Teachers' Perspectives of Children's Mental Health Service Needs in Urban Elementary Schools

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This study uses a phenomenological approach to investigate elementary school teachers' perspectives on children's mental health service needs. Focus groups were conducted at two elementary schools with differing levels of available social services in a moderate-sized urban midwestern school district. Data collection centered on six prominent themes from children's mental health and school social work literature: school safety, parental support and involvement, problem recognition, knowledge of community resources, service effectiveness, and service barriers. Similarities and differences were evident when comparing responses across schools. Implications for practice are discussed.

KEY WORDS: children's mental health; elementary schools; parental support; service barriers; urban schools

Children's mental health problems have been the focus of numerous investigations during the past few decades. However, children's mental health needs have historically been addressed inadequately in policy, practice, and research (Williams, Ayers, Abbott, Hawkins, & Catalano, 1999; Williams, Ayers, Van Dorn, & Arthur, 2004). Estimates indicate that 12 percent to 22 percent of all youths younger than age 18 have mental health service needs (Center for Mental Health in Schools at UCLA, 2005). Furthermore, a sizeable proportion of youths meet the lifetime criteria for selected DSM-IV diagnoses (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Kessler, Berglund, Demler, Jim, & Walters, 2005). Epidemiological studies estimate that 13.3 percent of children and adolescents meet diagnostic criteria for a mental disorder in a given year (Costello et al., 2003). Perhaps as concerning is the notion that these rates may be understated because of problems in the operationalization, measurement, and methodology. Studies estimate prevalence rates of diagnosable mental disorders in children up to 36 percent (Costello et al., 2003; Kessler et al.), with only a small percentage ever receiving intervention or treatment services (Burns et al., 1995; Pastor & Reuben, 2002).

Schools are a significant provider of mental health services for children (Burns et al., 1995; Center for Mental Health in Schools at UCLA, 2005; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Specifically, it is estimated that of the children who receive mental health services, between 70 percent and 80 percent receive these services in school (Hoagwood et al.). A review of 52 studies showed that the median estimated prevalence of psychopathology was 8 percent for preschoolers, 12 percent for preadolescents, and 15 percent for adolescents (Roberts, Attkisson, & Rosenblatt, 1998). Even very young children are not immune to mental health service needs. A study of 3,860 preschool children in a primary care pediatric setting found 8.3 percent of subjects expressing behavior problems, and 21.4 percent showed evidence of an Axis I disorder (Lavigne et al., 1996). Cause for concern is warranted as children's mental health problems may persist into adulthood. In one study, 60 percent of children diagnosed with attention deficit hyperactivity disorder (ADHD) continued to demonstrate
mental health problems into adulthood (Ingram, Hechtman, & Morgenstern, 1999). Furthermore, early mental health problems have been associated with subsequent alcohol and other drug use (Kessler et al., 2005), which also has been shown to relate to delinquent or more serious violent behavior (Hawkins et al., 1998). The considerable individual and social cost of children's mental illness and its related sequelae raises serious issues with regard to mental health services early in life, and more specifically, the role of schools and teachers in the recognition and redress of these problems.

Several studies have focused on the number of children with mental illness and their level of unmet needs in educational settings (Burns et al., 1995; Costello et al., 2003; Rones & Hoagwood, 2000). Only 16 percent of children receive any mental health services, and the overwhelming percentage of those in receipt of services get them in the school setting (Rones & Hoagwood). Although schools are a primary provider of or gateway to mental health services for children, studies of mental disorder among youths have typically focused on diagnostic labels used by noneducation personnel (Zahner, Pawelkiewicz, DeFrancesco, & Adnopoz, 1992). These studies have not been extended to assess the role and function of teachers in the identification of students' mental health problems and in their facilitating the transition into treatment. There remains a limited understanding of how children are referred in the school environment for treatment and, conversely, what barriers prevent the identification and referral process from being more effective. More specifically, given that schools are gateway providers of mental health services, one principal determinant for children receiving mental health services is the teachers' perspective of their students' mental health service needs.

The referral process for children primarily begins with teachers and may be directly related to the degree that teachers' perceptions of a student can be distorted by characteristics indigenous to teachers. Schwartz and colleagues (1997) found that length of teaching experience is an important factor in referrals. It has also been hypothesized that teachers' responses to classroom misbehavior and other issues may be mediated by their beliefs about themselves and their perceived efficacy in dealing with misbehavior (Martin, Linfoot, & Stephenson, 1999; Scott-Little & Holloway, 1992). Teachers' level of concern, level of confidence, and support of the school administration are also related to decision making with regard to classroom misbehavior (Martin et al.).

