

Running head: TEACHER PERCEPTION OF MH NEEDS IN ORTHODOX SCHOOLS

TEACHERS PERCEPTIONS OF MENTAL HEALTH SERVICES IN ORTHODOX JEWISH
SCHOOLS: A SURVEY STUDY

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ABSTRACT

Mental health plays an integral role in an individual's long term development and functioning from childhood through adulthood (Department of Health and Human Services, 2017). Research indicates that school-based interventions aimed at targeting mental health issues are associated with positive academic and psychological outcomes (Levitt et al., 2007; Williford & Mendenhall, 2007). Research examining the role that teachers play in supporting students' mental health needs highlights that teachers maintain a unique position to implement classwide behavioral interventions which can mitigate the effects of mental health issues within the classroom. In addition, teachers act as a referral source to help students access mental health services in or outside of school. However, the literature regarding access to mental health services and teacher perceptions in regard to their role in supporting students is limited within the Orthodox Jewish private schools. This study was meant to fill this gap in the research. This study examined, in a sample of teachers ($N = 71$) working in private Orthodox Jewish schools, their perceptions regarding their role, level of burden, and perceived efficacy related to identifying, supporting, and referring students for mental health services. In addition, this study examined mental health services available within the Orthodox schools as well as the barriers preventing students from receiving these services. It was predicted that degree and level of training would predict teacher self-efficacy in supporting the mental health needs of their students and that reported self-efficacy would correlated with reported levels of burden in supporting student mental health in the classroom. Teachers completed anonymous surveys online about their perceptions in the aforementioned areas. Surveys were gathered through the use of snowball sampling. Results of multiple regression analysis revealed that teacher training was a significant predictor of teacher self-efficacy in supporting the mental health needs of their

students, when controlling for years of teaching experience ($\text{adj. } R^2 = 0.16$; $F(1,68) = 4.67$; $p = .004$). However, teacher degree was not a predictor of teacher reported levels of self-efficacy ($p = .057$). Results from Spearman correlation tests found teacher reported level of burden and reported levels of self-efficacy were significantly correlated ($p = .008$). Findings from the current study suggest that school psychologists can play an integral role in assisting teachers with further training and supports in regard to student mental health which can help teachers feel more efficacious within their role. Future research can also target how Orthodox Jewish schools can work with their resources to support student mental health and reduce the stigma that currently exists as a significant barrier to treatment.

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Introduction

The mental health of an individual is comprised of one's psychological and social well-being (Saini, 2016). Mental health affects individuals on a daily basis and plays an integral role in the way people function from childhood through adulthood. Studies highlight that over 20% of children younger than age 18 experience mental health issues and approximately 21% have a diagnosable mental disorder (Burns et al., 1995; Hazen, Hough, Landsverk & Wood, 2004; Merikangas et al., 2010; U.S. Department of Health and Human Services, 2017). More specifically, research indicates that approximately 14% of adolescents with mood disorders usually experience a lifetime prevalence, 32% of adolescents with anxiety disorders experience a lifetime prevalence, and 20% of adolescents with behavioral disorders experience a lifetime prevalence (Merikangas et al., 2010). However, these studies indicate that only a small percentage of children, .6% to 16%, are identified as having a mental health concern and fewer than one half of the students identified as needing services actually receive those services (Kataoka; 2002; Levitt, Saka, Hunter-Romanelli & Hoagwood, 2007). Studies estimate that only a small percentage of students are receiving adequate care to address mental health problems with many uninsured and underinsured children and families particularly at risk for receiving inadequate care (Hoagwood et al., 2001; Ringeisen, Henderson & Hoagwood, 2003).

Mental health problems left untreated are associated with poor academic performance, disrupted psychological development, lower rates of high school graduation, and increased health risks (Kessler et al., 2005). Additionally, these mental health problems can persist into adulthood and are often associated with increased health risks and disrupted psychosocial development (Kataoka, Zhang & Wellis, 2002; Moon, Williford & Mendenhall, 2007; Williams et al., 2007). School-based interventions targeting mental health issues in children and

adolescents have been associated with positive academic and psychological outcomes (Adelman & Taylor, 2006; Franklin et al., 2012; Levitt et al., 2007; Mazzer & Rickwood, 2015; Ohrt et al., 2020). Children and adolescents at risk for or who are currently experiencing mental health problems depend on adults to assist and recognize these issues. These children and adolescents often require supports and referrals to appropriate mental health professionals (Jorm et al., 2010).

Schools and teachers play a key role in identifying students with mental health needs (Kratochwill & Shernoff, 2004; Reinke et al., 2011; Shernoff, Bearman & Kratochwill, 2016). Within the last decade, there has been research dedicated to understanding teachers' roles in identifying and referring students for mental health services (Levitt et al., 2007; Moon et al., 2017). There have been numerous studies indicating that teachers are often aware that they can play a key role in identifying students who struggle with mental health problems (Adelman & Taylor, 2000; Ghaith & Yaghi, 1997; Lynagh, Gilligan & Handley, 2010; Mazzer & Rickwood, 2015). However, there continues to be a gap between a broader role for teachers in supporting students struggling with mental health problems, including classroom support and classwide evidence-based interventions (Andrews, McCabe & Wideman-Johnston, 2014; Moon et al., 2017).

Private Schooling and Support for Mental Health

Private schools comprise approximately 25% of U.S. schools. Private schools do not rely on the government for funding and therefore, are not regulated by the same guidelines as public schools (Van Hoof et al., 2004). Private schools are not required by law to abide by the No Child Left Behind Act (2001) or the Individual with Disabilities Education Improvement Act (2007). This lack of conformity to federal laws may impact services available to students and the amount of training teachers receive to support and identify students with mental health problems.

Furthermore, very little is known regarding rates of mental health problems in Orthodox Jewish private schools or teachers' beliefs regarding their role and efficacy in supporting student mental health needs (Pelcovitz, 2005). This knowledge would help further service the mental health needs in Orthodox Jewish private schools.

The Orthodox Jewish community generally places a significant focus on education, with extensive demands for curriculum and limited tolerance for students who are unable to meet the rigorous academic demands. According to Goldberg (2004), this academic pressure is correlated with mental health of students within the Orthodox Jewish community. Goldberg (2004) conducted a study examining mental health in Orthodox Jewish middle schools and found a significant correlation between academic difficulties and behavioral problems in children ($r = -.328, p < .01$). In Orthodox Jewish schools, there is also the additional expectation for students to learn Hebrew, placing significant academic pressure on students which may also explain the relationship between academic problems and externalizing behavior problems (Goldberg, 2004). Another study conducted within the Orthodox Jewish population (17 elementary Orthodox elementary schools) found a strong correlation between teachers' sense of efficacy and reports of ability to support student mental health ($r = 0.67; p < .01$; Weisel & Dror, 2006). This finding highlights that teachers in Orthodox Jewish schools may not receive formal training to support student mental health, which may be associated with a lower sense of efficacy related to supporting students with mental health problems (Grossman, 2010).

Therefore, the goal of this study was to examine, in a sample of Orthodox Jewish teachers, their perceptions regarding their role, level of burden, and perceived efficacy related to identifying, supporting, and referring students for mental health services. In addition, the study

examined teachers' reports of mental health services available within the Orthodox schools as well as perceived barriers to students receiving those services.

Prevalence of Mental Health Problems in Children and Youth

According to the U.S. Department of Health and Human Services (2017), one in five children and adolescents within the U.S. experience mental health problems. More specifically 9.4% of children in the U.S. who were studied in the 2016 National Survey of Children's Health (approximately 6.1 million) received a diagnosis of ADHD, 7.4% of children (approximately 4.5 million) received a diagnosis of behavior problems (i.e. ODD, CD), 7.1% of children (approximately 4.4 million) received an anxiety diagnosis, and 3.2% of children (approximately 1.9 million) received a diagnosis of depression (Ghandour et al., 2018). Furthermore, studies also indicate that only one half of children identified with mental health needs receive appropriate care and nearly two thirds of the children and adolescents receive these services in school (Jensen et al., 2011; Levitt et al., 2007). It is important for teachers to be able to identify and assist in referring students who may need services. Although schools have a primary focus on educating students, this can only be accomplished if all needs of the children are being met, including their mental health functioning (Levitt et al., 2007; Powers, Wedmann, Blackman & Swick, 2014).

Within the last several decades, the Orthodox Jewish community has become more aware of the mental health needs within their community and there has been a significant increase in the number of Orthodox Jews seeking out mental health professionals (Rosmarin et al., 2009; Schnall et al., 2014; Twerski, 2002). However, potential lingering reluctance to seek help and the fear of stigmatization may contribute to limited understanding of the rates of psychological

difficulties among Orthodox Jewish children (Frosh, Lowenthal, Lindsey & Spitzer, 2005; Lindsey, Frosh, Lowenthal & Spitzer, 2003).

One of the first known studies conducted within this population was completed in London, England and found that children within the community showed very similar levels of psychological difficulties when compared to national samples (Frosh et al., 2005). For example, Frosh found that both parents and teachers rated similar levels of mental health problems (15% of children experienced emotional difficulty) when compared to parents and teachers in the secular population (10% of children experiencing similar symptoms; Frosh et al., 2005; Meltzer et al., 2003). The Frosh et al. study highlighted that children in Orthodox Jewish families were often born into very large families and experienced higher levels of poverty, which has been found to be correlated with higher mental health problems (Holman & Holman, 2002). However, high levels of community cohesion and support may serve to buffer or mitigate potential risk factors associated with the development of mental health problems within this community (Frosh et al., 2005).

Studies conducted with adult populations found that the overall lifetime rate of psychiatric disorders among Orthodox Jews within the sample did not differ from rates among non-Jews (Rosen, Greenberg, Schmeidler & Shefler, 2008; Schnall et al., 2014). However, there are differences in distribution of psychiatric disorders, for example, Rosmarin et al., (2009) in his study found Orthodox Jews reported elevated risk for depression and anxiety compared to general populations. However, Orthodox Jews reportedly had lower rates of alcohol abuse when compared to the general population (Kohn, Levav, Zolondek & Richter, 1999; Pirutinsky, Rosmarin, Pargament & Midlarsky, 2011; Rosmarin et al., 2009; Schnall, 2006). Despite comparable, estimated rates of mental health problems among Orthodox children and youth, little

is known regarding teachers working in Orthodox Private schools and their beliefs regarding their role in providing classroom support and identifying students with mental health needs. The goal of this study was to address this gap in the literature.

