maybe taking that ownership that they are educators of social emotional learning and mental health, just like we've been working with our teachers to understand that they need to be educators of language to support multilingual learners, [and] that we are educators of mental health and social emotional learning [too]. And that is part of [their] identity. Yes, there [are] experts [they] can go [to for] support, but that [they] have that ownership and identity [themselves]."

Participant 16 compared education to the medical field when they talked about seeing a primary doctor or general practitioner versus receiving a referral to a medical specialist. The general practitioner should have a "universal functioning knowledge to facilitate discussions" just as the specialist does, but the difference lies in the general practitioner recognizing when their knowledge of a particular area has come to an end and it's time to make a referral to a specialist. The same is true for classroom teachers as general practitioners. The group was also reminded by Participant 15 that "we have to be careful that SEL is not synonymous with mental health […]

Not every teacher needs to be a counselor or a mental health specialist." Participant 12 responded to the conversation by saying there is a "difference between awareness/literacy, identifying needs, and treatment/support for these needs" referring to "awareness/literacy" as appropriate for classroom teachers and "treatment/support" as something more appropriate for building specialists, like school counselors. As is clear by these comments, there are various opinions on what alignment would look like.

What's Missing?

Finally, I asked participants to share what topics or questions we have missed that still need to be explored. Participants brought up incorporating "SEL/MHL/Health" into "classroom observations" and teacher evaluations (Participant 5), "staff mental health" (Participant 3), "cultural perspectives around mental health and social emotional learning" (Participant 16), and "identifying areas where the work crosses over and where the work is different from one another" (Participant 12). Several participants talked about "community perspectives" (Participant 9), such as "how parent/caregivers are being included" (Participant 8) and what about various "subgroups: ethnicity, socioeconomic status" (Participant 13). Lastly, Participant 12 wondered about "missing [the] crossover with special education and relevant components of differentiation and adaptations with this work/content."

Breakout Group Discussions

Each theme will be accompanied by frequency counts for the total number of comments related to the theme ($n = TC$), the number of questions in which the theme appeared ($n = Q$), and the number of participants who referred to the theme ($n = P$). The total number of comments analyzed from the breakout sessions was 199. I collected 71 comments from group one, 77 from group two, and 51 from group three. The total number of questions was 26, and the total number

of participants was 14. Group one and two had four participants each, and group three had five. Excerpts are included as they were written by participants and may include typing errors. Excerpts with brackets were modified for clarity. The groups did not have adequate time to discuss questions 10, 24, 25, and 26. Each group worked diligently to wordsmith questions and provide clarity. They discussed the many layers of each question and the potential challenges. The adapted questions suggested by each group are provided at the end of this section in table 12. The most common themes are listed here in the order of most frequent comments.

Words Matter. The meaning we derive from words influences our actions. In the case of survey development, using one word over another can elicit very different responses. It is important to be as clear as possible to limit misinterpretation and to highlight district priorities. Here I have provided examples of when participants discussed how a different word was more meaningful and purposeful, as well as when they suggested a word should be defined to promote greater clarity. The combined total comment count for this section was 46.

Word Choice. Participants frequently made comments related to *word choice*, such as suggesting to use one word over another (*TC* = 27, 13.5%; *Q* = 9, 34.6%; *P* = 9, 64.3%). Multiple word swaps and comparisons were discussed, but not always incorporated into the final question or were left on the table for future consideration, such as “instruction” versus “materials” (Participant 3), “recommendation” versus “guidance” (Participant 3), “encourage” versus “provide” (Participant 19), “assignments or projects during class time” vs “provide opportunities” (Participant 19), “promoting” versus “treatment” (Participant 6), “appropriate school or community based supports” versus “counseling supports” (Participant 9), and “strategic” versus “universal support” (Participant 12). Participant 5 struggled with the word ”treatment” in question 11, *health and safety promotion and treatment,* and “tracking” in

question 13, *identify and track students with emotional, behavioral, and mental health needs*. They suggested using "access" instead of "treatment," and "documentation" instead of "tracking."

Participant 9 pointed out that "schoolwide health promotion and prevention is very different from one-on-one counseling sessions" and Participant 1 pointed out that "access" and "implement" are different. Participant 6 drew attention to the use of appreciation in the context of diversity, saying, "it's like appreciation, not necessarily the inclusion of diversity, we appreciate you, now, here's how you need to act here, it's kind of worrisome for me." There was also a discussion about the pros and cons of keeping or removing the word *psychosocial* in question 17, *positive school climate* (Participant 9). Participant 16 reminded the group that it's important to call out the unique contributions of different concepts, because "trauma [being used] interchangeably with SEL" is problematic.

Definitions. Participants frequently made comments related to needing to *define* words (*TC* = 19, 9.5%; *Q* = 9, 34.6%; *P* = 7, 50%). Participants recommended defining "age appropriate, adequate, sequential, [and] consistent" (Participant 3), "a system for identifying" student needs and "access" (Participant 6), "appropriate supports" (Participant 5), "psychosocial" (Participant 5), "life transitions" (Participant 9), and "all students" (Participant 11). Participant 9 wanted more clarity on "who are the staff members we're talking about that should be collaborating with counseling or social services, like who are those people in the school building?"

Access and Treatment. Participants frequently made comments related to *access* and *treatment*. I will start by discussing *access* as it related to question 6, *assignments encourage student interaction with family and community*, and question 21, *school-wide social and*

emotional learning. Then I will end with discussing question 11, *health and safety promotion and treatment,* as it has connections to both *access* and *treatment.* The combined total comment count is 34.

Access. The concept of *access* was mentioned on numerous occasions (*TC* = 25, 12.5%; *Q* = 3, 11,5%; *P* = 10, 71.4%). The primary conversation around question 6 involved the health education skill of "accessing information" and how there may be barriers for some students in accessing information at home or in the community. Participant 15 said, "We can't control what kids have available to them outside of the building." In regards to "students experiencing houselessness," Participant 3 said,

> "that's part of what we're wanting to encourage is connecting [students] with resources. So those could be McKinney-Vento resources, like that would be making connections with trusted adults and community organizations."

The primary conversation around question 21 involved *universal access* and *access* versus *implementation*. Universal access was defined as "every student in the school has access to the material, whether it is modified in a small group [or in] whole class instruction" (Participant 12). This was brought up because "we could be implementing programming that students don't have access to" (Participant 12). The primary conversation around question 11 involved *access* versus *treatment*. Ultimately, the group decided to focus on access, rather than treatment. Participant 9 asked, "Can we assume that the student and family is together, like, if you're providing access to something for the student that the family is automatically included?" Access also opens opportunities for families, while "treatment is student specific" (Participant 18). Participant 5 reminded their group why access is important by saying, "Schools are some of the only ways that students or families would make [a] connection [to support] or get [connected] whether it's in the building or outside of the building."

Treatment. The concept of *treatment* was mentioned on multiple occasions throughout the focus group (*TC* = 9, 4.5%; *Q* = 1, 3.8%; *P* = 4, 28.5%). Participants generally felt that access was a better concept than treatment. Participant 5 said, "I do get hung up on the word treatment, so I'm wondering, like you just used the word access." Some of the concern was around what was considered treatment in the school setting. Were "small group counseling sessions" considered treatment (Participant 9)? Participant 6 added,

> "I don't know whether the school necessarily needs to be providing treatment. We should refer to people to provide the treatment. It's more of that promoting the emotional [aspect] for students and families [that we need to focus on]."

Multi-Tiered System of Support. Participants frequently made comments related to the *MTSS* model (*TC* = 31, 15.5%; *Q* = 8, 30.8%; *P* = 8, 57.1%). The participants were encouraged to focus their energy on developing questions that would be appropriate for tier one of the *MTSS* model, support that is delivered using a universal approach and is provided to the whole student body. It is designed to be proactive and preventative. The concept of health promotion fits well at tier one. The MTSS theme addresses concepts related to universal structures (tier one), proactive and preventative activities, health promotion school-wide, and systems in general. Participant 12 introduced the concept of universal access by saying,

> "If we've extended programming into universal instruction compared to where this programming [SEL and mental health] tends to live right now, which is that all kids don't get instruction in this area. You get it if you go to the counseling center. You get it if you're in a small group. But you don't get it if you're just going to class or haven't been identified for having emerging needs [whereas the term universal access] means that every student in the school has access to that material, whether it is modified in a small group or whole class instruction."

Other comments related to universal structures were concerns about some questions leading to tier two or three supports, such as "if we're identifying and tracking, then it no longer becomes a

universal" (Participant 9). Another example included moving the focus away from counselors to school staff members, because they "felt that helped communicate this is a universal or building expectation" (Participant 5). It was also mentioned that "providing access" was more in a "proactive preventive category" whereas "treatment" seemed to fit in a different category (Participant 5). They were referring to tier one versus tier two or three. Participant 9 commented that "schoolwide health promotion and prevention is very different from one on one counseling sessions," again referring to tier one versus tier two or three.

The remaining comments discuss systems more generally. For example, Participant 6 wondered if systems that are appropriate for reading are also appropriate for mental health and "what systems there [were] for getting help in multiple ways rather than just asking for it." They also said,

> "When I was reading [question 16] I was wondering even if we know that there's been a suicide or a death in school, and we have the flight team come in, is that linking people appropriately to supports? Would that count as having a system? And in some ways is that referring and linking [to supports]? I think we really need to define what that would be, the system for identifying, as well as what it means to find the appropriate supports."

Participant 9 summarized their group's discussion by saying,

> "We also talked a lot about systems. [We] talked about how we might want to word questions. Like systems for referring versus systems for providing "treatment." A lot of the questions were good, it's just they're kind of like are systems in place? Something to note that if I am filling this out and there's nothing I could do as far as putting these systems in place, is that more of like an [administrative] type of question."

Roles and Responsibility. Participants frequently made comments related to *roles* and *responsibility*. They are combined under one theme, as there is overlap between the two subthemes. The combined total comment count was 27. Participant 3 provided a summary of a discussion by group 1 when they said,

> "We spent a fair amount of time differentiating what was like an instructor's role versus what was the role of the curriculum and where we wanted to put responsibility for having certain pieces met."

Participant 5 added to the theme when they said,

> "that's not stuff that is the sole responsibility of those roles [i.e., counselors]. They might have a component in it. [But] the comments really speak to the nervousness of [it]. It places a lot of pressure on those roles to do all those pieces."

Responsibility. The concept of *responsibility* was mentioned frequently throughout the focus group (*TC* = 14, 7%; *Q* = 8, 30.8%; *P* = 5, 35.7%). Participants wanted to know "whose job is it in the end" (Participant 9) and "where are we gonna put the responsibility [to make the content engaging]" (Participant 3). Participant 16 said, "teachers become responsible for everything;" therefore, "unless we're doing things at the district level and providing those collaborative spaces" some things may not be possible. There was also reference to some of the questions being more appropriate for administrators (Participant 5).

District Roles. The concept of *roles* was mentioned frequently throughout the focus group (*TC* = 13, 6.5%; *Q* = 4, 15.4%; *P* = 5, 35.7%). A couple participants wanted the questions to "represent a little bit more about what our players look like in [our district]" (Participant 12) and "reflect [our district] staffing" (Participant 6). It was suggested to include "student success coach [and] a wellness program coordinator" even though "not all schools have all the things" (Participant 5). Participant 16 reminded others that some roles "function in so many different capacities based on the site [administrator]."

Identify, Track, and Refer. Participants frequently made comments related to the concepts of *identifying, tracking, and referring* students (*TC* = 22, 11%, *Q* = 6, 23%, *P* = 6,

42.9%). There was a decent amount of overlapping conversation around these concepts; therefore, I combined them into one theme. The questions most relevant to this theme include question 13, *identify and track students with emotional, behavioral, and mental health needs*, question 14, *establish referral system*, and question 16, *identify and refer students involved in violence*. As previously mentioned, it was recommended that a "system for identifying" be defined (Participant 9) and that replacing "tracking" with "documentation" might be a better choice in regards to "we're making sure we didn't lose sight of this, that this kid didn't fall into cracks" (Participant 5). Participant 12 pointed out that often students don't receive instruction in this area if they are "just going to class." First, they need to be "identified [as] having emerging needs" and is this what we want to be doing? Participant 6 made a connection between reading literacy and how "we do records that are tracking our kids' data. So do we have some system to be tracking our mental health in anyway." They went on to say,

> "How do we know when they need to move past the universal? Is it only when it's an emergent need or only when they get super far behind or do we have some stuff to notice when they're falling off the track to be able to bring them back in?"

As far as referring students, Participant 9 felt it was important for staff to "know when to refer" and to whom students should be referred.

Programming. According to the Merriam-Webster online dictionary (2023), a program is defined as "a plan or system under which action may be taken toward a goal." A program in the educational setting includes instruction, materials, curriculum, and implementation. In this section I will share results about *instruction versus materials* and *SEL programming*, with a combined total comment count of 21.

Instruction vs. Materials. The concept of *instruction versus materials* was mentioned on multiple occasions throughout one of the focus groups (*TC* = 10, 5%; *Q* = 5, 19.2%; *P* = 4,

28.6%). This theme was discussed solely by group one as they worked through the health education questions in questions 1 through 5. Group one decided to have question 1, *health education taught in all grades,* focus on instruction and question 2, *sequential health education curriculum consistent with standards,* focus on materials. Participant 15 explained by saying, "I wanna be sure that we're creating questions that allow us to evaluate the curriculum. We have ways of evaluating teaching practices" and "Are we using this to evaluate our health curriculum or are we using this to evaluate the teaching instruction?"

SEL Programming. The concept of *SEL programming* was mentioned on multiple occasions throughout a different focus group (*TC* = 11, 5.5%; *Q* = 2, 7.7%; *P* = 4, 28.5%). This theme was discussed solely by group three as they worked on question 21, *school-wide social and emotional learning*. All but one comment was connected to question 21 and it was a reference to "CASEL competencies" in question 23 (Participant 13). Participant 12 wanted to know "how robust the system or programming is" and Participant 1 wanted to know "How, when, which program, and to what extent is the program being utilized?" Participant 16 brought up a couple points to consider around *SEL programming*, such as what about parents who say "my kid doesn't need that SEL" or teachers who say "I do that, [but] I don't call it SEL." They go on to ask, "So are we talking about the intentionality of the work under this larger program initiative?"

Health Education. Participants frequently made comments related to *health education* (*TC* = 20, 10%; *Q* = 7, 26.9%; *P* = 3, 21.4%). Group one had all of the *health education* questions. A variety of topics were discussed, such as writing questions in a way that leaves the task of teaching health open and inclusive to whomever may be teaching it (Participant 19). The PE teacher, math teacher, or counselor may be teaching components of health, so they suggested

focusing on whether students are receiving the content rather than pinpointing who would be teaching the content. Quality health curriculum was discussed as needing to be "age appropriate, adequate, sequential, consistent" and "culturally appropriate" (Participant 3). Participant 3 offered context to the word "adequate" by saying,

> "adequate is really getting to the quantity. Oftentimes in health education we put up a poster, so we're good [laughter]. So getting at this adequate amount of time, I feel like when we're coming up with our sequence that we're also making sure that it's a chunk of content, not just a brief mention."

It was also mentioned that "a lot of the curriculum doesn't come skills based. So we need to make it skills based. Then it gets down to where we place that responsibility" (Participant 3). Is this a teacher or district responsibility? Participant 3 suggested that it is a little of both. The group discussed the tension between the need to connect with family and community members in order to effectively practice skills and "prepare [students] to be community members" (Participant 3), and the reality that "not all students have the same access" (Participant 15). Finally, the group discussed the unique place health education holds in the academic context. Participant 3 states,

> "health is scrutinized differently than other content. I think that in other content areas we expect teachers to take something that maybe is kind of dry or boring and make it bigger and fancier and more engaging. But there's some nervousness around [health education]. There [are] oftentimes expectations that teachers stick to the script or stick to the curriculum."

Professional Development. Participants frequently made comments related to *professional development,* also referred to as PD (*TC* = 20, 10%; *Q* = 5, 19.2%; *P* = 7, 50%). *Professional development* was mentioned in question 7 about *health education*, question 8 about *delivering curriculum*, question 9 about *classroom management techniques*, and question 19 about *meeting diverse needs of students*. In regards to question 7, Participant 3 said,

> "I'm so excited by the thought of this question, like we get a lot of health teachers who often times get a lot of PD in education in general, but very little is specific to health education."

There was some conversation around the purpose of *professional development*. Question 7 was considered general health education professional development and question 8 was considered professional development on the adopted health education curriculum (Participant 19). Participant 13 shared some questions that are important to consider when preparing *professional development*:

> "What is the purpose of the training? Is it to inform us? Is it for us to be able to work with kids? Is it to provide services? Why do I have to learn this information if there's no next step?"

Participant 12 was curious what the "floor" or minimum *professional development* would be "for training teachers in the diverse needs of students." Other topics of discussion included types of *professional development*, such as "maybe instead of PD, it should have been more of modeling or an experience. Educator training can look really different," (Participant 16) or "our PDs aren't always full on implementation PDs. [It can be] continuous growth and learning the changes and what's coming up type of PD" (Participant 19). Frequency was also a concern, as illustrated by Participant 3 who said, "with all of the things we ask of elementary teachers, like to also make sure that once a year they're getting health education. It's asking a lot."

Culturally Responsive and Inclusive. Participants frequently made comments related to *culturally responsive and inclusive* (*TC* = 15, 7.5%; *Q* = 4, 15.4%; *P* = 10, 71.4%). Question 5, *culturally appropriate activities and examples*, specifically addresses this theme. In relation to health education, Participant 15 asked two questions: "Is the curriculum culturally responsive?" and "Is the teacher presenting it [in a] culturally responsive [way]?" Participant 3 responded, "I don't know that we can make a blanket statement across our entire district that the health

curriculum we select would be culturally appropriate for our entire student body." Ultimately, group 2 replaced "culturally appropriate" with "culturally responsive," focusing on curriculum, and decided to keep it as separate question to prioritize its importance and not "water it down" (Participant 8) with all of the other health education qualifiers. Question 17, *positive school climate,* was also modified to include *culturally responsive and inclusive.* Participant 6 shared their worry about one of the bullets in question 17 saying they needed to "make sure that there [was] some cultural awareness in the expectations," because it talked about the appreciation of diversity, but "not necessarily the inclusion of diversity." Participant 12 suggested that question 19, *professional development on meeting diverse needs of students*, was "inherently a cultural competency question" due to the fact that it's addressing the "diverse cognitive needs, emotional needs and social needs" of students. Participant 11 added that cultural responsiveness was one of their "core values [and that] we need more cultural responsive professional development."

