



# Teachers as School Mental Health Professionals and their Daily Practices

Rodrigo Rojas-Andrade<sup>1</sup> · Samuel Aranguren Zurita<sup>2</sup> · Gabriel Prosser Bravo<sup>1</sup>

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## Abstract

Despite the fundamental role of teachers in School Mental Health Systems, their work has been under-recognized and under-supported. Moreover, few studies on this role have been conducted in low- and middle-income countries. This study explores and describes the mental health actions undertaken by teachers in schools and categorizes them using latent class analysis. The study collected data from 726 teachers in Chile using snowball sampling. Three self-reported questionnaires were administered: Mental Health Actions and Teaching Role Questionnaire; Interprofessional Competence in Mental Health Questionnaire and Checklist of Mental Health Issues Addressed in School. The results showed that teachers play a significant role in identifying and addressing mental health issues among students, with 90% of respondents reporting that they had provided support to students with mental health concerns. The results also suggest that teachers face several challenges in this role, including a lack of training and resources, time constraints, and the need for better communication and collaboration with mental health professionals. Six latent class of teachers was founded: low activity Class, Classroom-Centered Class, Individual Emotional Support-Centered Class, Self-Care and Professional Development Class, Mental Health Curriculum-Centered Class, and High activity Class. Based on the results provides applied recommendations for teachers to support their students' mental health, such as creating a safe and supportive classroom environment, promoting social-emotional learning, and collaborating with specialised school mental health professionals. Overall, this study highlights the need for a comprehensive and integrated approach to school mental health that involves teachers, mental health professionals, and other stakeholders.

**Keywords** School Mental Health Systems · Teacher's role · Latent class · Interprofessional competence · Daily practices

## Introduction

Mental health issues among children and adolescents have become a global concern, increasing in significance over recent decades (Kieling et al., 2019). The World Health Organization (WHO, 2022) estimates that approximately 20% of children and adolescents across the globe suffer from mental health problems, with depression, anxiety, and attention deficit/hyperactivity disorder being the most common. These issues extend beyond affecting emotional and social well-being and have significant implications for academic

performance and lifelong development (Hamoda et al., 2021; Suldo et al., 2014).

The relationship between academic performance and mental health is complex and bidirectional. Suldo et al., (2014) identified that fluctuations in one can forecast changes in the other, underlining the importance of ongoing mental health monitoring among continually shifting academic demands. The COVID-19 pandemic further highlighted this connection, as abrupt alterations in educational environments—such as confinement and the shift to online learning—had a marked effect on students' mental health (Hamoda et al., 2021).

However, the pandemic's impact on the mental health of children and adolescents was not uniform. The effects varied, depending on individual school systems and broader ecological circumstances (Panchal et al., 2023). This variation was especially pronounced in middle- and low-income countries, including Latin American nations (Gallegos et al., 2022; Kola et al., 2021). Factors such as psychosocial

✉ Rodrigo Rojas-Andrade  
rodrigo.rojas.a@usach.cl

<sup>1</sup> Escuela de Psicología, Universidad Santiago de Chile, Ecuador 3650, Estación Central, Santiago, Región Metropolitana, Chile

<sup>2</sup> Universidad Alberto Hurtado, Santiago, Chile

vulnerability, violence, and poverty contribute to one in two schoolchildren experiencing a mental health problem (Larraguibel et al., 2021).

## School and Mental Health

The pandemic has underscored the indispensable role of schools in supporting students' mental health. Not only do schools serve as venues for academic learning, but they also provide a vital environment for the social and emotional growth of children and adolescents (Doll et al., 2017). Recognizing this significance, various nations and international organizations are increasingly championing the integration of mental health into educational policies (Hamoda et al., 2021).

Due to compulsory education, schools have become an ideal setting for offering mental health services, as most children and adolescents spend substantial portions of their day in this environment. This unique role of schools is evident across both developed and developing countries, where educational institutions often serve as the primary avenue for mental health care accessible to young people (Fazel et al., 2014a, 2014b; Fazel et al., 2014a, 2014b).

In this context, the strategic positioning of schools enables nearly universal access (Berry et al., 2016), aiding in overcoming multiple obstacles often tied to youth mental health care, such as stigma, logistical hindrances, and financial constraints (Greenberg et al., 2017). Consequently, research has shown that students attending schools with mental health systems in place are 3 to 10 times more likely to receive assistance than those lacking such resources (Bains & Diallo, 2016).

