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# A comparison of mental health service delivery programs in Arkansas public school systems

Lisa Braddock Moon

*Louisiana State University and Agricultural and Mechanical College*

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A COMPARISON OF MENTAL HEALTH SERVICE DELIVERY PROGRAMS IN  
ARKANSAS PUBLIC SCHOOL SYSTEMS

A Dissertation

Submitted to the Graduate Faculty of the  
Louisiana State University and  
Agricultural and Mechanical College  
in partial fulfillment of the  
requirements for the degree of  
Doctor of Philosophy

in

The School of Social Work

by

Lisa Braddock Moon  
B.S.W., University of Louisiana-Monroe  
M.S.W., University of Southern Mississippi  
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For John and Jacob

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## ABSTRACT

This primarily descriptive research study was designed to provide an initial review of the mental health services being offered in the Arkansas public school system by assessing the current delivery of these services and examining certain demographic correlates. The study utilized an established national survey instrument, developed by SAMHSA, which was administered as an email survey to 140 Arkansas schools. The respondents for this study were the Local Education Agencies/Special Education Supervisors in individual school districts. Seventy-eight schools (55%) completed the survey, including 26 elementary schools, 25 junior high schools and 27 high schools. Sixty-two schools (79.5%) identified themselves as rural school districts and 16 schools (20.5%) were identified as urban schools. Eighteen (23.0 %) schools reported operating a school-based mental health clinic, while 60 (77%) had mental health services provided by community providers, but were not identified as having a school-based clinic. Schools identified 12,061 students (30.0%) as recipients of mental health services in the schools in the 2007-2008 school year. Several objectives reviewed in this study were: the way mental health services are organized administratively (under the special education department or in a separate department), how staff is organized (hired by district or via contract with the district), where authority rests for various administrative tasks (hiring and supervision of staff), what type of mental health services are being provided, what primary mental health problems are exhibited by children receiving these services, what data the schools are currently collecting, and the mechanisms used by the school to coordinate mental health and educational services between the school and the community. The study found significant results by identifying the following specific needs: services barriers among rural children, specific mental health-related problems reported for boys and girls, unmet service provision for Hispanic children, methodological strategies with respect

to specific informants used for data collection, deficiencies in data collection among some schools, and lack of coordination of strategic planning across school districts.

## CHAPTER 1: INTRODUCTION

### Introduction

The common mission shared by many public educational systems in the United States is to help all children enroll in a learning environment that will equip them with skills and knowledge to realize their aspirations, think critically and independently, inspire them to their fullest potential, and help them become productive, caring citizens who are prepared to succeed in a global society (Bruns, Walrath, Glass-Seigel, & Weist, 2004; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). However, at times social problems interfere with school attendance and performance, presenting obstacles to children's educational success. The mission of the school should be to help children, families, and communities remove these obstacles and advocate a setting that promotes success for all children. Children face personal obstacles such as disabilities, physical/mental health problems, drug use, adolescent pregnancy, and learning problems while family problems like domestic violence, divorce, child abuse, homelessness, and family illness impact their lives as well. In addition, school problems like poor facilities, ineffective teaching, and bullying add to the complicated picture to reduce the success rate of the school system (Ayers, Dohrn, & Ayers, 2001).

The provision of services available in the public educational system in America has seen many changes since its inception. During the Progressive Era in our country the climate of the education system changed to encompass the changing needs of society. The passage of compulsory school attendance and child labor laws from 1895-1918 marked a major shift in philosophies and policies governing American education. This would eventually become a philosophy of inclusion, and would be confirmed a half century later in the U.S. Supreme Court decision in the landmark case *Brown v. Board of Education of Topeka, Kansas (1954)*. This

decision held firm to the fact that every child was entitled to an equal education on equal terms (Shoemaker, 1998).

With the changes in the educational system came a change in the types of students attending schools. There was an increase in the number of immigrant children attending school, and with the urbanization of the country the educational system became concerned with the stability of the social order. The addition of these children to the educational system created problems associated with increased numbers of students in classrooms, students who were not ready to learn, increased discipline problems, and the public health and social control problems that would result if all children were not educated (Flaherty & Osher, 2003).

The changing atmosphere of the public educational system was faced with the challenge of finding a resolution to these issues. Developments in the fields of psychology, social work, special education, and health care would influence the educational system and assist in the resolution of these problems.

### Psychology

Child psychology began in the 20<sup>th</sup> century with an emphasis on the knowledge of the development of children, skills in interviewing children, performing assessments, and diagnostic formulations (Hoagwood & Erwin, 1997). The psychologist was introduced to school mental health to assist in the testing and placement of children for special services like special education. Their services were provided on a referral basis and they often were not located on the school campus. With the passage of the Education for All Handicapped Children Act in 1975, these services became more crucial and staff was often hired by the individual school or school district to provide more permanent services (Hoagwood & Erwin, 1997).

### School Counselors

School counselors were often referred to as guidance counselors when they began

providing services in the schools in the early 1900s (Flaherty & Osher, 2003). They were often teachers with additional training who were employed to assist in the vocational development of the students. The role of the counselor increased in the 1920s and 1930s in an attempt to increase individualized opportunities for each student. During the 1950s, the role of the counselor was expanded and often included testing and referral to community agencies (Flaherty & Osher, 2003).

### Social Workers in the School

The history of social workers in the school has followed the historic concerns of education. The first social workers in schools were hired in recognition of the fact that conditions, whether in the family, neighborhood, or school itself, that prevented children from learning and the school from carrying out its mandate were legitimate concerns (Constable, McDonald, & Flynn, 2002). School social work began during the school year 1906-1907 concurrently in New York, Boston, Hartford, and Chicago. Most of the workers came from the settlement houses and their purpose was to work between the schools and communities promoting understanding and communication. In 1916, at the National Conference of Charities and Corrections, Jane Culbert presented a definition of school social work. The definition was full of the concepts of inclusion, respect for individual differences, and education as a relational process that focused on the environment of the child and the school. By 1920 the National Association of Visiting Teachers was organized. This organization published a journal called *The Bulletin* until 1955 when it merged into the newly formed National Association of Social Workers (Constable, McDonald, & Flynn, 2002).

In 1949 Florence Poole described a more developed rationale for school social work practice derived from the right of every child to an education. She believed that education should change to help all children benefit from the school experience-even the ones who were

having difficulty (Shoemaker, 1998). During the 1960s the school social worker focused mainly on a clinical role as shown by the work of Lela Costin and John Alderson. The social interaction model, developed by Alderson, was based on systems theory including persons in environments that involved pupils, their families and the schools in a reciprocal interaction (Shoemaker, 1998). Costin's work included the school community pupil relations model which focused on school deficiencies and how they interact at various stress points in the students' life cycle. Outlined in this model were seven broad groups of functions of the school social worker. These were direct counseling with individuals, groups, and families; advocacy; consultation; community linkage; interdisciplinary team coordination; needs assessment; and program and policy development (Shoemaker, 1998).

### Special Education

Early education for what we now call Special Education teachers included generic training or training involving mental retardation. In the 1950s and 1960s behavior disorders became a major area of focus and research. The passage of the Individuals with Disabilities Education Act in 1975 required each child to receive a free and appropriate public education, including children with emotional and mental handicaps (Flaherty & Osher, 2003).

### School Nurses

The first school nurse was placed in New York City in the early 20<sup>th</sup> century. While they had no direct influence on mental health services, the mission was to improve the overall health and well being of all children enrolled in the school system. The goal of the nurse was to maximize the health of the children, which in turn would enable their academic development. Nurses were responsible for ensuring that children were immunized, did screenings for hearing and vision problems, and referred children with more intense problems for outside medical care (Lear, Gleicher, St. Germaine, & Porter, 1991). With the increased number of nurses in the

school came new awareness of the increased number of mental health issues surrounding children and the impact these problems had on their academic achievements. School nurses, realizing that social problems are often at the core of health problems, became involved in the development of teams to serve the needs of the children in the school system and to refer the children to outside community services (Flaherty & Osher, 2003).

### School Based Health Centers

The placement of nurses in the school system had a positive impact on the physical health of the students and in addition improved their academic pursuits (Dryfoos, 1988). To further expand on the idea that healthy students make better learners, schools began to offer services in school based health clinics following the traditions of the public health center. In the 1980s, to meet the primary health care needs of teenagers and to assist with general concerns about the educational risks associated with adolescent pregnancy and parenting, the number of school based health clinics increased in junior and senior high schools throughout the country (Dryfoos, 1988). With over 20% of visits to the school-based health center being for mental health issues (Lear et al., 1991), the need for developed mental health services became apparent. In the early 1990s, clinics in suburban and urban areas had added the service of a master's level mental health clinician to assist with the increasing number of mental health issues (Flaherty & Osher, 2003).

### School-Based Mental Health Services

Increases in the number of problems associated with risk taking such as teen pregnancy, sexually transmitted diseases, drug and alcohol abuse, adolescent suicide and homicide, and drop out rates (approaching 80% in some urban areas) (Lear et al., 1991) lead to the establishment of school-based mental health clinics in the mid 1990s. These centers provided diagnostic assessment; individual, group, and family psychotherapy; crisis intervention; and case

management (Flaherty & Osher, 2003) to students enrolled in both special and regular education classes. In this model of service delivery, children were referred and received mental health services on the school grounds. Family participation was encouraged and often the centers were involved in prevention and education services including classroom consultation and mental health education. School-based mental health clinics employed case managers, master's level therapists, psychiatrists, psychologists, physicians, and mental health nurses (Flaherty, Weist, & Warner, 1996).

Currently mental health services in the school are delivered in several different ways. Schools may employ their own staff to provide mental health services to the children or they may opt to participate in school-based mental health services where an outside agency (either public or private) operates a clinic on the school campus and provides the services during the school day. Finally, the school may refer children identified in need of services to a community provider for additional evaluation and treatment (Weist, Myers et al., 2000). Brenner, Martindale, and Weist (2001) found that almost half of all schools have an arrangement with a community-based organization to provide mental health services to assist with these problems.

### School Social Workers

Social workers in the school are often faced with providing services, including those targeted at mental health issues, to the children in their school. Child and adolescent mental health issues cause problems in a wide array of areas, including the educational system. While these problems may not initially appear to be related, the application of Maslow's (1954) hierarchy of needs would suggest that if students are not having basic needs met, difficulty in other areas, including academics, will be observed. The provision of mental health services in the school offers the student the opportunity to address mental health needs as well as educational needs (Lynn, McKay, & Atkins, 2003).



With the advent of mental health programs and clinics being offered in the schools, much discussion is centered on agency turf and the ability of one provider to provide the needed services to the entire district. Sedlak (1997) has referred to this relationship as an uneasy alliance while Franklin (1998, 1999, & 2000) described the increase of school-based mental health service delivery as a challenge to the established roles and practices of school social workers. Additionally, other barriers to mental health services in the schools include available paraprofessionals and professionals to provide the services, financial responsibility for the services, and available facilities (on the school campus) to conduct the services (Lynn et al., 2003).

To examine some of the discrepancies in the roles and tasks of the social worker, research (Allen-Meares, 1994, 2004; Bailey, 2003) has been conducted on a national level to address the definition of tasks and functions, patterns of delivery of services, and traditional versus non-traditional school social work activities. Allen-Meares (2004) identified traditional school social work roles to include advocacy, case manager, community interventionist, crisis manager, educator, home-school liaison, facilitator, and mediator. Specific tasks included assessment of children, referrals to community services including child protection services, education about diagnosis and medications, conducting home visits with parents, networking, and arranging for additional services in the community. Working with a multidisciplinary team was identified as a major component of the school social worker's job.

Bailey (2003) used the same roles to define the traditional school social worker in a study that compared school employed social workers to non-school employed social workers performing as mental health clinicians in the school system. This study highlighted the importance of school employees' knowledge of the role of the social worker and the differing role of the mental health social worker. Regardless of the role of the social worker, whether as a

school social worker or as a mental health clinician, the school system was more comfortable with the school employed social worker and often this caused the blurring of the roles identified in other studies (Allen-Meares, 2004; Repie, 2005). These studies, however, all identified the need for a mental health worker in the schools.

Repie (2005) also identified a need for mental health services in the school, but this study found that schools viewed the services of the counselors, psychologists and social workers with little difference in determined roles. Schools expressed a concern over increased school violence, increased teen risk taking behaviors, and poverty as indicators that mental health services were needed. When a comparison was done between the counselors, psychologists, and social workers there were different perceptions about ways to handle the situations. The counselors identified increased individual interaction, the psychologist viewed additional therapy as a solution, and the social workers reported a need for a variety of services to both the individual and their families (Repie, 2005).

#### Evaluation of Current School-Based Mental Health Services

A research study conducted by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration entitled *School Mental Health Services in the United States, 2002–2003* (Foster et al., 2005) provided the first broad and comprehensive description of the prevalence and distribution of mental health services in a nationally representative sample of approximately 83,000 public elementary, middle, and high schools in the United States. This study found 73% of schools reported social, interpersonal, or family problems among their students. All students in the school were eligible to receive mental health services, more than 80% of schools provided assessment for mental health problems, and referrals to community mental health had increased 60% in the last year while availability of outside providers had decreased. Response rate for this study was low and only aggregate data was reported based on

state location (north, south, east, or west). No specific data was reported or is available on findings for the state of Arkansas. The findings indicate that schools are addressing the need for mental health services but multiple challenges are still faced by the schools to administer these programs.

While findings (Bailey, 2003; Repie, 2005; Foster et al., 2005) indicate the need for mental health services in the schools, little research has been conducted to evaluate school-based mental health programs (Mills et al., 2006). Mills et al. (2006) indicate a need to evaluate the programs for policy formulation and standardization of treatment, to review school-based services in rural areas, to identify barriers that could prevent the delivery of mental health services, to describe administrative arrangement for services, to review the type of data collection and problem identification, and to establish standards to assist schools in making service delivery decisions. Schools need knowledge of established programs and a more detailed protocol to development a program that will provide appropriate interventions to children in all school systems. These schools need a more effective way to develop, implement, and monitor school-based mental health programs to deliver programs that will impact the current mental health issues in the school system (Evans, Weist, & Serpell, 2007).

#### Purpose/Importance of Study

Mental health services in Arkansas schools began as a result of the Individuals with Disabilities Act (IDEA). This law requires that goals be established and related services be provided to a student whose behavior impedes his or her learning or that of others. These goals and services must be identified on the students Individual Education Plan (IEP). Related services such as occupational therapy, physical therapy, speech therapy, transportation services, psychological counseling, and social work services are commonly found in student IEPs and districts are responsible for making sure that these services are delivered whether they employ or

contract these services with other providers. Based on the increased need for mental health services in the schools, the decision was made to put together a system that would create a standard way of delivering mental health services in the schools, which allows districts to be accountable for the services being delivered. In 2004, the School Based Mental Health Network was established to provide these services (Arkansas Department of Education, 2009).