Collaboration. The concept of *collaboration* was mentioned on multiple occasions throughout the focus group (*TC* = 11, 5.5%, *Q* = 2, 7.7%, *P* = 3, 21.4%). Collaboration was addressed in question 12, *collaborate with other school staff members*, and question 20, *collaboration to promote social and emotional learning*. Group 2 discussed question 12 and their primary discussion was about switching the focus from do specialists collaborate with school staff members to "[do] school staff members collaborate with specialists" (Participant 9). Group 3 discussed question 20 and they discussed a variety of topics, such as "what [does] collaboration look like at schools" and the "lack of collaboration opportunities" (Participant 12). For example,

> "A lot of the times it is care teams that are meeting (i.e., these counseling and psychological services) and teachers doing their thing in the classroom without a lot of connection" (Participant 12).

Participant 16 shared some of the challenges to collaboration, including:

> "The timing, the scheduling and then just the priorities of the site admin. Their dedication to this work, to creating space. What does this collaboration look like if the admin is not on board."

However, collaboration also "honors the work [and] dignifies the work," as well as protects teachers from becoming "responsible for everything" (Participant 16). Collaboration can bring awareness to a classroom teacher by

> "understanding how [their] practices can misalign with supports that are in place for our babies and those supports are in place after collaborations with trained mental [health] practitioners. [Teachers can ask themselves:] How could I go and erode, exacerbate, [or] trigger? How can I create counter spaces? And then who are my partners in this work? And how do I access those partnerships as opposed to [I am] responsible for this."

Implementation. The concept of *implementation* was mentioned on multiple occasions throughout the focus group (*TC* = 10, 5%; *Q* = 3, 11.5%; *P* = 4, 28.5%). The conversation around question 7, *professional development in health education,* and question 8, *professional development in delivering curriculum,* was about *implementation*. Sometimes there is professional development at the start of *implementation,* particularly when there has been a curriculum adoption, but this isn't always the case (Participant 3). The remaining comments were connected to question 21, *school-wide social and emotional learning*. Participant 1 suggested that the terms "access" and "implement" have different meanings when applied to curriculum. They went on to say, "Yeah, [students] have access to [SEL], [but] are [teachers] using it, no" (Participant 1). Participant 16 said, "We have a pathway for access. We have permission to do the work. There is no accountability that's honestly holding folks accountable for doing it, for implementing it." They went on to say,

> "And the reality is that our district has an expectation or has provided time allocation whether it's morning meeting or advisory for some of this very specific SEL work to playout. But the accountability of whether or not it is truly being implemented, thats

> where it gets a little fuzzy and hairy, because we still have a large system where folks can opt in to do it. And we still have some spaces where they're resistant. That's where that "all" factor for "all kids" really becomes very difficult to qualify or quantify. Because we would like to presume that it is playing out everywhere. When we don't have an accountability measure, even the data, to say people are really doing this with fidelity."

Teacher Evaluation. The concept of *teacher evaluation* was mentioned on multiple occasions in one focus group (*TC* = 8, 4%; *Q* = 4, 15.4%; *P* = 2, 14.3%). Group one was the only group that discussed teacher evaluation, and it was addressed in question 3, *active learning strategies*, question 4, *opportunities to practice skills*, question 5, *culturally appropriate activities and examples*, and question 9, *professional development in classroom management techniques*. In response to question 4, Participant 15 said,

> "Are we using this to evaluate our health curriculum or are we using this to evaluate the teaching instruction? I wanna be sure that we're creating questions that allow us to evaluate the curriculum. We [already] have ways of evaluating teaching practices."

Participant 3 summarized some of the discussion in group 1 by saying, "[we focused] on the materials [question 5] because we felt like being a culturally responsive teacher was something that should be covered in our teacher evaluation."

Accountability. The concept of *accountability* was mentioned on multiple occasions throughout the focus group (*TC* = 7, 3.5%; *Q* = 3, 11.5%; *P* = 4, 28.6%), particularly in relation to question 21, *school-wide social and emotional learning*. Comments consisted of phrases like "this doesn't hold me accountable" (Participant 11), "absence of accountability" (Participant 16), "accountability marker" (Participant 12), and "are teachers actually doing what the curriculum tells them to" (Participant 19). Participant 13 wondered,

> "does [the survey] audience provide some of that accountability though their answer to this? This isn't one person going to one school and assessing it. It's sort of the surveying

> of lots of players that are involved in this work and maybe that would be the accountability piece."

Participant 16 was interested in accountability in the sense of how the final SHI and its data would be used by the district: "any data tool could be both the object, and the means to the end; the end, and the means to the end." I asked Participant 16 to expand on their comment in an unrecorded conversation. They explained that after we finish constructing the SHI it can be used simply as a tool that provides data (the end), has the risk of being "manipulated and exploited," or it can be used to "push the discourse" (the means). Ultimately, "is it the end AND the means" (Participant 16). How do we not stop at just data collection, but continue to seek "qualitative data, which can be inconvenient," and follow the path of "implementation science?" (Participant 16).

Ease of Task. The idea that the task participants were given was easy or difficult was mentioned on multiple occasions throughout the focus group (*TC* = 6, 3%, *Q* = 4, 15.4%, *P* = 5, 35.7%). There was a general sentiment that the task they were given was challenging. Though explicit comments were minimal, the sense of urgency to get through all the questions and the multiple components addressed for most questions demonstrate a level of challenge. Participant 5 stated, "My brain hurt after going through all of them" and Participant 12 stated, "I thought this was going to be the easy one[..]. This is really hard."

Mental Health and Trauma. *Mental health* and *trauma* were mentioned a handful of times (*TC* = 6, 23%; *Q* = 5, 19.2%; *P* = 3, 21.4%). Participant 12 stated,

> "mental health lives right now lives in the counseling center. It lives in small groups. It lives in intervention for safety needs. It lives with behavior. It doesn't live inherently in the content that we go over with the whole group. Do we talk about social and emotional and mental health in more spaces than the counseling center?"

In response to question 19, *professional development on meeting diverse needs of students,* Participant 16 said,

> "Is it from a [classroom] space? Is it from a mental health space? And I'm always leery of conflating/deflating or merging them. We've all heard trauma used interchangeably with SEL. Like if you're doing one, you're doing the other."

I asked Participant 16 to expand on their comment in an unrecorded conversation. They explained that the classroom space includes the physical space and the mental health space is the inner (i.e., mental) landscape of the classroom with some physical components. They said,

> "Can students and teachers recognize needs? Do they know how to access supports? Is the space safe? does it protect and foster the mental health of students and staff? The [classroom] space should be overwhelmingly a mental health space. [However, it is important that they are distinct] in order to call them out and be intentional. How does the classroom community create a classroom system that honors the mental health space?"

They talked about teachers being mental health supporters and promoters in a universal space, which is distinctly different from being a mental health specialist. In response to their comment about trauma being used interchangeably with SEL, they explained that SEL can support trauma informed care and trauma informed care has SEL components, but they are not the same and it's important to honor this distinction in each of them. For instance, Participant 16 shared that many educators believe that all students are traumatized, such as the universality of racialized trauma, but this isn't the case. Though trauma informed practices are beneficial for all students, this does not mean that all students have trauma. Participant emphasized that this distinction is important. We need to honor personal narrative and personal experiences and recognize individual needs. No doctor prescribes the same medicine for all their patients. Participant 16 also mentioned that we need to take special consideration of the mental health and possible trauma of school staff. They may struggle to support students due to their own trauma, so how can the district and schools create psychologically safe or trusting spaces for teachers? (Participant 16).

Suicide. Suicide was mentioned in two comments (*TC* = 2, 1%; *Q* = 2, 7.7%; *P* = 2, 14.3%). Participant 9 stated that question 15 was a "good proactive measure, especially as the whole point of this is to reduce suicide." Participant 6 mentioned suicide in an anecdote about the idea of the flight team responding to a student suicide as an example of "linking people to appropriate supports."

Adapted School Health Index

Table 11 displays the adaptations to the SHI questions proposed by each group. It was recommended that some of the questions be kept as is, some should be discarded, and others needed further discussion. There wasn't enough time to discuss all of the questions.

Table 11

School Health Index Adapted Questions or Actions

SHI Questions	Adapted Questions or Actions
1. Do students receive health education instruction in all grades?	1. Do students receive health education instruction at each grade level?
2. Do all teachers of health education use age-appropriate health education curriculum materials that are sequential and consistent with state or national standards for health education and the district's requirements for health education?	2. Are the materials used for health education age-appropriate, adequate, sequential, and consistent with state, national, and district standards/guidance?
3. Do all teachers of health education use active learning strategies and activities that students find engaging and make learning relevant to their daily lives?	3. Discard
4. Do all teachers of health education provide opportunities for students to practice or rehearse the skills needed to maintain and improve their health?	4a. Are the materials used for health education skills-based? 4b. Do all teachers of health education provide opportunities for students to practice or rehearse the skills needed to maintain and improve their health?
5. Do all teachers of health education use a variety of culturally-appropriate activities and examples that reflect the community's cultural diversity?	5. Are the materials used for health education culturally responsive?
6. Do all teachers of health education use assignments or projects that encourage students to have interactions with family members and community organizations?	6. Do all teachers of health education provide opportunities for students to make connections with trusted adults and/or community organizations?
7. Do all teachers of health education participate at least once a year in professional development in health education?	7. Do all teachers of health education participate in professional development in health education at least once a year? (ex: Academic Seminar, trainings/workshops/conferences, etc.)
8. Have all teachers of health education received professional development in delivery of the school's health and safety curriculum in the past two years?	8. Do all teachers of health education receive professional development in district-adopted health curriculum prior to implementation?
9. Have all teachers of health education received professional development in classroom management techniques in the past two years?	9. Discard
10. Does your school have access to a full-time counselor, social worker, or psychologist for providing counseling, psychological, and social services? Is an adequate number of these staff members provided based on the following recommended ratios? (A list was provided.)	10. Ran Out of Time

Table 11

School Health Index Adapted Questions or Actions (Continued)

SHI Questions	Adapted Questions or Actions
11. Does the counseling, psychological, or social services provider promote the emotional, behavioral, and mental health of and provide treatment to students and families in the following ways? (A list was provided.)	11. Does the counseling, psychological, or social services provider promote the emotional, behavioral, and mental health of and provide access to students and families in the following ways?
12. Does the counseling, psychological, or social services provider collaborate with other school staff members to promote student health and safety in at least six of the following ways? (A list was provided.)	12. Do staff members collaborate with the counseling, psychological, or social services provider to promote student health and safety in at least six of the following ways?
13. Does the counseling, psychological, or social services provider have a system for identifying and tracking students with emotional, behavioral, and mental health needs?	13. Discard
14. Does your school implement a systematic approach (including the following components) for referring students, as needed, to appropriate school- or community-based counseling, psychological, and social services? (A list was provided.)	14. Keep
15. Does your school aid students during school and life transitions (such as changing schools or changes in family structure) in the following ways? (A list was provided.)	15. Keep
16. Does the counseling, psychological, or social services provider have a system for identifying students who have been involved (as a bystander, victim, perpetrator, or some combination of these) in any type of violence (e.g., child abuse, dating violence, sexual assault, bullying or harassment, fighting, suicide and self-harm behaviors) and, if necessary, refer them to the most appropriate school-based or community-based services?	16. Further Discussion Needed
17. Does your school foster a positive psychosocial school climate using all of the following practices? (A list was provided.)	17. Does your school foster a positive, culturally responsive and inclusive psychosocial school climate using all of the following practices?

Table 11

School Health Index Adapted Questions or Actions (Continued)

SHI Questions	Adapted Questions or Actions
18. Does your school take steps to foster peer relationships among students in each of the following ways?	18. Ran Out of Time
19. Have all teachers received professional development on meeting the diverse cognitive, emotional, and social needs of children and adolescents in the past two years? (A list was provided.)	19. Further Discussion Needed
20. Do teachers at your school collaborate with counseling and psychological services staff to promote social and emotional learning (e.g., providing information to students on developing self-awareness, managing emotions, or maintaining interpersonal relationships; referring students for support services) for students?	20. Further Discussion Needed
21. Does your school implement social and emotional learning programs for all students?	21. Do teachers consistently implement a universally accessible social and emotional learning program?
22. Does your school partner with community organizations to provide students with educational materials and/or resources (e.g., fact sheets on socioemotional well-being, information on community-based counseling services, stress management skill building, depression screenings) to promote social and emotional learning and wellbeing for students in school?	22. Ran Out of Time
23. Has the school established a climate, in each of the following ways that prevents harassment and bullying? (A list was provided.)	23. Further Discussion Needed
24. Do staff members actively supervise students, in each of the following ways, everywhere on campus (e.g., classroom, lunchroom, playground, locker room, hallways, bathroom, and school bus)? (A list was provided.)	24. Ran Out of Time
25. Does your school prioritize efforts to engage all students (i.e., diverse students, including but not limited to racial/ethnic minority youth, LGBTQ youth, youth with disabilities, youth with chronic conditions, homeless youth, etc.) in extracurricular school activities to foster student sense of belonging in the following ways? (A list was provided.)	25. Ran Out of Time
26. Does your school take steps to prevent violence, in each of the following ways? (A list was provided.)	26. Ran Out of Time

CHAPTER V

DISCUSSION

This study was conducted in a three-phase process to explore health education, SEL, and MHL at the elementary school level as an avenue for improving overall health in children and preventing suicide. In phase one, I completed an artifact analysis that consisted of gathering resources relevant to health education, SEL, and MHL, while making note of where these concepts aligned. I utilized the data gathered in phase one to create a presentation that I shared with participants. In phase two, participants watched the presentation and completed the SHI survey. Data from the survey were analyzed and a summary of findings was shared with participants in the final phase. Phase three consisted of a focus group where participants worked to adapt the SHI based on the survey data and their own professional experience. The combined findings from phases one, two, and three provide important insights on how to move forward in this work. In this chapter I will start by answering each of my research questions and presenting a conceptual model. I will then share the limitations of this study and discuss the implications for practice. I will end my manuscript by discussing opportunities for future research and a brief conclusion.

The Presence and Alignment of Health Education, SEL, and MHL

The first research question explored to what extent health education, SEL, and MHL were present and aligned in the PNWSD. What I found as I explored this question is the presence of something is more multidimensional than I had originally anticipated. First, the results clearly demonstrate that health education, SEL, and MHL are present in the sense of available curricula. They also show how the objectives in each curriculum overlap and align to varying degrees with the skills in each skill set. It is important to note that these results do not evaluate or discuss the

quality of any of the curricula. The skill sets show considerable alignment or agreement with one another. Although each skill set has its own unique perspectives and strengths, they complement the other skill sets well. They can easily build off each other and provide depth and nuance where it is needed. The Ontario health and physical education curriculum provides an example of how these skills can work together in harmony within the same curriculum (Ontario Ministry of Education, 2019).

As far as actual implementation, things start to get a little messy. One question that arose from the data regarded whether the materials or curriculum were being implemented with fidelity and intentionality. This was an important factor in the literature on health education and SEL (Durlak et al., 2011; Videto & Dake, 2019; Wood, 2020). The district has given permission and provided pathways for access, but teachers are responsible for implementation. If teachers don't implement the prescribed program, then students cannot access the content. Currently, in the PNWSD, it is difficult to know the level and quality of implementation. According to Videto and Dake (2019), such lack of evidence regarding the quality of health education is not uncommon.

The concept of whether the curricula are truly accessible to all students and what that means were additional questions posed by participants. What is relevant here is that the district may have curriculum, but is it accessible to all students? Access is more than just sitting in front of the material. Is the material and instruction culturally responsive and developmentally relevant? Can students identify with the content? Is it accessible for students with different learning styles and abilities? Is it accessible to advanced learners? Will these students be stretched and challenged by the content? Is the language of instruction accessible? Is it accessible in the sense that we give students ample opportunity to practice the skills? Simply having the space and materials to teach does not make something accessible. Even if the teacher implements

the program as designed, it may not be accessible to all students. There will always be barriers to access as far as capacity, time, resources, funding, collaboration, and training, but it is vital educational institutions work towards breaking down these barriers. The concept of accessible materials and instruction are not explicitly addressed in the research I have presented here; however, an MTSS model provides a framework for providing universal access (Robinson et al., 2018).

The data presented a question about whether teachers felt prepared to teach health education, SEL, and MHL skills and concepts in the classroom. We know from the Health Education Adoption Survey that roughly one third of teachers do not feel prepared to teach concepts related to mental health, and this supports the research (Iizuka et al., 2015). Participants felt that collaboration and professional development may help school staff in a variety of roles to support the needs of students. At the very least, teachers need to have a "universal functioning knowledge to facilitate discussions" around these topics (Participant 16).

The last question I will address here focuses on student outcomes. The presence of health education, SEL, and MHL may exist, there may be curriculum, there may be solid implementation, it may be accessible to students in a variety of ways, and teachers may feel prepared to teach these concepts, but is it making an impact on students? According to the student data presented in this study, students are clearly struggling with their mental health. On a hopeful note, Participant 6 suggests that if schools proactively teach these skills, then students will not only be healthier, but will also succeed academically, which is supported by research (Durlak et al., 2011).

Educator Perceptions of Opportunities and Challenges

The second research question explored educator perceptions of the challenges, opportunities, and potential alignment of health education, SEL, and MHL. Prior to joining the study it was clear to participants that elementary school students were struggling with their mental health and staff were scrambling to meet the need. However, the data were presented in a way that helped them reflect on the current reality and think critically about the relationship between MHL and self-reported mental health. Once a baseline was established, participants shared numerous challenges that also offered glimpses of opportunity.

There was a clear tension around who is responsible for mental health in the school setting. According to the WSCC framework, mental health is primarily the responsibility of school counselors, school psychologists, and school social workers (CDC, 2021a). However, ASCA guidance recommends school counselors provide a range of supports (ASCA, 2019). Elementary school counselors wear a lot of hats, as do elementary school teachers. What came to mind for me as I was looking at the data was an analogy involving a deck of cards. In one case, the classroom teacher holds an entire deck of cards fanned out in their hands. The individual cards represent student needs. It's a lot of cards to manage. Some of the cards are hidden behind other cards, and some cards may get dropped. It's overwhelming and stressful at times. On the other hand, school support staff, such as a school counselor, have multiple decks of cards in front of them. At any given moment, they pull a number of cards from each deck. Managing all these cards and making sure they don't get lost in the mix can feel like a big task. None of these educators have more or less to manage; it's just different.

There appears to be a fundamental misunderstanding of teacher and counselor roles in the MTSS model in regards to mental health. As referenced by Hymel (2017) and Participant 16,

teachers are clearly not trained to be mental health specialists, nor is it necessary or appropriate, but they can learn to be mental health promoters and supporters. Everyone has a role to play. No one can do all the pieces, nor should they. Collaboration and partnerships are essential for this work to be effective. Regarding school counselors, there appears to be some confusion. They are considered mental health specialists by many educators, and they do have training in the field of counseling, but the mental health field as a whole is vast, with many disciplines. To assume that the school counselor is a mental health expert might be an overstatement. Depending on the school counselor's training and compared to other disciplines in the building that might actually be true, but in a broad scope, it cannot be said that all school counselors are mental health experts. The professional standards and competencies provided by ASCA (2019) do not support school counselors as mental health experts, but they do provide guidance for school counselors as part of an MTSS model that supports student "mental, social/emotional and physical well-being" in a variety of capacities.