Schools as a Setting for Mental Health Service Delivery

Orthodox parents typically send their children to Orthodox schools where their religious beliefs are respected and a strong secular and Jewish education is supported (Schnall et al., 2014). Over 90% of children growing up in Orthodox Jewish homes attend Orthodox schools (Schnall et al., 2014).

Teachers are tasked with educating learners, however, a prerequisite for children to achieve academically is to ensure that their mental health needs are met. Therefore, all schools, including Orthodox schools, must address mental health and psychosocial concerns of students. Public schools are conceptualized as ideal settings to provide mental health services to children due to the significant amount of time children spend in school (Moon et al., 2017; Weist et al., 2012; Weist, Evans & Lever, 2014). The same case can be made for Orthodox Jewish schools, where hours of attendance are even longer than public schools and ideally should be a setting that can provide mental health services to students.

National surveys indicate that schools provide mental health services including individual counseling, crisis intervention, assessment, behavioral consultation, and referral to specialized programs (Andrews et al., 2014; Frauenholtz, Williford & Mendenhall, 2015). Schools present a unique opportunity to reach children and provide a multitude of services across a continuum and to differentiate services depending on student level of need. Schools can accomplish these services by ensuring adequate opportunities for students to address mental health concerns and deal with issues that arise (Graham, Phelps, Maddison & Fitzgerald, 2011; Saini, 2016).

Typically, mental health services delivered in public schools are organized around tiered models. Universal interventions (Tier 1) are designed to target all students, regardless of risk, whereby each student receives some level of interventional supports (Adelman & Taylor 2006; Hoagwood et al., 2001). Universal interventions include classroom or school wide interventions, such as positive behavioral interventions and support or social and emotional learning that are designed to prevent students from moving up the tiers of support by providing prevention services. Research conducted within the tiered intervention models found that universal school wide interventions had small but significant positive effects on disruptive behaviors, concentration problems, emotion regulation and prosocial behavior (Bradshaw, Wassdorp & Leaf, 2012). Teachers are often the key implementers within this level of support. They are expected to implement various classwide behavioral interventions at the classroom level to support student social and emotional development.

Targeted interventions (Tier 2) are a more intensive level of support and include interventions targeted to small groups or students at risk for mental health problems (Meyer & Behar-Horenstein, 2015). Tier 2 interventions are aimed at reducing escalation of problem behaviors and enhancing protective factors in student lives (Yong & Cheney, 2013). Some examples of targeted mental health programs delivered in schools include Coping Power (Lochman & Wells, 2003), The Incredible Years (Webster-Stratton, Reinke, Herman & Newcomer, 2011), and Second Step (Committee for Children, 2016). Several studies were conducted with the Tier 2 level interventions to study the effects of student mental health. These studies found that students who received Tier 2 interventions experienced a positive impact on mental health in both internalizing and externalizing behaviors (Herman et al, 2011; Winzer, Lindberg, Guldbrandsson & Sidorchuk, 2018; Yong & Cheney, 2013). Teachers have been

identified to play a key role in this area as well, including providing smaller group instruction and implementing behavioral plans for students.

Intensive interventions (Tier 3) are provided to students with identified mental health disorders and are often dependent on a specific mental health problem and formal diagnosis. This support includes students working with individuals trained in mental health interventions. Although these services are not provided by teachers, their involvement and support for students can help enhance success for students (Greenwood et al., 2011).

Tiered service delivery models in schools can potentially provide guidance to schools and teachers regarding their role in supporting the prevention of mental health problems and promoting healthy development using effective classroom management and positive classroom climate. Tiered service delivery models can also guide schools in their role in identifying and referring students for more intensive services outside the classroom. In Orthodox Jewish Schools, mental health services are also organized around tiered models where teachers are involved in providing universal, classwide behavior interventions. There are additional supports in Orthodox schools including individual services for students with higher levels of need (Grossman, 2010). However, there are limited studies describing tiered levels of support within the Orthodox schools and therefore, this study examined these services as well.

Teachers Role in Identifying and Supporting Students with Mental Health Needs

Despite the unique role that schools play in ensuring the mental health needs of students are met, questions remain regarding the role that teachers play in identifying and supporting students with mental health problems (Mazzer & Rickwood, 2015). Teachers are in a unique position to help implement preventive interventions as well as raise awareness of the specific needs of their students (Burnett-Zeigler & Lyons, 2010; Moon et al., 2017; Reinke et al., 2011;

Shernoff et al., 2016). Teachers are not involved in the delivery of intensive Tier 3 services, but they play a key role in identifying target students in need of these services (Adelman & Taylor, 2000; Frauenholtz et al., 2015; Levitt et al., 2007). In addition, teachers are often asked to implement classroom-based, universal interventions. Teachers are consulted as a primary resource when students present with behavioral issues. Therefore, it is necessary to understand teachers' attitudes and perspectives within their unique role, to enable more effective teacher collaboration (Reinke et al., 2011). Understanding teacher perceptions of their roles in supporting students with mental health problems may provide important information to help bridge the research to practice gap in school based mental health service delivery (Reinke et al., 2011).

There have been numerous studies designed to examine teachers' perceptions of their roles in recognizing the mental health concerns of their students (Andrews et al., 2014; Koller & Bertel, 2006; Walter, Gouze & Lim, 2006). Teachers are often tasked with making complex decisions regarding interventions as well as evaluations and monitoring of student progress (Meyer & Behar-Horenstein, 2015). However, this expectation presents teachers with a unique role where they must learn to work within a larger framework, thus enabling them to reach a larger number of students (Buffum, Mattos & Weber, 2009). Examining teachers' perceptions concerning their roles and influence on mental health can bridge the research to practice gap and increase the number of effective mental health practices delivered in schools (Reinke et al., 2011; Walter et al., 2006). Review of the current literature highlighted that several factors influence mental health within the schools and access for students. These include teacher efficacy, teacher training and teacher reported level of burden, and therefore, these constructs were examined as they relate to student mental health within schools.

Teacher efficacy. Self-efficacy includes teachers' beliefs about their personal ability to make a difference in student behavior, learning, and development and beliefs about their ability to bring about desired outcomes of student engagement and learning, including students who are difficult to manage or who have lower motivation (Tschannen-Moran, Woolfolk & Hoy, 2001). Bandura (1994) described self-efficacy as an individual's belief in their innate ability to achieve goals and effectively deal with situations. Teachers who experience high levels of self-efficacy can be more successful in supporting their students' mental health and are willing to approach difficult tasks and learn to master challenges rather than avoid them (Bandura, 1994).

Self-efficacy in the context of the current study included teacher beliefs regarding their current knowledge and skills to be effective in identifying and supporting student mental health needs. Studies have demonstrated that a teacher's self-efficacy beliefs to bring about desired outcomes of student engagement and learning are related to student achievement and motivation (Stipek and Byler, 1997), teacher commitment (Coladarci, 1992), and longer-term retention (Burley, Hall, Billeme & Brockmeier, 1991). Several factors identified in the literature may contribute to teacher self-efficacy in supporting student mental health. Those factors include formal training and level of burden teachers experience when teaching students who struggle with mental health problems.

Training. Some studies have documented that teachers do not receive adequate preservice training and support to help identify and implement school-based interventions (Kratochwill & Shernoff, 2004). Teachers often identified feeling unqualified to recognize signs and symptoms of mental health problems (Lynagh et al., 2010). Teachers in private schools may not have continued for higher education and may doubt their knowledge or have limited training in mental health disorders in children and adolescents (Cvinar, 2010).

Burden. Studies document that one of the major stressors related to teaching in public schools includes student disruptive behavior (Shernoff et al., 2011, 2016). Teaching large numbers of students who struggle with behavior problems is one of the strongest predictors of teacher turnover and is also identified as one of the most important professional development needs identified by teachers (Shernoff et al., 2016). Roeser and Midgley (1997) reported that teachers' sense of efficacy was negatively correlated with feelings of burden related to student mental health and supporting their needs. Teachers who described feeling less effective with their students reported higher levels of burnout from teaching.

Barriers to Orthodox Students Receiving Mental Health Services in School

In addition to efficacy, role and burden influencing the extent to which students attending Orthodox private schools' access mental health services, there are several barriers specific to the Orthodox community that could influence mental health service delivery and receipt (Pelcovitz, 2005). These barriers include potential stigma related to mental health services, lack of effective services within the private sector, and the role of Rabbinical leaders play within this community.

Stigma. One potentially important contributor to lower referral rates for mental health services in Orthodox schools is the long-standing stigma attached to seeking help from mental health professionals (Rosen et al., 2008). The Orthodox Jewish community is very close knit which acts as a support, providing protective factors for many individuals. Within the Orthodox community, there has been a trend to focus on the welfare of the larger community, which at times may be valued over interventions to benefit the individual (Pelcovitz, 2005). Although there have been great strides in services made available in Orthodox communities, there is still a stigma attached to receiving services. Parents may be concerned with perceived long-term

negative outcomes tied with receiving mental health supports and may be reluctant to engage with mental health professionals (Pelcovitz, 2005; Rosen et al., 2008; Schnall et al., 2014).

Additionally, Orthodox Jewish children are typically in school for about 8 to 10 hours a day. Children typically learn both Hebrew and English subjects which places an added burden on the students. Many parents within the Orthodox community are more likely to seek help regarding academics via tutoring and after school help sessions (Pelcovitz, 2005). Studies document that Orthodox Jewish parents want their children to perform well and view academics as an avenue to achieve success (Schnall et al., 2014). Therefore, it is important to capitalize on this value to guide and motivate the parents to take advantage of available mental health services.

Limited effective services. Another barrier for Orthodox Jews is that there are fewer services available (Hoffman, 2014). NASP (2017) proposed that there should be a ratio of 1,000 students per school psychologist. Evidence suggests that these standards are not being met in many school districts (NASP, 2017). School psychologists are expected to work with more students and are often unable to meet all the needs. Private schools are not governed by the same legislations and therefore, there is often a lag in the services they provide (McEvoy, 2017). Therefore, the students have limited access to the expertise and training that a school psychologist can offer. As research indicates, teachers are more likely to refer students for services if they believe there are appropriate mental health supports in place (Slade, 2002). Lack of availability of proper care has been identified as one of the leading barriers to teachers seeking out mental health support for their students (Reinke et al., 2011). If teachers believe there are limited services available, or are unaware of what those services are, they will be less likely to refer their students to receive mental health support.

