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Do school-based mental health programs have a positive outcome on elementary, middle and high school aged student's functioning from the perspective of teachers in urban public school systems in New York City, Boston and Berkeley, Ca?

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ABSTRACT

This mixed methods, primarily quantitative study examined the perceptions of urban public school teachers about school-based mental health (SBMH) programs and services. The participants included public elementary, middle, and high school teachers from the urban areas of New York City, Boston, and Berkeley, California. Forty participants responded to an online survey, which included questions addressing the demographic characteristics of participants and ideas for improving the SBMH program at their schools. Twenty-five of the participants were from Boston, eight were from New York City, and seven were from Berkeley. Seventeen participants were teachers in elementary schools, ten were teachers from middle schools, and thirteen were teachers in high schools. This study addressed the following research question: Do school-based mental health programs have a positive outcome on elementary, middle, and high school aged student's functioning from the perspective of teachers in urban public school systems?

DO SCHOOL-BASED MENTAL HEALTH PROGRAMS HAVE A POSITIVE

OUTCOME ON ELEMENTARY, MIDDLE, AND HIGH SCHOOL AGED

STUDENT'S FUNCTIONING FROM THE PERSPECTIVE OF TEACHERS IN

URBAN PUBLIC SCHOOL SYSTEMS IN NEW YORK CITY, BOSTON, AND

BERKELEY, CA?

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

INTRODUCTION

Schools in this day and age are faced with the responsibility of meeting the needs of children in a more comprehensive fashion. Now the medical and mental health needs of children are taken into consideration when looking at how to help children reach their full potential both academically and socially. The task of educating children that are suffering from complex mental health issues is not easy and has proven to be one of the biggest growing concerns for educators in this country. Mental health problems are very prevalent for this country's youth, with more than 20% of children and adolescents suffering from them (Taras & Young, 2004). 16% of these children receive mental health services and out of that number 70% to 80% receive services in the school setting (Rones & Hoagwood, 2000). Based on the current situation it is important to look at the role of school-based mental health (SBMH) programs in meeting children's needs in a more focused manner. An essential part of this process involves looking at these types of programs from the perspective of the teachers. Teachers play a pivotal role in the school environment and due to the amount of time they spend with the children involved in SBMH they are able to observe their functioning on an everyday basis. The focus of this particular study will ask the question, do school-based mental health programs have a positive outcome on elementary, middle, and high school aged student's functioning from the perspectives of teachers in urban public school systems in New York City, Boston, and Berkeley, CA?

Despite the fact that a major percentage of the children who are receiving mental health services access them while in school, there is little known about the quality or type of services offered in school-based mental health services, partly because there are few school-based mental health programs that have been evaluated empirically (Rones & Hoagwood, 2000). In order to build more support for these types of services Armbruster & Lichtman (1999) point to the need for more systematic evaluations to take place. Much of the previous research about SBMH programs has been centered in two areas: on the children who are receiving the services and the different mental health problems the students are facing. Looking at school-based mental health services, Flaherty, Weist & Warner (1996), reflect that, "In terms of treatment outcome, there has been some limited evaluation of the impact of school-based health services" (p.347), and believe that, "There is a crucial need for well designed outcome research" (p.348). There is also little information on the interrelationships between the collaborative partners in SBMH programs (Kury & Kury, 2006). A limitation of the studies that have looked at outcome measures is that they do so from the perspective of clinicians, leaving out the important perceptions of teachers and parents (Armbrustrer & Lichtman, 1999).

The purpose of this study is to determine the level of effectiveness of SBMH programs on elementary, middle, and high school aged student's functioning from the perspective of teachers. As stated earlier the perspective of teachers is immensely important to take into consideration when looking at whether or not SBMH programs are effective in meeting student's mental health needs. For this reason the research done in this study will focus on obtaining information from public elementary, middle, and high school teachers about their perceptions of the effectiveness of SBMH programs,

specifically when it comes to addressing students overall functioning. The study was conducted in New York City, Boston, and Berkley, CA in public schools that have SBMH programs that are contracted with outside entities. Surveys were emailed to teachers with the hopes that they would fill them out accurately and honestly. The surveys were conducted online through SurveyMonkey, so that teachers could submit them anonymously. The intended audience for the study is clinical and consulting mental health professionals (i.e. social workers, psychologists, psychiatrists, psychiatric nurses, and mental health counselors) and school staff and administration.

This study provided useful information to the field of social work by collecting empirical evidence about an area of clinical importance within a school setting. It is demonstrating a clearer picture of teacher's perceptions of mental health services and will inform the field of social work in terms of implementating and evaluating SBMH programs. This project also discusses the meaningful collaboration with members of the children's school environment, racial and cultural issues that may affect perceptions of mental health work, and other areas of need when it comes to serving children and their families in this environment. School-based clinicians are in an ideal situation to achieve the needed level of interaction with the child, the child's peers, or adults in the child's environment to attain clinically significant improvements (Evans, Axelrod & Sapia, 2000), which highlights the need for this type of research in the field of social work. SBMH program administrators want to be able to provide clear quantitative evidence that program services relate to positive changes in academic performance and behavior within the school or district (Nabors, Weist & Reynolds, 2000). This study was an attempt to contribute to this evidence while at the same time supporting this meaningful work.

CHAPTER II

LITERATURE REVIEW

The provision of mental health services in the public school system of this country has a long history dating back to the late 19th and early 20th century (Sedlak, 1997), with the earliest programs being set up in New York City, Boston, and Hartford, Connecticut in the year 1906 (Allen-Meares, 2006). A review of the historical evolution of school-based mental health (SBMH) services in the United States reveals that while these services have been seen as important at times, they have not always been considered as having a crucial place in the school environment (Sedlak, 1997). The role of these types of services has been defined and redefined, with some of the key terms associated with SBMH transforming and evolving over time. Taking a look at the mental health needs of urban youth and current reasons for SBMH programs will point to the importance of these types of services within schools and the reasons that teachers play a vital role in the evaluation process. Reviewing these reasons will also underscore why schools are in many ways the perfect place for providing services to address the psychosocial difficulties of students (Flaherty, Weist & Warner, 1996). Analyzing the literature on teachers and SBMH will shed light on teachers' views of student mental health needs and the role that mental health plays in school. It will also highlight the reasons why collaboration with and inclusion of teachers' input is not only essential, but a characteristic of quality SBMH programs as well.

This literature review will take a closer look at the history of SBMH in this country, focusing on the changing relationship between schools and mental health workers in the school environment. It will examine literature that point out the different mental health needs of urban youth and current reasons for the use of quality SBMH programs with an exploration on what is currently needed, to more effectively meet the needs of urban students with mental health problems. It will attempt to explain important definitions and key terms in SBMH, and will explore the spectrum of services that are offered. The roles SBMH providers play and how schools serve as optimal settings for the provision of mental health services will also be included in the review. Another focus of this literature review will be to explore literature that focuses on teacher's perceptions of SBMH in terms of its level of effectiveness, need, and place in urban public school systems. This will draw attention to literature that addresses the need to collaborate with teachers, when implementing mental health services for students, as an important characteristic of quality SBMH programs. Overall, this review of the literature on SBMH will underscore the importance of the question: Do school-based mental health programs have a positive outcome on elementary, middle, and high school aged student's functioning from the perspective of teachers in urban public school systems in New York City, Boston, and Berkeley, Ca?

The History of School-Based Mental Health Services in the United States

The history of mental health services in schools started in the late 19th and early 20th century and was rooted in the movement to establish a comprehensive package of social services, which included mental and physical health, social welfare and vocational preparation programs, in elementary and secondary schools (Sedlak, 1997). This

endeavor was in response to a growing racial, ethnic and socioeconomic diversity in the student population attending schools. At one time schooling was only intended for the elite and was taught in a traditional manner, which was characteristic of earlier classical schools, however the 20th century school was open to all children, from poor and middle classes as well as the upper classes (Sedlak, 1997). As educators began the process of redefining the social functions of schools, from just teaching disciplinary knowledge to providing more comprehensive services, they challenged different social groups to rouse enthusiasm for the new role schools would play in shaping contemporary industrial America (Sedlak, 1997). Social activists, mainly women who were involved in local, community-centered movements, like settlement house workers, women's groups and philanthropists were focused on improving the welfare of children. These women encouraged schools to more completely meet the needs of children by, "providing medical inspections and inoculations, eyeglasses, warm coats and hot lunches, visits to family homes and many other new services" (Sedlak, 1997, p. 351). The educational establishment welcomed these attempts, especially because of the financial resources and volunteer labor that was provided (Sedlak, 1997). By the early 20th century guidance counselors were incorporated into the school setting to help students find a connection to a career after they graduated. "Among the earliest, but also among the smallest, were programs to inquire into, and attempt to treat, emotional and mental problems among schoolchildren" (Sedlak, 1997, p. 351). Schools attempted to take on increasingly more social welfare functions and attempted to do what had previously only been in the realm of families (Flaherty et al., 1996). The individuals who were taking on this responsibility

were the first mental health workers to work with children and adolescents in the school setting (Sedlak, 1997).

Some of these early mental health workers are blamed for having participated in the "Americanization of immigrant children", in part because of directing immigrant and African-American youth to find jobs that suited their racial identity (Sedlak, 1997, p. 354). As the evolution of school-based mental health continued during the next 50 years or so and the roles of mental health workers became "professionalized", the focus of the mental health work being done shifted towards, "individual case analysis, and away from attempting to improve broader social and economic conditions" (Sedlak, 1997, p. 354). The use of new "state-of-the-art" measurement techniques and evaluative instruments also changed the way mental health professionals in schools viewed the etiology of student's mental health problems, seeing them as, "less rooted in social and economic deprivation and more grounded in family dynamics, or internal psychological conflicts" (Sedlak, 1997, p. 355). With this change in view came more of a focus on treating children from the middle and upper classes, which represented a change from the earlier focus of social service provision to all students. In the 1950's after several national reports were published that emphasized the responsibility of schools in providing more comprehensive physical and mental health programs, professional social work and mental health practitioners retrained their focus towards providing more therapeutic, clinical, and personality adjustment based services. Another result of these reports was more federal funds being given to schools to provide counseling, guidance, special education, and social welfare services, which helped justify the educational value of these services (Sedlak, 1997). The influx of federal funding once again was another major reason for

the educational establishment to appreciate these services being provided in schools. This feeling of appreciation would change in the next couple of decades.

During the 1960's there was a renewed interest in providing social welfare services to the poor and children of color, with the idea that these services would serve as, "mechanisms for removing the barriers of learning that confronted children of the poor or those who suffered racial or economic discrimination" (Sedlak, 1997, p. 357). These services addressed issues of truancy, vocational training, and job placement for poor urban youth. The little funding that was afforded for these services came from the federal and state governments, but because the cost of providing these services was so high, schools found themselves hampered financially to provide these services (Sedlak, 1997). This marked a change in the formerly respectful relationship between schools and mental health providers, with the new relationship being characterized by a tension based on economic concerns. In order to protect themselves different boards of education refused to make SBMH programs permanent, which influenced the future of these programs and created tensions between teachers and mental health workers who felt that their jobs were being put at risk by one another (Sedlak, 1997).

In the 1980's figures were published in national reports that showed a growing need for mental health service provision for youth. There was an increased concern for issues facing adolescents like teenage pregnancy, sexually transmitted diseases, drug and alcohol abuse, rising rates of teenage suicide, homicide, and school drop-out rates which approached 80% in some urban areas (Sedlak, 1997). The rate of poverty for American children also grew substantially in the 1980's (Sessions and Fanolis, 2006). Due to the growing concern of poverty and its effects on the social and emotional functioning of

students, the development of SBMH programs increased and there was more pressure put on schools by the government to find ways to incorporate SBMH services (Flaherty et al., 1996).

In 1986, the U.S. Office of Technology Assessment reported that approximately 7.5 million out of 63 million children were in need of mental health support and that only around 2 million of those children were receiving services each year (Flaherty et al., 1996). In response to these numbers, the past twenty years has shown an increase in the importance placed on providing school-based services for youth. With current numbers of youth of color under the age of 18 rising in this country, both education and mental health have been slow to adapt teaching and clinical practice methods (Sessions and Fanolis, 2006), which is an issue that SBMH attempts to address. Although it seems to be a lengthy process for programs to be instituted and funded, SBMH services are now seen as imperative to the future of effective education in the United States (Goldman, 1997). The many obstacles that students have faced in recent years and currently face in 2008 include living in violent communities, lacking resources, and experiencing the problems associated with a failing education system. Now, more than ever SBMH programs are needed in our urban centers.

Definitions and Key Terms in School-Based Mental Health

To begin any discussion of SBMH programs it is essential to examine and think about important definitions and key terms in the field. With out this examination, an understanding of what SBMH programs have the potential of providing is not as rich or as meaningful. Another result of this focus on important definitions and key terms will be to highlight some of the current problems in the rendering of SBMH services, with a

specific concentration on the terms marginalization and fragmentation and how they have

an impact on the effectiveness of SBMH programs. A deeper understanding of

definitions and key terms in SBMH will underscore the significance of schools as optimal

settings for the provision of mental health services for urban youth. It is also essential

when thinking about SBMH programs to think about who it is that provides the services

and the different roles that they serve in the process of attempting to meet the mental

health needs of students.

Diversity of services offered by SBMH programs

It is important to first define school-based, school-linked, and urban school

counseling services. School-based services refer to services that are provided on-site

within the school setting or campus and school-linked services refer to services that are

provided outside the school setting, but that have formal connections to school sites. In

both cases the services that are provided may be owned by either schools, community-

based organizations, or in some situations by both (Adelman & Taylor, 1998). Bailey

(2000) distinguishes SBMH treatment as, "differentiated from traditional mental health

services through the provision of on-site primary preventive, diagnostic, and treatment

services in the school" (p. 239). Green, Conley, & Barnett (2005) define urban school

counseling as, "school counseling personnel and programmatic services that are

specifically geared toward meeting the multiple and often complex needs of students

living and attending school in culturally diverse environments" (p. 190). Although all

these types of services are crucial in meeting the needs of students, families and

communities, the research in this study is looking at school-based services, with a

particular focus on services that are provided on-site at the school by an outside entity.

Weist, Myers, Danforth, McNeil, Ollendick, and Hawkins (2000) describe these types of programs as normally symbolizing, "a joining of the school with providers from community-based programs such as community mental health centers" (p. 260).

The range of services provided by SBMH programs is very diverse and changes depending on the structure and set up of the program. In larger school districts there is a broad array of preventive and corrective services that are geared towards students' problems, with some programs being implemented throughout the school district and some being connected to specific schools (Adelman & Taylor, 1998). The interventions can be offered to all students in a school, students in a certain grade, or to those students that are considered "at risk". The programs can be put into operation in regular and special education classrooms or be designed to serve groups, individuals, and entire classes (Adelman, & Taylor, 1998). In the literature on SBMH the spectrum of services that are offered are described in many ways. When talking about the continuum of SBMH models, Lynn, McKay, and Atkins (2003), view selective approaches at one end of the spectrum, which are focused on the concerns that caused students to be referred in the first place, and at the other end universal approaches, which are focused on incorporating mental health awareness into daily school life (i.e. schoolwide curriculums for prosocial behavior and teacher consultation strategies). It is important to note here that many public schools do not have mental health services at all let alone SBMH services.

The next two paragraphs will describe two important models of SBMH programs. Taras & Young (2004) in an article on SBMH for the Committee on School Health encourage the reader to classify school or district's mental health programs as a three

tiered model of services and needs: the first tier being a range of preventive services that are aimed at all children in all school settings that center on lowering risk factors, building resilience, connecting students to community and family supports and providing a positive and friendly open social environment; the second tier being mental health services that are targeted at children, that have one or more mental health needs, but who function at a level where they can engage successfully in many social and academic settings. The services in this tier would entail, "the provision of group or individual therapy to students" and "behavioral components" (p. 1840) of individualized education plans (IEP's) for students in special education. The third tier includes mental health services whose main objective is to meet the needs of students with severe or chronic mental health diagnoses or symptoms. The most common models of SBMH only provide individual therapy or counseling to the students, which underutilizes the mental health clinicians that are providing the services.