The truth is that the mental health and wellness of students is the responsibility of all staff, regardless of role. Each person has a different role to play that is equally valuable. It is not reasonable or appropriate for every adult to be responsible for all three tiers of mental health, but it is essential that everyone is aware of the system and knows where they fit into the system. According to Robinson et al. (2018) and the National Center for School Mental Health (NCSMH, 2020), mental health promotion and suicide prevention are best situated in an MTSS model, and the only way for this approach to work is if all educators come together and play to their strengths.

Collaboration was a significant theme in the data. There was a strong consensus that teachers and support staff need time to collaborate to better serve students. Participant 12 pointed

out that we need better "understanding of interdisciplinary roles and how to leverage these differences [to better] serve students." Without this collaboration, teachers are often left in the dark about the systems and supports that are in the works for their students. It was mentioned that the SHI needs to reflect the roles in the PNWSD, including care coordinators, student success coaches, wellness instructors, and behavior specialists. Those and many more all have a role to play. Collaboration is foundational to the WSCC framework (ASCD & CDC, 2014; Lewallen et al., 2015).

One of the many components of an MTSS model and critical to suicide prevention, are educators who are able to identify and refer students who need support (Hymel, 2017; Stone et al., 2017; Wyman et al., 2010). Participants discussed in length the concepts of identification, tracking, and referring students. They had some questions about the systems for identification, but primarily they felt that the concept of tracking had a lot of negative baggage in education (Participant 2), and it seemed to come from a deficit perspective (Participant 3). Tracking was not mentioned in the literature as something necessary for suicide prevention.

Solutions to Meet the Mental Health Needs of Elementary School Children

The final research question explored the solutions educators provided to meet the mental health needs of elementary school children. Throughout this study, participants frequently grappled with word choice. This wasn't something I had considered as a possible solution to meet the mental health needs of students, but it makes perfect sense and it is the reason I'm including it in this section. Words have power. They convey meaning and intent. They can make a concept more or less equitable. They can also stigmatize or destigmatize, an important component of MHL and suicide prevention in general (Kutcher et al., 2016a; Townsend et al., 2017). Something worth considering is the difference and implications of using a phrase, such as

emotional, behavioral, and mental health, as stated in the SHI, versus social emotional, mental, and physical health, as suggested by Participant 2. The way something is phrased creates a mental image about where that concept lives and what field or discipline is more responsible for that work. It is also important to think about the context in which the phrase is being used. Using the term behavior in a mental health setting has different implications than using it in an educational setting where student discipline is a factor. I do not have the answer, but I think this topic is something that needs to be considered.

Access was another theme that caused participants to consider the appropriate word choice and which plays a significant role in meeting the needs of students. It's important to reflect on the concept of providing services or treatment versus creating avenues and access to services and treatment. In the first case, focusing on the provision of treatment in schools poses a number of challenges, such as retaining the appropriate mental health staff, protecting their position from added responsibilities, and establishing the appropriate mental health infrastructure. The needs in a school setting are often too diverse for schools to provide all necessary treatment, whereas prioritizing the creation of avenues and access to services opens up opportunities for culturally responsive, relevant, and specific treatment. As suggested by Participant 14, finding creative avenues and providing access to mental health support for students is critical equity work. An excellent blend of access and treatment is community partnerships that bring mental health therapists into the schools. Access to quality mental health care was discussed in multiple articles (Johnsson Chiang et al., 2017; Kosic, 2018; Stone et al., 2017) and is a key component of the social determinants of health model (Dahlgren & Whitehead, 1991).

The theme of accountability appeared frequently in the data, and initially I could not decide where it fit in the findings. After analyzing all the data, I realized one way to view the concept of accountability is that we need some form of accountability to meet the mental health needs of students. This accountability can come from a variety of methods and avenues. It can be accountability to self, to students, to administrators or the district. Accountability doesn't always have to be a formal evaluation or evidenced by data. It can also be present when a school team collectively reflects on school systems and practices. Participant 13 was curious if the adapted SHI would provide a level of accountability to schools. The CDC describes the original SHI as a tool for self-evaluation and planning (CDC, 2017). What is important to remember here are the words of Participant 16 who brought up how tools and their resulting data can be used to manipulate and exploit or they can be used to "push the discourse." The only reference to accountability in the research presented in this study includes a reference to Basch (2010) who said that accountability alone cannot improve health practices.

Conceptual Framework

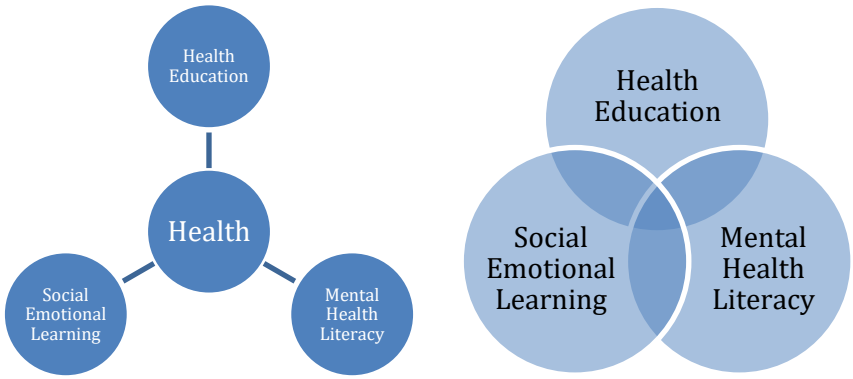
Comprehensive health education is usually discussed as best practice (Videto & Dake, 2019), but comprehensive can mean covering concepts broadly. It doesn't necessarily address how the elements interact to make a whole, which is what unified means. A visual of something that is comprehensive may look more like a web map, whereas something that is unified may be represented as a Venn diagram (see Figure 13).

I asked a question earlier in this paper, and I want to expand on it here. How do we change systems and structures in order to honor students as dynamic human beings with strengths and weaknesses, risk factors and protective factors, interwoven in and with societal and

cultural influences? When we oversimplify and silo aspects of and influences on health, we can distract from legitimate solutions to health problems (Crawford, 1980).

Figure 13

Comprehensive Health Education versus Unified Health Education



I propose that we take the concept of comprehensive and unified health education a step further. Sometimes a metaphor can speak more clearly to how different parts work together and can provide a road map for future action. I have chosen a suspension bridge to represent a conceptual framework for how SEL and MHL are embedded in health education as an upstream approach to suicide prevention in elementary schools (see Figure 14).

What I like about a suspension bridge is that it can span longer distances than other types of bridges. If I think about the stream or river below the bridge as distress, mental health challenges, and trauma, then the suspension bridge can span small to significant obstacles in a student's life. In this metaphor, the deck of the bridge is health education. It's the roadway across the river from kindergarten to the transition to middle school, but it can't get students across

without the tension of cables and suspenders, or the compression of the towers. Before I discuss the suspenders and cables, I want to draw attention to the towers. The towers represent SEL and MHL. They are placed deep under water and placed on a strong foundation of equitable and culturally responsive practices, ultimately providing support as forces spread throughout the bridge. Each tower shares a unique contribution to the development of health skills. They are also strategically placed from left to right, because SEL lays the groundwork for MHL. The deck is held up by vertical suspenders, which represent the many skills students learn and practice as they cross the bridge. The main cables that hold up the vertical suspenders and provide compression on the towers are health promotion practices that ultimately lead to suicide prevention. All of these components need to work together with tension and compression, as well as regular maintenance (e.g., systems and accountability) or the bridge will collapse.

Figure 14

A Conceptual Framework for an Upstream Approach to Suicide Prevention

Limitations of This Study

In every study, it is important to consider and address limitations, and this study is no different. The limitations in this study include my role as the researcher, sample size and participant participation, instrumentation, generalizability, and limited research. These potential threats to validity can be addressed through further study and research.

Role of the Researcher

My positionality is a limitation and an opportunity. I brought the lens of an elementary school counselor, a position I held for 16 years, to this research. I am now the health education COSA in the district where this study was set. My close connection to the topic and the district may have resulted in bias as I gathered and analyzed my data. However, my experience, expertise, and employee access brought richness and depth to the topic. There were several decisions I made throughout the study to address the limitations of my positionality. First, I decided that it was important for my voice as the health education COSA to be included in the SHI survey. However, my participation was anonymous. As I analyzed the data, I was cognizant not to weigh my comments over the comments of other participants. I attempted to view my own comments objectively, as much as that is possible. Second, I created a focus group protocol that minimized opportunities for me to influence the process and outcomes. To protect the focus group experience and continue the work, I shared my professional feedback and advice after the focus group was completed and data collection was over. Finally, I utilized member checking with multiple participants to ensure accuracy of interpretation and coding prior to determining themes.

Sample Size and Participant Participation

I was initially concerned that due to workload and individual capacity I would have a small sample, but I was pleased with the initial pool of 20 participants. They spanned multiple disciplines and carried a variety of influence (school support staff to district-level administrators). However, not all participants from phase 2 were able to continue on to phase 3 due to scheduling conflicts. Through attrition, we lost the only two participants who worked at the school building level and one of the district-level administrators. The administrator who did remain for phase three did not contribute to the discussion but preferred the observer role. Although the remaining participants were present during the focus group, not all participants engaged equally in the discussion. Despite group agreements, it was common for two participants to share in the discussion more frequently than others. For one or two participants, the lack of participation was due to technology issues.

Instrumentation

There were a number of instruments accessed and used in this study. The Oregon SHS was the only instrument with documented technical adequacy evidence. All other instruments were simple question-answer surveys created by the district. The Mental Health Literacy Survey was developed by a school counselor in the district, after failing to find a research-based MHL survey that could be appropriate for the student population and setting. Without further research, it is not possible to know whether the survey was written in a way that was easily understood by students, particularly if the student's first language was not English or they had a learning challenge. However, the questions were read aloud, and words like "maintenance" were explained. Because the students were not prompted to say more, sometimes their answers were very brief or vague, which may not be an indication of lack of knowledge.

The Health Education Adoption Survey had a mistake in the second and third question. The answers included "Self-Management" as an option, which is one interpretation of the health education skill of "Practice Health-Enhancing Behaviors." However, self-management is also a SEL competency and the definition of this term is different in that framework. This may have impacted the results of the survey. The Social Emotional Learning Educator Survey had a mistake in question two. Educators were asked to provide a definition for SEL, and some of them simply spelled out the acronym instead of providing details regarding the components of SEL. Finally, there were some complications with the SHI Survey. I received multiple questions related to who the audience for the survey would be and how the questions would be answered. I decided to spend a little more time during the focus group explaining the purpose, audience, question format, and end result. Despite my attempts to explain, it appeared that there was still confusion around these questions. This may be researcher error or the fact that participants have many competing responsibilities and keeping track of a new project is a challenge.

Generalizability

The lack of generalizability in qualitative research is not uncommon. The samples are small, and each context has its own nuances. However, the PNWSD is not an atypical school district. It is facing a lot of the same challenges as other districts around the nation. I would think that a lot of the ideas in this study would be fairly universal. Nevertheless, this is one small sample of mostly district office staff from one school district in the Pacific Northwest. Thus, the results may not generalize to other settings.

Lack of Prior Research Studies

When each concept in this study is researched in its own right there is plenty of research, but research where any of these concepts overlap is limited. There was also minimal research on MHL in the United States, and health education was rarely linked to suicide prevention.

Implications for Practice

Despite the limitations mentioned above, this study provides a wealth of important implications for schools, districts, and state departments. The challenge of meeting the mental health needs of elementary school students is not going away. Therefore, educational settings need to come together and think outside the box.

Recommendations for State Departments of Education

Leadership starts at the top, but it is only effective when it listens and considers the needs and ideas presented by multiple stakeholders. The data are clear that elementary school students struggle with their mental health, just as secondary students do. It is clear that teachers feel unprepared to meet the need, and school counselors cannot be responsible for all things mental health related. My recommendation to the state department of education is to model from the top how health education, SEL, and MHL work together. Avoid siloing the work. The new health education standards and SEL standards will be coming out soon. Ensure that there is guidance on how they align. My hope is that mental health, and particularly MHL, are clear and present in the standards. If they are not, take the time to promote MHL in the classroom and in teacher training.

Recommendations for School Districts

This research study primarily focused on the perceptions of district office staff and the adaptation of the SHI, but the work is not complete. The PNWSD is still in the process of adapting the SHI to align with their systems and goals. When the final product is ready, I

recommend piloting it with several schools to iron out any kinks. Then promote the use of the instrument while providing the time and resources for schools to participate.

I recommend that school districts consider hiring a School Health Coordinator. This role can help implement the WSCC model district wide and facilitate the use of the SHI at each school. The primary purpose of this role would be to build stronger systems and facilitate collaboration between departments in order to advance health and wellbeing for students, families, and staff across the district.

The sustainability of this work can be a challenge if it is not part of a district's strategic plan. I encourage school districts to find where universal supports for suicide prevention and mental health promotion fit into their plan. Add an addendum if necessary. Make it clear that this work is being prioritized at the core of district initiatives. Pull together teams to create a logic model and theories of change in order to ground the work in action. When budget cuts come around ensure that this work doesn't get left behind.

Provide opportunities for collaboration within buildings, at the district office, and across disciplines, not only in the context of immediate student need, but from a proactive, preventative lens. There may appear to be space for collaboration now, but this study clearly shows that there is not enough collaboration between disciplines. These connections may need facilitation and encouragement. Some of the barriers to collaboration are misunderstanding each other's roles and responsibilities. It is important that the district and building administrators clearly define roles and that the responsibilities of each role are communicated.

I recommend that districts look closely at the skill alignment between health education, SEL, and MHL to reduce the amount of duplication while recognizing the benefits of continuous skill practice in multiple contexts. Integration may increase accessibility for students and

decrease the burden on teachers. However, it is important not to merge SEL, MHL, and health education. They are not interchangeable. They each have their place, but they can and must work together.

Speaking of teacher burden, it's essential that districts look more closely at staff wellness and mental health. This caution was mentioned a couple times by participants. If staff do not feel safe or healthy, how can they support students?

It is recommended to prioritize health education, SEL, and MHL at the universal level. This needs to be modeled and supported. While this is happening, it is not appropriate to pull support from tier two and three. It is important that we have strong supports at all three levels.

I encourage school districts to take their health data, such as the SHS, and utilize it widely, as well as dig in. What I mean by use it widely is to share the data with school counselors, classroom teachers, and students. This would be great data to share in health classes. When I say dig in, I mean that districts should ask more questions. Find out which student populations are most and risk and go talk with them. Sit down and listen to what they have to say. Include them in the planning process.

Recommendations for School Sites

Whether school buildings use the original SHI or the adapted version, I recommend that they set aside a reasonable amount of time to discuss, reflect, and create goals that will improve universal supports that focus on mental health promotion and suicide prevention. When the school year gets busy and needs start to rise, it is tempting to use something like the SHI as a checklist without allowing it to improve systems. I encourage schools to ask for support. Be innovative. Respect the learning differences and needs of teachers. Not everyone starts at the same place, and that is okay. This work isn't linear. Everyone has different strengths. Use the

tool to improve practice. Include the SHI action plan and goals in the School Improvement Plan. Create space for a multidisciplinary team of educators and school staff (i.e., counselors, PE teachers, nurses, health assistants, classified staff) to collaborate on school health promotion systems and activities. Communicate opportunities and provide release time for essential staff and willing staff to attend mental health and suicide prevention trainings. The more the merrier. Ensure that all health education, SEL, and MHL instruction includes language scaffolding and trauma-informed practices to increase access and limit harm.

Opportunities for Future Research

This study provides important insight for educational settings that want to align health education, SEL, and MHL to promote mental health and prevent suicide. Replication of this study in other school districts would help to verify the findings discussed here. However, the findings also revealed a number of questions that present opportunities for future research, such as the perception of who is responsible for mental health in the school setting. Additionally, I would like to see more researchers pick up the work of Kutcher et al. (2016a) and conduct studies on the effectiveness of MHL in the United States, particularly in younger grades. It would also be beneficial to develop an MHL assessment that can be delivered to elementary school students. Furthermore, there is limited research exploring the overlap in the concepts or skills of health education, SEL, or MHL, or even a combination of just two of these. Future research in these areas would be helpful to multiple fields of study.

Conclusion

I have spent many years of my career frustrated that I couldn't do more for students. I felt isolated from my educational colleagues as I spun my wheels to support students. I realize now that we all felt isolated, and we were all doing what we felt was best. What I know now is that

we need to come together and bring our collective professional lenses to provide support from tier one to tier three and all the multidimensional layers in between. Students are complicated and messy, because they are growing human beings, figuring things out, just as we all are. The best that we can do is provide them with the tools and the skills to live their best lives. The purpose of this study was to explore an upstream approach to suicide prevention and mental health promotion in elementary education. I discussed the opportunities and challenges of aligning health education, social emotional learning, and mental health literacy in order to provide students with the skills they need to face future challenges. I will remind us here that this work is a practice in the concept of "both…and" thinking. Schools must focus on building essential skills in children *and* address the numerous obstacles students face every day. This work is far from finished, but it's a start.

APPENDIX A

IRB APPROVAL

UNIVERSITY OF OREGON | Research Compliance Services

EXEMPT DETERMINATION

January 31, 2023

Erin Hanson

ehanson4@uoregon.edu

Dear Erin Hanson:

The following research was reviewed and determined to qualify for exemption.

Type of Review:	Initial Study
Study Title:	Suicide Prevention at the Intersection of Mental Health Literacy and Social Emotional Learning in Elementary Education
Principal Investigator:	Erin Hanson
Parent Study ID:	STUDY00000752
Documents Reviewed:	• Application - Initial Review_RAP.pdf, Category: IRB Protocol; • Elementary School Health Index - Google Form, Category: Survey Instrument; • Hanson_HSD Research Proposal, Category: Data Collection Materials; • Hanson_Phase 2_Focus Group Protocol.pdf, Category: Data Collection Materials; • Hanson_Phase 2_Informed_Consent, Category: Consent Form; • Hanson_Phase 2_Recruitment, Category: Recruitment Materials; • Hanson_Research Plan_1.25.23, Category: IRB Protocol; • hrp-921_-_template_-_hs_coi_form_8.15.22 (1).pdf, Category: IRB Protocol;
Approval Date:	1/31/2023
Effective Date:	1/31/2023
Expiration Date:	1/30/2024

For this research, the following determinations have been made:

- This study has been reviewed under **the 2018 Common Rule** and determined to qualify for exemption under **Title 45 CFR 46.104(d) categories (2)(ii) Tests, surveys, interviews, or observation (low risk) and (4) Secondary research on data or specimens (no consent required).**

The research is approved to be conducted as described in the approved protocol using the approved materials. Approved materials can be accessed in the protocol workspace in the IRB module of the research administration portal (RAP).

