

Educators' Perspectives on a Mental Health Check-Up Model for Adolescents: Qualitative Study

Juliana Sinzato, Rodrigo Affonseca Bressan, Pedro Mario Pan, Francisco Da Silva Jr, José Diogo Ribeiro de Souza

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Abstract

Background: Schools play a critical role in identifying adolescent mental health needs early, yet the effectiveness of school-based strategies often depends on how well health information is communicated to educators.

Objective: This study explores how pedagogical leaders perceive a proposed model for adolescent mental health check-ups and identifies key factors for designing effective communication tools between healthcare professionals and schools.

Methods: Two participatory workshops were conducted with 44 pedagogical coordinators and educational counselors from elite private schools in São Paulo, Brazil. Structured group discussions and collaborative design activities were used to elicit responses to proposed mental health report formats. Data were analyzed thematically using an inductive approach supported by manual coding and cross-checking by two independent reviewers. No software was used; inter-rater reliability was achieved through iterative discussion.

Results: Participants expressed a strong preference for mental health reports that are clear, context-sensitive, and co-developed with educators. Key themes included the need for pedagogical rather than clinical language, the importance of mediation by coordinators, and the value of aggregate data for family engagement and institutional planning. Co-creation of communication tools was reported to enhance educators' sense of relevance and confidence in discussing mental health. These preferences were consistently reported across participants regardless of years of experience, suggesting shared epistemic needs across the field.

Conclusions: The study highlights the value of user-informed communication models in mental health screening. Co-created tools aligned with pedagogical practices are more likely to be used and trusted. Effective communication design should be prioritized alongside the development of screening instruments themselves. Further research is needed to adapt this approach to low-resource public school contexts.

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Original Manuscript

Educators' Perspectives on a Mental Health Check-Up Model for Adolescents: Qualitative Study

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Abstract

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Conclusions: The study highlights the value of user-informed communication models in mental health screening. Co-created tools aligned with pedagogical practices are more likely to be used and trusted. Effective communication design should be prioritized alongside the development of screening instruments themselves. Further research is needed to adapt this approach to low-resource public school contexts.

1. Introduction

Adolescence is a critical period for the emergence of mental health challenges, yet the identification and support of students facing such difficulties remains inconsistent across educational systems [1]. In recent years, school-based mental health screening tools have gained attention as a way to detect early signs of emotional distress. However, their effectiveness depends not only on the validity of the instruments, but also on how the results are communicated to the educators responsible for acting upon them [2,7].

Recent publications have advanced the development of digital screening tools targeting youth populations, underscoring their feasibility and diagnostic reach [3]. Yet these tools often lack contextual adaptations for implementation in school environments, particularly with regard to how results are interpreted by educators. Even effective tools may face systemic resistance if implementation does not align with school-specific practices, time constraints, or professional roles [4].

This article focuses on the design of communication tools that translate screening results into formats that are usable, pedagogically relevant, and contextually appropriate. Unlike prior work that emphasizes the development or validation of diagnostic tools, we examine the interface between mental health information and the school environment—a space shaped by complex routines, competing responsibilities, and variable training.

We propose that this communication process can be conceptualized through a design lens, aligned with implementation science frameworks such as the Consolidated Framework for Implementation Research (CFIR) and the Normalization Process Theory (NPT) [5,6]. These frameworks help understand how new tools become embedded in organizational routines and how staff make sense of them collectively.

Drawing on participatory design methods, we explore the perspectives of pedagogical leaders from high-resource private schools in São Paulo, Brazil. These schools were selected due to their experience with mental health initiatives and access to external referral networks. While this selection limits generalizability, it provides a robust context for testing communication designs in settings where referral and resource barriers are less prominent.