Although teachers' behaviors are important, one cannot overlook the social environment that students and teachers function within and its influence on behaviors and services. Many schools in the nation's urban centers are nested in communities with high rates of poverty and crime, making school safety a primary concern for many urban school districts. Nationally 42 percent of urban students are eligible to receive subsidized school lunches, and 40 percent attend schools defined by the Department of Education as high-poverty schools (U.S. Department of Education, 1996). At the present rate, the United States will, in 25 years, have a majority of minority students in its urban public schools, enrolling most of the African American students in large cities, with more than half of them living in communities of poverty (Council of the Great City Schools, 1994a, 1994b; Orfield, 1993). It is apparent from the literature that a neighborhood's socioeconomic status, racial and ethnic composition, population mobility and loss, and family structure can affect the ability of children to live safe and productive lives (Van Dorn, Bowen & Blau, 2006). It is not surprising that schools in such communities inherit the difficulties of the communities as well as the problems of the children who live there. Studies have confirmed that neighborhood social disorganization is highly correlated with level of disorder in schools, student body composition, staffing and resources, organizational climate, parental involvement and support, and security (Bowen & Van Dorn, 2002; Garbarino & Crouter, 1978; Gottfredson & Gottfredson, 1985; Hellman & Beaton, 1986; Jencks & Mayer, 1990; Laub & Lauritsen, 1998). Much of the research investigating the link between schools and communities has focused on delinquency,
violence, and substance use. However, little is known about how relevant community characteristics may represent barriers for teacher’s referrals for mental health services, or how these community characteristics may affect children, particularly minority children.

African American children and youths represent 16 percent of the school population, yet they represent 21 percent and 25.1 percent of the enrollment in special education and those identified as having emotional and behavioral disorders, respectively (U.S. Department of Education, 1998). African American boys are identified as exhibiting symptoms of ADHD at a much higher rate than other children. In addition, a child who is poor, African American, and male is much more likely than others to be physically disciplined, suspended, expelled, or made to repeat a grade (Gingerich, Turnock, Litfin, & Rosen, 1998; Center for Mental Health in Schools at UCLA, 2005). Furthermore, an African American boy is three times as likely as a white boy to be placed in vocational education or in classes for children with a learning disability (Allen & Jewell, 1995; Myers, 1998). African American children identified as severely emotionally disturbed are also overrepresented in various sectors of the juvenile justice system (Jonson-Reid, Williams, & Webster, 2001).

Minority youths are also at increased risk of mental health problems compared with nonminority youths (Center for Mental Health Services, 2001). Although the prevalence of mental disorders for racial minorities is similar to that for white people when other conditions are equal, in reality, minority children often face multiple stresses that make them more vulnerable to mental illnesses. For example, African American children and youths are overrepresented in the juvenile justice and child welfare systems (Center for Mental Health Services). The increased rate of poverty for African Americans also increases the risk of mental disorders. In a recent meta-analysis, poverty doubled a child’s risk of experiencing serious emotional disturbance (Costello, Messer, Bird, Cohen, & Reinherz, 1998). For children living in inner cities, neighborhood disadvantage can have deleterious effects on normal development (see for example, Elliott et al., 1996). High rates of crime and violence in inner cities is another risk factor that affects the psychological wellness of children as exposure to violence has been found associated with post-traumatic stress disorder and other psychiatric disorders (for example, Martinez & Richters, 1993; Mazza & Reynolds, 1999).

The literature has identified several important themes related to children’s mental health and pathways to service use in urban schools to support an exploratory study with teachers in urban schools. First, a significant percentage of children and youths meet criteria for mental disorders. Second, a large proportion of mental health services for children are provided in schools, and teachers are instrumental in identifying mental health problems and providing service referrals. Third, large proportions of minority children are educated in segregated urban schools and are disproportionately represented in special education classes. However, these same students are less likely to be referred for counseling and psychological services. Finally, there is limited qualitative or phenomenological data detailing teachers’ perspectives on barriers they face when referring children for services, specifically for teachers in urban schools and for teachers of African American children. This study gathered data on identified themes related to teacher’s perspectives regarding children’s mental health service needs in two predominantly African American urban elementary schools.

