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A View from the Top: Superintendents' Perceptions of Mental Health Supports in Rural School Districts

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Article

A View From the Top: Superintendents' Perceptions of Mental Health Supports in Rural School Districts

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Abstract

Purpose: A chasm exists between the expanding mental health needs of school-aged youth and the school resources available to address them. Education agencies must efficiently allocate their limited resources by adopting innovative public health models. The need for these effective approaches is acute in rural regions, where resources tend to be scarce. This mixed-methods study of school superintendents illuminates key opportunities to optimize access to care for students struggling with mental health needs in rural communities. **Method:** Superintendents serving rural California school districts were targeted for a web-based, mixed response-type, 53-item survey designed to examine their perceptions across three school mental health-related categories: (a) strengths and gaps in community ethos and district infrastructure, (b) school personnel groups' knowledge and skills, and (c) predominant barriers. Of the targeted respondents, 16.7% completed the survey ($N = 62$). Quantitative data were analyzed using a series of descriptive analyses and paired-sample t tests. Qualitative data were analyzed using a constant comparative method with an open-coding

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Part 1: Understanding the Problem

The Mental Health Crisis: The 20/20 Problem

- Twenty percent of school-aged youth in the United States experience mental health challenges that interfere with learning and daily life functioning
- Suicide has risen to become the second leading cause of death for young people ages 10 to 24 (Centers for Disease Control and Prevention [CDC], 2014; Perou et al., 2013).
- More than half of young people with mental health needs remain untreated or undertreated (Kessler, Amminger, Aguilar-Gaxiola, Alonso, Lee, & Usfun, 2007).
- Only one-third of young people with mental health needs receive treatment and most receive treatment only after their needs have reached more progressed levels of severity (Merikangas et al., 2011).

The Rural Context

- Prevalence of mental health concerns in children is similar across rural and urban environments (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012; Meit et al., 2014)
- Unique demographic and psychosocial characteristics of rural populations may affect the need for, access to, and uptake of mental health supports.

The Rural Context: Inhabitants

- Patterns of help-seeking behavior
- Social stigma, privacy, and independence
- Non-western narratives around etiology, presentation, and course of mental health-related diseases

Rural Context: School Personnel Experience

- Rural schools are less likely than urban schools to require that (Demissie & Brener, 2017) :
 - newly hired school counselors, school social workers, and school psychologists be licensed, certified or credentialed by state agencies or licensing boards.
 - school mental health workers earn continuing education credits.
- Lower base salaries in rural locales and disparity between rural and city salaries grows as teachers increase their levels of education (NCES, 2012b).
- Tend to work in isolation, absent a community of professional colleagues functioning in similar roles (Hussar, 2015).

Rural Context: School Leadership Experience

- Most school leaders have little to no formal education or professional background in mental health-related fields (Kowalski, McCord, Petersen, Young, & Ellerson, 2010).
- School leaders report many challenges with adopting and implementing MTSS (Dulaney, Hallam, & Wall, 2013).
 - Building capacity among existing staff through training and ongoing coaching,
 - Difficult gathering and using progress-monitoring data,
 - Challenges overcoming school cultures where collaboration has not been historically cultivated

The Rural Context: Partners and Innovation Centers

- Access to fewer community-based partners, including partners with special missions to serve children and their families from diverse racial, ethnic, and linguistic backgrounds (Barley & Beesley, 2007).

Part 2: Research Aims

- The purpose of this study is to examine district leaders' perceptions of variables that facilitate or inhibit the provision of school mental health supports in rural California school districts.



Data Sources:
OSHPD, Healthcare Workforce Development Division
U.S. Census Bureau
January 2006

The Case for California

- Nearly 12% of schools in California ($N = 1220$) are considered rural (NCES, 2014); together over 350,000 students attend these rural schools.
- Whereas only 5.6% of California students attend rural schools, the sheer number of students is more than the total student populations of 15 other states (NCES, 2013).
- The total number of students attending rural schools in California is more than the number attending rural schools in all other states with the exception of Texas (NCES, 2013).