The Department of Education made the decision to place the responsibility for these services under the Special Education Department. The Special Education department is organized into Local Education Agencies (LEA) that are administered by the Special Education Supervisor for that school district. Currently, there are 140 LEAs in Arkansas who manage all school districts. Local Education Agencies may be responsible for one district or up to five different school districts, depending on the size of the district. Initially, mental health providers arranged to provide contract services with the LEA or were hired by the school or district to provide mental health services. However, the creation of the School Based Mental Health Network required schools to apply for the school-based program through the LEA. The application was three part and required approval by the Department of Special Education, Arkansas Medicaid, and the Division of Behavioral Health Services, a division of the Health and Human Services Department. Initially, eight schools applied and were approved. Conditions for approval included: the school must contract with a mental health agency to provide mental health services, the schools must provide a location on the school grounds for the administration of the program, and schools must allow the mental health provider access to the students located in the school district. Currently there are 52 school-based mental health clinics operating in the state that are licensed by the Division of Behavioral Health Services (DBHS) to provide school-based mental health services. To participate in these programs the school must make application on a yearly basis with DBHS. These schools are considered school-based mental health providers by

DBHS once they complete the approval process and meet the required conditions to continue their participation. These programs are also eligible for Medicaid payment for services they provide (Arkansas Department of Special Education, 2009).

Since the inception of this program, there has been no research conducted to better understand how services are provided or evaluate the impact services have had on school systems. Data have been gathered on the number of individuals served in the DBHS qualified school-based mental health clinics and the total cost of Medicaid dollars paid for services provided in any school. However, no research has been conducted to compare the services received by these qualified school-based districts to the types of services being offered in schools not participating in the qualified school-based mental health program. There are also no available data on the type of services being provided or the qualifications of the providers. In 2005, the Arkansas Legislature passed Act 2209 of the Regular Session requiring the State to move toward an established System of Care to provide mental health services to all children in Arkansas (Arkansas Department of Special Education, 2009).

In 2006 the State hired the Human Service Collaborative from Washington, DC to interview stakeholders around the state, review current programs, and provide a framework to establish a System of Care. This agency conducted an extensive review and provided the state with a lengthy report that detailed the identified problems. These problems included a provider/payment driven mental health system, a system with no accountability, identified services not reaching all children, services in schools and juvenile courts provider regulated, families not included in services, no incentive to manage spending for services, services delivered in a scattered way, and no statewide data set identifying who is receiving services. Other problems identified were numbers in acute care beds too high in relation to other states, rural transportation problems, no services for substance abuse clients, no wrap-around services,

lack of qualified professionals, school districts that require children to withdraw from other providers to receive services in their schools, and few to no bilingual mental health service providers in the state. The report was presented in late 2006 and in 2007 plans begin to emerge to develop a System of Care by Arkansas stakeholders. In late 2007 figures were publicized showing the tremendous increase in Medicaid billing for children. The amount increased from \$100,658,563 million in 2001 to \$201,199,524 in 2005. The Governor's office called for immediate action and improvement in the mental health delivery system to children in Arkansas (Arkansas Department of Special Education, 2009).

In an effort to begin to evaluate these programs and determine the most efficient way to serve this population, this research project will use the instrument developed by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. A study of randomly selected schools in Arkansas will be conducted to determine the current delivery methods of mental health services in the public school system in the state of Arkansas. Attention will be paid to the level of services being provided, who is referring children to these services, the types of services needed and to ascertain if the different types of providers (school based or not) affect the service delivery. The initial research questions are: What are the mental health services currently being provided to students in Arkansas school districts, who are providing these services, where are the services administered, and what are some of the barriers to providing the services to the children of Arkansas?

Mills et al. (2006) identified these same needs nationwide, and reported little to no evaluation of school-based mental health programs and the need to establish generalized standards of care for all recipients of school-based mental health services. Research obtained from this study will provide information for Arkansas, and aid in the development of the System of Care program that would provide needed services to children and decrease the number of

school-related mental health problems. Additionally, this research could provide broader information to all school-based mental health providers on barriers to mental health service delivery, problems displayed by children in the schools system, administrative arrangement for school mental health services, and problems specific to rural areas of the country. Officials at the Department of Education and the Special Education department are in support of this research and view the research as valuable information for the continuation of mental health services to the children of Arkansas.

## CHAPTER 2: REVIEW OF RELATED LITERATURE

### Introduction

The purpose of this research study is to identify and describe the characteristics of mental health services provided to children enrolled in the public education system in Arkansas and to identify characteristics of issues facing school-based mental health programs in rural areas. Areas of evaluation will include the type of mental health services provided, credentials of service providers, location of the services, barriers to services, and what children are receiving these services. This literature review is organized around the definition of mental health services provided in the school, the development of mental health services in the school systems in this country, characteristics of persons and agencies providing these services, effectiveness of the current mental health services offered to children, demographics of children who receive mental health services, and ways that the current delivery of mental health services in the schools are evaluated.

Estimates show that yearly 20% of children and adolescents in the U.S. display symptoms of a disorder that can be diagnosed by the Diagnostic and Statistical Manual of Mental Disorders and about 5% display symptoms that could impair major life functioning (U. S. Department of Health and Human Services, 1999). These figures translate to 11 million children who come to school with significant mental health issues, and it is estimated that less than one-third receive the mental health services they need (Richardson, Keller, Shelby-Harrington, & Parrish, 1996). Since 1980, the suicide rate among children ages 10 to 14 has doubled with suicide remaining the third leading cause of death of adolescents (Lazear, Nations, Vaughn & Chambers, 1999). Twenty percent of high school students report they have seriously thought about suicide and 15.7% have made a specific plan to commit suicide (Centers for Disease Control and Prevention, 1997). In 1999, a study of high school students showed that 14%



indicated they were worried most of the time while 7% stated they had been angry enough to hurt someone, and 4% reported they were depressed most of the time (Dwyer, 2000).

Young children (ages 3-5) also display mental health needs as seen in a study of 3,860 preschool children that found 8.3% showed some behavior problems while 21.4% had evidence of an Axis I disorder as diagnosed by the Diagnostic and Statistical Manual of Mental Disorders (Lavigne et al., 1996). Additionally, statistics from the Office of Technology Assessment (1991) suggest that 12 to 15% of adolescents present emotional and behavioral problems at levels requiring intervention, and another 15% are believed to be at risk (Flaherty et al., 1996). Studies have also found that these behavioral and emotional problems occur more often in vulnerable populations (Armstrong, Dedrick, & Greenbaum, 2003; Epstein, Kutash, & Duchnowski, 1998; Marder & D'Amico, 1992), such as poor and minority children. The intervention these children receive is of shorter duration, and the problems can persist into adulthood if no changes are made. Children with social and emotional problems are also at a greater risk for dropping out of school, having difficulty in developing peer relationships, becoming discipline problems, and exhibiting a higher incidence of family dysfunction (Short, 2003). Kessler and Foster (1995) also discovered that these same children are more likely to develop problems associated with alcohol and other drug use.

Research shows that two-thirds of the students who exhibit poor academic performance and drop out of school suffer from either a behavioral or health problem (Knitzer, Steinberg & Fleisch, 1991). Kessler and Foster (1995) reported that 14.2% of high school dropouts have a history of psychiatric problems compared to only 5% of high school graduates that did not attend college. In addition, among the dropout cohort surveyed, the survey found that 23.6% of males and 22.7% of females had a history of early onset of psychiatric problems. The study concluded that the impact of the early onset of psychiatric problems prematurely shortens the educational

attainment of approximately 7.2 million Americans. Stoep, Weiss, Kuo, Cheney, and Cohen (2003) reported that 46% of children who do not complete secondary school attribute their failure to psychiatric disorders, making the situation critical for school intervention.

### Development of Mental Health Services in the School

The intervention of schools in non-academic related issues began in the early part of the 20<sup>th</sup> century with the placement of nurses in the school system because it was understood that children with health concerns could not learn and function in the school system. The primary function of these nurses was to screen children for vision and hearing problems and to make certain their immunizations were up to date (Flaherty et al., 1996). With increased importance on the education and risks of teenage pregnancy, school based clinics continued to grow in importance and numbers during the 1970s and 1980s (Dryfoos, 1988). The addition of problems relating to adolescent suicide, homicide, increased risk taking with alcohol and drugs (especially the advent of crack cocaine), and staggering drop-out rates lead to recognition that mental health issues were impacting the school system (Flaherty et al., 1996).

With the addition of laws promoting the improved mental health of children and the right of all children to receive an appropriate education in the least restrictive environment, school based clinics began to offer more and more mental health services to children. These clinics began to employ master's level therapists who could assist in the treatment of these children. School-based health clinics grew in numbers from 200 in 1990 to 1380 in 2000 (Flaherty & Osher, 2000). Originally these clinics were in high schools, but over time they have been added to middle schools and to elementary schools due to increased number of referrals in elementary school (Flaherty & Osher, 2003). A study (Lear et al., 1991) reported that mental health concerns were the second most reason for visits to the school-based health clinic with 21% of the visits for mental health concerns compared to 26% for health problems.

From these established school-based health clinics came school mental health programs (Flaherty & Osher, 2003). The Centers for Disease Control and Prevention (1999) issued a report utilizing The Youth Risk Behavior Survey with a nationally representative survey of youth that identified problems from daily sadness and hopelessness (experienced by over one quarter of students) to thoughts of suicide (20%) to attempted suicide (8%). Many of the children with these conditions had not been identified and many had not received services. Costello et al. (1996) completed a study of Appalachian youth in North Carolina and found three out of five children with diagnosed mental health problems had received no recent mental health services. Of those students who had received services, between 70 and 80 percent were seen by school-based providers.

#### Characteristics of Students

Characteristics of students seen by school-based mental health clinics have been studied by Wolk and Kaplan (1993), who found that the students were more likely to be female, have a lower GPA than other students and exhibit more high risk behaviors in the areas of substance use, sexual activity, and family and peer relationships. They concluded that the school-based mental health centers attracted high risk youth who would need a higher degree of services. Armbruster, Gerstein, and Fallon (1997) conducted a study to compare the utilization of services in the school-based clinic to community based clinics and found that participants in the school sample were more economically disadvantaged and minority, yet they were as psychiatrically impaired as the community users. In an earlier study, Armbruster and Fallon (1994) discovered these same factors as predictors of people who drop out of treatment. Thus, the availability of services located within the school system would remove a barrier to treatment for these impaired individuals. Other high risk behaviors that may indicate need for services include children with Attention Deficit Hyperactive Disorder, suicidal clients, children experiencing sudden loss or

crisis in their lives (Hoagwood & Erwin, 1997), depression, substance abuse, anxiety, school avoidance, truancy, exposure to community violence, exposure to crime, domestic conflict, poverty, and impaired self esteem (Weist, Nabors et al., 2000).

### Referral Process

School-based providers will usually provide interventions that target children who are referred by teachers in the school system. This referral process is often influenced by the teacher's perceptions of the student and can be distorted by individual characteristics of the teacher (Williams, Horvath, Wei, Van Dorn, & Jonson-Reid, 2007). Other factors that influence the referral process may include length of teaching experience (Schwartz, Wolfe, & Casser, 1997), teachers' beliefs about themselves and their ability to handle classroom misbehavior, and teachers' level of concern, level of confidence, and support of school administration regarding classroom misbehavior (Martin, Linfoot, & Stephenson, 1999). However, Williams et al. (2007) found that teachers often confuse behavior with mental health problems. Still, they felt comfortable in referring children for services and indicated that classroom externalizing behavior was usually responsible for referral for services. Some examples they cited included aggression toward other students, outbursts in class, inappropriate sexual behavior, being out of their seats, noncompliance, and disruptiveness; however, they also conveyed they could detect sadness and withdrawal in their students.

### Available Services

When the referral has been made to the school mental health program a variety of mental health services may be available to students in both regular and special education. These include services that could be offered in hospitals, community health centers, and private offices such as assessment; individual, group, and family psychotherapy; crisis intervention and case management. In addition, the programs may offer educational programs and consultation for

classroom problems, as well as referral for more intensive services such as medication or inpatient treatment (Flaherty & Osher, 2003). Adelman and Taylor (1993) suggested the functions of the mental health provider should include: (1) direct intervention, (2) consultation with teachers about classroom behavioral problems, (3) mental health education through presentations to groups of students, parents, or teachers on issues such as common mental health problems, (4) outreach with other social service agencies in the community, (5) resource identification and development by enhancing resources for referral of students, and (6) networking by facilitating the coordination of services by providers of mental health services within and outside the school system. Brenner et al. (2001) also identified instruction, developing systems, programs, and resources, and connecting school and community resources as major components of school mental health programs.

School mental health services do not represent the local community mental health centers coming into the school and functioning in isolation but instead should use the model of coordinating services between the family, the school and the community (Lever et al., 2006). An example of this would include the advent of Student Assistance Programs in the school system. Early student assistance programs were modeled after employee assistance programs which were used by companies to address employee alcoholism and improve productivity in the workplace. Schools also used these programs to target students using alcohol and drugs that were previously referred to outside treatment agencies for assistance. The programs have evolved into more diverse programs offering assistance to students suffering from alcohol and drug problems, family problems, social isolation, and mental health issues. Benefits from the programs have been improved attendance, improved quality of referral to special education, and greater collaboration between schools and their communities. These programs have been cited as one of the most effective school-based prevention and early intervention strategies in the school system

and work best when staffed with a multidisciplinary team located on the school campus easily accessible to all students (Office of Substance Abuse, 1991).

### Roles of Mental Health Providers

Lever et al. (2006) identified roles of the school mental health clinician that include therapist, mentor, child and parent advocate, case manager, consultant, resource facilitator, team member, educator, crisis intervention specialist, and good will ambassador. Positive qualities of a school mental health clinician would include flexibility, creativity, visibility, accountability, cultural sensitivity, energy, good clinical skills, respect of individuals and the schools, and finally the ability to function as a team player. Taylor and Adelman (1996) outlined the scope of psychosocial and mental health needs and barriers to learning that should be addressed by school mental health workers. Some of these include school adjustment problems (including prevention of truancy, pregnancy and dropouts), relationship difficulties (including dysfunctional family situations and insensitivity to others), language difficulties, abuse by others (physical and sexual), substance abuse, emotional upset, and delinquency (including gang-related problems and community violence). Barriers to learning that should be examined are competence deficits (low self-efficacy/self esteem, skill deficits), threats to self-determination/autonomy/control, personality disorders or psychopathology, personal and familial crises and emergencies (including school wide), transition difficulties (stages of life, schooling, life circumstances), and the severity and pervasiveness of the problems (Taylor & Adelman, 1996).

### Barriers to Services

Evans, Langberg, and Williams (2003) report that mental health services in the schools provide the opportunity to work in the setting where the presenting problem exists. The mental health workers have access to the identified situation and the opportunity to receive first hand information from key informants in the school setting. Often, in the traditional setting, the

worker must depend on written reports and information from a third party. The placement of providers in the school setting assures the worker of direct access to not only the child but to teachers, other school employees who can provide pertinent information, and original documentation of issues and behavior plans for the child. Additionally, schools are a natural service setting and can provide a more naturalistic environment for families to seek services and for children to receive services (Mills et al., 2006). From a social ecology perspective this would allow disadvantaged and vulnerable children to receive services, as well as other children, in an environment where there were better opportunities to engage parents and teachers. Additionally, in this setting, prevention and early intervention could result in more opportunities for the child. Short and Talley (1997) reported, “as the single institutionalized program that touches the lives of virtually every American, schools reflect the merging of culture, values, and priorities of diverse citizens in their surrounding communities and society at large” (p. 234). Schools are often more accessible to the family and this also increases the chance that the family will participate in service delivery (Mills et al., 2006).