As a result of the changing needs of students and the development of the school social work field Massat, Ornstein & Moses (2006) identified three principal models of school mental health service delivery in an article on school social work in the Twenty-First Century; the traditional model, community-school partnerships, and full-service schools, with all three involving partnerships or collaborations with the community and community agencies. Each model will be explained and reviewed. In the first model, "school social workers offer individual and group counseling and crisis-intervention to assist children with problems that interfere with learning" (Massat et al., 2006, p. 97). If there are other concerns for the student that involve issues outside of barriers to learning or require long-term residential or family treatment, the school social worker is expected

to make a referral and connect the student to the necessary services located in the community. In this model school social workers are normally not expected to take on the role of mental health case manager; that role is assumed by the community mental health center or family service agency. School districts operating under this model bill Medicaid for the mental health services that are provided. A problem that is associated with this model is the small amount of school social workers that are expected to meet the mental health needs of many students. The fact that many mental health issues experienced by students do not clearly affect academic functioning, but still impact the student negatively and possibly their classmates is another problem with this model that is identified by the authors. There is a lack of existing research exploring the impact of mental health services on academic performance.

The community-school partnerships model, "involves partnering between community agencies and schools to bring into the school additional social workers, psychiatrists, and other mental health professionals to provide longer term or more intensive therapeutic services" (Massat et al., 2006, p. 98). School districts utilizing this model will typically contract with one or more mental health agencies to provide services within the school setting. Grant funding is a common way that these types of services are funded. A benefit that is connected to this model is the improved ability to provide more mental health services to students in schools. A weakness of this model is that mental health professionals coming from outside the school setting do not have the same level of awareness as school social workers of the whole school context or the chances to intervene with sources besides the individual or family. As a result, the school social worker's role in providing interventions to the classroom or entire school is significantly

limited in this model. It is important to note that there are exceptions where clinicians focus on this barrier and develop strong relationships with or in schools.

In the full-service school model both students and community members have access to services which include, "vaccination and health clinics, family-planning services, drug and alcohol treatment, as well as mental health services" (Massat et al., 2006, p. 98). There are not many schools that are full-service; the obstacles in the way of more schools employing this model include funding issues, political influences as many schools are now focused solely on academic performance and standardized testing results instead of the overall interest of the child, competition between schools and agencies for the limited private and public insurance funding that is available, and issues involving the difficulty of maintaining confidentiality due to both the visible nature of school settings and the differences in ethical codes between teachers and mental health providers.

After looking more closely at the multiplicity of services that are offered as a part of SBMH and the manner in which they are provided, it is clear that there are strengths and weaknesses to each approach, but made even clearer is the fact that funding for SBMH is scarce and thus, is heavily sought after. According to Foster, Rollefson, Doksum, Noonan, & Robinson (2005) in a study of school mental health services in the United States between 2002 and 2003, school district leaders from a representative sample of more than 1,000 districts reported that most funding for school mental health came from federal and state special education dollars, with a combination of local, general state, and Medicaid revenues making up the difference. In this same study district leaders noted that funding for these types of services had decreased from the year before even though student mental health needs had increased. Federal and state

mandates also play a major role in influencing how many student mental health service professionals are employed by schools (Adelman & Taylor, 1998). In a report on the findings from the National School Health Survey from 1993-1994 (Davis, Fryer, White, & Igoe, 1995) it was shown that in a representative sample of 482 school districts of different sizes in 45 states that 55% had counselors, 40.5% had psychologists, 21% had social workers, and 2.1% had psychiatrists. Considering the estimates of the number of students who are experiencing mental health related problems these percentages are quite low.

Due to issues in funding, many school psychologists, social workers and other mental health support workers are forced to alternate between schools that they serve, which leads to a trend in which they carry out their duties separately from one another and other essential personnel that are invested in the mental health of students (Adelman & Taylor, 1998b). There are few schools that have enough resources or funding to provide more than the minimum of services that are needed. In some cases SBMH practitioners cannot do much more than assess for special education eligibility, offer brief consultations and aid in making referrals to special education or community resources. Only programs with enough funding and support can provide services like continuing consultation, program development, advocacy, quality assurance, health education, services and guidance (Adelman & Taylor, 1998; Adelman & Taylor, 1998b), which are programs that students who are experiencing mental health problems need in order to help them function at a healthy level.

Taking into account the funding issues that are impacting SBMH one can see the importance of the need for schools and the federal and state governments to increase their

dedication to mental health for students. Throughout the literature on SBMH, funding for services is an issue that is considered crucial. Some ideas for maintaining current funding and increasing future funds are to frame the use of SBMH as an approach to addressing academic and non-academic barriers to learning, to reveal outcome measures that are consistent with this goal, and to demonstrate enhanced cost-effectiveness of services (Adelman & Taylor, 1998, 1998b; Weist, Lindsey, Moore, & Slade, 2006).

SBMH Providers: Roles played and Interventions Provided

This study focuses on SBMH services that are provided by outside specialists. School districts rely on different types of professionals to carry out activities related to mental health, included are school counselors, psychologists, social workers, psychiatrists, psychiatric nurses and in certain situations by other kinds of therapists (i.e. art, dance, music, occupational, physical, speech, language-hearing, and recreational therapists) (Adelman & Taylor, 1998b). Although these professionals fulfill a large role in attempting to address the mental health of students, sometimes it may not be enough. The needs of students are so significant that frequently teachers and other professionals in the school setting are asked to play a role as well like nurses, special education and resource staff, administration, students (i.e. peer counselors), family members, clerical staff, aides, cafeteria workers, custodians, volunteers and even bus drivers (Adelman & Taylor, 1998b). Students are presenting with different layers of difficulties and often need a team of people to provide an effective school intervention. When schools contract with outside mental health agencies, clinics or hospitals and have SBMH programs on-site that employ mental health specialists it can provide not only extra help, but also relief for school professionals that already have a heavy burden placed on them.

The different roles and interventions that are provided, which are built-in to the jobs of SBMH workers are also very diverse. A representative list of interventions include promoting mental health, addressing the stressors associated with psychosocial and socioeconomic problems, managing psychotropic medication, playing a part in systems of care, enhancing the efficacy of special education programs, providing culturally competent diagnostic assessment and consultation, crisis intervention, engaging parents and teachers, substance abuse prevention work and counseling, transition services (i.e. orientations, social support for new students), conflict resolution, primary prevention, and providing individual, group, and family therapy. Besides being mental health practitioners, some of the other roles that they fill are advocators, administrators, mentors, leaders, liaisons, collaborators, coordinators, case managers, teachers, and program developers (Adelman & Taylor, 1998,1998b; Bailey, 2000; Bryan, 2005; Mills, Stephen, Moore, Weist, Daly, & Edwards, 2006; Taras & Young, 2004; Teasley, 2004). Considering the mental health needs of today's urban youth, these interventions and roles are both a critical piece of SBMH practice and necessary point of focus when it comes to developing new school-based programs in the future.

Marginalization and Fragmentation of SBMH service delivery

Throughout the literature on SBMH there is a call to address the lack of cohesion between the different mental health services that are offered within schools (Adelman & Taylor, 1998; 1998b; Allen-Meares, 1993; Mills et al., 2006; Taylor & Adelman, 2000). Despite the growing attention on SBMH and the increased number of programs that are being developed in urban schools, there is still a need to organize the services being provided so that enhanced cohesion becomes a reality. Marginalization and

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fragmentation are terms that play a big role in the lack of cohesion that currently exists in most SBMH programs. Looking closer at these terms will shed light on the impact that they have on the quality and effectiveness of SBMH service provision. It will not only highlight the importance of the need to pull together both school and community resources, but also focus on a more comprehensive approach in meeting the mental health needs of school communities.

In order to develop some sort of understanding about the ways in which fragmentation and marginalization affect SBMH, it is important to give some examples from the literature on SBMH. Taylor & Adelman (2000) in an article on the impact of marginalization and fragmentation in SBMH, draw attention to the fact that no matter the range and stage of development of the different programs and services offered in SBMH, that many of them operate separately from one another as a result of the organizational structures that group them into different divisions and that there are only a small number of school districts that have organized the different services and departments in a manner in which they can coordinate with each other. Taylor & Adelman (2000) note that, "Because of the categorical way programs are supported, students with problems may be involved in multiple programs, and staff for each program may have little contact" (p. 210). Taylor and Adelman (2000) also note that in cases where families have multiple children that are experiencing problems in varying levels of school that, "well-meaning staff from each school may contact the home, rather than developing and implementing a cohesive intervention plan for working with the family in a unified way" (p. 210), which has an affect on the effectiveness of the work being done both with each individual child and the family as a whole. There is also a struggle with SBMH clinicians consulting with

outpatient and medical providers. Often these providers are unaware that a child is receiving SBMH services. This lack of coordination impacts the perception of the quality of the services being provided. Another example of fragmentation that is considered to be one of the most significant is the provision of interventions without the inclusion of teachers as integral members in the process of intervention, planning and execution (Taylor & Adelman, 2000). Fragmentation of SBMH services is also perpetuated by, "the failure of policy makers at all levels to recognize the need to reform and restructure the work of school and community professionals who are in a position to address barriers to learning and facilitate development" (Taylor & Adelman, 2000, p. 211).

Some examples of the ways that SBMH is marginalized come in the form of educational policy and the way that it has an effect on the emphasis that is placed on mental health in schools by school reformers. According to Adelman & Taylor (1998), "The current situation is one in which, despite awareness of the many barriers to learning, school reformers continue to concentrate mainly on improving instruction and school management" (p. 183), which in effect is placing an emphasis on student's ability to perform well academically regardless of any barriers they are facing. An example of one of these policies is the *No Child Left Behind Act* of 2001, Weist, Lindsey, Moore & Slade (2006) argue that there are provisions in this act that connect closely to SBMH and that a crucial way to encourage support for mental health services in schools is to find ways of pointing this out to schools. Mills et al. (2006) also call attention to the need for more examining of the President's New Freedom Commission on Mental Health to reduce the marginalization of SBMH services. This is an important step considering the

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commission strongly advocates for the provision of SBMH services as a means of addressing the mental health needs of children, youth, and families.

The literature on addressing issues of fragmentation point to the need of taking a more comprehensive approach to providing SBMH services, as a means of improving the effectiveness of these services and increasing the overall functioning of all students. Taking a comprehensive approach entails finding ways of connecting the already existing programs and services in schools and making them apart of the everyday proceedings that take place in schools, which will necessitate a process of resource and needs mapping and analysis (Taylor & Adelman, 2000). This also requires, "connecting families of schools, such as high schools and their feeder middle and elementary schools, to enhance efficiency and effectiveness and achieve economies of scale" (Taylor & Adelman, 2000, p. 211). The call for more comprehensive approaches in SBMH is seen as a way to more fully meet the needs of those already being served and also as a way of serving larger numbers of students (Adelman & Taylor, 1998), with the purpose being, "to evolve a continuum of programs and services encompassing instruction and guidance, primary prevention, early-age and early-after-onset interventions, and treatments for severe problems" (Adelman & Taylor, 1998, p. 181). One way of achieving this approach is to, "balance generalist and specialist approaches in offering education support programs and services" (p. 180). Another way is develop and create more full-service schools (Adelman & Taylor, 1998; Massat, Ornstein & Moses, 2006).

Schools as Optimal Setting for the Provision of Mental Health Services

When examining the literature on SBMH it becomes abundantly clear that schools are seen as one of the most optimal settings for the provision of mental health services for

youth (Adelman & Taylor, 1998; Bruns, Walrath, Glass-Siegel, & Weist, 2004; Flaherty et al., 1996; Gonzalez, 2005; Mills et al., 2006; Paternite, 2005; Rones & Hoagwood, 2000; Taras & Young, 2004; Walter, Gouze, & Lim, 2006; Weist, Lindsey, Moore & Slade, 2006). Schools are settings that provide exceptional chances to develop and provide intensive and comprehensive intervention and prevention programs as well as presenting opportunities for important research (Adelman & Taylor, 1998). According to Bruns et al. (2004), " As the system that touches almost all young people from childhood to adolescence, the school provides the most efficient point for identifying and engaging students who may be exhibiting markers of risk for developing a psychological disorder" (p. 492). The idea of schools as optimal settings for conducting research is an important one in terms of this research study. It is also significant because of the need, in the field of SBMH, to have more research that underscores the value of mental health in the lives of students.

Considering the many barriers that urban youth face when getting their mental health needs met, SBMH presents the possibility to reduce these barriers simply because of the fact that the services are received in schools (Rones & Hoagwood, 2000). Mills et al (2006) argue that, "Schools are natural service settings with historic ties to children, families and communities and can therefore provide a more naturalistic environment for families to seek assistance for mental health needs" (p. 155). With over 52 million youth enrolled in 114,000 schools and 6 million adults working in schools, Paternite (2005) notes that, " In the United States, schools offer unparalleled access to youth as a point of engagement for addressing their educational, emotional and behavioral needs" (p. 657).

The familiarity of the school setting also has the potential of reducing the amount

of stigma for students and their families that is sometimes connected to receiving mental

health services in unfamiliar settings, which in some cases are not as culturally

compatible as well (Taras & Young, 2004). The stigma surrounding receiving mental

health services begins before adulthood and can be seen in the way that peers make fun of

classmates suffering from mental health issues because they are different (Massat et al.,

2006). According to Massat et al. (2006), "School social workers can and must

contribute to stigma reduction in a variety of ways" they add that, "At the individual

level, school social workers can assist students with mental illness who are experiencing

negative views of themselves from internalized stigma" (p. 99). Gonzalez (2005)

believes that school settings, "continue to have the best potential for the delivery of

preventive mental health services with minimal risk for stigmatization" (p. 252).

Gonzalez (2005) also notes that, "School-based mental health initiatives further reduce

the fear of stigmatization by encouraging parental involvement in the treatment of

children and by empowering parents to become agents of change on behalf of their

children" (p. 252). According to a study by Kaplan, Calonge, Guernsey, & Hanrahan

(1998) adolescents with access to mental health services provided by a school-based

health clinic were 10 times more likely than students with out access to schedule a visit

for mental health or substance abuse treatment. Since one of the main obstacles to

providing mental health services for students is getting access to information on their

functioning in different environments and situations, Taras & Young (2004) point out

that, "Schools have a wealth of opportunities to acquire information on how children deal

with physical and social stresses and challenges and on how they perform in the academic

setting, on community-related roles in which children engage, and on the nature and extent of many sorts of interpersonal relationships" (p. 1842). An investigation of the literature on SBMH makes it obvious that schools provide optimal settings for both students in receiving mental health services and SBMH providers in furthering the field and increasing the efficacy of their work. Due to the fact that 20% of youth face some sort of unmet mental health need (Bruns et al., 2004; Taras & Young, 2004), with higher numbers in urban communities due to violence and trauma exposure, higher poverty rates, less resources, and the fact that many outpatient child and youth mental health services have extensive waitlists for treatment, schools are even more of an optimal setting at this point in history.

School-Based Mental Health Programs Meeting the Needs of Urban Students

School systems are faced with the daunting task of educating students who are confronted with ever increasing barriers and distractions to learning. These come in the form of emotional and behavioral problems, learning difficulties, family struggles, and social and environmental issues. An important way for schools to meet the needs of students faced with these types of problems is to offer intensive mental health services to youth in schools through different partnerships between educational and community based mental health systems (Flaherty et al., 1996). The mental health needs of students in all parts of the U.S. are a concern, but there are various challenges and barriers that exist even more so for students who live in urban communities because of things like lack of after school or recreational activities, language barriers, immigration and acculturation, community and family violence, poverty, lack of employment opportunities, inadequate housing, substandard quality schools, single parent households, high concentrations of

crime and drug abuse, higher drop out rates, racism, discrimination, and lack of access to resources like health insurance and quality healthcare. Challenges of this nature are in no way only linked to urban contexts, yet children and families living in urban environments experience significantly greater levels of adversity, more co-occurring stressors, increased negative consequences, and more limitations to coping than do families in other environments (Stern, Smith, & Joon Jang, 1998). It is clear that youth and families faced with the environmental stresses associated with concentrated poverty, have less resources from which to draw support, however when taking into account the fact that in some urban communities there is increased isolation and erosion of traditional social institutions this situation becomes even worse (Stern et al., 1998). The factors that impact urban youth of color accentuate the need for SBMH programs even further. "The urgent and unique needs of low-income, urban families demand a response from the mental health community in the form of accessible, effective, culturally sensitive, and ecologically meaningful services" (Atkins, Frazier, Abdul Adil, & Talbott, 2003, p. 166).