In addition, a substantial body of evidence lends robust support to the implementation of mental health services within schools (Kutcher et al., 2015). Programs designed to nurture the well-being of children and adolescents have been found not only to bolster mental health but also enhance academic performance and reduce the potential risk of developing mental disorders (Durlak et al., 2011; Ekornes, 2015).

## School Mental Health Systems

Historically, mental health services in schools have primarily been tailored to evaluate and treat students with special educational needs (Paternite, 2005). However, the post-COVID-19 era has seen a gradual shift toward more comprehensive programs that address mental health on a broader scale (Hamoda et al., 2021). Although varied in their approaches, these services uniformly aim to collaborate with health care providers to support children and adolescents at

risk or those who have already encountered mental health challenges (Doll et al., 2017).

The integration of these services within schools allows for a dual focus on mental health needs and educational objectives, aligning with education law mandates. Successful integration hinges on fostering collaboration among schools, families, and mental health service providers, as represented in the implementation of School Mental Health Systems (SMHS). These systems comprise multilevel support structures designed to prevent, identify, and address student mental health difficulties and promote overall well-being and success (Zabek et al., 2023). Key components include evidence-based interventions, data-driven decision-making, and early detection, all of which are interwoven with local networks (Arora et al., 2019).

SMHS are organized into 3 tiers, delineating promotional, preventive interventions from individual treatment support. Tier 1 encompasses whole-school interventions to enhance well-being and mitigate risk factors across the entire community. Tier 2 involves frequent and intensive preventive actions for students with mild symptoms or emotional vulnerabilities. Finally, Tier 3 focuses on individualized, specialized support for students dealing with mental health issues that are unresponsive to previous interventions (Arora et al., 2019).

## Teachers in School Mental Health Systems

Historically, not all models of school mental health have placed teachers at the center of action (Weston et al., 2008). First, these services followed biomedical models that focused on individualized care for children and young people outside school. Over the years, approaches that promoted action within the school began to be suggested and adopted internationally, with the teacher as one of the beneficiaries or recipients of interventions (Ball et al., 2010). The shift in recent years to ecological, systemic, and multilevel models involved rethinking the role of the teacher in a new framework (Weist et al., 2023).

SMHS are implemented through an interdisciplinary team, including psychologists, counselors, social workers, psychiatrists, and teachers (Zabek et al., 2023). Despite this collaborative model, teachers often find themselves relegated to a supporting role, sometimes considered only as consulting members or strategic partners in screening and referral (Ekornes, 2015; Kratt, 2018). This view contrasts sharply with the growing understanding that promoting mental health goes beyond mere problem identification, encompassing proactive measures, prevention, and holistic support for students' well-being.

A growing number of researchers and practitioners call for broadening the roles of teachers. They emphasize the

need for increased support and collaboration that goes beyond the conventional "frontline" duties, evolving into more profound engagement with students' mental well-being (Maclean & Law, 2022; Mellin et al., 2017; Ormiston et al., 2021).

Poor recognition of teachers as vital components of mental health teams in schools might impede the success of SMHS. Additional challenges include the time required for follow-up tasks, potential misunderstandings stemming from confidentiality rules, and lack of common collaborative language (Ekornes, 2015). Richter et al. (2022) underscored these obstacles, highlighting dysfunctional communication, ambiguous objectives, and weak feedback as significant barriers.

At Tier 1, teachers are known to act as mediators, fostering a positive environment and promoting healthy relationships among students (Durlak et al., 2011). In fact, in middle- and low-income countries, teacher-led programs are often more effective than those managed by other professionals (Zabek et al., 2023). At Tier 2, teachers are usually the most involved professionals, carrying out the detection of participants who would benefit from the intervention and often carrying out these interventions, although they do not have the training, resources, or time for them (Townes et al., 2023). In Tier 3, teachers tend to limit their role to the early detection of mental health problems in students, find barriers to their participation in the interventions that are generally related to the knowledge and skills needed to do it, and associate their participation with feelings of frustration and disappointment (Shelemy et al., 2019).

Teachers' constant involvement in multi-tier mental health initiatives contrasts with the existing literature, demonstrating a frequent lack of proper training. Such a deficiency may lead them to rely more on personal convictions than on evidence-based practices (Maclean & Law, 2022; Ormiston et al., 2021). This situation unveils a fundamental contradiction: Teachers are active in wellness and prevention actions that often remain underrecognized, and only their role in detection and referral is acknowledged and emphasized, marginalizing their vital contributions in other areas (Shelemy et al., 2019; O'Farrell et al., 2023).