METHOD
Design
A phenomenological approach was chosen for this study to better understand teachers’ actions and to discern the commonalities and uniqueness of issues teachers face in identifying mental health problems in children and making referrals to school- or community-based resources (Giorgi, 1975, 1986). To accomplish the study objectives, focus groups were conducted in two urban elementary schools in a midwestern inner city. Focus groups are an effective methodology for exploratory studies of this nature (Krueger, 1988). This approach allows for more feedback from participants and leads to greater...
exploration and understanding of the meaning of actions that are constant in the participant's life across different situations (Giorgi, 1975, 1986; Morgan, 1988, 1993; Patton, 1990). When investigating teachers' perspectives on the identified themes from the literature, the focus group methodology allows the teachers an opportunity to meet fellow colleagues and be reflective on everyday common experiences (Miles & Huberman, 1994). This method allows the researcher to gain a richness and holistic overview of the context that may not be elicited when meeting teachers as individuals (Miles & Huberman; Morgan, 1988).

We facilitated two 90-minute focus groups conducted at two elementary schools in a midwestern urban center. Participant recruitment was conducted by mailing informational flyers to teachers at both schools and having the principals announce the focus groups at staff meetings. Six themes were identified from the children's mental health and urban school literature to develop a questioning sequence: (1) perception of school climate and safety, (2) perception of parental involvement and community support, (3) skill and comfort with recognizing mental health problems in students, (4) knowledge of resources and services available to students with mental health problems, (5) whether students benefit from the services, and (6) barriers to services. After obtaining informed consent and allowing time for inquiries about human subject protocols or the project in general, participants completed a brief demographic questionnaire. The focus groups were conducted at the end of the school day. Both groups were audi-taped, the tapes were transcribed verbatim, and the transcripts were checked for accuracy and edited for identifying information.

The schools were selected to capitalize on both similarities and differences across the institutions. One school was located in a southern section of the city (school A). School A is nested in a more racially diverse neighborhood with lower levels of crime and violence. School A has a student enrollment of approximately 400 students with a teacher-to-student ratio of 18 to 1. Ninety-six percent of the students are African American, 1.7 percent are Asian, and fewer than 1 percent are either Hispanic or Caucasian. Ninety-eight percent of students are eligible for free or reduced-price lunch. The years of teaching experience average 8.1 years, and 30 percent of the teachers had a graduate degree (Department of Elementary and Secondary Education [DESE], 2004).

School B is located in a northern section of the city, nested in a neighborhood that was 100 percent African American, with higher levels of crime and violence. School B has a student enrollment of approximately 250 students with a teacher-to-student ratio of 17 to 1. One hundred percent of the student population is African American and 100 percent of the students are eligible for free or reduced-price lunch. The years of teaching experience average 16.5 years, and 46 percent of the teachers had a graduate degree (DESE, 2004).

The two elementary schools differed in the types and amounts of services available to the students. School A had a very limited array of school-based services. There was a part-time counselor who provided limited group and social skills training–related classroom activities. This counselor was not certified and therefore could not provide individual or family counseling. School A also had a part-time school social worker who focused primarily on attendance problems, clothing needs, and special education and provided limited individual and family counseling. The school social worker was on site one to two days per week. Teachers expressed some concerns regarding the limited number of services available to them.

In comparison with school A, school B had a full-time counselor, a full-time nurse, a community service worker, a licensed master's degree family and children's advocate, a resource worker, case managers, and a district mental health coordinator. Weekly meetings were held at school B to discuss students' behavioral problems. Teachers at school B indicated that the broad range of services benefited students and supported classroom activities. They also concurred that even with a significant amount of services being provided, additional support and staff were needed.
Participants
Participants were teachers at two elementary schools in the urban core of a moderate-sized midwestern city. Participants were recruited through a collaborative effort between the research team and principals of the schools. All participants received a $25 gift certificate. The groups consisted of 19 teachers from the two schools (10 from school A and nine from school B). Of the 19 participants, 18 were female and one was male. Thirteen of the participants were African American and six were Caucasian. Participants' ages ranged from 30 to 60 years, with a mean age of 39.65 years. The number of years teaching at their current school ranged from one to 15, with the mean of 4.3 years. Teachers from K-5 were represented among the participants, with the majority of the participants teaching third, fourth, and fifth grades and one participant teaching a special education class. Four of the participants had previous teaching experience in special education. Class sizes for the teachers ranged between 10 and 32, with the mean class size of 23.

