

Assessment of Teachers' Knowledge, Attitudes, Readiness, and Perceived Barriers Toward Student Mental Health in Saudi Arabia

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Abstract

Introduction: Mental health disorders such as anxiety, depression, and behavioral disorders significantly impact students' academic performance, social interactions, and overall well-being. Teachers, as the first point of contact for many students, are in a unique position to identify early signs of mental health issues and facilitate timely intervention. However, their level of knowledge, attitudes, readiness, and perceived barriers to supporting student mental health in Saudi Arabia remain underexplored clearly. **Objectives:** This study aimed to assess the knowledge, attitudes, readiness, and perceived barriers among schoolteachers in Saudi Arabia regarding student mental health. **Materials and Methods:** A cross-sectional study was conducted between July and December 2025 in public and private schools across various regions of Saudi Arabia, encompassing both urban and rural areas. Licensed male and female teachers from primary, intermediate, and secondary schools were recruited through official Ministry of Education channels and social media platforms. Data were collected using a structured, self-administered questionnaire adapted from validated instruments. The questionnaire assessed five domains: Sociodemographic characteristics, practice and experience, awareness, attitudes and readiness, and perceived barriers. Responses were scored according to predefined scoring systems specific to each domain. **Results:** A total of 422 participants completed the survey. Participants were equally distributed by gender (211 females and 211 males), and most were married (73.9%). Public schools represented 74.9% of respondents, with representation across regions (central region: 31.0%; Eastern: 24.4%; Western: 19.0%; Southern: 15.9%; Northern: 9.7%). Teachers frequently observed student mental health-related concerns, including aggression/violence (80.1%), social pressure events such as parental death/divorce (75.4%), issues with focus/concentration (74.2%), peer issues (73.0%), and anxiety (72.7%). Training related to student mental health was reported by 72.0%, and 83.9% had previously reported/referred a student for a mental health concern; among those who reported, 90.1% indicated action was taken. Awareness was high: 93.6% had heard of behavioral interventions, 77.0% had heard of behavioral interventions applied in schools, and 75.6% reported learning/training in behavioral interventions during college/practice. Overall scoring (max = 231) showed most participants were categorized as moderate (84.6%), with 13.0% high and 2.4% low; overall score level differed significantly by age group ($P = 0.018$), educational qualification ($P < 0.001$), and years of teaching experience ($P = 0.032$).

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Conclusion: Reported exposure to student mental health-related concerns was high, and awareness of behavioral interventions was generally strong. Despite broadly supportive item-level attitudes toward teacher involvement in student mental health, these findings support strengthening structured professional development, standardizing school-based referral pathways, and addressing system-level barriers to improve consistent implementation of behavioral interventions and student mental health support in schools.

Key words: Awareness, Mental health, Readiness, Saudi Arabia, Teachers

INTRODUCTION

Mental illness is a serious medical condition that impacts a person's ideas, emotions, mood, and actions.^[1] In contrast, from the perspective of positive psychology or holism, mental health may refer to one's capacity to enjoy life and maintain a balance between daily tasks and efforts to acquire psychological resilience.^[2] Such illnesses may emerge as attention deficiencies, cognitive problems, lack of motivation, and low mood, all of which can significantly affect academic growth.^[3]

Worry and fear are typical in young people, but when these fears linger, they can lead to anxiety.^[4] Anxiety encompasses a wide range of issues, including general anxiety and social anxiety.^[5] It develops as uneasiness, apprehension, fear, and worry. Furthermore, it may cause somatic symptoms and disturbances.^[5] Depression in youth is a severe public health concern due to its increasing rate, major medical burden, suicide risk, co-occurring psychiatric disorders, and high probability of relapse.^[6] Depression is often known as a major depressive illness or clinical depression, and it is recognized when individuals have depressive symptoms for at least 2 weeks.^[7] Autism spectrum disorder (ASD) has been linked to various illnesses, with attention deficit hyperactivity disorder (ADHD) consistently showing a significant association; a considerable number of youths with ASD display symptoms of ADHD.^[8,9] In terms of diagnosis, autism is defined by widespread difficulties with social communication as well as limited and/or repetitive attitudes and activities, whereas ADHD is defined by developmentally inappropriate symptoms of hyperactivity-impulsivity and/or inattention.^[10]

The likelihood of dropping out of school is increased by mental illnesses such as anxiety or depression.^[11] A better prognosis and functional success in adulthood can arise from early detection and treatment of such mental health illnesses during adolescence.^[12] Teachers in particular can be in a great position to guide students to mental health care facilities because they are frequently the first point of contact for young people and parents who are concerned about their child's psychological well-being.^[13]

According to data for the year 2020, depression, one of the most prevalent disorders, affects over 264 million people. Anxiety disorders, such as generalized anxiety disorder and panic disorder, impact >275 million persons. ASDs are diagnosed in 1 in 160 children. Anxiety, phobias, ADHD,

and bipolar disorders affect millions of people.^[14] Lifetime prevalence rates of anxiety and major depressive disorder are 12.1% and 16.6%, respectively.^[15]