This situation reveals a disconnect that relegates teachers to a secondary or invisible position within SMHS. By viewing them merely as early referrers, the current perspective often overshadows the substantial impact that teachers can and do have on students' mental health from within the education sector.

Ignorance of their importance is a problem for SMHS: their role in the system becomes less clear, and less importance is given to training them and supervising their practice, as well as involving them in decision-making and other interprofessional actions. In this context, it is necessary to develop research to reduce this gap by identifying various

mental health actions that teachers deploy at school and the professional challenges they face in implementing them.

## This Study

In low- and middle-income countries, including Chile, school SMHS are increasingly receiving recognition and becoming integrated into educational policies (Kola et al., 2021; Rojas-Andrade et al., 2023). However, in many regions, the practical emphasis is on outside health professionals intervening in schools (Canenguez et al., 2023) or specialized school teams (López et al., 2021), often overshadowing the mental health-related actions that teachers perform.

This study explores and describes the mental health actions undertaken by teachers in schools and categorizes them using latent class analysis. By defining this daily practice, we intend to gain insights into how mental health is addressed in classrooms. The goal of this study is to provide crucial information that can guide teacher training in mental health and help shape policies that recognize teachers as central and essential members of SMHS collaborative teams.

## Method

### Participants

We collected data throughout Chile using a self-reported questionnaire on the Survey Monkey platform, targeting teachers in public and subsidized schools. We used snowball sampling (Salkind, 2021) and reached out through several channels: (1) teachers involved in programs coordinated by the Mental Health Department of the Ministry of Health, (2) teachers linked to initiatives led by the Center for Mental Health in Educational Communities, (3) teachers of the Barrancas school district, (4) listings of publicly available educational administrators at the national level, (5) pedagogy graduates, (6) associates within scientific and academic networks, (7) connections with territorial and social organizations, and (8) faculty from various universities. From these efforts, we obtained 1,128 responses, of which 1,054 were complete and valid. We did not take into account 328 participants in the analysis of the study because, although they worked in schools and filled out the entire questionnaire, they were not teachers. We were thus left with a final sample of 726 teachers, with an average age of 43.8 years and 14.5 years of teaching experience; in terms of training, 80% indicated that they had no postgraduate studies; and, with respect to gender, 73.1% indicated that they identified themselves as women and 26.1% as men.

## Measures

### Mental Health Actions and Teaching Role

We developed a questionnaire based on focus group discussions with experts in school mental health (Rojas-Andrade et al., 2021). The instrument consists of 18 items, each referring to school mental health practices, such as detection, screening, emotional support, psychological first aid, and psychoeducation. We scored the items on a binary scale, with one meaning "non-systematic" that is not carried out in a recurring or planned manner and 2 meaning "systematic" that is carried out recurrently and following a plan. The instrument showed an internal consistency of  $\alpha=0.914$ .

### Checklist of Mental Health Issues Addressed in School

This instrument was developed to assess various mental health issues that teachers might address in Chilean classrooms. It consists of 18 key topics organized into 4 main dimensions: (1) Mental Health Disorders and Challenges: This dimension explores how teachers handle specific mental health disorders and challenges (e.g., anxiety, depression, alcohol and/or other drug use, trauma and/or rights violations); (2) Emotional, Social, and Cultural Development: This part focuses on topics related to emotional growth, social skills, and cultural awareness (e.g., social-emotional education, resilience, intercultural mental health, gender, sexuality, and affection); (3) Crisis Management, Violence, and Safety: This category assesses teachers' preparedness for emergencies, crises, and violence-related issues (e.g., crisis and emergencies, mental health and violence, suicide); (4) Self-care and General Mental Health Awareness: This dimension includes aspects of work, self-care, and overall mental health awareness (e.g., mental health, work and self-care, attention deficit disorder, autism spectrum disorders).

Teachers responded to each item on the checklist, indicating whether they addressed the topic in their work during the year. The checklist serves as a valuable tool for understanding the multifaceted nature of mental health in educational settings.