Data Analysis and Interpretation
Data reduction was conducted to simplify the focus groups transcriptions to make the data more accessible and to extract specific content related to the six themes (Berg, 2004; Miles & Huberman, 1994). The data were sorted and organized to support reasonable conclusions and interpretations. After reduction, the data were organized by school and displayed in matrix form to allow for the drawing of analytical contrasts and comparisons of teacher's perspectives on the identified themes (Berg; Miles & Huberman). Our data analysis steps included familiarizations of the transcription through reading and rereading, organizing data into clusters related to the themes, and condensing the data into organized concepts around the themes (Giorgi, 1975, 1986). Table 1 shows proportions of various statements, short blocks of text, quotes, and phrases used to develop the data matrix. The matrix also allowed for cross-schools analysis to enhance generalizability and validate impressions across groups. Interpretation and verification of the data were carefully checked by having three members of the research team independently examine group notes, transcripts, and the data matrix to determine whether comparable conclusions were reached (Miles & Huberman).

Results
As expected, numerous experiences and comments related to the six themes emerged across the two schools. Although many group members expressed common experiences and perceptions, some experiences reflect differences across the schools.

School Climate and Safety. Recent school shootings and other acts of violence have drawn public attention to school crime and safety; however, crimes against students and teachers had decreased over the previous years (Bureau of Justice Statistics, 2002). Currently, the vast majority of schools are safe. Teachers' experiences and responses regarding school climate and safety were mixed across the schools. A range of the comments related to school climate and safety are highlighted in Table 1. On the one hand, teachers at school A indicated they felt safe at school. They stated that although most students were not aggressive, occasional problems would arise when parents or other people from the community would come into the building without the knowledge of teachers or administration. Overall, the teachers felt safe, but they made a point to emphasize that many of their students did not feel safe in school or in the community. Many of the teachers at school A felt that students' perceived lack of safety was a factor in their school and classroom behavior. This phenomenon may be as consequential to the mental health of students. On the other hand, teachers at school B expressed no concerns with safety at their schools. They indicated a positive organizational climate that supports a safe environment. They attributed this positive climate to the principal and collaboration with parents.

Parental Involvement and Community Support. Similar to the school climate and safety experiences, teachers' experiences related to parental involvement, support, and engagement were also different between schools. A range of comments related to parental involvement
### Table 1: Response Matrix: Urban Elementary School Teachers’ Perspectives on Children’s Mental Health Service Needs (N = 19)