The research questions

1. What strengths and gaps exist in terms of the rural school district ecology—community ethos and district mental health infrastructure, specifically—that support or hinder the development of public health models of school mental health?
2. How do school boards, district leadership, school leadership, instructional staff, student support staff, and classified staff vary in terms of rural superintendent-rated knowledge and skills related to school mental health?
3. What implementation barriers exist in providing school-based mental health supports using a public health model in rural schools?

Sample

- National Center for Education Statistics' (NCES) database: all schools identified as rural (fringe, distant, and remote) in CA
- Sample further limited by eliminating charter and magnet schools and schools that were not Title I eligible.
- A total of 510 schools were identified in a total of 372 school districts.
- The names and emails of the superintendents of all 372 school districts were identified via an internet search of publicly available information.
- 62 respondents answered at least 92.3% of the survey items; the majority (86.6%) of respondents answered every question. **The response rate for the sample submitted to subsequent analysis was 16.7%.**

Instrument

- 53-item web-based survey instrument
- Item content was developed based on a review of existing literature describing fiscal, structural, and cultural drivers and constraints related to the provision of school-based mental health services.
- Survey was submitted to review by two independent subject matter experts; item content and response format were refined based on their feedback.
- Final survey items were grouped under three major conceptual topics: community ethos and district mental health infrastructure, personnel school mental health-related knowledge and skill, and implementation barriers.

Instrument

- **Community Ethos & District Mental Health Infrastructure.** 10-item section of the survey included three community ethos items focused on superintendents' perceptions of historical school practices, support from the local community, and support from the school board, and seven items on the district's infrastructure-related supports for mental health. ($\alpha = .78$).
- **Mental Health-Related Knowledge and Skill Among School Personnel.** The second section of the survey focused on superintendents' perceptions of the student mental health-related knowledge and skill expressed by six different personnel groups. Using a 5-point Likert-type scale (Disagree, Somewhat Disagree, Neither Agree nor Disagree, Somewhat Agree, Agree), superintendents rated the degree to which they agreed with seven statements for each of the six personnel types. ($\alpha = .82-.88$)
- **Implementation Barriers.** The final section of the survey asked superintendent respondents to rank the implementation barriers that they perceived to be most pressing. Thirteen barriers were identified from the existing literature, including barriers related to community ethos, mental health infrastructure, and personnel knowledge and skill.

Analytical Approach: Mixed Methods Design

- Community Ethos Subscale
 - descriptive statistics
- School Personnel Mental Health-Related Knowledge and Skill
 - Computation of Index scores for each personnel group
 - matched t-test comparisons across Index scores
- Implementation Barriers
 - Total count computed
 - Magnitude of priority computed
- Open-ended item
 - constant comparative method and open coding approach

Results: Community Ethos & District Mental Health Infrastructure

Table 1. Community Ethos and District Mental Health Infrastructure Item Statistics.

Item	<i>M</i>	<i>SD</i>
1. My school district collects local data to help understand the need for student mental health supports.	3.39	1.25
2. My school district is encouraged by the <i>local community</i> to support students' mental health needs.	3.54	1.26
3. My school district is encouraged by the <i>school board</i> to support students' mental health needs.	4.21	.87
4. My school district has adequate <i>fiscal</i> resources to address identified student mental health needs.	1.91	1.12
5. My school district has adequate <i>personnel</i> resources to address identified student mental health needs.	1.75	1.19
6. My school district has historically encouraged schools to implement student mental health supports.	3.36	1.28
7. My school district collaborates with other youth-serving partners to build student mental health supports.	3.84	1.07
8. My school district has considered the cultural and linguistic backgrounds of students in selecting mental health supports.	3.64	1.03
9. My district helps schools <i>select</i> student mental health supports that match their contexts and needs.	3.40	1.23
10. My district helps schools <i>implement</i> mental health supports that match their needs.	3.66	1.14

