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PERCIEVED BARRIERS TO DEVELOPING A SUCCESSFUL SCHOOL-BASED MENTAL HEALTH PROGRAM

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PERCEIVED BARRIERS TO DEVELOPING A SUCCESSFUL SCHOOL-BASED MENTAL HEALTH PROGRAM

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For students to be successful in school, all their needs must be met. Mental and emotional well-being are core conditions for overall health necessary to lead a happy and productive life, to form healthy relationships, and to successfully adjust to change and overcome difficulties (Burton, Pavord, & Williams, 2014; Minnesota Department of Health, 2002). School-based mental health (SBMH) is one method for schools to make a positive change on the mental health status of children. The prevalence of mental health disorders in youth is increasing at an alarming rate. One in five students in America's public schools have significant mental health needs (NAMI, 2015; NIMH, 2010). A significant concern is that the majority of these students in need of mental health services are actually untreated. To address the many unmet mental health needs facing America's students, SBMH programs have been implemented in some schools.

The purpose of this study is to determine the perceived barriers to developing successful SBMH programs. The study is based upon two surveys. The first survey was to be completed by faculty, and focused on their perceptions of the mental health needs and practices of the SBMH program. The second survey was completed by the implementation team and focused on the stages of implementation of the SBMH program. The research showed that SBMH programs are needed because each participant had experienced working with students who exhibited behaviors associated with mental health issues. The major barriers to implementing an SBMH program identified by the research include stigma, funding sources, and language and cultural

barriers while working with culturally diverse students and families. The major benefits to implementing an SBMH program identified by the research include improved school connectedness, a more positive relationship with home and school, and students being less likely to "fall through the cracks." These findings are beneficial for schools that are looking at implementing a SBMH program.

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CHAPTER ONE: INTRODUCTION

Introduction

For youngsters to be successful in school, all their needs, including both physical and emotional, must be met. The condition of an individual's mental health is a core factor contributing to his/her overall health; being mentally or emotionally healthy is necessary to lead a happy and productive life, to form healthy relationships, and to successfully adjust to change and overcome difficulties (Burton et al., 2014; Minnesota Department of Health, 2002). The National Institute of Mental Health (NIMH) has identified emotional and behavioral problems as serious barriers to teaching and learning (Adelman et al., 1999; NIMH, 2010). A school-based mental health (SBMH) program is one approach schools can take to make a positive change on the mental health status of children. Weist, Evans, and Lever (2003a), state that when mental health programs are available at school, students have greater access to a mental health professionals and mental health services.

The definition of a child versus an adolescent is explained here:

> Adolescence begins with the onset of physiologically normal puberty, and ends when an adult identity and behaviour are accepted. This period of development corresponds … to the period between the ages of 10 and 19 years, which is consistent with the World Health Organization's definition of adolescence (Age Limits and Adolescents, 2003; WHO, 2003).

Thus, when discussing children, those are individuals under the age of 10, and adolescents are those between the ages of 10 and 19. For purposes of this paper, the terms 'youngster' and 'youth' comprise both children and adolescents, and may, at times, be used interchangeably.

The prevalence of mental health disorders in youth is increasing at an alarming rate. One in five United States public school students has significant mental health needs (NAMI, 2015;

NIMH, 2010). Of equal concern is that the majority of these students in need of mental health services are untreated (Pfeiffer & Reddy, 1998; Yung, 2016). When these students are neglected, the cost to society is great. Students with untreated, undertreated, or ineffectively treated mental health needs experience uniformly poor outcomes, including lower grades, high retention and absenteeism rates, increased risks of suicide, lowered rates of employment, little success finding employment after school, and an increased likelihood of involvement in the criminal justice system (Pfeiffer & Reddy, 1998; Yung, 2016).

While the current capacity of children's mental health services remains inconsistent and insufficient, federal and state governments have made modest progress in addressing problems over the last two decades (Price, Behrens, & Lear, 2013). To address the many unmet mental health needs facing America's students, SBMH services and programs have been implemented in some schools (Paternite, 2005; Pfeiffer & Reddy, 1998; Stiffler & Dever, 2015). These programs enhance access to services for youth, reduce stigma for seeking help, increase opportunities to promote and maintain treatment gains, and enhance mental health promotion and prevention (Macklem, 2014; Paternite, 2005). The purpose of this study is to determine perceived barriers to developing successful SBMH programs.

The study is based upon two surveys. The first survey was completed by school faculty, and focused on their perceptions of the mental health needs and practices of SBMH program. The second survey was completed by the implementation team and focused on stages of implementation of the SBMH program. The results of this current research study will identify effective strategies and techniques which schools have used to overcome barriers to developing a successful SBMH program. This first chapter of the dissertation presents the background of the study, identifies the problem of the study, demonstrates the study's significance, and presents the

methodology used. The chapter will also include limitations, delimitations, and definitions of terminology used throughout the dissertation.

Background

Mental and emotional well-being is a core condition for overall health components that lead to a happy and productive life, to form healthy relationships, and successfully adjust to change and overcome difficulties (Minnesota Department of Health, 2002). Mental and emotional well-being are interconnected with social conditions such as stress, poverty, and lack of social support, as well as issues relating to physical health, genetics, and environments (Minnesota Department of Health, 2002). According to the National Alliance on Mental Health or NAMI (2014), over 43 million adults experience a mental health issue in a given year, and 10 million of those adults live with a serious mental illness. As for children, nationwide, "nearly one in five children and adolescents experience symptoms of mental health disorders and of those only 15% to 20% receive services" (Bains, 2014, p. 83). A large number of these children and adolescents will suffer from more than one mental health disorder (Wade, Johnston, Campbell, & Littlefield, 2007). The onset of common mental health disorders occurs in 50% of all cases by age 14, and 75% of all cases by age 24 (Wade et al., 2007, p. 108). "After onset in adolescence, many chronic mental health disorders carry over into adulthood, leading to ongoing significant mental health impairment during the adult years" (Evans & Seligman, 2005, p. xxv).

In Minnesota, 168,000 adults and 56,000 children live with serious mental health conditions (NAMI, 2010). Only 22% of those residents receive services from the Minnesota public mental health system. Data shows that 9% of school-age children, and 5% of preschool children have serious emotional disturbances, and nearly one in ten Minnesota children age 20 and younger have a mental health diagnosis (Minnesota Department of Health, 2013). These

statistics do not include children or adolescents who remain undiagnosed. In Minnesota, the leading cause of hospitalization for children ages 5 to 14 is a mental health disorder, and it was the second leading cause for children age 15 to 19 (Minnesota Department of Health, 2013). According to the Minnesota Department of Health (2013), studies have shown that "untreated mental health problems can turn into more serious psychosocial impairments as the child matures, placing them at risk for school failure, dropping out, and being placed in more restrictive settings" (para. Xxx).

Data strongly supports the need for early intervention initiatives and programs for youth mental health. Current research shows that mental health disorders begin early in age, and there is an average lag of 8 to 10 years between the onset of a mental health condition and the beginning of treatment (NAMI, 2015). Early mental health interventions aid in preventing behavior problems, poor physical health, and inferior school performance (Minnesota Department of Health, 2002; Yung, 2016). However, over 50% of children and adolescents with mental health problems do not receive services (Minnesota Department of Health, 2002; Yung, 2016). School-based mental health programs augment traditional school mental health services offered by school counselors, school psychologists, and nurses by linking schools to community mental health centers allowing SBMH programs to provide an array of services to youth in schools (Weist & Christodulu, 2000; Weist, Lever, Bradshaw, & Owens, 2014).

In the early part of the 20th century, nurses were placed in schools due to an awareness that children in poor health would have, and do have, difficulty learning (Flaherty, Weist, & Warner, 1996; Paternite, 2005). The general focus of these school-based health services was to ensure that children completed required immunizations, had vision and hearing screenings, and, for those children with more significant needs, were referred to outside services (Flaherty et al.,

1996; Weist et al., 2014). Due to the success of these programs, their development continued. A number of factors influenced the initiation and expansion of mental health services in schools, including legal mandates to encourage the development of SBMH. Federal policies strengthened the obligation of schools to provide appropriate educational services to children with emotional problems (Cummings, Lucas, & Druss, 2013; Flaherty et al., 1996). Another factor in the need for expansion of mental health services in schools is a very large gap which exists between children who need services and those who actually receive the appropriate mental health services (Paternite, 2005; Santor & Bagnell, 2008; Weist, 1999). "School-based mental health programs were implemented to provide an array of mental health services in both general and special education including assessment, case management, treatment, and prevention" (Weist & Christodulu, 2000, p. 195). Despite the growing number of SBMH programs, no best practice model has been identified for delivering these types of programs, and because of this, there are factors that limit the effectiveness of implementation in schools (Santor & Bagnell, 2008).

Statement of the Problem

Every day, teachers and school support staff ask for assistance in dealing with student problems as they explore ways to support their students' social and emotional development (Adelman & Taylor, 1999; Weist et al., 2014). Emotional and behavioral health issues present significant barriers to learning, academic achievement, and test scores; however, mental health interventions are effective and can significantly improve academic performance scores (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Students who have mental health issues (especially those who have not been identified) are at a higher risk for failure or dropping out of school. The same students often have excessive absences and fall behind on schoolwork, as they often disengage themselves or stop attending of school. A student

at risk is one identified as being in danger of failing to complete his or her education due to risk factors such as low achievement, behavior problems, poor attendance, limited English proficiency, and low socioeconomic status (Blount & Wells, 1992; Nunn & Parish, 1992; Sanders, Munford, & Liebenberg, 2016; Slavin & Madden, 1989). Educators are consistently being called upon to bridge the gap between students' psychological adjustment and their academic functioning (Nunn & Parish, 1992; Weist et al., 2014).

Despite the fact that schools provide invaluable services to students and families in need, and offer a unique opportunity to provide mental health support, a large number of schools do not have SBMH programs. This is partially due to the fact that no best practice model has been identified for implementing these services, and because of this, strategies for overcoming barriers to implementation are limited (Santor & Bagnell, 2008). Weist, Lever, and Stephan (2004) identified three components vital to a successful SBMH program: "partnership between schools and community agencies and programs, it is for both youth in general and special education, and it must move toward a full continuum of evidence-based prevention, promotion, early intervention, and treatment" (p. 191). Regardless of what the research shows about the effectiveness of SBMH programs, many schools continue to struggle to implement and expand such programs effectively. This research is designed to contribute toward meeting this need.

There are several barriers that arise with the implementation of school-based mental program (Hicks-Hoste, 2015; Nabors, Weist, Tashman, & Myers, 1998; Reinke, Stormont, Herman, Puri, & Goel, 2011; Weist, Nabors, Myers, & Armbruster, 2000). The most significant barriers as identified through the literature include:

1. developing programs so they mesh with the programs that already exist within the school system;

2. ensuring relevant shareholders are involved on a continuing basis;
3. developing long term and stable funding;
4. identifying systems of quality assurance and evaluation;
5. identifying stigmas related to mental health support; and
6. determining ways to analyze issues and improving programs to better address problems such as family involvement, concerns about confidentiality, privacy, and after school and summer programing

Research Questions

The purpose of this study was to determine perceived barriers to developing successful SBMH programs. This research identified attributes that school personnel perceive as having contributed to their success in developing SBMH programs. Given the complexities, variations, and SBMH program policies, programs and initiatives, this study was limited to 3 similarly sized middle schools in the Minnesota metropolitan area, and identification of SBMH programs in place at those schools. Quantitative measures were used to identify schools with such programs, and to determine the school personnel's perceptions of key components and practices of developing a successful SBMH program.

To contribute to the literature on this broad topic of SBMH, the following research questions were used to address the collected and analyzed data:

RQ1. What types of student mental health issues are faculty dealing with? Do these issues differ among schools?

RQ2. What student mental health services are perceived to be helpful to students? How are these perceptions different among schools?

RQ3. What are faculty perceptions of the roles and responsibilities of different stakeholders within the SBMH program?

How are these perceptions different among schools?

RQ4. What are the perceived barriers to implementing an SBMH program?

How are these perceptions different among schools?

RQ5. What are the perceived benefits to implementing an SBMH program?

How are these perceptions different among schools?

RQ6. What are the perceived barriers or risks to be communicated at each stage of implementation?

How are these perceptions different among schools?

Significance to the Field

Nationwide "nearly one in five children and adolescents experiences symptoms of mental health disorders and of those only fifteen to twenty percent receive services" (Bains, 2014, p. 83). A large number of these children and adolescents will suffer from more than one mental health disorder (Wade et al., 2007). The onset of common mental health disorders occurs in 50% of all cases by age 14, and 75% of all cases by age 24 (Wade et al., 2007). The data strongly supports the need for early intervention initiatives and programs for youth mental health services.

Currently research shows that mental health disorders strike early in age, and that there is an average lag of 8 to 10 years between onset of a mental health condition and the start of treatment (NAMI, 2015). Teachers work with students who suffer from significant mental health issues on a daily basis. Those students who suffer from disruptive mood, impulse-control, and conduct disorders have difficulties controlling their emotions and behaviors (American Psychiatric Association, 2013). Students who suffer from these types of mental illness have problems with self-regulation, and these problems manifest in behaviors that violate the rights of others (for example, aggression, destruction of property), and/or bring the student into significant conflict with authority figures (American Psychiatric Association, 2013). Students with

behavioral disorders often experience frequent conflicts with parents, teachers, and peers resulting in impairments in such student's emotional, social, and academic adjustment (American Psychiatric Association, 2013).

These students have dropped out of school, have become incarcerated, have committed suicide, and have been labeled negatively by their communities, among other things. Many of these outcomes could potentially have been avoided if appropriate mental health services were provided to them. Early mental health interventions and universal screenings help prevent behavior problems and poor school performance later in life (Minnesota Department of Health, 2002; Stiffler & Dever, 2015). School-based mental health programs can provide a place to identify student's mental health needs, reduce stigma for seeking help, reduce the wait to see a mental health professional, and provide the prevention, intervention, and treatment plans for students who need the support (Paternite, 2005).

Researchers cite the urgency of developing, implementing, and maintaining SBMH programs (Adelman & Taylor, 1998; Weist et al., 2014). This research will add to the literature of what school personnel perceive to be contributing factors to overcoming barriers to developing a successful SBMH program, one which will meet the mental health needs of students, which, in turn, will increase student achievement, attendance, and overall behaviors. Until now, there has been limited empirical data on what school districts have accomplished to develop successful programs; this research will contribute to the current limited body of research. In addition, mental health professionals and educational leaders may benefit from the research. The data could be used to better inform practitioners and educators of what components contribute to overcoming barriers to developing successful SBMH programs and how they can implement them.

The study has potential significance for future studies, which could focus on meeting students' emotional and academic needs. The study focused on a small, exploratory sample that could be replicated on a larger scale or in other school districts. Identifying what it takes to develop a successful SBMH program can influence policy, as lawmakers and school boards use the information to ensure that all students' mental health needs are met.

Methodology

This research focused on a comparative analysis of perceived barriers to developing a successful SBMH program. "Several well-known SBMH models have been developed across the country through the advocacy efforts of local school systems and community mental health agencies" (Baker, 2013, p. 1). "Baltimore City Schools have a comprehensive mental health model with services such as individual, family and group therapy, consultation, and assessment services; which take place in each building through a partnership with community mental health providers" (Baker, 2013, p. 2) Charlotte-Mecklenburg provides services to 24 of their public elementary schools, and Salt Lake City Public Schools developed a treatment program within their schools to integrate services within the school setting (Baker, 2013). Similarly, Des Moines Municipal School in New Mexico has developed its own school-based health and wellness center in collaboration with their local hospital (ASCD, 2011). These schools serve as models that demonstrate SBMH programs can be successfully implemented. Through the research two or more schools were compared in terms of perceived barriers to developing a successful SBMH program. Data for this research study was collected through two unique surveys which gathered opinions and perceptions of faculty and administration.

Limitations/Delimitations

This research study does include limitations and delimitations. One limitation of the survey is the accuracy and reliability of the surveys. The validity of the data was dependent on the honesty and openness of the research participants. The research was conducted on a small sample of Minnesota metropolitan schools. The study did not include input from other areas of Minnesota, or from other geographic areas of the nation. The demographics in this area do not represent that of the entire state of Minnesota or that of the entire nation. All responses were gathered from school personnel during the school year, and were furthermore limited to the fact that participant responses were voluntary. This may have limited the number of participants and responses gathered. This survey was a voluntary online survey with no incentives. This could be an identified limitation for those not interested in SBMH programs, or not having time to partake in surveys. The response rate to the *Implementation Stage* survey was a limitation to the research. One school district did not respond to that survey, and overall there were limited responses to this survey, constraining the reliability of the results.

Definition of Terms

American Psychological Association (APA): the leading scientific and professional organization that represents psychology in the United States (APA, 2017).

Anxiety: a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities (American Psychiatric Association, 2013).

Assessment: the action or an instance of making a judgment about something (Merriam-Webster.com, 2018).

At-Risk: one who is identified as being in danger of failing to complete his or her education with an adequate level of skills due to risk factors such as low achievement, behavior problems, poor attendance, limited English proficiency, & low socioeconomic status (Slavin & Madden, 1989; Nunn & Parish, 1992; Blount & Wells, 1992; Bulger & Watson, 2006; Sanders, Munford, & Liebenberg, 2016).

Conduct Disorder: a repetitive or persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated (American Psychiatric Association, 2013).

Coping Skills: are methods a person uses to deal with stressful situations (American Psychiatric Association, 2013).

Depression: a brain disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life (American Psychiatric Association, 2013).

Disruptive Mood Disorder: chronic, severe persistent irritability (American Psychiatric Association, 2013).

Implementation: the process of putting a decision or plan into effect

Impulse Control Disorder: an inability to control one's self (American Psychiatric Association, 2013).

Limited English Proficiency: a person who is not fluent in the English language

Mental Disorder: is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental function (American Psychiatric Association, 2013).

Mental Health: includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices (National Alliance on Mental Health, 2015).

Metropolitan Statistical Area: consists of one or more counties that contain a city of 50,000 or. more inhabitants (U.S. Census Bureau, 2016).

Minority: the smaller in number of two or more groups constituting a whole (Merriam-Webster.com, 2018).

National Alliance of Mental Health (NAMI): the nation's largest mental health organization that focuses on supporting families affected by mental illness (NAMI, 2017).

Onset: the beginning (Merriam-Webster.com, 2018).

Oppositional Defiant Disorder: a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness (American Psychiatric Association, 2013).

Oppression: unjust or cruel exercise of authority or power (Merriam-Webster.com, 2018).

Prevention: to keep from happening or existing (Merriam-Webster.com, 2018).

Resilience: the ability to recover from or adjust easily to misfortune or change (Merriam-Webster.com, 2018).

School-Based Mental Health (SBMH): school-based mental health programs refer to the close partnerships between schools, families, and community agencies to develop a full array of effective mental health promotion and intervention to youth in both general and special education (Weist & Christodulu, 2000).

Screening: the evaluation or investigation of something as a part of a methodical survey or to assess suitability (Merriam-Webster.com, 2018).