Role of Rabbinic leaders. The Orthodox Jewish community typically seeks counsel from their Rabbinical leaders regarding many areas of their daily living (Freund & Band-Winterstein, 2017). The Rabbi is viewed as a mentor and leader in all areas including religion, education, physical and mental health. The role of the Rabbinical leaders can have a significant effect on teachers and their knowledge of the mental health needs of their students. Teachers may be reluctant to refer students, particularly if they believe an issue can be dealt with by a Rabbinical leader. In addition, many individuals within the Orthodox community are lacking information regarding mental health and its symptoms (Pelcovitz, 2005; Rosmarin et al., 2009). It is therefore possible that behaviors that may be viewed as a warning sign in other communities are more likely to be tolerated within the Orthodox Jewish sector, due to lack of information or knowledge regarding pathology (Buchbinder, 1991). Orthodox Jewish schools often have a rabbinic advisory board which is involved in all decisions on school matters. The Rabbis could also play a role in highlighting the importance of mental health care availability to students in these schools (Pelcovitz, 2005). To ensure success with clients, mental health professionals, including school psychologists, must work together with the Rabbinical figures to help service the Orthodox clientele (Hoffman, 2014). Understanding the Rabbis' crucial role helps garner trust with the client and may reduce client resistance and facilitate a culturally sensitive therapeutic process (Freund & Band-Winterstein 2013; Schnitzer, Loots, Escudero & Schechter, 2011).

Summary

Research within the field of psychology has identified that the context of services plays a large role in its effectiveness (Burnett-Zeigler & Lyons, 2010; Moon et al., 2017). It is important for mental health professionals to attend to these needs and deliver services within their area of

competency and training, while providing culturally appropriate care (Kirmayer, 2011). It is paramount when treating Orthodox Jewish children and adults to understand how the culture and religion influence treatment. Orthodox Jews are a religious group that live apart, valuing their separateness and ascribing sanctity to their lifestyle (Greenberg & Witztum, 2013). This study was largely focused on the schools within the Yeshiva Orthodox subgroup, exploring teachers' perceptions of their roles, as well as the availability of mental health services within those schools.

Numerous studies have identified the need to address mental health concerns in youth and adolescents to allow for intervention and prevention in their formative years (Andrews et al., 2014; Cvinar, 2010). Over the last decade, there has been an interest in understanding teachers' perceptions and their role in supporting mental health service delivery for students (Moon et al., 2017; Reinke et al., 2011). Teachers can play a key role in supporting student mental health by referring children and adolescents to receive appropriate services (Atkins et al., 2017). In addition, teachers are often directly involved with many classroom behavioral interventions. Numerous studies have examined teachers' perceptions of the mental health needs of students within public schools (Lynagh et al., 2010; Reinke et al., 2011; Repei, 2005; Walter et al., 2006). However, little is known regarding teachers' perceptions of mental health and the role they play in private schools and specifically Orthodox schools (Benjamins & Whitman, 2010; Van Hoof, 2004). The current study was aimed at addressing this lack of knowledge specifically within the Orthodox Jewish private schools. The purpose of this study was to bridge these two lines of research, teacher perceptions of their roles and mental health service delivery in Orthodox school settings to better identify and understand barriers to effectively helping students with mental health concerns.

Research Questions and Predictions

With these issues in mind, the current exploratory study was designed to examine the following research questions:

Research Question 1. How frequently and what types of mental health problems are Orthodox Private School Teachers (OT) in this sample observing in their classrooms?

Research Question 2. What do OT in this sample believe their role is in supporting students who struggle with mental health problems?

Research Question 3. What do OT in this sample report as their level of burden and self-efficacy in identifying, supporting, and referring students for mental health services?

Research Question 4. What do OT in this sample identify as the most frequent barriers to students receiving mental health services in their schools?

Research Question 5. Does type of degree or level of training in supporting student mental health predict teacher self-efficacy in supporting the mental health needs of their students when controlling for teachers' years of experience?

Prediction. Teachers are often expected to support students in many areas and research highlighted that teachers who reported higher levels of self-efficacy, were willing to engage and support students which correlated to a higher academic performance (Day, 2019). Reinke et al., reported that teachers expressed higher levels of self-efficacy, if they felt responsible for playing a role in supporting student mental health, as well as feeling adequately trained and prepared (2011). The current study was modeled after the Reinke article and was aimed at understanding if these constructs play a role within the Orthodox Jewish schools. Therefore, this study was aimed to understand the role teachers play with regard to supporting student mental

health. In the current study it was predicted that the level of training and degree held by teachers would have a positive relationship with reported levels of self-efficacy.

Research Question 6. Does level of self-efficacy in supporting student mental health predict the teacher reported level of burden in supporting student mental health in OT classroom?

Prediction. Research highlights that teacher efficacy is correlated with teacher commitment and increased student engagement and motivation (Stipek and Byler, 1997). Teachers who experience more engagement with students are reported to feel less burnout with their tasks (Reinke et al., 2011). Therefore, this study is aimed to better understand the correlation between reported levels of self-efficacy in supporting the mental health needs of students and teachers' level of burden. It was therefore predicted that there would be a significant correlation between self-efficacy and burden.

Method

Participants

Participants for this study were Orthodox Private School teachers (OT) working in K-8 grade Orthodox Schools in the tristate area. Inclusion criteria consisted of the following: (1) general education teachers in grades K – 8th, (2) current employment in an Orthodox Jewish private school. Exclusion criteria for participants consisted of the following: (1) teachers who were employed in high school, (2) teachers who were employed as special education teachers.

Demographics

The sample was comprised of 71 individual participants. Survey respondents were predominantly female ($n = 70$), with only one male completing the survey ($n = 1$). All the respondents identified as Caucasian/ European American ($n = 71$). Participants ranged from ages 20 – 63, with 76% ranging in age from 20-32. Fifty-eight percent of teachers earned a Master's

degree as their highest degree ($n = 41$), 24% earned a Bachelor's degree ($n = 17$), 4% earned an Associate's degree ($n = 3$) and 14% received a high school diploma or GED ($n = 10$).

Participants had a mean of 8.35 years of teaching ($SD = 8.91$; Range = 0 – 34). Teachers were also asked to report on level of training received in supporting student mental health. Eighteen percent of participants responded receiving no formal training ($n = 16$), 6% reported completing “pre-service course work” ($n = 5$), 44% reported receiving “in service training” ($n = 40$), and 12% reported receiving “preservice and in-service training” in student mental health ($n = 11$). Forty-eight percent of respondents taught for 0-5 years ($n = 34$), 31% reported teaching for 6-10 years ($n = 22$), 3% reported teaching 11-15 years ($n = 2$), 1% reported teaching 16-20 years ($n = 1$) and 17% reported teaching for more than 21 years ($n = 12$). Table 1 summarizes the demographics information for teachers who completed the survey.

Procedures

Approval for this study was obtained from the Institutional Review Board (IRB) at Rutgers, the State University of New Jersey, prior to data collection. After IRB approval was obtained data was collected through an anonymous online survey. The survey was administered through Qualtrics (Smith, Smith, Smith, & Orgill, 2002), an online web-based survey program. Snowball sampling, which is a non-probabilistic form of sampling where individuals are recruited and used as informants to locate additional eligible participant, was used to access participants (Baltar & Brunet, 2012; Penrod, Preston, Cain & Starks, 2003). Snowball sampling is often employed with special or rare populations with investigators who have familiarity with members of the targeted group for the study (Atkinson & Flint, 2001; Marcus et al., 2017). Snowball sampling secures participants in a “ripple effect” with one contact leading to multiple contacts, which helps to increase the participant pool (Charmaz, 2000). Therefore, this technique

can help access a greater number of teachers who are employed in Orthodox Jewish schools and would otherwise be difficult to reach.

An electronic link was sent to a cohort of teachers (who graduated from the teaching program together with the researcher), who were then requested to forward to other co-teachers who work in Orthodox Jewish schools, to increase the pool of participants (See Appendix B for initial email.) All teachers were sent a cover letter briefly describing the purpose of the survey, as well as a link to the online site. The email included study rationale, how results will be utilized and a review of informed consent, confidentiality and instructions for completing the survey (See appendix B for informed consent). Teachers who received the original email were sent two follow up emails, at one-week intervals. Both emails contained a link to the survey and a request that teachers complete the survey and then forward it to the teachers in Orthodox private schools. The online survey was designed for anonymous responding, meaning no identifying information was collected and thus respondents could not be identified based on their responses.

To recruit a sample of teachers, snowball sampling was used (Given 2008). Twenty teachers, who met the above inclusion criteria, were contacted electronically and invited to participate in the survey. The teachers who were contacted were predominantly female and European American, reflecting national demographics for teachers (USDOE, NCES, 2013). All survey responses were anonymous. Targeted teachers were asked to forward the link to their colleagues who were teaching in other Orthodox Jewish schools from K through eighth grade. This method of recruitment allowed for a larger number of participants to be reached making the sample more inclusive (Sadler et al., 2010). A power analysis was conducted, which determined that 67 participants was a sufficient sample size to detect medium effects in a multiple regression with up to two predictors. Therefore, a 67 participant threshold was considered adequate to

perform the proposed analyses. The final sample size of respondents ($n = 71$) reflected similar sample size obtained in previous research using snowball sampling with teachers, which ranged from 25-95 participants (Cassady, 2011; Jepson & Forest, 2006).

Instrument

The current study was modeled after two surveys and was adapted to address concerns regarding teachers within Orthodox Jewish schools (Reinke et al., 2011; Roeser & Midgley, 1997). The Reinke et al. 2011 survey was administered to 292 teachers across five school districts (rural, suburban and urban). This survey included 42 items across three main categories: (1) teachers' perceptions and attitudes regarding the roles of schools in fostering students' mental health, (2) teachers' knowledge of evidence-based interventions, and (3) demographics. The Reinke et al. survey had established content validity based on five expert scholars who reviewed and provided feedback on the survey. The final items included in Reinke et al.'s survey were developed based on an iterative review process which included feedback from a range of individuals with expertise on this topic (Aarons, 2004; Chorpita, Becker, & Daleiden, 2007; National Center for Education Evaluation & Regional Assistance, 2003; White & Kratochwill, 2005). The original Reinke survey included 42 items across 5 subscales: Mental Health Concerns, Knowledge Skills and Training, Barriers, Reasons Children Fall Through the Cracks and Roles of School Personnel.