Sessions and Fanolis (2006) believe that many low-income children without the benefit of these services offered to them will end up in the juvenile justice and child welfare systems. Further Sessions and Fanolis (2006) say that, "These frequently overburdened public bureaucracies are often not sufficiently prepared to address mental health needs, contributing to the greater likelihood that low-income children, particularly children of color, will have their mental health symptoms managed with restraint and punishment" (p. 303). With many of the barriers and distractions that face students expected to rise, Flaherty et al. (1996) believe that schools can be a, "single point of access to services in a non-threatening atmosphere, and reduce barriers to meeting the

needs of children and their families" (p. 351). Another reason for the implementation of SBMH is to increase the chances of early success for children in schools, which is thought to reduce the likelihood of school failure, dropping out, becoming drug addicted and delinquent, and developing serious emotional disorders (Drewes, 2001). Sessions and Fanolis (2006) see the incorporation of school-based services as enhancing the likelihood of academic success for children. The task of providing this kind of support has fallen primarily on the already overloaded shoulders of school-employed mental health professionals (i.e. guidance counselors and school psychologists) (Porter, Epp, & Bryant, 2001), which points to the need for SBMH programs that are affiliated with community mental health clinics or agencies. Research regarding these types of collaborative partnerships has largely been limited to various case studies of school-based centers around the country (Kury & Kury, 2006). In the literature on SBMH urban populations are an under studied group, especially in terms of the effectiveness of the services that are provided when attempting to meet the needs of this population.

The combinations of social and ecological factors over the course of time have created high concentrations of crime, violence, and poverty in many urban environments (Green et al., 2005). As a result many urban neighborhoods are filled with youth who have experienced these problems first hand. "A neighborhood's socioeconomic status, racial and ethnic composition, population mobility and loss, and family structure can affect the ability of children to live safe and productive lives" (Williams, Horvath, Wei, Van Dorn, & Reid, 2007, p. 96). Generally urban youth come across more crime and violence than suburban and rural youth, which has resulted in the presentation of higher rates of problems such as depression, post-traumatic stress disorder, school avoidance,

and delinquent behavior (Weist et al., 2000). Community violence affects 80% of children in urban communities (Atkins, Frazier, Birman, Adil, Jackson, Graczyk et al., 2006; U.S. Department of Justice, 2003). Exposure to violence has been associated to both internalizing problems in youth, such as symptoms connected to depression and posttraumatic stress disorder, and externalizing problems as well (Albus, Weist, & Perez-Smith, 2004). "Not surprisingly, prevalence rates for children's disruptive behavior in urban communities are almost three times national estimates and predictive of ongoing school difficulty and delinquency" (Atkins et al., 2003, p. 146). Massat et al. (2006) claim that, "For children who are poor, it is critical, to reduce barriers to services and to identify children who have lived in persistent poverty, because this living condition is a strong risk factor" (p. 96). There is an active and changing interaction between youth and the different systems they are involved in, which is important to consider when looking at adversity and the different outcomes for urban youth (Stern et al., 1998). Also important to consider is the fact that, "Urban schools in large measure reflect the characteristics of the environment in which they are located" (Lee, 2005, p. 185), however no matter what the geographic location is, the needs of urban youth must be attended to from a view point that takes into consideration the context of the environments in which they live (Green et al., 2005).

Examining what strengths urban environments provide in terms of meeting the needs of students is an area that is lacking in the literature on SBMH. Some of the strengths that are present in urban environments are multigenerational families, community organizing, church and religious groups, community centers, schools, cultural and ethnic diversity, cultural heritage, resiliency, family, social support networks, and

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communal histories. Green et al. (2005) argue that, "Although many challenges exist, the cultural richness of any urban environment creates opportunities for exchange through diversity that can promote healthy development of all students" (p. 189).

"Despite the large need for mental health services, children and families in urban communities remain a largely underserved population" (Atkins et al., 2003, p. 166). Urban children and more specifically low-income children of color have an increased risk of developing some sort of mental health problem, and at the same time are less likely to get effective child mental health services (Gonzalez, 2005). "Urban children presenting with the greatest risk of psychopathology, and those whose socio-environmental situations are most difficult, are less likely to be engaged in mental health treatment and are more likely to disengage from care before positive treatment outcomes are achieved" (Gonzalez, 2005, p. 246). For those who do engage in treatment services there are attrition rates of 50% that are experienced because of stigma, lack of information about services, transportation difficulties and inaccessible location of services, unresponsive providers, and problems understanding the complex service delivery and reimbursement system (Atkins et al., 2006). These circumstances highlight the need to provide mental health services for this population in a setting that is not only accessible to them, but also meaningful as well, which emphasizes the point made earlier in this literature review that schools are optimal settings for the provision of mental health services.

Mental Health Needs of Urban Youth of Color

The history of SBMH has proven the necessity of school-based programs to meet the need of poor and disadvantaged children as well as children of color, who in many cases may be from a family that comes from a different country, who do not have access

to these types of mental health services in their communities. There are a multitude of barriers that these children and youth face which prevent access to mental health services. These barriers include lack of access, transportation problems, poverty, insurance problems, poor knowledge of mental health services, stigma associated with mental health services, perceived lack of effectiveness of therapy, and language barriers (Atkins et al., 2006; Garrison, Roy, & Azar, 1999; Gonzalez, 2005; Kataoka, Zhang, & Wells, 2002; Massat et al., 2006; Teasley, 2004; Weist et al., 2000). Community violence, which may cause feelings of anxiety associated with living in certain neighborhoods, is another barrier that specifically faces urban students of color. Although the fear of neighborhoods is not a universal struggle for students of color or urban students in general, it is something that is impacting many students in urban communities daily. "The delivery of school based mental health services is increasingly being recognized as an effective means to overcome such demographic and service delivery barriers that prevent at-risk children and youth from obtaining needed care" (Garrison et al., 1999, p. 200). Racial and ethnic minority students are at a greater risk for poverty and related stressors like discrimination and racial oppression that create more stress and mental health needs for this population (Massat et al., 2006).

"The greatest challenge confronting the nation remains within large urban metropolis where large numbers of minority students attend underfunded and low-performing schools with low standardized test scores and high dropout rates" (Teasley, 2004, p. 19). Over 50% of the children that attend urban school systems are African American, which is striking considering that the nation's 25 largest school systems are in urban America (Teasley, 2004). In the next 25 years the U.S. will have a majority of

minority students in its urban public schools, with most of the African American students living in communities of poverty within large cities being enrolled in these schools (Williams et al., 2007). African American boys are identified at a much greater rate than other children to have ADHD related symptoms (Williams et al., 2007). Further Williams et al. (2007) argue that, "Although the prevalence of mental disorders for minorities is similar to that for white people when other conditions are equal, in reality, minority children often face multiple stresses that make them more vulnerable to mental illnesses" (p. 97). Because of these and other realities that African American students face like high levels of unemployment and underemployment, high poverty rates, and high rates of family disruption within their communities, "urban school-based practitioners need special training in the development of skills that promote and advance the educational needs of urban black students" (Teasley, 2004, p. 21). There is also a lack of accessible, responsive and culturally competent services to meet the needs of urban students of color, which is a problem that needs to be addressed in SBMH. "The demographic character of our nation is drastically changing, and in response, school social workers will need to increase their knowledge for effective practice with diverse pupil groups" (Allen-Meares, 2006, p. 40).

Garrison et al. (1999) wrote about the need for more appropriate mental health services for children of color, specifically Latino children and their families. The needs that they observed are best served by culturally competent treatment in SBMH programs. They discuss many barriers to treatment for the Latino community like language differences, fear of deportation, cultural stigma, lack of health insurance, and high rates of poverty and racial discrimination. SBMH programs offer some relief to these barriers

by being able to "offer a single point of access to mental health services in a familiar, non-threatening atmosphere relatively free of stigma" (Garrison et al., 1999, p. 207). Some research has shown that African American and Latino children have lower rates of mental health service use than do Caucasian children (Kataoka et al., 2002). In a study (Kataoka et al., 2002) looking at the National Survey of American Families data it was found that Latino children and uninsured children had the greatest rate of unmet mental health needs. This finding is particularly alarming given the fact that national estimates suggest that Latino adolescents have greater rates of suicidal thoughts, depression, and anxiety symptoms and higher rates of dropping out of school than white adolescents (Kataoka et al., 2002). Kataoka et al. (2002) contend that, "services could be improved for Latinos by dealing with barriers such as financial constraints and lack of bilingual bicultural mental health providers" (p. 1552).

In a research study (Armbruster & Lichtman, 1999), focusing on Children's Global Assessment Scale, Global Assessment of Functioning scores, and DSM IV diagnoses comparison, that attempted to assess the effectiveness of an urban SBMH program and the treatment received in the outside clinic that hosted the school program, the results suggested that school-based services may have been as effective as clinic based services. A review of different research studies done on SBMH programs reveal that programs with the strongest evidence of impact were those that were directed toward changing specific behaviors and skills connected to academic and social functioning (Rones & Hoagwood, 2000). Children living in poverty, many of them children of color; have many different factors that influence their academic performance and emotional well being. Research using a nested model (Atkins et al., 2006) shows that quality SBMH

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programs (in this case a PALS program), aimed at dealing with some of these factors, can be effective. There are few research studies on these services and urban populations, which underscores the need for the research done in this thesis study.

SBMH meeting the needs of urban GLBT youth

For youth who identify themselves as gay, lesbian, bisexual, or transgender there are added specific risks like violence and harassment at schools and at home (Massat et al., 2006). GLBT youth are often faced with the difficult task of learning and socializing in settings which can be very insensitive to individuals who's sexual and gender identities are different from traditional societal beliefs. The adverse reactions of family and society and internalized homophobia experienced by GLBT youth at times leads to a pervasive sense of hopelessness and despair, which may account for the increased risk of suicide for these youth (Massat et al., 2006). SBMH can meet the needs of GLBT youth by doing things such as assisting transgendered youth reduce their burden of secrecy and isolation by helping them express their feelings about their personal sense of gender difference, forming support groups for GLBT youth in order to increase socialization and reduce alienation, and providing education to students, teachers, and administrators about the needs of GLBT youth so that they are treated with sensitivity and respect not discrimination and teasing (Massat et al., 2006). Important to note is the fact that GLBT youth of color face an additional level of discrimination as there may be more stigma and lack of acceptance in urban communities.

Characteristics of Quality SBMH Programs with a Specific Focus on Teachers'

Perceptions of SBMH

There are many characteristics that are a part of evaluating quality SBMH

programs. This section will review these characteristics with a specific focus on the roles

of teachers. First, there will be a discussion on what factors are seen as important parts of

SBMH, second, this section will look at previous research that focuses on teachers'

perceptions, and lastly, this section will discuss the significance of SBMH providers

collaborating with teachers to enhance the provision of these services. Paternite &

Johnston (2005) point out the need to view educators, teachers in the case of this study, as

respected customers and colleagues. Paternite & Johnston (2005) note that, "Educators

are valued customers in that mental health professionals must take the initiative to

demonstrate the links between emotional/behavioral health and learning, and they must

incorporate a focus on academic and school success outcomes in assessing the

effectiveness of school-based mental health interventions" (p. 43). For the purposes of

this study this viewpoint is very important when thinking about what characteristics are

parts of quality SBMH programs. Teachers have customarily not been viewed as key

players when it comes to SBMH, which has prevented them from feeling a sense of

empowerment when it comes to embracing their vital health promoting roles (Paternite &

Johnston, 2005). When looking at expanded school mental health, Paternite & Johnston

(2005) highlight the importance of mental health professionals actively engaging

educators in order to enhance system integration of mental health services within schools.

Obtaining teachers' perceptions of the effectiveness of SBMH is a part of this process.

Several other important characteristics of good quality SBMH programs are illustrated,

some examples are: adopting an inclusive definition of the term educator, establishing formal relationships with key opinion leaders within the school system, striving to achieve immersion in the school community, conducting detailed, needs assessments from the perspectives of educators, students and parents, promoting and providing action-oriented in-service trainings and workshops on mental health that are responsive to the needs assessed, prioritizing mental health promotion and prevention initiatives, and finally promoting effective mental health and education practices within schools (Paternite & Johnston, 2005). Looking at these characteristics more closely, again accentuates the importance of the research conducted in this particular study.

In a research study by Atkins, Graczyk, Frazier, & Abdul-Adil (2003) that compared three different school-based models for providing effective mental health services, accessibility, promotion of children's social and academic functioning, and sustainability were emphasized as very important characteristics of good programs. An important aspect of this study was the opportunity to assess the effect of services on multiple markers of children's functioning like academic performance, peer relations (social functioning), and classroom behavior (Atkins et al., 2003). Weist et al. (2000) when looking at the design of expanded school mental health programs point out the importance of considering factors such as developmental, geographic, and cultural concerns as a characteristic of quality programs.

Research on Teachers' Perceptions

To integrate the literature review to the research in this study, an examination of literature on teachers and SBMH is important. Due to the lack of research in this area, this literature review has focused on seven studies in particular. Included in this section

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will be an analysis of research studies that have been done in the past, with a detailed examination of three seminal studies and a brief description of other studies that attempt to measure teachers' perceptions, beliefs, and attitudes regarding SBMH and youth related mental health services. Also, in this section will be included an investigation of literature that indicate collaboration and inclusion of teachers as essential characteristics of quality SBMH programs. These studies are not all set in urban environments, however they are the some the few existing studies in the literature that really center on teachers' perceptions.

In this section research studies on the beliefs and perceptions of essential school personnel, with a specific focus on teachers, will be examined. It will draw attention to a quantitative research study by Roeser & Midgley (1997), in which the focus was determining teachers' views of issues that affect students' mental health. The next study of importance that will be concentrated on in this section of the literature review will be a quantitative study (Repie, 2005) looking at the perspective on school mental health issues of regular and special education teachers (in levels of school from elementary through high school), school counselors, and school psychologists. Data collection in this study concentrated on measuring perceptions of presenting problems of students, available community mental health services, family-based and community-based barriers to services, and the provision of mental health services in schools. Significant differences were found based on school level and geography, position of the professional, and thoughts about the place of mental health services in schools. The third and last study described in this literature review will be a quantitative study (Walter, Gouze & Lim, 2006) that surveyed 119 teachers from six different elementary schools in the Midwestern

United States. The results of this study highlight the need to collaborate with and gain teachers' opinions when evaluating mental health needs in schools and educate and train teachers in mental health information pertaining to students.

The first study by Roeser & Midgley (1997) was part of a longitudinal study, conducted in 20 different Midwest elementary schools, on student motivation and well-being during the transition from elementary to middle school. 200 regular education teachers were used for the study, of that number 80% were Caucasian, 15% African American, and 3.3% were Hispanic. A general teacher survey, teachers' ratings of student adjustment, a principal survey, and a student survey were used as instruments. They also used school records for race/ethnicity, special education status and gender demographics. Both descriptive and correlational approaches were used for data analyses. In this quantitative study Roeser and Midgley (1997) focused on three measures of perception, which were teachers' views of their role in promoting their students' mental health, their mental health related beliefs and corresponding instructional practices, and their sensitivity to individual student mental health needs. Roeser and Midgley (1997) conducted the study as a way to address the lack of attention being paid to teachers' perceptions of their student's social and emotional needs and their perceived role in addressing these needs. Roeser & Midgley (1997), note that, "Such a perspective is critical, however, if viable efforts aimed at prevention, intervention, and health promotion are to be implemented in public schools" (p. 116).

With regard to the first issue explored in this study the researchers also attempted to measure whether teacher's viewed the mental health needs of their students as a burden. The researcher's predicted that a majority of teachers would see addressing the

mental health needs of students as a part of their role and that the students' problems

would also be seen as a burden. Concerning the first issue explored, the results of the

study showed that 68% as opposed to 32% of teachers saw the mental health needs of

their students as a burden and that 99% saw addressing mental health needs as a part of

their role. With respect to the second issue the researchers made an effort to see how

teachers' perceptions of their role also relate to their professional experience and

education, characteristics of the schools they work in, and characteristics of the students

they teach. In relation to this issue the researchers made several predictions which

included that teachers who felt a greater sense of efficacy would see students' socio

emotional needs as part of their role and as less of a burden. Another prediction was that

teachers use of task-focused instructional practices and years of teaching experience

would be positively linked to beliefs that addressing mental health needs are part of a

their role and negatively linked to feelings of burden, that poorer, urban, and larger

schools would be positively linked to feelings of burden due to less resources and

support, and that in classrooms where teachers experienced more feelings of burden that

students would report higher levels of distress and lower levels of psychological

functioning and academic adjustment. There are many results in this study worth noting.