All changes to this research must be assessed to ensure the study continues to qualify for exemption. Research Compliance Services has developed specific guidance to help you understand when a modification is required before a change can be implemented. It is your responsibility to ensure modifications are submitted when required and approval secured before implementing changes to the protocol

Continuing Review is not required for this study. **An institutional approval period has been established based on your application materials.** If you anticipate the research will continue beyond the approval period, you must submit a **Continuing Review Application** at least 45-days days prior to the expiration date. A closure report must be submitted once human subject research activities are complete. Failure to maintain current approval or properly close the protocol constitutes non-compliance.

With the submission of your request, you agreed to uphold the responsibilities of the Principal Investigator and have agreed to follow the requirements listed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB module of the RAP.

If you have any questions regarding your protocol or the review process, please contact Research Compliance Services at ResearchCompliance@uoregon.edu or (541)346-2510. The University of Oregon and Research Compliance Services appreciate your commitment to the ethical and responsible conduct of research with human subjects.

Please consider completing our user satisfaction survey. It only takes a few minutes, and we would like to hear about your experience working with our office!

Sincerely,

Research Compliance Services
on behalf of the Committee for Protection of Human Subjects

cc: Julie Alonzo

APPENDIX B

CONSENT FORM

Consent for Research Participation

Title: **District-Level Focus Group**

Researcher(s): Erin R. Hanson, University of Oregon

Researcher Contact Info:

You are being asked to participate in a research study. The box below highlights key information about this research for you to consider when making a decision whether or not to participate. Carefully consider this information and the more detailed information provided below the box. Please ask questions about any of the information you do not understand before you decide whether to participate.

Key Information for You to Consider
● **Voluntary Consent**. You are being asked to volunteer for a research study. It is up to you whether you choose to participate or not. There will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate or discontinue participation. ● **Purpose**. The purpose of this research is to explore the challenges, opportunities, and potential alignment of mental health literacy and social emotional learning as a tool for suicide prevention and school health promotion in elementary schools. As part of the exploration, the focus group will develop a School Health Index (a list of program questions) that schools will use to discuss and evaluate the health efforts in their building. ● **Duration.** It is expected that your participation will last approximately two hours (15 minute presentation, 45 minute survey, and 90 minute focus group). ● **Procedures and Activities.** A brief presentation will be shared with you regarding the topics of mental health literacy, social emotional learning, and health education in the district. In a survey format, you will be asked to provide your feedback on the current School Health Index and make suggestions for improvement. As a group, you will convene to discuss the feedback provided and come to consensus on the final questions to include in the School Health Index. ● **Risks.** There are no foreseeable risks or discomforts anticipated by participating in this study. ● **Benefits**. Some of the benefits that may be expected include increased collaboration between departments and greater alignment among district goals.

- **Alternatives.** As an alternative to participation in the video recorded focus group, you could simply watch a recording of the presentation and provide your feedback in the survey. Participation in any part of the study is voluntary. You are free to not participate.

Who is conducting this research?

The researcher Erin R. Hanson from the University of Oregon is asking for your consent to this research. She is conducting this research as part of her doctoral dissertation study. She also holds the position of PK-12 Health Education COSA in Hillsboro School District.

Why is this research being done?

The purpose of this research is to explore the challenges, opportunities, and potential alignment of mental health literacy and social emotional learning as a tool for suicide prevention and school health promotion in elementary schools. As part of the exploration, the focus group will develop a School Health Index (a list of program questions) that schools will use to discuss and evaluate the health efforts in their building.

You are being asked to participate because you are a district-level employee who actively participates in work related to mental health, social emotional learning, or health education. You may also have been chosen because you have a specialty in a related field. About 10 people will take part in this research.

What happens if I agree to participate in this research?

If you agree to be in this research, your participation will include a brief presentation regarding the topics of mental health literacy, social emotional learning, and health education in the district. This activity will be completed by watching a recording of the presentation. The presentation lays a foundation for the work ahead and will take no more than 15 minutes.

In a digital survey format, you will be asked to provide your feedback on the original School Health Index and make suggestions for improvement. You will read the question and indicate whether it should be kept, adapted, or deleted. You can also indicate that you do not have enough information to answer the question. There will be space for you to explain your reasoning and/or your suggested adaptations. You will be provided space to create your own questions. Do not discuss your feedback with other members of this study. All feedback will be gathered and presented in the focus group.

As a focus group, you will convene with other participants in a virtual meeting to discuss the feedback provided. The group will come to consensus on the final questions to include in the School Health Index and explain their reasoning. The new and improved School Health Index will be utilized in the school-level focus groups.

The meeting will be held in Zoom and recorded for the purposes of accessing a transcription of the discussion to be used for data analysis. Find a quiet space to join the meeting. You may meet in the same room as other participants as long as you use headphones and remain muted unless speaking.

You may turn your camera off if you do not wish to have your face included in the recording. You will be told about any new information that may affect your willingness to continue participation in this research.

What happens to the information collected for this research?

Information and data collected for this research will be used as part of a final dissertation project.

Your name will not be used in any part of this study. I may publish or present the results of this research. However, I will keep your name and other identifying information confidential. Personal information collected as part of this research, even if identifiers are removed, will not be used or distributed for future research studies.

How will my privacy and data confidentiality be protected?

I will take measures to protect your privacy. Despite taking steps to protect your privacy, I can never fully guarantee your privacy will be protected. Measures I will take include maintaining confidentiality of identifiable information by not sharing raw data. Focus group members will be reminded of the importance of maintaining confidentiality of sensitive topics discussed during the focus groups. Due to the collaborative nature of this work in the district, it is unlikely that the content of the focus group discussion will remain private, as is generally accepted.

I will take measures to protect the security of all your personal information including securely storing data (survey results, recordings, and transcripts) on an external hard drive or a password protected computer. Only the deidentified and analyzed data results will be shared in my final dissertation. I will retain the raw data for a period of two years, after which, it will be securely disposed of. Despite these precautions to protect the confidentiality of your information, we can never fully guarantee confidentiality of all study information.

What are my responsibilities if I choose to participate in this research?

If you take part in this research, you will be responsible for watching or participating in a short presentation, providing feedback on the School Health Index, joining a virtual meeting to discuss results, and coming to a consensus on the adapted School Health Index. You are not to discuss the School Health Index with colleagues who are participating in the study prior to convening for the focus group.

What other choices do I have besides participation in this research?

It is your choice to participate or not to participate in this research.

What if I want to stop participating in this research?

Taking part in this research study is your decision. Your participation in this study is voluntary. You do not have to take part in this study, but if you do, you can stop at any time. You have the right to choose not to participate in any study activity or completely withdraw from continued participation at any point in this study without penalty or loss of benefits to which you are otherwise entitled.

Your decision whether or not to participate will not affect your relationship with the researcher, the University of Oregon, or your school district. Participation in this research is not a requirement of your employment.

Will it cost me money to take part in this research?

There are no costs associated with participation in this research study.

Will I be paid for participating in this research?

You will not be paid for taking part in this research.

Who can answer my questions about this research?

If you have questions, concerns, or have experienced a research related injury, contact the research team at:

Erin R. Hanson

An Institutional Review Board ("IRB") is overseeing this research. An IRB is a group of people who perform independent review of research studies to ensure the rights and welfare of participants are protected. UO Research Compliance Services is the office that supports the IRB. If you have questions about your rights or wish to speak with someone other than the research team, you may contact:

Research Compliance Services

5237 University of Oregon

Eugene, OR 97403-5237

(541) 346-2510

ResearchCompliance@uoregon.edu

STATEMENT OF CONSENT

I have had the opportunity to read and consider the information in this form. I have asked any questions necessary to make a decision about my participation. I understand that I can ask additional questions throughout my participation.

I understand that by signing below, I volunteer to participate in this research. I understand that I am not waiving any legal rights. I have been provided with a copy of this consent form. I understand that if my ability to consent or assent for myself changes, either I or my legal representative may be asked to re-consent prior to my continued participation in this study.

As described above, you will be video recorded during the focus group session.

Initial the space below if you consent to the use of video as described.

_____I consent to this interview being audio recorded for transcription purposes

_____I do not consent to this interview being audio recorded for transcription purposes

I consent to participate in this study.

Name of Participant Signature of Participant Date

Researcher Signature (to be completed at time of informed consent)

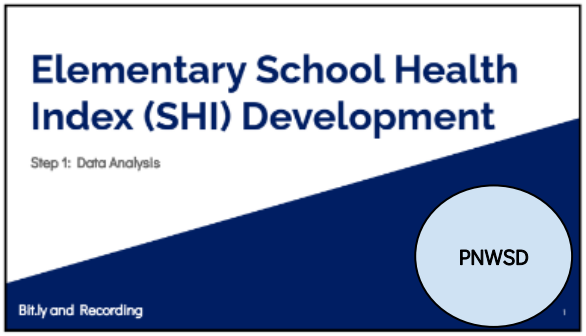
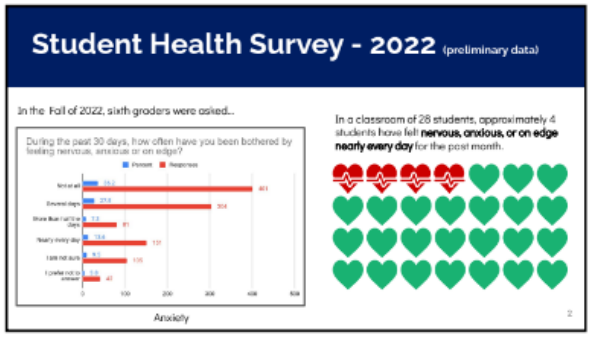
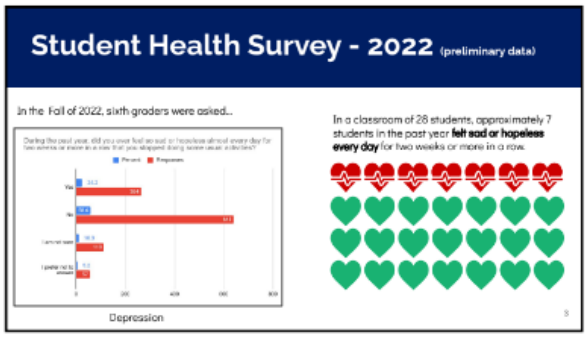
I have explained the research to the participant and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to participate.

Erin R. Hanson

Name of Research Team Member Signature of Research Team Member Date

APPENDIX C

PHASE 2 PRESENTATION

	**Slide 1** Welcome and thank you again for participating in the Elementary School Health Index Development project. Your insight and experience are invaluable to this work. For the next 15 minutes I will share some data with you. You may be familiar with some of it and some of it will be new. My goal is to share data relevant to the mental, social, emotional, and physical health of our students while attempting to avoid sharing my opinion or interpretation. I will go through the slides fairly quickly, but I will give you access to this slide deck. Data that I wanted to share, but do not have time to discuss is included in the appendix. Let's dive in.
	**Slide 2 - Anxiety** I will start this presentation by sharing some of the preliminary data gathered from this school year's Student Health Survey. I only pulled 6th grade data as this project focuses on the elementary level. At the end of each slide I will pause for a few seconds to give you a little time to digest the data. For each piece of data I approximated the impact on a classroom of 28 students. For instance, in a classroom of 28 students, approximately 4 students have felt **nervous, anxious, or on edge nearly every day** for the past month.
	**Slide 3 - Depression** In a classroom of 28 students, approximately 7 students in the past year **felt sad or hopeless every day** for two weeks or more in a row.

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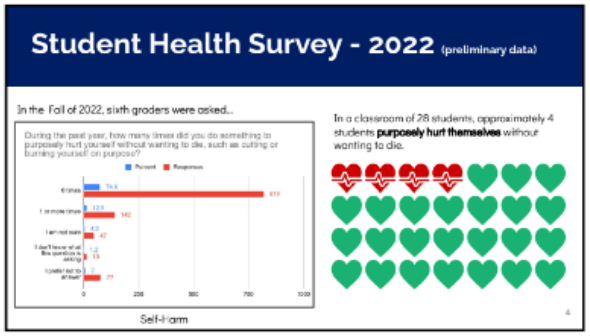
<tr>
<td> 
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<td>Slide 4 - Self-Harm

Approximately 4 students purposely hurt themselves without wanting to die.</td>
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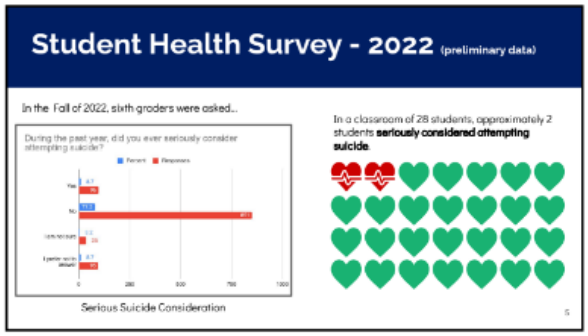
<td> 
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<td>Slide 5 - Serious Suicide Consideration

Approximately 2 students seriously considered attempting suicide.</td>
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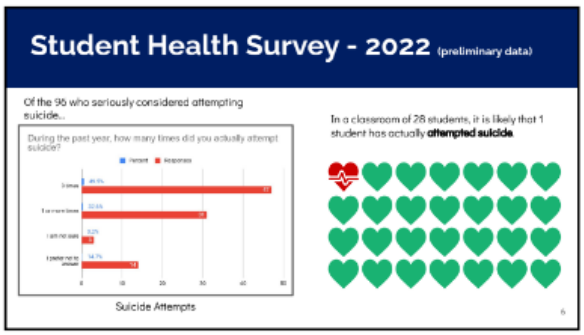
<td> 
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<td>Slide 6 - Suicide Attempts

In a classroom of 28 students, it is likely that 1 student has actually attempted suicide.</td>
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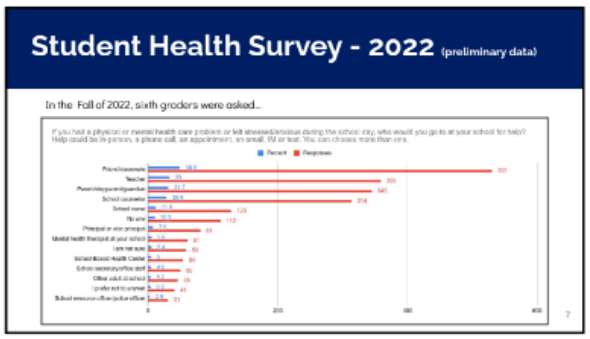
<td> 
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<td>Slide 7 - Who would you go to?

The last question that I pulled from the Student Health Survey is “If you had a physical or mental health care problem or felt stressed/anxious during the school day, who would you go to at your school for help?”

Nearly 50% of 6th graders said they would go to a friend or classmate.
33% said a teacher</td>
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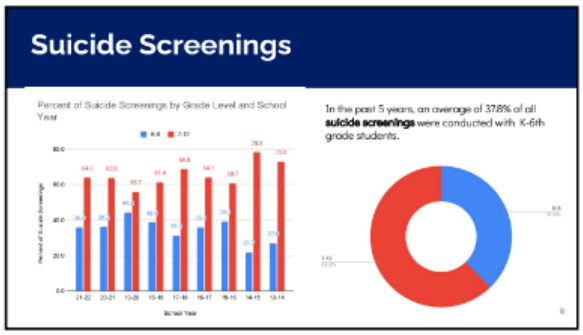
<td> 
</td>
<td>Slide 8 - Suicide Screenings
Thankfully our district has a strong suicide intervention protocol, which includes suicide screenings.

In the past 5 years, an average of 37.8% of all suicide screenings in the district were conducted with Kindergarten through 6th grade students.</td>
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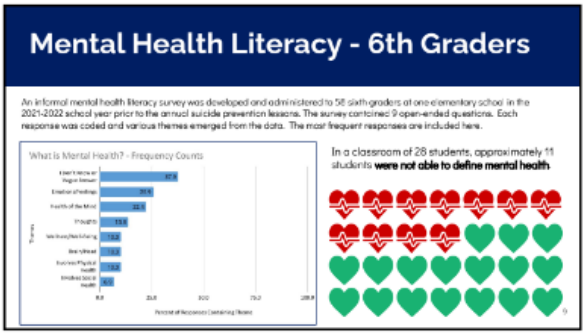
<td> 
</td>
<td>Slide 9 - Mental Health Literacy - Define Mental Health
In the 21-22 school year, an informal mental health literacy survey was developed and administered to a sample of 58 sixth graders at one elementary school prior to the annual suicide prevention lessons. The survey contained 9 open-ended questions. Each response was coded and various themes emerged from the data. The most frequent responses are included in the next few slides.

Once again, for each piece of data I approximated the impact on a classroom of 28 students.

Students were asked to define mental health and in a hypothetical classroom of 28 students, approximately 11 students were not able to define mental health. However, 8 students knew it involved emotions or feelings.</td>
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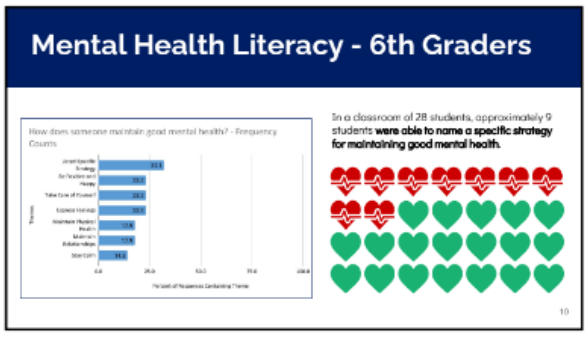
<td> 
</td>
<td>Slide 10 - Mental Health Literacy - Maintenance

In a classroom of 28 students, approximately 9 students were able to name a specific strategy for maintaining good mental health.

Approximately 6 students suggested being positive and happy, taking care of yourself, and expressing feelings.</td>
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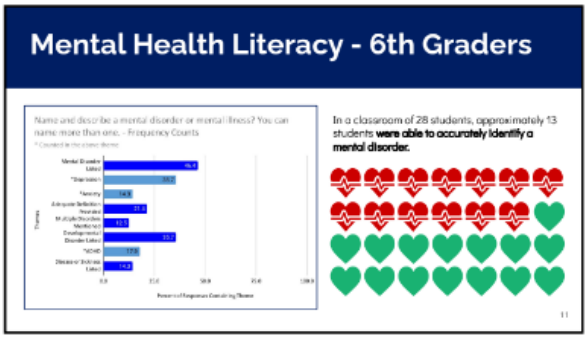
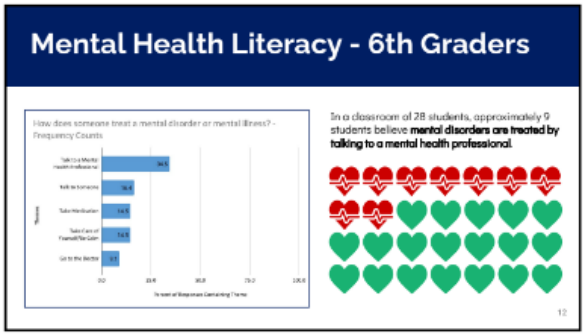


Slide 11 - Mental Health Literacy - Mental Disorder

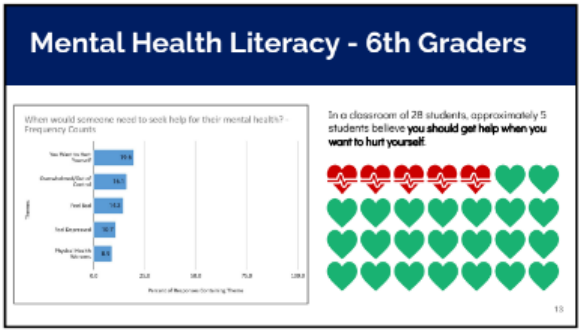
approximately 13 students **were able to accurately identify a mental disorder.**

The majority mentioned depression and then anxiety. However, approximately 4 students believe a mental disorder is a disease like cancer or some other illness.