Special Education Student: a student with a disability who needs specialized instruction

Treatment: to act upon with some agent, especially to improve or alter (Merriam-Webster.com, 2018).

Stigma: a mark of shame or discredit (Merriam-Webster.com, 2018).

Chapter One Summary

This chapter outlined the current state of childhood mental health within school settings and opportunities for expansion of those services. Further, this chapter discussed the challenges and opportunities that exist within mental health servicing for children and adolescents. School based mental health programs were identified as a significant component directly affecting a child's mental well-being. The benefits and challenges for such programs were also identified. Following is chapter two, the literature review, which will examine SBMH programs from both a literary and historic perspective.

CHAPTER TWO: REVIEW OF THE LITERATURE

Literature Review

This review of literature presents an overview of current literature, which demonstrates the mental health needs of children and adolescents in the United States. This review is organized to focus on SBMH programs as a means to meet the mental health needs of children and youth in the United States, as well as SBMH models as identified through the research. The research will focus on barriers of SBMH programs, and provide examples of schools where such programs have been successful. Finally, this literature review provides research on the implementation of evidence-based practices.

Child and Adolescent Mental Health

Mental and emotional well-being are core conditions for overall health, leading leads to a happy and productive life, to formation of healthy relationships, and to successful adjustment to change, and an ability to overcome difficulties (Burton et al., 2014; Minnesota Department of Health, 2002). Mental and emotional well-being are interconnected with social conditions such as stress, poverty, and lack of social support, as well as related to physical health, genetics, and environments (Farahmand, Grant, Polo, & Duffy, 2011; Minnesota Department of Health, 2002).

As schools begin to address barriers to learning as a way of increasing academic success, addressing unmet mental health needs of youngsters is a significant area of focus. A school's main priority is to educate children; however, schools are no longer able to push social-emotional, behavioral, and mental health needs aside, as these are behaviors identified as impeding academic performance (Adelman & Taylor, 2006). Fostering the social and emotional health in children is a critical element in healthy child and adolescent development. A mental health disorder defined "is a syndrome characterized by clinically significant disturbance in an

individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association, 2013, p. 20).

To fully understand the issue of the mental health needs of children and adolescents, it is important to recognize the breadth and depth of issues these youngsters are dealing with at a staggering rate. Half of lifetime mental health problems begin to emerge by age 14, and 75% emerge by the mid-20s (Burton et al., 2014; NAMI, 2015). [Ten percent] 10% of 5-15 year olds have a diagnosable mental health disorder, suggesting that approximately 1.1 million children and adolescents under the age of 18 would benefit from specialized services (Burton et al., 2014). It has been estimated that approximately 20% of students in the U. S. have a mental health condition which interferes with their academic functioning (Powers, Edwards, Blackman, & Wegmann, 2013). Nearly one in five children and adolescent youth live with a mental health condition (NAMI, 2015). Despite these numbers, only about 16% of those children's conditions will be identified and will they receive treatment for their mental health issues (Burton et al., 2014; Rones & Hoadwood, 2000; Yung, 2016).

The National Alliance on Mental Illness (NAMI) is the nation's largest mental health organization which focuses on supporting families affected by mental illness (NAMI, 2017). NAMI leads the nation in providing educational programs that ensure hundreds of thousands of families, individuals, and educators receive the support and information they need (NAMI, 2017). NAMI provides a helpline, which allows them to personally respond to requests and provide free referrals, information, and support, as well as serving as an advocate to help shape public policy for those with mental illness and their families, while providing volunteer leaders

with the tools, resources, and skill to support mental health in all states (NAMI, 2017). Through their resources, educators are able to learn, support, and help the students they serve.

The American Psychological Association (APA) is the leading scientific and professional organization that represents psychology in the United States (APA, 2017). The focus of APA is to advance the creation, communication, and application of psychological knowledge to improve people's lives (APA, 2017). The APA also provides a wide variety of resources for teachers and psychologists to support the needs learners in their schools. The APA is not to be confused with the American Psychiatric Association, which is an organization

> of psychiatrists working together to ensure humane care and effective treatment for all persons with mental illness, including substance use disorders. It is the voice and conscience of modern psychiatry. Its vision is a society that has available, accessible quality psychiatric diagnosis and treatment (American Psychiatric Association, 2013, para. 1).

Mental health disorders that occur at the highest rates in grades K-12 schools include: depression, anxiety, attention deficit disorder, oppositional defiant disorder, and conduct disorder (Perfect & Morris, 2011). Depression occurs in nearly 5% of children and 8% of adolescents, with 14% to 20% of those youth receiving depression-related diagnoses in their lifetimes (Perfect & Morris, 2011). Depression is defined as a brain disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life (American Psychiatric Association, 2013). Anxiety-related disorders affect up to 18% of children, and nearly 13% of adolescents (Perfect & Morris, 2011). Anxiety is defined as a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities (American Psychiatric Association, 2013). Approximately 13% of youth have a conduct disorder, defined as a pattern of behavior in which the basic rights of others, or major age-appropriate societal norms or rules, are violated (American Psychiatric

Association, 2013; Perfect & Morris, 2011). Oppositional defiant disorder affects up to 13% of youth, while attention deficit disorder affects 12% (Perfect & Morris, 2011). Oppositional defiant disorder is defined as a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness, while attention deficit disorder is defined as a persistent pattern of inattention and/or hyperactive-impulsivity that interferes with functioning or development (American Psychiatric Association, 2013).

Many mental health concerns manifest in students through academic concerns, attendance issues, poor social skills, and behavior problems (Powers et al., 2013). With so few students receiving services versus those who need services, it reveals a deficit in the processes for identifying and providing support to students with mental health needs which can lead to youngsters eventually having poor employment outcomes, overall physical health problems, inadequate coping skills, and an increased likelihood of involvement in the criminal justice system (Bear, Finer, Guo, & Lau, 2014; Yung, 2016).

Currently, research shows that mental health disorders strikes early in age and there is an average lag of 8 to 10 years between the onset of a mental health condition and the start of treatment (NAMI, 2015). Early mental health interventions help prevent behavior problems and poor school performance later (Burton et al., 2014; Minnesota Department of Health, 2002). Mental health promotion strategies give children and adolescents an opportunity to strengthen their well-being and increase their ability to stay mentally healthy and able to cope with difficulties that they may face (Burton et al., 2014).

Early Identification Through Screening

There is a growing body of research that supports the need for early intervention and screening for students with mental health needs (Levitt, Saka, Romanelli, & Hoagwood, 2007;

NAMI, 2014). Early identification leads to increased early intervention and a disruption in the mental health issue (NAMI, 2014). Mental health experts believe that it is critical to assess children for mental health problems as a proactive means of identifying youth at risk (Nemeroff et al., 2008). Thus, the early identification of mental health problems through screening and assessment can be considered a form of prevention (Levitt et al., 2007). Schools offer the greatest potential for early identification programs because they work with children on a daily basis, which puts them in a position to screen and assess large numbers of children (Nemeroff et al., 2008). The goal of these screenings is to identify youth who have risk factors for mental health problems; once identified, second and third assessments would be given to assess risk more thoroughly, the presence of a disorder, and for treatment need (Adelman & Taylor, 2006; Levitt et al., 2007). Due to the practical concerns surrounding universal screening approaches, it may be beneficial for some schools to consider alternative approaches to early mental health identification. Programs that utilize teacher or school based mental health professionals to select students who may have an elevated risk for mental health issues may be a more feasible approach (Levitt et al., 2007). Training teachers and other staff to identify mental health risks and involving them in the early identification process may be more sustainable for schools over time (Levitt et al., 2007).

School-Based Mental Health (SBMH) Programs

In the early part of the 20th century, nurses were placed in schools due to the realization that children in poor health would have, and do have, difficulties learning (Flaherty et al., 1996; Paternite, 2005). The general focus of these school-based health services was to ensure that children complete immunizations, vision and hearing screenings, and to refer children with more significant needs to outside services (Flaherty et al., 1996; Weist et al., 2014). Due to the

success of these programs, their development continued, and SBMH programs were established. School-based mental health programs augment traditional school mental health services offered by school counselors, school psychologists, and nurses by linking schools to community mental health centers, which allows them to provide an array of mental health services to youth in schools (Weist & Christodulu, 2000; Weist et al., 2014).

In addition, several factors influenced the initiation and expansion of mental health services in schools, including legal mandates to encourage the development of SBMH. Federal policies strengthened the obligation of schools to provide appropriate educational services to children with emotional problems (Cummings et al., 2013; Flaherty et al., 1996). Another factor in the expansion of mental health services in schools is consideration of the large gap between children who need services and those who actually receive the appropriate mental health services (Paternite, 2005; Santor & Bagnell, 2008; Weist, 1999). "School-based mental health programs were implemented to provide an array of mental health services in both general and special education including assessment, case management, treatment, and prevention" (Weist & Christodulu, 2000, p. 195).

School-based mental health programs strengthen young people and their environments through collaboration with schools and community experts (Massey et al., 2005; Weist et al., 2014). These programs provide a range of services in schools that help address the issue that most youth in need of mental health care do not receive it and assists schools in moving a community toward a system of care (Weist & Albus, 2004). Due to the amount of time youth spend in schools, they become the most universal, natural setting to implement services for children. The primary goal of school mental health programs is to facilitate school success by

eliminating or reducing conditions of stress that serve as barriers (Weist, Goldstein, Morris, & Bryant, 2003b; Weist et al., 2014).

Weist et al. (2003b); Paternite, 2005; Weist et al. (2014) identified the importance of SBMH programs having core elements within the program to support its success. These elements include:

1. A full continuum of mental health interventions
2. Offered to both youth in special education and general education
3. Complements the work of school hired mental health supports
4. Is a partnership between schools and community agencies

Weist et al. (2000) and Paternite (2005) have identified quality assurance indicators that reflect program quality; when these are in place, the probability of enhanced effectiveness is increased. These indicators include:

1. Experience, training, and supervisions of staff,
2. Productivity of clinicians,
3. Percentage of youth actually seen by the therapists,
4. Participation of therapists in school wide committees, teams, and overall involvement,
5. The ongoing and significant involvement of stakeholders, specifically families, in the program

History of School-Based Mental Health Programs

Several pieces of legislation have helped improve mental health service delivery to children in schools. The *Education for All Handicapped Children Act* of 1975 is the original legislation that required all schools to open their doors to all children with disabilities

(Commonwealth of Virginia, 2010). This act has been re-authorized frequently with the most notable re-authorizations occurring in 2007 and 2004 in which services and protections were expanded (Commonwealth of Virginia, 2010). One added provision was that any student with a disability could obtain mental health counseling to assist with his or her disability (Commonwealth of Virginia, 2010). Section 504 of the Rehabilitation Act of 1973 guarantees accommodations to ensure access to major life activities for those with a disability or those suffering from effects of a disability (Commonwealth of Virginia, 2010). The 2002 re-authorization of the Elementary and Secondary Education Act of 1965, known as *No Child Left Behind*, allowed schools to expand services to address mental health needs of children not requiring special services (Commonwealth of Virginia, 2010). In 2005, the report on School Mental Health Services in the United States, 2002-2003 provided some of the nation's first baseline data regarding mental health services in schools (Commonwealth of Virginia, 2010). These events were catalysts for further events and funding in the United States.

Funding

Developing and sustaining funding streams to support the delivery of school mental health programs is an obstacle at local, state, and national levels (Cammack, Evangelista-Brandt, Slade, Lever, & Stephan, 2014). To meet the needs of all youth, it is critical to identify funding in natural settings, such as schools (Cammack et al., 2014). Financial support for SBMH programs has not increased at the rate that is consistent with the need for the services; often these programs are faced with challenges due to persistent budgetary deficits at the local, state, and national level (Cammack et al., 2014).

Federal funding is one source that can be utilized by schools; however; state and federal funding are traditionally designed to pay for treatment services and are not intended to fund

mental health prevention (Cammack et al., 2014). SBMH programs are commonly supported through grant dollars, which require ongoing advocacy and maintenance, and can be allocated in four ways: through block grants, project grants, legislative earmarks, and direct payments (Cammack et al., 2014). Almost half of all public school revenues come from state sources, and some states include SBMH programming in their budgets (Cammack et al., 2014).

States have different initiatives from which to fund their SBMH programs. In some states, programming operates as an extension of Medicaid, with higher income limits for eligibility, which increases those who can access services (Cammack et al., 2014). Certain states can apply for waivers to customize their programs and other states have initiated a grant program to expand the funding stream (Cammack et al., 2014).

To combat difficulties associated with securing funds, many schools seek funding from multiple funding streams; this allows schools to receive adequate funding and supplement the costs associated with providing mental health services (Cammack et al., 2014). There are two common strategies used to combine multiple funding streams. Braided funding involves coordinating multiple funding streams that originally were separate (Cammack et al., 2014). Blended funding combines funds from multiple streams into one (Cammack et al., 2014). In order for schools to fully determine funding options, it is vital that a comprehensive evaluation of existing funding options at the national, state, local levels, as well as, contracts, fee for service payments, and interagency agreements are identified, which can result in the identification of funding streams that were not previously determined (Cammack et al., 2014).

School-Based Mental Health Models

Satcher (2004) has acknowledged a model with a variety of services that are provided to students in a tiered structure. The first tier is systems of prevention, which focuses on

preventative mental health practices, and targets all students in all school settings through programs that focus on decreasing risk factors and building resilience (Satcher, 2004). The second tier is systems of early intervention and consists of targeted services designed to assist students who have one or more identified mental health need, but function well enough to engage successfully in most social, academic, and other daily activities (Satcher, 2004). Services in this tier are provided in a small group setting. Tier three services are identified as systems of care and target the smallest population of students who have severe mental health diagnosis and symptoms (Satcher, 2004). According to Satcher (2004), prevention strategies should include: (1) multiple opportunities for students to build coping and resilience skills, (2) behavior and discipline plans, (3) mental health curriculum. School staff training should focus on building a supportive school environment, behavior management techniques, and how to recognize mental health problems (Satcher, 2004). This model allows schools to develop a collaborative model with other social agencies, public health departments, and providers of community based services (Satcher, 2004).

Rossen and Cowan, (2015) have identified a multi-tiered system of support as a continuum of providing mental health support in schools. Tier one focuses on universal wellness promotion and primary prevention (Rossen & Cowan, 2015). The goal of this tier is to promote resilience, positive behavior, safety, and develop a supportive school environment where all students are valued, connected, and respected, while identifying students who may be at risk for or are experiencing mental health issues (Rossen & Cowan, 2015). Tier two focuses on targeted prevention and intervention (Rossen & Cowan, 2015). This tier targets specific problems at the school level and groups a subset of students who are all experiencing the same difficulty for a targeted intervention such as small group social skills or anger management counseling sessions

(Rossen & Cowan, 2015). The third tier focuses on individual interventions and provides direct student level mental health services, including counseling and other therapeutic interventions (Rossen & Cowan, 2015). At this level, schools coordinate with community agencies and clinicians who provide these time intensive, clinical services (Rossen & Cowan, 2015). All three levels provide their own important functions of meeting the diverse needs of students that can be offered simultaneously within the school (Rossen & Cowan, 2015).

Kutash, Duchnowski, and Lynn, (2006) have identified a model, Interconnected Systems, which is comprised of a continuum of services that aim to balance efforts at mental health promotion, prevention, early identification, and intervention. The first level of service is systems of prevention. Services at this level are implemented through universal interventions that are given to all students that are low cost and can include things such as character education programs and drug and alcohol education (Kutash et al., 2006). The second level of service focuses on those students who are at risk and have a moderate need for targeted services, which can include assistance such as dropout prevention programs, work experience programs, and pregnancy prevention programs (Kutash et al., 2006). The third level of service focuses on the systems of care. In this level, students are high risk and have severe and long-standing needs, requiring intensive treatment (Kutash et al., 2006). Students within this level receive wraparound services tailored to the strengths and needs of the youth and his or her family, and include therapy services (Kutash et al., 2006). This approach allows schools and communities to meet the mental health needs of children and adolescents (Kutash et al., 2006).

Barriers to the Implementation of School-Based Mental Health Programs

Stigma has been identified as the leading barrier as it related to SBMH. Stigmatization plays a role in whether individuals initiate and adhere to treatment (Evans, Foa, & Gur, 2005).

Stigma is a barrier to treatment due to the fear of being labelled negatively, as well as the perception that stigma exists within the mental health sector (Bowers, Manion, Papadopoulos, & Gauvreau, 2013). If a family has a negative perception towards mental health in the family, then young people tend to feel more shame towards their illness; within school's youth are more concerned with the actions of teachers and students (Bowers, et al., 2013). Despite what the research shows about SBMH programs, many schools continue to struggle to implement expanded SBMH programs effectively. Ideas to eliminate or reduce this have been provided, but research on what schools specifically have done to overcome these challenges or barriers is extremely limited.

There are multiple challenges that impede the implementation and sustainment of SBMH programs. The most significant barriers as identified include: developing programs, finding relevant stakeholders, determining funding, identifying stigmas, and identifying ways to analyze and improve the program (Nabors et al., 1998; Weist et al., 2000; Reinke et al., 2011; Hicks-Hoste, 2015).

Sustaining SBMH programs can be difficult due to unclear curriculum, ineffective delivery, lack of administrative support, inadequate staffing, and lack of feedback or evaluation processes (Horner, Sugai, Lewis-Palmer, & Todd, 2001; Massey et al., 2005). Barriers to the referral process can include poor knowledge of the services, difficulty paying for the services, transportation, limited capacity of the impact of services, and stigma (Massey et al., 2005; Weist, 1999). Even though schools provide invaluable access to students and families in need, and offer a unique opportunity to provide mental health support, many schools do not have SBMH programs. This is partially due to the fact that no best practice model has been identified for

implementing these services, and because of this, strategies for overcoming barriers to implementation are limited (Santor & Bagnell, 2008).

Cultural Barriers to Accessing Mental Health Resources

Schools have an important role to play in the elimination of mental health care disparities as they can offer better access for families (Clauss-Ehlers, Serpell, & Weist, 2013). Many non-white families underutilize mental health services and seek therapy only when problems have become severe (Bains, 2014; Griner & Smith, 2006). Cultural values of non-white individuals can be incongruent with traditional mental health practices, which have focused on therapeutic needs of European Americans (Griner & Smith, 2006). Within the Asian, Hispanic, and African American cultures, it is believed that a mental illness can be treated or overcome through willpower and avoidance of morbid thoughts, rather than seeking professional help (Leong & Kalibatseva, 2011). African Americans are less likely to seek services if they perceive that their family and peers will stigmatize their use of mental health services, which is a result of years of oppression and discriminatory practices that have affected their faith in the healthcare system (Bains, 2014).