The Roeser and Midgley survey (1997) was comprised of 94 items and was administered to $n = 200$ general education teachers, $n = 20$ principals, and $n = 880$ students. The scales assessed: teachers' views of their role in promoting their students' mental health, teachers' feeling of burden, teachers' beliefs regarding mental health related issues, and teachers' sensitivity to mental health needs of their students. The authors provided minimal information of

the psychometric characteristics of the survey and therefore, reliability and validity measures were limited. The survey was comprised of three scales: (1) teacher efficacy ($\alpha = .77$), (2) perception that students' mental health is part of a teacher's role ($\alpha = .76$) and (3) feeling of burden in relation to student mental health needs ($\alpha = .70$). Scales were created by taking the mean of constituent items.

For the current survey, the two aforementioned surveys were adjusted to better address the aims of this study, within the Jewish Orthodox population. The survey used in the current study included 23 questions across four subscales (see Appendix A). The four measures included in the current study were adapted from the Reinke et al., (2011), and the Roeser and Midgley survey (1997).

The first measure, *Efficacy*, assessed teachers' perceptions of their ability to support the mental health needs of their students, within the classroom. This measure consisted of 4 items. The first and second items were from the Roeser survey ($\alpha = .77$), while the third and fourth items were from the Reinke survey. The four items were rated on a 5-point Likert scale: Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree.

The second measure, *Role*, assessed teachers' beliefs regarding the extent to which schools should be involved in the mental health needs of their students, and who is primarily responsible to address these needs. The roles measure consisted of 4 items, with two items from the Roeser survey ($\alpha = .76$) and two items from the Reinke survey ($\alpha = .78$). All four items were rated on a 5-point Likert scale: Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree.

The third measure, *Burden*, assessed teachers' beliefs regarding the negative impact of student mental health problems on teachers. This measure consisted of 2 items from the Roeser

survey ($\alpha = .75$). These two items were rated on a 5-point Likert scale: Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree.

The fourth measure, *Barriers*, assessed teachers' beliefs concerning why students may not receive mental health services in schools. This scale was comprised of one item from the Reinke survey. This question was adapted from the Reinke survey to include potential barriers unique to Orthodox Jewish schools (i.e. involvement of Rabbinical leaders). The internal consistency for this measure was adequate (Cronbach's $\alpha = .82$). At the end of the survey, teachers were asked to describe their demographics including age, gender, and professional training. The last several questions asked teachers to describe their classroom makeup and perception of their students' mental health needs.

Data Analysis

Descriptive statistics, including frequency, means and other measures of central tendency were used to answer research questions 1 through 4. This included examining the current mental health services available in Orthodox Jewish schools, as well as teachers' perceptions of their roles in supporting student mental health, reported levels of burden, and reported levels of barriers for lack of effective mental health services. For research question 5, a multiple regression analysis was used to determine if a relationship existed between type of degree or training experience and teachers' reports of self-efficacy in supporting student mental health needs.

For research question 5, the two predictor variables included degree and level of training. Each predictor was tested at an alpha level of .05 and expected to detect a medium effect size with .80 power (Cohen, 1992). The sample included teachers with years of experience ranging from one to 33 years. The literature expressed that teachers' perception of their job changes

frequently, particularly in early career stages (Day, 2019). To control for the potential impact on teachers' level of self-efficacy in supporting student mental health, years of teaching experience was included as a covariate in research question five.

According to Cohen (1992), when running multiple regression analysis with two predictors, to achieve 80% power, approximately 30 participants were needed to detect a large effect, 67 participants to detect a medium effect, and approximately 481 participants to detect a small effect.

For research question 6, a Spearman's rank order correlation (Gibbon, 1993) was used to determine if there was a relationship between teachers' reports of self-efficacy in supporting student mental health and teacher reported levels of burden. Given the small sample size in the current study, it was determined that using a non-parametric alternative to the Pearson correlation would provide more accurate results. Therefore, Spearman's rank order correlation was used in this study (Gibbon, 1993).

The original survey was sent to approximately 20 teachers. Research on snowball sampling varies regarding the ability to predict the number of respondents. However, an estimate of approximately 80 teachers were predicted to respond (Atkinson & Flint, 2001). This estimate had sufficient power at or above the recommended level to detect a medium or large effect but not a small one.

Missing Values Analysis

Data were analyzed using IBM SPSS Statistics Version 26. The number of survey responses initially recorded in Qualtrics was 90. Missing value analysis revealed that missing data ranged from 7.8% to 25.6%, depending on the variable. There were 9 incomplete entries, defined as entries for which no response was provided past consent to take part in the study

and/or entries that were recorded as fewer than 75 seconds, which was the estimated time it took to click through the survey. These entries were missing between 58% to 85% of their data.

Listwise whole case deletion was conducted prior to conducting analysis to avoid any misinterpretations that missing data may have caused. A missing value analysis was once again conducted and an additional ten entries were excluded, due to missing data (i.e. demographic information, missing responses on self-efficacy scale). Following the deletion of all unusable cases, the final sample size was 71. Data were then screened for outlier values and invalid scores, with no outliers, or invalid scores found within the dataset.

Results

Mental Health Problems Observed in Jewish Orthodox Classrooms

Figure 1 summarizes descriptive statistics for mental health problems reported in the current sample. Seventy-eight percent of teachers responded that approximately 1% to 24% of their students struggle with mental health concerns, and 21% of teachers reported that 25% to 49% of students struggle with mental health concerns. Thirty-four percent ($n = 64$) of respondents indicated teaching students with ADHD, with 34% ($n = 64$) reporting at least one or two students with ADHD symptoms. Thirty-two percent ($n = 60$) of teachers reported teaching students with anxiety, with 8 teachers reporting seeing between 3 to 4 students in their classroom with anxiety symptoms. Seventeen percent of teachers ($n = 32$) reported students exhibiting Disruptive Behavior Disorder. Ten percent of teachers ($n = 20$) reported observing depressive symptoms in their students and 7% of teachers ($n = 14$) reported observing trauma related symptoms in their students (see Table 2 for further results on mental health observed in Jewish Orthodox classrooms)

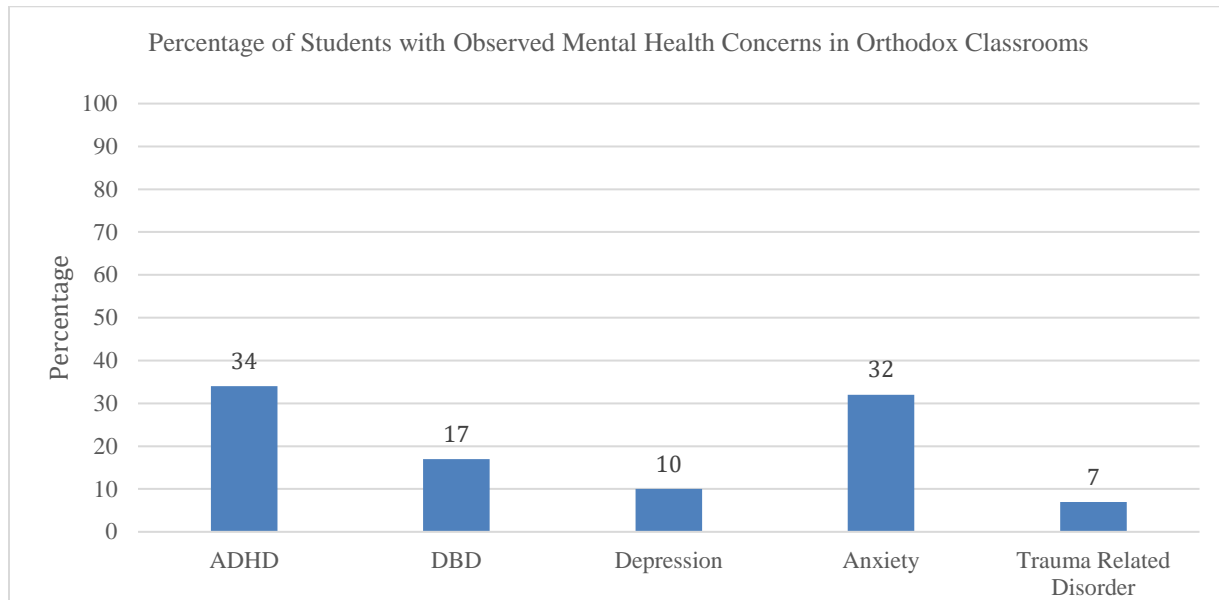


Figure 1. Results are expressed as percentage of students observed with specific MH challenge in Orthodox Jewish classroom.

Teacher Perceived Role in Supporting Student Mental Health Problems

Teachers were asked to rate their perceptions of their role in regard to student mental health needs, within the classrooms (see Table 3). Overall, 87% of respondents ($n = 62$) “agreed” that it was within their roles to be involved in assessing and referring students for mental health services. For example, when respondents were asked to rate the extent to which they believe “teachers should be involved in addressing student mental health needs within the classroom,” 94% ($n = 66$) of respondents “agreed.” Ninety-one percent of teachers “agreed” that they cannot teach students effectively unless they also consider emotional and social needs of their students. However, when teachers were asked if they believed other professionals within the school should take primary responsibility for student mental health 72% of teachers ($n = 51$) reported that they “agreed” or “strongly agreed” with this statement, and only 9% ($n = 6$) reported that they “disagreed.”

Teachers Perceived Level of Burden in Supporting Student Mental Health Needs

Teachers were asked to respond to two items on the survey asking about their reported level of burden in dealing with the mental and emotional needs of their students (Figure 2).

When teachers were asked “I feel overwhelmed by the emotional problems my students bring to school,” 62% of teachers responded that they agreed with this statement. Teachers responded similarly when asked “I do not feel qualified to deal with the emotional and behavioral problems I see in my students,” where 62% of teachers agreed with this statement.