Providing services in the school may also decrease some of the barriers to mental health services that prevent children from completing treatment. Families can encounter barriers that include program attributes, overloaded case workers, staff fluctuations, location of services, transportation to services, stability of program funding, and untrained or under trained staff (Vanderbleek, 2004). Weist, Evans, & Lever (2003) also identified barriers in traditional mental health service delivery that included scheduling constraints and long waiting lists, especially for after-school appointments; more adult oriented interventions that do not focus on prevention, and lack of strategies that include behavioral changes for school settings. These barriers combined with parental attributes of unemployment, divorce, parenting difficulties, drug or alcohol abuse, and financial difficulties create a negative view of the mental health center and prevent

enrollment and retention of children in need of services (Vanderbleek, 2004). The placement of mental health services in the schools can assist in the prevention of the negative perceptions. Research has shown that children with significant mental health problems, who would not have ordinarily obtained services in traditional mental health clinics, often do obtain these services because the services were offered in the schools (Lynn et al., 2003). The Vanderbilt School-Based Counseling Program (Catron & Weiss, 1994) used a comparison study to determine program attendance and completion. A matched group of children from comparison schools were referred to either the school-based mental health clinic or the local community mental health center. After six months, 98% of the children referred to the school-based program had attended counseling while only 17% had attended the community mental health center. Study limitations included short duration and limited focus (Catron & Weiss, 1994).

### Delivery of Services

Weist et al. (2003) provided a description of five different ways the administration can arrange for the delivery of mental health services in schools: (1) School-financed student support services where the school district hires professional staff to provide traditional mental health services; (2) formal connections with community mental health services where formal arrangements are made between schools and one or more community agencies to provide services within the school or in a community agency; (3) school district-operated mental health clinics that provide services, training, and consultation to schools within the district; (4) classroom based curricula where the approach is activity driven and the interventions are led by a teacher; and (5) comprehensive integrated approaches where the district brings in multiple community agencies to provide a variety of services to the children receiving services and their families. The services maybe administered by a variety of professionals in these various settings.



## Providers

Staffing structures for school mental health centers may include school guidance counselors, school psychologists and/or school social workers (Centers for Disease Control and Prevention, 2000) but other arrangements include school nurses, special education teachers and aides, occupational therapists, and other healthcare staff (Flaherty et al., 1996). Bailey (2003) conducted a study that compared school-employed mental health providers to non school-employed mental health providers. This national study utilizing an email survey was comprised of 164 respondents with 67 being school-employed and 97 being non school-employed. Comparisons found that the majority of both school-employed and non school-employed mental health workers were master level social workers with more non school employed workers having earned doctorates. This study also discovered that the non school-employed centers had more psychiatric consultation available, and all the employees worked twelve months a year, as opposed to the school-employed who worked ten months a year.

Additionally, this study (Bailey, 2003) looked at the characteristics, tasks, and job responsibilities of the school-based mental health provider. The study was based on an earlier study by Allen-Meares (1994) which surveyed school social workers nationally. A comparison of school-employed workers and non school-employed workers showed the differences in tasks were related to the educational degree of the social worker, the guidelines of the school district, and the individual differences of the designated social worker. School-employed workers had higher degrees and more often were involved in therapy sessions while the non school-employed workers dealt with more case management and community service roles. The school district expected the school-employed worker to have more contact with special education students while the non school-employed worker was more often referred to regular education students. School-employed workers reported that they preferred to provide more non-therapy services like

education and prevention while the non school-employed workers preferred to provide more individual therapy and less education and prevention services (Bailey, 2003).

Due to the documented differences in the roles of these providers, careful consideration must be used so as not to confuse the term “school social workers” and “social workers who provide mental health services” in the schools, as both can be employed simultaneously. Penner (2004) documented concerns about the interchange of these terms and provided some guidelines to alleviate this confusion. A school social worker is often responsible for providing a broader array of services to students including obtaining financial assistance, providing transportation, assisting in community development programs, referrals to community providers, and conducting educational workshops for school staff and parents. The social worker in the mental health setting usually provides assessment and treatment and may not understand the role of the school social worker. This turf issue could become a barrier to services if correct reference is not used as schools are likely to have school social workers and social workers serving as mental health clinicians at the same time (Penner, 2004).

### Existing Intervention Research

Students continue to display emotional, social, and behavioral problems that affect their lives and their educational abilities. The ability of the school system to provide mental health services can assist children in completing their education and can decrease the number of behavioral problems experienced in the schools (Adelman et al., 1999). School-based mental health, where mental health services are delivered on the school campus, is one method for providing these services. Recent research has been conducted to show a continued need for these services, compare the types of services provided, and identify people who perform these services and the people who receive these services (Mason & Wood, 2000; Stephan et al., 2007).

When school-based programs are done well, positive changes are apparent in many areas (Bruns et al., 2004). Evidence of improved grades, attendance, and behavior in students, improved school climate, and decreased inappropriate referrals to special education were discovered in a cross-sectional study completed in the Baltimore Schools with two comparison groups of eight elementary schools (Bruns et al., 2004). All school faculty members, a total sample of 456, were administered the Climate Survey, a 23-item survey designed to assess the general climate of the school including safety, staff collaboration, positive involvement of parents, availability of mental health services, mechanism for referral, and proactive initiatives. Eight schools in the study had school-based mental health services and seven schools did not and referred students to community agencies. Results showed that staff had more involvement with parents, were more aware of the availability of services, completed more appropriate referrals to special education services, and perceived the safety of the school to be higher in schools with a school-based mental health clinician (Bruns et al., 2004).

Longitudinal research in six inner-city schools in Chicago (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003) found increased usage of mental health services, improved awareness of mental health issues, and sustained use of mental health services in schools with school-based mental health clinicians. One hundred students in six inner-city schools in Chicago were studied across a three year time period following referrals to school-based clinics. Researchers were looking for improvement in academic performance, peer relations, and classroom performance; more active parent involvement, and continued use of services in a neighborhood with traditionally skeptical attitudes toward intervention and intrusion. To conduct this research the Positive Attitude Toward Learning in Schools (PALS) was utilized by the school-based mental health clinician. The program was provided to half the sample which included classroom-based behavior modification training for students, home visits by the therapist or case manager, weekly

meetings at the school with the teacher and therapist, and parental instruction in behavior modification mirroring the classroom behavior modification techniques. The control group was assigned to the mental health clinic. The three schools with the PALS program had more positive results than the control group, including higher rate of completion of the program, decreased inappropriate behaviors, and more family involvement with the school system. Researchers found that without the services two-thirds of the control group dropped out of services, behaviors were unchanged, and parent involvement was not improved (Atkins et al., 2003).

A study (Fraser et al., 2005) conducted to promote social competence and reduce aggressive behavior by strengthening children's coping skills was conducted with three successive cohorts of third-grade students by the University of North Carolina at Chapel Hill. This study used Making Choices: Social Problem Solving Skills for Children curriculum and included classroom instruction weekly for twenty weeks to 576 students. Students were divided and received the Making Choices Plus curriculum or were placed in a control group who received the regular health curriculum. The students received lessons taught by program specialists who were educational counselors, psychologist, or social workers who had previous teaching experience. At the end of the three years, the students who had received the Making Choices Plus program displayed significantly improved social competence and they engaged in less social and overt aggression. Additionally, scores on their skills tests showed more goal formation and higher scores in information processing skills. This school-based program was a success in assisting third graders to develop life skills to combat the negative outcomes of aggressive behavior (Fraser et al., 2005).

Further examination of outcome studies related to targeted behaviors like depression, aggressive behavior, substance abuse, and bullying shows a positive impact on these issues when school-based treatment was available. Gillham, Reivich, Jaycox, and Seligman (1995) found

that over the course of a 12 week program high school students in the treatment group (composed of students who were trained in cognitive restructuring skills and social problem solving skills in a school-based program) had fewer depressive symptoms than students in a non-treatment control group. Students were instructed in a school-based setting on increasing self esteem, avoiding depressing thoughts, and handling everyday life problems. These students were reevaluated one year following completion of the program and only 7.4% of the students trained in the program displayed depressive symptoms as compared to 29% of the students who had been in the non-treatment comparison group.

A review of research pertaining to aggressive behavior problems (Conduct Problems Prevention Research Group, 1992) found that children who exhibit conduct disordered behavior prior to or during early adolescence are at the highest risk for future repeated delinquent and antisocial acts. Hussey and Guo (2003) conducted a study with 201 students in elementary school who displayed severe emotional and behavioral problems. The study provided intensive wrap-around services to the child and family in both the school and community setting. Services were provided in a school-based clinic and the children received an average of 3 hours per week of individual and group therapy. Parental participation was improved and parents reported services were easier to obtain due to location and support of on-site staff. Students who participated in the study showed significant changes in their behavior and psychiatric symptoms, including conduct and attention problems, and in depression. Limitations of the study included the use of only respondents who received Medicaid funding and the non-random assignment of students to experimental groups (Hussey & Guo, 2003).

Substance abuse problems grow progressively more serious as grade level increases (Stormshak, Dishion, Light, & Yasui, 2005). In an effort to combat this problem, a study utilizing the Adolescent Transitions Program was conducted longitudinally over a three year

period in four middle schools with 584 students. This school-based program was a family-centered intervention program designed to reduce problem behavior and prevent drug use. A parent consultant worked to help develop and support positive parenting practices known to serve as protective factors. Interventions were implemented both in the home and at school allowing the behaviors to be assessed in different environments. Outcomes showed the implementation of the program was effective in reducing problem behaviors while substance use and abuse was decreased as compared to the control group (Stormshak et al., 2005).

Olweus (1997) conducted research on peer victimization over a period of 2.5 years with students in fourth through seventh grades using a school-based program that capitalized on the existing environment: teachers and other school personnel, students and parents, along with mental health professionals. This prevention program used a questionnaire to assess school feelings about bullying and then a bullying committee was formed of students, teachers, and parents who use behavior modification techniques to decrease rewards for bullying and promote more positive activities. Counselors meet individually with both victims and people targeted as bullies by other committee members. Both primary and secondary effects were observed and there were documented reductions in general antisocial behavior such as vandalism, fighting, and truancy (33%-64%); improvements in the social environment of the class with improved order and discipline; positive social relationships; positive attitudes regarding schoolwork; and a reduction in the number of new victims (50%-70%). This practice innovation of addressing bullying through the restructuring of the social environment supports the concept of the practice of school-based mental health providers because the program operates through a multidisciplinary approach in the environment where the offense often occurs. School safety interventions were also examined (Astor, Meyer, Benbenishty, Marachi, & Rosemond, 2005) and results showed that school-based programs with methods-based intervention for students

combined with skills training for staff and parents increased the effectiveness of violence prevention programs and made schools officials more likely to comply with the established program.

### New Freedom Commission

To continue to provide quality school based mental health programs, evaluation must be conducted and opportunities for improvement noted. To assist in this process, programs highlighting the establishment of quality indicators (QI) or quality assessment indicators (QA) have been developed. This is a new process in school based mental health that is continually being developed and most recently influenced by the publication of the President's New Freedom Commission on Mental Health: *Achieving the Promise: Transforming Mental Health Care in America (2003)*. This report, presented under President George W. Bush, was developed after a year of study and input from more than 2,000 mental health stakeholders. Included in the report is an initiative with six goals and 19 recommendations that seek to transform and improve child, adolescent, and adult mental health services nationwide. Of the 19 recommendations, 13 deal either directly or indirectly with mental health services for children in the school system. These recommendations include reducing the stigma associated with mental health care and establishing a strategy for suicide prevention, developing individualized plans for every child with a serious emotional disturbance, involving consumers and families in the system, creating a comprehensive state mental health plan, protecting the rights of people with mental illness, improving access to mental health services, promoting the mental health of young children, and expanding school mental health programs.

### Evaluation of Schools with School-based Services

Evaluation of schools that offer mental health services to students in a school-based environment has recently been established as paramount to the continuation of services.

Research has provided many positive displays of successful interventions offered in school-based mental health programs, and research has established that school-based programs are more successful in providing these programs when compared to non school-based programs. However, research showing the evaluation of the actual school-based program is limited.

Multiple research projects (Astor et al., 20005; Atkins et al., 2003; Bruns et al., 2004; Hussey & Guo, 2003) conducted intervention research that showed positive results, but all studies were conducted in urban areas with no data/comparisons presented for rural areas. Mason and Wood (2000) conducted a study in a rural Hispanic community near the Mexican border and identified problems unique to the rural area. Some of these problems were transportation issues, the lack of enough qualified mental health workers, and cultural issues regarding the stigma of mental health treatment. They also identified the need to find a way to evaluate the program and recommended data collection of student behavior problems and referrals for mental health problems.

Further means of evaluation were presented in Bruns et al (2004) when research in 16 elementary schools in Baltimore identified more appropriate referrals to special education services when school-based mental health services were provided. Results showed that inappropriate referrals (students with behavior characteristics only) were decreased by 32% and an improved school climate was found when the school staff were administered the School Climate Survey. Williams et al (2007) also identified more appropriate referrals to special education services when school-based mental health services were offered in the school.

Collaboration is an important part of school-based mental health programs. To establish quality mental health programs in the schools that will continue to show improvement in interventions, school staff must be included in the planning and implementation process. Nastasi et al. (2000) found that a collaborative approach is a positive way to develop a school based



program because the staff members are identified as stakeholders and are included in the early development stages. They can be helpful in establishing the referral process and eliciting parental involvement. Additionally, Guerra and Williams (2003) found that the inclusion of principals and administrators increased their support and cooperation with the program and established lines of authority and accountability, while programs created in tandem with communities and influential constituents (child welfare, juvenile justice workers, unions, and professional organizations) increased cooperation and resource allocation (Mills et al., 2006).

Flaherty et al. (1996) identified problems from lack of coordination in his study in Baltimore in 16 schools. He discovered multiplicity of programs, programs not integrated with community, no family involvement, unreferral internalizing problems with teachers, and a decrease in services. Research showed that without coordination school administration was unsatisfied and even asked for the removal of school-based teams from two schools. Suggestions were for evaluation of team meetings, attendance at school functions, and development of in-services for staff to improve integration. Dwyer (2000) also emphasized the need for collaboration in his intervention study to improve outcomes and Nabors et al. (1999) suggested attending PTO meetings, attending field trips with students, and providing workshops that allowed for improved integration.

Hoagwood and Erwin (1997), in a review of studies found that to adequately evaluate school-based programs, coordination of services must be included as part of a plan that leads to an established system of care. To evaluate programs they suggested to review arrangement of services (for coordination/collaboration), types of services provided (prevent duplication of services), administrative alignment (school inclusion), and if programs are involving families in treatment (coordination with communities). Lynn et al. (2003) added to this evaluation the number of meetings the school-based providers had with teachers, the embedding of the school-

based mental health program into the school, and establishment of strong relationships with teachers. Meyers and Swerdlik (2003) echo this in research with psychologists in the schools. Emphasis was placed on being a team player, educating stakeholders about tasks school-based providers are able to perform, and working with other school-based providers to prevent turf issues.

Mills et al. (2006) established evaluation techniques that include: (1) demonstrating need, (2) establishing consensus, (3) involving key stakeholders, (4) empowering and supporting key stakeholders, and (5) promoting evidence-based practice. Demonstrating need involves advocating for mental health services on a daily basis and not just when a crisis brings attention to the need for mental health services. Establishing consensus involves all the stakeholders working in collaboration to provide an organized, effective, and comprehensive approach to serving youth and not another fragmented service in overburdened schools. Involving all the stakeholders in the initiation and development of the program would include families, school employees, community service providers, juvenile service systems, and child welfare services. The empowerment and support of these groups would include continued educational opportunities, exploration of their roles and responsibilities to increase understanding, and appreciation of the difficult tasks they face on a daily basis. To promote evidence-based practice the mental health providers must learn to conduct research that includes providing data for accountability, using rating scales to measure progress, and monitoring and evaluating infrastructure for needed policy changes. Additionally, school-based providers work to identify and reduce barriers to treatment that include transportation problems, inconvenient services, lack of insurance coverage, and stigma of mental health treatment (Mills et al., 2006).