Therapists use of traditional European American values and an unfamiliarity for other cultures has not helped foster the trust in mental health services for non-white clients (Griner & Smith, 2006). According to Leong and Kalibatseva (2011), there is a greater likelihood of misdiagnosis for African American clients than for Caucasian clients as a result of cultural misunderstanding and invalidity of diagnostic instruments that were standardized with Caucasian samples. To engage non-white clients, mental health professionals need to actualize multicultural competencies put forth into culturally specific and relevant interventions (Clauss-Ehlers et al., 2013). Access is another barrier to receiving mental health services. Mental health

services may be unaffordable for individuals with a low socioeconomic status (Leong & Kalibatseva, 2011). Minority youth and families are less likely to have access to general affordable health care (Hoagwood, 2005; Leong & Kalibatseva, 2011). Finally, low English proficiency of immigrants and the scarcity of bicultural and bilingual mental health professionals can be a barrier to accessing services (Leong & Kalibatseva, 2011). Language difficulties can be especially challenging for these families who may be less likely to enter and stay with services due to lack of understanding (Leong & Kalibatseva, 2011).

Schools with School-Based Mental Health Programs

Baker identified two public school models in his 2013 article in Counseling Today. Baltimore Public Schools invited the inclusion of comprehensive mental health services such as individual, family, and group therapy, and consultation and assessment services into their building through a partnership with the Baltimore City Health Department (Baker, 2013). They have school-based health centers in 19 schools, which include services of a doctor's office at school to help students avoid health-related absences, and they can get the support they need to succeed in the classroom (Baker, 2013).

Charlotte-Mecklenburg public school system has collaborated with Behavioral Health Centers, a division of the Carolinas HealthCare System; through this cooperative process, mental health services have been provided to 24 public elementary schools (Baker, 2013). Salt Lake City Public Schools collaborated with a local behavioral health care provider to develop a treatment program that is similar to off-site day treatment programs (Baker, 2013). This program was designed to increase inclusion and supports within the school (Baker, 2013).

Further research shows Des Moines Municipal School in New Mexico collaborated with community stakeholders to develop an SBMH center in a small farming community (ASCD,

2011). The center is managed by the school district and receives guidance from the State Department of Health and Education (ASCD, 2011). Cuyahoga County School Districts in Ohio have developed a comprehensive toolkit for families, which describes their multi-tiered systems of support, and what services are available at each level (The Center for Community Solutions, 2008). This toolkit explains processes for their delivery service model, how they will implement their mental health services, and provides parent and teacher resources. Through this model, all schools within the Cuyahoga County school district have an assigned mental health provider, utilizing eight community mental health providers, while smaller districts within the county have specific schools receiving services (The Center for Community Solutions, 2008).

Implementation of Evidenced Based Practices

The process of implementing or carrying out, innovative practices influences and improves services designed to support the mental health need of children and families (Aarons, Hurlbut, & Horwitz, 2011). Many efforts to execute programs designed to improve the quality and outcomes of human services have not reached their full potential due to a variety of challenges inherent in the implementation process (Aarons et al., 2011). "Important to communities considering evidenced based practices, is an understanding of what aspects of the implementation process are necessary for program success and what resources are necessary to complete them" (Saldana, Chamberlain, Bradford, Campbell, & Landsverk, 2014, p. 177.) Reliable and valid measures of implementation components are essential in planning effective supports, assessing progress toward implementation capacity, and conducting research (Fixsen, Blasé, Naoom, & Duda, 2015).

A growing body of research and discussion has arisen around the science of dissemination and implementation of SBMH programs (Aarons et al., 2011). A review of

implementation models reveals several themes, including: (a) many models divide the process of implementation into core themes that are relevant to the current state of implementation science; (b) there are many common components, but different models emphasize specific factors as more important; and (c) a lack of evidence is not yet available to clearly understand how prioritize which variables are likely to play key roles in any given implementation context (Aarons et al., 2011). It becomes clear that the implementation model, or approach, chosen becomes a part of the way the community in which implementation occurs understands the problem and communicates (Aarons et al., 2011).

In 2014, researchers Metz and Albers proposed that wide-scale implementation of evidence-based practices requires: careful assessment and selection of the *what*, which include: (a) a stage-based approach providing adequate time and resources for planning and installation activities; (b) the co-creation of a visible infrastructure by key stakeholders including funders, policy makers, program developers, and implementing sites; (c) and the use of data to guide decision-making and foster curiosity into continuous improvement. As implementing sites consider various evidence-based models, the sites must assess goodness of fit among the model, organizational contexts, and the needs of the children and adolescence (Metz & Albers, 2014). Conducting a feasibility assessment prior to implementation helps increase the likelihood of fidelity and sustained services. Within the field of implementation science, it is a general recognition that implementation occurs in stages with critical activities and core functions installed at each stage; as implementation is a process involving multiple decisions, actions, and corrections to change the structures and conditions of the program (Metz & Albers, 2014).

Metz and Bartley (2012) and Fixsen et al. (2015), identified four functional implementation stages, which include the exploration stage, the installation stage, the initial

implementation stage, and the full implementation stage. During the exploration stage, the goal is to examine the degree to which the program meets the school's needs, and whether implementation is feasible (Fixsen et al., 2015; Metz & Bartley, 2012). Through this stage, the implementation team can take time to explore what to do, how to do it, and who will do it, assess barriers to implementation, and create a clear implementation plan (Fixsen et al., 2015; Metz & Bartley, 2012).

The installation stage occurs after the decision has been made to begin implementing a new program; there are tasks that need to be accomplished before the change in practice actually begins which includes creating the infrastructure for the program (Fixsen et al., 2015; Metz & Bartley, 2012). The initial implementation and full implementation stages begin when the program begins and when 50% of the participants are using the innovation with fidelity and good outcomes, and where the new ways are now the standard ways of work (Fixsen et al., 2015; Metz & Bartley, 2012). Metz and Bartley (2012) and Fixsen et al. (2015) identified competency drivers, organization drivers, and leadership drivers as vital components of the implementation process.

The development of an aligned and sustainable infrastructure is vital for effective implementation of evidence-based programs and this infrastructure is described through implementation drivers (Metz & Albers, 2014). The drivers include:

1. Competency drivers, which include mechanisms to develop, improve, and sustain the ability to implement the program;
2. Organization drivers, which includes developing the supports and systems interventions needed to great an environment needed to ensure that competency drivers are accessible, effective, and data is used for continuous improvement; and

3. Comprehensive leadership capacity, which includes developing strategies for maintaining and implementing an evidence informed focus on the change process and its obstacles (Metz & Albers, 2014).

The implementation drivers are the core components of building blocks of the infrastructure needed to support practice, organization, and systems change (Fixsen et al., 2015; Metz & Bartley, 2012). Competency drivers are mechanisms to develop, improve, and sustain practitioners' and supervisors' abilities to implement programs or innovations to benefit children and families (Fixsen et al., 2015; Metz & Bartley, 2012). Within the competency drivers, training, coaching, and performance assessment were identified as mechanisms to ensure competency within the program (Fixsen et al., 2015; Metz & Bartley, 2012). Organizational drivers develop the supports and systems needed to create a hospitable environment for new programs and innovations by ensuring the competency drivers are accessible and effective and that data is used for continuous improvement (Fixsen et al., 2015; Metz & Bartley, 2012). These drivers include decision support data systems, facilitative administration, and systems intervention; these drivers further ensure that the organization is ready for implementation (Fixsen et al., 2015; Metz & Bartley, 2012). Leadership drivers ensure that implementation teams are developed; these teams provide an internal support structure to move selected programs and practices through the stages of implementation (Fixsen et al., 2015; Metz & Bartley, 2012). These team focuses on:

1. Increasing buy-in and readiness,
2. Installing and sustaining the implementation infrastructure,
3. Assessing fidelity outcomes,
4. Building linkages with external systems, and

5. Problem-solving and sustainability.

This aspect of the drivers ensures that there are leaders in place to continue moving the program forward (Fixsen et al., 2015; Metz & Bartley, 2012).

Numerous efforts to implement programs designed to improve quality and outcomes of human services have not reached their full potential due to a variety of challenges inherent within the implementation process, which led Aarons et al. (2011) to review multiple models of implementation. This review led to the discovery of several core themes. First, many models divide the process into several phases with an understanding that implementation may not move linearly through the phases (Aarons et al., 2011). Secondly, there are many common components across implementation models, but each different model emphasizes a specific factor above others (Aarons et al., 2011). Finally, a relative lack of evidence is available to understand how to prioritize which variables play a more prominent role in any given implementation effort (Aarons et al., 2011).

Aarons named four implementation stages et al. (2011) as vital components of the implementation process: exploration, adoption/preparation, implementation, and sustainment. Within the exploration stage an awareness of either an issue that needs attention or of an improved approach to an organizational challenge; the adoption/preparation stage is where a decision on what program will be implemented is made as well as determining what preparation needs to occur before implementation; the implementation stage is where the new evidence-based program is implemented through a large and smaller systems approach; and the sustainment stage is where identification and implementation of supports for long term sustainment occurs (Aarons et al., 2011).

Leading Change

According to Kotter (2012), 70% of all major change efforts in organizations fail. This is because organizations often do not take a comprehensive approach necessary to see the change through to completion. Kotter (2012) has identified 8 reasons that organizations fail to implement change which include:

1. Not establishing a great enough sense of urgency,
2. Not creating a powerful enough guiding coalition,
3. Lacking a vision,
4. Under communicating the vision by a factor of ten,
5. Not removing obstacles to the new vision,
6. Not systematically planning for and creating short term wins,
7. Sustain acceleration, and
8. Not anchoring changes in the organization's culture.

In a rush to plan and take action, many companies ignore the importance of creating a sense of urgency within the organization (Kotter, 2012). Kotter (2012) has determined that leaders often underestimate how difficult it is to drive people out of their comfort zones, lack the patience necessary to develop the appropriate urgency, or overestimate how successfully they have done so. It takes a significant amount of time to get the number of staff needed to create the sense of urgency to move forward change. Change often begins with one or two people, but it is important to make additions to the group to establish enough power to lead the change (Kotter, 2012). According to Kotter (2012), the right coalition of people to lead a change initiative is critical to its success and this group must have the right composition with a significant level of trust and a shared objective. Kotter (2012) has identified four qualities of an effective guiding coalition that include the following:

1. Enough key players on board so that those left out cannot block progress,
2. All relevant points of view should be represented so that informed intelligent decisions can be made,
3. The group should be seen and respected by those in organization so that the change will be taken seriously by others, and
4. The group should have enough proven leaders that are able to drive the change process.

Without a sensible vision, a transformation effort can easily dissolve into a list of confusing and incompatible ideas (Kotter, 2012). According to Kotter (2012), a clear vision simplifies detailed decisions, motivates people to take action in the right direction even when it is difficult, and coordinates the actions of people in an efficient manner. Kotter (2012), also states that the vision must provide real guidance and be focused, flexible, and easy to communicate. If you can communicate the vision and get a reaction of understanding and interest the vision is clear (Kotter, 2012). Once the clear vision has been established, the next step is communicating that vision for buy-in. According to Kotter (2012), in this stage gaining and understanding and commitment of a new direction is difficult and under communication and inconsistency typically are rampant. To avoid this the vision should be simple, vivid, repeatable, and invitational (Kotter, 2012). Leaders who transform their organizations walk the talk and seek to become a living example of the new culture that the vision aspires to (Kotter, 2012).

Kotter (2012) identifies that many times the internal structure of an organization are at odds with the change vision and realignment is necessary. By removing barriers, leaders provide for the freedom necessary for staff to work across boundaries and create real impact (Kotter, 2012). According to Kotter (2012), real transformation takes time and efforts risk losing momentum if there are no short-term goals to meet and celebrate. These short-term wins must

be visible, unambiguous, and related to the change effort; these wins reward the change agents by providing positive feedback which boosts morale and motivation (Kotter, 2012). When done well these short terms wins can increase the true sense of urgency.

According to Kotter (2012), resistance is always waiting in the wings to re-assert itself and resistors may be driven underground where they wait for an opportunity to emerge when you let up. Whenever you let up before the job is done momentum can be lost, regression will follow, and rebuilding the momentum is a daunting task (Kotter, 2012). New behaviors and practices must be driven into the culture to ensure long-term success; this can be done by launching more projects to drive the change deeper into the organization (Kotter, 2012). Kotter (2012), states that new practices must grow deep roots to remain firmly planted in the culture and becomes the way things are done. Tradition is a powerful force and change is kept in place by creating a new supportive and strong organizational culture; the majority of this culture needs to embrace and take on this new culture for a chance at success in the long term (Kotter, 2012).

Rothwell, Stavros, and Sullivan (2009) state that organizational development and change management help people in organizations identify and plan how to deal with changes that can both be intentional and unintentional within their environment. Organizational development is a process that applies a broad range of knowledge and practices to help organizations build their capacity to change and increase effectiveness (Rothwell et al., 2009). Organizational development is long range in perspective, as its focus is to bring about complex, deep, and lasting change (Rothwell et al., 2009).

Rothwell et al., (2009) also argue that organizational development works best when supported by top managers as they are the chief power brokers and change agents in any organization. Organizational development also effects change primarily through educating

people by expanding their ideas, beliefs, and behaviors so that the new approach can be applied (Rothwell et al., 2009). Through this organization-wide learning includes a change in culture and change within a whole systems management, as well as, elicit knowledge and new knowledge that can be organized and used to improve performance (Rothwell et al., 2009). Finally, organizational development emphasizes employee participation in assessing the current state and in planning for a positive future including how the implementation should proceed (Rothwell et al., 2009).

Burke (2011) identified four phases of leading change as prelaunch, launch, post launch, and sustainment. Prior to launching a change effort, it is vital that the leader takes time to reflect and take stock of what is ahead in the change process; the reflection includes self-awareness, motives, and values (Burke, 2011). A critical component in the prelaunch phase is to assess the external environment to identify forces that will impinge upon and affect the future success of the organization (Burke, 2011). Determining these forces will help define the degree of need for change, which is primary responsibility of the change leader (Burke, 2011).

The first stage in the launch phase is communicating the need for change by establishing the gap between the current situation and where the organization needs to be (Burke, 2011). Burke (2011) states that communication can take several forms as long as it is the best fit for the culture or the new culture to be identified and strived for. This stage also addresses the resistors. Burke (2011) argues that resistors have energy and care about something and as change leaders, it is our duty to redirect that energy.

Within the post-launch stage, it is critical that the change leader stays the course through perseverance, consistency, repeating the message, and patience (Burke, 2011). Sustaining the change is the most difficult of the four phases. In this phase, there are unanticipated

consequences that arise and it is critical that the change leader see that the problem is addressed immediately and fixed (Burke, 2011). Seeking ways to recognize and reward organization members who have helped make the change facilitates momentum; when milestones are reached, celebrating these achievements can also support momentum (Burke, 2011). Living the phases and leading people through them is a formidable set of tasks and change leaders need a as much support as they can get (Burke, 2011).

Chapter Two Summary

The literature recognizes a significant need for mental health support for children and youth. School-based mental health programs, which have progressed in the services available to students, have been identified to provide these services. Furthermore, the literature reflects a variety of models that have been utilized by schools to implement their SBMH supports. With this information, the literature also continues to show us that there are many barriers to implementation and without a clear implementation structure, implementing and sustaining an SBMH program can be difficult.

CHAPTER THREE: METHODOLOGY

Methods

This study focused on the perceived barriers to developing a successful SBMH program. The study was designed to explore (1) the status of each school within the four stages of the implementation process of their SBMH program; (2) the barriers to the implementation process; and (3) staff's perception of an SBMH programs supports, benefits, and barriers.

Research Design

This is a quantitative study utilizing online surveys to examine the perceived barriers to developing a successful SBMH program. The study is based upon two surveys. Survey research provides a numeric description of opinions of a population by studying a sample of that population (Creswell, 2014). This study includes a cross-sectional sample of educators at one point in time. Through the research, 3 schools were compared in terms of their perceived barriers to developing a successful SBMH program. This is a study with a non-experimental design with no attempt at the manipulation of variables. The first survey was completed by staff and is focused on their perceptions of the mental health needs and practices of the SBMH program. The second survey was completed by the implementation team and will focus on the stages of implementation of the SBMH program.

In order to contribute to the literature on this broad topic of SBMH, the following research questions were used to collect and analyze data:

1. What types of student mental health issues are faculty dealing with?
2. Do these issues differ among schools?
3. What student mental health services are perceived to be helpful to students?
4. How are these perceptions different among schools?

5. What are faculty perceptions of the roles and responsibilities of different stakeholders within the SBMH program?
6. How are these perceptions different among schools?
7. What are the perceived barriers to implementing an SBMH program?
8. How are these perceptions different among schools?
9. What are the perceived benefits to implementing an SBMH program?
10. How are these perceptions different among schools?
11. What are the perceived barriers or risks to be communicated at each stage of implementation?
12. How are these perceptions different among schools?

Research Variables

The Dependent Variable (DV) used in this study is:

DV: Faculty perceptions based on survey responses.

The Independent Variables (IVs) used in this study include:

1. Gender: As identified on the survey.
2. Faculty Age: As identified on the survey.
3. Faculty Race: As identified on the survey.
4. Faculty status: teachers, counselors, school social workers, school psychologists or administrators.
5. Faculty years in education profession: As identified on the survey.
6. Faculty education level: As identified on the survey.
7. Faculty academic degree earned: As identified on the survey.

Participants

The participants in this study were from 3 Minnesota metropolitan suburban middle schools. The 3 middle schools range in size from 950-1,500 students. The study includes

teachers, administrators, counselors, and those who were a part of the SBMH program implementation process. All 3 of these school districts have an SBMH program in place for at least two school years. The proposed sample size is approximately 40-60 participants per school. The racial and ethnic composition of the schools vary. One school serves predominately Caucasian students, one serves predominately African American students, and one serves predominately Hispanic students. The total population of students served in the 3 schools range from 28% to 84% White, 3% to 35% African American, and 5% to 43% Hispanic (Minnesota Department of Education, 2017). The 3 schools vary in free and reduced lunch status from 16.56% to 66.99% (Minnesota Department of Education, 2017).

To protect human subjects, this researcher requested Institutional Review Board (IRB) approval, as well as approval from the local school districts in which the study took place. Informed consent was secured from all participants. All participants in the study were adults, over the age of 18. All data was kept confidential, and participant anonymity was maintained throughout the study. To ensure anonymity, all surveys were held in a secure online database until all data collection and analysis were completed. Once data collection and analysis were completed, and retainment deadlines were met, all information obtained from participants was destroyed.

Instruments

The first instrument that was used during this process consisted of a validated survey from the *Mental Health Needs and Practices in Schools Survey,* modified by Massey (2015). This survey focused on the perceptions of school staff in regard to the SBMH program in their school. A brief demographic self-report questionnaire was included in this survey. It contains

items pertaining to participants' background, education, years of teaching experience, and position.

To establish the validity for the survey instrument, Massey (2015) put together a panel of eight faculty members from throughout the district where the research was conducted. Panel members include those in positions of classroom teacher, counselor, social worker, school psychologist, and administrator. Once the panel was selected, they were asked to determine if the survey and interview questions had the correct content to address the research questions. The panel was asked to review the appropriateness of the language of each question, and to examine the organization of the survey items included in the instrument to ensure clarity. Any changes in the survey or overall structure was based on the panel's recommendations, which resulted in a uniform interview protocol (Massey, 2015). To address reliability data collected from Massey's study it was statistically analyzed through validity testing. Cronbach's alpha was used to test if the instrument was consistent in the data collection process (Massey, 2015).

