



Finding a Common Voice: Lessons Learned from a Pilot Mental Health Literacy Intervention for Secondary Students with Disabilities

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ABSTRACT

The current study evaluates lessons learned from a feasibility and acceptability trial of the *Think, Be, Do*, curriculum (a mental health literacy curriculum) for transition age students (14–21) in special education classrooms. Six teachers and sixty-two students from a northwest state in suburban and rural settings participated in the intervention group and were exposed to the *Think, Be, Do* curriculum twice a week for five weeks. Data were collected from students, teachers, and observers. A mixed methods approach captured quantitative and qualitative data from participants. Results from the implementation suggest the curriculum was feasible to implement, acceptable to teachers for their classrooms, and had preliminary increases in student mental health literacy. Lessons learned from the initial implementation and implications for research and practice are discussed.

Schools have been and continue to be the main source for mental health services for school age youth (Burns et al., 1995; Weist et al., 2018). Across the age spectrum from young children to adolescents and young adults, a diverse presentation of mental illness has and will impact a school's student population. Experiencing a threat to your mental health at a young age may have a significant impact on outcomes later in life (Brent & Weersing, 2008). In fact, experiencing a threat to one's mental health is so salient within children and adolescents, it is estimated that approximately one in five students will qualify for a mental health diagnosis during their time in school (Merikangas et al., 2010). Schools may see a variety of mental health diagnoses impacting the student body dependent on the age of the students the school serves. For example, in elementary settings, schools may serve more students that exhibit externalizing disorders such as conduct disorder or attention deficit hyperactivity disorder. In contrast, high schools may serve more students with internalizing disorders such as depression and anxiety. In fact, prevalence rates for internalizing disorders begin to increase beginning in middle school and throughout high school (Merikangas et al., 2010). Even subthreshold depression and anxiety constitutes as a concern for a substantive portion of youth (Lewinsohn et al., 2000).

To address the growing concerns of student risk to mental illness and other behavioral concerns, schools are implementing preventative efforts that are both universal and targeted in nature. School-wide preventative programming, such as Positive Behavioral Interventions and Supports (PBIS), which have been implemented in over 27,000 schools, have long been implemented and has demonstrated positive prosocial skill development across the age spectrum (Connors et al., 2021; Eber et al., 2019; McIntosh et al., 2014). Other preventative models, such as the Boone County Mental Health Coalition (Reinke et al., 2018) collaborate with schools to provide school-wide academic, behavioral, and mental health screening for all students (elementary, middle, and high).

These preventative models have been successful due to the ability to implement social emotional learning and mental health literacy interventions which have shown promise in supporting student mental health outcomes (Durlak et al., 2011). Students who have received mental health literacy interventions often experience positive effects on mental health knowledge, stigma reduction, and help-seeking behaviors (Cheng et al., 2018; Coles et al., 2016; Jorm, 2000, 2012; Swartz et al., 2017). In addition, there evidence to indicate an inverse relationship with low mental health literacy and higher depression in secondary students (Lam, 2014; Lincoln et al., 2006). Furthermore, Lam (2014) suggests that increasing mental health literacy in students should be considered an important preventative measure to counter mental health problems in youth.

Unfortunately, even with the growing efforts to serve students, under half of students with a psychiatric disorder receive any treatment (Costello et al., 2014; Weist et al., 2007). In addition, there are disparities in services for minoritized students of culturally and linguistically diverse backgrounds (Husky et al., 2012). Research on youth and adolescent mental health has illuminated that common mental health disorders have differential presentation not only across the age spectrum but also heterogeneity within a cross-section of the student population. For example, students with disabilities have been identified as a subgroup of students to be more vulnerable to experience a threat to their mental health or a mental illness. Prevalence estimates suggest students with disabilities are at higher risk for experiencing a mental illness (Forness et al., 2012). In addition, students who experience specific disabilities, such as intellectual disabilities, may be two to three times more likely to experience a mental illness compared to their peers with other disabilities (Einfeld et al., 2011; Emerson & Hatton, 2007). Although current research has not replicated earlier findings, research does suggest that youth with disabilities may experience a higher likelihood of factors that could contribute to mental illness such as lower self-esteem, lower self-concept, and higher levels of external locus of control (Bender, 1987; Margalit & Shulman, 1986).

As schools attempt to address the current needs of their student body, they face a multitude of challenges. One challenge is the coordination of prevention and treatment efforts; only a fraction of students who need services are receiving them (Forness et al., 2012; Masia-Warner et al., 2006). This could be for a myriad of reasons including having low mental health literacy, lack of skills to seek help, lack of mental health resources available for students, ineffective procedures to connect students to treatment after referral, among other explanations (Hunt & Eisenberg, 2010; Seeley et al., 2018).