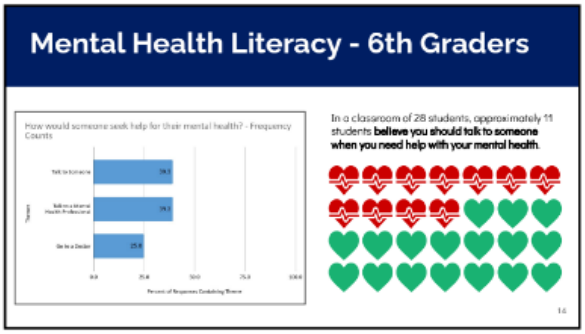
Slide 12 - Mental Health Literacy - Treatment

Approximately 9 students believe **mental disorders are treated by talking to a mental health professional**. These professionals were often stated as counselors, therapists, or psychologists.



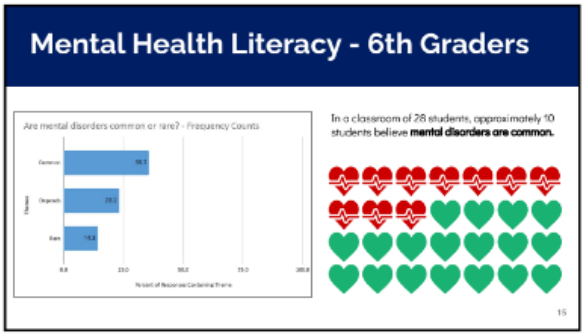
Slide 13 - Mental Health Literacy - When to seek help

Approximately 5 students believe **you should get help when you want to hurt yourself**. And 4 believe you should get help when you feel overwhelmed or out of control.



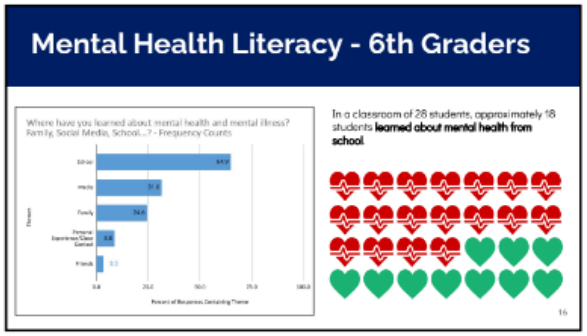
Slide 14 - Mental Health Literacy - How to seek help

Approximately 11 students **believe you should talk to someone when you need help with your mental health**, or specifically talking to a mental health professional.



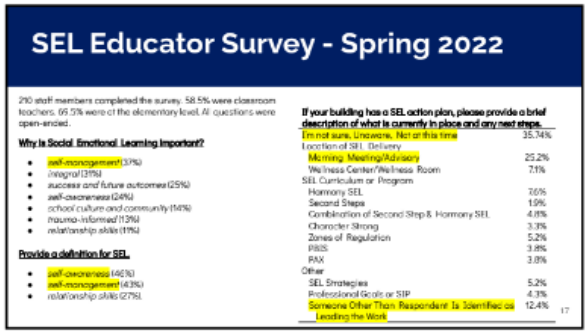
Slide 15 - Mental Health Literacy - Stigma

Approximately 10 students believe **mental disorders are common.**



Slide 16 - Mental Health Literacy - Source

And finally, In a classroom of 28 students, approximately 18 students **learned about mental health from school**.



Slide 17 - SEL Educator Survey

In Spring 2022, 210 staff members completed a SEL survey. All questions were open-ended.

The first question asked was **Why is Social Emotional Learning important?**

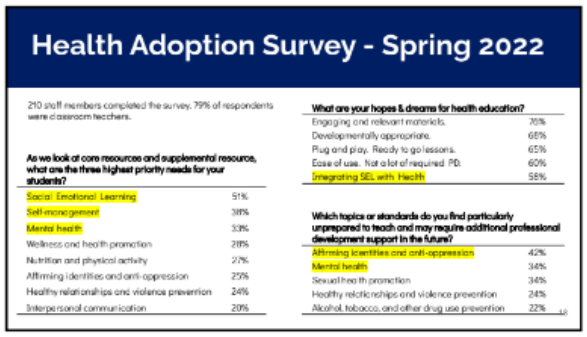
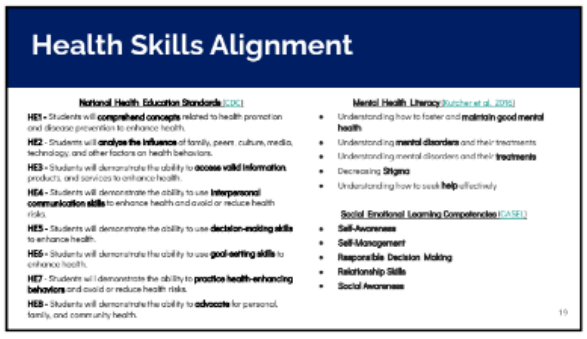
The themes most frequently referred to by respondents were…

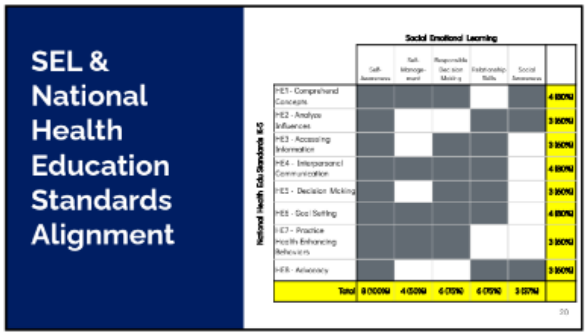
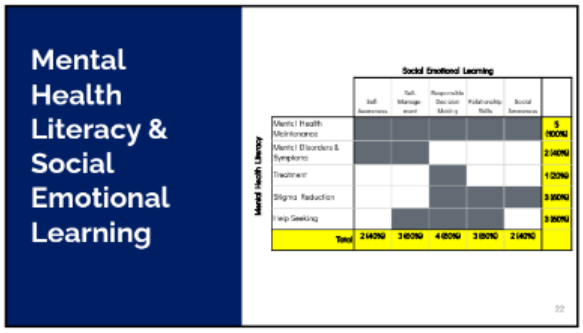
The need for students to learn and grow in their ability to self-manage. You can see next that teachers believe SEL is integral to a student's ability to learn and be successful in the future.

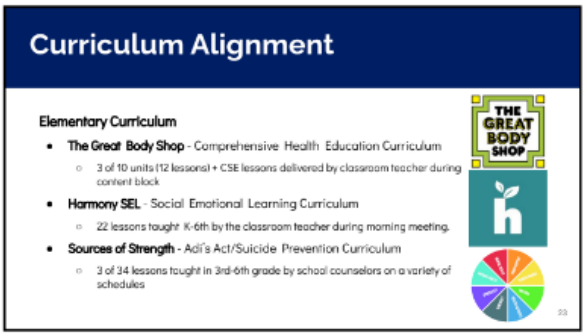
Teachers were then asked to **Provide a definition for SEL.**

The most frequent responses included the SEL competencies of *self-awareness* and *self-management*. The third most frequent responses included *relationship skills*.

Finally, teachers were asked **if their building had a SEL action plan, to please provide a brief description of what was currently in place and any next steps.**

	Nearly 36% of respondents indicated "I'm not sure," "unaware," and "not at this time." The second most frequent theme was *Morning Meeting/Advisory* which is a reference to where SEL is most often delivered. The next most common theme was *someone other than respondent is identified as leading the work*. Sometimes the "school counselor" or the "student success coach" would be referenced as someone who delivers the lesson or leads small groups.
	**Slide 18 - Health Adoption Survey** In the early months of 2022, the district was in the process of an elementary health curriculum adoption. They sent out a survey to all elementary teachers and 210 staff members completed the survey. Teachers were asked to identify **the three highest priority needs for their students. Just over 50% indicated SEL. 38% indicated self-management and then 33% mental health.** Teachers were also asked for their hopes and dreams for health education. I want to draw your attention to 58% of teachers indicating the **integration of SEL with Health.** Teachers were asked **which topics or standards they found particularly unprepared to teach and may require additional professional development support in the future.** I want to draw your attention to **affirming identities and anti-oppression at 42% and mental health at 34%.**
	**Slide 19 - Health Skills Alignment** Now we're going to take some time to look at skill alignment or another way to say it is where do the skills share similarities and overlap in their definitions. I looked at the national health education standards for K-5, the mental health literacy skills outlined by Stan Kutcher and colleagues, and the social emotional learning competencies defined by CASEL. As we move through the next few slides you'll see how each of these overlap in a variety of ways to

	provide students with mental, social, emotional, and physical health skills.
	**Slide 20 - SEL & NHS** We'll start with the alignment of SEL and the National Health Standards. Here you can see the health standards in the left column and SEL competencies across the top. You can look vertically and see how self-awareness is present throughout the health standards. Responsible Decision Making and Relationship skills are present in 6 out of 8 standards. If you look horizontally you'll see that several health standards align with 4 out of 5 of the SEL competencies. I'll give you a moment to take this in. I encourage you to notice where there is strong alignment and where there is minimal or no alignment.
	**Slide 21 - MHL & NHS** Now we'll look at the alignment of the health standards in the left column and MHL which is across the top. Maintaining positive mental health isn't explicitly addressed in each standard, but we can argue that many health activities promote mental health such as nutrition, exercise, sleep, conflict management, and avoiding risky behavior. The standards address a variety of help seeking behaviors such as talking to trusted adults or health professionals. If you look at the cells horizontally you'll see accessing valid information and decision making aligns with 4 out of 5 of MHL skills.
	**Slide 22 - MHL & SEL** And finally, we'll look at the alignment of MHL in the left column and SEL across the top. The most evident alignment is that all SEL competencies align with mental health maintenance. 3 out of 5 SEL competencies support stigma reduction and help seeking. I'll give you a moment to look this over.



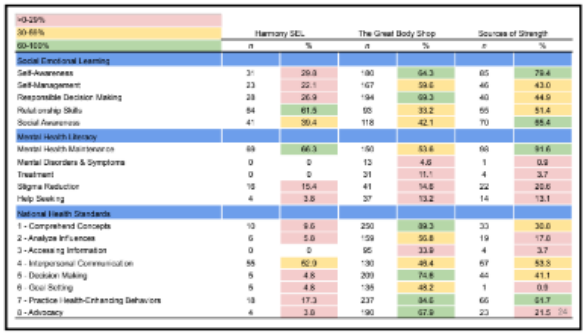
Slide 23 - Curriculum Alignment

Now, let's look at how this plays out in the classroom. We have three elementary curricula that we are using to address mental, social, emotional and physical health. Our comprehensive health education curriculum is The Great Body Shop. This past year, we chose to teach three of the 10 units in addition to our comprehensive sexuality education lessons.

We are also using Harmony SEL for our social emotional learning curriculum. This is taught in its entirety.

And finally, we have a new curriculum called Sources of Strength, which addresses suicide prevention. 3 of the 34 lessons are required in 3rd-6th grade and are taught by school counselors.

On the next slide I will show you how each curricula aligns with the skills we have discussed thus far.



Slide 24 - Curriculum Alignment

Here I have the skills listed in the left column and the curricula listed across the top. I've included total counts and percentages. Some of this work was completed for me as Harmony SEL and Sources of Strength documented where their lessons aligned to SEL competencies, and TGBS documented where their lessons aligned with the NHES. When there wasn't documented alignment I would look at the lesson descriptions and/or objectives and compare it with the skills definition.

For easy viewing I highlighted cells with 60% or higher alignment in green. Yellow shows 30-59% and pink is >0-29%. The green, yellow, and pink do not indicate good or bad. It just indicates how frequently that skill is being taught in the curricula.

	**Slide 25 - Is this the whole story?** I know I threw a lot of data at you and I'm sure you haven't been able to digest much of it. If you need time to process I encourage you to go back through and sit with the data. What is the data suggesting? What is missing? What questions do you have? What do you want to know more about? What now?
	**Slide 26 - SHI** I do have one answer for that last question. Now I would like to tell you a little about the School health Index that you will complete over the next week.
	**Slide 27 - SHI Background** ● The original SHI, developed by the CDC, is divided into 10 modules, which align with the 10 components of the Whole School, Whole Community, Whole Child Framework. For our purposes we're going to start with the modules that most closely relate to social emotional learning, mental health, and health education. I have circled them here. All of these modules have universal support elements and have a significant impact on suicide prevention and overall health promotion. ● We are going to develop an PNWSD version of the CDC Elementary School Health Index that school teams can use to evaluate their school health promotion practices and develop goals for improvement.

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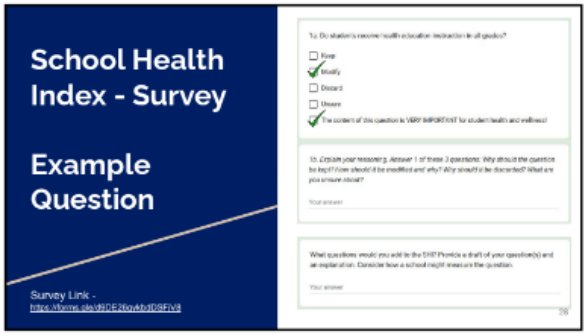
<td> 
</td>
<td>Slide 28 - SHI Instructions

● In order to respect your time and encourage you not to spend too much time on this survey, I recommend reading all of the questions through once and marking your initial response.
● Consider whether the question is a keeper, needs to be modified, should be discarded (meaning we shouldn't use it in our final SHI), or you are unsure based on lack of knowledge with the content or unclear wording. You must mark one of the 4 options.
● Then go back through and provide more detail.
● Consider whether the content of the question is VERY IMPORTANT for student health and wellness. Be selective about which questions you mark as very important.
● Provide an explanation for your response to the question. This does not have to be detailed or in complete sentences but do try to make your explanation clear.
● There is space at the bottom to add your own questions.
● The survey will close at the end of the day on Friday, March 3rd. I will then analyze the results. I will share our combined scores and a summary of the explanations at our scheduled meeting. Come prepared to discuss and finalize the PNWSD Elementary School Health Index.</td>
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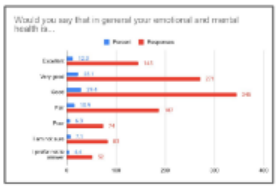
Student Health Survey - 2022 (preliminary data)

In the Fall of 2022, sixth graders were asked...

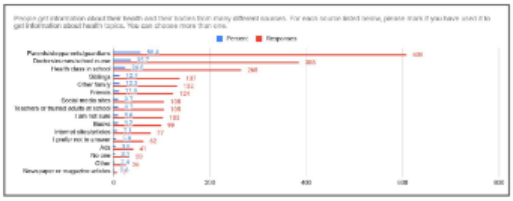


In a classroom of 28 students, approximately 6 students perceive their **emotional and mental health** as fair or poor.

Emotional & Mental Health

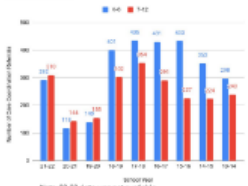
Student Health Survey - 2022 (preliminary data)

In the Fall of 2022, sixth graders were asked...

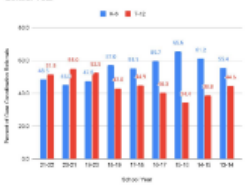


Care Coordination Referrals (*n* & %)

Number of Care Coordinator Referrals by Grade Level and School Year

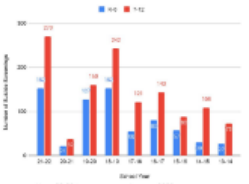


Percent of Care Coordinator Referrals by Grade Level and School Year

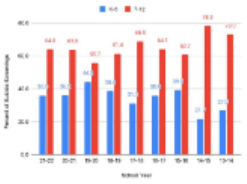


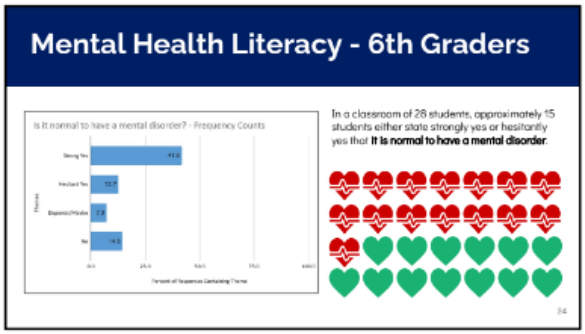
Suicide Screenings (*n* & %)

Number of Suicide Screenings by Grade Level and School Year



Percent of Suicide Screenings by Grade Level and School Year




Mental Health Literacy - 6th Graders
Is it normal to have a mental disorder? - Frequency Counts
In a classroom of 28 students, approximately 15 students either state strongly yes or hesitantly yes that It is normal to have a mental disorder.

APPENDIX D

SCHOOL HEALTH INDEX SURVEY

BACKGROUND

- "The SHI is built on CDC's research-based guidelines for school health programs that identify the policies and practices most likely to be effective in reducing youth health risk behaviors" (CDC, 2022).
- The SHI is divided into 10 modules, which align with the 10 components of the Whole School, Whole Community, Whole Child Framework. For our purposes, we're going to start with the modules that most closely relate to social emotional learning, mental health, and health education. These modules are called Social and Emotional Climate; School Counseling, Psychological, and Social Services; and Health Education. All of these modules have universal support elements and have a significant impact on suicide prevention.

PURPOSE

- Develop a district version of the CDC Elementary School Health Index that school teams can use to evaluate their school health promotion practices and develop goals for improvement.
- This tool can be used to educate school staff on school health promotion.
- The focus is primarily on universal supports.
- The district version can be expanded in the future to include additional components of the Whole School, Whole Community, Whole Child Framework.

INSTRUCTIONS

- If you would like to see and or reference the original School Health Index, I've included the link here: SHI Google Document. The sections referred to in this survey are on pages 6-11 (skip S.1), 22-28, and 32-39. The document includes definitions for all bolded and underlined words, a scoring rubric for each question, and planning questions at the end of each module.
- I recommend reading all of the questions through once and marking your initial response. Consider whether the question is a keeper, needs to be modified, should be discarded (meaning we shouldn't use it in our final SHI), or you are unsure based on a lack of knowledge with the content or unclear wording. You must mark one of the 4 options.
- Then go back through and provide more detail.
- Consider whether the content of the question is VERY IMPORTANT for student health and wellness. Be selective about which questions you mark as very important.
- Provide an explanation for your response to the question. This does not have to be detailed or in complete sentences but do try to make your explanation clear.
- There is space at the bottom to add your own questions.
- There are currently 27 questions. This may be too many questions for a school team to reasonably analyze. Try to narrow it down to the most essential questions. 20 questions may be more reasonable.