The second instrument utilized was the validated survey from the National Implementation Research Network (NIRN) on the *Stages of Implementation* (Fixsen et al., 2015). The NIRN focus is to contribute to best practices and science of implementation and organization change to improve outcomes across the spectrum of human services. They do this through research and evaluation. A major goal of NIRN is to help establish a foundation for the implementation processes and practices of evidence-based programs. The beginning steps in this effort have been taken with a review of the components thought to be necessary for implementation, a review of the research literature related to those components, and a review of the current implementation practices of evidence-based programs (NIRN, 2017).

There are four sections to the *Stages of Implementation Survey*. The first section focuses on the exploration stages of implementation of an evidenced based practice. The second section focuses on the installation stages of implementation of an evidenced based practice; while the third and fourth stages focus on initial implementation and full implementation of evidenced based practices.

Data Collection and Analysis

The participants in this study were invited to complete the surveys, via google form, by an identified staff member within their school. The participants were invited to participate and have access to survey results, which can be used to create an action plan for their school building. The surveys were open for three weeks in November, so participants had time to complete them. The participants were given two reminder emails to complete the survey, and no incentives were provided.

For this study, data was collected using online surveys, each of which is relevant to the participant's role in the research topic. This researcher provided the link to the two google forms and the individual schools provided time for each individual to complete the surveys. Data collected from this study was entered in a *Statistical Package for Social Sciences* (SPSS) spreadsheet for analysis. The purpose of this analysis was to examine the perceptions of teachers, administrators, and other schools staff toward their SBMH programs, as well as perceptions of implementation of their programs.

To answer each research question, data from the two surveys were analyzed using descriptive statistics of means and standard deviations, or descriptive statistics of percentages. Ratings higher than the mean of three (out of a five-point scale) were considered as agreeable responses. The staff perceptions gathered through the survey instruments were compared using

Kruskal-Wallis test followed by a Post Hoc test (Mann Whitney U Test) to determine any significant difference among the sub-groups in the survey. The significance level was set at .05. A Kruskal-Wallis test is a rank-based test that is applied to one-way data with more than two groups (McDonald, 2014). According to McDonald (2014), the test allows the researcher to compare scores from the 3 schools. There are a few assumptions from the test that include:

1. Dependent variable should be measured at the ordinal level (Likert scale),
2. Independent variable should be two or more independent groups, and
3. Each group should have different participants.

A Mann-Whitney U test was utilized as the post hoc test. A post hoc test is one that is distribution free. A Mann-Whitney U test compares differences between two independent groups because the Kruskal Wallis test will identify if there are differences between groups, however, it will not identify which groups are different from each other (Dinno, 2015).

Limitations

This research study does include limitations and delimitations. One limitation of the survey was the accuracy and reliability of the surveys. The validity of the data was dependent on the honesty and openness of the research participants. The research was conducted within a small sample of Minnesota metropolitan schools. The study did not include input from other areas of Minnesota, or from other areas of the nation. The demographics in this area do not represent that of the entire state of Minnesota or that of the entire nation. All responses have been gathered from school personnel during the school year and were limited to the fact that responses are voluntary. This may have limited the number of participants and responses gathered. This survey was a voluntary online survey with no incentives. This could be a limitation for those who are not interested in SBMH programs or taking surveys. The response

rate to the *Implementation Stage* survey was a limitation to the research. One school district did not respond to the survey and overall there were limited responses to this survey. This has limited reliability of the results.

Chapter Three Summary

It is well documented that many youngsters have mental health needs. SBMH programs focus on providing services to these students. The questions in this study aim to focus on the perceived barriers to developing a successful SBMH program. The purpose of this chapter was to describe a method to gather data to answer each of the research questions. A quantitative method was employed for this study through the utilization of two online surveys to gather the necessary data to answer each research question.

CHAPTER FOUR: RESULTS AND FINDINGS

Findings

Emotional and behavioral health issues present significant barriers to learning, academic achievement, and test scores; however mental health interventions are effective and can significantly improve academic performance scores (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Every day, teachers and school support staff ask for assistance in dealing with student problems and they explore ways to support their student's social and emotional development (Adelman & Taylor, 1999; Weist et al., 2014). Students who have mental health issues (especially those who have not been identified) are at a higher risk for academic failure or dropping out of school. The same students often have excessive absences, fall behind on schoolwork, and often disengage themselves or drop out of school. A student who is at risk is one who is identified as being in danger of failing to complete his or her education (Blount & Wells, 1992; Nunn & Parish, 1992; Sanders et al., 2016; Slavin & Madden, 1989). Educators are consistently being called upon to bridge the gap between students' psychological adjustment and their academic performance (Nunn & Parish, 1992; Weist et al., 2014).

Despite the fact that schools provide invaluable access to students and families in need, and offer a unique opportunity to provide mental health support, a large number of schools do not have SBMH programs. This is partially due to the fact that no best practice model has yet been identified for implementing these services, and because of this, strategies for overcoming barriers to implementation are limited (Santor & Bagnell, 2008). Weist et al. (2004) have identified three components vital to a successful SBMH program: "partnership between schools and community agencies and programs, it is for both youth in general and special education, and it must move toward a full continuum of evidence-based prevention, promotion, early

intervention, and treatment" (p. 191). Despite what research informs about the effectiveness of SBMH programs, many schools continue to struggle to implement expanded SBMH programs effectively. This research was designed to contribute toward meeting this need.

The purpose of this study was to determine the perceived barriers to developing successful SBMH programs. This research identifies attributes that school personnel feel has contributed to their success in developing their SBMH programs. Given the complexities, variations, and SBMH program policies, programs, and initiatives, this study was limited to 3 similarly-sized middle schools in the Minnesota metropolitan area, and the identification of SBMH programs within those schools. Quantitative measures were used within the study to determine the school personnel's perception of key components and practices of developing a successful SBMH program.

The study was based upon two surveys. Survey research provides a numeric description of opinions of a population by studying a sample of that population (Creswell, 2014). This study includes a cross-sectional sample of educators at one point in time. Through the research, 3 schools were compared in terms of their perceived barriers to developing a successful SBMH program.

This was a study with a non-experimental design with no attempt at the manipulation of variables. The first survey, completed by school staff, focused on their perceptions of mental health needs and practices of SBMH programs. The second survey was completed by the implementation team and focused on stages of implementation of the SBMH program.

To answer each research question, data from the two surveys were analyzed by using descriptive statistics of means and standard deviations, or descriptive statistics of percentages. Ratings higher than the mean of three (out of a five-point scale) were considered as agreeable

responses. The staff perceptions gathered through the survey instruments were compared using Kruskal-Wallis test followed by a Post Hoc test (Mann Whitney U Test) to determine any significant difference among the sub-groups in the survey. The significance level was set at .05. A Kruskal-Wallis test is a rank-based test that is applied to one-way data with more than two groups (McDonald, 2014). The findings from the quantitative research regarding perceived barriers to developing a successful SBMH program are presented in this chapter. The data collected from both quantitative surveys were synthesized to provide evidence to answer the research questions.

Quantitative Research Instruments

The first instrument used during this process consisted of a validated survey from the *Mental Health Needs and Practices in Schools Survey,* modified by Massey (2015). This survey focused on perceptions of school staff in regard to SBMH programs in their schools. A brief demographic self-report questionnaire was included in this survey. It contained items pertaining to participants' background, education, years of teaching experience, and position. This survey was divided into 6 sections: Section 1 focused on the demographic data of the respondents; the following sections asked participants to select their responses from a series of rank-order questions, or to choose their role as school staff.

Demographic information was obtained from participants. From the first survey, 77.6% of the respondents were female, and 22.4% male. These data are representative of the employees in the responding school districts, and is represented in Table 1. Participants also reported demographic information related to race. Of the participants, 3.5% were African American, 1.2% were American Indian, 1.2% Asian/Pacific Islander, 2.4% Hispanic, 2.4% mixed, and 89.4% were white. These data are also representative of the employees in the responding

districts, and is represented in Table 2. Participants responded to demographic data regarding their position within the schools. Of the respondents, 50.6% were general education teachers, 17.6% were special education teachers, 1.2% were school social workers, 3.5% were school counselors, 9.4% were administrators, and 17.7% were reported as other. With the majority of staff in a school building being general education teachers, these data are representative of the employees within the responding Minnesota metropolitan area school districts.

Table 1.

Gender Demographic Profile of Research Population (N = 85)

Gender	Frequency	Percent
Female	66	77.6
Male	19	22.4
Total	85	100.0

Table 2.

Ethnicity Demographic Profile of Research Population (N = 85)

Race	Frequency	Percent
African American	3	3.5
American Indian	1	1.2
Asian/Pacific Islander	1	1.2
Hispanic	2	2.4
Mixed	2	2.4
White	76	89.4
Total	85	100.0

Table 3.

Role Demographic Profile of Research Population (N = 85)

Current Position	Frequency	Percent
General Education Teacher	43	50.6
Special Education Teacher	15	17.6
School Psychologist	0	0.0
School Social Worker	1	1.2
School Counselor	3	3.5
Administrator	8	9.4
Other	15	17.7
Total	85	100.0

Sections 2, 4, and 5 utilized a 5-point Likert scale where '5' was identified as *"Strongly Agree,"* '1' was identified as *"Strongly Disagree,"* and '3' was identified as *"Neutral."* Ratings higher than the mean of 3 (out of a 5-point scale) were considered as *agreeable* responses. These scores indicated a positive association with the proposed question or concept. Section 2 focused on indicating if respondents had experience working with students with specific mental health issues. Section 4 focused on the perceptions of participants with regard to programs or supports required to help students with mental health needs, and section 5 focused on participants' perceptions of barriers for providing mental health services in schools.

Section 3 focused on the participants' perceptions of the primary role for specific responsibilities related to SBMH programs. The response options reflected positions within the school setting. The positions are general education teacher, special education teacher, school counselor, school psychologist, school social worker, school administrator, or not a role for the school. Section 6 of the survey focused on the respondents' perceived benefits of having an SBMH program. A score of 'yes' on this section was considered *agreeable*, and a 'no' or 'not sure' was considered *not agreeable*.

The second instrument utilized was the validated survey from the *National Implementation Research Network* (NIRN) on the *Stages of Implementation* (Fixsen et al., 2015). The NIRN's focus is to contribute to best practices and science of implementation and organizational change, to improve outcomes across the spectrum of human services. They do this through research and evaluation. The second survey focused on the perceptions of school staff in regard to the stages of implementation of their SBMH program. This survey was divided into 5 stages. Section 1 focused on the demographic data of the respondents. The following sections asked participants to select their response from a series of questions and a predetermined

answer list where the respondent was prompted to select the appropriate answer form the list. Schools 2 and 3 provided responses to the stages of implementation survey while School 1 did not provide any responses. Respondents were able to provide open-ended answers to the survey questions.

The participants in this study were invited to complete the surveys, via google form, by an identified staff member within their school. The participants were invited to participate and had access to survey results, which could be used to create an action plan for their school. The surveys were open for three weeks, from October 16 to November 3, 2017 so participants had time to complete them. The participants were provided two reminder emails, with the first reminder after one week, and the second after the second week; there were no incentives given.

Demographic information was obtained from participants as well. From the first survey, 66.7% of the respondents were female, 25% male, and 8.3% preferred not to say. These data are representative of the employees in the responding school districts. This information is represented in Table 4. Participants also reported demographic information related to race. Of the participants, 8.3% were African American, 0% were American Indian, 0% Asian/Pacific Islander, 0% Hispanic, 8.3% Middle Eastern, and 83.3% were White. This also is representative of the employees in the responding districts. This information is represented in Table 2. Participants also responded to demographic data regarding their position within the school. Of the respondents, 8.3% were general education teachers, 8.3% were special education students, 0% were school social workers, 25% were school counselors, 0% were school psychologists, and 58.3% were administrators. Those outside of the classroom and in support staff or leadership positions often lead the implementation team. These data are representative of the employees on the implementation team within the responding school districts.

Table 4.

Gender Demographic Profile of Research Population (N = 12)

Gender	Frequency	Percent
Female	8	66.7
Male	3	25.0
Prefer not to say	1	8.3
Total	12	100.0

Table 5.

Ethnicity Demographic Profile of Research Population (N = 12)

Race	Frequency	Percent
African American	1	8.3
American Indian	0	0.0
Asian/Pacific Islander	0	0.0
Hispanic	0	0.0
Middle Eastern	1	8.3
White	10	83.3
Total	12	100.0

Table 6.

Role Demographic Profile of Research Population (N = 12)

Current Position	Frequency	Percent
General Education Teacher	1	8.3
Special Education Teacher	1	8.3
School Psychologist	0	0.0
School Social Worker	0	0.0
School Counselor	3	25.0
Administrator	7	58.3
Total	12	100.0

Examination of Research Questions

The rank-order questions were analyzed using the Kruskal-Wallis and Mann-Whitney U non-parametric tests. The Kruskal-Wallis test was utilized because it is a rank-based test that is applied to one-way data with more than two groups (McDonald, 2014). Kruskal-Wallis H was statistically significant at the .05 level. If a question resulted in being statistically significant, a

result is not attributable to chance. A Mann-Whitney U test was utilized as the post hoc test. A post hoc test is one that is distribution free. A Mann-Whitney U test compares differences between two independent groups, as the Kruskal-Wallis test will identify if there are differences between groups; however, it will not identify which groups are different from each other (Dinno, 2015). If a question results in being statistically significant, a result is not attributable to chance.

RQ1

What types of student mental health issues are faculty dealing with and do these issues differ among schools?

This research question focused on an analysis of the data collected from the quantitative survey, *Perspectives of a School-Based Mental Health Program,* from questions 1 through 18. The question was intended to examine participants' perceptions of the mental health needs their students are facing and to determine if these perceptions differ among the 3 schools.

In order to determine the behaviors that the participants had the most experience with, this researcher utilized descriptive statistics to determine agreement frequencies of the responses of the survey participants. Descriptive statistics were utilized to describe the basic features of the data in the study as they provide simple summaries about the data sample and the measures. These data reveal that as the agreement frequency goes up, it shows that there are a greater number of participants who have had experience working with students with mental health needs. Of the 85 participants, all had experience working with students with disruptive behaviors and peer problems. The student behavior that participants had significant experiences with were bullying (Q3, 98.8% agreement), hyperactivity/inattention (Q11, 98.8% agreement), and victim of bullying (Q18, 98.8% agreement). The participants also had experience with anxiety problems (Q2, 97.6% agreement), defiant behavior (Q4, 97.6% agreement), and

aggressive behavior (Q1, 95.3% agreement). See 'Additional Data' in Appendix 3. The values described indicate that the participants have had a significant amount of experience working with students with mental health needs.

The behaviors that school personnel are dealing with mirror what the research has shown. Mental health disorders that occur at the highest rates in K-12 schools include: depression, anxiety, attention deficit disorder, oppositional defiant disorder, and conduct disorder (Perfect & Morris, 2011). Depression occurs in nearly 5% of children and 8% of adolescents, with 14% to 20% of those youth receiving a depression related diagnosis in their lifetime (Perfect & Morris, 2011). Anxiety related disorders affect up to 18% of children and nearly 13% of adolescents (Perfect & Morris, 2011). Approximately 13% of youth have a conduct disorder, defined as a pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated (American Psychiatric Association, 2013; Perfect & Morris, 2011). Oppositional defiant disorder affects up to 13% of youth while attention deficit disorder affects 12% (Perfect & Morris, 2011). Participants reported working with students with these mental health needs.

The Kruskal-Wallis test was used to analyze questions 3, 11, and 18 to determine if there was a statistical significance among the 3 schools. Question 2 asked participants to indicate if they have had experience working with students who bully. The analysis of question 2 showed no significance among schools [H= 3.765 (df= 2); p=.152]. Question 11 asked participants to indicate if they have had experience working with students who are hyperactive or inattentive. The analysis of question 11 showed no significance among schools [H=3.765 (df= 2); p= .152]. Question 18 asked participants to indicate if they have had experience working with students

who were a victim of bullying. The analysis of question 18 showed no significance among schools [H=3.765 (df= 2); p= .152].

Table 7.
Questions 3, 11, and 18 - Kruskal-Wallis H Test

Question	Kruskal Wallis H	P
Q3	3.765	.152
Q11	3.765	.152
Q18	.688	.709

RQ2

What student mental health services are perceived to be helpful to students and do these perceptions differ among schools?

This research question focused on an analysis of the data collected from the quantitative survey, *Perspectives of a School-Based Mental Health Program,* from questions 40 through 49. The research question was intended to examine participants' perceptions of the mental health supports their students need to cope with potential mental health issues, and to determine if these perceptions differ among the 3 schools.

In order to determine the program or supports that participants felt are needed to support students with mental health needs; descriptive statistics were utilized to determine agreement frequencies of the responses of the survey participants. Descriptive statistics were utilized to describe the basic features of the data in the study as they provide simple summaries about the data sample and the measures. The higher the agreement frequency, the higher the number of participants who felt that the support would help students with mental health needs. Participants felt that ongoing monitoring for students with mental health issues was a significant area of support (Q49, 97.6% agreement). Administrator support was also identified as a vital support for students with mental health needs (Q46, 96.5% agreement) as well as intervention programs for

children with externalizing behaviors (Q41, 96.5% agreement). Early intervention programs and bullying programs were also identified as key supports (Q42 & Q43, 95.3% agreement). See 'Additional Data' in Appendix 3.

The percentages indicate that the participants feel strongly that interventions and monitoring are vital supports for students with mental health needs. Early identification leads to increased early intervention and a disruption in the mental health issue (NAMI, 2014). Mental health experts believe that it is critical to assess children for mental health problems as a proactive means of identifying youth at risk (Nemeroff et al., 2008). Thus, the early identification of mental health problems through screening and assessment can be considered a form of prevention (Levitt et al., 2007). Schools offer the greatest potential for early identification programs because they work with children on a daily basis and are in a position to screen and assess large numbers of children (Nemeroff et al., 2008). The goal of these screenings is to identify youth who have risk factors for mental health problems; once identified second and third assessments would be given to assess risk more thoroughly, the presence of a disorder, and for treatment need (Adelman & Taylor, 2006; Levitt et al., 2007).

The Kruskal-Wallis H test was used to analyze questions 41, 42, 43, 46, and 49 to determine if there was a statistical significance among the 3 schools. Question 41 asked participants to indicate if intervention programs for children with externalizing problems are needed to help students with mental health needs. The analysis of question 41 showed no significance among schools [H= 5.475 (df= 2); p=.065]. Question 42 asked participants to indicate if bullying programs are needed to help students with mental health needs. The analysis of question 42 showed no significance among schools [H=2.548 (df= 2); p= .280]. Question 43 asked participants to indicate if early intervention programs are needed to help students with

mental health needs. The analysis of question 43 showed no significance among schools [H=2.857 (df= 2); p= .240]. Question 46 asked participants to indicate if administrator supports are needed to help students with mental health needs. The analysis of question 46 showed no significance among schools [H= 5.170 (df= 2); p= .075]. Question 49 asked participants to indicate if ongoing monitoring for students with mental health issues are needed to help students with mental health needs. The analysis of question 49 showed a statistically significant difference with a mean rank of 42.00 for School 1, 42.00 for School 2, and 36.94 for School 3 [H= 8.228 (df= 2); p= .016].