For instance, at Franciscan University in Ohio, 33% of students reported experiencing depression and 40% reported anxiety.^[16] A Malaysian survey found that 37% of students had moderate stress, 63% had anxiety, and 23.7% had depression symptoms.^[17-21] Globally, there is growing interest in the role of teachers in identifying and responding to student mental health concerns. In a 2025 cross-country study (Kenya, Pakistan, Colombia), teachers demonstrated limited knowledge about depression and anxiety, with average scores below 10 on validated literacy scales. Only 30.3% felt confident identifying or responding to mental health issues, though training significantly improved scores.^[22]

A 2023 Australian study highlighted that while teachers frequently observed distress in students, they often felt underprepared to respond. The study emphasized the need for professional development in early detection, communication with parents, and referral protocols.^[23]

Despite the increasing prevalence of mental illnesses among students, the extent of teachers' awareness and readiness to recognize and respond to these concerns remains unclear. Teachers' knowledge, attitudes, readiness, and perceived barriers toward student mental health are largely underexplored in Saudi Arabia. Studies indicate that only a portion of teachers demonstrate adequate knowledge about mental disorders, and many report low readiness to support students, citing barriers such as lack of training, unclear referral pathways, and limited school policies.

Objectives

This study aims to assess their knowledge, perceived preparedness, and the barriers within the school environment that may hinder effective mental health support for them.

MATERIALS AND METHODS

Study design and setting

This study employed a cross-sectional design and was conducted between July 2025 and December 2026

using a structured, self-administered questionnaire. The target population consisted of licensed male and female schoolteachers working in primary, intermediate, and secondary schools across Saudi Arabia. Teachers from both public and private schools were included. A convenience sampling approach was used, with study invitations distributed through social media platforms (Twitter, WhatsApp, and LinkedIn) targeting teacher groups.

Sample size

The sample size was calculated using the Raosoft online sample size calculator, assuming a 5% margin of error, a 95% confidence level, and an expected response distribution of 50%. The minimum required sample size was 384 participants. To account for potential non-response or incomplete questionnaires, an additional 15% was added, resulting in a target sample size of approximately 442 participants.

Inclusion and exclusion criteria

The inclusion criteria were teachers currently employed in primary, intermediate, or secondary schools across Saudi Arabia, in either the public or private sector, who had direct interaction with students, possessed at least 6 months of teaching experience, and agreed to participate by completing the study questionnaire. Teachers who were on leave, retired, not actively teaching, administrative staff or other non-teaching personnel without regular student contact, and those who declined to provide informed consent were excluded from the study.

Data collection method and instruments

Data were collected using a self-administered questionnaire available in both Arabic and English. The questionnaire was adapted from a validated tool developed by Mulla and Bawazir (2020), which assesses teachers' knowledge, readiness, and perceived barriers related to supporting students' mental health.

The survey was distributed online through Ministry of Education channels, official school networks, and social media platforms, including WhatsApp, Twitter, and LinkedIn, targeting teacher groups across different regions of Saudi Arabia.

The questionnaire consisted of five main sections. The first section collected sociodemographic information, including gender, age, region, school role, and years of teaching experience. The second section assessed teachers' practice and experience by identifying whether they had encountered specific student mental health issues, such as anxiety, depression, bullying, and attention-deficit/hyperactivity disorder (ADHD). Responses were recorded as "Yes" (1)

or "No" (0). In addition, the level of training in behavioral interventions was rated on a scale from 1 (no training) to 5 (advanced training).

The third section evaluated teachers' awareness of behavioral interventions for student mental health, including familiarity with such interventions and their implementation in schools, with total awareness scores ranging from 0 to 3. The fourth section explored attitudes and readiness using a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The fifth and final section assessed perceived barriers using the same Likert scale, with higher scores indicating greater perceived obstacles to supporting student mental health.

The questionnaire required approximately 5–10 min to complete. All responses were collected anonymously, and no identifying personal data were obtained. Electronic informed consent was obtained from all participants before survey completion.

Scoring system

The questionnaire was divided into five domains, each scored separately. Cut-off points were applied using Bloom's criteria (80–100%, 60–79%, and <60%) to classify levels as high, moderate, or low.

Practice and experience domain

This domain consisted of 17 items, including items assessing observed student mental health symptoms and training level. Scores ranged from 0 to 19. Levels were classified as high (80–100%), moderate (60–79%), or low (<60%).

Awareness domain

The awareness domain included three items, with total scores ranging from 0 to 3. Scores were categorized as high (3 points), moderate (2 points), or low (0–1 point).

Attitudes and readiness domain

This domain comprised 24 items measured on a five-point Likert scale, with total scores ranging from 24 to 120. Levels were classified as positive (80–100%), moderate (60–79%), or negative (<60%).

Perceived barriers domain

The perceived barriers domain included 18 items measured on a five-point Likert scale, yielding scores ranging from 18 to 90. Levels were classified as high (80–100%), moderate (60–79%), or low (<60%).

For scoring, each practice/experience item indicating exposure to student mental health issues (e.g., aggression, anxiety, bullying, or school phobia) was scored as Yes = 1 and No = 0. The item assessing receipt of training related to student mental health was scored similarly. Self-rated training or experience in behavioral interventions was scored on an ordinal scale (0 = no training, 1 = limited training/need more training, 2 = moderate training/somewhat confident, 3 = advanced training/very confident). The maximum score for the practice/experience domain was 18.