Another challenge for schools is the continued lack of supports available for students with disabilities. Although some universally designed preventative efforts may support some students with disabilities, most do not take into account ways to support the unique needs and strengths of students with disabilities nor have they been validated for this subgroup of the student body (Skaar et al., 2020). Furthermore, many treatment providers also have minimal to no background serving students with disabilities (Milson, 2002). Thus, leaving a gap in programming for schools and special educators to use with their students with disabilities.

These challenges influence a school's decisions on how to serve and who is best to serve students with disabilities. In many schools, teachers not trained in mental health are asked to be a first line of defense in handling mental illness in their students. On one hand, teachers are optimal candidates to identify and refer students in need due to their constant proximity with the students they serve (Johnson et al., 2011; Maag & Reid, 2006). For example, in the case of a student suffering from Major Depressive Disorder (e.g., American Psychiatric Association, 2013) a teacher may be able to see a shift in a student's mood that includes an increase in sadness, irritability, or withdraw over time. Other criteria for Major Depressive Disorder that a teacher may see in a student include, loss of interest in preferred activities, or changes in weight or eating habits, and shifts in typical hygiene patterns. Non-clinically specific criteria that may also impact youth with disabilities include peer relationship problems or poorer than typical academic performance.

Yet, there must be room for caution, as research regarding teacher referral versus systematic screening has shown, a reliance on teachers to refer students for services falls short in capturing all students in need compared to more systematic screening (Eklund & Dowdy, 2014; Eklund et al., 2009).

Furthermore, we must acknowledge that teachers have a primary job of educating students and should be reinforced for their efforts to support students holistically (e.g., supporting student's academics and social emotional/mental health). What complicates the holistic approach is a reliance on teachers to address mental health when there are lack of trainings, professional development opportunities, or resources designed to support them. It has been documented that teachers would prefer increased training in both classroom behavior management (Reinke et al., 2011) and strategies to support students with mental illness (Poppen et al., 2016; Weist, 2005).

Current study

Curriculum development

The need for such supports laid the groundwork for the development of the *Think, Be, Do* curriculum (Sinclair, 2016); a mental health literacy curriculum designed to be implemented by teachers to support their students with disabilities in secondary settings. Mental health literacy has five core components (a) prevention through good mental health behaviors, (b) symptom recognition, (c) self-help strategies, (d) help seeking strategies and treatment options, and (e) how to support others in need (Jorm, 2012). In addition, a focus on increasing mental health literacy in adolescents is seen as an important protective measure of mental health problems (Lam, 2014).

In addition, the *Think, Be, Do* curriculum was developed as an adaptation of the Coping with Depression course (Lewinsohn, 1984), an evidence-based clinical program that has been effective in reducing depressive symptomatology in adolescents and adults. Because this was a new intervention, the Quality Implementation Framework (QIF; see Meyers et al., 2012) was used to guide the development of the *Think, Be, Do* (TBD) curriculum. This framework was designed to assist in the development and implementation of novel interventions and consists of four steps: (a) assessment, (b) developing an implementation plan, (c) implementation and support strategies, and (d) improving future applications by learning through experience.

Using the QIF as a guide and the Coping with Depression course as a curricular framework, an iterative development cycle was established to develop a feasible and acceptable mental health literacy intervention for special educators and students with disabilities. During the development process, the developer of the TBD curriculum worked closely with special education teachers to design and evaluate developed lesson content, materials, and activities to establish a baseline understanding of feasibility and acceptability. In addition, to address the gaps of current practice, the TBD curriculum was designed specifically to support teachers (through training on the curriculum prior to implementation and the use of scripts in each lesson) and students (through an I do, we do, you do content delivery approach and the use of multiple modalities for learning). Lastly, structural considerations were also taken into account to address school and student needs. Curriculum lessons were designed to take place within a typical class period of 60 minutes, the number of curriculum lessons were reduced to align with brief mental health treatment (i.e., ten lessons; Substance Abuse and Mental Health Services Administration, 2015) and to make it feasible for teacher to implement during the school term (two lessons a week for five weeks), and curriculum content was targeted on two common mental health disorders (i.e., depression and anxiety) found among adolescents and young adults in secondary educational settings. The iterative development cycle for the TBD curriculum resulted in a curriculum that discusses what mental health is, behavioral components of mental health, cognitive components of mental health, mental illness (depression and anxiety), and lastly coping and problem-solving skills. See Table 1 for a synopsis of each lesson in the curriculum. See (Sinclair, 2016) for a detailed account of curriculum development.

Study purpose

Within the research cycle (Onken et al., 2014), specifically during intervention development certain steps should occur prior to full efficacy and effectiveness testing. In the development process, it is critical to determine, through pilot testing, if an intervention is feasible and acceptable to implement,

Table 1. Think, be, do curriculum summary.