Table 8.
Questions 41, 42, 43, 46, and 49 - Kruskal- Wallis H Test

Question	Kruskal Wallis H	P
Q41	5.475	.065
Q42	2.548	.280
Q43	2.857	.240
Q46	5.170	.075
*Q49	8.228	.016

*Statistically Significant

A Mann-Whitney U test was utilized as the post hoc test. The analysis between Schools 1 and 2 showed no statistical significance [Mann-Whitney U= 408.000; p= 1.000], and the analysis between Schools 1 and 3 showed no statistical significance [Mann-Whitney U= 119.000; p= .139]. The analysis between Schools 2 and 3 showed a statistical significance [Mann-Whitney U= 336.000; p= .014]. See 'Additional Data' in Appendix 3. Table 19.

Table 9.
Question 49 - Mann Whitney U Test

Question	School Comparison	Mann Whitney U	P
Q49	1-2	408.000	1.000
Q49	1-3	119.000	.139
Q49	2-3	336.000	.014

RQ3

What are faculty perceptions of the roles and responsibilities of different stakeholders within the SBMH program and do these perceptions differ among schools?

This research question focused on an analysis of the data collected from the quantitative survey, Perspectives of a School-Based Mental Health Program, from questions 19 through 39. The question was intended to examine participant's perceptions of the roles and responsibilities of key stakeholders within the SBMH program and to determine if these perceptions differ among the 3 schools.

In order to determine the most frequent behaviors the participants had experience with; descriptive statistics were utilized to determine responses of the survey participants. Descriptive statistics were utilized to describe the basic features of the data in the study as they provide simple summaries about the data sample and the measures. The higher the percentage reported, the higher the number of participants who feel that the defined role is the responsibility of that stakeholder. Participants responded that screening for mental health problems is the role of the school psychologist (54.1%) or the school counselor (23.5%). 8.2% felt it was the role of the general education teacher, 7.1% perceived it was not a role for the school, 4.7% thought it was the role of the school social worker, and only 2.4% thought it was the role of the special education teacher. The participants responded that monitoring student progress was primarily the role of the general education teacher 67.1% and 16.2% identified it as a role of the special education teacher. A few of the participants, 10.6% identified the school counselor as the one who takes on this role and a small amount, 3.5% think it is the school psychologist's role. Only 1.2% felt it was the role of the school administrator while another 1.2% felt it was the role of the school social worker.

Staff development training was identified by participants as the role of the school administrator (84.7%). The rest of the findings show that 7.1% felt it was the role of the school psychologist, 3.5% felt it was the role of the school counselor, and 2.4% felt it was the role of the general education teacher. There were 1.2% felt it was the role of the school social worker and another 1.2% felt it was the role of the special education teacher.

Assessing for emotional and behavioral problems was identified as the role of the school psychologist (64.7%) and 17.6% felt it was the role of the special education teacher. In addition, 5.9% felt it was the role of the school counselor and 4.7% felt it was not the role of the school. A small amount, 3.5% saw it as the responsibility of the school social worker, 2.4% saw it was the role of the general education teacher, and only 1.2% saw it as the role of the school administrator. Participants responded that case management is the role of the special education teacher (70.6%). Only 20% felt it was the role of the school social worker and another 5.9% saw it as the role of the school counselor. A mere 2.4% felt it was not a role for the school and only 1.2% thought it was the role of the school psychologist. Participants responded that provision for SBMH services for families is a role for the school administrators (17.6%), school counselor (16.5%), school psychologist (22.4%), and school social worker (35.3%). A small percentage, 5.9%, felt it was not a role for the school, while general and special education teachers each were identified as having this role by 1.2% of the participants.

Participants responded similarly in terms of the role of student behavior management consultation with parents with general education teacher (17.6%), school administrator (24.7%), school counselor (22.4%), and special education teacher (21.2%). Participants responded in a variety of ways in terms of referral to specialized school-based programs/services with general

education teacher (20.0%), school administrator (16.5%), school counselor (24.7%), and school social worker (15.3%). See 'Additional Data' in Appendix 3.

RQ4

What are the perceived barriers to implementing an SBMH program and do these perceptions differ among schools?

This research question focused on an analysis of the data collected from the quantitative survey, Perspectives of a School-Based Mental Health Program, from questions 50 through 61. The question was intended to examine participant's perceptions of the barriers to implementing an SBMH program and to determine if these perceptions differ among the 3 schools. In order to determine the participants perceived barriers to implementing an SBMH program; descriptive statistics were utilized to determine agreement frequencies of the responses of the survey participants. Descriptive statistics were utilized to describe the basic features of the data in the study as they provide simple summaries about the data sample and the measures. The higher the agreement frequency, the higher the number of participants who felt that it was a barrier to implementation.

Participants felt that insufficient number of mental health professionals was a barrier to the implementation of SBMH programming (Q51, 80.0% agreement). Lack of adequate training for dealing with children's mental health needs was another area participants agreed was a barrier to implementation (Q52, 87.1% agreement). Participants also felt that gaining parental cooperation and consent was a barrier (Q53, 84.7% agreement). Stigma associated with receiving mental health services was another barrier participants agreed impeding the implementation of SBMH services (Q54, 78.9% agreement). Participants felt that language and cultural barriers while working with culturally diverse students and families was a barrier to

implementation (Q55, 84.7% agreement) as well as a lack of funding for SBMH services (Q57, 87.8% agreement). See 'Additional Data' in Appendix 3.

Previous research has aligned with many of the perceived barriers identified by the survey participants. Stigma has been identified as the largest barrier as it related to SBMH. Stigmatization plays a role in whether individuals initiate and adhere to treatment (Evans et al., 2005). Research participants perceive stigma to be a barrier to providing SBMH services (Q54, 78.8% agreement). Participants also identified lack of funding as a barrier (Q57, 78.8% agreement). Developing and sustaining funding streams to support the delivery of an SBMH program is an obstacle at local, state, and national levels (Cammack et al., 2014). Many non-white families underutilize mental health services, and seek therapy only when problems have become severe (Bains, 2014; Griner & Smith, 2006). Cultural values of non-white individuals can be dissimilar to traditional European American mental health practices (Griner & Smith, 2006).

The participants' responses to the identification of barriers to implementing an SBMH program were analyzed using the Kruskal-Wallis H test on questions 50 through 61 to determine if there was a statistical significance among the 3 schools. The analysis of questions 50, 52, 53, and 56 through 61 showed no significance among schools.

Question 50 asked participants to indicate if difficulty identifying children with mental health needs was a barrier for providing mental health services in their school. Question 52 asked participants to indicate if lack of adequate training for dealing with children's mental health needs was a barrier for providing mental health services in their school. Question 53 asked participants to indicate if gaining parental cooperation and consent was a barrier for providing mental health services in their school. Question 56 asked participants to indicate if

referral options in the community were barriers for providing mental health services in their school. Question 57 asked participants to indicate if lack of funding for school-based health services was a barrier for providing mental health services in their school. Question 58 asked participants to indicate if mental health issues not being considered the role of the school were a barrier for providing mental health services in their school. Question 59 asked participants to indicate if competing priorities taking precedence over mental health services was a barrier for providing mental health services in their school. Question 60 asked participants to indicate if the belief that mental health problems do not exist was a barrier for providing mental health services in their school. Question 61 asked participants to indicate if academic demands were a barrier for providing mental health services in their school. See 'Additional Data' in Appendix 3.

Question 51 asked participants to indicate if an insufficient number of mental health professionals was a barrier for providing mental health services in their school. The analysis of question 51 showed a statistically significant difference with a mean rank of 44.74 for School 1, 36.84 for School 2, and 49.50 for School 3 [H= 8.070 (df= 2); p= .018]. Question 54 asked participants to indicate if stigma associated with receiving mental health services was a barrier for providing mental health services in their school. The analysis of question 54 showed a statistically significant difference with a mean rank of 33.32 for School 1, 44.94 for School 2, and 37.34 for School 3 [H= .828 (df= 2); p= .033]. Question 55 asked participants to indicate if language and cultural barriers with working with culturally diverse students and families was a barrier for providing mental health services in their school. The analysis of question 55 showed a statistically significant difference with a mean rank of 23.68 for School 1, 46.66 for School 2, and 42.44 for School 3 [H= 29.811 (df= 2); p= .000].

Table 10.

Questions 50-61 / Kruskal- Wallis H Test

Question	Kruskal Wallis H	P
Q50	1.751	.417
*Q51	8.070	.018
Q52	3.940	.139
Q53	2.160	.340
*Q54	6.828	.033
*Q55	29.811	.000
Q56	.477	.788
Q57	.140	.932
Q58	.244	.885
Q59	2.112	.348
Q60	1.905	.386
Q61	1.404	.496

*Means statistically significant

The Mann Whitney U test was utilized as the post hoc test. The analysis between Schools 1 and 2 of question 51 showed no statistical significance [Mann-Whitney U= 328.500; p= .119] and the analysis between Schools 1 and 3 showed no statistical significance [Mann-Whitney U= 120.000; p= .163]. The analysis between Schools 2 and 3 on question 51 was statistically significant [Mann-Whitney U= 264.000; p= .011]. The analysis between Schools 1 and 2 on question 54 was statistically significant [Mann-Whitney U= 291.000; p= .012] and the analysis between Schools 1 and 3 showed no statistical significance [Mann-Whitney U= 122.500; p= .560]. The analysis between Schools 2 and 3 on question 54 was statistically significant [Mann-Whitney U= 312.000; p= .088]. The analysis between Schools 1 and 2 on question 55 was statistically significant [Mann-Whitney U= 176.500; p= .000] and the analysis between Schools 1 and 3 was statistically significant [Mann-Whitney U= 73.000; p= .006]. The analysis between Schools 2 and 3 on question 55 showed no statistical significance [Mann-Whitney U= 344.000; p= .090]. See ‘Additional Data’ in Appendix 3.

Table 11.
Questions 51, 54, and 55 – Mann Whitney U Test

Question	School Comparison	Mann Whitney U	P
Q51	1-2	328.500	.119
Q51	1-3	120.000	.163
Q51	2-3	264.000	.011
Q54	1-2	291.000	.012
Q54	1-3	122.500	.560
Q54	2-3	312.000	.088
Q55	1-2	176.500	.000
Q55	1-3	73.000	.006
Q55	2-3	344.000	.090

RQ5

What are the perceived benefits to implementing an SBMH program and do these perceptions differ among schools?

This research question focused on an analysis of the data collected from the quantitative survey, *Perspectives of a School-Based Mental Health Program,* from questions 62 through 73. The questions examine participants' perceptions of the benefits of implementing an SBMH program and determine if these perceptions differ among the 3 schools. Descriptive statistics were utilized to determine agreement frequencies of participant responses to examine their perceived feelings on the benefits of implementing an SBMH program. Descriptive statistics were further utilized to describe the basic features of the data in the study as they provide simple summaries about the data samples and the measures. The higher the agreement frequency, the higher the number of participants who felt that the question was a benefit of implementing an SBMH program.

Participants felt that SBMH programs provide an improvement in school connectedness (Q64, 82.4% agreement) and participants felt that it improved the relationship between home and school (Q69, 83.5% agreement). Participants felt that with an on-site SBMH program that

students would be less likely to "fall through the cracks" (Q72, 85.9% agreement). Participants were asked if reducing poverty would be a benefit of implementing, an SBMH program and respondents did not feel that this would be a benefit (Q70, 23.5% agreement). School-based mental health programs augment traditional school mental health services offered by school counselors, school psychologists, and nurses by linking schools to community mental health centers, which allows them to provide an array of mental health services to youth in schools (Weist & Christodulu, 2000; Weist et al., 2014). School-based mental health programs strengthen assets in young people and their environments through collaboration with schools and community experts (Massey et al., 2005; Weist et al., 2014). These programs provide a range of services in schools that help address the issue that most youth in need of mental health care do not receive it and assists schools in moving a community toward a system of care (Weist & Albus, 2004). Due to the amount of time youth spend in schools, they become the most universal, natural setting to implement services for children. The primary goal of school mental health programs is to facilitate school success by eliminating or reducing conditions of stress that serve as barriers (Weist et al., 2003b; Weist et al., 2014).

The Kruskal-Wallis H test was used to analyze questions 64, 69, and 72 to determine if there was a statistical significance among the 3 schools. Question 64 asked participants to indicate if improvement in school connectedness was a benefit for providing on-site mental health services. The analysis of question 64 showed no significance among schools [H= 5.101 (df= 2); p=.078]. Question 69 asked participants to indicate if improving the relationship between school and home was a benefit for providing on-site mental health services. The analysis of question 69 showed no significance among schools [H= 1.028 (df= 2); p=.598]. Question 72 asked participants to indicate if students would be less likely to 'fall between the

cracks,' as a benefit for offering on-site mental health services. The analysis of question 72 showed no significance among schools [H= 1.384 (df= 2); p=.501]. See 'Additional Data' in Appendix 3.

Table 12.
Questions 64, 69, and 72 - Kruskal- Wallis H Test

Question	Kruskal Wallis H	P
Q64	5.101	.078
Q69	1.028	.598
Q72	1.384	.501

RQ6

What are the perceived barriers or risks to be communicated at each stage of implementation and do these perceptions differ among schools?

This research question focused on an analysis of data collected from the quantitative survey, *Stages of Implementation*. The question was intended to examine participants' perceptions of the barriers that need to be communicated at each of the four implementation stages, and to determine if these perceptions differ among the 3 schools. At the exploration stage, participants responded that it was important to clearly communicate. This includes clearly communicating roles and responsibilities, the sustainment and evaluation plan, and guidelines for a referral process. Other barriers identified at this stage are analyzing the data, the cost, how it works with insurance, and the stigma of receiving mental health services.

At the installation stage, participants responded that, again, communication was important. This includes communication regarding the referral process, procedures, communication among school staff and therapists, and a plan for supporting ongoing implementation and feedback. Cost, fit of therapists, insurance, fidelity of implementation, and

stigma of receiving mental health support were other areas identified in this stage as important barriers or risks that need to be communicated.

In the initial implementation stage, participants responded that it was important to have a clear data system to track and analyze data to determine success of services. Participants also agreed on the importance of clearly defining roles and communicating effectively with staff and therapists. Reliable and valid measures of implementation components were essential to planning effective implementation supports, assessing progress toward implementation capacity, and conducting research on implementation (Fixsen et al., 2015). Metz and Bartley (2012) and Fixsen et al. (2015), identified four functional implementation stages which include the exploration stage, the installation stage, the initial implementation stage, and the full implementation stage. During the exploration stage, the goal is to examine the degree to which the program meets the school's needs and whether implementation is feasible (Fixsen et al., 2015; Metz & Bartley, 2012). Through this stage, the implementation team is able to take the time to explore what to do, how to do it, and who will do it, assess barriers to implementation, and create a clear implementation plan (Fixsen et al., 2015; Metz & Bartley, 2012).

The installation stage occurs after the decision has been made to begin implementing a new program; there are tasks that need to be accomplished before the change in practice actually begins which includes creating the infrastructure for the program (Fixsen et al., 2015; Metz & Bartley, 2012). The initial implementation and full implementation stages begin when the program starts and when 50% of the participants are using the program with fidelity and good outcomes and where the new ways are now the standard ways of work (Fixsen et al., 2015; Metz & Bartley, 2012).

Follow-up. Due to a lack of response from one of the schools, a follow-up question was sent to the lead staff member on the implementation team for each school involved in the study. The follow-up question was:

What do you feel are the most significant barriers to implementing an SBMH program and why?

The 3 schools all agreed that cost and insurance can be a significant barrier for families. Although the services are provided within the school, the school does not pay for the services. The services in all 3 buildings are processed through a student's insurance, which entails a significant amount of paperwork and other activities that the families have to go through. This results in a decrease of follow-through from families. The respondents from the 3 schools also agreed that an unclear process can be a significant barrier to the success of the SBMH program. The respondents reported that it was vital that there be an understanding of mental health needs among staff. It was also reported that a clear referral process and understanding of roles was important, so there can be effective collaboration among school staff and mental health therapists.

CHAPTER FIVE: DISCUSSION AND IMPLICATIONS

Summary, Conclusions, and Recommendations

Summary

The purpose of this study was to determine the perceived barriers to developing successful SBMH programs. This research identifies attributes that school personnel feel have contributed to their success in developing their SBMH programs and barriers that have impeded implementation. Given the complexities, variations, and SBMH programs policies, programs, and initiatives, this study was limited to three similarly-sized middle schools in the Minnesota metropolitan area, and the identification of SBMH programs there. Quantitative measures were used for the identified schools in the research study who have SBMH programs. The research focused on determining the perceptions of school personnel in terms of key components and practices of developing a successful SBMH program.

The prevalence of mental health disorders in youth is increasing at an alarming rate. One in five students in America's public schools have significant mental health needs (NAMI, 2015; NIMH, 2010). Of equal concern is that the majority of these students in need of mental health services are untreated (Pfeiffer & Reddy, 1998; Yung, 2016). When these students are neglected, the cost to society is great. Students with untreated, undertreated, or ineffectively treated mental health needs experience uniformly poor outcomes, including lower grades, high retention and absenteeism rates, risk of suicide, lowered rates of employment and little success finding employment after school, and an increased likelihood of involvement in the criminal justice system (Pfeiffer & Reddy, 1998; Yung, 2016).

While the current capacity of children's mental health services remains inconsistent and insufficient, the federal and state governments have made modest progress in addressing

problems over the last two decades (Price et al., 2013). To address the many unmet mental health needs facing America's students, SBMH services and programs have been implemented in some schools (Paternite, 2005; Pfeiffer & Reddy, 1998; Stiffler & Dever, 2015). These programs enhance access to services for youth, reduce stigma for seeking help, increase opportunities to promote generalized and maintain treatment gains, and enhance mental health promotion and prevention (Macklem, 2014; Paternite, 2005). Research participants are seeing these trends within their schools. The research has identified barriers and benefits to implementing an SBMH program.

Conclusions

When analysis shows a statistical significance, it means that there is a relationship between the two variables, 2 schools being compared, which is caused by something other than random chance. When an analysis was done on Q49, it showed a statistical significance between Schools 2 and 3 [Mann-Whitney U= 336.000; p= .014]. This question focused on the need of adequate support programs to help students with mental health needs. The analysis between Schools 2 and 3 on question 51 was statistically significant [Mann-Whitney U= 264.000; p= .011]. This question focused on insufficient number of mental health professionals as a barrier to implementing an SBMH program. The analysis between Schools 1 and 2 on question 54 was statistically significant [Mann-Whitney U= 291.000; p= .012]. The analysis between Schools 2 and 3 on question 54 was statistically significant [Mann-Whitney U= 312.000; p= .088]. This question focused on the stigma associated with receiving mental health as a barrier to the implementing an SBMH program. The analysis between Schools 1 and 2 on question 55 was statistically significant [Mann-Whitney U= 176.500; p= .000] and the analysis between Schools 1 and 3 was statistically significant [Mann-Whitney U= 73.000; p= .006]. This question focused

on language and cultural barriers while working with culturally diverse students and families as a barrier to implementing an SBMH program.