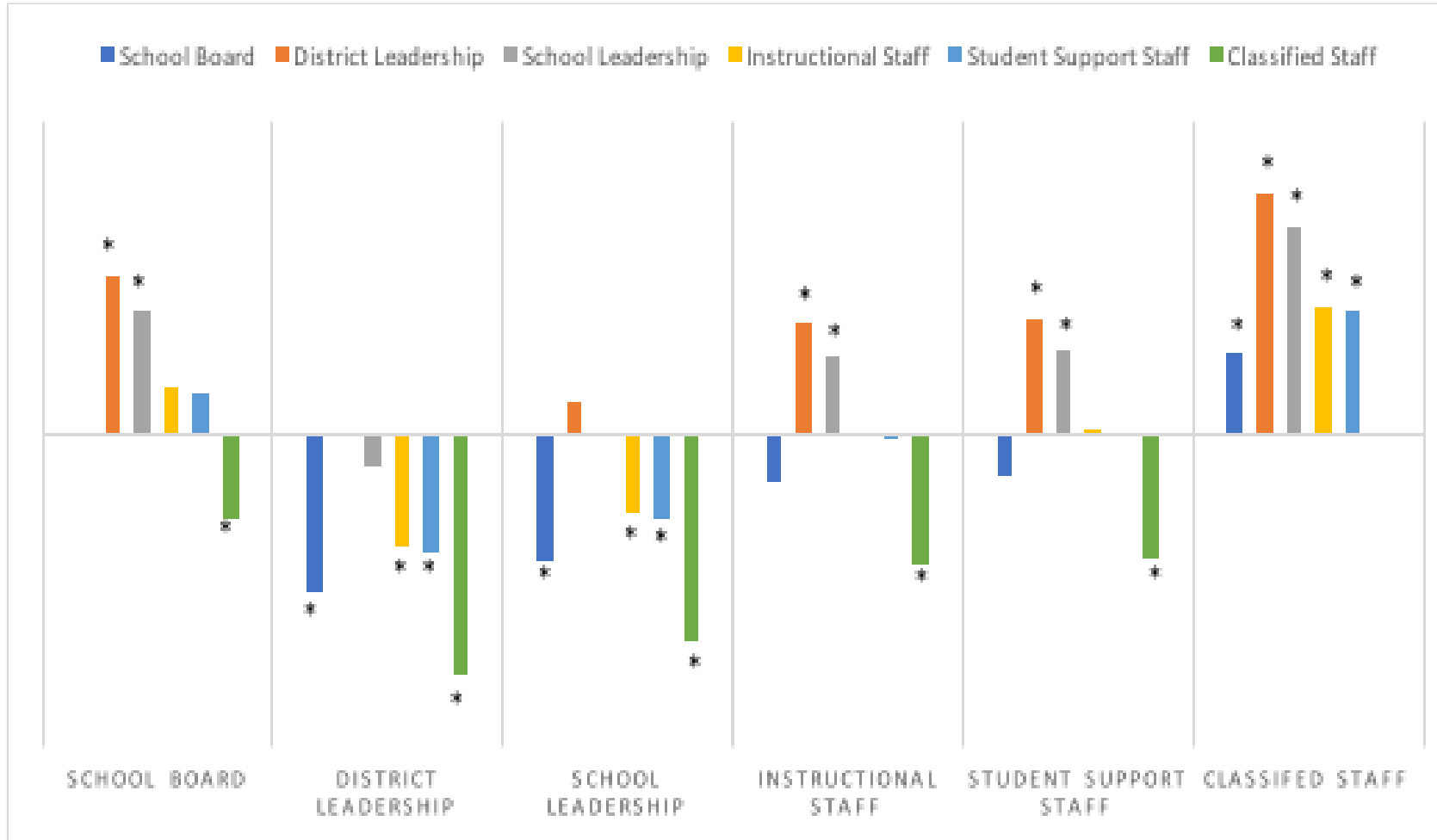
Results: School Mental Health Knowledge & Skill

Table 2. Superintendent Perceived Personnel School Mental Health–Related Knowledge and Skill Index Scores.

Personnel	<i>N</i>	Minimum	Maximum	Index Score	<i>SD</i>	Cronbach's α
School board	58	0.00	7.00	5.21	2.02	.88
District leadership	58	1.00	7.00	6.72	0.89	.82
School leadership	58	1.00	7.00	6.41	1.27	.84
Instructional staff	58	0.00	7.00	5.65	1.80	.86
Student support staff	58	0.00	7.00	5.60	1.74	.82
Classified staff	58	0.00	7.00	4.41	2.39	.87

Results: School Mental Health Knowledge & Skill

Between-Group Differences in Mean Index Scores for School Mental Health Knowledge and Skill (SMHKS)



Results: Barriers

Table 4. Perceived Implementation Barriers.