Lesson Title	Lesson Synopsis
1. What is Mental Health?	Lesson 1 introduces the <i>Think, Be, Do</i> curriculum and covering what the expectations are for the students receiving the curriculum. It introduces what mental health is and the mood and activity chart, which are present in all following sessions.
2. Actions, Thoughts, and Feelings	Lesson 2 covers how actions, thoughts, and feelings are connected and discusses how each individual interacts with their environment and how that might change depending on how the individual feels.
3. Locus of Control	Lesson 3 discusses what locus of control is and teaches students to be aware of what they have control of, including their actions, thoughts and feelings.
4. Pleasant Activities – Part 1	Lesson 4 reviews actions, thoughts, and feelings and encourages students to identify pleasant activities that they have complete control over. Session 4 then identifies a goal setting strategy, so students can begin setting goals around doing activities that are positively reinforcing.
5. Pleasant Activities – Part 2	Lesson 5 builds upon session 4 and continues the process of goal setting. Students are asked to set goals and action plans to achieve their goals by the time the curriculum is completed.
6. Negative and Wise Thoughts	Lesson 6 explains to students what automatic thoughts are and how to change automatic negative thoughts into wise rational thoughts.
7. Depression	Lesson 7 teaches students about depression. Then the session discusses how depression can impact the student's environment and his or her own academics and schooling.
8. Anxiety	Lesson 8 teaches students about anxiety. Then the session discusses how anxiety can impact the student's environment and his or her own academics and schooling.
9. Coping Strategies	Lesson 9 provides an opportunity for students to learn and practice two different coping strategies to help their minds and bodies during times of stress.
10. Problem-solving	Lesson 10 introduces a problem-solving technique for students to use when they are faced with difficult situations.

while also determining preliminary efficacy (Metz & Louison, 2019). The purpose of this study was to establish initial evidence of feasibility and acceptability of the TBD curriculum and to measure any change in mental health literacy in the treatment group. Research questions focused on lessons learned regarding, feasibility, acceptability, and potential efficacy. In addition, post-hoc interviews were conducted after the completion of the study to gather more data. The summative research questions for this study were:

- (1) Was the *Think, Be, Do* curriculum acceptable to teachers and students?
- (2) Was the *Think, Be, Do* curriculum feasible to implement by teachers?
- (3) Did the *Think, Be, Do* curriculum increase student's mental health literacy?
- (4) What were lessons learned from teacher's experience implementing the *Think, Be, Do* curriculum?

Method

This study was originally conducted as a small underpowered randomized controlled trial (RCT) in a Pacific Northwest state with 11 teachers and 115 students with disabilities in self-contained secondary special education classrooms (see Sinclair, 2016). The original study received IRB approval from the institution review board as well as district or principal approval in school districts in which the intervention was implemented. Due to the purpose of the study to determine preliminary feasibility and acceptability of the intervention, data from the implementation arm of the study will be presented in this manuscript. No comparisons will be made to a control condition. All information from the treatment group is used to identify implications for future research and help inform a strong efficacy trial.

The current study answers the research questions utilizing a convergent mixed-methods design where quantitative and qualitative data were collected in parallel (Creswell & Poth, 2018). In a convergent design, both quantitative and qualitative data are collected and analyzed, results are merged and compared so data may be interpreted to answer research questions (Creswell & Poth, 2018). Quantitative data from the treatment group are presented as a non-experimental pre-post design. Qualitative data gathered from treatment classrooms

(i.e., teachers and students who participated in the implementation of the *Think, Be, Do* curriculum) will be presented to describe lessons learned from the implementation of this novel mental health literacy intervention.

Author disclosure: the author of this manuscript is the developer of the intervention and participated in data collection and analysis. The author has experience with mixed methods approaches and built rapport with teachers to ensure member checking of qualitative data collected during the study. The author conducted all quantitative and qualitative data analysis individually and is aware that this positionality within the data may bias reporting of results. All data collection materials created by the author are available upon request.

Participants and setting

For teachers to meet criteria and be eligible to participate in this study, they were required to be the lead teacher in a self-contained special education classroom in either a high school (i.e., grades 9–12) or transition program (i.e., 18–21-year-old program) in the Pacific Northwest state and to consent to participate. Seven teachers were recruited from four different school districts in rural and suburban areas of the state. One teacher dropped out of the study immediately after pretests were administered due to a personal health concern; the final sample consisted of six teachers. Two teachers identified as female and four teachers identified as male. All teachers reported their race as white. The special education teachers held master's degrees and had been working in the field of special education between 5 and 14 years. No teachers had specific training on school-based mental health curriculum implementation prior to participation in the TBD study. Incentives were provided per teacher (\$225.00) and student (\$10.00) to participate in the implementation of the TBD curriculum and complete pre-post assessments.

For students to meet criteria and be eligible to participate in this study they were required to (a) receive special education services via an Individualized Education Program (IEP) or a 504 plan, (b) have parental consent and student assent or student consent (if over the age of 18 and were their own legal guardian). [Table 2](#) provides detailed demographic information on the 62 students who participated in the TBD curriculum.