- There is space at the bottom to add your own questions. If they want to suggest their own questions then they should provide a scoring guide.
- I will analyze the results when everyone is finished. I will then share our combined scores and a summary of the explanations at our scheduled meeting. Come prepared to discuss and finalize the HSD Elementary School Health Index.

Name:

Job Title:

Area of Focus (check all that apply)

- SEL
- Equity
- Mental Health
- Health Education
- Other:

I have read the consent form and agree to participate in this study.

- Yes
- No

1a. Do students receive health education instruction in all grades?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

1b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

2a. Do all teachers of health education use age-appropriate health education curriculum materials that are sequential and consistent with state or national standards for health education (see standards box) and the district's requirements for health education?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

2b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

3a. Do all teachers of health education use active learning strategies and activities that students find engaging and make learning relevant to their daily lives?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

3b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

4a. Do all teachers of health education provide opportunities for students to practice or rehearse the skills needed to maintain and improve their health?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure

- The content of this question is VERY IMPORTANT for student health and wellness!

4b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

5a. Do all teachers of health education use a variety of culturally-appropriate activities and examples that reflect the community's cultural diversity?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

5b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

6a. Do all teachers of health education use assignments or projects that encourage students to have interactions with family members and community organizations?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

6b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

7a. Do all teachers of health education participate at least once a year in professional development in health education?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

7b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

8a. Have all teachers of health education received professional development in delivery of the school's health and safety curriculum in the past two years?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

8b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

9a. Have all teachers of health education received professional development in classroom management techniques in the past two years?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

9b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

10a. Does your school have access to a full-time counselor, social worker, or psychologist for providing counseling, psychological, and social services? Is an adequate number of these staff members provided based on the following recommended ratios?

- One counselor for every 250 students
- One social worker for every 400 students
- One psychologist for every 1,000 students

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

10b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

11a. Does the counseling, psychological, or social services provider promote the emotional, behavioral, and mental health of and provide treatment to students and families in the following ways?

- 1-on-1 counseling/sessions
- Small group counseling/sessions
- Classroom-based health promotion and prevention
- School-wide health promotion and prevention

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

11b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

12a. Does the counseling, psychological, or social services provider collaborate with other school staff members to promote student health and safety in at least six of the following ways?

- Developing plans to address student health problems (e.g., individual health care plans, individual education plans, 504 plans, school team plans)
- Providing professional development on managing student health and safety concerns, a component of which educates staff on the impact of Adverse Childhood Experiences (ACES) and the principles of a trauma-informed school
- Developing policy
- Identifying, revising or developing curricula or units/lessons
- Developing and implementing school-wide and classroom activities
- Developing School Improvement Plans
- Establishing communication systems with other school staff

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

12b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

13a. Does the counseling, psychological, or social services provider have a system for identifying and tracking students with emotional, behavioral, and mental health needs?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

13b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

14a. Does your school implement a systematic approach (including the following components) for referring students, as needed, to appropriate school- or community-based counseling, psychological, and social services?

- Case management, including assessment, referral, education, support, and monitoring, is offered.
- Referral information is distributed widely (e.g., through flyers, brochures, website, student handbook, health education class) so that students, staff, and families can learn about school and community services without having to contact school staff.
- Staff members are given clear guidance on referring students to school counseling, psychological, and social services.
- Referral forms are easy for staff members to access, complete, and submit confidentially.
- A designated staff person (e.g., school counselor, social worker, or psychologist) regularly reviews and sorts referral forms and conducts initial screening.
- With written parental permission, additional information (e.g., questionnaires, relevant records, brief testing) is gathered as necessary and in compliance with FERPA, and all information is kept confidential.
- Written consent is obtained, in compliance with HIPAA, to gather relevant records from other professionals or agencies in a confidential manner, if applicable.
- A list is kept and regularly updated of youth-friendly referral providers along with basic information about each (e.g., cost, location, language, program features, previous client feedback, types of insurance accepted)
- Meetings are held with all relevant parties to discuss referral alternatives.
- Potential barriers (e.g., cost, location, transportation, stigma), and how to overcome them, are discussed.
- Follow-up (e.g., via telephone, text messaging, email, personal contact) is conducted to evaluate the referral and gather feedback about the service.
- A status report is provided to the person who identified the problem, if applicable and in compliance with FERPA and/or HIPAA.
- Professional development is provided to all staff members about the referral process.

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

14b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

15a. Does your school aid students during school and life transitions (such as changing schools or changes in family structure) in the following ways?

- Matching new students with another student or buddy
- Opportunities for students to check-in with a trusted adult
- Orientation programs that focus on adapting to transitions

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

15b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

16a. Does the counseling, psychological, or social services provider have a system for identifying students who have been involved (as a bystander, victim, perpetrator, or some combination of these) in any type of violence (e.g., child abuse, dating violence, sexual assault, bullying or harassment, fighting, suicide and self-harm behaviors) and, if necessary, refer them to the most appropriate school-based or community-based services?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

16b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

17a. Does your school foster a positive psychosocial school climate using all of the following practices?

- Communicate clear expectations for learning and behavior to students, and share those expectations with families to encourage them to reinforce them at home
- Foster pro-social behavior by engaging students in activities such as peer tutoring, classroom chores, service learning, and teacher assistance
- Foster an appreciation of student and family diversity and respect for all families' cultural beliefs and practices
- Hold school-wide activities that give students opportunities to learn about diverse cultures and experiences
- Use instructional materials that reflect the diversity of your student body
- Establish an expectation that staff members to greet each student by name
- Expect staff members to encourage students to ask for help when needed
- Expect staff members to take timely action to solve problems reported by students or parents
- Expect staff members to praise positive student behavior to students and their parents

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

17b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

18a. Does your school take steps to foster peer relationships among students in each of the following ways?

- Allow students time to socialize and engage with one another outside of classroom or learning time (e.g., classroom breaks, lunch, recess)
- Incorporate structured time for socialization during the school day (e.g., classroom breaks or group activities)
- Refrain from enforcing silent lunch

Check all that apply.

- Keep
- Modify
- Discard
- Unsure

- The content of this question is VERY IMPORTANT for student health and wellness!

18b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

19a. Have all teachers received professional development on meeting the diverse cognitive, emotional, and social needs of children and adolescents in the past two years?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

19b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

20a. Do teachers at your school collaborate with counseling and psychological services staff to promote social and emotional learning (e.g., providing information to students on developing self-awareness, managing emotions, or maintaining interpersonal relationships; referring students for support services) for students?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

20b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

21a. Does your school implement social and emotional learning programs for all students?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

21b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

22a. Does your school partner with community organizations to provide students with educational materials and/or resources (e.g., fact sheets on socioemotional well-being, information on community-based counseling services, stress management skill building, depression screenings) to promote social and emotional learning and wellbeing for students in school?

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

22b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

23a. Has the school established a climate, in each of the following ways that prevents harassment and bullying?

- Staff members, students and parents are informed through a variety of mechanisms of policies defining harassment and bullying and explaining the consequences of such behaviors
- Disciplinary policies are fairly and consistently implemented among all student groups
- Staff members and students treat each other with respect and courtesy
- Fair play and nonviolence is emphasized on the playground, on the school bus, and at school events
- Students are encouraged to report harassment or bullying, including through anonymous reporting methods

- Support is provided for victims of harassment or bullying

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

23b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

24a. Do staff members actively supervise students, in each of the following ways, everywhere on campus (e.g., classroom, lunchroom, playground, locker room, hallways, bathroom, and school bus)?

- Observing students and being available to talk to students before, during, and after school
- Anticipating and effectively responding to unsafe situations
- Discouraging pushing and bullying
- Promoting prosocial behaviors, such as cooperation, conflict resolution, and helping others

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

24b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

25a. Does your school prioritize efforts to engage all students (i.e., diverse students, including but not limited to racial/ethnic minority youth, LGBTQ youth, youth with disabilities, youth with chronic conditions, homeless youth, etc.) in extracurricular school activities to foster student sense of belonging in the following ways?

- Plan activities and events that intentionally include all members of the student body

- Provide space and time for students with similar interests to interact
- Include representations of youth from diverse backgrounds in school posters and/or advertisements
- Take measures to protect the emotional and physical safety of all students

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

25b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

26a. Does your school take steps to prevent violence, in each of the following ways?

- School administrators and staff implement and enforce a clear and consistent code of conduct to uphold a standard of nonviolence for students
- Students and families receive hard copies and/or electronic copies of the school's code of conduct and must read and sign to acknowledge receipt of the code of conduct
- School administrators and staff implement and enforce a written policy prohibiting any weapons (e.g., guns, knives, makeshift weapons) on school campus.
- Teachers implement conflict prevention strategies (e.g., mediation)
- Teachers and staff demonstrate and encourage the use of appropriate conflict resolution skills
- Staff members are regularly assigned to be responsible for monitoring and protecting student safety on the school campus

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

26b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

27a. Does your school take steps to prevent violence, in each of the following ways?

- School administrators and staff implement and enforce a clear and consistent code of conduct to uphold a standard of nonviolence for students
- Students and families receive hard copies and/or electronic copies of the school's code of conduct and must read and sign to acknowledge receipt of the code of conduct
- School administrators and staff implement and enforce a written policy prohibiting any weapons (e.g., guns, knives, makeshift weapons) on school campus.
- Teachers implement conflict prevention strategies (e.g., mediation)
- Teachers and staff demonstrate and encourage the use of appropriate conflict resolution skills
- Staff members are regularly assigned to be responsible for monitoring and protecting student safety on the school campus

Check all that apply.

- Keep
- Modify
- Discard
- Unsure
- The content of this question is VERY IMPORTANT for student health and wellness!

27b. Explain your reasoning. Answer 1 of these 3 questions: Why should the question be kept? How should it be modified and why? Why should it be discarded? What are you unsure about?

What questions would you add to the SHI? Provide a draft of your question(s) and an explanation. Consider how a school might measure the question.

Comments:

APPENDIX E

FOCUS GROUP PROTOCOL

Title: Phase 3, Focus Group Protocol

Researcher(s): Erin R. Hanson, University of Oregon

Researcher Contact Info:

Time of Focus Group: 10:00 AM - 12:00 PM

Date: Tuesday, March 7th, 2023

Location: Zoom

Interviewer: Erin R. Hanson

Participants:

Recording/Storing Information about the Interview

The focus group will be conducted over Zoom and video recorded and transcribed using the Zoom application. The recording and transcript will be stored on the private hard drive of the researcher and in a password protected computer.

Purpose Statement

This study is exploring how the intersection of social emotional learning (SEL) and mental health literacy (MHL), in the context of health education, can improve health promotion in schools and ultimately prevent student death by suicide. The combination of social, emotional, mental, and physical health education in schools can be used as a protective factor against the onset and severity of mental illness and overall distress in students from kindergarten through 12^{th} grade. Both SEL and MHL are skills-based, as is health education. They are also universal prevention that is provided to all students regardless of need. When SEL is implemented with intentionality and integrated into core content for all students, it can improve academics, decrease negative behaviors, and improve the overall climate and culture of a school (Durlak et al., 2011). But SEL alone rarely bridges the gap to suicide prevention. MHL provides necessary mental health skills that lead to management and treatment of mental health conditions.

Prior to the Focus Group

After informed consent is granted, participants will be sent a brief presentation regarding the current state of mental health literacy, social emotional learning, and health education in the district. This activity will be completed by watching a recording of the presentation. The presentation lays a foundation for the work ahead and will take no more than 15 minutes.

In a digital survey format, they will be asked to provide their feedback on the original School Health Index and make suggestions for improvement. They will read the question and indicate whether it should be kept, modified, or discarded. They can also indicate that they do not have enough information to answer the question. There will be space for them to explain their reasoning and/or suggested adaptations. They will be provided space to create their own questions. They are not to discuss their feedback with other members of this study. All feedback will be gathered and presented in the focus group.

Focus Group Details

This is a semi structured focus group protocol. Participants are district personnel who support health education, SEL, and/or mental health as part of their work (ie. school counselors, teachers on special assignment (TOSAs), care coordinators, health teachers). Signed consent is emailed to participants at the time of scheduling and received prior to the scheduled interview time. The consent includes information about the virtual meeting and that it will be recorded and transcribed. The focus group will last approximately 1 hour and 30 minutes and will be conducted virtually through Zoom. Remind participants in advance to find a quiet location without interruptions and a strong internet connection. Fill in the details below and review each procedure with the participants as indicated.

Research Questions

RQ1. How, and to what extent, are health education, social emotional learning, and mental health literacy present and where do they align, if at all?
RQ2. What are educator perceptions of the challenges, opportunities, and potential alignment of health education, social emotional learning, and mental health literacy?
RQ3. What innovative and alternative solutions do educators provide to meet the mental health needs of elementary school children?

Moderator Responsibilities

- Ensure that you are familiar with Zoom, how to record, and how to access the transcription.
- Share the Zoom link in advance of the meeting, Unless you are meeting in person. In that case, you'll use the Zoom room as a recording and transcription device only.
- Prepare to share the feedback provided on the original School Health Index.
- Make participants feel welcome and appreciated for their participation.
- Ensure participants are familiar with Zoom and how to use the chat.
- Review group agreements and make sure everyone has the opportunity to speak.
- Avoid sharing personal opinions and commentary on what participants share.

- Manage pacing and complete the list of questions.
- When an explanation would be helpful, probe for additional information.
- Ask for examples and illustrations.
- Be alert and present in the conversation.
- Keep centered on the purpose and goals of the focus group.
- Present question in the order they are presented
- Take brief notes about what is said and observed.
- Check your Zoom settings in your online account to ensure that closed captioning and live transcription is enabled.

Moderator Agenda

Minutes	Activity
Prior to Start	Set-up Zoom functions
10:00	Welcome. Remind participants that the group will be recorded and start recording.
10:03	Group agreements
10:05	Presentation
10:07	Questions and Discussion
10:32	Final Product
10:37	Participant Instructions
10:42	Group Work
11:30	Reporters Share Out
11:55	Wrap-up
12:00	Stop recording. Save transcript.

Focus Group Activities & Memo

1. **Set-up Zoom Functions**

    a. *Click "Show Captions."*
    b. *Create 3 breakout rooms.*
        i. *Choose "Let participants choose rooms."*

ii. *Click "Options." Make sure "Allow participants to choose rooms" and "Allow participants to return to the main session at any time" are the only boxes checked.*
iii. *Click "Open All Rooms."*
iv. *Open "Participants" menu. When co-hosts arrive, click on "..." and add them as co-hosts.*

c. *Be prepared to record after the welcome message.*

2. Welcome (10:00)

a. *Make everyone feel comfortable.*
b. *Thank participants for participating.*
c. *As an opening activity, ask each participant to write in the chat the number of years they have been in their current role, and previous positions related to student social emotional learning, mental health, and/or health education.*
    i. *Copy & paste into chat:* 1. How many years have you work in education? 2. How many years have you been in your current role? What positions have you held that relate to student social emotional learning, mental health, and/or health education?
d. *Tell participants that you'll start recording.*
    i. *Ask if everyone knows where the chat function and raise hand function are. Help those who are not familiar. See "Chat" and "Reactions" in the menu on the bottom of the screen.*
e. *Start recording. Click on "Record".*
f. *Open presentation.*

3. Group Agreements (10:03)

a. *Share the ground rules. Refer to slide 2.*
    i. "Before we dive into the questions, I'd like to share a few group agreements. First, I ask that we stay present and on topic during this time."
    ii. "I ask that we share the floor. If you notice you're sharing a lot, try stepping back. If you notice you aren't sharing very much, try to step in."
    iii. "The third agreement is that discussion is encouraged. Feel free to unmute and add to someone else's thoughts or share a different perspective. I'll get us moving when we need to go to the next question. I apologize if I cut you off at some point."
    iv. "The fourth agreement is that we'll use the chat as our Parking Lot. If the conversation made you think of something that we don't have time to discuss, feel free to use the chat. Include a PL before typing, so I know it's a Parking Lot item and not something we need to dive into right now. Or I may ask you to add it to the chat for discussion at a later date."
    v. "I originally allotted 1.5 hours for this focus group, but quickly realized that wouldn't be enough time to complete our task. If you cannot stay until

12:00, please type in the chat when you'll need to head out and leave a quick goodbye message when you leave."

4. Presentation (10:05)

a. Give a brief summary of the purpose of the focus group, the presentation shared with them prior to this meeting, and define any terms as needed. Refer to slide 3.

i. "Explore how the intersection of social emotional learning, mental health literacy, and health education can improve health promotion in schools and ultimately prevent student death by suicide."
ii. "The alignment of social, emotional, mental, and physical health education in schools can be used as a protective factor against the onset and severity of mental illness and overall distress in students from kindergarten through 12th grade."
iii. "Both SEL and MHL are skills-based, as is health education. They are also universal prevention that is provided to all students regardless of need. Today's focus is elementary."
iv. "Today, we'll start with a few discussion questions and then we'll dive into the survey results in about 25-30 minutes."

5. Questions and Discussion (10:07 - 25 minutes)

a. Refer to slide 4.
b. (10:07) "Prior to coming together you had time to reflect on some district data. What came to mind for you as you reviewed the data? You are welcome to unmute or write your response in chat. You're welcome to ask questions, but I may not be able to give you a full answer at this time.
   i. Put the question in the chat. Share presentation link.
   ii. Probes: "Tell me more." "Can you expand on that statement?"
c. (10:12) "What are your thoughts regarding the current state of social emotional learning, mental health literacy, and health education in the district? I know this question is broad, so here are some sentence starters to spark your thinking:"
   i. Put the question in the chat.
   ii. *Copy & paste into chat:* "I think we need more/less of…", "In my opinion we could…", "I would like to see…", "I am encouraged/surprised by…"
   iii. They are welcome to unmute to speak or write their response in chat.
   iv. Probes: "Tell me more." "Can you expand on that statement?"
d. (10:17) "What are the opportunities and challenges of aligning this work? We're going to use a chat waterfall. First, I want you to think about opportunities. When I say "waterfall" go ahead and click enter. I'll give you some time to think.
   i. Put the question in the chat: What are the opportunities of aligning this work?
   ii. Read out some of the responses.
   iii. Probes: "Tell me more." "Can you expand on that statement?"
e. (10:19) "Now, let's do the same thing for challenges.

   i. *Put the question in the chat:* What are the challenges of aligning this work?
   ii. *Read out some of the responses.*
   iii. *Probes: "Tell me more." "Can you expand on that statement?"*
f. (10:22) "What does alignment look like? It's okay to think practically or innovatively here."
   i. *Put the question in the chat:* What does alignment look like?
   ii. *They are welcome to unmute to speak or write their response in chat.*
   iii. *Probes: "Tell me more." "Can you expand on that statement?"*
g. (10:27) "What topics or questions have we missed that still need to be explored? We won't be able to dive into these here, but I want to give you the opportunity to put your ideas on the table. Please put your comment or question in the chat."
   i. *Put the question in the chat:* What topics or questions have we missed that still need to be explored?
   ii. *Give think time. Have participants make a list in the chat. Read out comments.*

6. Final Product (10:32 - 5 minutes)

a. Refer to slides 6-9.
b. Briefly review the components of the SHI.
   i. "Based on some of the questions I received, it might have been helpful to have a more detailed understanding of the final product prior to completing the survey, so we're going to take a moment now to review the components that will be included in the final product."