When participants were asked what they felt was the most significant barriers to implementing an SBMH program and why? The 3 schools all agreed that cost and insurance can be a significant barrier for families. Although the services are provided within the school, the school does not pay for the services. This results in a decrease of follow through from families. The respondents from the 3 schools also all agreed that an unclear process can be a significant barrier to the success of the SBMH program. The respondents reported that it was vital that there was an understanding of mental health needs among staff. It was also reported that a clear referral process and understanding of roles in important so there can be effective collaboration among school staff and mental health therapists.

RQ1. What types of student mental health issues are faculty dealing with and do these issues differ among schools?

Mental health disorders that occur at the highest rates in K-12 schools include: depression, anxiety, attention deficit disorder, oppositional defiant disorder, and conduct disorder (Perfect & Morris, 2011). Overwhelmingly there was agreement by participants that aggressive (Q1, 95.3% agreement) and disruptive (Q9, 100% agreement) behaviors are present within schools. This aligns with the approximately 13% of youth who have a conduct disorder which is defined as a pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated (American Psychiatric Association, 2013; Perfect & Morris, 2011). Oppositional defiant disorder also effects up to 13% of youth (Perfect & Morris, 2011). Participants overwhelmingly agree that defiant behavior was present within school (Q4, 97.6% agreement). Depression occurs in nearly 5% of children, and 8% of adolescents, with 14% to

20% of those youth receiving a depression-related diagnosis within their lifetimes (Perfect & Morris, 2011). Participants had a 94.1% agreement rate of having experiences with students with depression within the school (Q5). Participants also expressed that anxiety was extremely prevalent within the school setting (Q2, 97.6% agreement). Anxiety related disorders affect up to 18% of children, and nearly 13% of adolescents (Perfect & Morris, 2011). Attention deficit disorder affects 12% of youth (Perfect & Morris, 2011). Participants in this study also agreed that they have experience working with students with attention deficit disorder (Q11, 98.8% agreement). Research participants also felt that they had significant experience with bullying and peer problems (Q3, 100% agreement, and Q12, 100% agreement). Such high agreement rates, demonstrated there is minimal difference among the 3 schools and their perceptions of their experiences with students with a variety of needs. Overall, research participants reported that they work with students with a variety of mental health needs. Some of the needs that the participants reported to have had experience with include: students who are bullies, students who exhibit disruptive behavior, students who are hyperactive/inattentive, students who have peer/social problems, and students who have been victims of bullies.

RQ2. What student mental health services are perceived to be helpful to students and do these perceptions differ among schools?

Early mental health interventions help prevent behavior problems and poor school performance later (Burton et al., 2014; Minnesota Department of Health, 2002). Mental health promotion strategies give children and adolescents an opportunity to strengthen their well-being and increase their ability to stay mentally healthy and able to cope with difficulties that they may face (Burton et al., 2014). Participants felt that intervention programs for children with

externalizing problems are needed (Q41, 96.5% agreement). Participants also felt that bullying programs could help support students with mental health needs (Q42, 95.3% agreement).

Early identification leads to increased early intervention and an interruption in the mental health issue (NAMI, 2014). Mental health experts believe that it is critical to assess children for mental health problems as a proactive means of identifying youth at risk (Nemeroff et al., 2008). Thus, the early identification of mental health problems through screening and assessment can be considered a form of prevention (Levitt et al., 2007). Participants felt that early intervention programs and early screening and pre-referral programs would help support the needs of students with mental health needs (Q43, 95.3% agreement and Q44, 94.1% agreement). Schools offer the ultimate prospective for early identification programs because of the work they do on a daily basis with children and their ability to screen and assess large numbers of children (Nemeroff et al., 2008). Participants also agreed that ongoing monitoring for students with mental health issues was a vital support (Q49, 97.6% agreement).

Training teachers and other staff to identify mental health risks and involving them in the early identification process may be more sustainable for schools over time (Levitt et al., 2007). Staff training at school should focus on building a supportive environment, behavior management techniques, and how to recognize mental health problems (Satcher, 2004). Administrator support, staff training, and coaching on mental health issues was an area of support that participants identified as in need of assistance (Q45, 89.4% and Q 46, 96.5% agreement). Such high agreement rates, demonstrate there is minimal difference among the 3 schools and their perceptions on the supports or programs needed for students with mental health needs. Research participants have identified that students need services and intervention programs to support their mental health needs. They agreed that students needed intervention

programs for students with externalizing or acting out behaviors, ongoing monitoring for students with mental health needs, bullying programs, early intervention programs, and that administrative support to help and support students at school.

RQ3. What are faculty perceptions of the roles and responsibilities of different stakeholders within the SBMH program and do these perceptions differ among schools?

Through the results, the participants responded that the mental health responsibilities differed based on the specific duty within the school environment. Participants were given the option of choosing general education teacher, special education teacher, school counselor, school social worker, school psychologist, administrator, or not a role for the school for each question. When looking at screening for mental health problems, 54.1% of participants felt that this was the role of the school psychologist, and 23.5% felt it was the role of the school counselor. [Eight-point two percent] 8.2% felt it was the role of the general education teacher, 7.1% perceived it was not a role for the school, 4.7% thought it was the role of the school social worker, and only 2.4% thought it was the role of the special education teacher. Data collected from survey participants identified that provision for SBMH services for families had an assortment of responses. Of the participants, 35.3% felt it was the role of the school social worker, 22.4% identified that it was the role of the school psychologist, 17.6% felt it was the role of the school administrator, and 16.5% identified it as the role of the school counselor. A small percentage, 5.9%, felt it was not the responsibility of the school, while general and special education teachers were identified as being responsible for this role by 1.2% of the participants.

Survey participants felt that provision for health services for children was the role of a variety of school personnel. Of the participants, 30.6% of them felt it was the role of the school social worker, 20% felt it was the role of the school administrator, 18.8% felt it was not a role for

the school, and 17.6% felt it was the role of the school counselor. A small number, 11.8%, felt it was the role of the school psychologist and a select few, 1.2% felt it was the role of the general education teacher. Conducting behavioral assessments was identified by 44.7% of the participants as the role of the school psychologist and by 32.9% who felt it was the role of the special education teacher. 9.4% of participants felt it was the role of the school counselor, 7.1% felt it was the role of the general education teacher, 3.5% felt it was the role of the school social worker, and 2.4% felt it was not a role of the school.

Monitoring student progress was identified by 67.1% of the participants as the role of the general education teacher and 16.2% identified it as a role of the special education teacher. A few of the participants, 10.6% identified the school counselor as the one who takes on this role and a small amount, 3.5% think it is the school psychologist's role. Only 1.2% felt it was the role of the school administrator while another 1.2% felt it was the role of the school social worker.

The findings showed that 31.8% of the participants thought the role of provision of early intervention program services was the general education teacher, and 23.5% thought it was the role of the school counselor. In addition, 14.1% felt it was the role of the school administrator, 10.6% feel it was the role of the school social worker, and another 10.6% felt it was the role of the special education teacher. Only 4.7% thought it was the role for the school psychologist, and another 4.7% felt it was not a role for the school.

Consultation with teachers and parents was identified by 30.6% of participants as the role of the school counselor, and by 27.1% as the role of the school administrator. The participants reported that 14.1% of respondents feel it was the role of the special education teacher, 12.9% of participants reported it was the role of the school social worker, and 10.6% felt it was the role of

the general education teacher. An overwhelming number of respondents (84.7%) felt that providing staff development training was the role of the school administrator. The rest of the findings demonstrated that 7.1% felt it was the role of the school psychologist, 3.5% felt it was the role of the school counselor, and 2.4% felt it was the role of the general education teacher. There were 1.2% who felt it was the role of the school social worker, and another 1.2% who felt it was the role of the special education teacher.

Assessment for emotional or behavioral problems was identified by 64.7% as the role of the school psychologist and 17.6% felt it was the role of the special education teacher. In addition, 5.9% felt it was the role of the school counselor and 4.7% felt it was not the role of the school. A small amount, 3.5% saw it as the responsibility of the school social worker, 2.4% saw it was the role of the general education teacher, and only 1.2% saw it as the role of the school administrator. Student behavior management consultation with parents was found to be the responsibility of the school administrator (24.7%), the school counselor (22.4%), the special education teacher (21.2%), and the role of the general education teacher (17.6%). A small number (9.4%) saw it as the role of the school social worker and 4.7% saw it as the role of the school psychologist.

Case management was overwhelmingly identified as the role of the special education teacher with 70.6% response rate. Only 20% felt it was the role of the school social worker and another 5.9% saw it as the role of the school counselor. A mere 2.4% felt it was not a role for the school and only 1.2% thought it was the role of the school psychologist. Crisis intervention was identified as the role of the school counselor (30.6%) and the school social worker (36.5%). Another 10.6% saw this as a role for the school administrator and another 10.6% saw it as a role

for the school psychologist. A small amount of the participants felt it was the role of the special education teacher (5.9%) and the general education teacher (5.9%).

Individual counseling was perceived as a duty belonging to the school counselor at 57.6% and the school psychologist at 27.1%. A small amount (8.2%) saw it as the role of the school social worker while 4.7% felt it was not the role of the school, and 2.4% saw it as the role of the special education teacher. Group counseling was perceived as the role of the school with 51.8% of the participants responding this way. Another 22.4% felt it was the role of the school psychologist and 16.5% saw it as the role of the school social worker. Only 8.2% felt it was not the role of the school and a mere 1.2% saw it as the role of the special education teacher. Participants saw trauma counseling as a shared role with 35.3% seeing it as the role of the school psychologist, 24.7% saw it as the role of the school social worker, 23.4% saw it as the role of the school counselor, and 15.3% do not feel it was the role for the school. A mere 1.2% perceived it to be the role of the special education teacher. Parent counseling had mixed results with 30.6% thought it was the role of the school social worker, 29.4% did not feel it was the role for the school, and 25.9% thought it was the role of the counselor. Only 8.2% saw it as the role for the school psychologist, while 5.9% felt it was the role of the school administrator.

A large number of respondents (52.9%) thought that medication management was not a role for the school. Another 18.8% felt medication management was the role of the school psychologist, 11.8% felt it was the role of the school administrator, and 9.4% saw it as the role of the school social worker. A small amount (5.9%) saw it as the role of the school counselor and a mere 1.2% saw it as a role for the special education teacher. A large number of participants (47.1%) perceived that classroom and school wide positive behavior supports were the responsibility of the general education teacher, while 27.1% saw it as the role of the school

administrator. Another 12.9% saw it as the role of the special education teacher and 8.2% thought it was the role of the school counselor. A small number of participants (1.2%) saw it as the role of the school social worker.

A large majority of respondents (41.2%) felt that function based behavioral assessment and intervention planning was the role of the special education teacher and another 24.7% saw it as the role of the school psychologist. Only 10.6% felt it was the role of the school counselor and another 10.6% saw it as the role of the general education teacher. Another 5.9% saw this as the role of the school administrator, and 5.9% saw it as the role of the school social worker. A mere 1.2% felt that it was not a role for the school. Referrals to specialized school-based programs or services was identified as the role of the school counselor (24.7%), the general education teacher (20%), the school administrator (16.5%), and the role of the school social worker (15.2%). Another 11.8% saw it as the role of the school psychologist, 10.6% saw it as the role of the special education teacher, and 1.2% did not feel it was a role for the school. Referrals to community-based services or programs were identified by 44.7% of respondents as the role of the school social worker, and 17.6% saw it as the role of the school counselor. A smaller amount (12.9%) of participants saw this as the role of the school administrator, and 9.4% saw it as the role of the school psychologist. [Seven-point 1 percent] 7.1% felt that it was the role of the general education teacher, 5.9% did not feel it is a role for the school, and only 2.4% saw it as the role of the special education teacher. Overall, within the SBMH, there are multiple components and responsibilities that need to be addressed and taken care of. There is a significant need for all school personnel to be involved, as each member plays a vital role and has an impact on the SBMH program.

RQ4. What are the perceived barriers to implementing an SBMH program and do these perceptions differ among schools?

Previous research has aligned with many of the perceived barriers identified by the survey participants. Stigma has been identified as the largest barrier as it related to SBMH. Stigmatization plays a role in whether individuals initiate and adhere to treatment (Evans et al., 2005). Research participants perceive stigma to be a barrier to providing SBMH services (Q54, 78.8% agreement). Participants also identified lack of funding as a barrier (Q57, 78.8% agreement). Developing and sustaining funding streams to support the delivery of school mental health programs is an obstacle at local, state, and national levels (Cammack et al., 2014).

Many non-white families underutilize mental health services and seek therapy only when problems have become severe (Bains, 2014; Griner & Smith, 2006). Cultural values of non-white individuals can be incongruent with traditional mental health practices, which have predominantly focused on therapeutic needs of European Americans (Griner & Smith, 2006). Survey participants perceive language and cultural barriers while working with culturally diverse students and families a significant barrier to providing SBMH supports (Q55, 84.7% agreement). Survey participants also identified gaining parental cooperation and consent as a significant barrier (Q53, 84.7% agreement). The survey participants felt that there were other perceived barriers that were not identified with in the literature. Other perceived barriers as identified by the survey participants include an insufficient number of mental health professionals (Q51, 80% agreement), and lack of adequate training for dealing with students' mental health needs (Q52, 87.1% agreement). The agreement rates demonstrate there is minimal difference among the 3 schools and their perceptions on barriers to implementing an SBMH program. Largely, research participants reported that there are many barriers to successfully implementing an SBMH

program. They identified lack of adequate training, gaining parental cooperation and consent, lack of funding, stigma, and language and cultural barriers when working with culturally diverse students and families as some of the most significant barriers.

RQ5. What are the perceived benefits to implementing an SBMH program and do these perceptions differ among schools?

The research participants identified that an improvement in school connectedness was a benefit to implementing an SBMH program (Q64, 82.4% agreement). Another perceived benefit of implementing an SBMH program was the improved relationship of home and school (Q69, 83.5% agreement). Research participants also perceived that SBMH programs would keep students from falling through the cracks (Q72, 85.9% agreement). Current research shows that mental health promotion strategies give children and adolescents an opportunity to strengthen their well-being and increase their ability to stay mentally healthy and able to cope with difficulties that they may face (Burton et al., 2014). The goal of SBMH programs are to promote resilience, positive behavior, safety, and develop a supportive school environment where all students are valued, connected, and respected, while identifying students who may be at risk for or are experiencing mental health issues (Rossen & Cowan, 2015). The agreement rates show that there was minimal difference among the 3 schools and their perceptions on the benefits of implementing an SBMH program. The top benefits as identified by the research participants are an improvement in school connectedness, and improvement in the relationship between home and school, and that students are less likely to 'fall between the cracks.'

RQ6. What are the perceived barriers or risks to be communicated at each stage of implementation and do these perceptions differ among schools?

At the exploration stage, participants responded that it was important to communicate clearly. This includes clearly discussing roles and responsibilities, sustainment and evaluation plan, and guidelines for a referral process. Other barriers identified at this stage were analyzing the data, the cost, how the program works with insurance, and the stigma of receiving mental health services. At the installation stage, participants responded that, once again, communication is vital. This includes dialogue regarding referral processes, procedures, continual discussion among school staff and therapists, and a plan for supporting ongoing implementation and feedback. Cost, fit of therapists, insurance, fidelity of implementation, and stigma of receiving mental health support were other areas identified in this stage as important barriers or risks that need to be communicated. In the initial implementation stage, participants responded that it was important to have a clear data system to track and analyze data to determine success of services. Participants also responded that clearly defining roles and communicating how staff and therapists will be supported within the school. The research findings align with Weist et al. (2000) and Paternite (2005) who have identified quality assurance indicators which reflect program quality; when these are in place, the probability of enhanced effectiveness is increased. Overall, the participants identified that communication was a barrier at each stage of implementation, including communicating roles and responsibilities as well as the referral process.

Key findings. Through this current study, key findings were identified based on their high agreement rates among research participants. These findings can be useful and beneficial for those implementing, or seeking to implement, SBMH programs. The current study shows that teachers in multiple schools and school districts are seeing students with a variety of mental health needs within their schools. Among the needs that stood out were bullying (both

perpetrator and victim), hyperactivity / inattention, anxiety, depression, and defiant behaviors. See Chapter Four, page 53 and 54 for a full list of research findings. These findings support the need of a broader menu of supports for students.

Previous research has aligned with many of the perceived barriers identified by the survey participants. Stigma has been identified as the largest barrier related to SBMH. Research participants perceived stigma to be a barrier to providing SBMH services. Participants also identified lack of funding as a barrier. Developing and sustaining funding streams to support the delivery of school mental health programs was an obstacle at local, state, and national levels. Survey participants perceived language and cultural barriers to providing SBMH supports while working within culturally diverse communities and families. Many non-white families underutilize mental health services and seek therapy only when problems have become severe (Bains, 2014; Griner & Smith, 2006). Cultural values of non-white individuals can be incongruent with traditional mental health practices, due to the predominant focus on the therapeutic needs of European Americans (Griner & Smith, 2006). Survey participants also identified gaining parental cooperation and consent as a significant barrier. Brainstorming and problem-solving identified barriers during the exploration stage of implementation would be a benefit to those implementing an SBMH program. See Chapter Four, pages 60 through 63 for a full list of research findings.

When focusing on benefits of SBMH program, the research participants identified that an improvement in school connectedness was a significant benefit. Another perceived benefit of implementing an SBMH program was the improved relationship between home and school. Research participants also perceived that SBMH programs would keep students from 'falling through the cracks.' The goal of SBMH programs are to promote resilience, positive behavior,

safety, and develop a supportive school environment where all students are valued, connected, and respected, while identifying students who may be at risk for, or are, experiencing mental health issues (Rossen & Cowan, 2015). See Chapter Four, pages 64 and 65 for a full list of research findings. During the exploration and implementation stages of implementing an SBMH program, brainstorming ensures benefits are made a priority.

Implications for practice. This current study aligns with research and demonstrates the importance of understanding challenges students are facing. If teachers and school staff are able to identify, understand, and refer students with mental health needs, they will more likely be able to support students toward academic success. Students with mental health needs have gone on to drop out of school, become incarcerated, commit suicide, and have been labeled negatively by the community, among other things. Many of these outcomes could be avoided if the correct mental health services are provided to students. Early mental health interventions and universal screenings help prevent behavior problems and poor school performance (Minnesota Department of Health, 2002; Stiffler & Dever, 2015). School-based mental health programs can provide a place to identify student's mental health needs, reduce stigma for seeking help, reduce the wait time see a mental health professional, and provide the prevention, intervention, and treatment plans for students who need the support (Paternite, 2005).

This research study has identified some significant barriers to the implementation of an SBMH program. Stigmatization plays a role in whether individuals initiate and adhere to treatment (Evans et al., 2005). Stigma was noted as a barrier to treatment due to the fear of being labelled negatively, as well as the often-erroneous perceptions that associate stigma with mental health (Bowers, et al., 2013). There are multiple challenges that impede the implementation and sustainment of SBMH programs. The most significant barriers have been identified through the

literature include: developing programs, ensuring relevant stakeholders, finding long term funding, identifying stigmas, and determining an appropriate program evaluation processes (Hicks-Hoste, 2015; Nabors et al., 1998; Reinke et al., 2011; Weist et al., 2000).