Observers were five special education graduate students interested in mental health, special education, and implementation science, and were administered a two-hour training on the curriculum. Observer training included detailed review of curriculum lessons, data collection sheet, and relevant components of the curriculum to observer in-vivo. Inter-observer agreement was conducted after training during the first lesson was implemented. Inter-observer agreement was 95% across all five independent observers. After the initial observation, observers rated four randomly selected lessons of the teachers they were assigned (or 50% of all lessons). The curriculum developer required check-ins with observers after each classroom observation to discuss any questions or concerns.

Teacher training

Teachers were required to receive a two-hour training on delivering the pre- and posttest measures as well as the *Think, Be, Do* curriculum in order to participate in the study. The teachers were trained on how to deliver the student measures and teacher-report measures. The teachers were also trained on how to implement the curriculum in the classroom, which included training on: (a) the expectations of the curriculum; (b) the format of each session; (c) the main concept(s) of each session; (d) the activities in each session; and (e) the main expected student outcome(s) for each session. Teachers were informed if their level of fidelity of implementation (as reported by an observer or themselves) fell below 80% they would receive coaching from the curriculum developer on the particular aspects of the lesson to increase implementation skill.

Table 2. Student self-reported demographic information.

	Treatment	
	<i>n</i>	%
Gender		
Male	47	75.8
Female	15	24.2
Transgender	0	0.0
Prefer not to specify	0	0.0
Race/Ethnicity		
White	43	69.4
African American	5	8.1
Latino/Latina/Hispanic	5	8.1
American Indian/Native American	4	6.5
Asian	2	3.2
Pacific Islander	0	0.0
Prefer not to specify	3	4.8
Sexual orientation		
Heterosexual	36	58.1
Lesbian/Gay/Bisexual	5	8.1
Other	7	11.3
Prefer not to specify	14	22.6
Grade		
9 th grade	14	22.6
10 th grade	9	14.5
11 th grade	7	11.3
12 th grade	12	19.4
18–21 year old program	19	30.6
Missing	1	1.6
Special education label		
Autism	15	24.2
Learning disability	13	21.0
Multiple disabilities	10	16.1
Other health impairment	6	9.7
Intellectual disability	2	3.2
Speech or language impairment	2	3.2
Emotional/Behavioral disorder	1	1.6
Hearing impairment	1	1.6
Traumatic brain injury	1	1.6
Visual impairment	0	0.0
Orthopedic impairment	0	0.0
Do not know	10	16.1
Missing	1	1.6

Measures

Acceptability

Acceptability data were collected via the use of social validity assessments. For teachers, social validity was measured using the Abbreviated Acceptability Rating Profile (AARP; Carter, 2010). Sample reliability of the AARP was good ($\alpha = .853$). For the students, a five-item unique student social validity (SSV) measure was used to assess student participant perceptions of the curriculum. Sample reliability calculated for the SSV measure resulted in strong internal consistency ($\alpha = .923$).

Feasibility

Feasibility was measured using multiple fidelity of implementation measures (e.g., teacher report and observer report). Teachers completed using a researcher-designed self-report form after every lesson. This form measured level of fidelity of implementation, perceptions of feasibility, level of overall student engagement, level of teacher mastery on the curriculum, and perceived effectiveness of the curriculum on a 1 to 4 Likert agreement-scale (strongly disagree to strongly agree). Observers used

a research-designed rater form and indicated the percentage of implementation (on a 1 [59% or below] to 5 [90–100%] scale) of the overall curriculum procedures, scripts read, and activities implemented.

Mental health literacy

Mental health literacy was measured using a pre-post researcher-designed 10-item knowledge questionnaire (one item aligned with each of the lesson's content) to assess student's knowledge of the *Think, Be, Do* curriculum's core principles. The knowledge questionnaire was part of a demographic questionnaire completed by participants before the intervention began and was administered a second time after the five-week intervention was completed. Questions included multiple choice and true/false items including "what is mental health?" "True/False: our behaviors can impact our environment" and "what are common symptoms of depression?"

Lessons learned

To measure lessons learned, post-hoc semi-structured interviews were conducted after the completion of the study. Post-hoc interviews were not required by teachers in the original study procedures at the time of consent and no additional incentives were provided for teachers to participate in interviews. It is hypothesized that only three out of the six teachers agreed to participate in the post-hoc interviews because a request for follow-up interviews was not required as part of the original study but was asked after the implementation of the study had concluded. The three teachers came from both suburban and rural settings. The post-intervention interviews asked teachers about their past training in mental health, the training they received on the curriculum prior to implementation, what they found to be positives about the curriculum, what they found to be difficult to implement and challenges they had implementing the curriculum, what disability specific concerns the teachers had for their student population, what adaptations they made, and future adaptations they would make if they implemented the curriculum again. In addition to post-hoc interviews, open-ended responses on the feasibility, fidelity of implementation measure was also examined for additional data to address lessons learned. The multiple sources of data provided an opportunity to triangulate data and learn from teachers during and after the implementation of the curriculum.