Evaluation methods also included a survey of 62 school administrators in Connecticut, Maryland, Virginia, and West Virginia using the Survey of Youth Mental Health Issues (Weist,

Myers et al., 2000). This survey included urban and rural schools and identified problems expressed by students to include acting out behaviorally and substance abuse. Students in elementary, junior high and high school were surveyed and barriers identified were inability to pay for services, poor knowledge of mental health services, and a need to complete needs assessments to assist schools in developing a school-based mental health program. A very small response rate in the study encouraged the authors to recommend evaluation taking place at local levels to attract more participants.

Repie (2005) conducted a national study with counselors, psychologists, regular education teachers, and special education teachers where he identified barriers to include family based obstacles, transportation problems, stigma of receiving services, and long waiting lists. Recommendations of the study (Repie, 2005) included assessments on smaller populations to evaluate the needs of a specific area, evaluation of different types of services provided, and improved data collection. The identification of a key informant to collect data about identified problems, service provision, and school issues was identified as a way to strengthen school-based mental health programs.

Continued evaluation will require standardized assessment instruments be developed to show program integrity. Several evaluation tools have been developed to date that include the School Mental Health Quality Assessment Questionnaire by Weist et al. (2005) which evaluates 10 principles and 45 indicators of best practice, and the Psychosocial Environment Profile, developed by the World Health Organization, which evaluates the degree of health and mental health promotion of a school environment. No documentation is available on the use of these tests and the continued testing and refinement of these instruments will be needed (Mills et al., 2006).

## SAMHSA Study

While there is little doubt that mental health services are needed in the schools, little guidance has been offered or evaluated in the development and implementation of these programs. Schools are often left to develop these programs on their own, and having little experience in providing mental health services, leaves these schools at a disadvantage. To begin baseline evaluations of programs on a national level, the U.S. Department of Health and Human Resources, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services developed a survey that was administered electronically to a random sample of 2,125 schools in 1,595 districts (Foster et al., 2005). These schools were drawn from the U.S. Department of Education's public school data file and the sample size was designed to provide reliable estimates of regular public schools by level (elementary, middle, and high school), by school size as measured by student enrollment, by region of the country and locale (urban, suburban, and rural). Targeted response rate for the study was 80 percent, but after telephone calls and second mailing of surveys, the final completion rate was 60.5 percent with 1,147 schools in 1,064 districts completing the survey. The researchers determined that these results were nonbiased and reflected quantifiable data that would benefit the continued development of school mental health services and policies (Foster et al., 2005).

The survey instrument was designed for a baseline study to address information gaps and was developed by an expert panel of school officials, mental health researchers, policymakers, and representatives of professional organizations. The panel also reviewed the literature to ensure that it reflected the most up-to-date characteristics of school mental health. (Members of the expert panel are listed in Appendix F.) The survey was reviewed and endorsed by professional mental health associations and representatives of the state education associations. Finally, the survey was tested on a small number of school staff members who represented the

intended respondent types (Foster et al., 2005). This survey is available for use by any individual or organization as long as reference is cited (SAMHSA, 2005).

The questionnaire did not provide definitions of staff categories, mental health problems, or services. This was due to the variation in the staff titles for persons with similar training who perform similar functions in the school. The expert panel arrived at a set of staff categories that were derived from the literature and were most likely to be recognizable to respondents across the country. Mental health categories were also derived from the literature and adapted by a licensed child psychologist. These categories represented a range of severity from interpersonal/family problems to major psychiatric disorders. Groupings for school/school districts were the standard variables used for comparison in education research to include geographic region (North, South, East, and West) and locale or setting that included urban, suburban, or rural (Teich, Robinson, & Weist, 2007). All terminology was vetted with respondents in several school districts in different geographic regions and with the expert panel prior to finalizing the survey instrument (Foster et al., 2005).

Data received from the study were tabulated, frequencies established, and reported. No cross tabulations were conducted between established numbers and other identified variables (school size, school location, or age of student). No data are available from this study for state level; only aggregate sectional data were presented in the study (Teich et al., 2007).

Evaluation of the SAMHSA results found that 80 percent of schools provided assessment for mental health problems in the school with services being most commonly provided by school counselors, then nurses, school psychologists and finally social workers. Eighty-seven percent of schools reported that all students were eligible for services and one-fifth of enrolled students had received services in the preceding year. Identified problems were social, interpersonal, and family problems (highest across all school levels) followed by aggression and disruptive

behaviors (in males), and adjustment issues for females. Depression and substance abuse problems increased as age increased. Forty-nine percent of school districts had formal agreements with community-based providers to provide services in the schools, while 28% employed mental health clinicians. The study identified 80% of schools provided crisis intervention and referrals to specialized programs while family support services were the most difficult to deliver. Thirty-two percent used school district staff for services and 40% of schools reported they held interdisciplinary meetings monthly and 33% held quarterly meetings (Foster et al., 2005). Teich et al. (2007) identified the need for continued research on barriers to treatment, data collection, and problem identification to continue to assess types of service needs and evaluation of programs. Nationally, schools reported a 60% increase in the number of referrals for mental health services in the previous year (Foster et al., 2005).

Limitations of the study were initially the extremely poor response rate. The 60.5% response rate was only achieved after multiple telephone calls using refusal conversation, re-mailing of instruments to 36% of original sample, telephone calls to school administration to ask for support in completion, and finally an identification of critical questions (15) to make response time shorter. The initial survey had no place to indicate if you did not offer a school-based mental health program and many responders identified this as the reason they did not complete the survey. They were uninformed that they could still provide information on other areas like problem identification and data collection.

The identification of a targeted respondent was identified as a problem (Teich et al., 2007) as telephone calls found many instruments still on desks as they were just addressed to school administration and clerical staff were unsure who should complete. Data collection lasted for eight months and during that time districts were redrawn, schools changed administrators, and sample size was affected by these changes. Respondents also indicated they were unable to

provide adequate numbers about providers or services because the survey was district-based and not individual school identified. They reported not knowing how to identify employees who worked in several different locations or provided multiple services (Teich et al., 2007).

### Theoretical Overview

This subsection provides an overview of the theoretical frameworks that inform this research. Review of the research on the topic of school mental health shows the application of several main theories. The medical model shows the emergence of school-based mental health services while systems ecological theory, the social equity model, and community development theory can be used to show the growth and continued evaluation of mental health services in the school (Meyers & Swerdlik, 2003).

The use of the medical model in school systems establishes an understanding of the services that the social worker can provide in the school system, the need for the treatment of mental health issues in the school, and the tremendous number of students affected by mental health issues in the schools (Schaeffer, Weist, & McGrath, 2003). This model operates to assume that the client or patient has a sickness that requires the expert therapist to seek and provide a cure for the illness. This can be seen in the early years of social work and in the psychoanalytical movement of the profession. Problems are identified and solutions are provided to the client with the expert therapist overseeing the entire process (Payne, 2005). However, with the inception of the school based health clinic the social worker was employed in an agency that was directed by nurses, physicians, and clinical psychologists. The social worker was expected to function in their arena and participate as a member of the medical team (Mason & Wood, 2000).

Systems theory focuses on the individual as part of and working with other systems to create a more balanced and organized relationship with the other systems operating in the school system. The system must attempt to maintain homeostasis with other systems and within the

system while processing different inputs into the system (Gitterman & Germain, 1981). Adding the ecological approach allows the social worker to see their client as interdependent with others and with their environment. This causes the worker to seek to improve the fit between people and their environment by increasing their coping mechanisms and influencing environmental forces so they can respond to changing life situations (Payne, 2005). Meyers and Swerdlik (2003) report that the integration of mental health services into the school system has allowed for an interdisciplinary approach, making it consistent with the ecological based approach to service delivery. Based on the systems theory of organization, school systems have offered the inclusion of the family, school officials, and community providers/stakeholders resulting in more effective treatment of the children (Meyers & Swerdlik, 2003).

Shifting the focus from the individual child to the interaction problems of the system allows the child to benefit from interventions including behavior management and individual therapy that can be offered in the school system (Vanderbleek, 2004). Studies involving the addition of other systems (families, school personnel, and community stakeholders) in treatment have shown improvement in students with problems including violence (Stein et al., 2002), attention-deficit/hyperactivity disorder (Edwards, 2002), school refusal (Heyne, King, Tonge, & Cooper, 2001), early childhood problems (Fox, Dunlap, & Powell, 2002), cultural differences in children (Vanderbleek, 2004), and adolescent problems, conduct disorder, and substance abuse (Rones & Hoagwood, 2000).

With the justification of the need for further development of the services comes the emergence of social equity theory. This theory involves the coexistence of all people on an equal basis and emphasizes participation as the government deals with the issues of marginalized communities. The government must work to improve social institutions so that this planned changed process brings a better fit between human needs and social policies (Payne, 2005). The



school-based clinic can operate and market both the health and mental health services that are needed by children in the school system. This allows for children to receive these services, and mental health services provided at the school can reduce the stigma associated with seeking mental health care (Schaeffer et al., 2003). Findings are limited, but there is evidence that integrated mental health care and health care decreases the overall costs involved in treatment (Chiles, Lambert, & Hatch, 1999) and healthy outcomes improve when the services are offered together (Kibby, Tye, & Mulhearn, 1998).

The inclusion of the community development model incorporates the continued evaluation of mental health services in the school and better planning for these services. This is accomplished through analysis of social problems and policy goals as well as evaluating services and policies related to school-based mental health services (Payne, 2005). The mental health worker in the school must provide the initial evaluation of student need and presenting problems to assist in the development of the program (Mason & Wood, 2000). After the establishment of the program, evaluation must continue to make certain the primary stakeholders (school personnel) are satisfied with the program and can see the benefits of the program. The mental health clinician must work as a change agent to assist in the continued acceptance of the program and quality of the services provided (Nabors, Weist, Reynolds, Tashman, & Myers, 1999).

The combination of these theories produced a conceptual framework for establishing mental health services in the school-based health center and the continued evaluation and development of the programs. The ability of the mental health worker to function in the educational system and make changes to the system shows the combination of the theories with the end result to provide the best and most effective services for children in the educational system (Mason & Wood, 2000).

## Summary and Implications of the Literature Review

Establishing mental health programs in schools is a justifiable approach to increase the supply and availability of services to children and families of diverse socioeconomic and cultural backgrounds (Armstrong et al., 2003; Epstein, et al., 1998; Marder & D'Amico, 1992). Research (Knitzer et al., 1991) has shown the problems facing children in schools today and the number of children who do not receive needed mental health services result in devastating consequences for the children, their families, and the school system, including the inability of these children to complete academic endeavors. School mental health programs offer a variety of services including assessment, prevention, case management, and treatment services to youths (Lever et al., 2006) experiencing a variety of problems including depression, suicidal ideation, school avoidance, delinquent behavior and experimentation with high risk behaviors like sexual activities and substance abuse (Bruns et al., 2004). Numerous studies (Astor et al., 20005; Atkins et al., 2003; Bruns et al., 2004; Hussey & Guo, 2003) have shown the positive impact of interventions completed in a school-based mental health program and mental health programs in the school decrease barriers to treatment by their placement in the schools (Armbruster & Fallon, 1994; Weist et al., 2003). However, evaluation of school-based programs themselves has only recently been discussed in the literature.

The completion of the President's New Freedom Commission has solidified the need for continued development, evaluation, and expansion of these services (Mills et al., 2006). Socioeconomic factors and increased violence in this country warrant the continuation and expansion of school-based mental health services. However, continued empirical research on school-based mental health clinics will be needed to advocate for further service provision to ensure barriers to mental health treatment are minimized. Some variables to include in these evaluations will be coordination of services in the schools, collaborations with schools and

communities, administrative arrangement of services, student problem identification, barriers to services, and data collection (Mills et al., 2006).

Based on a review of the literature, this study will begin to evaluate school-based mental health services, especially those provided in rural areas, by utilizing an altered version of the SAMHSA questionnaire. Respondents will be asked to identify if they have a school-based mental health program or not. Unlike the SAMHSA study, they will be directed to continue the questionnaire regardless of this answer. An identified respondent will receive the questionnaire to prevent problems reported in the SAMHSA study and funding questions will be eliminated based on research showing the decreased response rate when funding issues are evaluated. The increased response rate should build on and improve the data from the SAMHSA study. Also, the use of an identified person for one school will decrease the confusion in reporting the number of staff providing services, type of staff providing services, and amount of time spent providing services.

Variables identified as important for evaluation in the literature that were evaluated in this study include urban and rural services as defined by educational research, data collection activities, barriers to services, problem identification, and administrative alignment of mental health services. Collaboration with school systems and coordination with community providers will also be evaluated. Review of these areas as suggested in the past literature will increase the knowledge base about school-based mental health programs, especially those in rural areas; show collaboration with the schools, and provide information to assist in the development of a system of care.

## CHAPTER 3: CONCEPTUAL FRAMEWORK AND METHODOLOGY

### Purpose of the Research Study

Twelve percent or 7.5 million youth have mental, behavioral, or developmental disorders, but only one-fifth of these children receive treatment (Weist et al., 2003). Adelman et al. (1999) found that youth who do not receive these needed services are at greater risk for educational failure, as well as serious psychological, emotional, and social problems. Schools play an ever-increasing role in the delivery of mental health services to children and youth. Little is known, however, about the most effective development, implementation, and evaluation of these programs. The goal of this study is to identify and describe the current method of mental health service delivery in public schools in Arkansas and to examine certain demographic correlates of these services.

### Research Objectives

A review of the literature on mental health services in the public schools provided several objectives for consideration in this study: the way mental health services are organized administratively (under the special education department or in a separate department), how staff is organized (hired by district or via contract with the district), where authority rests for various administrative tasks (hiring and supervision of staff), what primary mental health problems are exhibited by children receiving these services, what data the schools are currently collecting, and the mechanisms used by the school to coordinate mental health and educational services between the school and the community.

Reviewing these objectives and examining current research established the basis for the development of the following research questions:

- (1) What type of student is eligible for mental health services in the school?
- (2) What type of mental health services are provided in the schools?

- (3) What is the administrative arrangement for the delivery of mental health services in the schools?
- (4) How are services collaborated between the mental health provider and the school system?
- (5) What are the types and qualifications of staff providing mental health services in schools?
- (6) What are the three most frequent psychosocial or mental health problems seen in the school system?
- (7) What barriers to receiving mental health services are identifiable?
- (8) How are services coordinated with community providers?
- (9) What type of data collection and reporting are the schools currently utilizing?

The SAMHSA study results will provide a frame of reference for the data received from the Arkansas study. Data were reviewed on types of students eligible for the services, types of disciplines providing services (school-based mental health services or non school-based mental health services), and a review of most common identified mental health problems. The collection of these data will provide the baseline for services in Arkansas and expand the knowledge by reviewing these criteria in relation to urban and rural settings. This research will allow the state to begin to evaluate mental health programs in regards to evidence-based, recovery-focused, and consumer and family driven practice while promoting early intervention for children identified to be at risk for mental disorders.

To increase the knowledge base regarding mental health services in the school, data from this study will be used to compare the type of provider (school-based or non school-based) in the rural areas of the state to urban areas of the state. Identification of primary mental health problems between males and females, grade levels, and urban versus rural school placement will

also be evaluated. Further comparison will review school-based mental health programs and non school-based mental health programs on the frequency of collaboration activities and services between the provider and the school and the coordination of services between the mental health provider and the community provider, types of service provided to students (school-based verses non school-based mental health programs), data collection (school-based verses non school-based mental health programs), and barriers to services (urban verses rural schools).