The awareness domain consisted of three Yes/No items assessing exposure to and training in behavioral interventions, producing a total score range of 0–3. Attitudes/readiness and perceived barriers scores were calculated by summing Likert-scale responses across items within each domain.

An overall score was calculated by summing the scores of the practice/experience, awareness, attitudes/readiness, and perceived barriers domains, with a maximum possible score of 231. Domain scores were converted to percentages and categorized according to Bloom's criteria.

Pilot study

A pilot study was conducted with 20 participants to assess the clarity, feasibility, and comprehensibility of the questionnaire. Feedback from the pilot study was used to refine the survey instrument. Data obtained from the pilot study were not included in the final analysis.

Data entry and statistical analysis

Data were entered into Microsoft Office Excel (Windows version 2021) and subsequently exported to the Statistical Package for the Social Sciences, version 21.0 (IBM Corp., Armonk, NY, USA), for statistical analysis. Descriptive statistics were used to summarize numerical variables, while categorical variables were presented as frequencies and percentages. The Chi-square test was applied to examine associations between categorical variables, with statistical significance set at an appropriate level.

RESULTS

Table 1 presents the sociodemographic characteristics. A total of 422 participants completed the survey. Participants were evenly distributed by gender (female: 211, 50.0%; male: 211, 50.0%). Most respondents were Saudi nationals (411, 97.4%). Regarding age, nearly half were 40–49 years (195, 46.2%), followed by 30–39 years (114, 27.0%), ≥50 years (87, 20.6%), and 20–29 years (26, 6.2%). Most participants were married (312, 73.9%). The most common educational qualification was a bachelor's degree (245, 58.1%), followed by master's degree (117, 27.7%), diploma (37, 8.8%), and PhD or equivalent

Table 1: Sociodemographic characteristics of participants (*n*=422)

Parameter	No.	Percentage
Gender		
Female	211	50.0
Male	211	50.0
Nationality		
Saudi	411	97.4
Non-Saudi	11	2.6
Age group		
20–29	26	6.2
30–39	114	27.0
40–49	195	46.2
≥50	87	20.6
Marital status		
Single	50	11.8
Married	312	73.9
Divorced	52	12.3
Widowed	8	1.9
Highest educational qualification		
Diploma	37	8.8
Bachelor's degree	245	58.1
Master's degree	117	27.7
PhD or equivalent	23	5.5
Region of school		
Southern region	67	15.9
Western region	80	19.0
Central region	131	31.0
Eastern region	103	24.4
Northern region	41	9.7
School type		
Public	316	74.9
Private	106	25.1
Role in school		
Teacher	153	36.3
Psychologist	101	23.9
Trainer/Administrator	131	31.0
Principal/Vice principal	37	8.8
Years of teaching experience		
1–5 years	117	27.7
6–10 years	142	33.6
>10 years	163	38.6

(23, 5.5%). Most respondents worked in public schools (316, 74.9%). The largest region represented was the central region (31.0%), and the most common role category was teacher (36.3%). Teaching experience was predominantly ≥6 years, with >10 years being the most frequent category (38.6%).

Table 2 summarizes practice/experience. Teachers frequently reported observing student mental health-related concerns in schools. The highest-reported observations were aggression/violence (80.1%), social pressure events such as parental death/divorce (75.4%), issues with focus/concentration (74.2%), peer issues (73.0%), and anxiety (72.7%). In terms of preparation, 304 participants (72.0%) reported receiving training related to student mental health. When asked to rate their level of experience with behavioral interventions, the most common response was "moderate training/somewhat confident" (137, 32.5%), followed by "I do not know" (113, 26.8%). Among trained participants (multiple responses allowed), online courses were the most frequently reported training format (138, 45.4%), followed by university courses (92, 30.3%) and in-school training (92, 30.3%). Reporting behavior was common: 354 participants (83.9%) had previously reported or referred a student due to a mental health concern. Among those who reported, 319 (90.1%) indicated that an action was taken following the report.

Table 3 displays awareness of behavioral interventions. Awareness was high overall: 395 (93.6%) had heard of behavioral interventions for mental health, 325 (77.0%) had heard of behavioral interventions being applied in schools, and 319 (75.6%) reported having learned or been trained in behavioral interventions during college or practice.

Table 4 presents attitudes and readiness. Across most items, a majority selected "Agree" or "Strongly agree," indicating broadly favorable attitudes toward teacher involvement in student mental health. For instance, 75.1% agreed/strongly agreed that it is their role to participate in managing students' mental health issues, and 77.3% agreed/strongly agreed that mental health lessons/exercises should be incorporated into school curricula. Readiness to adopt behavioral interventions was also notable under enabling conditions: 78.9% agreed/strongly agreed that they would adopt behavioral interventions if they were understandable to them. Despite generally supportive item-level responses, the aggregate attitude/readiness score was most often in the moderate range, suggesting room for strengthening consistent confidence and readiness across all domains.