Data analysis

Descriptive statistics were conducted to answer research questions one (curriculum acceptability [posttest only]), and two (curriculum feasibility [concurrent with curriculum]). To answer research question three, a paired samples t-test was conducted on the student knowledge questionnaire for pre- and posttest. To answer question four (lessons learned), post-hoc interviews were recorded, transcribed, and analyzed. Thematic analysis as described by (Miles et al., 2013) was performed on post-hoc interviews, and data were triangulated with observer and teacher fidelity open-ended responses to lesson items throughout the implementation of the curriculum (Creswell & Poth, 2018). Data from post-hoc interviews were evaluated and inductive coded was used to identify major themes. A secondary analysis identified secondary level themes. Themes from open-ended responses were then cross-referenced with themes from the post-hoc interviews to determine a master list of lessons learned. Data from quantitative and qualitative teacher, observer, and student responses were used to answer each research question.

Results

Research question 1: was the TBD curriculum acceptable?

To answer the first research question, teacher and student social validity ratings were analyzed. Teachers completed the AARP to evaluate the acceptability of the curriculum as a treatment for students in their classrooms. The overall mean score for the AARP was 5.18 (*min.* = 4.25, *max.* =

5.88, $SD = 0.54$) rated on a 6-point scale (1 – strongly disagree to acceptability of the intervention to 6 – strongly agree to the acceptability of the intervention). No teacher disagreed with any of the items.

Students completed the five-item SSV form after the completion of the curriculum to determine the acceptability of the *Think, Be, Do* curriculum. Mean scores indicated that there were slightly more students who enjoyed participating in and learned from the *Think, Be, Do* curriculum than students who did not. The overall mean score for the SSV was 6.81 ($min. = 1.80$, $max. = 10.00$, $SD = 2.20$) rated on a 10-point scale (1 – disagree to the acceptability of the intervention to 10 – agree to the acceptability of the intervention).

In the post-hoc interview with teachers, they were asked the likelihood of teaching the *Think, Be, Do* curriculum again. One teacher reported “100%.” Another teacher said “*I thought it was easy to implement and I definitely plan on using it, because there isn’t a disability specific curriculum that addresses mental health like this one does on such a comprehensive level, so absolutely.*” The last of three teachers stated, “*and what I loved about it was . . . there is nothing out there like this, and this group of students absolutely needs this desperately, . . . because before you can even get to the basics of school and homework and taking responsibility they need to be able to understand why they think the way they do.*” These encouraging words suggest that the teachers felt the *Think, Be, Do* curriculum was acceptable for their classrooms and were wanting to implement the curriculum to future cohorts.

Research question 2: was the TBD curriculum feasible

To answer the second research question, data from teacher and observer reported fidelity of implementation were examined. Overall mean teacher-rated fidelity of implementation score was 3.02 (on a scale from 1 – strongly disagree to 4 – strongly agree the intervention was implemented with fidelity; ranging from $min = 2.91$, $max = 3.29$). Overall mean observer-rated fidelity of implementation score was 3.99 (on a scale from 1% to 59% or less of the session was implemented with fidelity to 5– 90–100% of the session was implemented with fidelity; ranging from $min 3.30$, $max 4.86$).

Item level analysis was also conducted to capture different components of fidelity of implementation. To measure adherence and compliance, teachers were asked to rate themselves on if “*the activities were implemented as described in the lesson plan*” This item had an overall mean score of 3.04 ($min. = 2.50$, $max. = 3.90$, $SD = 0.43$). To measure quality of delivery teachers were asked to rate themselves on if “*the scripts and examples given in the lesson were used to achieve the learning outcomes.*” This item had an overall mean score of 3.16 ($min. = 2.60$, $max. = 4.00$, $SD = 0.40$). To measure an aspect of exposure teachers were asked to rate themselves on if “*overall the lesson was feasible to implement with my students.*” This item had an overall mean score of 3.08 ($min. = 2.40$, $max. = 4.00$, $SD = 0.48$).

Research question 3: did the TBD curriculum increase student’s mental health literacy?

To answer the third research question, data collected from the pre-post, 10-item, knowledge questionnaire were analyzed. A paired samples *t*-test was conducted examining student participant knowledge at time 1 (pretest) and time 2 (posttest). Results from the paired sample *t*-test indicate that the *Think, Be, Do* curriculum had a statistically significant positive increase in mental health literacy, $t(61) = 6.029$, $p < .01$, with a medium-sized effect $d = 0.76$.

Research question 4: what were lessons learned from implementing the TBD curriculum?

To answer research question four, data from post-hoc interviews and teacher and observer-reported open-ended responses on lesson fidelity of implementation forms were analyzed. First, results will be provided on the challenges teachers experienced implementing the curriculum. Second, results will be provided on the strengths of implementing the curriculum identified by teachers and observers.

Challenges

Three major themes emerged when analyzing the qualitative data related to implementation challenges. The three themes included (a) certain activities created for certain lessons in the curriculum, (b) tasks and demands of students in certain lessons, and (c) understanding certain concepts taught in the lessons.