### Inter-professional Competencies in Mental Health Questionnaire

(*Chilean Ministry of Health*): This self-report questionnaire consists of 21 items rated on a 5-point Likert scale, ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). It was designed to assess health professionals' perceptions of their competencies in mental health care across 5 dimensions:

(1) Skills for Mental Health Care: This dimension evaluates professionals' competence in the application of techniques and approaches, coordination with mental health teams, and adaptation of communication and behavior for mental health care (e.g., utilizing digital tools in mental health work, promoting collective decision-making). (2) Knowledge of Public Health and Mental Health: Measures understanding of mental health within a broader public context, including disorders, treatments, policies, and mental health systems at the public level (e.g., in-depth knowledge of the country's legal framework in mental health); (3) Attitudes toward One's Mental Health: Focuses on individual attitudes and beliefs related to self-care and valuing one's mental well-being (e.g., recognizing the importance of professional development for personal mental health); (4) Knowledge about Detection and Diagnoses: Assesses professionals' ability to identify and diagnose mental illnesses, including a profound understanding of associated symptoms and signs (e.g., identifying early symptoms of prevalent mental illnesses); (5) Attitudes toward Mental Health: Explores general attitudes and beliefs toward mental health, including perceptions and opinions about patients with mental illnesses, treatments, and the overall mental health system (e.g., defending public policies favoring mental health). The validity and reliability of the instrument were confirmed with internal consistency values ranging from  $\alpha=0.700$  to 0.895.

### Data Analysis

The R packages *poLCA*, *Tidyr*, and *Psych* were used to perform a latent class analysis, adjusting models ranging from 1 to 7 classes and considering the 18 mental health actions that constituted the instrument. The model that produced the lowest values for the Bayesian information criterion (BIC), the Akaike information criterion (AIC), and the logarithmic likelihood (LL), high entropy values, and statistically significant scores of VLMRT-LRT, BLRT was selected. We also discarded any model in which the smallest class represented less than 10% of the sample and sought parsimony in the results (Schreiber, 2017; Sinha et al., 2020). In addition, we performed contrasts of proportions and variances to determine if the resulting classes differed in their mental health competencies or in the mental health topics addressed in school.

## Results

Table 1 illustrates the frequency with which teachers engage in various school mental health practices. Notably, the activities performed most frequently included (A01) Detection, (A03) Emotional Support, and (A11) Internal Referral, all systematic conducted by over 60% of the

**Table 1** Frequency of school mental health actions

School mental health actions	Non-systematic		Systematic	
	<i>n</i>	%	<i>n</i>	%
(A01) Identify students who need mental health support	220	30,30%	506	69,70%
(A02) Collaborate and/or apply mental health detection or evaluation instruments	519	71,49%	207	28,51%
(A03) Emotionally support individuals affected by crisis	246	33,88%	480	66,12%
(A04) Apply psychological first aid	439	60,47%	287	39,53%
(A05) Give mental health talks to students and their families	556	76,58%	170	23,42%
(A06) Incorporate emotional education content into pedagogical activities	329	45,32%	397	54,68%
(A07) Incorporate mental health content into pedagogical activities	414	57,02%	312	42,98%
(A08) Implement pedagogical methodologies that promote positive mental health (e.g., yoga, meditation, morning circle)	489	67,36%	237	32,64%
(A09) Apply programs or promotional activities related to mental health (e.g., resilience, social skills, socio-emotional learning)	445	61,29%	281	38,71%
(A10) Apply programs or preventive activities to improve mental health (e.g., suicide prevention, drug use, depression, or anxiety)	471	64,88%	255	35,12%
(A11) Refer students to school mental health teams within the school	287	39,53%	439	60,47%
(A12) refers students to public or private mental health specialists (outside the school)	427	58,82%	299	41,18%
(A13) Provide mental health counseling to students and their families	516	71,07%	210	28,93%
(A14) Assist with mental health pharmacological treatments in school (e.g., remind medication time, and administer medication)	595	81,96%	131	18,04%
(A15) Participate in mental health self-care activities	444	61,16%	282	38,84%
(A16) Participate in professional development activities related to mental health	517	71,21%	209	28,79%
(A17) Participate in meetings with mental health teams	566	77,96%	160	22,04%
(A18) Make curricular or pedagogical adjustments for students with mental health problems	455	62,67%	271	37,33%

Note: *n* Number of people who responded to this option, % percentage of people who responded to this option

participants. Among these, detection emerges as the most prevalent action among teachers.

In contrast, the school mental health actions that teachers perform the least involve (A04) Psychological First Aid, incorporating mental health in (A08) Pedagogical Methodologies, (A09) Implementing Promotional Mental Health Programs in School, (A10) Implementing Preventive Mental Health Programs, (A13) Family Counseling, (A14) Pharmacological Assistance, (A15) Teacher Self-Care, (A16) Professional Development, (A17) Collaborative Work, and (A18) Pedagogical Adjustment. All these actions were "non-systematic" performed by more than 60% of the participants, with actions related to

pharmacological assistance highlighted as the least performed by teachers.