Table 5 summarizes perceived barriers to implementing student mental health support. The most prominent barriers (agree/strongly agree) were an insufficient number of school counselors/social counselors (77.0%), lack of resources for mental health services in schools (73.2%), and insufficient training to deal with students' mental health needs (71.3%). Stigma and the absence of a clear referral system were also frequently endorsed. Overall, this pattern indicates that implementation challenges are both structural (staffing, resources, referral pathways) and capacity-related (training and confidence).

Table 2: Frequency distribution of practice/experience items ($n=422$)

Parameter	No.	Percentage
Aggression/violence		
Yes	338	80.1
No	84	19.9
Anxiety		
Yes	307	72.7
No	115	27.3
Phobia/Fear		
Yes	287	68.0
No	135	32.0
Bullying (physical/verbal/social/internet /racial)		
Yes	280	66.4
No	142	33.6
Wanting to leave school		
Yes	229	54.3
No	193	45.7
Depression/hopelessness		
Yes	267	63.3
No	155	36.7
Defiant behavior (property damage, etc.)		
Yes	220	52.1
No	202	47.9
Social pressure (parent death/divorce, etc.)		
Yes	318	75.4
No	104	24.6
Difficulty adapting to new environment/transition		
Yes	259	61.4
No	163	38.6
Peer issues		
Yes	308	73.0
No	114	27.0
Issues with focus/concentration		
Yes	313	74.2
No	109	25.8
School phobia		
Yes	278	65.9
No	144	34.1
Victim of bullying		
Yes	274	64.9
No	148	35.1

(Contd...)

Table 2: (Continued)

Parameter	No.	Percentage
Have you received any training related to student mental health?		
Yes	304	72.0
No	118	28.0
If yes, rate your level of experience with behavioral interventions for mental health		
Not trained (no/little knowledge)	48	11.4
Limited training (not confident)	74	17.5
I do not know	113	26.8
Moderate training (somewhat confident)	137	32.5
Advanced training (very confident)	50	11.8
Type of training received (select all that apply) [among trained teachers]		
Workshop/seminar	71	23.4
University course	92	30.3
Online course	138	45.4
In-school training	92	30.3
Other	26	8.6
Have you ever reported or referred a student for a mental health concern?		
Yes	354	83.9
No	68	16.1
To whom did you report the concern? (select all that apply) [among those who reported]		
School counselor	131	37.0
School administration	138	39.0
Parents/guardians	122	34.5
External mental health professional	56	15.8
Was any action taken after your report? (Among those who reported)		
Other	18	5.1
Yes	319	90.1
No	35	9.9

Items labeled as "select all that apply" were analyzed as multiple-response items. Percentages for training type are calculated out of trained participants ($n=304$), and percentages for reporting targets and action taken are calculated out of participants who reported ($n=354$)

Table 6 presents the distribution of participants across proficiency categories for each scoring domain (practice/experience, awareness, attitude/readiness, and perceived barriers) and for the combined overall score, reported as frequencies and percentages within each category. The mean ($\pm$ standard deviation) scores were 11.45 ± 3.22 for practice/experience (max = 18), 2.46 ± 0.84 for awareness (max = 3),

Table 3: Frequency distribution of awareness items ($n=422$)

Parameter	No.	Percentage
Have you heard of behavioral intervention for mental health?		
Yes	395	93.6
No	27	6.4
Have you heard of behavioral intervention being applied in schools?		
Yes	325	77.0
No	97	23.0
During your college years or years of practice, have you been trained/learned the use of behavioral interventions for mental health?		
Yes	319	75.6
No	103	24.4

91.24 ± 8.15 for attitude/readiness (max = 120), and 67.54 ± 6.25 for perceived barriers (max = 90). The overall score (max = 231) averaged 172.70 ± 13.47 . Most participants were categorized as moderate overall (357, 84.6%), while 55 (13.0%) were high and 10 (2.4%) were low.

Table 7 shows Chi-square tests examining associations between sociodemographic characteristics and overall score level. Significant associations were observed for age group ($P = 0.018$), educational qualification ($P < 0.001$), and years of teaching experience ($P = 0.032$), indicating that overall proficiency differed across these groups. In contrast, gender, nationality, marital status, school type, and role in school were not significantly associated with overall score level ($P > 0.05$). Because some demographic categories had small cell counts, Chi-square results for those variables should be interpreted with caution.

DISCUSSION

The aim of the present study was to evaluate the knowledge, attitudes, readiness/practices of teachers, and school staff members regarding their orientation in supporting the mental health of students in Saudi Arabia and to give a particular emphasis to awareness and acceptability of school-based behavioral interventions. This focus is timely as many mental health conditions appear in adolescence, and schools have become a suggested viable platform for early identification, initial intervention, and referral to specialized care.^[24-27] Overall, the majority of people who took part in the present study scored moderately on the composite score (84.6%), with 13.5% scoring highly, indicating that a meaningful basis is in place in schools, but that competencies are yet to be uniformly strong or supported by systems and resources.