Perceived Implementation Barrier	Total Count ^a	Primary Barrier ^b	
		Count	Percentage of Sample
Awareness of need within the student population	13	5	38.5
Background knowledge on topics related to mental health	5	1	20.0
Budget constraints	43	21	48.8
Competing priorities taking precedence	20	4	20.0
Lack of community partners to provide mental health services	44	12	27.3
Lack of school mental health support staff (e.g., counselors, psychologists, social workers)	47	15	31.9
Personal beliefs and ideologies (e.g., belief that mental health problems do not exist, belief that mental health problems are just an excuse, and belief that behavioral, social, emotional, and mental health issues should not be addressed at school)	11	2	18.2
Skills for influencing district policies	4	0	0
Skills for influencing school practices	6	0	0
Skills for organizing personnel resources	6	0	0
Skills for prioritizing school needs	4	0	0
Social stigma	8	0	0
Support from local community	6	1	16.7

^aTotal Count represents the number of respondents who endorsed each barrier, regardless of the barrier's rank in terms of respondent priority. ^bPrimary Barrier represents the number of respondents who endorsed the barrier as their highest ranked (i.e., highest priority) barrier and the corresponding percentage of the sample that ranked each barrier as their primary barrier.

Implications: Charted Territory: Fiscal and Personnel Barriers

- Confirmed known trends in fiscal and structural barriers rural schools face
 - Budget constraints
 - Opaque funding landscape
 - Personnel availability

*“There is a distinct lack of community resources, and . . . the need is desperate. We have 1.2 FTE school social workers for 600 students at two sites. We could use 2.2 FTE but budget constraints, space to house the services, and a lack of available qualified SSWs, school psychs [sic] all get in the way.”
(Respondent 35)*

Implications: New Insights: Public Health Model Uptake

- The move from traditional one-to-one services to public health approaches is happening slowly.
- Superintendents have mixed knowledge and use of public health models, including public health-related data use and implementation supports for evidence-based interventions.

Implications: New Insights: Heterogeneity in the Rural Experience

- Consistently reported a high level of support for school mental health efforts from members of their local school boards, but inconsistent support from their local communities.

“In our rural district, it is also an issue for parents to access services due to long travel distances. In addition, there is a “code of silence” and a desire for no government oversight or “interference” in our community. Many families simply won’t even access the few resources that are available.” (Respondent 40)

Implications: New Insights: Perceptions of Skills and Knowledge

- School superintendents tend to rate those with job duties similar to theirs as most knowledgeable about mental health, over and above school counselors and school psychologists.
- School board members are perceived to be among the least knowledgeable about mental health
- Classified staff were perceived by superintendent respondents to have the lowest mental health–related knowledge and skill of all personnel groups.

Key Considerations for Informing Practice

- Expand knowledge of innovative funding and service provision models
 - geographical designations as health professional shortage areas and medically underserved areas.
 - offset district expenses by seeking reimbursement from private and public health care insurers for school-based mental health services, particularly those that are intensive and individualized.
- Improve uptake of public health approaches
 - Use of free and publicly accessible evaluation systems, such as the School Health Assessment and Performance Evaluation System (Center for School Mental Health, 2018).

Key Considerations for Informing Practice

- **Harness the ESSA opportunity**
 - expand definitions of school success to include social and emotional domains, providing a foundation for the adoption of prevention programs meant to be implemented by trained instructional and school support staff.
- **Expand professional learning**
 - (a) promote empirically supported or evidence-based practices, particularly for universal (Tier 1) strategies; (b) incorporate a train-the-trainer model within the school to provide ongoing mentoring and coaching support; and (c) support teacher capacity to provide preventive strategies in the general education curriculum.

Key Considerations for Informing Practice

- **Improve mental health literacy**
 - knowledge-building training, such as YMHFA (National Council for Behavioral Health, 2018)
 - Readymade resources for stigma-reduction campaigns (e.g., stigmafree , National Alliance on Mental Illness).
- **Focus on school boards**
 - leverage school board professional networks to regularly share both convincing evidence of the relationship between mental health and educational outcomes and audience-specific summaries of research-supported models and programs for school mental health.

Limitations

- Response rate
- Demographic data on sample
- Online survey methods
- Self-report



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