Results showed that the support of addressing mental health concerns as part of a

teacher's role was positively connected to feelings of efficacy and the use of a task-

focused approach when instructing students. Further results showed that both teacher

efficacy and belief in the role of addressing mental health concerns were negatively

associated with feelings or burden. Other results that are important to mention are that

teachers located in schools outside of urban areas described slightly lower feelings of

burden, and that students whose teachers felt more burdened reported significantly more negative views of school, self-esteem, and academic efficacy. With respect to the issue of teacher sensitivity in regards to individual student mental health needs, the researchers made only two predictions. These predictions were that teachers would identify more males than females as needing mental health services and that teachers would identify students whom they feel as less adjusted both academically and social-emotionally for services, which would also be confirmed by student reports. Results in relation to this issue showed that males and special education students were more likely to be nominated for mental health services than females or those students not in special education. They also found that student self reports were positively linked to teachers' identifications of academic and social-emotional problems. Another significant finding of this part of the study also showed that African-American youth were slightly more likely to be nominated for services. Because of the findings of this study it is clear that teachers need to be given more opportunities to learn strategies that address the mental health needs of their students, that they deserve proper access to information and resources in regards to these issues in school settings, that they are sensitive to the mental health needs of students, and that helping teachers address these issues will improve their sense of self efficacy and satisfaction with teaching (Roeser & Midgley, 1997). The findings of the Roeser and Midgley study (1997) clearly point to the need for more studies that measure the essential perceptions of teachers in terms of both needs assessment and in the effectiveness of services that are provided in schools.

The second study by Repie (2005), that will be focused on in detail was a quantitative study which had 413 respondents from 50 different states in the U.S. as its

sample. The sample consisted of regular and special education teachers, school counselors, and school psychologists; out of this sample 76.5% were female, 19.9% were male, and school psychologists were the most frequent respondents followed by special education teachers, school counselors, and regular education teachers. The majority of respondents came from suburban (42.1%) school settings followed by rural (29.5%) and urban (26.2%) school settings. The elementary school level was the most frequently occurring in the data, but many respondents checked more than one school level. Repie (2005) used a previous survey from another study that had been used to measure school administrators opinions of factors relevant to developing SBMH programs, which included a broad needs assessment of life stressors, mental health problems, and resources for youth in elementary, middle, and high schools in urban, suburban, and rural communities. Survey sections were treated as scales and summary data was provided by descriptive and frequency statistics. Group comparisons were also made as well as an analysis of variance between mean scores of the scales. In this quantitative study Repie (2005) attempted to assess the perspectives of participants in terms of four measures of perception, which were the presenting problems of students, available community and mental health services, family-based and community-based barriers to service, and the provision of mental health services in schools. Repie (2005) conducted this study as a means of addressing the dearth of quantitative data that focuses on well designed and purposeful needs assessment in the development of SBMH programs. Further Repie (2005) argues that the study is important because, "it may provide insight into the differences of opinion between school personnel, and across the variables of school level and geography on this critical topic" (p. 281).

The results of Repie's study (2005) showed that all respondents viewed impaired self-esteem, ADHD, and peer relationships as the most difficult emotional and behavioral problems for the students in their schools, with suicidal thoughts and/or behavior, inappropriate sexual behavior, and alcohol and drug abuse as the least critical. The results also showed high school level respondents ranking depression, suicidal thoughts, and alcohol and drug abuse as notably more significant problems than did elementary school level respondents. Not surprisingly inappropriate sexual behavior was seen as far less of an issue by elementary school respondents than by middle and high school staff. With respect to geography and the problems exhibited by students, impulsive behavior and classroom disruptions were seen as more concerning for urban respondents than for suburban or rural ones. In general urban respondents rated the ten presenting problems on the survey as more serious than suburban or rural respondents.

In relation to the resources available within the community, respondents listed a total of 860 agencies within the different communities that provide mental health care, which were seen as more effective than ineffective. Family-based barriers that were identified consisted of apathy, avoidance, environment, financial problems, and family stress, with financial problems and family stress being perceived as the biggest obstacles. Regular and special education teachers saw family's lack of knowledge of services as a more significant barrier than did counselors. In terms of community-based barriers, managed care, long waiting lists, effectiveness, location of services, and financial problems were identified by respondents, with managed care and long waiting lists seen as the greatest barriers. Concerning geography suburban respondents rated transportation as less of a problem than urban or rural respondents.

Respondents saw local communities being receptive to children and adolescents receiving mental health in schools, however they did not believe that communities were supportive of the delivery of these services because of attitudes, financial issues, and stigma. Repie (2005) argues that this result, "may be translated as a general attitude supporting mental health services in schools, but less action to put such programs into effect" (p. 291). In relation to professional status, regular and special education teachers saw individuals being less receptive towards receiving mental health services in schools than were school psychologists and counselors, who also felt there is more community support for these services than did the teachers. With regards to mental health services being provided in schools the evaluation of emotional and behavioral problems, individual counseling services, and crisis intervention services were seen as the most available services in schools as well as being the services that are the most needed. Family counseling, substance abuse and educational presentations for students on mental health were seen as the least frequent services available. Regular and special education teachers saw family counseling and substance abuse services as being significantly more of a necessity than did school psychologists. The last question on the survey asked whether the current mental health services provided in respondent's schools are effective, to this question the respondents generally characterized the mental health services as being more ineffective than effective. Out of all respondents regular education teachers saw in-school services as being the least effective, which is interesting to note when thinking about the data collected for this thesis. The results of this study point out the potential for difference across professional positions, school level, and geography of

school location in terms of perceptions regarding SBMH and its level of need and effectiveness, which relate directly to the research conducted for this thesis.

The third study that will be looked at closely in this section is a quantitative study by Walter et al. (2006) that attempted to obtain teachers' beliefs about mental health needs in inner city elementary schools. The sample for this study consisted of 119 elementary school teachers from six different schools in a major city in the Midwestern United States. Out of this sample 82% were female, 95% taught regular education, with the other 5% teaching special education, and the average age of participants was 41 with an average of 15 years teaching. Of the six different schools involved, four of them were classified as disadvantaged public schools, with 42% of students meeting or exceeding state learning standards, 85% of the students being African American or Hispanic, and 88% being low income. One of the schools was classified as a high performing public school, with 86% of students meeting or exceeding state learning standards, 37% of the students being African American or Hispanic, and 21% being low income. The last school in the study was classified as a high performing parochial school with a mainly white middle class student population. The survey that Walter et al. (2006) used in this study assessed the participants' beliefs with regards to four areas; beliefs about the major mental health problems facing their schools and major barriers to over coming these barriers, preferences for mental health topics for in-service education, knowledge, attitudes, and beliefs of teachers related to mental health issues, and lastly education and experience in relation to mental health issues. The researchers hypothesized that more education and experience with respect to mental health issues would be linked to greater mental health knowledge and self efficacy and to more positive views of mental health in

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general (Walter et al., 2006). Analyses used in this study included one-way analysis of variance used to see whether significant differences were present between the schools among the three different outcome variables of knowledge, attitudes and beliefs, computation of correlation coefficients to look at associations between different variables, and three hierarchical regression analyses to inspect the hypothesis put forth by the researchers. The research for this study was conducted as a way of developing a comprehensive program of mental health services for the six schools involved in the study. Walter et al. (2006) support the notion that an essential part of developing SBMH services involves needs assessment and argue that, "Information about needs can be gathered from all key constituent groups, including school personnel, school board members, special education administrators, students, parents, and community leaders" (p. 62).

With reference to the first area explored in this study, the results showed that 48% of the participants ranked disruptive classroom behavior as the biggest problem, followed by lack of student motivation (15%), students disrespect for authority (13%), bullying and cliques (9%), and disruptive playground behavior (8%). Walter et al. (2006) also bring to light an important possible connection to consider between the tightening provisions of IDEA (individuals with disabilities education act), which have resulted in more students being retained in regular education settings, and teachers perceptions of disruptive behaviors being the most prevalent in classroom settings when they (Walter et al., 2006) say, "Disruptive behavior in the classroom prevents the teacher from maintaining an orderly, safe, and productive environment. As such, disruptive behavior constitutes a major barrier to learning for a substantial proportion of American students

and is one of the greatest challenges facing teachers today" (p. 66). The results in

relation to this first area also showed that the most often indicated barriers to surmounting

the mental health problems of students are lack of information and training, lack of time,

large class size, lack of parental involvement, and lack of resources for student support

services respectively. With reference to preferred mental health education and training

topics, the second area investigated in this study, the results showed that the highest

ranked topics respectively were disruptive behavior disorders, implementing behavior

plans, and ADHD. Pertaining to the third area that was looked at in this study, the results

showed that overall teachers had a limited amount of mental health knowledge, had

positive attitudes in connection with the appropriateness of the provision of mental health

services in schools, and that overall teachers did not feel confident about their ability to

manage the mental health problems in their classrooms. Relating to the fourth area that

was examined in this study, the results indicated that the majority of participants had

experience with teaching students with mental health concerns such as disruptive

behavior and ADHD. There were lower numbers of participants who had experience

with students displaying symptoms of depression, anxiety, PTSD, or who were suicidal

or homicidal. The majority of teachers had little past education or training around mental

health issues with the exception of education around issues having to do with ADHD and

disruptive behavior. The results of the regression analyses showed that teacher education

and experience jointly predicted teacher knowledge and self-efficacy, however they did

not predict attitudes regarding mental health. Overall the results of this study relate to

this thesis in that they point to the importance of obtaining teachers' opinions as a way of

developing quality SBMH programs. The results also stress the crucial aspect of

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providing more training and education to teachers to in terms of being able to meet the

mental health needs of students and improving their own feelings of self-efficacy.

Furthermore the results of this study lend support to the notion of collaboration with

teachers on the part of SBMH professionals as a characteristic of quality SBMH

programs, which is seen in other literature on SBMH as well.

Other studies for consideration

This section will briefly describe four relevant studies. In a study by Bruns et al.

(2004), they examined special education referrals in schools with and without expanded

school mental health programs. The results showed that teachers working in schools with

expanded school mental health made less referrals to special education based on

emotional or behavioral concerns than teachers working in schools without these

programs. Teachers working in schools with expanded school mental health also made a

positive association between the services offered and school climate. These results relate

to this thesis because they indicate that teachers working in schools with SBMH

programs may utilize the services properly in an effort to meet the needs of students.

This would reduce some of the strain placed on special education programs that are over

loaded by the amount of students being referred for their services based on emotional and

behavioral issues. It seems clear SBMH services allow for more options and flexibility in

connecting students to the right and appropriate services. A related study by Stanger &

Lewis (1993), looked at the agreement among parents, teachers, and children on

internalizing and externalizing behavior problems. The study showed that children

generally reported the most problems and teachers reported the least. However the

results also revealed that teachers' ratings of externalizing problems were the best

predictor of referral for mental health services. This gives support to the idea that if SBMH services are available that teachers will be able to assess the need for services correctly based on the externalizing behavior problems of students.

In a qualitative study by Williams et al. (2007), measured teachers' perspectives of children's mental health service needs in urban elementary schools. Focus groups were conducted at two different elementary schools in a urban Midwestern school district with different levels of social services available. Data collection for this study paid attention to school safety, parental support and involvement, problem recognition, knowledge of community resources, service effectiveness, and service barriers. Authors, Williams et al. (2007) list issues to support the need for this research. These issues are: the fact that a considerable amount of children and youth meet the criteria for mental health disorders, that a large percentage of the mental health services for children are provided in schools, with teachers playing key roles in the identification of mental health problems and the referral process, that large numbers of minority children are educated in urban schools and are disproportionately represented in special education classes, and that there is limited research on teachers' (specifically those in urban schools and those teaching African American students) perspectives on barriers they face when referring children for services. In relation to school safety the results of the study showed that overall teachers felt safe, but that they felt as if their students did not, which impacts school and classroom behavior. In terms of parental support and involvement, the teachers in the school with fewer services felt the most unsupported by parents. The attitudes of the parents were described as disengaged, uncooperative, and lack of taking responsibility for their child's actions. In the school with more services available,

teachers felt strong parent support, which they attributed to the presence of more support services and stronger community-school linkages. Most teachers in the study described feeling comfortable when it comes to recognizing mental health problems for students, with externalizing problems being listed as the most prevalent in terms of recognition. Overall teachers in this study felt like support services for students, especially mental health services, are beneficial, however the results also indicated that parents were the most significant barrier to services for students, with one of the main problems being obtaining parental consent. Even after consent is obtained, participation in treatment by parents is one of the more challenging aspects and barriers in SBMH. Another important result to note which relates strongly to this thesis is that teacher's confidence in referring students for services mainly centered on school-based services not outside services. This study's results suggest that teachers' perceptions of parental involvement and support may have a direct impact on whether or not or how comfortable they are with referring students for mental health services (Williams et al., 2007).

Ford & Nikapota (2000) conducted a study focusing on teachers' attitudes towards child mental health services, which involved interviewing 25 different primary school teachers. The study's aim was to gain increased knowledge with respect to teachers' experiences of child and adolescent mental health services so as to improve collaboration. Ford & Nikapota (2000) contend that, "As children spend a large proportion of their time at school, teachers could be involved in mental health promotion and reinforcing treatment strategies, in addition to being informants" (p. 460). The results of their (Ford & Nikapota, 2000) study showed that social behavior towards peers was the most cited area of functioning, that teachers saw themselves as role models and

made use of rewards and punishments within clearly defined rules to manage children's behavior. The teachers also stated that the most common barrier to managing children's behavioral disorders was problematic relationships with parents, which include lack of support from parents and poor parenting. In this study of the 20 teachers who had some experience with child and adolescent mental health services, four teachers thought that it had not helped. The most frequent complaints about the services by teachers were slow response and poor communication between teachers and mental health professionals. Another interesting finding of the Ford & Nikapota (2000) study indicates that teachers will most likely refer students for services that are located within the school as opposed to outside services, which reinforces the idea that more SBMH programs should be set up to provide services on-site. The results of this study suggest that teachers want services that provide rapid advice and good communication, which underscores the need for child mental health professionals to figure out ways to promote collaboration between mental health and education services (Ford & Nikapota, 2000).

Collaboration as an Important Characteristic of Quality SBMH Programs

Collaboration and inclusion of input between teachers and SBMH professionals is an essential ingredient to a healthy partnership between the worlds of academia and mental health. Research on the usefulness of other informants on child psychopathology shows that in regards to certain aspects of children's behavior problems, that teachers are better informants than children themselves or mothers (Loeber, Green, & Lahey, 1990). Throughout the literature on SBMH collaboration with teachers and other school personnel is emphasized as an important part of needs assessment, identification of students who could benefit from mental health services, productive prevention and

intervention work, and making meaningful change within schools (Bruns et al., 2004; Daly, Burke, Hare, Mills, Owens, Moore, et al., 2006; Lynn, McKay, & Atkins, 2003, Paternite & Johnston, 2005; Weist, Ambrose, & Lewis, 2006; Weist et al., 2000).

The success of SBMH programs necessitate that the mental health professionals build relationships with school staff, especially teachers, so that education around mental health problems and interventions with children can be done in a more significant way through the context of those relationships (Weist et al., 2000). Weist et al. (2000) argue that in order to gain more support from schools themselves for the development of SBMH programs that school personnel must be included in the process of gauging what problems students are facing and what services are needed. In an article centered on expanded school mental health which focuses on the partnerships between community mental health agencies and schools in creating SBMH programs, Weist, Ambrose, and Lewis (2006) write, "Within this partnership, strategies for collaboration should be made explicit, efforts to actually collaborate should be prioritized, and an atmosphere of mutual respect and support should characterize the work" (p. 49). Public school teachers from the pre-kindergarten level through 12th grade are resources that are under used in the field of integrated mental health and education (Daly et al., 2006). Daly et al. (2006) argue that the lack of effective collaboration "disables efforts to provide a seamless continuum of mental health promotion and intervention services that are seen as essential precursors to actualization of educational opportunities for children" (p. 448).

In terms of strategies to promote collaboration between school social workers and teachers, Lynn et al. (2003) list four important considerations which are: 1) establishing a positive environment where everyone recognizes the need to work together to meet the

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mental health and academic needs of children, 2) having regularly scheduled meetings

and consultations with teachers to guarantee frequent contact and communication, 3)

taking the time to understand teachers expertise in order to enhance clarity in relation to

role boundaries, and 4) developing a comprehension of the way the school and

community are experienced by teachers, students, and parents with the intention of

improving the assessment of clear and not so clear system issues. Lynn et al. (2003)

stress the significance of teacher consultations as not only a vehicle for collaboration, but

also a support for teachers, they note that, "consultation with teachers can help teachers

cope with day-to-day teaching stresses through informal support and through more

formal approaches such as mentorship programs, support groups, and in-service training"

(p. 203). The authors go on to argue that collaboration with teachers "can promote and

expand prevention, identification, and treatment of child emotional and behavioral

difficulties in school settings" (Lynn et al., 2003, p. 206). Clearly from an examination

of the literature on SBMH, collaboration with school personnel, especially teachers, is

seen as key characteristic and crucial element to the success of quality SBMH programs,

and also as a means of fostering positive views of SBMH from the perspective of

teachers, which is significant to the focus of this thesis.