7. Participant Instructions (10:37 - 5 minutes)

a. Refer to slides 11-14
b. Clearly outline what you are asking participants to do.
   i. *Slide 11: "*In a moment I'm going to break you up into groups. Each group will be assigned a certain number of questions. You'll have 30 minutes to review the data for each question and create a draft set of questions. I encourage discussion, but 30 minutes will go by quickly. You have approximately 3 minutes per question. We'll come back to this slide in a minute."
   ii. *Slide 12: "*One person in your group will be in charge of recording the breakout. I've provided some directions for this person here. You also need to choose someone who is willing to be your notetaker. This person will record key discussion points in the speaker notes. They can also be the scribe as you wordsmith the questions. Finally, you'll need someone who is willing to report back to the whole group. Their main job is to share your final questions, but can also share a few key details from your discussion."
   iii. *Slide 13: "*Here is an example of what each question slide looks like. Let's

start with the bar graph. This bar graph represents the percentage of people who indicated each of the options. In this case, 79% of people said KEEP. On the small table below it shows you how many people represent each percent, so 79% is about 16 people. I did not include this table in each slide, so you can refer back to this slide if you need a reference."

iv. "You'll also see some excerpts from the survey. It wouldn't be efficient or helpful for me to include every excerpt, so I chose excerpts that represented the main ideas presented in the data and would be helpful to inform our process."

v. "I have also included hearts, x's, and sticky notes in the margins. You may use these to interact with the slide. You simply click and drag to a location. It is not essential that you use these. I just thought they may be helpful."

vi. "Finally, there will be a text box for you to write down your final suggestions. You may write out a final question. You may suggest that the question be discarded or combined with another question."

vii. *Slide 14*: "Before we dive in, I want to share a couple reminders."
   1. Audience
   2. Purpose

viii. "Any questions?"

8. Group Work (10:42 - 45 minutes)

a. Create three breakout rooms.
b. Go into all breakout rooms in the first few minutes to make sure they understand the directions. After that, pop in and out of rooms every 5 minutes or so.

9. Reporters Share Out (11:30 - 15 minutes)

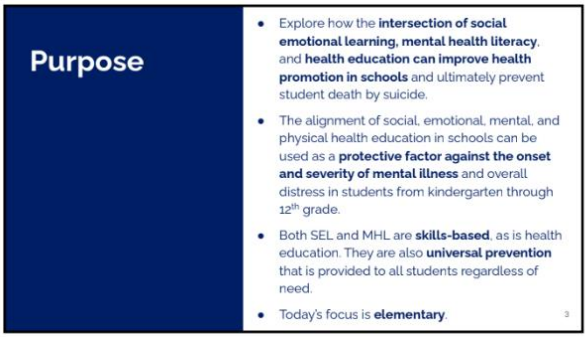
a. Give each group 5 minutes to share their group's conclusions.

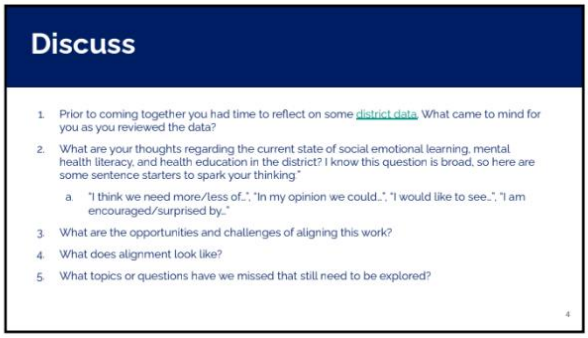
10. Wrap-Up (11:55)

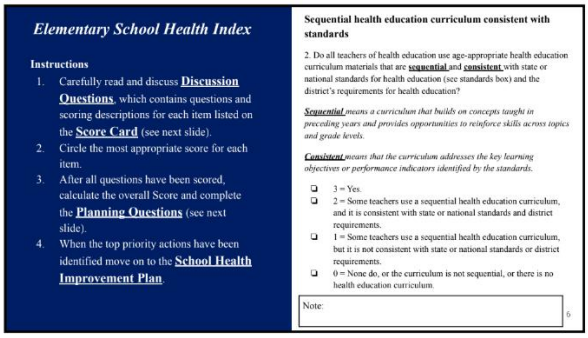
a. There is 15 minutes of wiggle room if a previous activity takes longer than expected.
b. Explain that a final draft of the SHI will be shared with the group. It will likely get a few more tweaks. The hope is to pilot this with a few schools before it goes live.
c. Thank the participants for their thoughtful dialogue and participation.
d. Stop recording. Click "Stop Recording." DO NOT CLOSE MEETING.
e. Click on Captions menu. Click "View Full Transcript." Click "Save Transcript."
f. Click "Show in Folder." Locate and ensure all files are accessible before closing Zoom.
g. Save the chat. Click on "Chat." Click three dots. Click "Save Chat" and "Show in Folder."
h. Close Zoom.

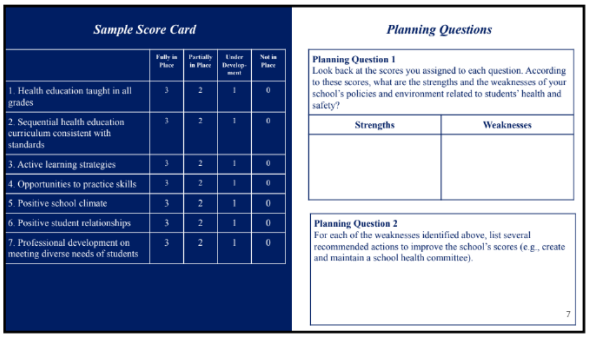
APPENDIX F

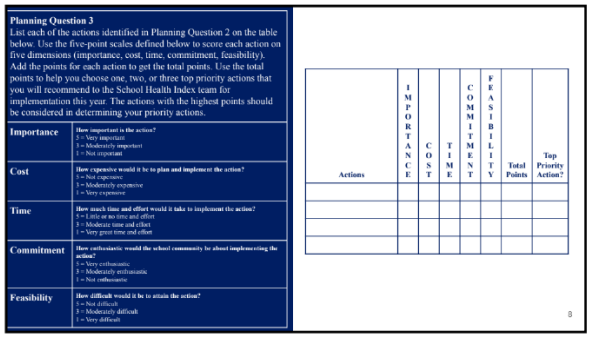
PHASE 3 PRESENTATION AND WORKING DOCUMENT











School Health Improvement Plan

Instructions

1. In the first column: list, in priority order, the **actions** that the School Health Index team has agreed to implement.
2. In the second column: list the specific **steps** that need to be taken to implement each action.
3. In the third column: list the people **who** will be responsible for each step and **when** the work will be completed.

Actions	Steps	By Whom and When
1.	a. Type here b. Type here c. Type here	Name; Date
2.	a. Type here b. Type here c. Type here	Name; Date
3.	a. Type here b. Type here c. Type here	Name; Date
4.	a. Type here b. Type here c. Type here	Name; Date
5.	a. Type here b. Type here c. Type here	Name; Date

9

Participation Instructions

10

Breakout Rooms

Instructions:

- Assign Note Taker & Reporter
- Read slide 16
- You have 30 minutes to read your questions and the results.
- Discuss how you can adapt the questions.
- You're welcome to pop into another breakout room.
- Come back to main room if you finish early.
- Reporter will present your recommendations (5 min each).

Room #1 - Q 1-10 (Slides 17-26)

Room #2 - Q 11-18 (Slides 27-37)

Room #3 - Q 19-26 (Slides 38-48)

11

Breakout Room Roles

Note Taker

- Record key discussion points in the speaker notes.

Reporter

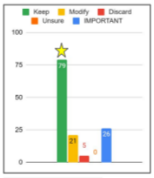
- Share out a brief summary of the discussion for each question and the draft questions.

Video & Transcript

- Erin will assign ___, ___, and ___as co-hosts.
- Click record & show captions.
- Before leaving the room, stop recording and click the captions menu ^.
  - Click "View Full Transcript." Click "Save Transcript."
- After the breakout room closes, the recording should start converting.
- Upload all files to this Google Folder.
- DO NOT delete from your desktop until Erin confirms they are uploaded to Google.

12

Example Question



Responses	%
21	5
5	26
10	50
15	75
20	100

Keep	• Legally required. Is it actually being implemented? • normalize the learning and understanding of our health • Good starting off point • Consistent access to health education essential to healthy students
Modify	• Could be changed to say "in each grade level". • Add "adequate health education" and define "adequate." • Combine with 2a • Consider CSE lessons and health standards/curriculum • "In which grades do students receive health education instruction?" and give teachers a breakdown of options.

Suggestion:

- Do students receive age-appropriate health education using curriculum materials that are adequate, sequential, and consistent with state and national standards for health education and the district's recommendations for health education at each grade level?

13

Remember!

Audience:

- Think Climate & Culture Team meets Care Team. It should be a mix of classroom teachers, maybe one from each grade level, and support staff, especially those who are part of Care Team.

Purpose:

- We are developing a tool that schools can use to reflect on and improve their health promotion practices.
- These practices include the universal supports that address the social, emotional, mental, and physical health of our students.

14

Survey Results

15

Read First: Questions & Comments

- Maybe put the curriculum questions first. Then the teaching practices. Then the systems?
- Are all staff members routinely encouraged and provided opportunities to participate in PD related to student mental health, mental health literacy, mental health first aid, and/or suicide prevention?
- Are students provided with adequate suicide prevention lessons?
- Add a question about the mental health education curriculum and the SEL curriculum. We don't want teachers to just pull any old thing off TPT and use it for instruction. There needs to be a reasonable rationale. For instance, does the SEL curriculum align with CASEL?
- I would add concepts about access through language/culture and family education/involvement.
- How are we supporting or challenging students with a higher EQ (emotional intelligence). "Have all teachers of health education received professional development on best practices for providing a learning environment that ensures each student is challenged..."
- A question around how mental health awareness has been built into instruction and PD opportunities for staff.
- The escalation cycle and restorative practices might fit in.

16

1a. Do students receive health education instruction in all grades?

Keep	• Legally required. Is it actually being implemented? • normalize the learning and understanding of our health • Good starting off point • Consistent access to health education • essential to healthy students
Modify	• Could be changed to say "in each grade level". • "In which grades do students receive health education instruction?" and give teachers a breakdown of options. • Add "adequate health education" and define "adequate." • Combine with 2a • Consider CSE lessons and health standards/curriculum

Suggestion:

- Do students receive age-appropriate health education using curriculum materials that are adequate, sequential, and consistent with state and national standards for health education and the district's recommendations for health education at each grade level?
  - See definition for Sequential and Consistent in 2a notes. Define adequate.

18

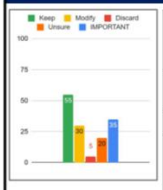
2a. Do all teachers of health education use age-appropriate health education curriculum materials that are **sequential** and **consistent** with state or national standards for health education and the district's requirements for health education?

Keep	• Again---they should be doing this. • The team at each school would be able to use this question to assess whether or not teachers are using the programs we adopted. • Very important for staff to analyze if they are providing a comprehensive program and not just piecing it together. • ..ensure that the info is vetted and delivered in a consistent way for all students. • Students deserve to have instruction that is well-developed and grows with them. • clear and consistent expectation
Modify	• Who is monitoring and what supports are needed to move the work forward? Is there dedicated time in schedules?
Discard	• Combine 1a & 2a • I don't really understand the necessity of this question if we already know there is a curriculum chosen and being used that meets these requirements.

Suggestion: See 1a

18

3a. Do all teachers of health education use **active learning strategies** and activities that students find engaging and make learning relevant to their daily lives?



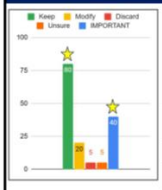
Keep	• Culturally relevant; takes a look at the teachers culturally RESPONSIVE teaching and their ability to accommodate a diverse group of students with various learning styles • Without engaging learning strategies we are "checking the box" • Deepens student understanding of content • Need 'buy in' from students; Students need to be able to make connections
Modify	• List examples; offer examples; What does this look like specifically? • Should we say "mental, social, emotional, and physical health education." rather than just focusing on health education?
Discard	• Redundant
Unsure	• Unsure how we'd measure something like this • Will staff be able to provide accurate feedback on what is happening outside their own classroom? • This is more about instructional strategies and teaching practices than health education

Suggestion: Combine 3a & 5a

Do all teachers of health education use **active learning strategies** and a variety of **culturally responsive activities** that students find engaging and make learning relevant to their daily lives, as well as reflect the community's cultural diversity?

19

4a. Do all teachers of health education provide opportunities for students to practice or rehearse the **skills needed to maintain and improve their health**?



Keep	• opportunity to practice and generalize skills; practice what they learn in order to build true mastery; practice and modeling is crucial; you need to practice skills to reinforce them, create habits • whole child • student engagement is so important, normalizing physical and mental health, encourage discussion, different points of view and practice in order to prepare students and encourage them to think critically about these topics. • Best practice in health education is a "skills-based approach" • role playing helps develop muscle memory
Modify	• more training and support is needed with the new curriculum • lots of modelling and possibly video examples
Discard	• My hope would be that this is addressed in our Health curriculum
Unsure	• measurement might be tricky.

Suggestion:

20

5a. Do all teachers of health education use a variety of culturally-appropriate activities and examples that reflect the community's cultural diversity?

Keep	• Equity • This should be something we consider for all lessons/curriculum • Diversity of the [redacted] community, build social awareness • Curriculum often tends to have bias. Additional texts or materials may need to be developed for underserved communities. • student's well-being is connected to culture. • Various cultures have varied approaches and understandings of health education that emerge out of an indigenous background • relevant to their lived experience • This is important for relationships and interpersonal connections especially around personal values and beliefs that support healthy behaviors and the shaping of group norms that value a healthy lifestyle.
Modify	• "do all teachers of health education in your grade level team use a variety of.." • Should we say "mental, social, emotional, and physical health education," rather than just focusing on health education? • culturally responsive.
Unsure	• requires a very intentional approach in terms of how it is defined and measured.

Suggestion: Combine 3a & 5a

Do all teachers of health education use **active learning strategies** and a variety of **culturally responsive activities** that students find engaging and make learning relevant to their daily lives, as well as reflect the community's cultural diversity?

21

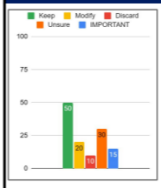
6a. Do all teachers of health education use assignments or projects that encourage students to have interactions with family members and community organizations?

Keep	• convos within the home is super important • We want facilitate student connection to family and community resources, and "accessing information" is one of the health skill standards. Regular connection with families also facilitates transparency around what is happening in the classroom and allows families to build on the concepts/skills taught in class in the context of their family values.
Modify	• merge with our SEL family nights • could present a barrier for students • needs to be adjusted. • examples representing alternatives to family; not just family members • projects that have an optional family or community component.
Discard	• I don't think that ASSIGNMENTS and PROJECTS is the correct approach for this. Modify: not teachers but school • not as important as some of the other questions.
Unsure	• does our curriculum have these • other questions on this survey are more helpful indicators

Suggestion: Discard

22

7a. Do all teachers of health education participate at least once a year in professional development in health education?



Keep	• systems check, opportunity to grow, learn from others, ask questions • access to new data, curriculum and collaboration with teachers. • We all carry with us our own personal experience and thoughts about health and professional development helps us not only provide accurate information but check our biases in this work.
Modify	• On going vs. continuous PD • Reflect training opportunities. • Teacher accountability vs. system accountability. Maybe this is two questions? • Maybe every 2 years? • Be more specific, are we saying district provided? School-based PD? Outside of the district? From the curriculum partners?
Discard	• just need one PD question • other questions are similar
Unsure	• I wouldn't want to ask the question unless I knew there were opportunities available. • What's the expectation? Is PD once a year on this topic a requirement/standard? • how realistic is 1x a year?

Suggestion:

23

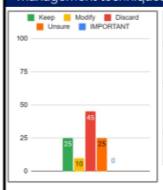
8a. Have all teachers of health education received professional development in delivery of the school's health and safety curriculum in the past two years?

Keep	• great systems check • PD provides accurate information and helps us to check our biases • Instructional strategies and resources should be updated and current to meet the needs of students • Health education is ever evolving, keeping teachers up to date
Modify	• reflects a sustainability model, realistic? • Include SEL and mental health in this question.
Discard	• ask #7 or #8, but not both • condense
Unsure	• Is this something the district offers? • I would say that if the curriculum doesn't change, PD may only be needed once? • Do we need it to say "in the past 2 years"? What is our goal? • Not sure how important this question is. A question on pd around school health promotion or universal supports would be better in helping teams develop goals for improvement.

Suggestion:

24

9a. Have all teachers of health education received professional development in classroom management techniques in the past two years?



Keep	• creating a safe environment in the classroom is going to have a big impact on how these concepts are going to be able to be approached.
Modify	• "have all teachers of health education received PD in building a classroom culture of safety and belonging?" • especially with all the new staff
Discard	• Not relevant; unrelated • not sure this is necessary • Classroom management is very broad and general. • Maybe new teacher PD
Unsure	• I don't find it AS important as some of the other questions • I'm unsure if it makes sense to include it in this health-specific index

Suggestion: Discard.

25

10a. Does your school have access to a full-time counselor, social worker, or psychologist for providing counseling, psychological, and social services? Is an adequate number of these staff members provided based on the following recommended ratios?

- One counselor for every 250 students - One social worker for every 400 students - One psychologist for every 1,000 students

Keep	• Advocate for more mental health support! • I think it's directly tied to the health and wellness of our students. • Service providers are essential to this work for supporting the mental health of students
Modify	• Helpful to understand the workload of mental health professionals in the building. But seems like the caseload numbers could be a separate question? • This is not the model we have in [redacted]. And..we can't afford it. Focus this on counselors and counseling • access to a counselor in their primary language. • break down into 3 questions: one for counselor, social worker, and psychologist
Discard	• more for admin? I don't think this evaluates the school's health promotion practices.
Unsure	• I'm curious how buildings will feel as they complete this if they DON'T meet this criteria, though? As it's not typically something they can do much about. • these numbers still seem high

Suggestion:

26

11a. Does the counseling, psychological, or social services provider promote the emotional, behavioral, and mental health of and provide treatment to students and families in the following ways?