Activities. One major activity of the TBD curriculum was focused on engaging students to develop goals that would encourage students to participate in pleasant activities. Focusing on increasing a student's participation from pleasant activities is based in "behavioral activation," commonly associated with the "b" in CBT or cognitive behavioral therapy. The *Think, Be, Do* curriculum implemented goal setting for pleasant activities to hope increase students moods. Yet, challenges occurred for both teachers and students. For teachers, more time was needed to teach students how to set goals and comprehend lesson materials. Across teachers, all six indicated that an adaptation they made to the curriculum was to take more time than indicated by the curriculum and have more discussion time to allow for student learning.

Challenges also occurred for teachers to help student monitor their goals. One teacher wrote "*the SMART goal process was difficult*" and another teacher wrote "*setting goals -students have a hard time seeing future things.*" Another teacher discussed a specific issue she had with her classroom "*several students with ASD trying to generate a list of social activities, Yikes! Lots of guidance*" suggesting more support was needed for some of her students.

Another challenge for teachers were the scripts and scenarios that were included to support lesson content learning. Teachers reported, in some cases, lesson scripts and scenarios were too long. One teacher wrote "*you'd think a group that [has] scripts would have an easier time!*" The length of the script or scenario made it difficult for some students who strengths were not aligned with verbal processing to engage with the material. One teacher wrote "*Scenarios were difficult to track for some students although they came up with good strategies.*" The teacher with students with ASD in her classroom also wrote "*students with ASD are challenged by perspective taking – the scripts are too 'other focused' for them.*"

Tasks and demands. While there seemed to be more challenges with the curriculum materials teachers were given, there were concerns about implementation regarding the tasks and demands that students were required as part of the curriculum. Teachers indicated that the curricular activities required the student participants to write too much. One teacher wrote "*lots of writing and thinking on own, which is hard.*" For context, in an effort to keep students engaged, students were asked to complete different activities within a student workbook which required them to write. This ultimately was more aversive than engaging for students. Another problem identified by observers when discussion problem solving was "*the partner activity was a little difficult. Students tended to have very different ideas [on how to solve a problem] so it was hard to partner.*"

Concepts. Lastly, teachers reported that some concepts were difficult for students to understand, or that there were too many concepts within one lesson. Both teacher and observer reports indicated the need for teachers to teach concepts over a prolonged time, which hindered the teacher's ability to complete the lesson in its entirety. One teacher wrote "*a lot of concepts at one time for the level of students in the room,*" and an observer wrote "*students seemed to have a difficulty separating out thoughts and feelings*" after the teacher taught Lesson 2 on Actions, Thoughts, and Feelings. In another lesson on irrational thoughts, one teacher wrote "*despite nice discussion some students had a difficult time grasping their negative thoughts [irrational thoughts] into wise [rational] thoughts.*" While, concepts were difficult for some students, one teacher did reflect on his instruction writing "*I need to have a better prep on how lessons go,*" noting that could be helpful for him and his students.

Strengths

Teachers reported on a variety of curriculum strengths and what they believed went well during curriculum implementation. Data analysis identified similar themes of (a) curriculum activities, (b) curriculum concepts, and (c) student engagement that were also regarded as challenges.

Activities. Teachers did suggest certain activities within the curriculum were very well received and helped students understand concepts better. For example, students participate in a lesson that focus on how an individual's actions, thoughts, and feelings are all interconnected. One teacher wrote *"two students embraced the TAF triangle and made it their own."* Another teacher thought the classroom discussion on how individuals feelings and actions interact with their environment went well, with another teacher writing *"environment and behavior, a lot of answer with the ME circle."* Teachers also reported two lessons, (a) the problem-solving lesson that used the "TBD" (i.e., think-be-do) mnemonic where students "think" about the problem at hand, "be" aware of different solutions to address the problem, "do" or act on the best solution, and (b) the coping skills lesson that used full-body relaxation to destress and reduce anxiety were both strengths of the curriculum. One teacher wrote *"Loved the Think Be Do strategy, it worked great!"* and another teacher wrote *"working through the TBD chart was fabulous! Great conversation!"*

In their interview, one teacher reported how lesson activities supported learning after the curriculum had been taught and the study was completed, *"... and that common language when we are problem solving and then we can generalize the curriculum into other areas, because then the curriculum is slipping outside of the classroom."* Another teacher commented on the specific needs of students with disabilities *"and kids with autism don't learn from being in the world like other kids do, they have to be taught these concepts and they really eat it up when you start teaching it, and you start seeing those light bulbs flickering, so I loved it, it was a nice sequential packet of things that you could move through."*

Curriculum design. Although certain concepts were difficult for some teachers to implement and students to learn, teachers did report appreciation for how the curriculum reinforced background knowledge from previous lessons. One teacher commented *"I thought it did a really good job reinforcing the concepts from lesson to lesson . . . and felt there was a lot of room for students and the teachers to bring in our prior experiences and prior knowledge and build on that."* Teachers also indicated, across data sources, they felt their students understood the core concepts in the curriculum's ten lessons.