Review of the literature shows that there will likely be a difference between the type and qualifications of the workers in the schools based on school-based or non school-based services (Bailey, 2003) but no clear delineation has been made comparing urban to rural districts. Additionally, Bailey (2003) found that more school-based providers offered classroom management while non school-based providers offered individual and group counseling, but no data were given regarding urban and rural districts. The SAMHSA study reported aggregate data divided by region of the country only (North, South, East, West), but again, no differentiation was made as to urban or rural and administrative type.

### Research Design

This primarily descriptive research study will utilize an established national survey instrument to assess the current delivery of mental health services in the Arkansas public school system. Rubin and Babbie (2001) reported that survey research of this type is most suitable for obtaining information about a sample of a specific population. Using a predetermined set of questions, surveys provide descriptive characteristics about the targeted population and what they know or perceive about the availability of services or unmet needs. Surveys are valuable tools that provide descriptive studies of large populations and improve external validity by making results that have generalizeability to the larger population. The survey is also a flexible instrument and can enable the researcher to analyze multiple variables at the same time if done

correctly (Dillman, 2000). The researcher must make the instrument easy to read and keep the questionnaire as short as possible to reduce non completion due to lengthy completion times. Explanations must be clear, precise, and include directions for completing the survey and resending the information. Pre-survey notices and thank you/follow-up reminders assist in a larger return rate and help ensure the validity of inferences to the larger population (Rubin & Babbie, 2001).

This research will utilize an email survey to a representative sample of Arkansas schools. Email and internet survey is not a new concept and has been used in qualitative and quantitative research with good results (Schaefer & Dillman, 2001). The email survey is a good tool to use because it is inexpensive to set up and administer, large numbers of respondents can be surveyed in a short period of time, respondents can look up information if they need to, and it can be completed at the convenience of the respondent (Schaefer & Dillman, 2001).

Dillman (2000) reported positive outcomes for the email survey to include faster response times, more completely filled out surveys, and longer responses to open-ended questions. In his study he found the response time for the email group was 9.16 days compared to 14.39 for the mailed survey, the email surveys had at least 95 percent of the survey completed compared to 56.6 for the mailed survey, and on open ended questions the email survey averaged 40 words per answer compared to 10 words on the mailed survey. Data can be collected at lower costs with no reduction in number of respondents, which will improve data quality and comparison to the population.

One problem identified with the email survey is the lack of perceived anonymity. This can affect the given answers to the survey and distort the collected dataset even when the respondent is assured that responses cannot be tracked to their individual computer (Royse, 2004). Another concern is the lack of computer skills of the people surveyed. Often people are intimidated by

computer applications and software needed to complete the survey. The researcher should be certain that the survey is designed as simply as possible to ensure completion. Finally, the researcher should be certain that the survey is designed with software that is compatible with most computers to ensure the respondent does not have problems downloading or returning the survey (Dillman, 2000).

### Key Terms

This section will begin with an operationalization of the major variables of the study and their specific parameters.

### Student

The student is a person who attends school and receives either general education or special education. This is a nominal variable that will be assessed in survey question #4, what students may receive these mental health services?

### Mental Health Services

Mental health services are defined in the literature (Foster et al., 2005) as those services and supports delivered to individual students who have been referred and identified as having psychosocial or mental health problems. Services identified in the literature (Foster et al., 2005) and included in the survey are assessment, behavior management consultation, case management, referral to specialized programs or services, crisis intervention, individual counseling, group counseling, substance abuse counseling, medications, referral for medication management, or family support services. This variable will be nominally measured by survey question #19, does your school provide the following services, either directly or through a community based organization with which you have a formal agreement?

### School

For the purpose of this research project the term school will refer to the actual campus that



houses the buildings where educational programs are provided. The administrator of this facility would be the principal and the special education program is directed by the Local Education Agency/Special Education Supervisor (LEA). Schools with students in grades one to twelve will be included in the study. Ordinal data for this variable will be assessed in question #1, for the current school year (2008-2009), please check the box for each grade offered at your school.

#### Administrative Arrangement

Literature (Foster et al., 2005) states administrative arrangement refers to the person who sets up the school-based program and is responsible for the following functions (Survey question #9 and #10): allocating funds for mental health services, establishing policies, guidelines, or standards on mental health delivery, determining the number and type of mental health staff needed in schools, hiring mental health staff, supervising mental health staff, planning in-services, training, and professional development for mental health staff, and administering contracts or agreements with outside organizations or agencies providing mental health services. Question #9 (general education services) and question #10 (special education services) evaluate this nominal variable, while question #5, how are mental health services managed in your school is also nominally evaluated.

#### Service Collaboration

Service collaboration refers to the relationship established between school-based mental health providers and school personnel. This nominal variable is assessed in this study by survey question #12, on average, please indicate how frequently your school staff uses the following strategies to coordinate activities and services for students in your school: interdisciplinary team meetings among mental health staff, joint planning sessions between mental health staff and regular classroom teachers, joint planning between mental health staff and special education

teachers, professional development on mental health topics for regular school staff, and sharing of mental health resources among staff (Foster et al., 2005).

### Types and Qualifications of Staff

Literature (Foster et al., 2005) has shown that schools employ many different people to provide mental health services. Based on the literature (Foster et al., 2005), staff will include school counselors, mental health counselors, school social workers, school psychologists, alcohol/substance abuse counselors, clinical psychologists, or psychiatrists. The qualifications will be assessed by determining the level of education-bachelors or masters degree or higher and licensed or non-licensed in their chosen field. This nominal variable will be assessed by survey question #13, how many of the following staff provide mental health services to students in your school? Include both school-based and district-based staff. Question #14, of the total staff in each category please indicate the number with a master's degree and a license or certification in their field. This study will also nominally assess this variable.

### Mental Health Problems

Literature (Foster et al., 2005) has defined (and this study will utilize) the most common mental health problems for children to include adjustment issues; social, interpersonal, or family problems; anxiety, stress, school phobia; depression, grief reactions; aggressive/disruptive behavior, bullying; behavior problems associated with neurological disorders; delinquency and gang-related problems; suicidal or homicidal thoughts or behaviors; alcohol/drug problems; eating disorders; concerns about gender or sexuality; experience of physical or sexual abuse; sexual aggression, including harassment; and major psychiatric or developmental disorders. This nominal variable will be assessed by question #17, using the coded list below, rank the 3 most frequent problems for each group and question #18, overall, which problem uses most of your school's mental health resources.

### Barriers to Mental Health Services

Barriers are obstacles that prevent the child from receiving the needed mental health services to assist in the treatment of their identified problem. Based on the literature (Foster et al., 2005), barriers for this study may include waiting lists, limited space or staff availability, confidentiality problems, parental consent and cooperation, financial constraints, language barriers, cultural barriers, community mental health resources inadequate to meet student needs, inadequate coordination/collaboration between school staff and community providers, and transportation difficulties. This nominal variable is evaluated in question #21, Using the following scale from 1 to 4 where 1 is not a barrier and 4 is a serious barrier, please indicate the extent to which each of the following is a barrier in delivering mental health services to your students.

### Service Coordination

Service coordination involves the activities between the school and the community provider or the school-based mental health provider and community agencies that provide services. This nominal variable is assessed in question #16, what are your general practices for routine referrals to and coordination with community-based organizations or providers.

### Types of Data Collection and Reporting

Data collection refers to the information the school is currently collecting on the enrolled students in their school. Previous research (Foster et al., 2005) indicates this would include types of mental health problems presented by students, types of school-based mental health services provided, demographic characteristics of students, number of units of mental health services delivered, number of referrals to community mental health providers, referrals for students on medication, bullying referrals, expulsions, seclusion data, suspensions, and youth suicide rates. These nominal variables will be evaluated with question #22, does your school collect or have

access to data on mental health services provided to students in your school; #23, what data are collected; and #24, how does your school use these data.

## Research Methods

### Sample

Bailey (2003) reported problems with surveys reaching the person identified to complete the survey and problems with identifying who to send the survey to. Foster et al. (2005) identified problems with surveys being sent to alternative school employees to complete or surveys being left on desks for people who were unsure how to complete. To alleviate some of these issues, the Department of Education, Special Education department suggested using the LEA for each school. The LEA is in charge of special education services, including mental health services for each school. Each LEA has email access available in the school, and the Special Education department maintains the LEA email list which they will provide to researcher.

The chosen population for this study will be the public school systems in the state of Arkansas. Currently there are 1048 schools that are organized under 140 LEAs. Each school will be entered as the population for this study and schools will be randomly chosen from the identified list of all schools. One school will be chosen for each LEA. Once a LEA has been selected, any subsequent schools from that LEA will be disqualified to prevent nesting effects.

### Overview of the Questionnaire

The current research project will utilize a national survey instrument developed by the U.S. Department of Health and Human Resources, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2005). (Appendix A). The Substance Abuse and Mental Health Services Administration (SAMHSA) is committed to improving the lives of people with or at risk for substance abuse and mental health problems. As part of their continued commitment to improving the programs provided to consumers, the 2002-2003 research project

was designed to investigate the types of mental health programs being offered in school systems nationally (Foster et al., 2005).

The survey instrument was designed for a baseline study to address information gaps and was developed by an expert panel of school officials, mental health researchers, policymakers, and representatives of professional organizations. The panel also reviewed the literature to ensure that it reflected the most up-to-date characteristics of school mental health. (Members of the expert panel are listed in Appendix F.) The survey was reviewed and endorsed by professional mental health associations and representatives of the state education associations. Finally, the survey was tested on a small number of school staff members who represented the intended respondent types (Foster et al., 2005). This survey is available for use by any individual or organization as long as the reference is cited (SAMHSA, 2005).

The questionnaire did not provide definitions of staff categories, mental health problems, or services. This was due to the variation in the staff titles for persons with similar training who perform similar functions in the school. The expert panel arrived at a set of staff categories that were derived from the literature and were most likely to be recognizable to respondents across the country. Mental health categories were also derived from the literature and adapted by a licensed child psychologist. These categories represented a range of severity from interpersonal/family problems to major psychiatric disorders. All terminology was vetted with respondents in several school districts in different geographic regions and with the expert panel prior to finalizing the survey instrument (Foster et al., 2005).

#### Description of the Instrument

The School Mental Health Questionnaire is divided into seven sections for completion. The first section asks for demographic information on students by indicating, from a provided list, the grades offered in the school. Ethnicity is reported by numerical figures on a provided list,

and numerical data report other identifying student information including students who are limited language learners, students with an Individual Education Plan (IEP), and students eligible for free lunch. Section two includes questions related to delivery of mental health services. Respondents were given structured checklists to indicate what students received mental health services, how mental health services are managed, if the school operated a mental health clinic, the location of the clinic, and if the school had an arrangement with community agencies. These questions were nominal measures as were the next two questions where respondents were asked to indicate management arrangements for mental health services in general/special education.

Section three, mental health staff in schools, provided checklists for staffing arrangements and a frequency chart to indicate strategies for coordination of student's activities. Respondents next entered numerical data for number of staff providing services, number of staff with a master's degree and number of staff with a license. Percentage data for time providing mental health services was also recorded.

Section four, arrangements with community organizations and individual providers, provided checklists to gather nominal data on the school's arrangements with community organizations and individual providers. Respondents also recorded the three most occurring mental health problems for males and females from a drop down checklist format. Mental health services and barriers to these services, section five, were assessed by nominal responses on charts and established checklists. Data collection and reporting information was nominally indicated in section six by use of established closed end checklists. Identifying school information and an open ended comment section completed the questionnaire.

The questions on the survey were designed to reflect the most relevant information about mental health services offered in schools. This study will utilize the SAMHSA survey without the section on funding of mental health programs. Foster et al. (2005) and Bailey (2003)

identified less response rate when providers were asked to identify funding sources. Due to time constraints, this issue will need to be evaluated in a future study.

The survey evaluates the prevalence of mental health problems so programs are developed that target the most expressed behaviors with the most identified types of services that are provided. Research (Foster et al., 2005) shows that schools often collect data to satisfy district or state guidelines and seldom are this data used to generate new programs or improve established programs. Types of data collection will be assessed in the survey to present examples of research that can evaluate current mental health needs in the schools, current mental health programs being offered in the schools, and justify expansion of current programs (Foster et al., 2005).

#### Procedures of Study

Administration of the email survey will be provided through Survey Monkey (surveymonkey.com, 2009), an internet site that was developed to design, administer, and aggregate data for analysis. Survey Monkey is an internet service that can be utilized free with limited responses and survey development or for a proprietary charge to administer larger and more complex surveys (surveymonkey.com, 2009).

To complete this process, the researcher will use a supplied list of all Arkansas Public Schools. From this population the researcher will randomly draw a sample of schools to be included in the study. From the list of public schools the researcher will divide the schools into urban or rural populations using population data for the selected schools as established by the Census Bureau. The rural list will be over-sampled to get a matched sample of half urban and half rural school districts. The name of these schools will be matched with the Local Education Agency (LEA) for that school district and recorded. Once a LEA has been selected, no other schools in that district will be used in the survey so that each LEA will fill out the survey only

one time. The email addresses for the chosen LEA's, provided by the Arkansas Department of Education, (Appendix B) will be entered into the database to receive the research survey. The researcher will send a pre-notice (Appendix C) to each recipient (LEA) to alert them to the survey, the purpose of the research project, and request their participation in the survey. Included with this pre-survey notice will be a letter of support from the Special Education Associate Director. Using the methods described (Dillman, 2000; Schaefer & Dillman, 1998), an email will be sent to the respondents three days later with a link to the survey for completion. Included in the email is the consent for participation and directions on how to contact the researcher (Appendix D). Seven days later a thank you/reminder to complete (Appendix E) is sent to all respondents (Schaefer & Dillman, 1998; Dillman, 2000). When the surveys are returned to the internet site, the data are stored and will then be downloaded for statistical analysis.

#### Limitations of Study

Limitations of this study will be the restricted use of the LEA respondent. This will allow only one school from an identified area to be in the sample and could present problems with representativeness and generalizeability. Also, the LEA will be asked to complete the study on a specific school, but there is no mechanism in place to check and ensure that the LEA does not report data from a different school. Ideal situations would allow the LEA to complete data on all schools in the district for comparison purposes, but this could present issues with nesting.

Additional limitations of the study result from the use of a cross-sectional descriptive research project. This research, conducted at one time, is good for broad representation but does not allow for cause to be included in the collected data lowering internal validity.

Standardization of the instrument also provides limitations as respondents are forced to choose an answer that fits the presented categories. While this may improve reliability, there is risk for reducing validity (Rubin & Babbie, 2005). These types of questions do not reveal social process



in the natural setting and respondents may have problems providing answers if they don't understand questions or know how to answer the question. This could cause problems with internal and external validity.

### Protection of Human Subjects

This study will utilize data obtained from the selected schools regarding mental health programs offered in their schools. No identifiable information about any subject will be obtained or used in this study. School officials will provide data as they would to any reporting agency. The survey will be identifiable by the LEA code number known only to the researcher and confidentiality will be maintained by storing data with this identifier in a locked file cabinet in the researcher's office.

Approval has been granted by the Institutional Review Board at Louisiana State University to complete this study. Included in the application is an informed consent that will be supplied to the respondent stating that completion of the survey acknowledges the receipt of the consent and agreement to participate in the study. Contact numbers for the principal investigator and the institutional review board are included in this information.