- 1-on-1 counseling/sessions - Small group counseling/sessions
- Classroom-based health promotion and prevention - School-wide health promotion and prevention

Keep	• countless students who would not access these necessary services if they weren't offered at school and I consider it critical equity work. • assess if services are being provided in multiple ways to meet the needs of students and families
Modify	• Would be good if these were individual questions so you could see what each school is receiving. • Most of those roles can't provide 'treatment' in a school setting. • I would add are services available in the language the family needs. • modify this to reflect current [redacted]staffing. This is not our model. Take out "psychological or social services." • pulse on where holes might be in the school counseling program. Or if the school counselor needs to improve communication on what services are being offered. In some buildings, different people may be helping to meet these needs. • We need to be careful that this doesn't feel evaluative for the school counselor.
Unsure	• Classroom-based and school-wide health promotion and prevention does not need to come from the counseling department. Ideally, they'd be the product of a diverse group of staff members and other stakeholders.

Suggestion:

27

12a. Does the counseling, psychological, or social services provider collaborate with other school staff members to promote student health and safety in at least six of the following ways?

Keep	• The more people we have advocating for and teaming together for students the better and I believe that helping professionals like social workers and counselors have a unique lens and skillset to offer. • accountability. This question allows for reflection and asking 'do we do this?' and may bring light to a situation where they might not be doing this. • Collaboration between the counseling dept and other staff is vital. • Collaboration...safeguards against bias, preferences, and assumptions • Student well-being is more than health curriculum • important to have mental health specialists "at the table"
Modify	• Read like there is one person doing this work. Can the question be more expansive to include other providers? • add family engagement; flesh out "developing and implementing school-wide and classroom activities" • Where does the number 6 come from? Take out "psychological and social services" • Counselor and success coaches and behavior specialists are the relevant players for this question I think.
Discard	• This feels very targeting and judgmental of a school counselor's role and program

Suggestion: Compare 12 & 20.

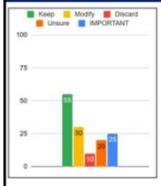
28

1. - Developing plans to address student health problems (e.g., individual health care plans, individual education plans, **504 plans**, school team plans)
2. - Providing **professional development** on managing student health and safety concerns, a component of which educates staff on the impact of Adverse Childhood Experiences (ACEs) and the principles of a trauma-informed school
3. - Developing policy
4. - Identifying, revising or developing curricula or units/lessons
5. - Developing and implementing school-wide and classroom activities
6. - Developing School Improvement Plans
7. - Establishing communication systems with other school staff

12a. Does the counseling, psychological, or social services provider collaborate with other school staff members to promote student health and safety in at least six of the following ways?

29

13a. Does the counseling, psychological, or social services provider have a system for identifying and tracking students with emotional, behavioral, and mental health needs?

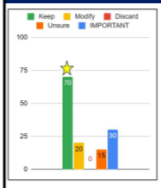


Keep	• Tracking systems are important for case management of any kind. • Very important as students move from school to school • Accountability • School teams should be involved in creating support systems for students. • Very important to identity and intervene with our at risk students.
Modify	• I'm not sure our staff would know that we actually do this as part of care team. • Take out "psychological and social services" • I'm not sure this should ONLY fall on these roles: "in collaboration with other school staff as appropriate"?
Discard	• This is very much a systems question. Not sure if this addresses school health promotion and universal supports.
Unsure	• Do we really want to be "tracking" students? That term has a lot of baggage. I think this question is trying to get at things like the Care Team process and referral process. We might be able to discard this question depending on how we modify the next question. • IF the tracking system does not perpetuate oppressive and marginalizing treatments, biases, and assumptions. • feels like deficit language

Suggestion:

30

14a. Does your school implement a systematic approach (including the following components) for referring students, as needed, to appropriate school- or community-based counseling, psychological, and social services?



Keep	• Good check on whether or not systems are clearly communicated • This is part of how we ensure that students' needs are being addressed and managed • necessary so students don't fall through the cracks.
Modify	• a lot of this specifically applies to Care Coordinators. Can we make it specific to them? • break up components: Very long • Families should receive support in the language that best supports students needs. • checks and balances, so that no one entity is responsible for referral. • Take out "psychological and social services". Discuss the term "referral," not referral to special education. • the first part of this question would reveal if the system of linking students to supports is well known and accessible to the larger team.
Unsure	• not as necessary of a data point as some of the other questions. • I'm not sure if this is the place for this. Is this more of a counseling department question vs. a climate & culture team question?

Suggestion:

31

1. Case management, including assessment, referral, education, support, and monitoring, is offered.
2. Referral information is distributed widely (e.g., through flyers, brochures, website, student handbook, health education class) so that students, staff, and families can learn about school and community services without having to contact school staff.
3. **Staff members** are given clear guidance on referring students to school counseling, psychological, and social services.
4. Referral forms are easy for staff members to access, complete, and submit confidentially.
5. A designated staff person (e.g., school counselor, social worker, or psychologist) regularly reviews and sorts referral forms and conducts initial screening.
6. With written parental permission, additional information (e.g., questionnaires, relevant records, brief testing) is gathered as necessary and in compliance with **FERPA**, and all information is kept confidential.
7. Written consent is obtained, in compliance with **HIPAA**, to gather relevant records from other professionals or agencies in a confidential manner, if applicable.
8. A list is kept and regularly updated of youth-friendly referral providers along with basic information about each (e.g., cost, location, language, program features, previous client feedback, types of insurance accepted)
9. Meetings are held with all relevant parties to discuss referral alternatives.
10. Potential barriers (e.g., cost, location, transportation, stigma), and how to overcome them, are discussed.
11. Follow-up (e.g., via telephone, text messaging, email, personal contact) is conducted to evaluate the referral and gather feedback about the service.
12. A status report is provided to the person who identified the problem, if applicable and in compliance with FERPA and/or HIPAA.
13. Professional development is provided to all staff members about the referral process.

14a. Does your school implement a systematic approach (including the following components) for referring students, as needed, to appropriate school- or community-based counseling, psychological, and social services?

32

15a. Does your school aid students during school and life transitions (such as changing schools or changes in family structure) in the following ways?

- Matching new students with another student or buddy - Opportunities for students to check-in with a trusted adult
- Orientation programs that focus on adapting to transitions

Keep	• Students get lost in transitions. This will help create a sense of belonging. • This seems like an important proactive practice. • Need to do a better job with this
Discard	• seems like a good question but not as vital as others • I'm not sure this question is necessary • May not be prioritized in the top 20 • This needs to be fleshed out. Are we talking about new students, 6th graders moving onto middle school...? Discussing transitions is important and this can be addressed through school systems, but if we need to discard a question this may be one.

Suggestion:

33

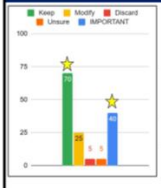
16a. Does the counseling, psychological, or social services provider have a system for identifying students who have been involved (as a bystander, victim, perpetrator, or some combination of these) in any type of violence (e.g., child abuse, dating violence, sexual assault, bullying or harassment, fighting, suicide and self-harm behaviors) and, if necessary, refer them to the most appropriate school-based or community-based services?

Keep	• I think being able to identify ACES in a proactive manner is always beneficial in the long run. • I love the idea of proactively supporting our bystanders not just perpetrators and victims.
Modify	• I appreciate that perpetrator is included in this conversation and I would add opportunities for transformative justice. • Maybe re-categorize these groups of people for [redacted] purposes as "SEL team" - "Does your SEL team have a system for identifying students.." • Take out "psychological and social services" • What would be some examples of systems for identifying students? • "Does your school aid students after being involved (..) in any type of violence (..) in the following ways?" - Referring them to appropriate school-based services - Referring them to appropriate community-based services - and so on
Discard	• I think this gets us into the universal screener territory which we have shied away from as a system in favor of a universal precaution approach. Right now we rely on self report and family report to specifically link students to support. • if you had to cut questions, I think this could go.

Suggestion:

34

17a. Does your school foster a positive psychosocial school climate using all of the following practices?



Keep	• It would be important for a teacher to be able to indicate which of the above areas are present and which may be areas for improvement. • Great list of universal supports and strategies for a positive climate and culture. • If staff is not mentally healthy it is difficult if not impossible for them to support the mental health of students.
Modify	• I'm sure we can probably add things to this list. • bullet 6 needs to be reworded; take out the word "to" • I feel as though some of these could be consolidate to make it more concise. • update to better reflect current language.
Discard	• I don't see this question being needed for this survey. I believe this question gets answered through the EAE committee.
Unsure	• Not convinced that it would be prioritized n the top 20. Thinking it could be integrated with the SEL question. Many of the answers reflect the SEL competencies

Suggestion:

35

1. - Communicate clear expectations for learning and behavior to students, and share those expectations with families to encourage them to reinforce them at home
2. - Foster pro-social behavior by engaging students in activities such as peer tutoring, classroom chores, service learning, and teacher assistance
3. - Foster an appreciation of student and family diversity and respect for all families' cultural beliefs and practices
4. - Hold school-wide activities that give students opportunities to learn about diverse cultures and experiences
5. - Use instructional materials that reflect the diversity of your student body
6. - Establish an expectation that staff members to greet each student by name
7. - Expect staff members to encourage students to ask for help when needed
8. - Expect staff members to take timely action to solve problems reported by students or parents
9. - Expect staff members to praise positive student behavior to students and their parents

17a. Does your school foster a positive psychosocial school climate using all of the following practices?

36

18a. Does your school take steps to foster peer relationships among students in each of the following ways?

- Allow students time to socialize and engage with one another outside of classroom or learning time (e.g., classroom breaks, lunch, recess) - Incorporate structured time for socialization during the school day (e.g., classroom breaks or group activities) - Refrain from enforcing silent lunch

Keep	• With peers being the primary people students turn to it's important to support positive peer relationships. • Humans are social animals and we need real world connection! • We need training for our lunch room supervisors. • This may be a no-brainer for some staff, but for others following the rules, quiet and compliance, and getting through the content tends to get prioritized over practicing social skills.
Modify	• I think the examples should be changed to reflect positive examples. • Can we add an element of instruction - Like directly teaching kids how to play/socialize? (Like Playworks?)
Discard	• This sort of naturally comes during the school day. • I don't see this question being needed for this survey. I believe this question gets answered through the EAE committee. • I am wondering if this question could be integrated in another way. It connects/aligns with any question that underscores SEL.

Suggestion:

37

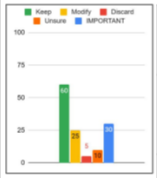
19a. Have all teachers received professional development on meeting the diverse cognitive, emotional, and social needs of children and adolescents in the past two years?

Keep	• This is information that is ever evolving and needs to be a basic component of working with children • This type of PD is super important for teachers to learn developmentally appropriate strategies and effective strategies for diverse learners. • More! How about a merged SEL + Health day at all our schools. Intentional focus to kick off the year. Not a cure-all but a start. • This is very important especially as we move to an inclusion model.
Modify	• This could use some adjustment to clarify what specific training we may recommend for this. This seems vague and I think this as is will create confusion and a range of answers. • Can be adapted to be our mental health PD question. Or we can have a PD question that addresses mental health. SEL, and health education... Maybe a list of PD options, rather than x, y, and z needs to be done in this timeframe.
Discard	• Not sure if I would prioritize this in the top 20 questions.
Unsure	• Seems too broad. May need examples of they types of training this would include

Suggestion:

38

20a. Do teachers at your school collaborate with counseling and psychological services staff to promote social and emotional learning (e.g., providing information to students on developing self-awareness, managing emotions, or maintaining interpersonal relationships; referring students for support services) for students?

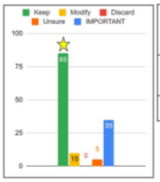


Keep	• Good reminder that teachers play an integral role in SEL • It is important to show the collaboration with school counselors when concerns arise about student well-being. • Teachers know their students and their needs etc, it is important for everyone at the table to be communicating. • We should be promoting teacher/counselor collaboration.
Modify	• "Do teachers at your school collaborate with other staff to promote social and emotional learning?" Check all that apply: - School counselor - Student success coach - Wellness counselor • may not be feasible for all teachers to collaborate with counseling staff given their schedule.... modify this to set meeting times per grade level • Take out "psychological services"; change (i to the 5 CASEL competencies • call out success coaches as well as counselors
Discard	• This may not be prioritized in the top 20. Wondering if this question could be combined/integrated with 21
Unsure	• Does this seem a little duplicative with question 12?

Suggestion: Compare 12 & 20.

39

21a. Does your school implement social and emotional learning programs for all students?



Keep	• Universal SEL not just in response to student need is important. • Primary prevention • This question should align with the mental health education and health education questions.
Modify	• Maybe add a follow-up asking to list the programs)? • At [redacted]ill school should be implementing so do we want to ask how? when? which programs?
Unsure	• Does this feel duplicative at all?

Suggestion:

40

22a. Does your school partner with community organizations to provide students with educational materials and/or resources (e.g., fact sheets on socioemotional well-being, information on community-based counseling services, stress management skill building, depression screenings) to promote social and emotional learning and wellbeing for students in school?

Keep	• This is promoting beyond the classroom. • It is important to raise awareness for students and families
Modify	• This happens at care team - most our staff doesn't know about the details of it. • I think that we should have some version of this
Discard	• Would the care coordinator be the person who helps with this? I'm not sure I see this as vital. • I think as a district we can help with these connections, rather than individual schools needing to do this. They should be ensuring that this information is being shared with families in a variety of ways.
Unsure	• I like the idea of this, but not sure I would chose this question over some of the other indicators • not positive about the importance of this question. • I am unsure if this is needed as a question for this survey.

Suggestion:

41

23a. Has the school established a climate, in each of the following ways that prevents harassment and bullying?

Keep	• Bullying and harassment have severe implications on mental and emotional health. Schools should prioritize plans to prevent bullying and harrassment./ The impact of bullying and harassment on suicide and suicidal ideation must be considered • Does racism or bias fall under bullying and does health curriculum address this subject. Heart disease has a direct correlation to the stress of racism.
Modify	• Need more training especially with Every Student Belongs. • bullet 2 is hard for me - consistent and fair means something different than considering what will work for each student to change behavior • I would add community building in and across classrooms is encouraged. SEL is being taught consistently with frequent opportunities to practice skills. All staff members know what to look for and how to intervene. Students are taught conflict resolution strategies and are encouraged to use them. Students who perpetuate harassment and bullying are provided skill building and mentorship. • Include support for those doing the bullying/harassment! Do not further ostracize.

Suggestion:

42

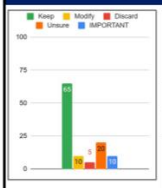
1. - Staff members, students and parents are informed through a variety of mechanisms of policies defining harassment and bullying and explaining the consequences of such behaviors
2. - Disciplinary policies are fairly and consistently implemented among all student groups
3. - Staff members and students treat each other with respect and courtesy
4. - Fair play and nonviolence is emphasized on the playground, on the school bus, and at school events
5. - Students are encouraged to report harassment or bullying, including through anonymous reporting methods
6. - Support is provided for victims of harassment or bullying

23a. Has the school established a climate, in each of the following ways that prevents harassment and bullying?

43

24a. Do staff members actively supervise students, in each of the following ways, everywhere on campus (e.g., classroom, lunchroom, playground, locker room, hallways, bathroom, and school bus)?

- Observing students and being available to talk to students before, during, and after school - Anticipating and effectively responding to unsafe situations - Discouraging pushing and bullying - Promoting prosocial behaviors, such as cooperation, conflict resolution, and helping others

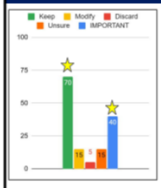


Keep	• This is a great way to catch if a school has times/places in the day or on campus that need adult supervision or MORE supervision because of incidents related to those times/areas. • This is critical to assessing the safety and trust needs of students for them to feel social and emotionally protected/ Lack of supervision may have very adverse effects on mental, emotional, and social health.
Modify	• We should have a question about PD for classified staff members. • The word supervise doesn't seem right. Take it out?
Discard	• I don't think this is necessary
Unsure	• Supervision alone isn't enough. Staff members need to be properly trained to support social interactions and intervene as appropriate. Without proper training, staff intervention can easily veer into punitive bullying/harassment. • This can be a difficult ask as teachers are so busy and sometimes it can be hard to get ahead of the behavior.

Suggestion:

44

25a. Does your school prioritize efforts to engage all students (i.e., diverse students, including but not limited to racial/ethnic minority youth, LGBTQ youth, youth with disabilities, youth with chronic conditions, homeless youth, etc.) in extracurricular school activities to foster student sense of belonging in the following ways?



Keep	• Promoting beyond the school day is so important • Culturally relevant extracurricular clubs (Clubs created from cultural pride interests)
Modify	• I think we should have a question like this for the school day as well. This can relate to classroom jobs, student awards.. This should say something about removing barriers that interfere with participation. Also, seeking student and community voice about when, where, and how activities should roll out.
Discard	• Not really necessary.. I think students foster a sense of belonging throughout their entire day.
Unsure	• We can encourage students to participate in extracurricular activities, but don't think it needs to be in this survey.

Suggestion:

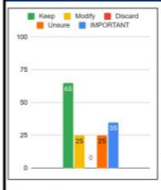
45

1. - Plan activities and events that intentionally include all members of the student body
2. - Provide space and time for students with similar interests to interact
3. - Include representations of youth from diverse backgrounds in school posters and/or advertisements
4. - Take measures to protect the emotional and physical safety of all students

25a. Does your school prioritize efforts to engage all students (i.e., diverse students, including but not limited to racial/ethnic minority youth, LGBTQ youth, youth with disabilities, youth with chronic conditions, homeless youth, etc.) in extracurricular school activities to foster student sense of belonging in the following ways?

46

26a. Does your school take steps to prevent violence, in each of the following ways?



Keep	• I feel like restorative justice and consequences are important to mental health in our schools and this could be a great questions to help track that. • This is huge in contributing to the lack of safety staff and students feel and should be folded in for sure.
Modify	• Include "The school implements/promotes a program/curriculum for developing healthy and dignifying relationship built upon shared humanity, empathy, and community" • Teachers will need mediation and de-escalation PD possibly to be able to navigate violent conflict • Training and onboarding for new staff.
Unsure	• I'm unsure if "clear and consistent" is code for "no tolerance." • Not sure if we want to delve into discipline stuff on this survey.

Suggestion:

47

1. - School administrators and staff implement and enforce a clear and consistent code of conduct to uphold a standard of nonviolence for students
2. - Students and families receive hard copies and/or electronic copies of the school's code of conduct and must read and sign to acknowledge receipt of the code of conduct
3. - School administrators and staff implement and enforce a written policy prohibiting any weapons (e.g., guns, knives, makeshift weapons) on school campus.
4. - Teachers implement conflict prevention strategies (e.g., mediation)
5. - Teachers and staff demonstrate and encourage the use of appropriate conflict resolution skills
6. - Staff members are regularly assigned to be responsible for monitoring and protecting student safety on the school campus

26a. Does your school take steps to prevent violence, in each of the following ways?

48

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