Summary

A synopsis of the literature on this area of concern reveals the importance of the

historical background of SBMH programs in this country and how their role has changed

over time within school settings. It defines important definitions and key terms in

SBMH, with a look at the various services that are offered, the problems with current

SBMH delivery, and the ways in which school serve as optimal settings for the provision

of these services. It also underscores the current need for SBMH programs to meet

mental health needs of urban students in public schools in order to improve the chances

of success for the students and to strengthen school communities overall. The literature

also sheds light on the lack of services for and unique mental health needs of students of

color and GLBT youth. Lastly, the literature points out important characteristics of good

quality SBMH programs that focus on collaboration with and the input of teachers and

other educators and important school personnel when evaluating outcome measures of

the effectiveness of these programs. A review of the literature makes it clear that asking

the question do school-based mental health programs have a positive outcome on urban

elementary, middle, and high school aged students from the perspectives of teachers

within the urban areas of New York City, Boston, and Berkeley, CA?, is important in

terms of promoting an area for further vital research in addition to expanding the crucial

knowledge base of social work practice.

CHAPTER III

METHODOLOGY

Formulation

The purpose of this study is to determine teachers' perceptions of the level of

effectiveness of SBMH programs for elementary, middle and high school aged students

in urban school districts. The research question is: Do school-based mental health

programs have a positive outcome on elementary, middle, and high school aged student's

functioning from the perspective of teachers in urban public school systems in New York

City, Boston, and Berkeley, CA? The question points to the assumption that obtaining an

idea of what teacher's perceptions are is essential when looking at SBMH programs place

and function within school settings. This assumption is also prevalent within the

literature on SBMH.

Research Design

This mixed method study is predominantly quantitative, using a survey that

includes two qualitative open-ended response questions. Anastas (1999) characterizes

fixed methods descriptive research as "developing a better understanding of a

phenomenon in detail" (p. 123), in which the boundaries, procedures, and relationship of

the observer to the observed are held constant throughout the process of the study. The

aim of this study was to get a sense of how teacher's perceive SBMH programs in

schools in the urban areas of New York City, Boston , and Berkeley, CA. In fixed

methods descriptive research the researcher attempts to describe the "nature of a

phenomenon in a specified, static context while viewed from a specific, fixed perspective" (Anastas, 1999, p.123), using data collection tools in a standardized fashion. The data collection tool in this study was an internet survey that asked for answers based on provided response sets and written responses for demographic information (i.e. years teaching, school level, previous education, racial/ethnic background, etc.) and a Likert scale (i.e. strongly disagree to strongly agree) that teachers from the different geographical locations and school levels were asked to complete. Two open ended questions requesting ideas about the program and related issues were also asked at the conclusion of the survey. The theoretical framework from which this study is based remained constant throughout the research process with the data analyzed in the same manner.

Anastas (1999) defines face or internal validity in fixed methods research as considering, "whether the manifest content of a data collection instrument or question actually seems to address the concept used to label it" (p. 321). The following are a list of some of the questions that the researcher hoped would be answered through the use of the internet survey: Do demographic factors such as age, race, gender, location, number of years teaching, or prior experience with mental health issues influence how teacher's perceive the effectiveness of SBMH? Do teachers believe that mental health provision has a place within school settings? Do teachers feel they have adequate SBMH services at their schools? Do teachers see a change in the overall social and academic functioning of students in school during and after their involvement with SBMH? And, what factors may influence this perception? Have teachers been familiarized with the goals and practices of the SBMH program at their school through collaboration with SBMH

professionals and have they received any training in this area? What suggestions do teachers have for improving the SBMH programs at their schools in relation to the provision of services and the collaboration between teachers and mental health professionals?

Sample

Forty participants were recruited for this study. The data retrieved for this study came from urban public schools in New York City, Boston, and Berkeley, CA that have mental health services provided on-site by outside agencies, clinics, hospitals, universities, and organizations. The sample of teachers used for this study were from schools in these areas that met this criteria. Out of this population of teachers for sample recruitment, several inclusion and exclusion criteria were identified.

The inclusion criteria for this sample required a teacher to, 1) be a certified, licensed teacher, 2) teach at a public school in New York City, Boston, or Berkeley, CA, 3) have mental health services provided on-site in their school by an outside mental health agency, clinic, hospital, etc., 4) have internet access, 5) be able to read English. The questions in the survey did not refer to school special education professionals, school psychologists, school guidance counselors or school social workers, so if potential participants were not aware of any mental health services being provided by an outside agency or clinic, they were asked to not complete the survey. If a teacher did not meet these requirements, they were excluded from the study. The sample is presumed to be diverse in race, ethnicity, and teaching experience due to the fact that the sampling occurred in urban areas where the general population is very diverse. There was not specific recruitment for diversity.

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Originally, the researcher had planned on conducting the study exclusively in New York City public schools. However, the research application process for both the New York City Board of Education and most school districts within the city was not feasible in the time allotted to complete this thesis study. As a result of this reality, the researcher expanded the geographic area due to these limitations. The researcher also had professional and personal contacts in the chosen urban areas. A convenience sample was chosen as the method of recruitment. Before the recruitment process began, permission from the Smith College School for Social Work's Human Subjects Review board was required in the form of an approval letter (See appendix C). The researcher utilized a snowball technique during the recruitment process, which entailed the use of personal and professional contacts, word of mouth, colleagues, and professional networking to recruit participants. Anastas (1999) notes that this technique is useful when, "there is initial access only to a very limited number of identifiable sample members" (p. 289), which was the case in this study at the start of recruitment. To start the recruitment process the researcher sent out a recruitment email (See Appendix D) to personal and professional contacts and colleagues. In this email the researcher requested that it be forwarded to any potential participants who met the inclusion criteria, with the hopes that the pool of potential participants would grow by word of mouth and networking on the part of the contacts. Attached to this email was the internet survey link with instructions for completing the survey and the informed consent form (See Appendix A) with the researcher's contact information. This allowed potential participants to have their own copies and information about the study. The researcher sent out numerous rounds of recruitment emails to contacts during the course of data

collection with the hopes that the sample size would increase, which turned out to be only minimally successful.

As stated earlier because of the nonprobability sampling technique that was used for this study and the low number of actual participants in the study, generalizations to the larger population of elementary, middle, and high school teachers familiar with SBMH in New York City, Boston, Berkeley, CA or elsewhere were not be able to be made. The other sampling bias to consider in this study is that there is a strong likelihood that the teachers who were willing to fill out the survey would be those that have or have had students involved in their school's SBMH program, which may have left out teachers who were not aware that they had students involved with the SBMH program and teachers who have experience with SBMH programs not in the chosen schools. Besides these biases, the sample chosen was expected to generate information that addressed the theoretical and conceptual framework of the study question.

Unfortunately, only forty participants responded to the survey. The goal was to have fifty responses. In regards to sample size there are several considerations that can be discussed regarding the small sample size. One possible reason may have been that some teachers who did meet the criteria simply did not feel comfortable commenting on the SBMH program, either because of personal feelings, lack of familiarity, or no interest in the study. Another possible reason is the reality that teachers are very busy, have few resources in urban schools and in many cases have very little time for themselves to fill out a survey. The time of year must also be considered. While the researcher was recruiting potential participants many teachers were preparing for standardized tests. This can often restrict the amount of energy and time they have for other things. There

was also no reward for participation, which may have been another reason that sample size was not larger. Yet another reason may have been that for teachers who are not comfortable with technology, completing an online survey may not have been easy to figure out. Sample size would most likely have been larger if the researcher was able to receive formal permission to conduct research from the local boards of education in each city in a feasible amount of time to complete the study. If this recruitment strategy had been possible more schools meeting the criteria may have been willing to distribute the survey to their teachers. In many cases bigger sample sizes are better, especially with probability samples, but important to note is that not every research study necessitates or even gains from a large sample size (Anastas, 1999).

Taking into account that research studies no matter how well designed and executed they are, are unable to have complete external validity (Anastas, 1999); it is safe to say that this study had limitations in this area. However this study did attempt to conduct research that provides information about how effective SBMH is in meeting the academic and social needs of elementary, middle, and high school aged students in public school from the perspective of essential figures in the student's lives, which will provide useful information to the field of SBMH that can be used outside of these particular schools. Generalizability, an essential aspect of external validity, is best achieved by replication (Anastas, 1999), which is something to consider in future research studies around SBMH.

Ethics and Safeguards

There was minimal risk expected from participation in this study. Participants may have experienced distress when reflecting on their experience with their school's mental health program and how such programs affect their students. Teachers may also have felt discomfort when thinking about the needs and unmet service needs of their student population in regard to mental health. Participants may have also been uncomfortable expressing their thoughts about this topic due to fear of their job security and retribution from school administrators. As a result of this, participants were assured through the consent process that all information gathered in the study would be held in confidence. The internet survey program, Survey Monkey, also allowed for anonymity of the participants. Furthermore, participants were asked not to identify students or co-workers by name, and to the best of their ability, not disclose individuals' identities. The participants were informed that the study was not connected to a particular school or school district.

Potential benefits of this investigation for participants include, reflecting on their understanding and perceptions of the collaboration between education and mental health. Their participation in this study will hopefully assist and inform program developers and mental health professionals, as well as the administrators in their schools, to better understand how the SBMH program affects them. It may allow participants an opportunity to reflect on ways they can help make these programs more successful. Other potential benefits may include having the opportunity to share their experience, concerns, and perceptions with others. Participants will not receive compensation for their participation in this study, all participation was voluntary.

The researcher attached copies of the informed consent form in the recruitment email sent to participants along with the recruitment flyer during the recruitment process, so that participants could review the study's purpose and its potential risks and benefits prior to completing the survey. At the end of the survey, participants had the option of submitting the results or not submitting the results. It was made clear that by submitting the results, participants were consenting to being a part of the study. The researcher included his contact information in the recruitment email if anyone had any questions about the survey. This information was both in the recruitment email and on the internet survey.

The anonymity of the participants in this study was protected in several ways. The survey that participants responded to was online, which prevented any person-to-person contact between the researcher and participant. This also prevented any tampering of information from an outside source. The researcher consulted www.surveymonkey.com on how to keep the survey completely anonymous. According to Survey Monkey, by sending an email to the potential participants from the researcher's own email address it would be sent third party, which would prevent any tracking of who responded to recruitment email as opposed to sending the survey through the researcher's mailing system. As part of the website's privacy agreement, the researcher had the ability to disengage the website from obtaining people's IP address. This ensured that surveys could not be traced back to a certain person or computer. Access to the data collected was limited to the thesis advisor, Smith College School for Social Work's research analyst, and the researcher. Yet another step to ensure anonymity was that each survey had a code. Due to the anonymous nature of the survey there was no risk of

participants releasing any identifying information. However, race, teacher experience, and geographic location will be stated in the aggregate and not attached to any survey responses. The results of this study will be reported for the group as a whole. All data, notes, and consent forms will be kept secure for a period of three years by the researcher as stipulated by federal guidelines, after which time they will be destroyed or continued to be maintained securely.

Data Collection

Each participant was asked to complete a 36 item internet survey on www.surveymoneky.com (See Appendix B). The beginning of the survey collected demographic data (age, gender, racial/ethnic background, years of experience, etc.) on the participants. This part of the survey asked for answers based on provided response sets and written responses. A Likert type scale was used in the majority of the survey. In addition, the survey asked for two written responses from participants asking for suggestions or thoughts about the SBMH program and related issues. The internet survey was anticipated to take participants approximately 15 to 20 minutes to complete. The survey attempted to gain a clearer understanding of the participant's perception of the SBMH program in their school.

There was no existing measure that fit the exact study questions. The survey was created by focusing on the specific study questions and with an understanding of how the data would be analyzed statistically. Questions were created to ensure that the data retrieved would be statistically significant. Using a survey rather than conducting individual interviews was intended to allow the researcher to attain data from a larger

sample set, and therefore get a broader understanding of the larger study question in general.

As a result of its concreteness and standardized nature, quantitative data was gathered. The researcher considered gathering qualitative data in the form of interviews, however, the research question did not lend itself to this research model. The researcher felt as though measuring teachers' perceptions based on numerical data from a survey would be more useful than obtaining the verbal responses of fewer teachers.

Using a survey as a data collection tool has several strengths and weaknesses. The use of a survey can be the least expensive method of asking questions to a large group of people (Anastas, 1999), which held even more true with the use of an internet survey. Anastas (1999) notes that, "standardized questionnaires or scales, are designed for use in any research situation to measure a specific concept or phenomenon" (p. 373) and goes on to say, "A questionnaire or ratings scale is always based on selected, predefined concepts or phenomena of interest to the research, and therefore questionnaires and rating scales can be used in any form of fixed methods research" (p. 373). Another factor to consider with the use of survey is that it sometimes makes participants feel more comfortable answering questions on a survey rather than an interview that may be perceived as threatening or anxiety provoking (Anastas, 1999).

One of the weaknesses of using a survey is that many times participants may disregard the invitation to take the survey (Anastas, 1999). Due to the chaotic schedules and demands which teachers face this may have been the case with the recruitment email that was sent out for this study. Another weakness to consider with the use of surveys is that responses to questions are left to the interpretation of the researcher (Anastas, 1999).

Before sending the data to the statistician it was collected and organized using Survey Monkey, an anonymous and secure web-based data collection site. Participants were connected to the survey by clicking on a link that was attached to the recruitment email. Once on the website participants were notified that clicking on "submit" at the end of the survey would automatically make them a participant in the study. Once submitted, participants were not able to withdraw due to the anonymous nature of the survey. In addition participants were encouraged to contact the researcher with any questions or concerns before taking the survey. The next part of the survey provided a series of demographic questions specific to geographic location, age, gender, race/ethnicity, years of schooling, time spent in the teaching field, school level. The next section of the survey provided questions answered using a Likert type scale, followed by two items asking for the participants' thoughts and suggestions in relation to the SBMH program at their school. The participants completed the survey by clicking on the "Submit" button.

Data Analysis

Descriptive statistics are used to provide a description of the sample itself, of the people, groups or organizations that are studied in the research (Anastas, 1999). Anastas (1999) sees descriptive statistics as, "a means for summarizing, and therefore condensing and simplifying, the information provided by sets of numbers" (p. 433). The researcher used descriptive to analyze the data collected. Each of the forty participant's (N=40) answers to the survey were put onto a spreadsheet with the results then being put into SPSS to be summarized and put into a comprehensive table in order to be analyzed in

different manners by a statistician to determine results. Interval and ordinal level measurements were used to look at the numbers that the data created.

Using descriptive statistics for this data collection tool allowed the researcher to compare the participants in terms of different demographic variables (i.e. race, gender, age, location, level of schooling, level of education and years of experience teaching). T-tests and analysis of variance (ANOVA) tests were run to determine if there were significant differences in the mean scores for two or more groups within the data. Several Spearman's rho tests were used to examine whether or not there were any correlations between the different variables within the data. The following are a list of the identified hypotheses of difference that were analyzed with the data: Perceptions of SBMH effectiveness in relation to academic and social functioning as they relate to gender, school level and geographic location, experiences of the lack or prevalence of SBMH services as they relate to geographic location, and the perception of the helpfulness of collaboration with SBMH professionals as it relates to wanting more consultation with SBMH professionals. The following are a list of the identified hypotheses of association that were examined with the data: The relationship of age, years teaching, previous mental health training, experience of the lack or prevalence of SBMH services, amount of consultation with SBMH professionals, frequency of services for students, and perception about the place of mental health within schools to the perception of SBMH effectiveness in helping the academic and social functioning of students, the relationship of wanting to know the diagnoses of students to previous training experience in mental health.

The researcher felt that due to the nature of the research question and the identified hypotheses of difference and association, analyzing the data in terms of frequencies, percentages, t-tests, analysis of variance (ANOVA), and Spearman's rho test, would best represent the participant's responses about SBMH.