Table 4: Frequency distribution of attitude and readiness items ($n=422$)

Parameter	No.	Percentage
I feel that it is my role to participate in managing students' mental health issues		
Strongly disagree	3	0.7
Disagree	10	2.4
Neutral	92	21.8
Agree	271	64.2
Strongly agree	46	10.9
I feel that I have the knowledge required to deal with students' mental health issues		
Strongly disagree	3	0.7
Disagree	26	6.2
Neutral	111	26.3
Agree	237	56.2
Strongly agree	45	10.7
It is important that teachers participate in screening/diagnosing students' mental health issues		
Strongly disagree	2	0.5
Disagree	17	4.0
Neutral	110	26.1
Agree	248	58.8
Strongly agree	45	10.7
It is necessary that teachers refer students/families to mental health services as part of school services		
Strongly disagree	5	1.2
Disagree	23	5.5
Neutral	129	30.6
Agree	229	54.3
Strongly agree	36	8.5
It is necessary to include behavioral interventions in school classes		
Strongly disagree	2	0.5
Disagree	10	2.4
Neutral	94	22.3
Agree	262	62.1
Strongly agree	54	12.8
It is necessary to include mental health exercises/lessons in school curricula		
Strongly disagree	1	0.2
Disagree	8	1.9
Neutral	87	20.6
Agree	266	63.0

(Contd...)

Table 4: (Continued)

Parameter	No.	Percentage
Strongly agree	60	14.2
It is necessary for teachers to assess students' behaviors		
Strongly disagree	0	0.0
Disagree	7	1.7
Neutral	87	20.6
Agree	265	62.8
Strongly agree	63	14.9
It is necessary for teachers to participate in identifying family issues		
Strongly disagree	2	0.5
Disagree	24	5.7
Neutral	121	28.7
Agree	247	58.5
Strongly agree	28	6.6
I would adopt behavioral interventions if they were understandable to me		
Strongly disagree	2	0.5
Disagree	7	1.7
Neutral	80	19.0
Agree	302	71.6
Strongly agree	31	7.3
I would adopt behavioral interventions if required by school administration		
Strongly disagree	4	0.9
Disagree	17	4.0
Neutral	88	20.9
Agree	249	59.0
Strongly agree	64	15.2
I would adopt behavioral interventions if based on convincing evidence/research		
Strongly disagree	2	0.5
Disagree	17	4.0
Neutral	88	20.9
Agree	234	55.5
Strongly agree	81	19.2
I would adopt behavioral interventions if there was a policy from the Ministry of Education		
Strongly disagree	2	0.5
Disagree	16	3.8
Neutral	98	23.2
Agree	251	59.5
Strongly agree	55	13.0
I would adopt behavioral interventions if they were not complicated		

(Contd...)

Table 4: (Continued)

Parameter	No.	Percentage
Strongly disagree	4	0.9
Disagree	13	3.1
Neutral	97	23.0
Agree	263	62.3
Strongly agree	45	10.7
I would adopt behavioral interventions if used by many other schools		
Strongly disagree	0	0.0
Disagree	14	3.3
Neutral	101	23.9
Agree	249	59.0
Strongly agree	58	13.7
I would adopt behavioral interventions if I had enough training and understanding to apply them correctly		
Strongly disagree	2	0.5
Disagree	12	2.8
Neutral	131	31.0
Agree	232	55.0
Strongly agree	45	10.7
I would adopt behavioral interventions if they were not a waste of time		
Strongly disagree	0	0.0
Disagree	12	2.8
Neutral	114	27.0
Agree	238	56.4
Strongly agree	58	13.7
I would adopt behavioral interventions if they were easy to implement/apply		
Strongly disagree	2	0.5
Disagree	13	3.1
Neutral	124	29.4
Agree	252	59.7
Strongly agree	31	7.3
School regional directorates influence choosing mental health services in schools		
Strongly disagree	7	1.7
Disagree	52	12.3
Neutral	90	21.3
Agree	250	59.2
Strongly agree	23	5.5
School advisor/supervisor influences choosing mental health services in schools		
Strongly disagree	10	2.4

(Contd...)

Table 4: (Continued)

Parameter	No.	Percentage
Disagree	25	5.9
Neutral	82	19.4
Agree	247	58.5
Strongly agree	58	13.7
School principal/vice principal influences choosing mental health services in schools		
Strongly disagree	6	1.4
Disagree	27	6.4
Neutral	75	17.8
Agree	256	60.7
Strongly agree	58	13.7
Teachers influence choosing mental health services in schools		
Strongly disagree	9	2.1
Disagree	20	4.7
Neutral	85	20.1
Agree	243	57.6
Strongly agree	65	15.4
School counselors influence choosing mental health services in schools		
Strongly disagree	2	0.5
Disagree	7	1.7
Neutral	83	19.7
Agree	246	58.3
Strongly agree	84	19.9
Social workers influence choosing mental health services in schools		
Strongly disagree	0	0.0
Disagree	7	1.7
Neutral	78	18.5
Agree	217	51.4
Strongly agree	120	28.4
Parents influence choosing mental health services in schools		
Strongly disagree	0	0.0
Disagree	16	3.8
Neutral	81	19.2
Agree	249	59.0
Strongly agree	76	18.0