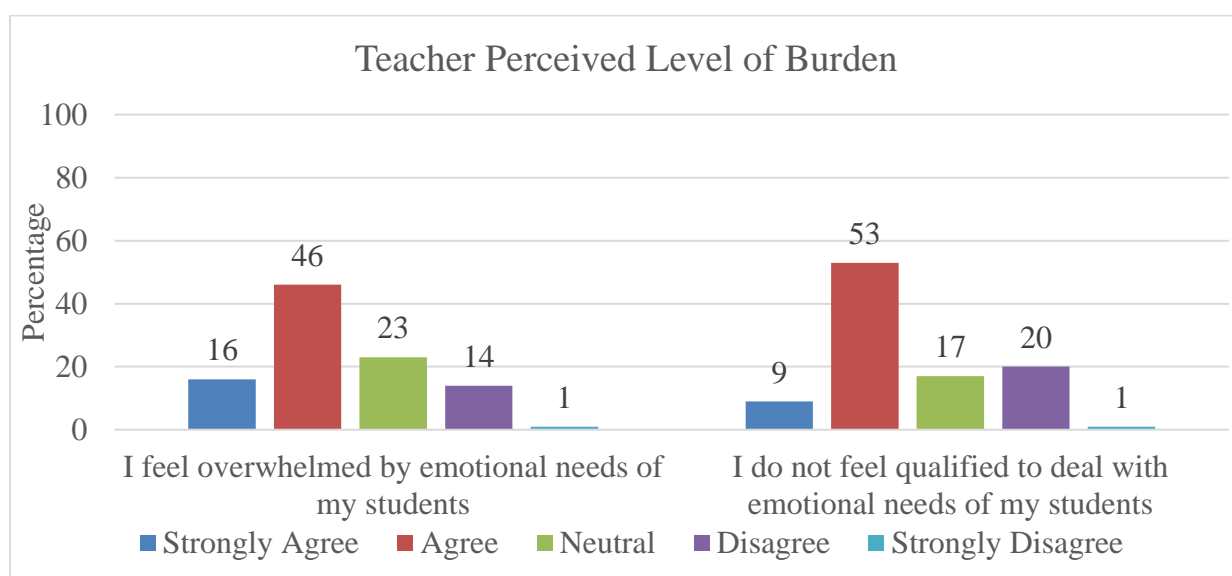


Figure 2. Results are expressed as percentage of teachers' response rates to level of burden

Teacher Reported Level of Self-Efficacy in Regard to Supporting Student Mental Health

Teachers were asked to respond to four items on a measure of perceived self-efficacy in supporting student mental health needs (See Table 3). Eighty-one percent of respondents indicated they are “certain they are making a difference in the life of their students ($n=57$).” However, when asked if teachers “feel I have the level of knowledge required to support the mental health needs of the children with whom I work,” 27% of teachers “agreed,” 31% of

teachers neither “agreed” or “disagreed” and 42% of teachers “disagreed.” When asked to report on teachers’ perceptions of their level of skill required to support the mental health needs of their students 35% of teachers “agreed” that they had the level of skills, 27% of teachers “neutral ” and 39% of teachers “disagreed” (See Table 4 for further break down of response rates).

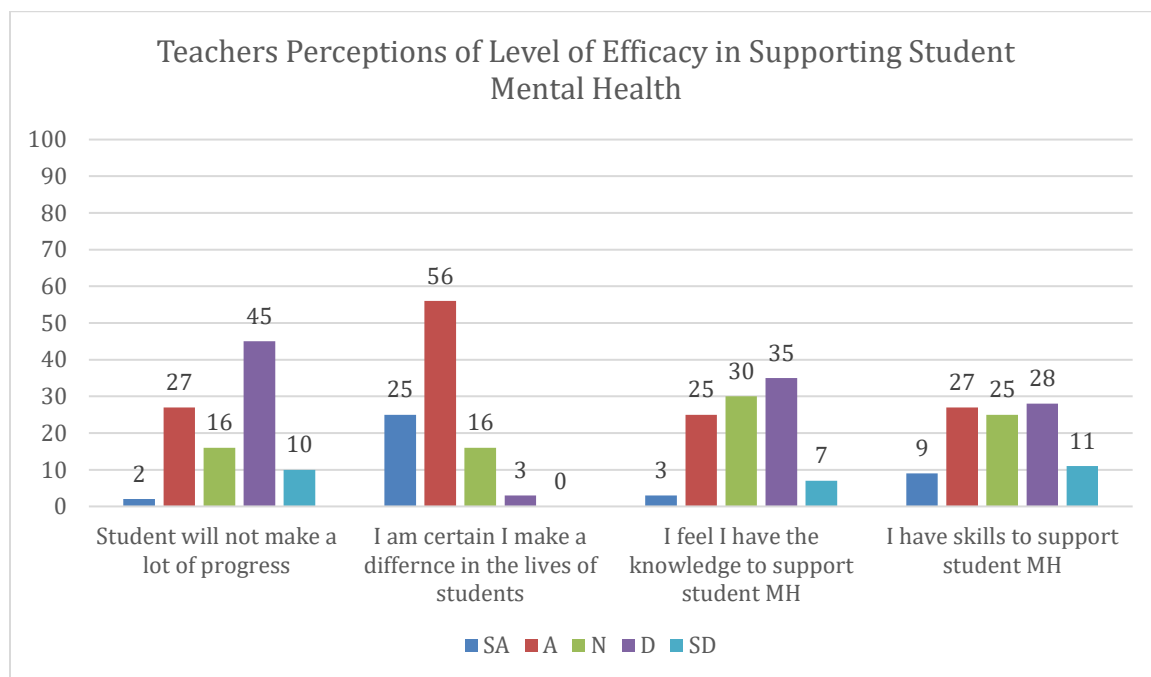


Figure 3. Results are expressed as percentage of teachers’ response rate to perceptions of self-efficacy in supporting student MH needs.

Barriers to Students Receiving Mental Health Services in Orthodox Jewish Schools

Teachers were asked to identify barriers that prevent children from receiving adequate mental services in the schools. Teachers were given a list of 13 items and asked to rate them on a 5-point Likert scale ranging from: “strongly disagree” to “strongly agree” that the items were barriers preventing students from receiving appropriate mental health services (Table 5). The top two barriers identified were stigma associated with mental health services and gaining parental

consent. Over 83% of teachers ($n = 59$) reported that they “agreed” with the statement that stigma associated with mental health services was a significant barrier, and 82% of teachers “agreed” with the statement that “gaining parental consent” ($n = 58$) was a significant barrier preventing students from receiving appropriate mental health care services in schools. In addition, over 62% of teachers identified insufficient numbers of school mental health professionals ($n = 46$), lack of funding ($n = 45$) and competing priorities ($n = 45$) as significant barriers for students receiving appropriate mental health services, within the Orthodox Jewish schools. Lack of support from Rabbinic leaders was identified as the least significant barrier with only 6% of teachers ($n = 4$) identifying that they “agreed” or “strongly agreed” that this acts as a barrier.

Correlation between Teacher Degree and Training and Reported Level of Self-Efficacy

Pearson correlations were conducted to assess the relationship between the independent variables (i.e. teacher training in mental health services, highest degree earned and years of teaching experience) and dependent variable of teacher reported level of self-efficacy in supporting the mental health needs of their students. The Pearson correlations among all variables are displayed in Table 7. Teacher training in supporting student mental health ($M = 1.65$, $SD = 1.00$) was significantly correlated with self-efficacy ($M = 3.11$; $SD = 0.61$) as measured by the mean scores of the four items on the self-efficacy measure ($r = .35$, $p < .01$), indicating a small, positive linear relationship between teacher training and teacher self-efficacy in supporting the mental health needs of their students. Self-efficacy was also significantly correlated with years of teaching experience ($r = .25$, $p < .05$), indicating a small, positive linear relationship between teachers’ years of experience and teacher reported level of self-efficacy in supporting student mental health, and their ability to impact their students. Teachers who

reported more years of teaching experience were correlated with higher reported levels of self-efficacy.

Two multiple regression analyses (MRA) were conducted to assess the relationship between self-efficacy in teachers' perception of their ability to support student mental health needs, and teacher training in children and adolescent mental health, as well as self-efficacy in supporting student mental health and teacher degree earned (see Table 8 for descriptive statistics).

In these analyses, the covariate used was years of teaching experience to control for possible effects of this variable on the dependent variable. The dependent variable was reported level of self-efficacy in supporting student mental health which was calculated by computing the mean of the four items on the Efficacy measure. For this analysis, there was sufficient power (80%) to detect a medium effect size at the $\alpha = .05$ level.

Teacher degree type and teacher training were recoded into dichotomous variables before regression analyses were conducted. For the Highest Degree Held Model, the high school diploma/GED degree was used as the constant. Therefore, all respondents in the study were comparisons between high school diploma/GED and respondents who held other degree types. For the training model, no training was used as the constant. Therefore, all results in this model were comparisons between no training, and in-service and/or preservice training.

In the first model, years of teaching experience was entered in the first block and years of teaching experience and teacher training in mental health needs of their students (i.e. pre-service coursework, and in-service training) was entered in the second block. The hierarchical multiple regression revealed that teacher training was a significant predictor for teacher reported level of self-efficacy in supporting student mental health, when controlling for teachers' years of

experience ($\text{adj. } R^2 = 0.16$; $F(1,68) = 4.67$; $p = .004$), accounting for 16% of the unique variance as measured by the semi-partial r squared.

In the second model, the MRA was used to examine whether teaching degree was correlated with self-efficacy when controlling for years of teaching experience (see Table 8). The predictor variable was highest degree earned (i.e., high school diploma/GED, Associates Degree, Bachelor's Degree, Master's Degree, Doctoral Degree) and the dependent variable was self-efficacy in supporting students' mental health and ability to be effective teachers, which was calculated by computing the mean of the four items on the Efficacy scale. For this analysis, there was sufficient power (80%) to detect a medium and a large effect size at the $\alpha = .05$ level. In the analysis, years of teaching experience was entered into the first block, and years of teaching experience and degree were entered into the second block. The multiple regression analysis revealed that teacher degree was not a significant predictor of teacher self-efficacy scores ($p = .057$).

Does Teacher Self-Efficacy Predict Teacher Reported Level of Burden?