Student engagement. Teachers reported that they were happy with the amount of student participation the curriculum allowed for. Multiple teachers wrote how well discussions went throughout the curriculum for example teachers wrote the following in their open-ended responses: *"students engaged in good discussion about internal versus external locus of control;"* *"Discussion around stressors;"* *"sharing goals and positive activities;"* *"describing anxiety and defining what it means."* Teachers also appreciated the flexibility to facilitate the curriculum in their own way. Scripts for all ten lessons were provided, but opportunities for teachers to share and connect with their students was explicitly placed throughout each lesson. Connecting with their students was regarded as a positive of the curriculum.

The teacher that discussed a common language around the problem-solving activity above iterated, *"being able to talk to a student in a common language and getting him back and getting him ready to perform in the classroom um, works."* He went on to say, *"whether a good mood or bad mood whatever things are bothering them outside the classroom and I think being able to sit down with that student individually and being able to say okay I can see that you are in a downward spiral, and now that student knows what the downward spiral means."* To provide context, mood spirals is a concept covered in lesson two of the curriculum.

Discussion

This pilot mental health literacy curriculum is one of the first school-based mental interventions designed for high school special education teachers to implement to students with disabilities. Results from a pilot group of teachers and students who participated in the *Think, Be, Do* curriculum suggest emerging evidence that a mental health literacy intervention is feasible, acceptable, and can have some impact on increasing student's mental health literacy.

The *Think, Be, Do* curriculum was developed due to the lack of resources available to schools and special educators to teach students with disabilities (Anaby et al., 2018; Skaar et al., 2020). Reiterating the purpose of the study, it was important to understand if a novel intervention, like the *Think, Be, Do* curriculum, was acceptable and feasible, and potentially increase mental health literacy in students with disabilities. Teacher ratings for acceptability (i.e., social validity) were overall high with teachers agreeing or strongly agreeing to all of the social validity items. That said, ratings from the student perspective were highly varied, suggesting more focus on making the curriculum acceptable to transition age youth is needed. Examining data from lessons learned, a few components of the curriculum may have impacted student ratings including difficulty with understanding some curriculum concepts and having to write more than expected throughout the ten lessons.

Examination of both teacher- and observer-reported fidelity of implementation data suggests that the *Think, Be, Do* curriculum is feasible to implement in high school special education classrooms. These are similar findings to mental health literacy programs implemented in non-clinical settings for typically developing youth (O'Connell et al., 2020). That said, clearly there have been both challenges and strengths during the implementation of the *Think, Be, Do* curriculum and further development and evaluation should occur to ensure the likelihood of optimal implementation fidelity. One aspect of improvement that was not discussed regarding the implementation of the TBD curriculum was teacher training. Researchers have begun to identify a one-time training can be insufficient for optimal implementation outcomes and suggest continued training and coaching throughout intervention implementation may be a factor in obtaining positive results (Reinke et al., 2014).

Similar to other psycho-educational and mental health literacy interventions (Katz et al., 2020, 2019) that take place in clinical or school-based settings, the *Think, Be, Do* curriculum was successful in increasing mental health literacy for students with disabilities who participated in the curriculum. While the main purpose of this study was to determine if the TBD curriculum was acceptable and feasible, a positive secondary finding such as an increase in mental health literacy can help inform future studies to determine efficacy of a school-based mental health literacy intervention for students with disabilities. A caution to the generalizability of these findings is the knowledge questionnaire that was given pre- and post-intervention was designed to measure mental health through topics covered in the curriculum. Thus, mental health literacy increases may not generalize beyond curriculum content.

The rich data collected from students and teachers provide an opportunity to evaluate the *Think, Be, Do* curriculum and make additional changes for future implementation. Future changes should strongly consider the sustainability and engagement. For example, future iterations must ensure that teachers feel trained and competent in the content of the curriculum. To be sustainable within a classroom the curriculum must also address the academic needs of students, improvements can be made by aligning core standards and academic instructional opportunities throughout the curriculum. It will also be imperative that issues of equity are more explicitly discussed throughout the curriculum as well. Minoritized students may be negatively impacted by systemic oppressive forces (e.g., racism, ableism) and incorporating a stronger ecological approach to what may impact a student's mental health would be a positive and necessary addition. Lastly, the curriculum should adapt to student preferences for engagement; more active participation from students, rather than passive experiences such as journaling or writing in workbooks will also be a necessary change.