Regarding the models of school mental health activities among teachers, a latent class analysis was conducted, and the results, including the BIC, AIC, LL, VLMRT-LRT, BLRT, entropy, and NP indices, are presented in Table 2. Among the evaluated models, models 6 and 7 demonstrated better performance according to the information criteria. Ultimately, model 6 was chosen for the following reasons: model 7 has a category with less than 10% of the population; in addition, model 6 adheres to the principle of parsimony.

The model predicts the likelihood of systematic conducting school mental health actions based on 6 latent classes

**Table 2** Fit information of latent class analysis

Model	NP	BIC	AIC	LL	VLMRT-LRT <i>p</i>	BLRT <i>p</i>	SCS	Entropy
2	37	13,279.15	13,109.41	-6517.706	<.001	<.001	.409	<b>0.921</b>
3	56	12,786.80	12,529.89	-6208.946	<.001	<.001	.263	0.871
4	75	12,645.09	12,301.03	-6075.512	<.001	<.001	.141	0.866
5	94	12,589.73	12,158.50	-5985.248	<.001	<.001	.129	0.829
6	113	<b>12,541.06</b>	12,022.67	-5898.334	<.001	<.001	<b>.119</b>	0.846
7	132	12,588.20	<b>11,982.64</b>	<b>-5859.322</b>	<.001	<.001	.046	0.858

Note: In bold the model with the best fit for each index, NP number of parameters, SCS smallest class size



that were named (C1) Low Activity, (C2) Classroom-Centered, (C3) Individual Emotional Support Centered, (C4) Self-Care and Professional Development Centered (C5), Mental Health Curriculum Centered, and (C6) High Activity (see Fig. 1).

We found that all the resulting classes systematic performed detection and internal referral actions, except for class C5, leading us to emphasize the other characteristics of each class for their definition. We characterize these 6 classes as follows:

**(C1) Low Activity Class (17.63%)**

This class distinguishes itself by a low likelihood of conducting school mental health action. Detection activities were the most performed, but at a far lower frequency than in the other groups.

**(C2) Classroom-Centered Class (12.67%)**

This class consists of teachers who are likely to center their actions on the attention they provide to students, emphasizing emotional support, psychological first aid, and curricular adaptations, and rarely engaging in self-care and professional development actions.

**(C3) Individual Emotional Support-Centered Class (18.6%)**

This class represents a group more inclined to concentrate on the detection, emotional support, and referral of students

with mental health problems, often neglecting other potential school mental health actions.

**(C4) Self-Care and Professional Development Class (16.94%)**

We identified this class with teachers more likely to direct their school mental health actions toward referral, self-care, and professional development, rather than actions that directly promoted students' mental health.

**(C5) Mental Health Curriculum-Centered Class (22.18%)**

As the class with the highest probability of belonging, it describes teachers who are likely to centralize their activities on the modification and execution of curriculums, programs, and methodologies that enhance socio-emotional development and mental health care in the school.

**(C6) High Activity Class (11.98%)**

This class, to which teachers are least likely to belong, stands apart from the rest. It features the likelihood that teachers will systematic perform all school mental health actions.

Table 3 displays the results of the Chi-square test conducted to evaluate the differences among various classes based on the demographic variables collected. No significant differences were found concerning the type of school or educational level. However, significant differences were identified in terms of gender. Specifically, classes (C4)