<table>
<thead>
<tr>
<th>Themes</th>
<th>School A (n = 10)</th>
<th>School B (n = 9)</th>
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<tr>
<td>School climate and safety</td>
<td>- Basically I feel safe. Sometimes there are parents that come in. I wish there was a little bit more monitoring of that.</td>
<td>- Yes, I feel safe because our principal strives to make the place safe for us. She’s added a lot of things that we hadn’t had before. Keeping the door locked. We’re supposed to get a surveillance camera outside.</td>
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<td>- Parents or anyone else. Kids from the middle school when they get out. As far as from our students, I feel relatively safe.</td>
<td>- I feel safe because I’ve been here long enough to know the area where I work.</td>
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<td></td>
<td>- As far as the students are concerned, I feel safe. I don’t feel threatened by the children. But you don’t know. All the doors are not locked, therefore anyone can walk in. Irate parents sometime do come up to the school. So, the threat is more from parents than children.</td>
<td>- I would like to add that the increase[d] involvement of parent participation leads to the safety of the building. We have this collaboration in process that even outside the building, the children know who you are in this vicinity.</td>
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<td>- There’s some aggression in some of the kids, but so far it’s been controllable.</td>
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<td></td>
<td>- Not what I saw on the playground yesterday. I was scared.</td>
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<td></td>
<td>- It was Ms. …… boy. Ms. …… couldn’t get him to settle down. He was cussing her out, and I didn’t know what he was going to do with her.</td>
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<td>- I feel safe, but I’ve had comments from the students that they don’t feel safe.</td>
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<td></td>
<td>- The children constantly have to defend themselves when they are out on the playground. Sometimes in the classroom because of the aggression of the students. It’s not an easy place, school, to be for the kids.</td>
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<td>Parent involvement and</td>
<td>- I don’t think we hear from parents unless they are upset. This just might be a circumstance of our world. I mean, everyone has to work well beyond 3 p.m. If they take time to leave their job, yes, they’re upset.</td>
<td>- You’re always going to have the exception, you know, someone has a child who’s just having a bad time and their parents are frustrated, but in general I would say, yes, most of my parents are really supportive. Every year, I have two or three that we have to spend more time talking to get back there, but we usually get back to the supportive stage.</td>
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<td>community support</td>
<td>- Children, when they are suspended, and unfortunately it’s basically the same children that we’re talking about that are suspended. Their parents, many of them, don’t take responsibility for their children’s actions.</td>
<td>- Having a full-time parent liaison in the building has increased the parental support and involvement in the PTO meetings in the past couple of years.</td>
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<td>- I tell them, “Our hands are tied. There is only so much we can do as educators, but you are the parent.” I always think to myself, “You birthed this child. If you can’t handle them, how can you possibly expect us to?”</td>
<td>- The development efforts of the neighborhood serve as a bridge between the school and the community. The sharing of information with students about activities in their community connects with education.</td>
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<td>- They feel as though we should have all the answers.</td>
<td>- Also, the principal participates in a roundtable with community agencies and community partnerships.</td>
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<td>- They come up with excuses.</td>
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<td>- Then you have some parents that are in denial, “My child does not act like that.”</td>
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<td>- There are times when the parent feels that because their child said it, it’s correct. They will go home and tell stories…what the teacher did, what the student did, but they never say what they did, and the parent is ready to come up and beat up the teacher or whatever kid bothered them.</td>
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<td>- I don’t think that anybody was really saying that the parents don’t respect us. I think we’re just saying that the parents don’t cooperate with what goes on here. They don’t follow up at home with the behavior that goes on at school; they don’t follow up at home with some type of consequence at home.</td>
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Recognizing mental health problems

- I don't think that kids display behaviors that are obvious as you might think. It's not obvious to say, "Oh that's a mental health problem" right then. There are aggressions that we see that are deviant from the normal behavior that stand out as overly aggressive or overly withdrawn.
- I think we have a few children here that really have mental health problems. I mean doing inappropriate things in the coat room.
- I think the biggest problem that I see from most of the students here is that they are angry, and they have outbursts continuously.
- Even the little bratty ones are so angry. They're so aggressive.
- I think it is due...there's a lot of television, and they emulate it at school.
- They emulate that but it seems like it carries over to the least bit of any authority telling them to do something. It's like a whole new personality comes out. Like this kid I had the other day, all I ask him to do was "Sit down and close your mouth for five seconds." He just started throwing book bags and beating the windows. He just went into this rage. I said, "I didn't ask you to do 100 math problems, turn 60 flips. All I ask you to do was sit down." There's something inside, a kind of rage or anger.
- Sometimes I do try to decide, when kids overboard, whether or not it's a mental illness or if it's emotional and many times when they go like say too far. I consider it mental illness.
- I think depression is evident in children when you can see the sadness. There are children that don't want to go home. You know they get really sad. You know [that's] some kind of depression.

Barriers to services

- I know in many instances, I've given them the names of agencies they can contact for assistance, and it doesn't seem as though they are doing that. But they want the school to always have the answers.
- Ninety-nine percent of the time, parents did not follow up on the suggestions given to them. At time[s] I think, it's almost like, why bother?
- Nothing's going to change. I'll call mom up, and it doesn't do any good. That's what I've found in my classroom.

Students benefit from services

- I think services would help, if they [parents] followed through, but the problem is that they don't follow through. We don't have time to go behind and check, but it's obvious by the continued behavior of the children that really nothing was done because you don't see a change.

- I feel like I'm so busy managing the behavior that I don't really have time to improve. Other than keeping it from destroying my classroom, I don't really have time to do something for that child. I'm just making sure that it doesn't mess up my class.
- No, we need some guidelines since we are not doctors, lawyers. In Special Ed they have more knowledge of recognizing mental illness. As a classroom teacher, we can see the behavior and see actions that are not "normal" in a sense. I would have no problem questioning it.
- I feel very comfortable addressing mental health problems. If I'm unsure, I feel comfortable enough to go to the nurse or the person that would have more knowledge of the student and the behavior and discussing the problems that I am having, talking about the observations that I've made, and getting information or suggestions.
- I would ask people to help me with students when they are depressed.