Discussion

It is assumed that methodological and personal biases are inherent parts of any research study that is completed. Therefore, the use of a survey in this research study brings with it, its own set of methodological biases. Requiring that participants choose their answers based on a scale that is provided is limiting because it compels one to compare their personal experience to a quantifiable number, which can be very difficult, and may in turn reduce the richness of the data. Using predetermined answers for participants to choose from may limit the variation of information collected compared to using a completely open-ended survey or interview.

Personal biases may also have affected the way in which the researcher carried out the study. For example, the researcher is very invested in this topic due to their commitment to wanting to provide mental health services to schools and youth in general. Since the researcher had experience providing SBMH services to a school in which the teachers had positive perceptions of SBMH, the study was designed to see if this was also the case with other teachers working in schools that have SBMH programs. Other researcher biases include being a product of the New York City Board of Education; having attended schools in New York City from pre-school through high school, being enrolled in a graduate clinical social work training program that emphasizes the benefits of therapy, knowing people who have been or are involved in working in SBMH, and

knowing children who have participated in SBMH. The fact that the researcher is also a

heterosexual, bi-racial black male might also have an effect on how the research findings

are viewed.

CHAPTER IV

FINDINGS

The major questions that were addressed in this research project were: Have teachers been familiarized with the goals and practices of the SBMH program at their school through collaboration with SBMH professionals and have they received any training in this area? Are teachers concerned with the clinical diagnoses of their students? Do demographic factors such as age, race, gender, location, number of years teaching, or prior experience with mental health issues influence how teacher's perceive the effectiveness of SBMH? Do teachers see a change in the overall social and academic functioning of students in school during and after their involvement with SBMH? And, what factors influence this perception? Do teachers feel they have adequate SBMH services at their schools? Do teachers believe that mental health provision has a place within school settings? What suggestions do teachers have for improving the SBMH programs at their schools in relation to the provision of services and the collaboration between teachers and mental health professionals? Both hypotheses of difference and association were explored in trying to determine answers to these questions. The major findings of the study indicated that teachers in the different geographic locations who responded to the survey had differing opinions about the effectiveness of their SBMH programs and other program related issues in general. The major findings of this study, as well as participants' thoughts about improving their SBMH program, will be discussed in more detail in this chapter. A section giving demographic data about the participants

including gender, age, race, geographic location, school level, previous education, and teaching experience will precede the results of the statistical analysis of the findings.

Demographics

The participants in this sample were elementary, middle, and high school teachers working in public schools in New York City, Boston, and Berkeley, CA that have SBMH programs. Forty participants completed and submitted the internet survey. All participants were considered for both their demographic data and information regarding the SBMH program at their school.

Demographic data outlining the geographic location, gender, race, school level, and teaching experience of the participants are outlined in Tables 1-5. Of the 40 (see Table 1) participants, 25 (62.5%) were from Boston followed by New York City with 8 (20%) and Berkeley with 7 (17.5%). The demographic data revealed that 31 (see Table 2) of the 40 participants were female and that the average age of participants was 35 years old with the youngest participant being 23 years old and the oldest being 59 years old. Of the 40 participants who stated their racial and ethnic background (see Table 3) on the survey, 30 stated that they were either White or Caucasian with 3 of them listing Jewish, Italian, or Native American ethnicities. Five participants stated they were Black or African American. Three stated they were Latino or Chicana with the last two stating they were mixed race Black and White and Asian American respectively. With respect to school level (see Table 4), 17 (42.5%) of the participants teach at the elementary level, 10 (25%) of the participants teach at the middle school level and 13 (32.5%) of the participants teach at the high school level. The number of years teaching experience (see

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Table 5) ranged from 0 to 35 among participants, with the average number being 8.7

years.

Table 1.

What is your general geographic location?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	berkeley ca	7	17.5	17.5	17.5
	boston	25	62.5	62.5	80.0
	new york city	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

Table 2.

What is your gender?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	female	31	77.5	77.5	77.5
	male	9	22.5	22.5	100.0
	Total	40	100.0	100.0	

Table 3.

Please state your racial/ethnic background

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	"Asian-American"	1	2.5	2.5	2.5
	African American	2	5.0	5.0	7.5
	Black	3	7.5	7.5	15.0
	Caucasian	8	20.0	20.0	35.0
	Caucasian, Jewish	1	2.5	2.5	37.5
	caucasian/native american	1	2.5	2.5	40.0
	Chicana	1	2.5	2.5	42.5
	latino	2	5.0	5.0	47.5
	mixed race black/ white	1	2.5	2.5	50.0
	White	18	45.0	45.0	95.0
	White (Italian)	1	2.5	2.5	97.5
	white/jewish	1	2.5	2.5	100.0
	Total	40	100.0	100.0	

Table 4.

What level of schooling do you teach? (If more than one option applies, please indicate the option which relates to this survey and where you spend the most time)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	elementary school	17	42.5	42.5	42.5
	middle school	10	25.0	25.0	67.5
	high school	13	32.5	32.5	100.0
	Total	40	100.0	100.0	

Table 5.

Number of years teaching (if this is your first year please put 0)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	4	10.0	10.0	10.0
	2	2	5.0	5.0	15.0
	3	4	10.0	10.0	25.0
	4	5	12.5	12.5	37.5
	5	3	7.5	7.5	45.0
	6	3	7.5	7.5	52.5
	7	1	2.5	2.5	55.0
	8	2	5.0	5.0	60.0
	9	4	10.0	10.0	70.0
	10	2	5.0	5.0	75.0
	12	1	2.5	2.5	77.5
	13	2	5.0	5.0	82.5
	15	2	5.0	5.0	87.5
	19	1	2.5	2.5	90.0
	25	2	5.0	5.0	95.0
	29	1	2.5	2.5	97.5
	35	1	2.5	2.5	100.0
	Total	40	100.0	100.0	

In addition to the previous demographic information, participants were also asked questions on the survey about their own previous education, level of familiarity with the SBMH program, and how many students they had referred for services in the past. With respect to previous education, 2 participants reported having a bachelor's degree, 9 reported having a bachelor's degree plus graduate or additional training, and 29 reported

having master's degrees. In terms of the number of years participants have been familiar

with the SBMH program in their school, only 39 participants answered this question.

Four of the 39 participants who answered this question reported being unfamiliar with the

program. The number of years being familiar with the SBMH program ranged from 1 to

20 with an average of 4.4 years. Thirty of the 40 participants reported referring students

to the SBMH program in the previous year. Out of that 30, the range was from 1 to more

than 20 students being referred for services, with 22 participants reporting that they had

referred between 6 and 10 students in the previous year.

Collaboration with SBMH Professionals

In terms of participants amount of collaboration with SBMH professionals, 7

participants reported that they met "often" with the SBMH professionals at their schools,

10 reported that they met "sometimes", 11 reported "infrequently", 9 reported meeting

"almost never" and 3 reported meeting "not at all" with the SBMH professionals.

Participants from New York City had the highest mean response (m=3.63) to this

question, which indicates that they have the least amount of consultation with SBMH

professionals out of the three cities. With respect to school level, participants from high

schools had a higher mean response (m=4.00) than participants from the other two school

levels, which suggests that they receive lower amounts of consultation than participants

teaching in either elementary and middle schools. One-way analyses of variance

(ANOVA) were run to determine if there were significant differences in the mean

responses to the question regarding the amount of consultation from SBMH professionals

to teachers by geographic location and school level. There was a significant difference in

the amount of consultation by location (f(2,37)=5.996, p=.006). A Bonferroni post-hoc

test showed the significant difference was between those participants located in Boston (m=2.32) and those located in New York City (m=3.63), which suggests that the participants from Boston receive more consultation than the participants located in New York City. There was a significant difference in the amount of consultation by school level (f(2,37)=20.051, p=.000). A Bonferroni post-hoc test showed the significant difference was between those in either elementary school(m=2.06) or middle school (m=2.40) and those in High school (m=4.00), which suggests that participants teaching at the high school level receive significantly less consultation than participants teaching at both the elementary and middle school levels. There were no significant differences between those in elementary schools compared to those in middle schools. Tables 6 and 7 show the mean responses to the question regarding the amount of consultation received, by both geographic location and school level respectively.

Table 6.

Descriptives

consult

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
berkeley ca	7	3.43	.787	.297	2.70	4.16	2	4
boston	25	2.32	1.145	.229	1.85	2.79	1	5
new york city	8	3.63	1.061	.375	2.74	4.51	2	5
Total	40	2.78	1.209	.191	2.39	3.16	1	5

Table 7.

Descriptives

consult

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
elementary school	17	2.06	.827	.201	1.63	2.48	1	4
middle school	10	2.40	1.075	.340	1.63	3.17	1	4
high school	13	4.00	.707	.196	3.57	4.43	3	5
Total	40	2.78	1.209	.191	2.39	3.16	1	5

Thirty-four of the participants reported wanting to consult and interact more with the SBMH professional, while more than half of the participants agreed that the collaboration they have with the SBMH professionals is helpful to them in terms of supporting their students. A t-test was run to determine if the were significant differences in how helpful participants' see collaboration with SBMH professionals being in supporting the students by whether or not participants said "yes" or "no" to wanting more consultation with SBMH professionals, no significant differences were found. When asked if participants feel as though they are part of a team with the SBMH professionals in their schools, 16 participants reported that they did not feel this way and 21 participants reported that they did feel this way to some degree. Three participants marked this question not applicable.

Training in Issues of Mental Health

When participants were asked to remark on whether they had obtained any previous training in issues of mental health such as emotional disorders, learning disabilities, behavior modification or psychotherapy, more than half of the participants either strongly or somewhat disagreed that they had. In fact, only 14 participants agreed to some degree that they had any previous training. When asked if participants felt

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knowledgeable about the mental health issues of those students who participate in the program, the responses were similar. While 5 felt knowledgeable about students' mental health issues, 9 reported that they were somewhat knowledgeable, 19 marked somewhat unknowledgeable, and 6 strongly disagreed that they were knowledgeable. Thirty-two of the 40 participants who responded to the survey agreed that their personal and professional experiences with mental health in general helped them be supportive of the SBMH programs at their schools.

Awareness of Clinical Diagnoses

Out of the 40 participants 34 disagreed that they have an awareness of the clinical diagnoses of the students they work with who participate in the program. However, 38 of the participants agreed that they would like to know these diagnoses, with all the participants in this study agreeing that knowing these diagnoses would be helpful in their work with the students receiving the services.

A Spearman's rho correlation was run to determine if there was a relationship between participants wanting to know about the clinical diagnoses of the students participating in the program and whether or not they had obtained any previous training in issues of mental health. No significant correlation was found (p>.05).

SBMH Program Effect on Student Functioning

Overall, participants who responded to the survey agreed that the SBMH programs at their schools have a positive effect on both the academic and social functioning of the students participating in them. However, the participants reported that the SBMH programs have a more positive effect on students' social functioning than academic functioning. When participants were asked if the SBMH program at their

school has a positive effect on the academic functioning of students receiving those services, only two participants felt the question was not applicable. While 2 participants reported that they strongly disagreed, 5 reported that they somewhat disagreed, 11 marked somewhat agree, 10 agreed, and 10 strongly agreed that the mental health services have a positive effect on academic functioning. Participants from New York City had a lower mean response (m=2.43) to this question than any of the other two cities, which suggests that these participants see the SBMH programs at their schools as having the least positive effect on the academic functioning of the students receiving the services. When participants were asked if the SBMH program at their school has a positive effect on the social functioning of students receiving those services, again only two participants felt the question was not applicable. While 2 participants felt that they strongly disagreed, only 2 somewhat disagreed, 11 reported that they somewhat agreed, 12 checked agree, and 11 strongly agreed that the mental health services have a positive effect on the social functioning of students. This information reveals that the majority of participants who submitted this survey felt that the SBMH services in their schools are more effective in improving the social functioning of students than they are at enhancing the academic functioning. Again, participants from New York City had the lowest mean response (m=3.14) to this question signifying that they feel the SBMH programs at their schools have the least positive impact on the social functioning of the students who are involved with the program.

A Spearman's rho correlation was run to look at the relationships between participants' age, teaching experience, and previous training to participant's perceptions of the SBMH program's positive effect on both the academic and social functioning of

students. No significant correlations were found between any of these variables (p>.05).

Spearman's rho correlations were also run (See Table 8) to determine if there were

relationships between participants' perceptions of the SBMH program's positive effect on

both the academic (Q.17) and social (Q.18) functioning of students and participants'

reports in regards to the amount of consultation with SBMH professionals (Q.12),

adequate SBMH services (Q.14), regularity of SBMH professionals meetings with

students (Q.24), and the place of mental healthcare in public school settings (Q.34).

There were no significant correlations found between participants' perceptions of the

SBMH program's effectiveness on both levels of student's functioning and participants'

reports on the amount of consultation and adequate SBMH services (p>.05). In terms of

participants' perceptions that the SBMH programs have a positive effect on the academic

functioning of students the findings were as follows. There was a significant and strong

positive correlation (p<.05) with participants' reports on the regularity of SBMH

professionals meetings with students (rho=.648, p=.000, two-tailed) and a significant and

moderate positive correlation (p.<.05) with the participants' beliefs that mental healthcare

has a place in public school settings (rho=.489, p=.002, two-tailed). Therefore the more

participants agreed that SBMH services have a positive effect on the academic

functioning of students the more they agreed that the SBMH professionals meet regularly

with the students and that mental healthcare should be provided in public school settings.

There were similar findings with respect to participants' perceptions that the SBMH

programs have a positive effect on the social functioning of students. There was a

significant and strong positive correlation (p<.05) with participants' reports on the

regularity of SBMH professionals meetings with students (rho=.661, p=.000, two-tailed)

and a significant and moderate positive correlation (p<.05) with participants' beliefs that mental healthcare has a place in public school settings (rho=.493, p=.002, two-tailed). Hence, the more participants agreed that SBMH services have a positive effect on the social functioning of students the more they agreed that students receive SBMH services regularly and that there should be a place for mental healthcare in public school settings. Table 8.

Spearman's rho Correlations

Correlations

			q17	q18	consult	q14	q24	q34
Spearman's rho	q17	Correlation Coefficient	1.000	.799*'	-.212	.235	.648*'	.489*'
		Sig. (2-tailed)	.	.000	.202	.156	.000	.002
		N	38	38	38	38	35	38
	q18	Correlation Coefficient	.799*'	1.000	-.046	.214	.661*'	.493*'
		Sig. (2-tailed)	.000	.	.782	.197	.000	.002
		N	38	38	38	38	35	38
	consult	Correlation Coefficient	-.212	-.046	1.000	-.246	-.398*	.007
		Sig. (2-tailed)	.202	.782	.	.127	.018	.965
		N	38	38	40	40	35	40
	q14	Correlation Coefficient	.235	.214	-.246	1.000	.311	.077
		Sig. (2-tailed)	.156	.197	.127	.	.069	.635
		N	38	38	40	40	35	40
	q24	Correlation Coefficient	.648*'	.661*'	-.398*	.311	1.000	.210
		Sig. (2-tailed)	.000	.000	.018	.069	.	.225
		N	35	35	35	35	35	35
	q34	Correlation Coefficient	.489*'	.493*'	.007	.077	.210	1.000
		Sig. (2-tailed)	.002	.002	.965	.635	.225	.
		N	38	38	40	40	35	40

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

A t-test and a one-way analysis of variance (ANOVA) were run to determine if there were significant differences in the mean responses to the two questions regarding participant's perceptions of the SBMH program's positive effect on both the academic and social functioning of students by participant's gender and school level. No significant differences were found. However, when a one-way analysis of variance (ANOVA) was run to determine if there were significant differences in the mean

responses to the two questions regarding participant's perceptions of the SBMH program's positive effect on both the academic and social functioning of students by participants geographic location, significant differences were found ($F(2,35)=4.981$, $p=.012$) in relation to participants perception of the SBMH programs positive effect on academic functioning. A Bonferroni post-hoc test showed the difference was between the Boston (m=3.83) and New York City (m=2.43) participants, which suggests that the participants from Boston agree that SBMH services have a positive effect on the academic functioning of students more than the participants from New York City. Table 9 shows the mean responses to both questions by geographic location.

Table 9.