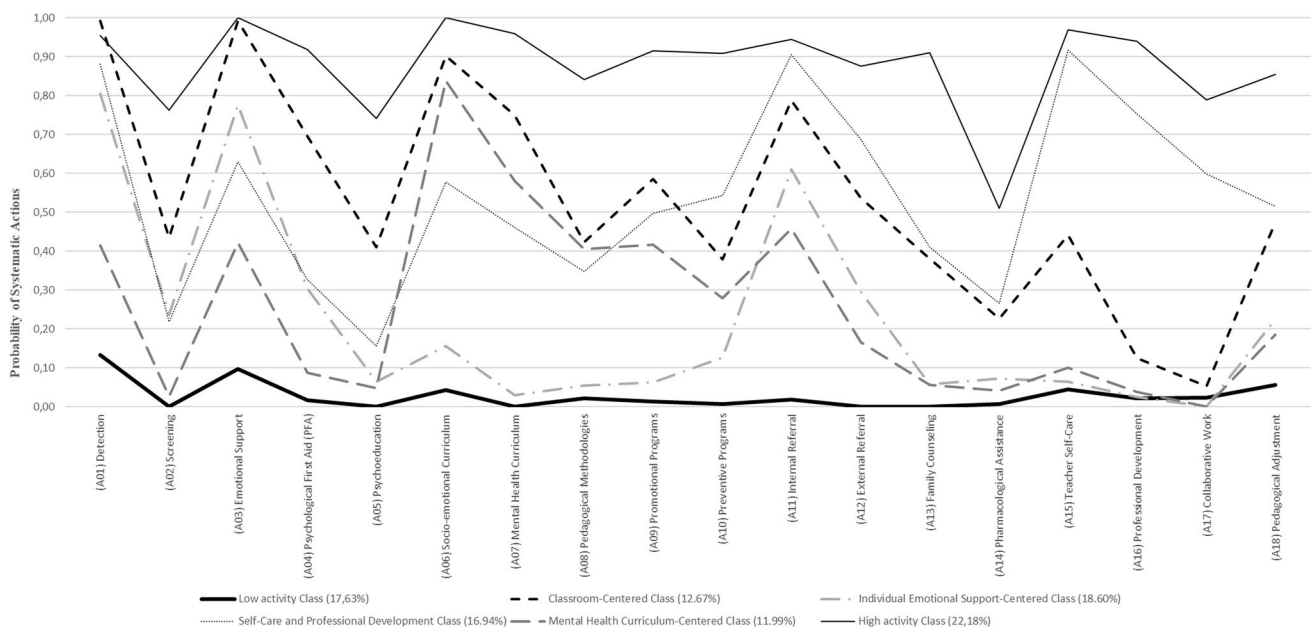


Fig. 1 Model of predicted probabilities of daily practices in school mental health

**Table 3** Demographic data and themes addressed in classrooms by class

Variable	$\chi^2$
Gender	.024*
<b>Type of school</b>	
Municipal Public	.623
Subsidized	.756
State Public	.863
<b>Educational level</b>	
Bachelor's Degree	.809
Professional Degree	.836
Diploma	.220
Postgraduate Degree	.301
Master's Degree	.351
<b>Themes</b>	
Anxiety	33.106***
Alcohol and/or Other Drug Use	15.125***
Crisis and Emergencies	36.900***
Depression	35.952***
Socio-emotional Education	65.436***
Gender	48.263***
Social Skills	23.962***
Resilience	27.829***
Mental Health	48.201***
Intercultural Mental Health	21.696***
Mental Health and Special Educational Needs	21.618***
Mental Health and Violence	35.949***
Suicide	40.200***
Work and Self-care	44.490***
Attention Deficit Disorder	5.082
Autism Spectrum Disorders	3.449
Trauma and/or Rights Violations	29.917***
Sexuality and Affection	48.263***

Note: Significance \*\*\*0,001, \*\*0,01, \*0,05

Self-Care and Professional Development Centered; (C5) Mental Health Curriculum Centered; and (C6) High Activity have a higher proportion of individuals who identify with the female gender than expected.

Regarding the topics addressed by teachers in the school, the most commonly discussed subjects include socio-emotional education, mental health, social skills, gender, sexuality, and affectivity. Table 3 reveals significant differences between the classes using the Chi-square test. (C1) Low Activity is characterized by reluctance to address most topics. (C2) Classroom-Centered avoids content related to Crisis and Emergencies and Suicide but balances Socio-Emotional Education. (C3) Individual Emotional Support Centered shows significant differences in the expected distribution, being negative. (C4) Self-Care and Professional Development Centered balances between addressing and not

addressing subjects. (C5) Mental health curriculum centered focuses on socio-emotional education and mental health, excluding intercultural mental health. Finally, (C6) High Activity addresses all the studied topics, emphasizing mental health, sexuality, and affectivity, except for Eating Behavior.

Finally, Table 4 shows the differences between classes in terms of Teaching Competencies in Mental Health; significant differences were found in Mental Health Care Skills ( $F=44.75$ ;  $p>0.000$ ), Knowledge of Public Health and Mental Health ( $F=12.57$ ;  $p>0.000$ ), and Knowledge of Detection and Diagnosis ( $F=12.10$ ;  $p>0.000$ ). On the other hand, no significant differences were found according to Attitudes toward mental health ( $F=0.16$ ;  $p=0.686$ ) and Attitudes toward own mental health ( $F=0.156$ ;  $p=0.690$ ).