### Contributions to Knowledge Base

The establishment of school-based mental health programs has allowed children to receive treatment that might otherwise not be available or attainable if the services were not available in the school (Richardson, Keller, Shelby-Harrington, & Parrish, 1996). As a justification for continued development of these programs, evaluative research has been conducted with interventions in the schools. These research projects (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003; Fraser et al., 2005; Hussey & Guo, 2003; Olweus, 1997) have shown that identified programs work best in a school-based environment. However, few studies have been conducted to show evaluation measures for the actual school-based program itself. Most of the

identified areas of evaluation have come from literature reviews on conducted intervention studies or observations from the intervention studies themselves.

Most of the intervention studies have been conducted in urban areas with no comparison available for rural areas (Astor et al., 20005; Atkins et al., 2003; Bruns et al., 2004; Hussey & Guo, 2003). Several studies have been conducted nationally and included rural areas (Bailey, 2003; Repie, 2005) but they have experienced low response rate and only reported aggregate data. Therefore, the evaluation of school-based services in rural areas remains an area that needs additional review to assist in providing information on problems, demographic characteristics, administrative management, and barriers to mental health services that are unique to rural areas.

To increase the knowledge base regarding school-based mental health services, this study will be conducted in a rural area of the country with population demographics that show underserved minorities in need of services. Mental health services will be assessed regarding the way they are provided in the schools, school-based or not school-based. Coordination and collaboration of these services will be evaluated as will management of mental health services in schools to begin to establish a knowledge base for services in rural areas. Barriers to mental health services will be assessed to assist in knowledge development for mental health providers so they acquire a more realistic idea of who will be receiving services. Finally, knowledge acquired in this study will be used to advance training, policy, and practice in mental health.

#### Data Analysis

To present the data in a manageable and understandable way, univariate analysis will be conducted on the entire survey to illustrate variable frequencies and measures of central tendency. Rubin and Babbie (2005) report that one purpose of research is to describe situations and events by referring to the characteristics of a population and the data in this study will be from a sample of people thought to be representative of the population. Variables will be measured and

percentages established for that measure. These measures will then be used to further explore relationships that were identified by the data.

A bivariate analysis is the best way to compare data from two variables (Rubin & Babbie, 2005) and chi-square analysis will be used to independently compare additional relationships within the data. Variables that will be evaluated by this method include school-based mental health clinics and non school-based mental health clinics to establish differences in the location (urban or rural), the types of services provided, differences in types of providers, differences in data collection activities, and differences in the frequency of coordinated activities and services for students. Barriers to mental health services for students will be compared between urban and rural schools while identification of mental health problems will be evaluated between male and female students, age of students, and urban or rural location. These comparisons will include what students are eligible to receive mental health services, who are providing the mental health services, problem identification to warrant mental health services, and finally the percent of mental health providers that are school-based.

### Sample Size

A power analysis was conducted in order to determine the sufficiency of the sample size for the planned types of statistical analysis. Kazdin (1998) reports that power is the extent to which a difference can be detected when a difference exists. Statistical power analysis assists in decision-making about sample size and addresses the probability of committing a Type II error. To determine the correct sample size the researcher established a standard statistical power of .80 for a level of significance set at .05 and determined that for a two-tail chi square analysis the correct sample size would be 45 (Lenth, 2006; Cohen, 1988). Of the total population of 140 LEA respondents, 78 responded to the email survey so this study does meet the above criteria.

## CHAPTER 4: RESULTS

### Introduction

This study was designed to provide an initial review of the mental health services being offered in Arkansas public schools. These results will be used as a foundation for the evaluation and proper integration of mental health programs into these schools. Results will be presented by describing the entire sample, and by using bivariate analyses to present relationships among selected data.

### Description of Sample

#### Demographic Information

The sample in this study included 78 schools (55%) of the 140 schools selected for the survey in the state of Arkansas. Of these schools, 26 (33.3%) provided educational services for grades one through six, 25 (32.1%) provided services to grades seven through nine, and 27 (34.6%) provided services to grades ten through twelve. In these 78 schools there was a total enrollment of 41,568 students with 133 (.3%) identified as American Indian, 414 (.9%) as Asian, 12,125 (29%) as Black, not Hispanic, 3001(7%) as Hispanic, and 25,895 (62%) as White, not Hispanic. Additionally, 2,249 (5.4%) students were identified as limited English proficient or English language learners, while 11,317 (27%) students had an Individualized Education Plan (IEP), indicating enrollment in special education services; and 27,002 (65%) students were eligible for a free or reduced price lunch. Sixty-two schools (79.5%) identified themselves as rural school districts (population under 10,000) and 16 schools (20.5%) were identified as urban schools (population above 10,000). Schools identified 12,061 students (30.0%) as recipients of mental health services in the schools in the past school year.

## Mental Health Program Management

Data were collected on the delivery of mental health services in the schools and of 78 schools, 77 (99%) reported that all students were eligible to receive mental health services, and one person managed these services for all students in each school. One school reported that mental health services were only provided for special education students enrolled in the school and again these services were managed by one person. Eighteen (23.0 %) schools reported the school operates a mental health clinic located inside the school, while 60 (77.0%) do not operate a mental health clinic, and mental health services are provided off the school campus. Additionally, 71 (91.0%) of the schools reported they work with community agencies to provide the mental health services in their schools.

Schools can manage their mental health service delivery in various ways that include school management, district management, or management by a collaborative unit (district organized by an educational cooperative, managed by the Department of Education). Schools were asked to describe the way their mental health services are managed based on seven criteria and to differentiate on services for general education students and special education students.

The following tables provide these descriptive data (See Tables 1, 2, 3, 4, 5, 6, and 7).

**Table 1.**  
**Responsibility for Allocating Funds for Mental Health Services (*n* =78)**

	General Education Frequency	General Education Percent	Special Education Frequency	Special Education Percent
Not				
Applicable	17	21.8%	16	20.5%
Schools	8	10.3%	7	9.0%
District	41	52.6%	44	56.4%
Collaborative Unit	12	15.4%	11	14.1%
Total	78	100.0%	78	100.0%

**Table 2.**  
**Responsibility for Establishing Policies for Mental Health Services (n = 78)**

	General Education Frequency	General Education Percent	Special Education Frequency	Special Education Percent
Not				
Applicable	11	14.1%	12	15.4%
Schools	9	11.5%	9	11.5%
District	47	60.3%	46	59.0%
Collaborative Unit	11	14.1%	11	14.1%
Total	78	100.0%	78	100.0%

**Table 3.**  
**Responsibility for Determining the Number and Type of Mental Health Staff (n = 78)**

	General Education Frequency	General Education Percent	Special Education Frequency	Special Education Percent
Not				
Applicable	13	16.7%	13	16.7%
Schools	6	7.7%	10	12.8%
District	48	61.5%	45	57.7%
Collaborative Unit	11	14.1%	10	12.8%
Total	78	100.0%	78	100.0%

**Table 4.**  
**Responsibility for Hiring Mental Health Staff (n = 78)**

	General Education Frequency	General Education Percent	Special Education Frequency	Special Education Percent
Not				
Applicable	16	20.5%	15	19.2%
Schools	10	12.8%	10	12.8%
District	38	48.7%	40	51.3%
Collaborative Unit	14	17.9%	13	12.8%
Total	78	100.0%	78	100.0%

**Table 5.**  
**Responsibility for Supervising Mental Health Staff (n = 78)**

	General Education Frequency	General Education Percent	Special Education Frequency	Special Education Percent
Not				
Applicable	16	20.5%	15	19.2%
Schools	10	12.8%	10	10.3%
District	38	48.7%	40	52.6%
Collaborative Unit	14	17.9%	13	17.9%
Total	78	100.0%	78	100.0%

**Table 6.**  
**Responsibility for Planning In-Service Training for Mental Health Staff (n = 78)**

	General Education Frequency	General Education Percent	Special Education Frequency	Special Education Percent
Not				
Applicable	18	23.1%	15	19.2%
Schools	10	12.8%	9	11.5%
District	38	48.7%	38	48.7%
Collaborative Unit	12	15.4%	16	20.5%
Total	78	100.0%	78	100.0%

**Table 7.**  
**Responsibility for Administering Contracts/Agreements for Mental Health Staff (n = 78)**

	General Education Frequency	General Education Percent	Special Education Frequency	Special Education Percent
Not				
Applicable	12	15.4%	10	12.8%
Schools	5	6.4%	9	11.5%
District	52	66.7%	50	64.1%
Collaborative Unit	9	11.5%	9	11.5%
Total	78	100.0%	78	100.0%

Mental health services are provided in schools in various ways that include school-based staff (employees of the district or school who are assigned to one particular school and work only in that school), district staff (employees of the district who are assigned to the district and travel to different schools, spending only part of their time in each school), a collaborative or intermediate unit (district organized by an educational cooperative, managed by the Department of Education) provides the mental health staff, or a community provider or organization provides the staff. Data from this survey showed that 55 (70.5%) schools rely on community providers to provide mental health services, 13 (16.7%) schools had school-based employees, 6 (7.7%) schools had district-based mental health staff, and 4 (5.1%) schools had mental health staff provided by a collaborative unit.

#### Mental Health Providers

Another area of mental health service delivery that varies from school to school is the type of person who is providing the mental health services. The person can be a school counselor, mental health counselor, school social worker, psychologist, alcohol/substance abuse counselor or psychiatrist. Data were collected in this survey to determine the number of each type of provider, how many full-time positions were available to provide services to students, how many part-time staff was available to provide mental health services, and what percentage of time each discipline spent providing mental health services.

In the survey all 78 schools reported at least one school counselor, with 41 schools (53%) reporting one counselor, 22 (28%) reporting two counselors, seven schools (.09%) had three counselors, six schools (.08%) had four counselors, one school (.01%) had seven, and one school (.01%) had eight counselors. Counselors were employed both full-time (131staff or 90%) and part-time (14staff or 10%) for a total of 145 counselors in all 78 schools. Educational attainment of the counselors showed 131 counselors (90%) were mastered degreed and had a license.



School counselors spent 30% of their time providing mental health services to students (See Tables 8 & 9).

Mental health counselors (non degree specific) were also identified in the study and data collected showed there was a total of 75 mental health counselors in 30 identified schools (38% of total schools) with eleven schools (37%) having one mental health counselor, four schools (14%) having two, nine schools (30%) having three, three schools (10%) having four, one school (3%) having five, and two schools (6%) having six mental health counselors. However, 48 schools (62%) had no mental health counselor. Fifty-seven (76%) of the mental health counselors were full-time and 18 (24%) were part-time employees with 74 (99%) having a master's degree and 73 (97%) having a license. Mental health counselors spent 80.2% of their time providing mental health services to students (See Tables 8 & 9).

School social workers were also identified in the study, and data shows that 67 schools (86%) had at least one social worker while 28 (36%) schools did not employ a school social worker. Schools reported that 50(75%) of the social workers were full time and 17 (25%) were part time while 60 (90%) had a master's degree and 53 (79%) were licensed to practice in social work. School social workers spent 37% of their time providing mental health services to students. Other providers of mental health services were school psychologists (29 total staff), alcohol/substance abuse counselors (3 total staff), clinical psychologists with PhD's (7 total staff), and psychiatrists (18 total staff). Of these mental health providers, all were part-time except seven psychologists and two clinical counselors. They all had a master's degree and license except one psychologist without a master's degree and two psychologists without a license (See Tables 8 & 9).

**Table 8.**  
**Staff Providing Mental Health Services**

Type of Staff	Total Number	Full Time Staff	Part Time Staff	Time Providing Mental Health Services
School Counselor	145	131 90%	14 10%	30.0%
Mental Health Counselor	75	57 76%	18 24%	80.2%
School Social Worker	67	50 75%	17 25%	37.0%
School Psychologist	29	7 24%	22 76%	23.5%
Alcohol/Substance Abuse Counselor	3	0 0%	3 100%	13.3%
Clinical Counseling Psychologist (PhD)	7	2 29%	5 71%	26.0%
Psychiatrist	18	0 0%	18 100%	2.5%

**Table 9.**  
**Staff with Master’s Degree and/or License**

	Total Number	Number with Master’s Degree	Number with License
School Counselor	145	131 90%	131 90%
Mental Health Counselor	75	74 99%	73 97%
School Social Worker	67	60 90%	53 79%
School Psychologist	29	28 99%	27 93%
Alcohol/Substance Abuse Counselor	3	3 100%	3 100%
Total	319	296 93%	287 90%

Service Delivery

Mental health services are provided by different staff and data from this survey showed that 35 (44.9%) of the schools surveyed had a formal contract with a community-based provider and 43 (55.1%) of the schools did not have a formal contract with a provider. To refer students to the community mental health provider, data showed that 11 schools (14.1%) make passive referrals (staff give brochures and phone numbers to the client) to the community provider and 55 schools (70.5%) make active referrals (staff completes form and sets up appointment with provider) to the community provider. Eighteen schools (23.1%) make follow-up calls to the

student or family to ensure the appointment is kept and to check for satisfaction while 48 schools (61.5%) make follow-up contact with the provider by phone, fax, or mail to check for client follow through in keeping scheduled appointments. Of the schools surveyed, 29 schools (37.2%) attended team meetings with the providers to monitor the progress of the students that were referred for mental health services and 49 schools (62.8%) did not attend team meetings.

To work with students in need of mental health services, a variety of strategies are utilized to ensure best practices. Schools reported on these strategies and how often they used the strategies to provide services. Interdisciplinary team meetings among mental health staff were used weekly by 32 schools (41.0%), monthly by eight schools (10.3%), quarterly by eight schools (10.3%), and never by 30 schools (38.5%). Joint planning sessions between mental health staff and general education classroom teachers were utilized weekly by 22 schools (28.2%), monthly by 16 schools (20.5%), quarterly by eleven schools (14.1%), and never by 29 schools (37.2%). Joint planning sessions were also utilized with special education teachers weekly by 25 schools (32.1%), monthly by eleven schools (14.1%), quarterly by 17 schools (21.8%), and never by 25 schools (32.1%). Professional development on mental health topics for school staff was completed weekly by four schools (5.1%), monthly by 16 schools (20.5%), quarterly by 51 schools (65.4 %), and never by seven schools (9.0%). Finally, sharing of mental health resources among staff members, like printed material and videos, was completed weekly by 19 schools (24.4%), monthly by 16 schools (20.5%), quarterly by 35 schools (44.9%), and never by eight schools (10.3%).

### Problem Identification

Identification of the mental health problems that are present in school systems is needed to ensure that programs are developed that meet the needs of the population and provide services that will be applicable to students and meet the mental health needs of the student. Schools were

asked to identify the three most prevalent mental health problems for male and female students. The established list included adjustment issues (difficulty transitioning to new school, new grade, or class); social, interpersonal or family problems; anxiety, stress, school phobia; depression, grief reactions; aggressive/disruptive behavior, bullying; behavior problems associated with neurological disorders (attention deficit, Tourette's syndrome); delinquency and gang-related problems; suicidal or homicidal thoughts or behavior; alcohol/drug problems; eating disorders; concerns about gender or sexuality; experience of physical or sexual abuse; sexual aggression, including harassment; and major psychiatric or developmental disorders (psychosis, bipolar disorder).

For males, the main problem identified was aggressive/disruptive behavior/bullying. Thirty-eight schools (48.7%) identified this as the main problem for male students while the second most identifiable problem was alcohol/drug use (13 schools or 16.7 %). The final problem identified for male students was social, interpersonal or family problems with 18 schools (23.1%) identifying this as the third most important problem experienced by male students.