2. Methods

Overview and Research Design

This study was part of a broader research and development (R&D) cycle within the Mindcheck initiative, a mental health check-up program for adolescents in Brazil. The aim was to explore and refine communication tools that translate mental health data into formats that are pedagogically relevant and useful in school settings. To guide the co-design process, we adopted a **backward planning** approach, ensuring that workshop activities remained focused on concrete learning and communication outcomes. This methodological choice, although not commonly referenced in mental health research, aligns with participatory design principles by anchoring discussions in the intended use of information rather than abstract clinical goals.

In addition to the workshops reported here, the R&D cycle included earlier ideation and feedback sessions with adolescents and caregivers. These prior encounters contributed to the iterative refinement of both the mental health screening model and its communication tools. Participants and Recruitment

Participants were selected through *intentional sampling*, focusing on middle and high school pedagogical coordinators and counselors from private schools in São Paulo, where students were likely to be involved in the Mindcheck screening. This ensured the relevance of feedback to the target implementation context.

No monetary or material incentives were offered. Participation was voluntary, and a WhatsApp group was created with the participants who wished to continue engaging with the project. As of the last session, the group had 40 members actively discussing the intersection between education and mental health.

Ethical Considerations

This study was approved by the ethics committee of the Federal University of São Paulo (UNIFESP), under protocol number IORG0004884. Written informed consent was obtained from participants capable of understanding the form; verbal consent was obtained from others. All participants were offered follow-up meetings with a psychologist should they wish to receive personal results or referrals. Data were anonymized and securely stored in institutional systems accessible only to the core research team.

Codesign Process and Tools

Two 2-hour participatory workshops were conducted in April and May 2024 with an average of 22 participants each. A third follow-up session was later organized at the request of participants, focusing specifically on the rising concerns around the overdiagnosis of ADHD in adolescents. The first workshop took place via Zoom and the second via Google Meet.

During each session, participants were introduced to a prototype of the mental health screening report, followed by guided small-group discussions that used triggering questions and “What if?” prompts to explore potential uses and concerns. Participants then collaboratively generated word clouds to reflect what such reports should contain or avoid, before engaging in a whole-group debriefing to synthesize insights and

propose improvements.

The workshops were facilitated by a multidisciplinary team of three professionals. A psychologist with training in design led the sessions and guided the activities, while two psychiatrists contributed with targeted questions and reflections to enrich the discussion and ensure the clinical relevance of the insights.

Qualitative Analysis

Data were analyzed thematically using Braun and Clarke's six-step approach, with two researchers independently coding transcripts and workshop materials. The coding process followed an open, inductive logic, allowing themes to emerge from participants' discourse rather than from pre-established categories. Discrepancies between coders were discussed in iterative review sessions, and themes were refined through consensus.

Manual analysis was selected over the use of Computer-Assisted Qualitative Data Analysis Software (CAQDAS) tools due to the *participatory* and *context-sensitive nature* of the project. This approach allowed closer engagement with the data and greater responsiveness to linguistic, emotional, and relational nuances—elements that often carry significant meaning in education and mental health contexts. Moreover, involving the research team directly in coding and interpretation reinforced ownership over the findings and enabled more flexible adaptation of emerging categories throughout the process. Rather than applying a fixed coding frame, the team was able to revisit and reorganize groupings based on ongoing dialogue and reflection.

To strengthen analytical consistency, coding frequencies were calculated for prominent themes, helping to identify the most recurrent ideas across participants. These frequency counts were not used for quantification per se but served to highlight patterns and inform interpretation. Analytical rigor was further supported by collaborative peer review and cross-validation among researchers involved in the workshops.

Development and Iterative Refinement

Throughout the workshops, participant feedback directly informed the refinement of the prototype mental health report. Visual materials (including word clouds) created during initial sessions were revisited in later meetings to validate terminology, structure, and tone. Suggestions led to adjustments such as the removal of clinical labels, the inclusion of a "What the School Can Do" section, and the use of domains familiar to educators (e.g., attention, peer interaction).

Participants did not yet test the reports in their schools, as the research team is currently evaluating the legal and procedural steps required to obtain family consent for school-based implementation.