- Time to address the problem.
- Time to try to seek out the person that you would have time to talk to and tell them that the child needs the proper help.
- Another barrier that I see a lot is just getting the parent's consent. We have to get the parents consent when you refer students to community agencies.
- I think in some cases you are just overwhelmed by the situation.
- Parents don't follow through with appointments that have been set up. We set up appointments for doctors. They don't go. We provide transportation, and they don't go. When the child's glasses are ready, they didn't go. The counselor had to go and pick them up.
- Lack of parental responsibility for the child is a major one. Parents don't do the job they should. They want you to do the job.
- I think they benefit, but there are always cases where more is needed. Of course, you continue to seek out resources, but at the level that you make a referral for someone to a program, then it is up to that program to assess and continue to refer to other agencies.
and community support are highlighted in Table 1.

Teachers at school A spoke of their concerns about the low level of engagement and lack of support from parents. School A teachers generally portrayed parents as uncooperative, disengaged, and unwilling to take responsibility for their children's actions. They expressed high levels of frustration with their efforts to engage parents and garner their support. Teachers felt that they and the parents were not in sync when addressing the best interests of the child. School B teachers described the majority of the parents as very supportive. Overall, they perceived parents as supportive of their efforts and willing to help when possible. They attributed the strong parent support to having additional service personnel in their school (parent liaison, librarian) and the strong work of their principal and the PTA. They also felt that neighborhood roundtables, linkages with local churches, and volunteers from various community organizations were instrumental in strengthening the school–family relationship.

**Recognizing Mental Health Problems.**

Table 1 details a range of comments related to teachers’ abilities to recognize mental health problems. Group participants at both schools felt comfortable recognizing mental health problems in students, but in general listed only externalizing behaviors (for example, aggression toward other students, outbursts in class, inappropriate sexual behaviors) without any additional prompting. After probing about internalizing behaviors, group members indicated they could identify sadness and withdrawal in their students.

When asked about identifying mental health problems in students, the participants said that they were too busy managing the behavior of the children, which left little time for anything else. However, most teachers felt comfortable in identifying problems, even to the point of recommending adjustments in medication. The teachers indicated that their strength was in identifying externalizing behaviors. They described the biggest problem in their classrooms as students who displayed a great deal of aggression and anger.

Barriers to Services. Teachers in both focus groups overall perceived parents to be significant barriers to mental health services for children. A range of comments detailing teachers' perceived barriers to services for children in their classrooms are highlighted in Table 1. The teachers said that parents often did not follow up on suggestions when given to them. They reported providing parents with names of agencies and resources where they can receive assistance. However, parents often did not follow through with recommendations. It was clear from teachers' responses that parents expected the schools to have all the answers. There were reports from teachers that parents lack consistency in initiating or following up on nonemergency medical care, transportation needs, or vision care.

Also related to the theme of parents as barriers was the lack of respect teachers feel they receive from parents. Focus group participants believed that parents expected teachers and the school system to resolve their child's problems. Teachers were hopeful for positive changes in the behavior of their students if parents would work with them in obtaining the appropriate services. However, as mentioned, teachers felt that many parents did not follow up, not only as a lack of respect for their referrals and their professional perspective, but also because the parents were dealing with their own personal issues, including a lack of education and low parenting skills in addition to the possibility of drug or alcohol use in the home. Teachers at both schools echoed a sense of overall frustration that nothing would change and that calling or notifying the parent does not bring about change.

The data become mixed when teachers discuss parental involvement and parents as barriers. For example, when discussing potential barriers to services, they reported that parents indicated that even the younger students displayed a great deal of aggression and anger. Teachers also tended to notice changes in students and would ask other teachers to observe to verify their initial assessment. They mostly saw an inability to focus, daydreaming, shyness, hyperactivity, aggressiveness, stubbornness, and manipulation.
were significant barriers and are unwilling to help or take the teachers' advice. However, when discussing parental involvement teachers from school B described parents as very supportive. They attributed the strong parent support to having additional service personnel in their school and the strong work of their principal and PTA. It is important to note that overall teachers perceived parents as barriers to services when students were referred for external services.