Given the small sample size in the current study, it was determined that using a non-parametric alternative to the Pearson correlation would provide more accurate results. Therefore, Spearman's rank order correlation was used (Gibbons, 1993) with teacher self-efficacy in supporting student mental health treated as the independent variable and burden in supporting student mental health treated as the dependent variable. The self-efficacy variable was calculated as the mean of the four items on the self-efficacy measure and the burden variable was calculated as the mean of the two items included in the burden scale. The correlation between self-efficacy and burden was significant $r_s(81) = -.304$, $p = .008$ (Table 9). The correlation was significant indicating a negative relationship between self-efficacy in supporting student mental health and

teacher reported level of burden in supporting student mental health. Thus, teachers who reported higher levels of self-efficacy in supporting the mental health needs of their students, reported lower levels of burden, while teachers who reported lower levels of self-efficacy in supporting the mental health needs of their students, reported higher levels of burden.

Discussion

Research has highlighted the importance of children receiving appropriate mental health services. Schools have been identified as a critical player in ensuring children success, as they spend most of their days in a school setting (Atkins et al., 2017). In addition, teachers are often expected to play an integral role in this process, as they are expected to conduct classroom wide behavioral interventions and often act as the initial referral source for students who need mental health services. Currently, there is limited knowledge regarding Orthodox teachers and their perceptions of their role, and the services provided within the Orthodox Jewish population. Therefore, the purpose of the current study was to bridge this gap in the literature and gain insight into private Orthodox Jewish schools. This study was aimed at understanding Orthodox Jewish teachers' perceptions regarding their role, level of burden, and perceived efficacy related to identifying, supporting, and referring students for mental health services. This study also examined teachers' reports of mental health services available within the Orthodox schools, as well as the barriers preventing students from receiving these services.

Mental Health Problems Observed in Jewish Orthodox Classrooms

Results from the current study indicated that teachers working in Orthodox Jewish schools face many students with mental health challenges within their classrooms. Seventy-eight percent of teachers responded that 1% to 24% of their students struggle with mental health issues. These results are similar to findings in the Reinke survey where 75% of teachers reported

referring students with mental issues yearly (Reinke et al., 2011). The prevalence rates appeared similar to previous research where teachers also reported comparable levels of behavior problems and depression (Ohrt et al., 2020). Given that teachers in Orthodox schools reported similar prevalence rates for mental health concerns with students, it is important that these teachers are adequately trained and comfortable with providing appropriate support and referrals for students to receive care.

Teacher Perceptions of their Role in Supporting Student Mental Health

Teachers are tasked with educating students. A prerequisite to children's academic success is that their emotional needs are being met, therefore, teachers often play a key role in identifying target students in need of services (Burnett-Zeigler & Lyons, 2010; Mazzer & Rickwood, 2015; Moon et al., 2017; Shernoff, 2016). In addition, teachers are in a unique position, within their classrooms, to implement behavioral supports and preventive interventions (Atkins et al., 2017; Moon et al., 2017; Reinke et al., 2011). Over 80% of teachers in this sample reported feeling that it was within their role to support student mental health needs and that recognizing their students' mental health needs played an integral role in servicing students. These results are consistent with previous studies in which teachers reported recognizing the importance of identifying the mental health needs and ensuring these needs are being met. Reinke et al. (2011) reported that 89% of teachers responded that schools should be involved in addressing the mental health needs of children, however, only 34% of teachers in the Reinke survey reported that they felt they had the necessary skills to adequately support those needs. These results highlight that teachers expressed that they feel it is within their position to identify and refer students with mental health concerns, however, they did not feel adequately trained. This is important in regard to understanding the research to practice gap where teachers reported

feeling in a position to support students mental health and that it is within their role, however, they do not feel adequately trained.

Similar to previous research, although 93% of teachers responded in the affirmative when asked about their perceptions of their roles within supporting student mental health, 74% of teachers in the current study indicated feeling ill-equipped to support their students' needs. This finding highlights the importance for teachers to receive appropriate training to best support the mental health needs of their students. Koller and Bertel, (2006) in their research, emphasized that in order to facilitate resilience and growth in children, there must be a systematic paradigm shift where promotion of mental health must occur at the certification and licensing level, where teacher training programs are aimed at providing teachers with appropriate training to identify and recognize the mental health needs of their students. In the current study, 18% of teachers responded that they had "no training at all" and 6% responded having "pre-service coursework" in training of mental health needs of children and adolescents. To better service students, it is essential that teachers receive training to understand the mental health needs of their students. In the current study, although 6% of teachers reported receiving pre-service coursework, 44% reported receiving in-service training, and 12% reported receiving both pre-service and in-service, 74% of teachers in this study responded that inadequate teacher training in supporting student mental health was a significant barrier. Ohrt et al., (2020) studied effective teacher training in mental health services. Ohrt expressed that trainings should include follow up coaching, as well as utilizing experts within the field to embed training within the work environment. Future research should be aimed at understanding effective teacher training and to help train teachers to be adequately prepared to support these needs of students within the classroom.

Teacher Reported Barriers to Students Receiving Mental Health Services

Results from the current study suggest the top barrier to students receiving mental health services was the stigma associated with services. Results indicated that 83% of teachers responded that stigma was a significant barrier to students receiving mental health services. This finding is consistent with much of the literature on Orthodox Jews and perceptions of mental health (Bineth et al., 2017; Freund & Band-Winterstein, 2013; Rosen et al., 2008). Research suggests that many Orthodox Jews are concerned about stigma and, therefore, are more likely to trust a Rabbi about concerns regarding social or emotional challenges (Lowenthal & Rogers, 2004; Rosmarin et al., 2009; Schnall et al., 2014). Research has indicated that the stigma attached mental health influences the under-utilization of services and is a primary obstacle to the provision of mental health care (Rosen et al., 2008; Sartoris, 2007). Previous research indicates that stigma can undermine adherence to treatment and reduce help seeking behaviors (Bineth et al., 2017; Mittal et al., 2012).

Findings from the current study and prior research point to the role that stigma plays in preventing Orthodox Jews from receiving mental health services. Although studies document knowledge around the need for mental health services have increased, results from the current study suggest that stigma attached to help seeking may pose barriers to teachers referring students for services (Rosen et al., 2008; Schnall et al., 2014.) Research has shown that within the Orthodox community, Rabbis and rabbinical bodies largely influence the community and can be utilized as a source of support in reducing stigma (Bineth et al., 2017; Lane, 2015). A pilot study within the Monsey community was conducted in 2010, in which school psychologists partnered with Orthodox schools to incorporate mental health services within the school (Goldman, 2010). This study found that when school psychologists partnered with schools, there

was a correlation among the sample of Orthodox Jewish schools in reducing bias and changing health attitudes. Goldman (2010) summarized what was conceptualized as by involving schools and community leaders to educate the staff and families regarding the significance of mental health treatment and the potential negative effects of leaving symptoms untreated. This small pilot study has relevance for other orthodox private schools with regards to helping school psychologists' partner with private schools to bring awareness about mental health and services available to address these needs. School psychologists can utilize their influence and knowledge to partner with the school and community to help reduce stigma attached to mental health services. This approach of integrating school psychology service delivery within the Orthodox community may help provide support for large populations who may be reluctant to seek help (Bineth et al., 2017).

It is important to recognize the barriers to disseminating services and work within the existing framework to address the needs of students, while honoring the culture that exists. Recognizing that Orthodox Jews may experience stigma associated with mental health services, it would be beneficial to work with Rabbis and school leaders to encourage community members to seek support. Researchers found that individuals were more likely to consent to treatment and remain open to receiving services when their Rabbis and Jewish leaders were consulted or involved in the process (Bineth et al., 2011; Greenberg & Witzum, 2013; Rosmarin et al., 2009; Schnitzer et al., 2011).

In the current study respondents also reported lack of funding as a significant barrier with 27% of respondents reporting that they "strongly agreed" and 38% reporting that they "agreed" that funding acted as a barrier. This is consistent with the research in the Reinke study (2011),

where 66% of teachers responded that funding acted as a large barrier to children receiving appropriate services.

Does Degree or Level of Training in Student Mental Health Predict Teacher Self-Efficacy?

Results from the current study suggest that while educational degree was not a significant predictor of self-efficacy in identifying and supporting the mental health needs of their students, teacher training was a significant predictor of self-efficacy in identifying and supporting the mental health needs of their students. Research indicated that teachers with a strong sense of self-efficacy in supporting student's needs, was associated with enhanced student academic performance and improved attendance (Bandura, 1997; Leithwood & Jantzi, 2008). Teachers who feel more efficacious are more likely to remain in teaching and be more successful when compared to teachers who did not feel efficacious within their role as teachers (Tew, 2017). Previous research also highlights that teacher qualifications likely influence classroom practice and, therefore, have an indirect effect on student learning (Guo et al., 2012). Similar to the current study, Guo et al., (2012) found that teacher education was not a significant predictor of teacher self-efficacy in identifying and supporting the mental health needs of their students. This finding highlights that there is a correlation between teacher training and teacher reported levels of self-efficacy in supporting the needs of their students. This can possibly be explained by the fact that teacher degree is distal while teacher training is proximal. Training is often provided after teachers are in the field and are utilizing skills in practice and therefore, may have a stronger impact on teacher self-efficacy. Self-efficacy is the belief in their personal ability to make a difference in student behavior, and ability to bring about desired outcomes of student learning and engagement (Tschannen-Moran et al., 2001). Therefore, teachers who are already working in the field may feel the training enhances their abilities and they may benefit more

from the in-service training than the training they had when earning their degrees more distally. Therefore, future research can focus on impacting teachers through specified training in supporting student mental health to adequately prepare them to identify and refer students as necessary.

Teacher Self-Efficacy and Reported Level of Burden

The current study found a significant negative correlation between teacher reported level of self-efficacy in identifying and supporting the mental health needs of their students and reported level of burden associated with the mental health needs of their students ($r = -.304$). Teachers who reported higher levels of self-efficacy reported lower levels of burden, while teachers who reported lower levels of self-efficacy reported higher levels of burden. These findings are consistent with Bandura's Social Learning Theory (1994). Bandura's theory is particularly salient for teachers, as those who reported lower levels of self-efficacy were more likely to feel overwhelmed by student demands and were more likely to experience burnout (Bandura, 1994). In this study, when respondents were asked about level of burden in relation to student mental health needs, over 50% of teachers reported that they do not feel qualified to deal with the mental health needs of their students. These findings highlight that as teachers are often tasked to deal with many needs of their students, and they do not feel adequately trained, it often leads to decreased levels of efficacy. As mentioned in previous research, it is important that teachers feel they have the necessary tools to provide student support to decrease level of teacher burnout and increase their effectiveness (Savas et al., 2014).