Exposure to student mental health and behavioral issues was high in the present sample. A large majority of respondents (83.9%) said that they had encountered at least one student with mental health issues in their school, and of these respondents, 90.1% said that they had taken some form of action. The issues of most concern to staff indicated a mix of externalizing and

Table 5: Frequency distribution of perceived barrier items $n=422$

Parameter	No.	Percentage
I feel that it is my role to participate in managing students' mental health issues		
Strongly disagree	2	0.5
Disagree	10	2.4
Neutral	102	24.2
Agree	272	64.5
Strongly agree	36	8.5
I feel that I have the knowledge required to deal with students' mental health issues		
Strongly disagree	2	0.5
Disagree	28	6.6
Neutral	129	30.6
Agree	222	52.6
Strongly agree	41	9.7
It is important that teachers participate in screening/diagnosing students' mental health issues		
Strongly disagree	1	0.2
Disagree	23	5.5
Neutral	95	22.5
Agree	257	60.9
Strongly agree	46	10.9
It is necessary that teachers refer students/families to mental health services as part of school services		
Strongly disagree	0	0.0
Disagree	16	3.8
Neutral	118	28.0
Agree	245	58.1
Strongly agree	43	10.2
It is necessary to include behavioral interventions in school classes		
Strongly disagree	0	0.0
Disagree	11	2.6
Neutral	94	22.3
Agree	250	59.2
Strongly agree	67	15.9
It is necessary to include mental health exercises/lessons in school curricula		
Strongly disagree	0	0.0
Disagree	16	3.8
Neutral	66	15.6
Agree	274	64.9

(Contd...)

Table 5: (Continued)

Parameter	No.	Percentage
Strongly agree	66	15.6
It is necessary for teachers to assess students' behaviors		
Strongly disagree	3	0.7
Disagree	9	2.1
Neutral	75	17.8
Agree	277	65.6
Strongly agree	58	13.7
It is necessary for teachers to participate in identifying family issues		
Strongly disagree	2	0.5
Disagree	18	4.3
Neutral	131	31.0
Agree	235	55.7
Strongly agree	36	8.5
Difficulty identifying students with mental health needs		
Strongly disagree	1	0.2
Disagree	39	9.2
Neutral	96	22.7
Agree	259	61.4
Strongly agree	27	6.4
Insufficient number of social counselors in the school		
Strongly disagree	2	0.5
Disagree	24	5.7
Neutral	71	16.8
Agree	245	58.1
Strongly agree	80	19.0
Insufficient training to deal with students' mental health needs		
Strongly disagree	0	0.0
Disagree	14	3.3
Neutral	107	25.4
Agree	233	55.2
Strongly agree	68	16.1
Difficulty obtaining parental consent and cooperation for mental health treatments		
Strongly disagree	0	0.0
Disagree	22	5.2
Neutral	109	25.8
Agree	232	55.0
Strongly agree	59	14.0
Stigma associated with receiving mental health services		

(Contd...)

Table 5: (Continued)

Parameter	No.	Percentage
Strongly disagree	5	1.2
Disagree	28	6.6
Neutral	90	21.3
Agree	240	56.9
Strongly agree	59	14.0
No clear referral system for students' mental health cases		
Strongly disagree	1	0.2
Disagree	19	4.5
Neutral	103	24.4
Agree	246	58.3
Strongly agree	53	12.6
No resources for mental health services in school		
Strongly disagree	0	0.0
Disagree	12	2.8
Neutral	101	23.9
Agree	251	59.5
Strongly agree	58	13.7
Mental health issues are not considered the school's role		
Strongly disagree	9	2.1
Disagree	58	13.7
Neutral	88	20.9
Agree	215	50.9
Strongly agree	52	12.3
Other priorities take precedence over mental health services		
Strongly disagree	4	0.9
Disagree	26	6.2
Neutral	123	29.1
Agree	236	55.9
Strongly agree	33	7.8
Belief that mental health problems do not exist and are just an excuse		
Strongly disagree	11	2.6
Disagree	53	12.6
Neutral	106	25.1
Agree	233	55.2
Strongly agree	19	4.5

internalizing problems with aggression/violence (85.1%), social pressure/family stressors (e.g., parental death/divorce) (82.2%), attention/concentration problems (80.1%), peer problems (79.9%), and anxiety (77.3%) topping the list. Bullying experiences (75.1%), depressed mood/hopelessness (71.6%), and school phobia or fear-related presentations

Table 6: Participants' proficiency levels by score domain and overall score (n=422)

Parameter	Frequency	Percentage
Practice and experience score level		
High	68	16.1
Moderate	215	50.9
Low	139	32.9
Awareness score level		
High	270	64.0
Moderate	99	23.5
Low	53	12.6
Attitude and readiness score level		
Positive	122	28.9
Moderate	289	68.5
Negative	11	2.6
Perceived barriers score level		
High	104	24.6
Moderate	308	73.0
Low	10	2.4
Overall score level		
High	55	13.0
Moderate	357	84.6
Low	10	2.4

(69.0%) were also commonly reported. This pattern is consistent with findings when adolescent mental health problems and psychosocial stressors manifest in school in terms of behavioral dysregulation, peer conflict, impaired concentration, and internalizing symptoms, making the role of school staff as observers a particularly salient one.^[26,27]

In the Qatar randomized controlled trial for the World Health Organization (WHO) School Mental Health Program, the low level of mental health literacy was recorded at baseline, with only about one quarter of teachers taking part rated as having adequate mental health literacy before the training.^[28] Although Qatar is not the same as Saudi Arabia in terms of context and study design, that baseline finding is consistent with the interpretation for a broad range of findings that many school staff start off with partial knowledge and with limited confidence, and that it is often necessary to provide structured training to advance from awareness to reliable, skillful response.