Descriptives

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
q17	berkeley ca	7	3.86	.900	.340	3.03	4.69	3	5
	boston	24	3.83	1.049	.214	3.39	4.28	2	5
	new york city	7	2.43	1.272	.481	1.25	3.61	1	4
	Total	38	3.58	1.177	.191	3.19	3.97	1	5
q18	berkeley ca	7	4.29	.756	.286	3.59	4.98	3	5
	boston	24	3.71	.999	.204	3.29	4.13	2	5
	new york city	7	3.14	1.574	.595	1.69	4.60	1	5
	Total	38	3.71	1.113	.181	3.34	4.08	1	5

Mental Healthcare's Place Within the School Setting

When participants were asked for their perception in relation to their schools having adequate SBMH services available (Q.14), 5 strongly disagreed and 11 somewhat disagreed, whereas 16 participants reported somewhat agreeing, 7 reported agreeing, and 1 strongly agreed that there are adequate SBMH services in their schools. In relation to participants being asked whether they agree that it would be helpful to have more SBMH professionals in their schools (Q.15), all 40 participants agreed in some way that more

SBMH professionals in the school setting would be helpful. A one-way analysis of variance (ANOVA) was run to determine if there were significant differences in the mean responses to both of these questions by the geographic location of participants. A significant difference was found $(F(2,37)=3.556, p=.039)$ in the responses to the question regarding having adequate SBMH services. A Bonferroni post-hoc test showed that the difference was between the participants from Berkeley (m=3.57) and the participants from New York City (m=2.13). Table 10 shows the mean responses to both questions by geographic location.

Table 10.

Descriptives

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
q14	berkeley ca	7	3.57	.976	.369	2.67	4.47	2	5
	boston	25	3.00	1.118	.224	2.54	3.46	1	4
	new york city	8	2.13	.991	.350	1.30	2.95	1	4
	Total	40	2.93	1.141	.180	2.56	3.29	1	5
q15	berkeley ca	7	4.57	.787	.297	3.84	5.30	3	5
	boston	25	4.44	.821	.164	4.10	4.78	3	5
	new york city	8	4.25	1.035	.366	3.38	5.12	3	5
	Total	40	4.43	.844	.133	4.16	4.69	3	5

The survey asked participants to comment on their perceptions with respect to mental healthcare being provided in public school settings. All but one of the 40 participants agreed in some way that mental healthcare should be provided in public school settings, with one participant only "somewhat" disagreeing that mental healthcare has a place in public school settings. This information in addition to the previous findings reveals that while some participants may have had concerns with respect to the amount of SBMH services and available mental health professionals in addition to the amount of collaboration and consultation that takes place with teachers, that an

overwhelmingly majority of the participants felt strongly that mental healthcare should be provided in school settings.

Findings on Issues of Diversity

Additional findings revealed that participants had mixed responses when asked to comment on the racial composition of the students receiving SBMH services. The participants were asked if they agreed that the racial make-up of the students in the SBMH program(s) is proportionate to the racial make-up of the student body. There were 5 participants who marked this question on the survey "not applicable", 13 participants disagreed and 22 agreed that the racial make-up of the students receiving SBMH services is proportionate to the racial make-up of the student body. When asked if there are a higher proportion of students of color and immigrant students in the SBMH program than there are in the general student population, the responses were different with 17 feeling that the students in the SBMH program(s) are not proportionately different in race or immigrant status than the student body and only 10 agreeing that there is a higher proportion of students of color in the program(s). There were 13 participants who marked this question as "not applicable", which may be a result of the fact that many of the public schools in the three cities in this study are predominantly filled with students of color, meaning that this would not be an issue in many schools. Only 3 participants disagreed that the SBMH professionals in their school are culturally, racially and ethnically sensitive while 30 agreed that they were, and 7 marked this question as "not applicable".

The survey asked participants if they agreed with the statement, "The school-based mental health professionals are gender sensitive and are aware of gender issues".

Only 1 participant "somewhat" disagreed that they are, 33 agreed that they are and 7 marked the question as "not applicable". These findings indicate that the participants see the SBMH professionals in their schools as being more gender sensitive than sensitive to issues of race, culture, and ethnicity.

Ideas for Improving the SBMH Programs

In the conclusion of the survey there were two-open ended questions that asked participants to share their thoughts about improving the SBMH programs in their school in relation to the provision of services and the collaboration between teachers and mental health professionals. Five themes arose out of the responses to these two questions. The themes were as follows: 1) The need for more mental health staff to meet with growing student numbers who are in need of services and increased of availability of current SBMH professionals, 2) Increased frequency of student meetings with SBMH professionals, 3) Teachers getting more information on the treatment and services that students are receiving, 4) Requests for more training in mental health issues, and 5) More time for consultation with mental health professionals.

In terms of having more SBMH staff in the schools, a number of the participants mentioned that it would be helpful to have more mental health staff available in the schools to meet the growing number of students who could benefit from such services. One teacher wrote, "I don't refer kids often because the caseloads are too big and the counselors can't possibly follow up on everything." This teacher also wrote, "If we had more people who had more time I would refer more students!" Another teacher wrote, "Of course more would be better. More of what we have, more time, more interns, more

space, etc...” In relation to the availability of mental health staff one participant wrote, “There need to be mental health staff available at all times for crisis intervention.”

In addition to more staff and availability some participants noted other areas for concern in regards to the frequency of mental health staff meetings with students. One participant commented, “Students in need should receive services regularly.” Another teacher requested, “More than once a week sessions” with students. A third teacher wrote, “Expand individual & group counseling to after school hours.” One teacher noted that, “There is a lot of frustration on the part of teachers when mental health professionals pull failing students out of our classes on a regular basis.” Another participant commented on a problem they see with the SBMH program at their school and said, “A big issue that I see is the children who have insurance and are not seen, because the mental health at our school only sees uninsured students. These are students who sorely need care, though are not seen, even after their families are encouraged to find them care.”

Several teachers felt that receiving more information about the treatment being done with students and the services being provided would improve the SBMH programs at their schools. One teacher remarked that, “Progress reports should be available so that students receiving services as well as teachers are able to view goals and related ongoing progress.” Another teacher wrote, “Be more open and clear about the services being offered for students and the process by which teachers can refer their students for help.” Another teacher commented, “I understand confidentiality, but the mental health clinicians in my school cannot tell us the diagnosis of our children. I think it would make it easier to work with the students if we knew what was going on with them.” Other

participants remarked that it would be nice to have a more clear system for following up about students who have been referred for services.

Many of the participants requested more training in issues of mental health in order to more fully understand the issues that students are dealing with. One participant wrote, "I would love to be educated about the clinical diagnoses of my students. Opportunities for learning more about these diagnoses would be valuable." Another teacher who was interested in mental health training wrote, "There should be a way to inform teachers of signs, benefits, etc so they can think critically about identifying and recommending students. The experts should run workshops for teachers on how to help students with certain common issues", another participant requested more "Teacher awareness training."

More time for consultation with SBMH professionals was a prevalent theme when participants were asked to comment about ways to improve the SBMH programs. One participant commented that in addition to initial meetings that they wanted, "Periodic follow up meetings to make sure teachers are knowledgeable about issues being addressed." And, went on further to say, "Teachers refer students because of visible problems, but often other issues arise." Another teacher wrote, "Encourage the administration to invite clinicians to meet with teachers regularly at grade level meetings, and not just at Student Support Team meetings." A third teacher wrote, "There should be a way for the teachers to communicate (and not just by randomly running into a mental health professional in the hallway) back and forth with the teachers and the mental health professionals."

Few participants had any negative comments, but one participant wrote, "The counselors are incompetent, the children uniformly hate going to see them, even the ones who love getting out of class for any other reasons!" This participant also wrote:

> The counselors are so terrible that often teachers end up ministering to the children's deep seated issues. We have an empathetic and caring faculty, but we are not trained in this problems and I worry that we are not the best "counselors" for the kids! (besides the fact that the blurring of the teacher/counselor line is extremely harmful to students).

Another participant that had a more positive attitude about the SBMH program in their school wrote, "Overall, our mental health team does a wonderful job helping students cope with the stresses of both their home and school life. They are an essential component of the success of our school."

Conclusion

The findings of this study illustrate that in general the participants of this study feel that mental healthcare should be provided in public school settings and that the SBMH programs in their schools do have a positive effect on both the academic functioning and social functioning of students participating in the programs. The more that participants agreed that the SBMH programs have a positive effect on both these areas of functioning the more they agreed that SBMH professionals meet regularly with the students and that mental healthcare has a place within school settings. There was a difference in participants' perceptions in regards to the having adequate SBMH services for the students in their schools depending on geographic location. The teachers also commented that more SBMH staff and more time for consultation, collaboration and trainings would make the services more successful. Overall, the findings revealed that

the participants felt mixed about the SBMH programs in their schools, but that they

would like to see them improve.

CHAPTER V

DISCUSSION

This predominantly quantitative study was designed with the purpose of finding

out how public elementary, middle, and high school teachers in three different urban

areas perceived the SBMH programs at their schools, with a particular focus on their

perceptions of program effectiveness when it comes to addressing student's functioning.

Since there have been no other studies that have been conducted with this particular

focus, the information obtained cannot either support or challenge existing data on this

specific subject. The major findings of this study, although not significant enough to be

generalized to the larger population of urban public school teachers in these three cities,

do provide helpful information in relation to several themes that were discussed in the

Literature Review chapter. The themes that will be discussed in this chapter are SBMH

programs meeting the needs of urban youth, SBMH professional's collaboration and

consultation with teachers, mental health training for teachers, and the place of mental

health within school settings. Following the discussion of the above themes, there will be

an examination of the strengths and limitations of this study, and implications for clinical

social work and further research.

Summary of Major Findings

In relation to the major question regarding SBMH programs and the impact on

student functioning, the majority of participants reported feeling to some degree that the

SBMH programs in their schools have a positive effect on both the academic and social

functioning of the students receiving the services. Overall, the participants felt like

SBMH services have a slightly more positive effect on the social functioning of students

than academic functioning, although there were no significant differences found in

reports between geographic locations of participants as there were with reports on

academic functioning between Boston and New York City.

The findings of this study also suggest that participants from New York City not

only see the SBMH programs in their schools as being least effective in terms of the

academic and social functioning of students than participants from the other two cities,

but also that they have lower amounts of adequate SBMH services and consultation

within their schools. While the findings for all three geographic locations indicate a need

for more SBMH services, these findings specifically emphasize the need for more

effective and adequate SBMH services in New York City. All of the participants agreed

in some manner that there should be more SBMH professionals working in their schools.

An overwhelming majority of the participants stated that they want more

consultation with the SBMH professionals in their schools. They also reported wanting

more information about student's clinical diagnoses, feeling that this information would

be helpful in their work with students. This points to a need for more training of teachers

in mental health issues that commonly affect students, so that teachers may understand

various types of diagnoses in a more meaningful way.

The findings also revealed participants perceptions in regards to the racial and

ethnic make-up of the students receiving the SBMH services. Demographic information

obtained from the participants showed that nearly all of the participants were Caucasian

and female. In addition, the findings indicated that almost all of the participants feel that

the SBMH professionals in their schools are both well trained and competent, and culturally, racially, and ethnically sensitive.

SBMH Programs Meeting The Needs of Urban Youth

Teachers play a vital role in assessing the effectiveness of a program related to their students' improvement, in that they are first hand witnesses to the changes that their students go through on a daily basis. A large majority of the participants agreed in some way that the SBMH programs in their schools have a positive effect on the academic and social functioning of the students receiving the services. In a review of research studies done on SBMH programs it was demonstrated that the programs with the highest evidence of influence were the ones that were geared towards changing specific behaviors and skills linked to academic and social functioning (Rones & Hoagwood, 2000). The findings of this study highlight the fact that teachers and their perceptions can be utilized in the process of shedding a positive light on SBMH programs when it comes to meeting the academic and social functioning needs of students. It is crucial to frame the use of SBMH programs in addressing academic and non-academic barriers to learning if SBMH programs are to be more fully supported within schools (Adelman & Taylor, 1998, 1998b, Weist, Lindsey, Moore & Slade, 2006). The literature on SBMH points out the importance of encouraging more support for and improving SBMH by looking more closely at the *No Child Left Behind Act* of 2001 and the President's New Freedom Commission on Mental Health (Mills et al., 2006, Weist, Lindsey, Moore & Slade, 2006). The fact that there was a significant difference in the reports on SBMH programs positive effect on academic functioning between New York City and Boston points out the potential for difference across geographic locations of schools, which is a finding that is

supported in Repie's study (2005), which looked at teachers' perceptions in regards to different mental health issues present in schools. SBMH services are vastly different in cities across the United States. This speaks to the need for a more strategic and unified attempt at organizing SBMH services.

The survey used for this study asked participants to comment on the racial and ethnic proportion of the students receiving the SBMH services in comparison to the general student body. The findings showed that more than half of the participants felt that the racial and ethnic make-up of the students receiving the SBMH services was proportionate to the racial and ethnic make-up of the student body in their schools. More participants disagreed that there was a higher proportion of students of color and immigrant students receiving SBMH services than in the general student population. The researcher felt that this finding may have been a result of the fact that many urban schools are predominantly populated by students of color and immigrant students, which would make this issue irrelevant. The history of SBMH illuminates its role in serving students of color and/or immigrant students (Sedlak, 1997). According to other studies conducted on race and SBMH services (Armbruster & Lichtman, 1999), SBMH programs provide access to mental health services for an underserved population of people of color and immigrants. Although this study does not support the idea that SBMH programs provide this type of access to this population, it does provide a descriptive picture of who uses the services to some extent. Owing to the fact that many youth who see SBMH professionals are students of color and that the importance of culturally competent treatment is emphasized in the literature on SBMH (Allen-Meares, 2006; Bailey, 2000; Garrison et

al., 1999), the finding that the participants feel that the SBMH professionals are culturally, racially, and ethnically sensitive is an important one.

SBMH Professionals Collaboration and Consultation with Teachers

Kury & Kury (2006) take note of the fact that there is little known about the collaboration that takes place between important figures in SBMH. The majority of the participants reported that the collaboration they have with the SBMH professionals is helpful for them in supporting the students in their classroom. Multiple authors have stressed the importance of SBMH professionals cultivating collaborative relationships with teachers in which meaningful consultation can take place (Adelman & Taylor, 2000; Lynn, McKay & Atkins, 2003; Paternite & Johnston, 2005; Taylor & Adelman, 2000; Weist et al., 2000).

Adelman & Taylor (1998, 1998b) identify issues of funding and support as possible reasons that continuing consultation may not take place. However, SBMH professionals providing interventions without the inclusion of teachers is seen as an example of the fragmentation that can take place within SBMH (Taylor & Adelman, 2000). In terms of ideas to improve the SBMH programs at their schools many of the participants wrote about wanting to have more time to consult and collaborate with the SBMH professionals, with all but four of the participants reporting that they would like to have more consultation regardless of whether or not they found it helpful in supporting the students in their classrooms. These findings support the literature that teachers should be seen as essential partners in making SBMH programs more effective (Lynn, Mckay & Atkins, 2003; Paternite & Johnston, 2005; Roeser & Midgley, 1997; Weist et al., 2000).

In fact research shows that teachers are better informants on student's behavior problems than parents and the students themselves (Loeber, Green & Lahey, 1990).

Training in Issues of Mental Health for Teachers

A majority of the participants reported not having any previous training in issues of mental health. The researcher believes that the participants were interested in knowing more about their student's diagnosis in efforts to better understand what they are going through and their experiences. The findings illustrate that even though most of the participants reported not having any previous training in issues of mental health that they all felt that knowing about their students clinical diagnoses would be helpful in their work with students. As noted earlier in this chapter, there needs to be more of an effort to emphasize the provisions in government mandates that are close to SBMH (Mills et al., 2006; Weist, Lindsey, Moore & Slade, 2006). This would allow for greater efforts aimed at providing valuable training opportunities for teachers. These trainings could increase awareness of how the symptoms of various clinical diagnoses common for urban students manifest themselves, which may in turn increase empathy, support, and understanding for the students dealing with different issues. This also may have an impact on teachers being able to appropriately recognize which students should be referred for SBMH services and how to deal with some of these issues in the classroom.

Since there are higher presentation rates in urban youth of depression, PTSD, school avoidance, and delinquent behavior (Weist et al., 2000) and that community violence is such a prevalent issue for children living in urban communities (Atkins et al., 2006; U.S. Department of Justice, 2003) teachers should be receiving training that helps them be more sensitive to the issues affecting urban youth. Research has shown that

some of the barriers to overcoming students mental health problems are lack of information and training (Walter, Gouze & Lim, 2006). Walter, Gouze & Lim (2006) found that, consistent with the findings of this study, teachers have a limited amount of mental health knowledge. It has also been shown that providing more opportunities and resources for teachers to address the mental health needs of their students will improve their sense of self efficacy and job satisfaction (Roeser & Midgley, 1998). As stated above, participants in this study wrote about wanting more trainings and information on students' diagnoses. Issues of confidentiality are important to take into consideration when thinking about giving teachers information on students' diagnoses, but if trainings were geared towards providing information on common diagnoses of students, mental health awareness, and the appropriateness of referrals then the efficacy of SBMH programs and encouragement for them may improve.