Limitations

There are a number of limitations that should be acknowledged. First, while the original study was conducted as small scale underpowered randomized control trial, data is only being presented from teachers, observers, and students who participated in the intervention. No inference on potential efficacy that the *Think, Be, Do* curriculum has on student knowledge or other mental health variables based on comparisons with a control group can be made. Yet, due to the novel nature of a mental health literacy intervention designed for and implemented in special education classrooms, the data collected and presented should be viewed as encouraging and provides some baseline information for future intervention development and implementation. A second limitation is that the qualitative data were analyzed by one individual intimate with the intervention and participants. Broad themes emerged from the data, but it is acknowledged that this paper did not implement rigorous qualitative methodology. The raw data collected from teachers and observers have been presented to help inform future intervention development and implementation. There are a number of limitations regarding the participant sample as well. Data were analyzed on a small number of students (i.e., $n=62$), and there was heterogeneity within disability category. These limitations to the sample also highlight caution when discussing generalizability of findings.

Lessons learned and implications for future research and practice

A focus on implementation may be the best way to ensure the data presented from the *Think, Be, Do* curriculum study can support future endeavors of mental health interventions in secondary special education settings. Reflecting on the implementation of the TBD curriculum usability, we can evaluate outcomes and provide suggestions for future implementation by using two tools. The first is *The Hexagon Tool* (Metz & Louison, 2019) which can help researchers and practitioners assess candidate interventions for need (i.e., the program matches and addresses the needs of schools and/or students), fit (i.e., does the program fit within current initiative priorities, and values of the implementation site), and capacity (i.e., is there capacity to implement the program as intended). The tool also helps assess evidence (i.e., potential outcomes of the program if implemented well), supports (i.e., availability of training, staffing or other programmatic supports if needed), and usability (i.e., specific program components, adaptations, modifications, and successful implementation) of the program.

Future research on and iterative development of the *Think, Be, Do* curriculum should build upon what has already developed to maximize how the intervention addresses all six components of *The Hexagon Tool*. That said, this current iteration has addressed many of these components already. For example need (this intervention provides a resource for special educators), fit (many states have and are currently passing legislation to support student's mental health), and usability (teachers reported that the curriculum was feasible to implement and that they were able to use many of the tools within the curriculum to help their students). Yet, further input from stakeholders and iterative development to strengthen capacity, supports, and evidence will be needed. Future research can include conducting additional needs assessments to determine what the capacities of schools and classrooms are and what is the optimal level of supports needed for teachers. In addition, building evidence of efficacy through rigorous research designs will also be required.

The second tool, the *Quality Implementation Framework*, should also be revisited as phase four includes improving future applications by learning from experience (Meyers et al., 2012). Data from the teachers who implemented and the observers that observed the implementation of the curriculum suggests the *Think, Be, Do* curriculum can be implemented and does provide opportunities for teachers to be flexible to help their students learn. With that in mind, the following suggestions may help future implementation of mental health literacy curricula in special education classrooms.

- (1) Know your students. This study was conducted with students with an array of disabilities. Each student is unique and may need specific educational supports to optimally interact with

a mental health literacy curriculum. For example, one of the teachers worked primarily with students with ASD and identified specific barriers and made certain adaptations to help increase access to the curriculum for her students. In addition, students may have differing interests and desires to discuss mental health in a classroom setting with other students, creating an environment of trust and positive regard is essential.

- (2) Focus on strengths. All students have experiences to share or ways to cope with difficult tasks. When discussing mental health, it may be easy to focus on things that are negative or have negative impact on mood (i.e., anxiety and depression), but having the discussion on what makes us happy and what brings joy into our lives is also just as important. For special educators, being strengths based is critical in instruction, and it is also critical for mental health.
- (3) Teach through a variety of modalities. Feedback from teachers who implemented the curriculum suggested that some students had a hard time always talking about mental health or mental illness during the 5 weeks. Students also did not engage to an optimal level with the student workbook due to the amount of writing that was encouraged. Having different modalities for students to express themselves (e.g., drawing, writing, music, discussions) and for teachers to demonstrate content could be a beneficial alteration to the curriculum.
- (4) Manage time and dissemination of content. One potential issue of this pilot implementation was the amount of time that was given to implement the curriculum (i.e., twice a week for 5 weeks). The short amount of time to implement the curriculum potentially did not provide the opportunity for teachers to cover all components of each lesson. For future research and implementation, ensuring that all of the curriculum components can be completed is critical. One suggestion for future implementation would be to extend the curriculum over 10 weeks (one lesson a week) to provide time for students to digest curriculum content as well as practice establishing and monitoring goals over a realistic time period.
- (5) Determine capacity and schedule for support. Discussing mental health and mental illness with students can be difficult for many reasons. For teachers who are implementing a mental health literacy curriculum like *Think, Be, Do*, having support from a school counselor or scheduling check-ins with the content creator to work through individualized concerns or classroom dynamics could be beneficial.

Conclusion

Establishing an evidence base begins with addressing a need, identifying the best ways to meet that need, and conducting preliminary testing to gather data to determine initial acceptability, feasibility, and potential efficacy. While there are limitations to the current study, preliminary evidence suggests the *Think, Be, Do* curriculum addresses a need and is acceptable and feasible for teachers to implement. Although additional evidence is needed to determine efficacy, it is critical that the field of school-based mental health does not forget students with disabilities.

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