Research highlights that teachers experienced increased self-efficacy if they felt they had the tools to best support students and reported lower levels of burden (Aydin & Wolfolk, 2005; Guo et al., 2012; Velthuis et al., 2014). One of the practical ways to improve teacher self-

efficacy is through professional development and providing support for teachers throughout the learning process (Bonner et al., 2012). Results from the current study found that when teachers were asked to respond to the statement, “I do not feel qualified to deal with the emotional needs of my students,” 62% of teachers reported that they agreed with the above statement. Many teachers indicated feeling overwhelmed by the needs, and inadequately prepared to meet their students demands, therefore, negatively impacting their ability to feel efficacious in their work. This is an important area where school leaders can focus to increase teachers’ sense of self-efficacy in supporting student mental health needs. If school administrators provide effective professional development and in-service training about recognizing and identifying mental health concerns in students, teachers may feel more efficacious within this domain (Latouche & Gasciogne, 2017).

Ninety-three percent of teachers in the current study reported that it was within their role to support students and identify those in need of mental health services, while 6% indicated receiving pre-service coursework to carry out this role. Therefore, if teachers received further training and support to identify and refer students with mental health concerns, they may simultaneously experience greater self-efficacy in supporting and identifying students’ mental health needs (Bonner et al., 2012; Perera & John, 2020). In addition, respondents in the current study reported that difficulty gaining parent cooperation and consent was a significant barrier to students receiving mental health services. Therefore, private schools should focus on disseminating this information to parents, as well, to help allay concerns and ensure that students receive adequate care. It is important to recognize the role of culture in disseminating services to help allay concerns and ensure students receive adequate care. Orthodox school administrators should take into consideration the role of the rabbinical leaders and include them in the process

of supporting student mental health. Given that schools often seek counsel from the Rabbinical board, this can instill trust in the mental health system and allow students to access services with less stigma (Freund & Band-Winterstein 2013; Pelcovitz, 2005; Schnitzer, Loots, Escudero & Schechter, 2011).

Limitations

One limitation of the current study was the use of snowball sampling. Snowball sampling methodology is limited in that it is difficult to know the true distribution of the sample and increases the risk of sampling bias. However, given that the Orthodox teachers are part of an insulated population, snowball sampling increased feasibility of the study. Teachers from within the researchers' private network were contacted and asked to forward the survey which allowed for a larger range of teachers to be contacted. Future studies within this area should understand the limitation of snowball sampling and recognize if there is a more comprehensive method to collect information.

Another limitation of the current study is the selected method of self-report scales that was used to collect data. There was no social-desirability scale and therefore it was difficult to assess accuracy of teacher response. It is possible that teachers may feel pressured to present positively which may not accurately portray their actual perceptions. To mitigate this effect, surveys were completed anonymously, however, future studies should consider using a social-desirability scale. In addition, the current study employed the use of a mono-method and mono-informant to collect data. The use of focus groups or individual interviews would potentially add more valuable information and further insight into teachers' perceptions and views on student mental health needs. Future research could expand to include multiple informants to better understand mental health within the Orthodox schools. It is possible that school psychologists

and school social workers may be able to provide further insight into the roles of schools in providing student mental health support. In addition, the survey was modeled after two surveys, Reinke et al., (2011) and Roeser and Midgley (1997). There were minimal psychometrics reported on this scale and therefore, limited information regarding the reliability and validity scales of the surveys. Future surveys should focus on using measures with reliable psychometrics to ensure more accurate reporting.

An additional limitation of the current study was the small sample size. This sample size does not provide adequate power to detect smaller significant results. Future studies within this area should include a larger pool of participants to increase the likelihood of detecting conclusively significant results (Cohen & Cohen, 1992).

Another important point to consider is the demographics of teacher participants. The study was focused on teachers within the Orthodox Jewish private schools. Research found that nine out of ten elementary school teachers were female (Kendal et al., 2014). In this research study, 99% percent of teacher respondents were female, and is therefore limited in its ability to assess a portion of the teacher population. Furthermore, the study was only conducted with teachers in grades K through eighth grade. Therefore, the results are not representative of teachers of students in higher grade levels. Teachers of these students may express different mental health concerns, barriers and training needs to the teachers surveyed in this sample.

Implications for Research and Practice

The results of this study add to the growing body of literature on teachers' perceptions with regard to mental health needs of their students, and teachers' efficacy in meeting these needs. The findings in this study indicate that although teachers reported feeling it was within their role to identify and refer students for mental health services, many teachers reported being

inadequately trained to do so. This is an important finding for school psychologists who are in a position to help support teachers to work more effectively with their students. The current study found that teachers did not feel trained to identify and support the mental health needs of their students and therefore, it would be incumbent upon the school psychologists to help facilitate this knowledge. Many teachers reported receiving the majority of their training in student mental health needs from in-service course work and, therefore, it would be helpful to use these methods to provide concrete trainings. As the current study highlights, self-efficacy in supporting student mental health needs was significantly correlated to levels of burden by student mental health needs. As the research has shown, helping increase teacher self-efficacy can have lasting significant impact on students' growth. Therefore, if school psychologists and other school personnel help lower this deficit in the schools, children can benefit immensely.

Stigma within the Orthodox community was identified as the most significant barrier to students receiving mental health services. Although there have been great strides within the Orthodox community, this continues to be identified as a barrier to receiving adequate care (Lightman & Shor, 2002; Schnall et al., 2014; Twerski, 2002). It is important to note that the Orthodox Jewish community relies and seeks counsel from their Rabbinical leaders (Freund & Band-Winterstein, 2017). Schools are largely influenced and also seek guidance from the Rabbinical board. Therefore, to help reduce the stigma, utilizing Rabbis as a source of support can be an extremely important aspect to assisting the Orthodox clientele. Future studies should focus on facilitating the culturally sensitive therapeutic process. School psychologists can also help facilitate this process as a liaison between the school and the Rabbinical leaders to provide the important support to meet the mental health needs of students.

Current research highlights the critical role that school psychologists play in providing consultation to teachers (Atkins et al., 2008; Bergan, Kratochwill & Luiten, 1980; Capella et al., 2012). Consultation is described as an indirect mental health service where a school psychologist works with one or more school personnel and/or parents to address specific concerns with a student and to work collaboratively to problem solve (Bergan et al., 1980; Kratochwill & Shernoff, 2004). Atkins et al., (2008) examined the use of Key Opinion Leaders (KOL) in schools, as KOLs serve as influential models for others in their social network. Including KOLs was associated with increasing the feasibility of implementing classwide interventions including enhancing classroom practices and behavior management (Capella et al., 2012). Although to our knowledge there is no literature regarding the use of KOLs within the Orthodox community, prior research posits that KOLs can help support teachers and is associated with positive outcomes related to student engagement and behavior. KOL influences were found to be particularly important in schools where there was distrust from outside experts (Atkins et al., 2008; Bryk & Schneider, 2002). Given stigma was identified in the current study as the top barrier to referring students for services and emerges as a top barrier in the mental health service delivery literature more generally, identifying community members within the Orthodox community who are trusted and respected may help bridge the gap between need and access (Rosmarin et al., 2009).

Future research should examine the use of consultation and identifying members who can be involved as Key Opinion Leaders to best support students in Orthodox schools. For example, given that the Rabbinical leaders play an influential role within the Orthodox community and are often consulted, identifying Rabbis who can endorse services has the potential to influence teachers and parents willingness to seek services for children and youth. If mental health

professionals facilitate communication between Rabbis and school personnel, it may prove effective in securing support for students and families of students struggling with mental health concerns and reducing stigma associated with help seeking. Future research can also examine the use of KOLs with Rabbinical leaders and the role school psychologists may have to utilize their support for students and teachers within the schools.

In addition, future research should examine the skills and knowledge of in-service training that teachers receive. Given that this was found to be significantly correlated with teachers reported level of self-efficacy, school administration can utilize trainings to target this gap in teacher knowledge (Powers et al., 2014).

Conclusion

Overall, teachers reported recognizing the necessity to support student mental health needs and recognize the importance of students receiving appropriate services. Research question five indicated that teacher self-efficacy in their ability to support mental health needs of their students was significantly correlated with teacher training. In addition, there was a significant correlation between teacher self-efficacy in supporting student mental health needs and reported level of burden. These results are important to guide future practice as teachers play a significant role in supporting student needs. If teachers receive adequate training and support from school psychologists, they can feel more effective within their role in supporting students and addressing their mental health concerns within the classroom. School psychologists have the necessary training to support this need and can help reduce this gap in schools.

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APPENDIX A: SURVEY**Efficacy:**

Please rate how much you agree with the following statements

1. Some Students are not going to make a lot of progress this year no matter what I do.

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

2. I am certain I am making a difference in the lives of my students

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

3. I feel that I have the level of knowledge required to support the mental health needs of the children with whom I work

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

4. I feel that I have the skills required to support the mental health needs of the children with whom I work

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Role:

5. I feel that schools should be involved in addressing the mental health issues of students

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

6. I cannot teach my students effectively unless I also consider their social and emotional needs.

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

7. Rate the extent to which you feel that teachers should be involved in addressing the following mental health needs of their students

- Screening for mental health problems

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Referring children for mental health problems

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Referring children and families to community-based service providers

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Implementing classroom behavioral interventions

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Teaching curriculum-based classroom social-emotional lessons

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Conducting behavioral assessments

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Monitoring student progress

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Identifying parent/family-based issues

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Other

8. I think professionals other than me, such as school counselor, social workers and psychologists, should take primary responsibility for my students' mental health and well-being.