Regional comparison within Saudi Arabia is also interesting. In the city of Riyadh, Mulla and Bawazir found that a majority of female teachers and staff from secondary schools had scores below a 75th percentile threshold in knowledge (74%), readiness (69%), and perceived barriers (64%), reflecting

Table 7: Association between sociodemographic characteristics and overall score level (Chi-square test) ($n=422$)

Parameters	Overall score level				P-value*
	High	Moderate	Low	Total ($n=422$)	
Gender					
Female	22 40.0%	185 51.8%	4 40.0%	211 50.0%	0.215
Male	33 60.0%	172 48.2%	6 60.0%	211 50.0%	
Nationality					
Saudi	53 96.4%	349 97.8%	9 90.0%	411 97.4%	0.277
Non-Saudi	2 3.6%	8 2.2%	1 10.0%	11 2.6%	
Age group					
20–29	4 7.3%	20 5.6%	2 20.0%	26 6.2%	0.018*
30–39	5 9.1%	108 30.3%	1 10.0%	114 27.0%	
40–49	33 60.0%	157 44.0%	5 50.0%	195 46.2%	
≥ 50	13 23.6%	72 20.2%	2 20.0%	87 20.6%	
Marital status					
Single	2 3.6%	48 13.4%	0 0.0%	50 11.8%	0.162
Married	45 81.8%	257 72.0%	10 100.0%	312 73.9%	
Divorced	6 10.9%	46 12.9%	0 0.0%	52 12.3%	
Widowed	2 3.6%	6 1.7%	0 0.0%	8 1.9%	
Highest educational qualification					
Diploma	5 9.1%	30 8.4%	2 20.0%	37 8.8%	<0.001
Bachelor's degree	30 54.5%	211 59.1%	4 40.0%	245 58.1%	
Master's degree	10 18.2%	105 29.4%	2 20.0%	117 27.7%	
PhD or equivalent	10 18.2%	11 3.1%	2 20.0%	23 5.5%	
Region of school					
Southern region	13 23.6%	49 13.7%	5 50.0%	67 15.9%	0.053
Western region	10 18.2%	68 19.0%	2 20.0%	80 19.0%	

(Contd...)

Table 7: (Continued)

Parameters	Overall score level				P-value*
	High	Moderate	Low	Total (n=422)	
Central region	16	112	3	131	
	29.1%	31.4%	30.0%	31.0%	
Eastern region	10	93	0	103	
	18.2%	26.1%	0.0%	24.4%	
Northern region	6	35	0	41	
	10.9%	9.8%	0.0%	9.7%	
School type					
Public	44	263	9	316	0.323
	80.0%	73.7%	90.0%	74.9%	
Private	11	94	1	106	
	20.0%	26.3%	10.0%	25.1%	
Role in school					
Teacher	22	128	3	153	0.356
	40.0%	35.9%	30.0%	36.3%	
Psychologist	10	91	0	101	
	18.2%	25.5%	0.0%	23.9%	
Trainer/Administrator	18	108	5	131	
	32.7%	30.3%	50.0%	31.0%	
Principal/Vice principal	5	30	2	37	
	9.1%	8.4%	20.0%	8.8%	
Years of teaching experience					
1–5 years	9	105	3	117	0.032*
	16.4%	29.4%	30.0%	27.7%	
6–10 years	20	122	0	142	
	36.4%	34.2%	0.0%	33.6%	
>10 years	26	130	7	163	
	47.3%	36.4%	70.0%	38.6%	

*Statistical significance was set at $P \leq 0.05$. *P value was considered significant if ≤ 0.05

significant disparities in preparedness levels even though staff reported awareness of the importance of adolescent mental health.^[29] Compared with the previous Saudi study, the current findings indicate a more positive attitude toward involvement and are reflected in high levels of support for involvement in the school and high levels of awareness of behavioral interventions. One potential explanation is a broader composition of the current sample (including teachers, social counselors, psychologists, and other staff positions), which could have resulted in greater overall familiarity with mental health processes. Nonetheless, the two studies seem to converge on the practical implication that one of the limitations of readiness is training gaps and system constraints, supporting the need for structured capacity building and clear care pathways in schools.^[29]

A unique contribution of the current study is a concentrated assessment of behavioral interventions in the school setting.