In addition to interpersonal barriers, teachers identified several contextual barriers. Specific barriers were related to the student's living situation (for example, living with grandparents, in group or foster homes, or in homeless shelters), lack of money or insurance, lack of resources, lack of household communication and reliable transportation, and community or family concerns (for example, domestic violence, gangs, drug dealings). Teachers also had a general belief that education was not very important to the parents or the children.

Teachers identified other systematic barriers related to providing services to children. These barriers included lack of resources in the school, large class sizes, no zero tolerance policy for certain behaviors, a lack of parenting classes, too much bureaucracy that impeded change, too many administrators and not enough teachers, and administrators focusing only on schools that are doing well. Teachers indicated that although they felt comfortable identifying mental health problems and recommending appropriate resources, they had inadequate time to do so. Teachers also stated that many children move during the school year (approximately 40 percent to 50 percent for the district) and that background information is not readily available. They also reported difficulty in obtaining parental consent, which is a major barrier for providing services. Finally, the teachers stated that many of the telephone numbers and addresses for the students are often incorrect, making effective outreach to the home difficult. Overall teachers endorsed that services are beneficial for students. They reiterated the need for additional services and increased parent compliance in securing services.

**DISCUSSION**

Several important comments stand out from the results of these two groups in relationship to the six themes. Participants reported that the relationship between parents and school was the most important issue related to children receiving services (Barnard, 2004; Barnett, Young, & Schweinhart, 1998). Specifically, the majority of the teachers indicated that they had tried, at one time or another, to refer a child to mental health services, either within the school or to a community-based agency. Their efforts, however, were most often not supported by parents. The importance of parental engagement and support in the school environment is consistent with previous educational and youth development research (Gutman & Eccles, 1999; Gutman, Sameroff, & Eccles, 2002). Results from this study suggest that a teacher's perception of the motivation and level of involvement by parents may have a direct effect on not only how, but also if they make a referral for mental health services. From these two focus groups, it was clear that teachers' past experiences with parents had colored their perceptions on whether referrals for mental health services would be followed. At times, it was clear that the teachers were expressing an almost hopeless feeling that anything they did regarding mental health services would make a difference. This finding was very consistent across group members. Overall, participants were uniform in their perceptions of parents being one of the most significant barriers to children accessing services.

The other primary area of concern expressed during the focus groups was the interpersonal and contextual barriers to mental health and other services for children in urban public schools. Teachers recognized the daily struggles and issues that parents must deal with to access and use services, including structural (for example, quality, level, availability) and interpersonal (for example, lack of resources, mobility, lack of education, parenting skills, substance use) barriers. In addition to the community and parental barriers, most teachers also identified various challenges within the schools as barriers to services. These barriers included a lack of resources, the bureaucratic structure of schools,
and overall time constraints placed on the teachers that reduce the likelihood of them following up on referrals made to families.

These results indicate that parents, schools, and communities can serve as potential barriers to students and families accessing mental health and other services (Bowen & Van Dorn, 2002; Lorion, 1998). All teachers agreed that organizational and community structural problems, along with parents' interpersonal deficits, were the primary barriers for subsequent service utilization. However, most teachers expressed confidence in their skills to not only recognize mental health problems, particularly externalizing behaviors, which is consistent with earlier research (Phares, 1997), but also act as a gateway to service utilization. A few teachers, however, acknowledged a lack of training and discomfort with labeling children as issues of concern. Finally, the teachers' overall confidence in referring children to services was mainly focused on referrals to school-based services. When it came to community-based services and resources, the teachers felt less confident in their abilities to make appropriate referrals.

Although this qualitative study identified important themes that have not been well studied in the scientific literature, it is important to note some of its limitations. First, this study used a small sample of teachers in a mid-size urban district, and men were underrepresented as participants in the focus groups. Next, the representativeness of the focus group participants is difficult to ascertain. Specifically, many of the participants may have been individuals who were more likely to attend the focus groups possibly because of an increased interest in the issues that were raised. Given these limitations readers should interpret the results with caution.

Despite the potential limitations of the methods used in this study, these findings suggest implications for practice and research in an area that is understudied and still not well understood. From these findings, teachers' primary concerns start with the behavioral management of students, and they appear to have stronger confidence in identifying externalizing behaviors. These features may result in a significant gender imbalance in referrals for behavioral and educational services (Gingerich et al., 1998). This imbalance may, over time, contribute to a disproportionate referral rate for African American children (Allen & Jewell, 1995; Jonson-Reid et al., 2001; Myers, 1998).