3. Results

The thematic analysis identified four main categories that represent how school-based professionals interpret and respond to mental health screening tools. These categories are described below with illustrative examples.

3.1 Clarity, Language, and Personalization

Across both workshops, participants repeatedly returned to the importance of accessible, plain-language reports that reflect how emotional or behavioral patterns appear within the school context. Reports written in clinical terminology—particularly those that included diagnostic categories—were often seen as alienating or misleading. Instead, educators favored descriptions that offered a window into the student's current experience in school, without suggesting permanence or pathology.

"We don't need labels that stick. What we need is to understand what's going on with this child during recess, in math class, in group work."

There was a clear distinction made between naming a condition and describing its manifestations. While diagnostic categories were not entirely rejected, they were considered useful only when translated into educational language. Several participants advocated for the removal of terms such as “generalized anxiety” in favor of expressions like “tends to avoid tasks perceived as high-stakes” or “appears dysregulated in unstructured settings.”

The question of tone also emerged as central. Educators valued reports that acknowledged variability, used conditional phrasing (“may benefit from...”), and emphasized possibilities rather than limitations. In one group, participants spontaneously proposed that reports include a dedicated section titled “What the School Can Do”, to explicitly translate findings into supportive actions.

“Just that phrase—‘what the school can do’—makes all the difference. It shifts the mindset from diagnosis to planning.”

This desire for personalization went beyond language. Reports that included basic contextual information—such as changes in sleep, screen use, or recent stressors—were considered more useful, especially when they helped frame behavior in relation to temporary conditions. Educators emphasized that, without this framing, there’s a risk of over-pathologizing common developmental reactions.

There was also discussion around the structure of reports. Word clouds produced during the workshop highlighted terms like “navigation,” “possibilities,” and “pedagogical translation” as core expectations. Participants reacted positively to visual formats that organize information by school-related domains (e.g., peer interaction, attention, self-regulation), especially when coupled with short descriptions of what teachers might observe.

To support this analysis, Figures 1 and 2 present the word clouds collaboratively created by participants when asked to reflect on what medical reports should contain—and what they should avoid—when shared with schools.

Figure 1¹. “What should medical reports contain?” – Word cloud was generated during the workshop.



Figure 2². “What should medical reports avoid?” – Word cloud generated during workshop.

1 Figure 1. “What should medical reports contain?” Word cloud generated collaboratively by participants during the co-creation workshop. Terms include: individualization, possible scenarios, guidance, specific guidance, detailed information, stages of work, proposed actions, recommended steps, family context, referrals, and prognosis.

2 Figure 2. “What should medical reports avoid?” Word cloud generated collaboratively by participants during the co-creation workshop. Terms include: labels, generalizations, meaningless referrals, depersonalization, blame, and isolated strategies.



The visualizations illustrate a clear demand for *individualized*, *actionable*, and *pedagogically relevant information*, as well as a strong rejection of *generalizations*, *meaningless referrals*, and *stigmatizing labels*.

Finally, participants stressed the importance of avoiding generic templates. Reports perceived as “copy-paste” or “checklist-driven” quickly lost credibility. The notion of authorship mattered: when educators sensed that a report had been thoughtfully constructed for a specific student, they were more likely to engage with its content.

3.2 Connection to Pedagogical Practice

Participants frequently emphasized that mental health information only becomes meaningful when it can be mapped onto their everyday responsibilities—namely, the task of supporting student learning. Reports that positioned emotional or behavioral observations in relation to classroom dynamics were seen as more valuable than those that described traits in isolation.

This orientation aligns with recent literature that calls for instructionally relevant mental health communication, particularly in inclusive and whole-child education frameworks (Couto et al., 2020; Weare & Nind, 2011). Rather than receiving reports as static descriptions of students’ difficulties, participants sought guidance for adaptive planning: how to time transitions more carefully, when to provide breaks, how to use visual supports, or which types of groupings might reduce social stress.