Post hoc analyses were performed using Tukey's test to examine the detail of the differences between classes in the three competencies in which significant differences were found. The High Activity Class (C6) exhibited significant differences from all other classes, demonstrating competencies higher than those of the remaining groups. Similarly, the Low Activity Class (C1) displayed a significantly higher mean than all other classes except High Activity (C6), which achieved the highest scores, and Self-Care and Professional Development Centered (C4), which showed no significant differences across variables.

The Classroom-Centered (C2) and Individual Emotional Support (C3) classes revealed significantly lower scores in the 3 competencies compared with C1 and C6; additionally, C2 scored lower than C4 in Skills for Mental Health Care, and C3 displayed a significantly lower score than C4 in Public Health and Mental Health Knowledge.

Finally, the Focus on Self-Care and Professional Development Class (C4) showed significantly higher scores than the Mental Health Curriculum Centered in Knowledge on Detection and Diagnostics class (C5), in addition to the previously noted differences with C2, C3, and C6.

## Discussions

The aim of this study was to describe the mental health actions that teachers perform in schools and to identify daily practices that allow us to understand how mental health is approached in classrooms.

In this regard, we identified six different classes that could be distinguished from each other by the approach used to address mental health in school, systematic conducting various actions. In the literature, the traits of different teacher groups found in this study can be identified; however, these groups have not been differentiated, and teachers are generally spoken of as a homogeneous set concerning mental health in schools.

**Table 4** ANOVA results between classes and teacher competencies in school mental health

Competences/Class (C)	M	DT	$F^{(1,724)}$	$p$
<i>Skills for mental health care</i>				
C1. Low Activity	2.622	0.946	44.75	.000***
C2. Classroom-Centered	2.181	0.807		
C3. Individual Emotional Support Centered	2.126	1.014		
C4. Self-Care and Professional Development Centered	2.563	0.986		
C5. Mental health curriculum centered	2.193	0.770		
C6. High Activity	3.415	0.897		
<i>Knowledge of public health and mental health</i>				
C1. Low Activity	3.322	0.952	12.57	.000***
C2. Classroom-Centered	2.925	0.941		
C3. Individual Emotional Support Centered	2.704	1.021		
C4. Self-Care and Professional Development Centered	3.274	1.001		
C5. Mental health curriculum centered	2.867	0.991		
C6. High Activity	3.717	0.855		
<i>Knowledge about detection and diagnoses</i>				
C1. Low Activity	2.912	0.902	12.10	.001***
C2. Classroom-Centered	2.402	0.838		
C3. Individual Emotional Support Centered	2.376	0.972		
C4. Self-Care and Professional Development Centered	2.730	1.014		
C5. Mental health curriculum centered	2.329	0.809		
C6. High Activity	3.301	0.935		

Note: Significance \*\*\*0,001, \*\*0,01, \*0,05

The most highlighted characteristic of the teaching staff in the literature is their concern for detection and referral. In this sense, we found that many teachers focus their resources on meeting academic demands, making detection and referral something they can reconcile with their work due to their position that leads them to be in constant interaction with students, allowing them to observe them in their day-to-day work (Kratt, 2018; O'Farrell et al., 2023; Reinke et al., 2011).

This characteristic appears to be reflected in most of the teacher daily practices found in this study, with one exception. In this case, the most common teacher practice in the sample was that they did not systematic perform detection and referral actions in the classroom. Instead, it focuses on resources on pedagogical topics and curricular modifications. These teachers may consider that they address mental health in school through actions inherent to their profession.

This apparent incongruity with the literature could be due to the bias of conducting mental health research in schools with samples that are committed to the subject and have relatively high levels of self-efficacy, contrasting with the broad and heterogeneous sample used in this study.

In the same vein, the literature has found that teachers tend to perceive themselves as the primary parties responsible for classroom interventions. In other words, besides detection and referral, emotional containment in crises marks a boundary between what teachers can achieve in their

role and what should be carried out by specialized mental health professionals (Reinke et al., 2011).

The daily practices that follow this pattern appear to be those with less development of mental health competencies. They tend to focus their actions solely on the student population and what they can do to respond to crises within the classroom, while a specialized professional can take charge of the matter. They differ among themselves by the consideration of including or not including mental health themes in their curricular planning. This could be due both to a lack of belief that they possess the necessary skills to perform mental health actions in school and not perceiving these actions as part of their job (Nygaard et al., 2023; O'Farrell et al., 2023).