The role of school social workers is particularly relevant to this topic. Specifically, innovative and creative ways to promote and increase parental involvement are needed. However, one obvious difficulty for school social workers, teachers, and parents is the limited time and financial pressures that all involved parties must face. The idea of a social resource network building or school-based health centers are ideas that appear to be relevant here as the teachers mentioned several contextual barriers and gaps in service delivery (Hallfors & Van Dorn, 2002; Van Dorn, 2004). Both of these ideas would seem to be worthy solutions, and more discussion on these topics is warranted.

An issue that cannot be neglected is the acknowledgment that funds, resources, and staffing for public schools continue to be less than ideal, which leads to the expectation that teachers should just "do more." Teachers must not only be good teachers and motivate their students, but also rally parents, ensure safety, and identify children who may need services for mental health or behavioral problems in addition to countless other duties. In this less-than-ideal situation, it becomes imperative that the children who are referred for services are those most in need and that teachers' perceptions and beliefs about identifying mental health problems and making appropriate referrals accurately reflect their abilities and decision-making processes.

One way to increase the likelihood of this outcome is to use multiple gating strategies while screening for relevant risk factors (Hallfors & Van Dorn, 2002; Williams et al., 2004). Teachers and school social workers could use a universal or schoolwide screening instrument (see for example, The School Success Profile; Bowen, Woolley, Richman, & Bowen, 2001) that would provide some indication of children who are at the highest risk of experiencing problematic outcomes. At the next stage, there could be an increased focus, through more refined and intensive screening protocols, on these identified...
children. The concept of multiple gating, which has been proposed for delinquency (Charlebois & Leblanc, 1994) and drug and alcohol (Hallfors & Van Dorn, 2002) screening appears to be one way to increase sensitivity, which would in turn lead to a more effective use of the already limited resources available in schools.

Although multiple gating appears to be one valid solution to some of the issues raised in this qualitative study, other issues must be addressed for the full effect of this screening protocol and prevention framework to be realized. First, it has been well documented that prevention is peripheral to the main mission of schools and that a strong prevention infrastructure is lacking in most schools (Hallfors & Van Dorn, 2002). Accordingly, to redress issues raised in this article there must be buy-in at all levels, starting with administrators. Without this, the likelihood of reducing mental health and behavioral problems by ensuring that those most in need receive the required services is unlikely. Next, there must be better access to and understanding of tested screening protocols. Also, effective and evidence-based services (Hoagwood et al., 2001) need to be made more available and implemented in a way that ensures fidelity. Finally, stronger partnerships among schools, parents, and communities, including faith-based organizations (Williams, Pierce, Young, & Van Dorn, 2001), schools of social work, and community-based treatment providers are vital. The skills and expertise of the social workers place them in a unique and very advantageous position to not only assist, but also lead the efforts of making schools a setting in which the prevention of problems not only is valued, but also becomes a normative framework.

This study underscores the value of qualitative data in better understanding the challenges elementary school teachers face in their schools and classrooms as gatekeepers to mental health services for children in urban locations. This article, and more broadly, this method of research, affords teachers the opportunity to provide feedback regarding their institutional and community struggles in getting the needed services to their students. Finally, the findings from this study can serve as the foundation for additional qualitative and quantitative research regarding the mental health service pathways for children enrolled in urban public schools.

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**When Their World Falls Apart**

*Helping Families and Children Manage the Effects of Disasters*

Lawrence B. Rosenfield, Joanne S. Caye, Ofra Ayalon, and Mooli Lahad

Addressed from cognitive and behavioral, family systems, and ecological perspectives, *When Their World Falls Apart* is a thought-provoking text that combines the international, cross-cultural, empirical, theoretical, and interdisciplinary expertise of four distinguished international authors. Many special activities throughout the book bridge the gap between cognitive and affective learning.

Readers who seek to be educated before disaster strikes have "struck gold" in this publication. It presents not only the content of our disaster knowledge in digestible form, but also stimulates critical thinking and application of the knowledge in a classroom or professional development setting. The "Touching Reality" and history-based vignettes make this a unique and intriguing teaching tool for undergraduate and graduate students as well as for professional audiences.


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