Several noted that the most useful reports were those that validated adjustments already in practice. For example, if a teacher had experimented with giving a student advanced notice before switching tasks, and the report confirmed that the student struggled with unpredictability, this alignment enhanced both pedagogical confidence and coherence across the support team.

Educators also requested that reports identify when formal individualized planning might be needed—without framing the student as a problem to be managed. The mention of potential links to PDI (Individual Development Plan) processes was generally welcomed, particularly when presented as part of a shared responsibility model. However, participants cautioned against formats that implicitly transferred therapeutic responsibility to classroom teachers.

A recurrent theme was the demand for reports that reinforce teacher autonomy rather than prescribe specific actions. Language such as “may benefit from” or “consider offering” was seen as enabling, whereas imperative forms (“must provide,” “should avoid”) were sometimes perceived as intrusive. For many, it was not only what the report said, but how it was said—and whether it trusted the teacher’s judgment in implementation.

Notably, none of the participants questioned the relevance of integrating mental health considerations into teaching. The tension lay in the form of that integration: whether the information would expand their capacity to plan more effectively or instead add layers of pressure without support. This distinction shaped their perception of the tool’s legitimacy.

3.3 Mediation and Role Clarity

While participants were broadly supportive of receiving mental health information, they drew clear boundaries around who should interpret and operationalize it within the school structure. Reports delivered directly to classroom teachers without prior mediation were viewed with apprehension. Many feared that such practices could lead to misinterpretation, overstepping of roles, or an erosion of professional focus.

“We already have a thousand things to deal with. If someone drops a mental health report on my desk without context, it becomes another problem instead of a tool.”

The solution most commonly proposed was the active mediation of information by school counselors or pedagogical coordinators. These professionals were seen as better positioned to frame the report within the school's planning structures and help teachers interpret findings without assuming therapeutic responsibilities. Several schools reported successful experiences where mental health data was integrated into existing planning or case discussion meetings, rather than handled in isolation.

“I don't want to ‘diagnose’ anyone, and I shouldn't. But if my coordinator brings this data into our planning conversation, then it makes sense to include it.”

This mediating role, however, was not without friction. Some coordinators expressed uncertainty about how much they could translate or filter the content without misrepresenting it. Others noted the lack of time and training to fulfill this bridging role effectively. Despite being positioned as key nodes in the communication flow, few felt adequately prepared for the responsibility of intersectoral interpretation.

Underlying these discussions was a subtle but important concern: who assumes risk when mental health information is misunderstood or mishandled? While participants were open to collaborative work, they also demanded clearer protocols, shared language, and explicit boundaries of responsibility. This finding echoes the need for institutional scaffolding that supports, not burdens, educators in engaging with students' emotional needs (Demarzo et al., 2014). As one participant put it, in a quiet moment after group discussion:

“The worst thing is when they send a report and just say, ‘do your best.’ That's not enough.”

3.4 Aggregated Data and Family Communication

The use of group-level data to support family dialogue and institutional planning was positively received. Reports that highlighted patterns across grade levels or age groups were perceived as effective in opening sensitive conversations with caregivers and building collective awareness.

“It makes a difference when we say this is happening with many students. Families realize it's not just about their child, and that helps us work together.”

Participants also noted that when reports came with visual aids, such as charts, heat maps, or graphic distributions, conversations became more focused and action-oriented. This approach is supported by the WHO's 2021 recommendation for mental health monitoring systems that incorporate school-wide indicators.

4. Discussion

This study explored how pedagogical leaders interpret and respond to adolescent mental health screening reports when they are invited to participate in the development of communication tools. The results show that the effectiveness of these tools depends not only on their content, but also on how well they are aligned with school practices, language, and expectations.