Sustaining SBMH programs can be difficult due to unclear curriculum, ineffective delivery, lack of administrative support, inadequate staffing, and lack of feedback or evaluation processes (Horner et al., 2001; Massey et al., 2005). Barriers to the referral process can include poor knowledge of the services, difficulty paying for the services, transportation, limited capacity of the impact of services, and stigma (Massey et al., 2005; Weist, 1999). Despite the fact that schools provide invaluable access to students and families in need and offer a unique opportunity to provide mental health support, a large number of schools do not have SBMH programs. Many non-white families underutilize mental health services and seek therapy only when problems have become severe (Bains, 2014; Griner & Smith, 2006). Cultural values of non-white individuals can be incongruent with traditional mental health practices, which have predominantly focused on therapeutic needs of European Americans (Griner & Smith, 2006). The results found in this study can be used to better inform practitioners and educators of what the perceived barriers to developing a successful SBMH program and so they can be prepared and overcome and avoid these barriers.

When comparing the 3 schools agreement on research questions, the schools aligned on agreement frequencies for most of the survey questions. This shows that many of the beliefs among schools are similar and that the participants have similar experiences. There were a few questions where the 3 schools did not align with their agreement frequencies. Schools 1 and 2 had similar agreement rates surrounding experience working with students who have had a friend of relative commit suicide (Q7, around 62% agreement), however, School 3 had an agreement

rate of only 18.8%. It would be beneficial for School 1 and School 2 to focus on supports for students who have had this experience. Another area where the schools differed was working with students who are homeless or transient. Schools 2 and 3 had similar agreement rates (Q14, 77.6% agreement and 81.3% agreement), while School 1 had an agreement rate of 43.8%. This shows that there was a need within School 2 and School 3 for supports for their homeless or transient population. It was important to determine what needs these students have so they can be best supported.

When looking at experiences regarding student drug use, School 2 and School 3 had similar agreement frequencies (Q16, about 69% agreement) and School 1 had a 43.8% agreement rate. For all 3 schools, it was important to teach staff warning signs and to develop relationships with students so support and help can be provided. When looking at barriers for providing school mental health services, Schools 2 and 3 felt that language and cultural barriers while working with culturally diverse students and families was a barrier (Q55, 98% and 87.5% agreement), and at School 1 only 50% felt that it was a barrier. This could reflect the demographics of the student population at School 1; however, it is important to understand that culture manifests in many forms, and it is important to be aware and understanding of other cultures so those who need support can receive it.

Schools 2 and 3 felt that an improvement in school connectedness was a benefit to SBMH supports (Q64, 81.6% and 100% agreement) while School 1 was less certain (Q64. 63.5% agreement). To determine this connectedness to be a benefit, schools would need to determine a way to measure the improvement. Students could be assessed on how they feel about school connectedness, however, having a trusted relationship with an adult in the school building can positively impact school connectedness. School 3 felt that an increase in graduation

rate was a benefit to SBMH supports (Q65, 93.8% agreement). Schools 1 and 2 felt it was a benefit, but at a lower agreement rate (Q65, 62.5% and 69.4% agreement). To determine if this really was a benefit, schools could look at their graduation data to determine if there had been an increase and to eliminate any other factors that could be influencing their graduation rate**.**

Implications for research. For students to be successful in school, their needs must be met. Mental and emotional well-being is a core condition for overall health components that lead to a happy and productive life, to the formation of healthy relationships, and to successfully adjust to change and overcome difficulties (Burton et al., 2014; Minnesota Department of Health, 2002). An SBMH program is one method for schools to make a positive change on the mental health status of children. Weist et al. (2003a) state that when mental health programs are available at school, students have greater access to a mental health professional and mental health services. This research study and current research have identified the fact that teachers are seeing students with significant needs in their classrooms each day. Many see and understand the need for SBMH programs. Further research needs to be done to continue identify the best model for implementation and how to get more schools to implement an SBMH program.

To address the many unmet mental health needs facing America's students, SBMH services and programs have been implemented in some schools (Paternite, 2005; Pfeiffer & Reddy, 1998; Stiffler & Dever, 2015). These programs enhance access to services for youth, reduce stigma for seeking help, increase opportunities to promote and maintain treatment gains, and enhance mental health promotion and prevention (Macklem, 2014; Paternite, 2005;). In order to meet students' needs that are being seen in schools and classrooms, more schools could benefit from the implementation of SBMH programs. Kutash et al. (2006) have identified a model, *Interconnected Systems*, which is comprised of a continuum of services aimed to balance

efforts at mental health promotion, prevention, early identification, and intervention. Further research needs to be done to determine which methods of early identification, screening, and intervention implementation are the best models for SBMH programs.

The first level of service is systems of prevention. Services at this level are implemented through universal interventions provided to all students at a low cost and can include things such as character education programs and drug and alcohol education (Kutash et al., 2006). The second level of service focuses on those students who are at risk and have a moderate need for targeted services, which can include things such as dropout prevention program, work experience program, or pregnancy prevention programs (Kutash et al., 2006). Research needs to be done to find the best way to deliver and implement the programs at this level. The third level of service focuses on the systems of care. In this level, students are high risk and have severe and long-standing needs, which require intensive treatment (Kutash et al., 2006). Students within this level receive wraparound services tailored to the specific strengths and needs of the youth and family and include therapy services (Kutash et al., 2006). This approach allows schools and communities to meet the mental health needs of children and adolescents (Kutash et al., 2006). Other research to be done should focus on what wraparound service model is best and to determine if that model of service works.

Further research needs to be done to determine which methods of early identification, screening, and intervention implementation is the best model for an SBMH program.

Recommendations

The study has potential significance for future studies which could focus on meeting student emotional and academic needs. This study focused on a small, exploratory sample within the Minnesota Metropolitan area which could be replicated in other school districts, both

larger and smaller ones, within Minnesota. This study could be replicated on a larger scale within Minnesota or in other states. Elementary and high schools could be added to the study as well. The results of these larger studies could continue to help identify and/or reinforce what it takes to develop a successful SBMH program, which in turn can influence policy, as lawmakers and school boards use the information to ensure that all students' mental health needs are met. Another addition to this study could be that of a student component to gain insight on their perspectives on SBMH supports. Students are the focus for providing support, so it would be a natural next step to really understand their perspectives on mental health and to understand where students feel support is needed.

Through the research many barriers have been identified. Many of this researcher's perceptions, which were based on experiences, seemed to be proven true. With this knowledge, this researcher would like to know more about how each of the barriers can be overcome. If stigma is a known barrier, what steps can be put in place to eliminate that stigma? If a lack of funding is an identified barrier, what steps need to be taken to ensure the funding stream can be increased? Further research on each of the barriers would further support the implementation of SBMH programs. Through the research benefits to SBMH programs were also identified. This researcher would like to know more about how to strengthen these benefits. If it is known that early identification and screening can help support those with mental health needs, what can be done to ensure that these things are happening within schools, and how do we further show the need to decision makers? This researcher also would like to know more about supports which are needed to help students with mental health needs. Research needs to be done to gather more evidence on these programs, their effectiveness, and how to ensure they are implemented within schools.

The prevalence of mental health disorders in youth is increasing at an alarming rate. A school-based mental health program is one method for schools to make a positive change regarding the mental and emotional well-being of children. Weist et al. (2003a), state that when mental health programs are available at school, students have greater access to a mental health professionals and mental health services. Schools within Baltimore Public schools, Charlotte-Mecklenburg Public Schools, and Salt Lake City Public Schools have SBMH services available to students. It would be important to further understand the success these schools have had, the barriers they have overcome, and what procedural methods they utilized with the implementation of their SBMH models. With the knowledge of SBMH models, and the success of schools having implemented them, it is recommended that schools initiate their own SBMH program to support the needs of their students.

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APPENDIX 1

Perspectives of a School-Based Mental Health Programs

* Required

For the purpose of this study, the Mental Health Needs and Practices in Schools Survey has been modified as follows. I appreciate your time and willingness to participate by completing this survey. Please be ensured that the survey is confidential. Any and all identifying information requested will be kept private. There are no known risks to participating in this study. By choosing not to participate or withdrawing from the study, it will not impact your relationship with the school system or Concordia University, St. Paul. If you provide your email address at the end to receive a copy of a summary of finding, it will be separated from your survey results. Your participation in this survey will not only enhance the understanding of the mental health need of students in your district, but also contribute to the care of child in need within your local community through this donation of your time, thoughts, and opinions. If you have any questions please contact Danielle Peterson, Principal Investigator at 320-491-9537 or the CSP IRB Office at 651-641-8723. I give my consent to participate in this research project. I understand that participation is voluntary and that I may withdraw my consent at any time without penalty. *

Mark only one oval.

- o I agree
- o I disagree

Gender *

Mark only one oval.

- o Male
- o Female
- o Prefer not to say
- o Other:

Age

Mark only one oval.

- o 22-29
- o 30-39
- o 40-49
- o 50+

Race *

Mark only one oval.

- o African American
- o White
- o American Indian
- o Asian/Pacific Islander
- o Hispanic
- o Middle Eastern

- Other:

I currently work at... *
Education: How many years have you worked in education? *
Mark only one oval.

- 1-5
- 6-10
- 11-15
- 16-20
- 20+
- Other:

Degree: What is the highest degree you have earned? *
Mark only one oval.

- Bachelors
- Masters
- Specialist
- Doctorate

Position: In what capacity do you currently work/interact with students? *
Mark only one oval.

- General Education Teacher
- Special Education Teacher
- School Psychologist
- School Social Worker
- School Counselor
- Administrator
- Other:

Please indicate if you have had experience working with students from the following categories. *
Mark only one oval per row.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Aggressive Behavior	o	o	o	o	o
Anxiety Problems	o	o	o	o	o
Bullying	o	o	o	o	o
Defiant Behavior	o	o	o	o	o
Depression	o	o	o	o	o
Suicidal Thoughts	o	o	o	o	o

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Friend or relative committed suicide	o	o	o	o	o
Self-Harm	o	o	o	o	o
Disruptive Behaviors	o	o	o	o	o
Family Stressors/Trauma	o	o	o	o	o
Hyperactivity/Inattention	o	o	o	o	o
Peer Problems	o	o	o	o	o
Social Phobia	o	o	o	o	o
Homelessness/Transient	o	o	o	o	o
Drugs	o	o	o	o	o
Neglect or Deprivation	o	o	o	o	o
Adjustment Issues	o	o	o	o	o
Victim of Bullying	o	o	o	o	o

With whom do you think the primary role of this responsibility lies? *
Mark only one oval per row.

	General Education Teacher	Special Education Teacher	School Counselor	School Psychologist	School Social Worker	School Administrator	Not a role for the school
Screening for mental health problems	o	o	o	o	o	o	o
Provision for SBMH services for families	o	o	o	o	o	o	o
Provision for health services for children	o	o	o	o	o	o	o
Conducting behavioral assessments	o	o	o	o	o	o	o

	General Education Teacher	Special Education Teacher	School Counselor	School Psychologist	School Social Worker	School Administrator	Not a role for the school
Monitoring student progress	o	o	o	o	o	o	o
Provision of early intervention program services	o	o	o	o	o	o	o
Consultation with teachers and parents	o	o	o	o	o	o	o
Staff development training	o	o	o	o	o	o	o
Assessment for emotional or behavioral problems	o	o	o	o	o	o	o
Student behavior management consultation with parents	o	o	o	o	o	o	o
Case management	o	o	o	o	o	o	o
Crisis intervention	o	o	o	o	o	o	o
Individual counseling	o	o	o	o	o	o	o
Group counseling/Therapy	o	o	o	o	o	o	o
Trauma counseling	o	o	o	o	o	o	o

	General Education Teacher	Special Education Teacher	School Counselor	School Psychologist	School Social Worker	School Administrator	Not a role for the school
Parent counseling	o	o	o	o	o	o	o
Medical/medication management	o	o	o	o	o	o	o
Classroom and school wide positive behavior supports	o	o	o	o	o	o	o
Function-based behavioral assessment and intervention planning	o	o	o	o	o	o	o
Referral to specialized school-based programs/services	o	o	o	o	o	o	o
Referral to community based services/programs	o	o	o	o	o	o	o

What programs or supports are needed to help students with mental health needs? * Mark only one oval per row.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Adequate support programs	o	o	o	o	o
Intervention programs for children with	o	o	o	o	o

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
externalizing (i.e. acting out, aggression, hyperactive disruptive behavior) problems					
Bullying program	o	o	o	o	o
Early intervention programs	o	o	o	o	o
Early screening and pre-referral programs	o	o	o	o	o
Staff training and coaching on mental health issues	o	o	o	o	o
Administrator support	o	o	o	o	o
Crisis planning and support	o	o	o	o	o
Implementation of existing programs as intended (i.e. programs not delivered as they should be)	o	o	o	o	o
Ongoing monitoring for students with mental health issues	o	o	o	o	v

I believe the following are barriers for providing mental health services in my school(s) *
Mark only one oval per row.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Difficulty identifying children with mental health needs	o	o	o	o	o
Insufficient number of mental health professionals	o	o	o	o	o
Lack of adequate training for dealing with children's mental health needs	o	o	o	o	o
Gaining parental cooperation and consent	o	o	o	o	o
Stigma associated with receiving mental health services	o	o	o	o	o
Language and cultural barriers while working with culturally diverse students/families	o	o	o	o	o
Referral options in the community	o	o	o	o	o
Lack of funding for school-based health services	o	o	o	o	o
Mental health issues are not considered the	o	o	o	o	o

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
role of the school					
Competing priorities taking precedence over mental health services (i.e. fear of losing academic time)	o	o	o	o	o
The belief that mental health problems do not exists and merely and excuse	o	o	o	o	o
Academic demands	o	o	o	o	o

Please answer the following questions referring to your perceived benefits of on-site mental health services *
Mark only one oval per row.

	Yes	Not Sure	No
Reduction in students' being tardy and/or absent	o	o	o
Overall academic improvement/success	o	o	o
Improvement in school connectedness	o	o	o
Increase in graduation rate	o	o	o
Decrease in the dropout rate	o	o	o
Improve parent/community perspective of the school	o	o	o

	Yes	Not Sure	No
Reduce the number of students using alcohol and/or drugs	o	o	o
Improve relationship of home and school	o	o	o
Reduce poverty	o	o	o
Reduce teen pregnancy	o	o	o
Students would be less likely to "fall between the cracks"	o	o	o
Reduce the number of students referred for special education/504s	o	o	o

Do you feel that you understand cultural differences that may impact a student's mental health? *
Mark only one oval.

- o Yes
- o No

Do you feel there are students who are identified as having a disability who have been placed in special education who may have an undiagnosed mental illness? *
Mark only one oval.

- o Yes
- o No

In your opinion, how can the mental health services program in your school(s) be better implemented and sustained? *

Once again, thank you very much for participating in this survey. You have the option to request a summary of the findings below. Would you like to receive a summary report of the findings of this research? *
Mark only one oval.

- Yes
- No

Please leave your email address if you would like to receive a summary report of the findings of the research.

APPENDIX 2

Stages of Implementation

* Required

For the purpose of this study, I appreciate your time and willingness to participate by completing this survey. Please be ensured that the survey is confidential. Any and all identifying information requested will be kept private. There are no known risks to participating in this study. By choosing not to participate or withdrawing from the study, it will not impact your relationship with the school system or Concordia University, St. Paul. If you provide your email address at the end to receive a copy of a summary of finding, it will be separated from your survey results. Your participation in this survey will not only enhance the understanding of the mental health need of students in your district, but also contribute to the care of child in need within your local community through this donation of your time, thoughts, and opinions. If you have any questions please contact Danielle Peterson, Principal Investigator at 320-491-9537 or the CSP IRB Office at 651-641-8723. I give my consent to participate in this research project. I understand that participation is voluntary and that I may withdraw my consent at any time without penalty. *

Mark only one oval.

- o I agree
- o I disagree

Gender *

Mark only one oval.

- o Male
- o Female
- o Prefer not to say
- o Other:

Age *

Mark only one oval.

- o 22-29
- o 30-39
- o 40-49
- o 50+

Race *

Mark only one oval.

- o African American
- o White
- o American Indian
- o Asian/Pacific Islander
- o Hispanic

- Middle Eastern
- Other

I currently work at...
Education: How many years have you worked in education? *
Mark only one oval.

- 1-5
- 6-10
- 11-15
- 16-20
- 20+

Degree: What is the highest degree you have earned? *
Mark only one oval.

- Bachelors
- Masters
- Specialist
- Doctorate

Position: In what capacity do you currently work/interact with students? *
Mark only one oval.

- General Education Teacher
- Special Education Teacher
- School Psychologist
- School Social Worker
- School Counselor
- Administrator

What stage of exploration are you currently in? *
Mark only one oval.

- Current
- Past

Stages of Implementation Analysis: EXPLORATION *
Mark only one oval per row.

	In Place	Initiated or Partially in Place	Not yet initiated
Form Implementation "team" or re-	o	o	o

	In Place	Initiated or Partially in Place	Not yet initiated
purpose/expand current group			
Develop communication plan to describe the exploration process (i.e. activities, participants, timeline, benefits, risks) to key stakeholder groups	o	o	o
Analyze data to determine need and prevalence of need	o	o	o
Select targeted areas to address need (i.e. child, adult, family outcomes)	o	o	o
Review and identify programs, practices, interventions that match target area and address need	o	o	o
Review and discuss "eligible" programs and practices in relation to need	o	o	o
Review and discuss "eligible" programs and practices in relation to fit	o	o	o
Review and discuss "eligible" programs and practices in relation to resources-sustainability	o	o	o
Review and discuss "eligible" programs	o	o	o

	In Place	Initiated or Partially in Place	Not yet initiated
and practices in relation to strength of evidence			
Review and discuss "eligible" programs and practices in relation to capacity to implement	o	o	o
Select programs/practices for continued exploration based on assessment results from above	o	o	o
Develop methods to promote exploration and assess "buy-in" for range of impacted stakeholders	o	o	o
Analyze information and results of exploration activities	o	o	o
Work group makes recommendation to appropriate level (i.e. state level team, local partner, alliance, funders)	o	o	o

What barriers or risks do you feel need to be communicated at this stage of exploration? *

What stage of installation are you currently in? *
Mark only one oval.

- o Current
- o Past

Stages of Implementation Analysis: INSTALLATION *
Mark only one oval per row.