Schools identified the most prevalent mental health problem for female students as social, interpersonal or family problems (29 schools or 37.2%) while the second most reported problem was also social, interpersonal or family problems (25 schools or 32.1%). The third identified problem was behavior problems associated with neurological disorders like attention deficit, epilepsy, or Tourette's syndrome (12 schools or 15.4%). Schools were also asked to identify the problem that used the most staff time and materials and 40 schools (51.3%) identified aggressive or disruptive behavior, bullying as the problem that used the most resources in the schools.

### Services Provided

Schools were asked to identify what types of mental health services were available to

students and who provided these services to the student, the school or a community agency. Sixty-nine schools (88.5%) provided assessment for emotional or behavioral problems, 42 schools (53.8%) provided behavior management consultation, case management was provided in 26 schools (33.3%), 67 schools (85.9%) referred students to specialized programs or services for emotional or behavioral problems, crisis intervention was provided by 39 schools (50.0%), individual therapy was provided by 35 schools (44.9%), group therapy was provided by 31 schools (39.7%), substance abuse counseling was available in 23 schools (29.5%), medications for emotional or behavioral problems were provided by 31 schools (39.7%), schools offered referrals for medication management in 76 schools, and family support services were provided by 78 schools (100%). The number of students receiving one or more of these services during the last school year was 12,061 students. The breakdown of who provided the mental health services to students is presented in Table 10.

**Table 10.  
Mental Health Services Provided to Students**

Mental Health Service	Service Provided To Student	Provided by School/District	Provided by Community Provider
Assessment for Emotional/Behavioral Problems	88%	48.7%	51.3%
Behavior Management Consultation	53.8%	42.0%	58.0%
Case Management	33.3%	30.8%	69.2%
Referral to Specialized Programs	85.9%	42.3%	57.7%
Crisis Intervention	50.0%	46.2%	53.8%
Individual Counseling	44.9%	48.7%	51.3%
Group Counseling	39.7%	43.6%	56.4%
Substance Abuse Counseling	29.5%	28.2%	71.8%
Medications for Emotional Problems	39.7%	30.8%	69.2%
Referrals for Medication	97.4%	50.0%	50.0%
Family Support Services	100%	100%	

Barriers to Mental Health Services

To create effective mental health programs in the schools, providers must determine barriers that prevent service delivery. Schools were asked to rate these barriers as “1” not a barrier, “2” somewhat of a barrier, “3” barrier to services, and “4” major barrier to treatment. Details of the schools’ data on these barriers are presented in Table 11.

**Table 11.**  
**Barriers to Delivering Mental Health Services (*n* = 78)**

Barrier	Barrier Rank	Number	Frequency
Inadequate Mental Health Resources	1	17	21.8%
	2	32	41.0%
	3	18	23.1%
	4	11	14.1%
Competing Priorities	1	52	66.7%
	2	22	28.2%
	3	1	1.3%
	4	3	3.8%
Protecting Confidentiality	1	66	84.6%
	2	9	11.5%
	3	2	2.6%
	4	1	1.3%
Parental Cooperation	1	34	43.6%
	2	28	35.9%
	3	10	12.8%
	4	6	7.7%
Financial Constraints	1	25	32.1%
	2	18	23.1%
	3	28	35.9%
	4	7	9.0%
Cultural Barriers of Students	1	53	67.9%
	2	19	24.4%
	3	6	7.7%
	4	0	0.0
Inadequate Community Mental Health Resources	1	21	26.9%
	2	16	20.5%
	3	28	35.9%

(Table cont'd)

	4	13	16.7%
Inadequate Coordination	1	43	55.1%
Between School and	2	24	30.8%
Community Providers	3	10	12.8%
	4	1	1.3%
Transportation Difficulties	1	22	28.2%
	2	16	20.5%
	3	27	34.6%
	4	13	16.7%

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### Program Evaluation

Evaluation of a program is crucial to ensure adequate program delivery and make necessary changes to the program. One way to evaluate programs is by data collection and reporting. Schools were asked to report if they collected data, the type of data collected, and the use of collected data. Seventy-one schools (91.0%) collected data on all students, while four schools (5.1%) collected data on special education students only, and three schools (3.8%) collected no data. Schools collected data on types of mental health problems presented by students (47 schools, 60.3%), types of school-based mental health services provided (30 schools, 38.5%), demographic characteristics of students who received services (31 schools, 39.7%), and number of units of mental health services delivered (24 schools, 30.8%). Fifty-two schools (66.7%) collected data on referrals to community mental health providers, 59 schools (75.6%) collected data on referrals for students on medication, and 57 schools (73.1%) collected data on the number of students referred for bullying other students. Data on suspensions (69 schools, 88.5%), data on number of students in seclusion (13 schools, 16.7%), and data on expulsions (57 schools, 73.1%) were also collected by schools. Also, schools kept data on youth suicide rates (27 schools, 34.6%).

Various reasons for collecting data included reporting to district or state offices (69 schools, 88.5%), developing training and professional development programs (39 schools,

50.0%), planning and evaluation of school-based mental health programs (48 schools, 61.5%), and planning and evaluation of community-based mental health providers (29 schools, 37.2%).

### SAMHSA Study

The SAMHSA study (Foster et al., 2005) collected data on a national level to evaluate the current trends in school based mental health programs and the data from that study were used as a frame of reference for the data in this study. This study showed that 98.7% of Arkansas schools provide mental health services to all students while national data showed 87% of all schools provided mental health services for all students (Foster et al., 2005). National data found that the main identified problem for males and females was social, interpersonal, or family problems (73%), in Arkansas the main problem for males was aggressive, disruptive behavior (48.7%), but for females it was social, interpersonal, or family problems (37.2%). Services were being provided nationally by school counselors (33.3%), Arkansas school counselors were the largest provider (35.9%). Most services were provided by community providers (55% SAMHSA results and 91% in Arkansas).

### Bivariate Analyses

Bivariate analyses were conducted among selected variables utilizing chi square tests. Seventy-eight schools responded to the survey and 18 schools (23%) offered school-based mental health programs while 60 schools (77%) did not offer school-based mental health services. An analysis was completed to test for significance in placement of school-based services in urban or rural areas. This test was not significant ( $\chi^2(1, n = 78) = .042, p < .10$ ), as 14 of 18 school-based clinics (77.7%) were in rural areas and 48 of 60 non school-based clinics (80.0%) were in rural areas.

School-based programs were compared to type of service providers and results showed that all 78 schools used school counselors to provide mental health services. No significant



associations were seen between school-based programs and school social workers, school psychologists, or substance abuse counselors when compared to school-based and non school-based programs. However, the following charts shows significant differences were observed in mental health counselors and school-based or non school-based programs ( $\chi^2(1, n = 78) = 41.786, p < .001$ ) and clinical psychologist and school-based or non school-based programs ( $\chi^2(1, n = 78) = 16.997, p < .001$ ). Schools with mental health clinics were more likely to have mental health counselors and psychologists available to provide services to students than were schools that did not offer school-based mental health programs (See Tables 12 & 13).

**Table 12.**  
**Mental Health Counselor by School-Based Provider (n =78)**

<b>School Operates Mental Health Clinic</b>	<b><u>Mental Health Counselors</u></b>		<b>Total</b>
	<b>Yes</b>	<b>No</b>	
<hr/>			
Yes (n=18)			
Row	100.0%	0	100.0%
Column	64.3%	0	23.1%
No (n=60)			
Row	16.7%	83.3%	100.0%
Column	35.9%	100.0%	76.9%
Total	100.0%	100.0%	100.0%

Note.  $\chi^2(1, n = 78) = 41.786, p < .001$ .

**Table 13.**  
**PhD Clinical Psychologist by School-Based Provider (n =78)**

<b>School Operates Mental Health Clinic</b>	<b><u>PhD Clinical Psychologist</u></b>		<b>Total</b>
	<b>No (n=71)</b>	<b>Yes (n=7)</b>	
<hr/>			
Yes (n=18)			
Row	66.7%	33.3%	100%
Column	16.9%	85.7%	

(Table cont'd)

No ( <i>n</i> =60)			
Row	98.3%	1.7%	100%
Column	83.1%	14.3%	
Total	100%	100%	

Note.  $\chi^2(1, n = 78) = 16.997, p < .001$ .

**Table 14.**  
**Psychiatrist by School-Based Provider (*n* = 78)**

School Operates Mental Health Clinic	<u>Psychiatrist</u>		Total
	No ( <i>n</i> =60)	Yes ( <i>n</i> =18)	
Yes ( <i>n</i> =18)			
Row	33.3%	66.7%	100%
Column	10.0%	66.7%	
No ( <i>n</i> =60)			
Row	90.0%	10.0%	100%
Column	90.0%	33.3%	
Total	100%	100%	

Note.  $\chi^2(1, n = 78) = 25.047, p < .001$ .

Data collected showed a significant association of schools that offer mental health programs in a school-based environment and availability of a psychiatrist ( $1, n = 78) = 25.047, p < .001$ ). Based on this data, schools that provide services through a school-based mental health program would be more likely to have a psychiatrist available to see students (See Table 14). Types of mental health service providers were also compared by urban and rural schools. Chi square tests were performed and results showed significant relationships between urban and rural providers and school counselors, school social workers, and school psychologists. The comparison between school counselors and school location showed that rural schools were more likely to have counselors providing mental health services (87.8%) than were schools located in urban areas (12.2%) [ $\chi^2(5, n = 78) = 12.364, p < .001$ ]. Significance was also seen in school

social workers located in rural areas (92.9%) compared to urban (7.1%) areas suggesting that rural areas were more likely to employ school social workers and that they would provide mental health services in addition to their other duties, while urban areas hired mental health counselors specifically to provide mental health services [ $\chi^2(4, n = 78) = 9.981, p < .05$ ]. School psychologists were also significantly associated with the provision of mental health services in rural schools (92.2%) compared to urban areas (7.8%) [ $\chi^2(2, n = 78) = 16.470, p < .001$ ].

Types of services provided were compared by schools offering school-based programs or non school-based programs. Of the eleven services offered for review, two services showed a significant comparison, case management services and substance abuse counseling. These services were shown to be more highly associated with being offered on the school campus when the school provided school-based services (see Tables 15 & 16).

It is important to ascertain what types of problems are in schools today so that appropriate services can be developed to help alleviate these problems. Analysis was completed to compare grade levels to problem identification. Grades were divided as designated by the Arkansas Department of Education into elementary (1-6), junior high school (7-9), and high school (10-12). In elementary schools there was a significant relationship for both males and females to the types of mental health problems predominantly identified. Males were significantly more likely to have problems with aggressive/disruptive behavior (30.8%) and neurological problems like Attention Deficit Disorder (30.8%) [ $\chi^2(14, n = 78) = 25.918, p < .05$ ] and females were significantly more likely to have problems associated with social, interpersonal or family problems (30.8%) [ $\chi^2(14, n = 78) = 24.726, p < .05$ ]. These gender-related problems were identified for all three school levels. Problem identification was also compared to urban and rural data and no significant observations were found.

**Table 15.**  
**Case Management Services by School-Based Provider (n = 78)**

<b>School Operates Mental Health Clinic</b>	<b><u>Case Management</u></b>		<b>Total</b>
	<b>Yes (n=26)</b>	<b>No (n=52)</b>	
Yes (n=18)			
Row	66.7%	33.3%	100%
Column	46.2%	11.5%	
No (n=60)			
Row	23.3%	76.7%	100%
Column	53.8%	88.5%	
Total	100%	100%	

*Note.*  $\chi^2(1, n = 78) = 11.70, p < .001$ .

At times mental health services are not accessible by clients because of barriers that prevent them from receiving services. This survey assessed nine possible barriers to services and they were analyzed in relation to urban and rural schools. No significant observations were observed. To increase cell size and give more power to the study, data were collapsed into two categories (Royse, 2004). Data were collapsed into “1” is not a barrier (from the data coded not a barrier and somewhat of a barrier) and “2” is a barrier (from the data coded barrier to services and major barrier to services). There were significant results in five of the nine surveyed areas. The first area of significance was school mental health services that were inadequate to meet needs in all 18 urban schools indicating this was a barrier (62.1%) compared to 37.9% for rural areas ( $\chi^2(1, n = 78) = 39.538, p < .001$ ), financial constraints of family was also significant ( $\chi^2(1, n = 78) = 19.047, p < .001$ ), with none of the urban schools recording this as a barrier compared to 41.7% of the rural population recording this as a barrier that could prevent services. Language and cultural barriers were identified as significant ( $\chi^2(1, n = 78) = 11.038, p < .001$ )

when compared to urban and rural populations, again with no urban school indicating this as a barrier and 41.7% of the rural population indicating this as a problem. Inadequate community mental health services were reported as significant ( $\chi^2(1, n = 78) = 25.930, p < .001$ ), again with no urban school defining this as a barrier and 68.3% of rural providers seeing this as a hindrance to treatment. The final barrier identified as significant was transportation difficulties ( $\chi^2(1, n = 78) = 24.632, p < .001$ ), where no urban school identified this as a barrier and 66.7% of rural schools identified this as a problem.

**Table 16.**  
**Substance Abuse Counseling by School-Based Provider (n = 78)**

<b>School Operates Mental Health Clinic</b>	<b><u>Substance Abuse Counseling</u></b>		<b>Total</b>
	<b>Yes (n=23)</b>	<b>No (n=55)</b>	
Yes (n=18)			
Row	72.2%	27.8%	100%
Column	56.5%	9.1%	
No (n=60)			
Row	16.7%	83.3%	100%
Column	43.5%	90.9%	
Total	100%	100%	

*Note.*  $\chi^2(1, n = 78) = 20.553, p < .001$ .

Schools collect data within their schools for varying reasons, most often to report to district and state offices for accountability (Foster et al., 2005). Schools were asked in this survey what types of data they collected and these results were compared to whether the school provides school-based mental health services or not. Three of the twelve types of data collection were significant when compared to school-based or non school-based clinics: (1) collects information on types of school-based mental health services provided (43.3%, [ $\chi^2(1, n = 78) = 11.268, p$

< .001]), (2) demographics of students receiving mental health services (41.95% [ $\chi^2(1, n = 78) = 10.372, p < .001$ ]), and (3) number of mental health service units provided (50.0% [ $\chi^2(1, n = 78) = 14.226, p < .001$ ]). These data are required reporting for school-based clinics and this association showed the school-based programs were the schools collecting and reporting this data.

### Anecdotal Responses

Twelve surveys (15.4%) used the comment section to provide comments on the survey. Ten of the surveys identified that their school was not a qualified school-based mental health provider and they were experiencing problems with too many providers on their school campus. When the school does not have a designated school-based provider, all providers are allowed on the campus and the respondents indicated this presented difficulties in controlling students being removed from class for services. The other two respondents indicating they were glad to see this type of project and wished the researcher good luck.

## CHAPTER 5: SUMMARY, DISCUSSION, IMPLICATIONS, AND LIMITATIONS

### Introduction

This primarily descriptive research study was designed to provide an initial review of the mental health services being offered in Arkansas public school systems by assessing the current delivery of these services and examining certain demographic correlates. These results will be used as a foundation for the evaluation and proper integration of mental health programs into school systems in Arkansas.

This study builds on research that shows that many school-children have untreated mental health problems. While the primary mission of the school system is not to treat mental health problems, educational opportunities are maximized to the extent that obstacles to the attainment of an education are removed (Weist et al., 2003). However, schools are often unsure how to formulate and implement these programs and how to offer the best available services for educational settings (Slade, 2002).