Regarding teacher practice focused on self-care and professional development, we found evidence that the COVID-19 pandemic, along with the consequent health measures—such as school closures and the implementation of virtual classes in most countries—brought about a greater concern for personal mental health (Palma-Vasquez et al., 2021). Teacher self-care can have benefits for both peers and students, improving the school climate and enabling them to have the personal resources needed to address other people's mental health issues. This is vital, considering that there is a strong association between teacher and student well-being, which can be partially explained by the significant presence of teachers in



the students' lives and the quality of the relationships they establish with the students (Harding et al., 2019).

Incidentally, this class could represent individuals who are concerned about the mental health of people in general. They have tried to develop their competencies in this area, which may secondarily benefit peers and students. However, their actions may be limited to detection and referral.

Finally, the High Activity and Low Activity Classes represent groups of professionals who tend to perform all mental health actions in the school with a frequency much higher or much lower than the rest of their colleagues, respectively. In addition, both groups stand out for having more developed competencies for school mental health, with the latter only slightly below the former.

This fact, combined with the observation that they do not differ from each other in terms of attitudes toward mental health, raises the question of what determines one behavioral practice over another. In this regard, the variables included in this study do not provide an answer to this question, but we can hypothesize the possible effects of other variables such as commitment to mental health, peer support, institutional support, mandate for carrying out these actions, or the presence of an established SMHS.

From the results, we determined that the development of knowledge and skills is strongly associated with how teaching staff operates in schools. This finding aligns with what has been found in the literature, pointing out that training and support in mental health are imperative for the well-being of the entire educational community (Ekornes, 2015; Maclean & Law, 2022; Ormiston et al., 2021). Conversely, attitudes toward mental health care were not related to any specific teacher practice.

On the other hand, a possible explanation for this diversity of teacher daily practice, in addition to a marked difference in knowledge and skills between groups, is the lack of consensus on the definition of mental health in schools, teachers' roles in this regard, or the boundaries of mental health work that can or should be done in schools. In this sense, the absence of a clear framework from which to work can trigger professional barriers among different groups addressing mental health in schools; communication problems when working on mental health topics and using different languages among professionals in the same institution; mental health problems among teachers, such as stress or depression when unable to satisfactorily meet the demands of the context; and a low effectiveness of the mental health actions carried out in the school (Kratt, 2018; Maclean & Law, 2022; Ormiston et al., 2021).

## Limitations and Future Directions

This study faced some limitations that must be considered when interpreting the results. First, using a snowball sampling method (Salkind, 2021) and data collection through specific channels may have introduced biases in the sample, limiting the generalization of the results. Second, a significant limitation is the lack of validated and standardized instruments in Latin America for measuring mental health actions and teacher work in this field. This must be considered when analyzing the results and planning future research. Third, the study did not consider important differentiating variables such as the course or stage of the life cycle in which they work. Future research could be considered from this perspective, considering that teachers are closer to students when they are younger.

Despite these limitations, the psychometric indicators of the instruments used are satisfactory, indicating that they are reliable and valid measures. Future studies should focus on developing or validating specific instruments to evaluate mental health practices in schools. Improving the instruments with which we perform these measurements would make it possible in future research to relate teaching practices to whole-school approaches, to conduct needs assessments of the school system in terms of capacities, or to measure the impact of the training and capacity building processes that teaching teams receive in this area. Along the same line, it allows for the establishment of relationships between teaching competencies and the results obtained by the interventions they perform in school, both mental health and academic.

Finally, the diversity of mental health approaches in Chile, ranging from a disorder-centered biomedical perspective to a community mental health approach, may have influenced the interpretation and response of teachers to the questionnaires. This conceptual diversity may have introduced additional variability and complexity in the interpretation of the results. Future research should qualitatively explore the implicit theories or representations of mental health present in schools and how they guide the practices carried out within them.

## Conclusions

This study provides a detailed and differentiated insight into the mental health actions that teachers perform in schools. The identification of six different classes of daily practice reveals the complexity of addressing mental health in the school setting, challenging the notion that teachers respond as a homogeneous group to this

phenomenon (Kratt, 2018; O'Farrell et al., 2023; Reinke et al., 2011). The diversity of approaches and practices underscores the need for more specific and differentiated training and support as well as a clear and coherent framework to guide teachers' work in mental health (Ekornes, 2015; Ormiston et al., 2021).

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**Data Availability Statement** The data that support the findings of this study are available from the corresponding author, R.R.A., upon reasonable request.

## Declarations

**Conflict of interests** The authors report there are no competing interests to declare.

**Ethical Approval** Research Ethics Committee approval was obtained from the Academia de Humanismo Cristiano University.

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