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Burden:

9. I feel overwhelmed by the emotional problems some of my students bring to school

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

10. I do not feel qualified to deal with the emotional and behavioral problems I see in some of my students

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Barriers:

11. I believe the following are barriers to students receiving mental health services in my school:

- Difficulty identifying children with mental health needs

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Insufficient number of school mental health professionals

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Lack of adequate training for dealing with children's mental health needs

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Gaining parental cooperation and consent

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Stigma associated with receiving mental health services

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Language and cultural barriers while working with culturally diverse students/families

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

- Lack of referral options in the community

- 1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
- Lack of coordinated services between schools and community
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
 - Lack of funding for school-based mental health services
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
 - Mental health issues are not considered a role of the school
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
 - Competing priorities taking precedence over mental health services
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
 - The belief that mental health problems do not exist and are merely an excuse
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
 - Lack of support for mental health services from Rabbinic leaders
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
 - Other (please specify)

Demographics

12. Your age _____ years _____ months

13. Your gender _____

14. Your race/ethnicity (check all that apply)

- American Indian or Alaskan Native
- Black or African American
- Hispanic or Latino/a
- Middle Eastern
- Asian American
- Native Hawaiian or Pacific Islander
- Caucasian/European American
- Other (Please specify): _____

15. Please indicate your highest educational degree currently held:

- High school diploma or GED
- Associates degree
- Bachelor's degree
- Master's degree
- Doctoral degree
- Other (Please specify): _____

16. Total years of experience teaching _____ years _____ months

17. Specify the type of training in supporting student mental health you received (check all that apply)

- Pre-service coursework
- In Service training/ workshops
- Other (please describe) _____

18. Total number of students in your classroom _____

19. Please indicate the total number of students you have referred for mental health services in the past school year _____

20. During each school year, approximately what percentage of students that you teach struggle with mental health problems (e.g., anxiety, depression, disruptive behaviors, trauma)

- 0%
- 1% to 24%
- 25% to 49%
- 50 % to 74%
- 75 % to 100%

21. Students mental health concerns (please check all that apply) and indicate range of students with the identified mental health concerns.

- ADHD
 - 1-2, 3-4, 5+
- Disruptive Behavior Disorders (DBD)
 - 1-2, 3 -4, 5+
- Depression
 - 1-2. 3-4, 5+
- Anxiety
 - 1-2, 3-4, 5+
- Trauma
 - 1-2, 3-4, 5+
- Other (please specify)

22. Level of support services available to students in your school (check all that apply):

- Classroom-wide interventions (i.e. PBIS, SEL, class-wide social skills)
- Targeted interventions (i.e. small group instruction)

- Intensive interventions (i.e. individual therapy)
- Other (please specify) _____

23. Types of mental health services available to students in your school (check all that apply)

- assessment for emotional or behavioral problems
- behavior management consultation
- crisis intervention
- individual counseling/ therapy
- group counseling/ therapy
- early intervention and prevention programs
- Classroom and school wide positive behavior support
- Referral to community-based services/programs
- Other (please specify) _____

APPENDIX B: EMAIL

Hello. My name is Tzipora Halberstam. I am a fourth year doctoral candidate at the Graduate School of Applied and Professional Psychology (GSAPP) school psychology doctoral program. I am seeking participants for my doctoral dissertation, examining teachers' perceptions of mental health services within Orthodox Jewish schools. The intended participants of this study are teachers of any grade from kindergarten through eighth in an Orthodox Jewish school. Special education teachers are excluded from this study. Your participation will help gather data and increase knowledge concerning mental health services for the students in Orthodox Jewish schools.

NOTE: Teachers were originally recruited from the researchers personal connections. If you were contacted and do not meet the eligibility criteria, please forward this attachment to those you know who do meet the above criteria.

Participation involves completion of a 10-15 minute survey. Upon completion of the survey you will have an opportunity to enter a raffle for a \$25 gift card to Amazon.

The study has been approved by the Rutgers University IRB 732-235-2866, or eIRB@ored.rutgers.edu Feel free to contact me with any questions at th454@gsapp.rutgers.edu or Dr. Elisa Shernoff at elisa.shernoff@gsapp.rutgers.edu.

I appreciate your time and look forward to receiving your responses.

Table 1

Demographic Characteristics

Variables	<i>n</i>	% of Sample
Gender		
Female	70	99
Male	1	1
Race/Ethnicity		
Caucasian/European American	71	100
Age of Individuals Completing the Survey		
20 – 25	30	42
26 – 30	20	28
30 – 35	5	7
36 – 40	0	0
41 or more	4	17
Educational Degree Type		
High School Diploma/GED	10	14
Associates Degree	3	4
Bachelor's Degree	17	24
Master's Degree	41	58
Doctoral Degree	0	0
Years Employed		
0-5	34	48
6-10	22	31
11-15	2	3
16-20	1	1
21 or more	12	17
Teacher Training		
No formal training	16	18
Pre-service Course Work	5	6
In Service Training/Workshops	40	44
Preservice and Inservice Training	11	12

Table 2

<i>Mental Health Concerns Observed in Classroom</i>		
Variable	<i>N</i>	%
Attention Deficit Hyperactivity Disorder	64	34
1 - 2 students	27	38
3 - 4 students	6	9
5 or more	7	10
Disruptive Behavior Disorder (DBD)	32	17
1 - 2 students	17	23
3 - 4 students	2	3
5 or more	2	3
Depression	20	10
1 - 2 students	12	17
3 - 4 students	0	0
5 or more	0	0
Anxiety	60	32
1 - 2 students	0	20
3 - 4 students	8	21
5 or more	0	7
Trauma Related Disorder	14	7
1 - 2 students	0	0
3 - 4 students	8	10
5 or more	0	0

Table 3

Teachers Perceived Level of Role in Supporting Student Mental Health

Variable	SA (%)	A (%)	N (%)	D (%)	SD(%)
Addressing Student MH in the classroom	35 (49)	31 (44)	2 (3)	1 (2)	1 (2)
I cannot teach unless I consider the MH of students	42 (59)	23 (32)	2 (3)	4 (6)	0 (0)
Screening for MH problems	8 (11)	39 (55)	12 (17)	10 (14)	2 (3)
Referring children for MH problems	16 (22)	46 (65)	7 (10)	2 (3)	0
Referring children to community-based services	10 (14)	37 (52)	14 (20)	10 (14)	0
Implementing classroom behavioral interventions	27 (38)	41 (58)	2 (3)	1 (1)	0
Teaching social emotional lessons	22 (31)	36 (50)	9 (13)	4 (6)	0
Conducting behavioral assessments	11 (16)	38 (53)	12 (17)	10 (14)	0
Monitoring student progress	27 (38)	42 (59)	2 (3)	0	0
Identifying parent/family-based issues	5 (7)	33 (47)	19 (27)	13 (18)	1 (1)
Other professionals should be responsible for student MH	13 (18)	39 (55)	14 (20)	5 (7)	0

Note: SA: Strongly Agree; A: Agree; N: Neutral; D: Disagree; SD: Strongly Disagree

Table 4

Teachers Perceptions of Level of Efficacy in Supporting Student Mental Health

<i>Variable</i>	<i>SA(%)</i>	<i>A(%)</i>	<i>N(%)</i>	<i>D(%)</i>	<i>SD(%)</i>
Students will not make a lot of progress	2 (2)	19 (27)	11 (16)	32(45)	7 (10)
I am certain I am making a difference in lives of my students	18(25)	40 (56)	11 (16)	2 (3)	0
I feel I have the knowledge to support student MH	2 (3)	18 (25)	21 (30)	25 (35)	5 (7)
I have skills to support student MH	6 (9)	19 (27)	18 (25)	20 (28)	8 (11)

Note: SA: Strongly Agree; A: Agree; N: Neutral; D: Disagree; SD: Strongly Disagree ; MH: Mental Health

Table 5

Barriers to Students Receiving Mental Health Services

Variable	SA (%)	A(%)	N(%)	D (%)	SD(%)
Stigma associated with receiving MH services	22(31)	37(52)	10 (14)	2 (3)	0
Gaining parental cooperation and consent	20 (28)	39(55)	9 (13)	3 (4)	0
Lack of training for dealing with student MH	14 (20)	38(54)	14(20)	5(7)	0
Insufficient number of school MH professionals	11(16)	35(50)	12 (17)	13 (18)	0
Lack of funding for school-based MH services	19 (27)	27(38)	15 (21)	0	10(14)
Competing priorities take precedence over MH services	6 (9)	40(57)	12 (17)	11 (16)	1(1)
Language and cultural barriers	7(10)	25(35)	22 (31)	17 (24)	0
Lack of coordination between schools and community	6 (9)	23(32)	18 (26)	23 (32)	1(1)
Difficulty identifying Children MH needs	1 (1)	26(37)	24 (34)	19(27)	1(1)
Lack of referral sources	5(7)	17(24)	24 (34)	23 (32)	2(3)
Belief that MH problems do not exist	21 (29)	0	9 (13)	30 (43)	11 (15)
MH issues are not considered within the role of school	1 (1)	16(23)	10 (14)	38(53)	6(9)
Lack of support for MH services from Rabbinic leaders	0	5(7)	13 (18)	41 (58)	12(17)

Note: SA: Strongly Agree; A: Agree; N: Neutral; D: Disagree; SD: Strongly Disagree

Table 6

Correlations Between Teacher Training, Degree, Years of Experience and Self-Efficacy

Variables	1	2	3	4
1. Teacher Training in Supporting Student MH Needs	-	.15	.35**	.16
2. Degree		-	.12	-.06
3. Self-Efficacy			-	.25*
4. Years of teaching Experience				-

Note: N = 71 *p < .05, two tailed. **p < .01, two tailed.

Table 7

Descriptive Statistics for Independent and Dependent Variables

Variable	Mean	Standard Deviation
Teacher Training in Mental Health Services	1.65	1.00
Highest Level Degree earned	3.25	1.07
Years of Teaching Experience	2.08	1.45
Self-Efficacy	3.11	0.61

Note: N = 71; IV: Teacher training, Degree, and Years of teaching experience; DV: self-efficacy

Table 8

Regression Analysis for Teacher Degree and Training as a Predictor for Self-Efficacy Scores

Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>F</i>	<i>Df</i>	<i>p</i>	<i>Adj.R</i> ²
Degree	0.08	.07	.14	1.16	3.05	2,68	0.057	.06
Level of Training	.18	.07	.30	2.63	4.67	1,68	.004	.16

Note: N = 71

Table 9
Spearman Correlation Between Self-Efficacy and Burden

Variable	<i>r</i> with Burden	<i>p</i>	M	SD
Self-efficacy	-.304**	.008	3.12	.64
Burden	-	-	3.53	.82

Note: **Correlation is significant at the 0.01 level