Mental Health within School Settings

In this study only one of participants "somewhat disagreed" that mental health should be provided in school settings while many of the participants wrote about the need for more SBMH professionals in their schools to meet the growing mental health needs of students and increased regularity of meetings between the mental health professionals and the students receiving the services. These findings are hopeful in view of supporters' arguments for increased SBMH services (Armbruster & Lichtman, 1999; Atkins et al., 2006; Flaherty, Weist & Warner, 1996). A problem identified with the traditional model of school mental health services delivery is the small amount of school social workers that are expected to meet the needs of many students (Massat, Ornstein & Moses, 2006). Having more SBMH professionals in schools would be one possible solution to this

problem. Taking a more universal approach to providing SBMH services is seen as another solution to meeting the mental health needs of more students (Lynn, McKay & Atkins, 2003). Another factor that affects the amount of mental health service professionals in schools are federal and state mandates (Adelman & Taylor, 1998).

Historically, researchers have questioned whether or not mental health programs should be present in schools (Armbruster & Lichtman, 1999; Flaherty, Weist & Warner, 1996). Advocates of SBMH argue that these services are more cost-effective than community mental health clinics and offers access to services that are otherwise not used by low-income individuals and people of color (Armbruster & Lichtman, 1999; Flaherty et al., 1996; Kaplan, Calonge, Guernsey & Hanrahan, 1998). There were significant positive correlations found between participants perceptions that the SBMH programs in their schools have a positive effect on both the academic and social functioning of students and the belief that mental health should be provided in school settings. The perceptions of participants with respect to the positive effect of the SBMH programs was also positively correlated with their reports on the regularity of SBMH professionals meetings with students. These findings support the need for more SBMH services and increased frequency of meetings between students and SBMH professionals from the perspective of teachers, which is a perspective that has largely been disregarded in the literature on this issue.

Strengths and Limitations of the Study

SBMH research is limited and mainly focuses on case studies of school-based centers, the perspective of clinicians, and the students who receive the services and the mental health issues they are faced with (Armbruster & Lichtman, 1999; Kury & Kury,

2006; Rones & Hoagwood, 2000). There is also a need to carry out more evaluations of SBMH programs (Armbruster & Lichtman, 1999; Flaherty et al., 1996). That said, it is important to point out the strengths of this particular study. This study looked at the role of SBMH programs in meeting the needs of students in a more concentrated manner by looking at the crucial perspective of teachers. The fact that this study focuses on the rarely examined perceptions of teachers is immensely important when considering how to improve the effectiveness of SBMH services, due to teacher's vital role in the school environment and the amount of time they spend with the students. The research conducted for this study will also contribute to the limited research base that looks at the effectiveness of SBMH programs, which as pointed out earlier is sorely needed in the field of SBMH. Lastly, a strength identified is that a study of this nature will possibly build more support for the provision of SBMH services in public schools across the nation, especially in urban areas.

The first limitation of this study is that it only provides information based on the functioning of students within the school setting, which leaves out major parts of children's lives, including their home life, parents, caregivers, friends, and other outside networks in which they interact. An additional limitation is the focus on teachers, although important, does not provide information on the perceptions of other important members of the school environment (i.e. principals, guidance counselors, teaching assistants). The next limitation is that this study will not shed light on the specific issues that teacher's face in trying to educate children with mental health issues. A recommendation for a future study would be to ask teachers qualitatively about their experiences with mental health issues in the school setting. As stated earlier, because of

the nonprobability sampling technique that was used for this study and the low number of actual participants in the study, generalizations to the larger population of elementary, middle, and high school teachers familiar with SBMH in New York City, Boston, Berkeley, CA or elsewhere were not be able to be made. Another limitation in this study is that there is a strong likelihood that the teachers who were willing to fill out the survey would be those that have or have had students involved in their school's SBMH program, which may have left out teachers who were not aware that they had students involved with the SBMH program and teachers who have experience with SBMH programs not in the chosen schools. Lastly, a limitation is that this study did not provide descriptive information about the SBMH program in each participant's school and the motivation for the SBMH services to be placed in the school in the first place. Consequently, assumptions were made about the mental health programs; such as they value teacher-therapist collaboration, cultural competence, and training and orientation for teachers.

Implications for Social Work in Schools and Future Research

After examining the literature on SBMH it is evident that schools are seen as one of the most favorable setting for the provision of mental health services for youth (Adelman & Taylor, 1998; Bruns, Walrath, Glass-Siegel, & Weist, 2004; Flaherty et al., 1996; Gonzalez, 2005; Mills et al., 2006; Paternite, 2005; Rones & Hoagwood, 2000; Taras & Young, 2004; Walter, Gouze, & Lim, 2006; Weist, Lindsey, Moore & Slade, 2006). Schools are also settings that present opportunities for important research in the field of mental health (Adelman & Taylor, 1998). Owing to the fact that 20% of youth in this country face some sort of unmet mental health need (Bruns, Walrath, Glass-Siegel & Weist, 2004; Taras & Young, 2004) and that there is a higher percentage in youth who

live in urban communities, schools are an even greater setting for the provision of mental health services. The expectation of this study was to provide useful information to the field of social work by providing empirical evidence about an area of clinical importance in doing work within the school setting. The researcher hoped to gain a better understanding of teachers' perceptions of SBMH which would inform the field of school social work in terms of program implementation, program evaluation, program usefulness, meaningful collaboration with members of the children's school environment, racial and cultural issues that may affect perceptions of mental health work, and other areas of need when it comes to providing mental health services to children and their families in this environment. SBMH clinicians are in an ideal position to achieve the needed level of interaction with the student, their peers, or adults in the student's environment to attain clinically significant improvements (Evans, Axelrod & Sapia, 2000), which underlines the need for this type of research in the field of social work. Teachers' perceptions are critical if any practical efforts at providing mental health services are expected to be made in public schools (Roeser & Midgley, 1998). The findings in this study provide clear quantitative evidence that SBMH services are seen as having an impact on students functioning in schools. This is valuable information for program administrators, principals, teachers, SBMH programs, students, and parents. Classroom teachers are in a unique position to view students' social skills, academic success, and emotional regulation to provide school mental health professionals with helpful information that will not only inform, but strengthen the treatment.

The data gathered in this study may be revealing for the field of social work in that it offers teachers' perceptions on topics such as collaboration and consultation with

SBMH professionals, requests for meaningful training, and the need for more adequate mental health services. The findings are somewhat limited in scope, but they provide an examination into the crossroads of mental health and public school education. The study also allowed teachers to share their perceptions about programs that affect their work in schools.

Future research should consider expanding on the inclusion of teachers' input when evaluating or researching SBMH programs. Other considerations include examining the ways in which collaboration and consultation between teachers and SBMH professionals can be improved to more fully meet the needs of students, identifying training topics and methods that public school teachers find useful, looking more closely at the effects of SBMH on academic functioning to help garner more support for SBMH, and studying the SBMH models that are the most effective at meeting the needs of students of color and immigrant students. Public school teachers are faced with the task of educating a majority of this nation's youth and are asked to do so under heavy amounts of pressure with little resources and support and for that reason they ought to have an opportunity to influence the SBMH programs that serve their students.

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Appendix A

Informed Consent Form

Dear Potential Participant:

I am a graduate student at Smith College School for Social Work conducting a study on how teachers perceive the school-based mental health programs at their school. The purpose of this study is to obtain information about your opinion of the mental health program at your school in particular and how it affects the academic and social functioning of the students in your school. I am also interested in suggestions you may have to improve the program.

I received permission to send you this by the administrator at your school and the superintendent of the school district. Your information will be used for my thesis and future publications and presentations.

Your information will be very helpful to social workers, particularly those working in the public school system. Data from this study will be compiled into a thesis, which will be submitted in partial fulfillment of the requirements for the degree of Master of Social Work, as well as used in professional publications and presentations on this topic.

The Nature of Participation
I am asking you to complete a survey that will be mailed to the researcher for the purpose of contributing and sharing your experience and perceptions of the mental health program at your school. Study participants will be individuals over the age of 21, who are elementary school teachers in the public school system. It will be important for you to be somewhat familiar with the mental health program in your school or with students who are utilizing the programs services. The internet survey will be used to get a sense of teacher's perceptions of school-based mental health programs as well as to help protect your confidentiality. Those who cannot read English will be excluded from the study.

To ensure confidentiality, each survey will have a code. Any identifying information on the questionnaire will be coded and the data aggregated for analysis. The results of this study will be reported for the group as a whole. Individual responses will not be linked to identifying data (though race may be stated in the aggregate).

Risks of Participation
Minimal risk from participation is anticipated. You may experience distress when reflecting on your experience with your school's mental health program in addition to how such programs affect your students. You may be uncomfortable expressing your thoughts about this topic due to fear of your job security and retribution from school administrators. Additionally, you will be asked not to identify students or co-workers by name, and to the best of your ability, not disclose individuals' identities.

Benefits of Participation
Potential benefits of this investigation include reflecting on your understanding and perceptions of the collaboration between education and mental health. Your participation in this study will hopefully assist and inform program developers and mental health professionals, as well as the administrators in your school, to better understand how his program affects you. It may allow you an opportunity to reflect on ways you can help make this program more successful.

Precautions Taken to Safeguard Confidentiality and Identifiable Information
Data in this thesis and professional publications or presentations will be presented in the aggregate without reference to identifying information.

Data, notes and consent forms will be kept secure for a period of three years as stipulated by federal guidelines, after which time they can be destroyed or continued to be maintained securely. In order to assure participant confidentiality, demographic information, researcher notes, and surveys will be kept separate from informed consent documents and will be identified by number codes rather than names or other identifiable information. Any names or other identifiable information from participants that could potentially be revealing will be removed or disguised during analysis and for use in the final thesis project.

You may contact the researcher at the email and/or telephone number listed on this consent form for questions or concerns about this study, before, or after filling out the survey.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION; THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of Participant: Date:

Signature of Researcher: Date:

If you have any questions or wish to withdraw your consent, please contact:
Mwaniki Mwangi

Appendix B

Internet Survey

TEACHER SURVEY

1) Do you have mental health services in your school provided by an outside agency or clinic? (If you check "no" you will be exited out of this survey and will not be included as a participant in this study)
     Yes □   **No** □

2) General Geographic Location: ❑ Boston ❑ New York City ❑ Berkeley, California

3) Gender: _____ Male _____ Female

4) Age: _____

5) Please state your racial/ethnic background: _____

6) What is the highest level of education you have achieved to this date?

_____ Less than a bachelor's degree

_____ Bachelor's degree

_____ Bachelor's plus some graduate training

_____ Masters Degree

_____ Doctorate

_____ Other: _____

7) Number of years teaching (if this is your first year please put 0): _____

8) What level of schooling do you teach? (If more than one option applies, please indicate the option which relates to this survey and where you spend the most time)

_____ Elementary School

_____ Middle School

_____ High School

The following questions address the school-based mental health program hosted by an *outside agency or clinics,* which provide individual, group and/or family mental health services for students in your school. These questions do not refer to *school special education professionals, school psychologists, school guidance counselors or school social workers*. If you are not aware of the mental health services provided by an outside agency or clinic, *please do not fill out this survey*, but make inquiries with the administrator(s) in your school.

9) How long have you known about the school-based mental health program in your school (if this is your first year being familiar with the mental health program please put 0, if you are not familiar with the program please put N/A):

_____

10) How many students did you refer to the school-based mental health program last year (approximately)?

_____ I was not here last year

_____ 0

_____ 1-5

_____ 6-10

_____ 11-15

_____ 15-20

_____ More than 20

11) Have you felt at any time that you have had students who need to be referred to the school-based mental health program, but have not been?

Yes □ **No** □

12) How often do you consult/interact with the school-based mental health professionals in your school? (These can be formalized meetings or quick consults in the hallways regarding student issues.)

_____ Often (many times a week)

_____ Sometimes (once a week)

_____ Infrequently (a few times a month)

_____ Almost never (once to a few times a year)

_____ Not at all

13) Would you like to consult/interact **more** with the school-based mental health professionals in your school?

Yes □ No □

For the following questions place a check in the option that best explains how you feel about the statement.

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
14) There are adequate school-based mental health services for students in this school					
15) It would be helpful to have more school-based mental health professionals working in my school					
16) The collaboration I have with the school-based mental health professionals is helpful for me in supporting the students in my classroom.					
17) The mental health services provided at my school have a positive effect on the academic functioning of the students participating in them.					
18) The mental health services provided at my school have a positive effect on the social functioning of the students participating in them.					
19) I feel like I am part of a team with the mental health professionals at my school.					
20) I feel knowledgeable about students' mental health issues who participate in the mental health program(s).					
21) I am aware of the clinical diagnoses of the students I work with who participate in the mental health program(s).					
22) I would like to know the clinical diagnoses of my students that participate in the school-based mental health program.					
23) Knowing these diagnoses **is/ would be** helpful in my work with these students.					
24) The school-based mental health professionals meet with the students receiving these services on a regular basis.					
25) The school-based mental health professionals should meet **more** regularly with the students receiving these services.					

26) My students like seeing the school-based mental health professionals.					
27) The race/ethnicity of my students in the school-based mental health program(s) is proportionate to the race/ethnicity of the student body in the school.					
28) There are a higher proportion of students of color and/or immigrant students in the school-based mental health program(s) than are in the general student population.					
29) The school-based mental health professionals at my school are well trained and competent.					
30) The school-based mental health professionals are culturally, racially and ethnically sensitive.					
31) The school-based mental health professionals are gender sensitive and are aware of gender issues.					
32) I have had training in issues of mental health (i.e., emotional disorders, learning disabilities, behavior modification, psychotherapy, etc.).					
33) My personal and professional experiences with mental health in general have helped me be supportive of the school-based mental health program(s) in my school.					
34) Mental healthcare should be provided in public school settings.					

35) Please share any suggestions that you may have for improving the school-based mental health program at your school.

36) Please share any thoughts or suggestions you have to improve collaboration between teachers and school-based mental health clinicians.

Appendix C

Human Subjects Review Board Letter of Approval

January 13, 2008

Mwaniki Mwangi

Dear Mwaniki,

Your revised materials have been reviewed and all is now in order. We are happy to give final approval to this study and hope you are very successful in your recruitment efforts.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Yoosun Park, Research Advisor

Appendix D

Recruitment Email

Dear Potential Participant,

I have received your e-mail address from a personal or professional contact of yours, who thought that you might be interested in participating in a study on *school-based mental health*. I am a masters level graduate student at the Smith College School for Social Work, and I am conducting a study about teacher's perceptions of school-based mental health programs.

For this research, I am surveying <u>licensed</u> elementary, middle and high school teachers who work in public schools (in **NYC, Boston or Berkeley, CA**) that have mental health services provided on-site *by outside agencies or clinics*. Participants will be asked to fill out a **15-20 minute** survey online. The survey will ask for some brief general demographic information about yourself and your teaching experience, but most of the questions will be focused on measuring your perception of the effectiveness of the school-based mental health program in your school when it comes to serving the students in your school who receive these services. You will also be given the chance to share some of your thoughts, in writing, about the program. All demographic and other information obtained in the survey will be kept completely anonymous.

If you are interested in being a participant in this study please click on the link attached to the following recruitment flyer, which will connect you to an internet survey on SurveyMonkey.com.

Also attached to this email is your copy of the informed consent should you choose to participate in the study. The informed consent form will highlight the potential benefits and risks of participation in the study as well as provide more information about the study and the measures taken to assure anonymity.

Whether you choose to participate in this study or not I am asking that you please forward a copy of this email to any other personal or professional contacts you may have who are licensed teachers that currently work in public schools (*in NYC, Boston or Berkeley, CA*) with school-based mental health programs. Participation in the study must be completed before March 27th in an effort to have the data analyzed by a statistician in a timely manner.

Please feel free to contact me directly with any questions or concerns you may have about participation in this study. Thank you in advance for helping to make this meaningful project a success.

 Sincerely,
Mwaniki Mwangi

Survey Link:
> https://www.surveymonkey.com/s.aspx?sm=BWrbiT_2b_2bff74zoolFaPOew_3d_3d