Awareness was high (93.6% had heard of behavioral interventions for mental health problems, and 77.0% had heard of behavioral interventions being used in schools) and 75.6% said that they had learned about behavioral interventions during college or practice. Importantly, feasibility and support of implementation were strong conditions of willingness to implement behavioral interventions. Most respondents said that they would be willing to adopt behavioral interventions if they were understandable (78.9%), supported by convincing evidence/research (82.9%), and accompanied by sufficient training to use them properly (83.6%). This “conditional willingness” is clinically meaningful because it implies that resistance is not primarily an attitudinal issue; rather, a rational professional threshold relating to issues of competency, safety, and expected effectiveness. Such findings are aligned with school mental health guidance highlighting the need for staff to have usable tools, training, and supervision if they are to deliver/support interventions with fidelity.^[27]

The much richer evidence base for these preferences and a plausible pathway for improving on the moderate readiness of this sample. A systematic review and narrative synthesis of secondary school teachers concluded that there is wide variation in baseline levels of mental health literacy and confidence and that training intervention generally improves mental health literacy and confidence among teachers; however, data heterogeneity in terms of measurement tools and follow-up periods means that it is not possible to be confident about the durability of these improvements and their consistent translation into observable helping behaviors.^[30] Complementing this, a meta-analysis of teacher-focused mental health literacy interventions found pooled effects of interventions on knowledge and reductions in stigma, with more mixed evidence of changes in help-seeking or helping-related behaviors.^[31]

Controlled trials give us tangible examples from regions and countries worldwide of what structured programs can deliver. In the Qatar trial of the WHO School Mental Health Program, the control group, teachers who had attended training, showed large improvements in mental health literacy at 3 days and 3 months compared with controls.^[28] Similarly, a randomized controlled trial of intervention with a mental health literacy module in school teachers showed significant improvements in knowledge and attitudes/beliefs in the intervention group compared with controls.^[32] These results of an intervention are closely parallel to the findings in the current study that the majority of staff are willing to implement behavioral interventions in the presence of adequate training and evidence. From an implementation standpoint, this implies that training programs should be more than just a process of raising awareness but should incorporate practical skill-building exercises, case-based exercises, and explicit referral and follow-up protocols, such that readiness/practice improves along with knowledge.^[27,28,32]

Importantly, improved literacy and training may influence real-world pathways to care, not only survey outcomes. In an open-access evaluation from Western Canada, implementation of Go-To Educator mental health literacy training in schools was associated with increased school-associated referrals to tertiary child and adolescent mental health services, along with changes in referral and clinical profiles compared with untrained and pre-training schools, which was interpreted as improved identification and triage to care.^[33] This evidence is directly relevant to the present study, where “actions taken” frequently involved referral (63.2%) and parent contact (52.8%), yet barriers such as unclear referral systems (66.6% agreement) and difficulty obtaining parental consent/cooperation (61.6% agreement) were common. Together, these findings suggest that training should be paired with systems work: Strengthening referral pathways, clarifying roles between teachers and school health professionals, and establishing parent engagement procedures that reduce delay and uncertainty.

The barrier profile in the present study underscores that strengthening individual competence must occur alongside strengthening school mental health infrastructure. The most frequently endorsed barriers were insufficient numbers of social counselors (77.0%), lack of resources for school mental health services (73.2%), and insufficient staff training (71.3%), alongside stigma (66.9%) and lack of a clear referral system (66.6%). These barriers closely reflect the dual implementation requirements emphasized in global policy briefs: effective school mental health depends on both workforce capacity (trained personnel, time, supervision) and systems capacity (resources, referral networks, multi-sector collaboration).^[27] Finally, the observed associations between higher composite scores and educational level and teaching experience suggest that advanced training and accumulated exposure may contribute to stronger capacity, reinforcing the rationale for tiered training and mentorship within schools.

Several limitations should be considered. First, the cross-sectional design limits causal inference regarding factors associated with higher scores. Second, the study relied on self-reported measures, which may be affected by recall and social desirability bias, particularly for questions about “actions taken.” Third, online recruitment may reduce representativeness if some regions, school types, or staff categories were less likely to participate. Finally, the present study did not objectively assess the quality of referrals, fidelity of reported practices, or downstream student outcomes. Future longitudinal and interventional studies that link staff training, referral pathway strengthening, and student-level outcomes would provide stronger evidence to guide sustainable, scalable implementation in Saudi schools.

CONCLUSION

In this national sample of 422 Saudi school staff, reported exposure to student mental health-related concerns was high, and awareness of behavioral interventions was generally strong. Despite broadly supportive item-level attitudes toward teacher involvement in student mental health, aggregate scores most commonly fell within moderate categories across domains, and the overall score was predominantly moderate (84.6%). Overall score level differed by age, educational qualification, and teaching experience, suggesting that professional maturity and training background may influence readiness and perceived challenges. These findings support strengthening structured professional development, standardizing school-based referral pathways, and addressing system-level barriers to improve consistent implementation of behavioral interventions and student mental health support in schools.

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ETHICAL APPROVAL

The study was fully explained to all participants, and it was emphasized that participation was voluntary. Written informed consent was obtained from each participant before enrollment. All collected information was securely stored and used exclusively for research purposes.

INFORMED CONSENT

Written informed consent was obtained from all study participants.

DATA AND MATERIALS AVAILABILITY

All data generated or analyzed during this study are included in this published article.

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