	In Place	Initiated or Partially in Place	Not yet initiated
Identify structural and functional changes needed (i.e. policies, schedules, space, time, materials, re-allocation of roles and responsibilities)	o	o	o
Make structural and functional changes needed to initiate the school based mental health program	o	o	o
Development of selection protocol for practitioners	o	o	o
Selection of practitioners	o	o	o
Identification of training resources or logistics	o	o	o
Training of implementers	o	o	o
Develop coaching or support plans for practitioners	o	o	o
Evaluate "readiness" and sustainability of data systems at consumer level (i.e. child, adult, family)	o	o	o
Evaluate "readiness" and sustainability of fidelity data system	o	o	o
Analyze and problem solve	o	o	o

	In Place	Initiated or Partially in Place	Not yet initiated
around the sustainability of training, coaching, data systems			
Establish communication links to report barriers and facilitators during the next stage of initial implementation	o	o	o

What barriers or risks do you feel need to be communicated at this stage of installation? *

What stage of initial implementation are you currently in? *
Mark only one oval.

- o Current
- o Past

Stages of Implementation Analysis: INITIAL IMPLEMENTATION *
Mark only one oval per row.

	In Place	Initiated or Partially in place	Not yet initiated
Communication plan(s) developed to inform stakeholders of "launch dates", activities, and convey support	o	o	o
Communication protocols developed for identifying barriers and adaptive challenges and problem-solving at each "level" (i.e.	o	o	o

	In Place	Initiated or Partially in place	Not yet initiated
weekly meetings, create plans, review results)			
Leadership develops support plan to promote persistence	o	o	o
Written coaching plan	o	o	o
Coaching system in place	o	o	o
Data systems in place for measuring and reporting outcomes	o	o	o
Data systems in place for measuring and reporting fidelity	o	o	o
Document that reviews initial implementation challenges	o	o	o

What barriers or risks do you feel need to be communicated at this stage of initial implementation? *

What stage of full implementation are you currently in? *
Mark only one oval.

- o Current
- o Past

Stages of Implementation Analysis: FULL IMPLEMENTATION *
Mark only one oval per row.

	In Place	Initiated or Partially in place	Not yet initiated
Monitoring and support systems are in place	o	o	o
Feedback process from practitioners to school administrators is in place and functional	o	o	o
Feedback process from schools to district personnel are in place and functional	o	o	o
Feedback process to state is in place and functional	o	o	o
School leadership and implementation team use data to make decisions	o	o	o
Improvement processes are employed to address issues through the use of data, development of plans, monitoring of plan execution and assessment of results	o	o	o

Once again, thank you very much for participating in this survey. You have the option to request a summary of the findings below. Would you like to receive a summary report of the findings of this research? *
Mark only one oval.

- Yes
- No

Please leave your email address if you would like to receive a summary report of the findings of the research.

APPENDIX 3

Additional Data

Agreement Frequencies for Experience Working with Students with the Following Needs: School 1

Q1	Aggressive Behaviors	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q2	Anxiety Problems	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q3	Bullying	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q4	Defiant Behavior	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q5	Depression	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q6	Suicidal Thoughts	Frequency	Percent
.00		4	25.0
1.00		12	75.0
Total		16	100.0

Q7	Friend or Relative Committed Suicide	Frequency	Percent
.00		6	37.5
1.00		10	62.5
Total		16	100.0

Q8	Self-Harm	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q9	Disruptive Behaviors	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q10	Family Stressors/Trauma	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q11	Hyperactivity/Inattention	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q12	Peer Problems	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q13	Social Phobia	Frequency	Percent
.00		4	25.0
1.00		12	75.0
Total		16	100.0

Q14	Homelessness/Transient	Frequency	Percent
.00		9	56.3
1.00		7	43.8
Total		16	100.0

Q15	Drugs	Frequency	Percent
.00		9	56.3
1.00		7	43.8
Total		16	100.0

Q16	Neglect or Deprivation	Frequency	Percent
.00		4	25.0
1.00		12	75.0
Total		16	100.0

Q17	Adjustment Issues	Frequency	Percent
.00		3	18.8
1.00		13	81.3
Total		16	100.0

Q18	Victim of Bullying	*Frequency*	*Percent*
.00		*0*	*0.0*
1.00		*16*	*100.0*
Total		*16*	*100.0*

Agreement Frequencies for Programs or Supports Needed to Help Students with Mental Health Needs School 1

Q40	Adequate support programs	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q41	Intervention programs for children with externalizing problems	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q42	Bullying Program	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q43	Early intervention programs	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q44	Early screening and pre-referral programs	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q45	Staff training and coaching on mental health issues	Frequency	Percent
.00		3	18.8
1.00		13	81.3
Total		16	100.0

Q46	Administrator support	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q47	Crisis planning and support	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q48	Implementing of existing programs as intended	Frequency	Percent
.00		4	25.0
1.00		12	75.0
Total		16	100.0

Q49	Ongoing monitoring for students with mental health needs	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Agreement Frequencies for Barriers for Providing Mental Health Services in School: School 1

Q50	Difficulty identifying children with mental health needs	Frequency	Percent
.00		*3*	18.8
1.00		13	81.3
Total		16	100.0

Q51	Insufficient number of mental health professionals	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q52	Lack of adequate training for dealing with children's mental health needs	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q53	Gaining parental cooperation and consent	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q54	Stigma associated with receiving mental health services	Frequency	Percent
.00		5	31.3
1.00		11	68.8
Total		16	100.0

Q55	Language and cultural barriers while working with culturally diverse students/families	Frequency	Percent
.00		8	50.0
1.00		8	50.0
Total		16	100.0

Q56	Referral options in the community	Frequency	Percent
.00		5	31.3
1.00		11	68.8
Total		16	100.0

Q57	Lack of funding for school based health services	Frequency	Percent
.00		3	18.8
1.00		13	81.3
Total		16	100.0

Q58	Mental health issues are not considered a role of the school	Frequency	Percent
.00		10	62.5
1.00		6	37.5
Total		16	100.0

Q59	Competing priorities taking precedence over mental health services	Frequency	Percent
.00		6	37.5
1.00		10	62.5
Total		16	100.0

Q60	The belief that mental health problems do not exist and are merely an excuse	Frequency	Percent
.00		11	68.8
1.00		5	31.3
Total		16	100.0

Q61	Academic demands	Frequency	Percent
.00		3	18.8
1.00		13	81.3
Total		16	100.0

Agreement Frequencies for Perceived Benefits of On-Site Mental Health Services: School 1

Q62	Reduction in students' being tardy and/or absent	Frequency	Percent
.00		6	37.5
1.00		10	62.5
Total		16	100.0

Q63	Overall academic improvement/success	Frequency	Percent
.00		5	31.5
1.00		11	68.8
Total		16	100.0

Q64	Improvement in school connectedness	Frequency	Percent
.00		6	37.5
1.00		10	62.5
Total		16	100.0

Q65	Increase in graduation rate	Frequency	Percent
.00		8	50.0
1.00		8	50.0
Total		16	100.0

Q66	Decrease in the dropout rate	Frequency	Percent
.00		6	37.5
1.00		10	62.5
Total		16	100.0

Q67	Improve parent/community perspective of the school	Frequency	Percent
.00		5	31.3
1.00		11	68.8
Total		16	100.0

Q68	Reduce the number of students using alcohol and/or drugs	Frequency	Percent
.00		8	50.0
1.00		8	50.0
Total		16	100.0

Q69	Improve relationship of home and school	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q70	Reduce poverty	Frequency	Percent
.00		12	75.0
1.00		4	25.0
Total		16	100.0

Q71	Reduce teen pregnancy	Frequency	Percent
.00		9	56.3
1.00		7	43.8
Total		16	100.0

Q72	Students would be less likely to "fall between the cracks"	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q73	Reduce the number of students referred for special education or 504s	Frequency	Percent
.00		10	62.5
1.00		6	37.5
Total		85	100.0

Agreement Frequencies for Experience Working with Students with the Following Needs: School 2

Q1	Aggressive Behaviors	Frequency	Percent
.00		0	0.0
1.00		49	100.0
Total		49	100.0

Q2	Anxiety Problems	Frequency	Percent
.00		2	4.1
1.00		47	95.9
Total		49	100.0

Q3	Bullying	Frequency	Percent
.00		0	0.0
1.00		49	100.0
Total		49	100.0

Q4	Defiant Behavior	Frequency	Percent
.00		1	2.0
1.00		48	98.0
Total		49	100.0

Q5	Depression	Frequency	Percent
.00		4	8.2
1.00		45	91.8
Total		49	100.0

Q6	Suicidal Thoughts	Frequency	Percent
.00		12	24.5
1.00		37	75.5
Total		49	100.0

Q7	Friend or Relative Committed Suicide	Frequency	Percent
.00		19	38.8
1.00		30	61.2
Total		49	100.0

Q8	Self-Harm	Frequency	Percent
.00		11	22.4
1.00		38	77.6
Total		49	100.0

Q9	Disruptive Behaviors	Frequency	Percent
.00		0	0.0
1.00		49	100.0
Total		49	100.0

Q10	Family Stressors/Trauma	Frequency	Percent
.00		0	0.0
1.00		49	100.0
Total		49	100.0

Q11	Hyperactivity/Inattention	Frequency	Percent
.00		0	0.0
1.00		49	100.0
Total		49	100.0

Q12	Peer Problems	Frequency	Percent
.00		0	0.0
1.00		49	100.0
Total		49	100.0

Q13	Social Phobia	Frequency	Percent
.00		12	24.5
1.00		37	75.5
Total		49	100.0

Q14	Homelessness/Transient	Frequency	Percent
.00		11	22.4
1.00		38	77.6
Total		49	100.0

Q15	Drugs	Frequency	Percent
.00		15	30.6
1.00		34	69.4
Total		49	100.0

Q16	Neglect or Deprivation	Frequency	Percent
.00		7	14.3
1.00		42	85.7
Total		49	100.0

Q17	Adjustment Issues	Frequency	Percent
.00		6	12.2
1.00		43	87.8
Total		49	100.0

Q18	Victim of Bullying	Frequency	Percent
.00		1	2.0
1.00		48	98.0
Total		49	100.0

Agreement Frequencies for Programs or Supports Needed to Help Students with Mental Health Needs School 2

Q40	Adequate support programs	Frequency	Percent
.00		4	8.2
1.00		45	91.8
Total		49	100.0

Q41	Intervention programs for children with externalizing problems	Frequency	Percent

.00		0	0.0
1.00		49	100.0
Total		49	100.0

Q42	Bullying Program	Frequency	Percent
.00		1	2.0
1.00		48	98.0
Total		49	100.0

Q43	Early intervention programs	Frequency	Percent
.00		2	4.1
1.00		47	95.9
Total		49	100.0

Q44	Early screening and pre-referral programs	Frequency	Percent
.00		1	2.0
1.00		48	98.0
Total		49	100.0

Q45	Staff training and coaching on mental health issues	Frequency	Percent
.00		3	6.1
1.00		46	93.9
Total		49	100.0

Q46	Administrator support	Frequency	Percent
.00		0	0.0
1.00		49	100.0
Total		49	100.0

Q47	Crisis planning and support	Frequency	Percent
.00		2	4.1
1.00		47	95.9
Total		49	100.0

Q48	Implementing of existing programs as intended	Frequency	Percent
.00		5	10.2
1.00		44	89.8
Total		49	100.0

Q49	Ongoing monitoring for students with mental health needs	Frequency	Percent
.00		0	0.0
1.00		49	100.0
Total		49	100.0

Agreement Frequencies for Barriers for Providing Mental Health Services in School: School 2

Q50	Difficulty identifying children with mental health needs	Frequency	Percent
.00		20	40.8
1.00		29	59.2
Total		49	100.0

Q51	Insufficient number of mental health professionals	Frequency	Percent
.00		15	30.6
1.00		34	69.4
Total		49	100.0

Q52	Lack of adequate training for dealing with children's mental health needs	Frequency	Percent
.00		7	14.3
1.00		42	85.7
Total		49	100.0

Q53	Gaining parental cooperation and consent	Frequency	Percent
.00		10	20.4
1.00		39	79.6
Total		49	100.0

Q54	Stigma associated with receiving mental health services	*Frequency*	*Percent*
.00		*6*	*12.2*
1.00		*43*	*87.8*
Total		*49*	*100.0*

Q55	Language and cultural barriers while working with culturally diverse students/families	Frequency	Percent

.00		1	2.0
1.00		48	98.0
Total		49	100.0

Q56	Referral options in the community	Frequency	Percent
.00		14	28.6
1.00		35	71.4
Total		49	100.0

Q57	Lack of funding for school based health services	Frequency	Percent
.00		11	22.4
1.00		38	77.6
Total		49	100.0

Q58	Mental health issues are not considered a role of the school	Frequency	Percent
.00		29	59.2
1.00		20	40.8
Total		49	100.0

Q59	Competing priorities taking precedence over mental health services	Frequency	Percent
.00		13	26.5
1.00		36	73.5
Total		49	100.0

Q60	The belief that mental health problems do not exist and are merely an excuse	Frequency	Percent
.00		25	51.0
1.00		24	49.0
Total		49	100.0

Q61	Academic demands	Frequency	Percent
.00		13	26.5
1.00		36	73.5
Total		49	100.0

Agreement Frequencies for Perceived Benefits of On-Site Mental Health Services: School 2

Q62	Reduction in students' being tardy and/or absent	Frequency	Percent
.00		19	38.8
1.00		30	61.2
Total		49	100.0

Q63	Overall academic improvement/success	Frequency	Percent
.00		11	22.4
1.00		38	77.6
Total		49	100.0

Q64	Improvement in school connectedness	Frequency	Percent
.00		9	18.4
1.00		40	81.6
Total		49	100.0

Q65	Increase in graduation rate	Frequency	Percent
.00		15	30.6
1.00		34	69.4
Total		49	100.0

Q66	Decrease in the dropout rate	Frequency	Percent
.00		15	30.6
1.00		34	69.4
Total		49	100.0

Q67	Improve parent/community perspective of the school	Frequency	Percent
.00		13	26.5
1.00		36	73.5
Total		49	100.0

Q68	Reduce the number of students using alcohol and/or drugs	Frequency	Percent
.00		19	38.8
1.00		30	31.2
Total		49	100.0

Q69	Improve relationship of home and school	Frequency	Percent

.00		10	20.4
1.00		39	79.6
Total		49	100.0

Q70	Reduce poverty	Frequency	Percent
.00		36	73.5
1.00		13	26.5
Total		49	100.0

Q71	Reduce teen pregnancy	Frequency	Percent
.00		22	44.9
1.00		27	55.1
Total		49	100.0

Q72	Students would be less likely to "fall between the cracks"	Frequency	Percent
.00		8	16.3
1.00		41	83.7
Total		49	100.0

Q73	Reduce the number of students referred for special education or 504s	Frequency	Percent
.00		20	40.8
1.00		29	59.2
Total		85	100.0

Agreement Frequencies for Experience Working with Students with the Following Needs: School 3

Q1	Aggressive Behaviors	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q2	Anxiety Problems	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q3	Bullying	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q4	Defiant Behavior	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q5	Depression	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q6	Suicidal Thoughts	Frequency	Percent
.00		4	25.0
1.00		12	75.0
Total		16	100.0

Q7	Friend or Relative Committed Suicide	Frequency	Percent
.00		13	81.3
1.00		3	18.8
Total		16	100.0

Q8	Self-Harm	Frequency	Percent
.00		3	18.8
1.00		13	81.3
Total		16	100.0

Q9	Disruptive Behaviors	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q10	Family Stressors/Trauma	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q11	Hyperactivity/Inattention	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q12	Peer Problems	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q13	Social Phobia	Frequency	Percent
.00		4	25.0
1.00		12	75.0
Total		16	100.0

Q14	Homelessness/Transient	Frequency	Percent
.00		3	18.8
1.00		13	81.3
Total		16	100.0

Q15	Drugs	Frequency	Percent
.00		5	31.3
1.00		11	68.8
Total		16	100.0

Q16	Neglect or Deprivation	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q17	Adjustment Issues	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q18	Victim of Bullying	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Agreement Frequencies for Programs or Supports Needed to Help Students with Mental Health Needs School 3

Q40	Adequate support programs	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q41	Intervention programs for children with externalizing problems	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q42	Bullying Program	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q43	Early intervention programs	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q44	Early screening and pre-referral programs	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q45	Staff training and coaching on mental health issues	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q46	Administrator support	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q47	Crisis planning and support	Frequency	Percent
.00		3	18.8
1.00		13	81.3
Total		16	100.0

Q48	Implementing of existing programs as intended	Frequency	Percent
.00		5	31.3
1.00		11	68.8
Total		16	100.0

Q49	Ongoing monitoring for students with mental health needs	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Agreement Frequencies for Barriers for Providing Mental Health Services in School: School 3

Q50	Difficulty identifying children with mental health needs	Frequency	Percent
.00		6	37.5
1.00		10	62.5
Total		16	100.0

Q51	Insufficient number of mental health professionals	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q52	Lack of adequate training for dealing with children's mental health needs	Frequency	Percent
.00		0	0.0
1.00		16	100.0
Total		16	100.0

Q53	Gaining parental cooperation and consent	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q54	Stigma associated with receiving mental health services	Frequency	Percent
.00		5	31.3
1.00		11	68.8
Total		16	100.0

Q55	Language and cultural barriers while working with culturally diverse students/families	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q56	Referral options in the community	Frequency	Percent
.00		6	37.5
1.00		10	62.5
Total		16	100.0

Q57	Lack of funding for school based health services	Frequency	Percent
.00		3	18.8
1.00		13	81.3
Total		16	100.0

Q58	Mental health issues are not considered a role of the school	Frequency	Percent
.00		9	56.3
1.00		7	43.8
Total		16	100.0

Q59	Competing priorities taking precedence over mental health services	Frequency	Percent
.00		3	18.8
1.00		13	81.3
Total		16	100.0

Q60	The belief that mental health problems do not exist and are merely an excuse	Frequency	Percent
.00		10	62.5
1.00		6	37.5
Total		16	100.0

Q61	Academic demands	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Agreement Frequencies for Perceived Benefits of On-Site Mental Health Services: School 3

Q62	Reduction in students' being tardy and/or absent	Frequency	Percent
.00		6	37.5
1.00		10	62.5
Total		16	100.0

Q63	Overall academic improvement/success	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q64	Improvement in school connectedness	Frequency	Percent

.00	0	0.0
1.00	16	100.0
Total	16	100.0

Q65	Increase in graduation rate	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q66	Decrease in the dropout rate	Frequency	Percent
.00		1	6.3
1.00		15	93.8
Total		16	100.0

Q67	Improve parent/community perspective of the school	Frequency	Percent
.00		5	31.3
1.00		11	68.8
Total		16	100.0

Q68	Reduce the number of students using alcohol and/or drugs	Frequency	Percent
.00		5	31.3
1.00		11	68.8
Total		16	100.0

Q69	Improve relationship of home and school	Frequency	Percent
.00		2	12.5
1.00		14	87.5
Total		16	100.0

Q70	Reduce poverty	Frequency	Percent
.00		14	87.5
1.00		2	12.5
Total		16	100.0

Q71	Reduce teen pregnancy	Frequency	Percent
.00		8	50.0

1.00		8	50.0
Total		16	100.0

Q72	Students would be less likely to "fall between the cracks"	Frequency	Percent
.00		3	18.8
1.00		13	81.3
Total		16	100.0

Q73	Reduce the number of students referred for special education or 504s	Frequency	Percent
.00		6	37.5
1.00		10	62.5
Total		85	100.0