Participants emphasized the importance of language that makes sense to educators and avoids clinical terminology. This echoes previous research showing that tools are more likely to be used when they adopt educational vocabulary and reflect the realities of classroom life [2,7]. Reports that described students' behavior in context, acknowledged variability, and offered suggestions without imposing rigid recommendations were perceived as helpful. In contrast, formulations that sounded clinical or diagnostic

tended to create discomfort or confusion, even when accurate [4].

These findings align with the idea that the characteristics of the tool itself - its complexity, compatibility with daily routines, and clarity - are key to successful implementation [5]. When educators feel that a report is speaking their language and supports their work, they are more likely to engage with it. This is supported by findings from a recent mixed-methods study showing that teachers are more likely to trust and act upon mental health data when dashboards use school-relevant categories and offer actionable summaries [16]. However, when the information seems disconnected from their role, it can become an additional burden rather than a resource.

Another recurring point was the need for mediation and collaboration within the school. Participants agreed that reports should not be sent directly to classroom teachers without support. Instead, they highlighted the importance of having pedagogical coordinators or counselors help interpret and translate the information, especially when it includes emotional or behavioral aspects. This internal process of sense-making is consistent with the principles of Normalization Process Theory, which emphasizes that new tools are more sustainable when they become part of collective routines [6].

Some coordinators mentioned feeling unprepared to mediate between clinical content and pedagogical planning. This tension suggests that schools may need clearer protocols and more structured training for staff who act as intermediaries between health and education. Even in well-resourced schools, these roles are not always formalized or supported.

In addition to individual reports, participants saw value in having access to aggregated data. When mental health indicators are presented at a group level, they can help guide institutional planning and support conversations with families. This broader use of data has been encouraged in recent guidelines by the WHO [1], and was also proposed in youth-focused care models that view school context as part of the mental health ecosystem [9].

Co-creation was not only a method used in the workshops, but also a driver of relevance. Similar findings were reported in a recent study that applied human-centered design to develop digital mental health reports with educators, highlighting how co-design improves trust and perceived usability across different school settings [15]. By contributing directly to the design of the report, educators reported increased clarity, ownership, and trust in the tool. This process helped bridge the gap between sectors, which has been identified as one of the challenges in previous studies on school-health communication [11].

We chose to use a researcher-led analysis instead of computer-assisted qualitative data analysis (CAQDAS) tools since it is the method indicated for participatory design. The analytical process supports active involvement of the research team and project stakeholders throughout the analytical process. This approach allowed for closer engagement with the data and enabled iterative refinement of emerging themes in collaboration with participants and facilitators. It was particularly well-suited to the context-sensitive nature of the project, in which co-construction of meaning and responsiveness to local narratives were essential.

The method also facilitated greater attention to linguistic, emotional, and relational nuances that may be constrained by structured coding frameworks. Analytical rigor was ensured through multiple cycles of peer review and collaborative validation among the research team.

It is important to note that this study was conducted in private schools, where participants had greater access to support networks and more flexibility for institutional experimentation. This setting offered the advantage of working with professionals already familiar with mental health discourse, but may limit the applicability of findings to public or under-resourced contexts. In future research, it will be important to test similar participatory approaches in public schools facing more profound structural barriers.

Finally, the study contributes to ongoing discussions about how schools can engage with mental health without becoming overwhelmed by responsibilities that belong elsewhere. Teachers do not need to become therapists, but they do need tools that support them in understanding and responding to students' emotional

needs. The results suggest that communication tools grounded in co-creation, adapted to pedagogical contexts, and supported by internal mediation may help make this possible [8,10].

5. Conclusions and Next Steps

In conclusion, this study explored how educators engage with mental health screening reports when invited to co-design how such information is presented and used in schools. Findings suggest that the format and tone of communication are as critical as the data itself. Reports that used accessible language, respected educational roles, and offered pedagogically framed suggestions were more likely to be accepted and integrated into teaching routines. The process of co-creation not only improved report usability but also fostered trust, clarified educators' needs, and encouraged a non-medicalized understanding of student behavior. These insights reinforce evidence on the value of participatory design and shared language in implementation efforts.

While this study was conducted in private school settings, the implications extend beyond this context. Internal mediation structures, access to aggregated data, and adaptable formats were seen as essential for meaningful use. Future research should test these approaches in diverse school systems, particularly public education, and further examine how shared frameworks between education and health professionals can be developed. Strengthening communication between these sectors is not only beneficial—it is necessary to support student wellbeing and learning.

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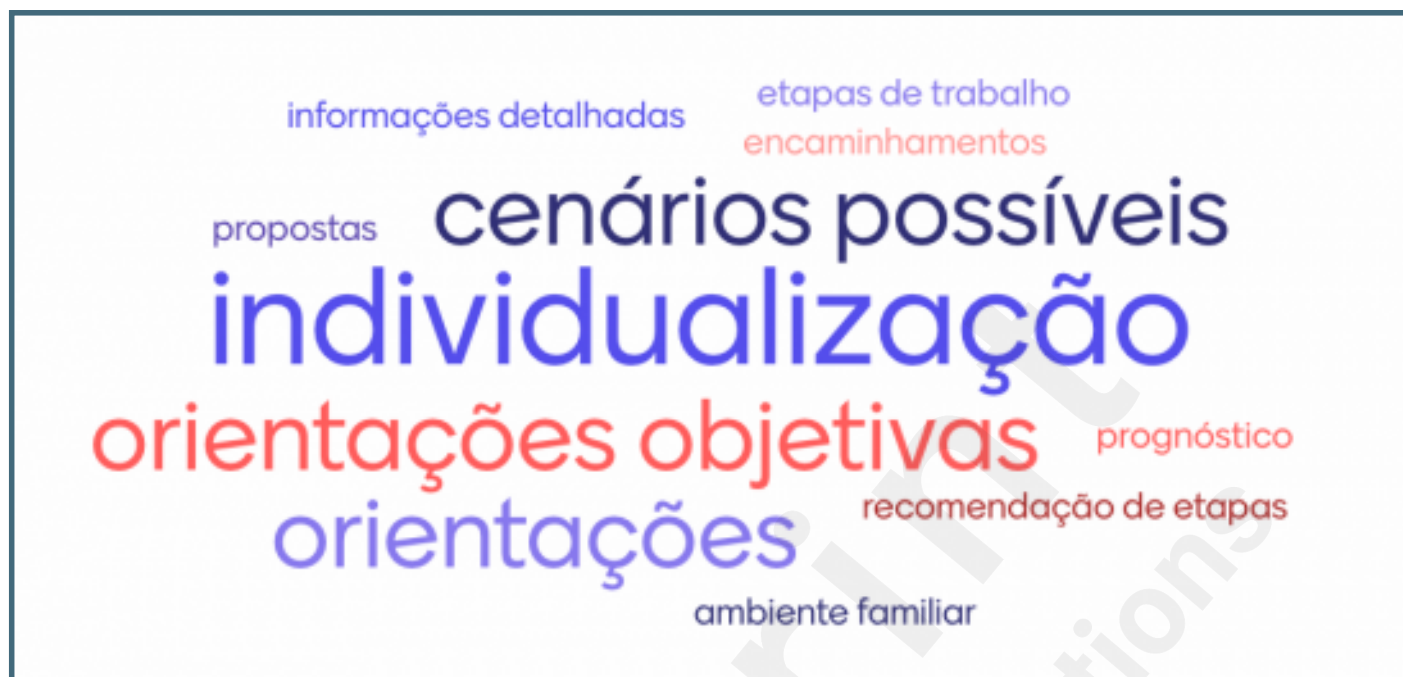
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Supplementary Files

Figures

“What should medical reports contain?” – Word cloud was generated during the workshop.



“What should medical reports avoid?” – Word cloud generated during workshop.