This chapter organizes discussion of the study findings and conclusions around the seven research questions posed by the study. These results are interpreted in the context of previous research and with the current state of knowledge. Details of the implications of this research for social work practice, education, and future research are presented as well as limitations of the study.

### Students Eligible for Mental Health Services

Participants in this study were 78 Arkansas public schools located in both urban areas (16 schools, 20.5%) and rural areas (62 schools, 79.5%). This adequately represents state populations as current data for Arkansas shows only eight identified urban areas in the state (U.S. Census Bureau, 2009). The schools were divided with 26 elementary schools, 25 junior high schools, and 27 high schools for a total enrollment of 41,568 students. Enrollment at these schools

showed that ethnically students were identified as American Indians (.3%), Asian (.9%), Hispanic (7%), Black, not Hispanic (29%), and White, not Hispanic (62%). These data are close matches with current Arkansas population figures that identify .08% American Indian, 1.1% Asian, 5.3% Hispanic, 15.8% Black, and 80.9% White (U.S. Census Bureau, 2009), with the exception that the study contained somewhat more non-White students.

Students were further identified as being enrolled in special education services (27%), being eligible for free or reduced price lunch (65%), and being limited English proficient or English language learners (5.4%). Current figures for Arkansas show that 34% of students receive special education services, 72% are eligible for free or reduced price lunches, and 5.0% are limited English proficient or English language learners (Arkansas Department of Education, 2009). Services were provided at schools with school-based clinics (18) and non school-based clinics (60). Students identified as receiving mental health services numbered 12,061 students (29%) and nationally 20% of students were reported as receiving mental health services (Foster et al., 2005).

### Types of Mental Health Services

Mental health services that were available in the schools were assessment for emotional or behavioral problems, behavior management consultation services, referral to specialized programs for emotional or behavioral problems, referral for medication management, family support services, and crisis intervention. Literature (Flaherty & Osher, 2003; Adelman & Taylor, 1993) identified these same services as necessary to assess and treat mental health disorders. Additional services that were offered in the current study and in a previous study (Foster et al., 2005) were individual counseling, group counseling, and counseling for alcohol/substance abuse. These services require more specialized mental health providers and were found in the schools when the school offered school-based mental health clinics. These results were used to confirm



that school-based mental health programs will provide a greater number of mental health services than non school-based programs. Case management services and substance abuse counseling were significantly more likely to be provided in school-based mental health programs, although they could have been provided in schools without school-based programs by individual providers.

#### Administrative Arrangement of Mental Health Services

Mental health services were available to all students in 77 of the 78 schools (99%) as compared to national data of 87% of students being eligible to receive services (Foster et al., 2005). Mental health services were reported as being managed by one person while nationally these services were separated into management for general education students and management for special education students (Foster et al., 2005). School districts were responsible for management of mental health services in all 78 schools for general and special education while nationally only 73% of districts managed services for both general and special education students (Foster et al, 2005).

Administratively, services were managed at the district level for allocating funds for mental health services, establishing policies for mental health services, determining the number and type of mental health staff, hiring mental health staff, supervising mental health staff, planning in-service training for mental health staff, and administering contracts and agreements for mental health staff. This study did not ask respondents to identify the specific personnel and processes involved in these decisions which are important areas for future research.

When this research project began, the Department of Education was contacted for assistance. The researcher was immediately referred to the Special Education division of this department as they are responsible for any mental health programs in the schools, school-based or non school-based. Arrangements are made for mental health services by the Local Education

Agency /Special Education Supervisor (LEA). This one person, who holds a degree in education, is authorized to make the decision about what type of services will be offered in the school system. These services can include speech therapy, physical therapy, occupational therapy, special education classes, and mental health services. LEAs may have knowledge of mental health issues and needs, but they are not required to attend any formal training on the subject. Additionally, to participate in the school-based program under the Department of Education, all applications and certificate of need forms must be completed by the LEA. Additional research could be conducted to review how decisions of need are based and to establish a more unified program that could be implemented statewide ensuring all students equal access to mental health services.

#### Collaboration of Mental Health Services

Schools reported using multiple strategies for collaboration of services to ensure best practices with students including interdisciplinary team meetings between mental health staff and education teachers, joint planning sessions between mental health staff and teachers, professional development on mental health topics, and sharing of mental health resources among staff. Variations among schools with respect to frequencies of these activities ranged from weekly to never for consultation and planning meetings, and from quarterly to weekly for professional development and resource-sharing activities. It appears the schools participating in this study make these decisions independently and there are no standards to determine how often meetings are held, meeting participants, planning session providers, or who arranges or participates in professional development in-services. To provide more standardized handling of referrals and staffings, the Department of Special Education would need to establish protocols for these events, hold state-wide trainings to ensure all staff understands the protocol, and conduct follow-up data collection to test for the efficacy and efficiency of the program. Research (Dwyer, 2000) has

identified the importance of maintaining collaboration with the school. Programs placed into the education system must satisfy the school or the services will be removed as seen in Flaherty et al. (1996). Including school staff at meetings, attending PTO meetings, going on field trips, and involving school staff as stakeholders is necessary for good collaboration and continuation of service provision in the schools (Nabors et al., 1999).

### Mental Health Service Providers

The questionnaire used in this study and in the national study (Foster et al., 2005) did not provide definition of staff categories. This was due to a variation in the staff titles for persons with similar training who perform similar functions in the school. The expert panel arrived at a set of staff categories that were derived from the literature and were most likely to be recognizable to respondents. The respondent was able to complete the survey based on their impression of who was actually providing the service without bias. While this was good for a baseline study, future research should ask respondents to identify the title and degree of each person completing job tasks to ascertain a more in-depth understanding of who is providing the actual services and their qualifications. Another way to conduct this part of the survey would be to have each individual provider complete an individual evaluation of their time spent providing mental health services.

Current research found staff that provides services were school counselors, mental health counselors, school social workers, psychologists, alcohol/substance abuse counselors, clinical psychologists (PhD), and psychiatrists. Nationally mental health services are provided most often by school counselors and current data revealed the same. This indicates that school counselors are often the only staff available to provide mental health services to students in need. Often they are not trained (Lever et al., 2006) to provide these services, but any intervention is often viewed as better than no intervention. Arkansas requires each school have a counselor so they are always

available in the school. Funding problems may adversely impact other mental health staff, but the position of counselor is essentially protected. With the number of services being provided by counselors, additional research could look at the tasks of counselors, the time involved in completing these tasks, problems with job performance, and number of additional counselors being hired. If the need for additional staff is a result of increased time spent providing mental health services, then schools could hire persons with mental health training and not additional counselors.

Mental health counselors are employees who are available to provide mental health services and have been identified in the literature (Foster et al., 2005) as master level social workers. School social workers, school psychologists, alcohol/substance abuse counselors, clinical psychologists, and psychiatrists were also identified as providers of mental health services in the current and national data (Foster et al., 2005).

Schools with school-based mental health clinics were compared to schools without school-based clinics in regards to providers and results showed more mental health workers provide services in school-based programs. While programs without school-based clinics may have had mental health workers on their campus, the number of workers was lower indicating that if mental health services are provided in these schools, they are provided by another discipline.

Comparisons for service delivery providers showed a significant relationship between clinical psychologist or psychiatrist and school-based programs. These providers were found in schools having a school-based mental health program more often than in schools without a school-based program, increasing the use of these providers to deliver mental health services in schools with school-based mental health programs. Anecdotal comments on the current survey

identified that schools with non school-based programs often have many providers from multiple mental health agencies on their campus providing mental health services.

Another comparison looked at the relationship between mental health providers and the location of the school (either urban or rural). Chi square tests were performed and showed a significant relationship between school counselors, school social workers, and school psychologists and the location of the school. School counselors were more likely to perform mental health counseling in rural areas, school social workers are more often employed in rural areas and provided mental health counseling as well as the school social work jobs for which they are hired, and rural areas hired more school psychologists to provide mental health services. With a small number of licensed providers in rural areas, schools must hire any licensed staff that is available. This is often seen in advertisements for jobs in these rural areas stating that any of these disciplines will be considered. Sedlak (1997) highlighted the problems that can occur with role confusion when identifying the social worker as a mental health worker. Staff is often unsure where to refer students and whom to contact when students are in need of assistance. Additionally, the use of psychologists as mental health workers can lead to role confusion as well since psychologists are usually hired to complete testing in schools and may not have experience in providing some aspects of mental health counseling. Mental health workers should take special consideration to distinguish their roles in the school system, and how they will work with school staff to improve delivery of all needed services. If role delineation is not appropriately completed, the schools could develop negative feelings about all mental health workers and may not support the continuation or advancement of these programs.

This questionnaire evaluated the type of providers by asking respondents to identify the total number of each staff providing mental health services, the number of full time and part time employees, and the amount of time they spent providing mental health services. It was not

possible to determine the actual amount of time each employee spent providing mental health services, since these data were reported for disciplines. Future research would need to individually identify the amount each person spent on mental health services and additional information on what mental health services they were providing. Additionally, this research identified a psychologist working without a license and one without a master's degree. From the way the questionnaire is worded it was not possible to distinguish what services these people were actually providing. This is another area where standardization of job titles and service delivery activities by the state agency would allow for more balanced services to all students.

### Problem Identification

To provide services and management for mental health services, schools must know what problems are exhibited by students. Schools were asked to identify the number one, number two, and number three most frequent problems for males and females. For males, the most frequent problem was aggressive, disruptive behavior, bullying; alcohol/drug use was identified as the second problem; and social, interpersonal or family problems was identified as the third major problem presented by male students. Foster et al. (2005) identified the problems for males as social, interpersonal, or family problems; then aggression or disruptive behavior, bullying; and finally behavior problems associated with neurological disorders. The number one problem for females in the current study was social, interpersonal, or family problems and this problem was also the second most identified problem. Foster et al. (2005) also identified this as the number one problem nationally for females but the second and third problems were both identified as anxiety and adjustment issues. In the current study, the third identified problem was behavior problems associated with neurological disorders like attention deficit, epilepsy, or Tourette's syndrome.

Comparisons found in this research showed that males were found to have more problems with aggressive, disruptive behaviors in elementary school and through out their educational career. Female students were identified by schools as having more problems in the social, interpersonal, family area throughout their educational career from elementary school through junior high and into high school. This problem was identified as the number one problem for females in all three categories, meaning females display this problem throughout their educational history. While some schools reported problems with alcohol or drugs, they were not identified as often as the problems from aggressive, disruptive behaviors.

To develop standardized programs that can be used to target all students, it was important to identify where and when the problems are identified. When problems for males were compared to school location, alcohol/drug problems were identified in both urban and rural locations, as were problems associated with aggressive behaviors. Gang problems were identified more in the urban area, but they were present in the data for rural areas as well. The combination of these problems may increase as grade level increases (Stormshak et al., 2005) and cause more anti-social behavior and decreases in educational goal attainment. Female problems in comparison to school location identified social, interpersonal family problems more often in rural areas, but also present in urban areas. The other strongly identified problem, aggressive/disruptive behavior, was evident in both urban and rural areas.

There are currently no standardized programs in Arkansas being utilized to educate faculty, staff, students, or parents about these problems and ways to decrease these problems. The identification of these problems in schools located in both urban and rural areas will allow for the expansion of knowledge about mental health problems and the development of services and programs that can be utilized across the curriculum in all schools. This will allow more efficient, evaluative measures to be developed for children and the programs could contain a

curriculum that would be used from elementary through high school. Examples would include the Olweus Bullying Prevention Program (Olweus, 1997) and Making Choices Plus (Fraser et al., 2005). Longitudinal research (Atkins et al., 2003; Fraser et al., 2005) found that results are greater when programs are enacted over a period of time and the content is reinforced with the student. The state could implement pilot projects around the state dealing with these identified problems and test for results. This would prevent schools from creating untested programs or programs only being offered to a select group of children.

### Barriers to Services

To develop programs that will benefit all children, barriers that prevent them from receiving services must be analyzed. Schools were asked to rank nine barriers on a scale of 1 (no barrier) to 4 (severe barrier), and barriers that were identified (scored “3” or “4”) included inadequate mental health resources, competing priorities for mental health services, protecting confidentiality, parental cooperation, financial constraints, cultural barriers of students, inadequate community mental health resources, inadequate coordination between school and community providers, and transportation difficulties.

National data (Foster et al., 2005) found the same barriers, but comparisons show that Arkansas ranked transportation and inadequate community mental health resources much higher than the national average while they ranked competing priorities and inadequate school mental health resources much lower than national averages. Mason and Wood (2000) identified these same barriers in a study in a rural Hispanic community near the Mexican border justifying the same needs in rural communities. Comparisons between barriers and school location showed significant results. All 18 urban schools indicated school mental health services were inadequate to meet needs while rural areas did not identify this as a barrier. Arkansas census data reports that 64% of the population lives in a rural area (U.S. Census Quick Facts, 2009). Rural schools



(41.7%) indicated that financial constraints of the family was a barrier to service while none of the urban schools recorded this as a barrier. Vanderbleek (2004) reported financial problems could be a barrier to service when parents were unsure of payment responsibilities or payment options were not adequately explained to parents. Further exploration of this barrier would be needed to determine what families are expected to pay for services, if there are issues with non-billing of Medicaid or private insurance claims, transportation costs, or other hidden costs the families are expected to pay or perceive they could be responsible for. Both school employees and mental health staff will need to be educated in costs of the program so that they can provide an adequate explanation to families referred for services.

Language and cultural barriers were identified as significant, again with no urban schools indicating this as a barrier and 41.7% of the rural population indicating this as a problem. With these two issues being grouped together it is difficult to determine the exact barrier and additional testing of this could provide more in-depth answers. However, because staff identified this as a possible barrier, service providers need to be aware of language and cultural differences that could affect program participation. If students, parents, or guardians do not understand mental health issues or treatment, then service provision could be seriously affected. Lynn, McKay, and Atkins (2003) reported that placement of mental health services in schools can help reduce negative perceptions of mental health treatment and allow children who might not have received services from a community provider to obtain the services that are needed. Census data for Arkansas indicate that a language other than English is spoken by 4.9% of the population and 26% of Arkansans are recorded as linguistically isolated (unable to participate in society due to language barriers). Sixty-four percent of these people speak Spanish, and 8,460 children are listed as enrolled in grades one through 12 who speak English “less than well” (U.S. Census, 2009). Currently there are no pamphlets or programs provided by the Department of Education

that present material in a language other than English. Development of multi-language pamphlets and brochures at the state level could assist in decreasing this barrier as well as statewide in-service trainings to alert service providers to the need for cultural sensitivity. Identification of providers could be researched here as well. Research (Mason & Wood, 2000) identified bilingual providers of mental health services are often non existent, especially in rural areas.

Inadequate community mental health services were also reported as a significant barrier, again with no urban school endorsing this as a barrier versus 68.3% of rural schools that did. Additionally, since 70.5% of schools indicated they receive mental health services through a community provider, this may impact service delivery by a greater percentage. If services are not available then children will go untreated and problems will become worse resulting in poor academic performance, increasing discipline problems and dropping out of school (Short, 2003). Studies have found that mental health problems in children are more prevalent in vulnerable populations such as poor and minority children, intervention is short term, and problems can persist into adulthood if no changes are made (Armstrong, Dedrick, & Greenbaum, 2003; Epstein, Kutash, & Duchnowski, 1998; Marder & D'Amico, 1992). Additional investigation of this barrier would include surveying the community mental health providers for input and information about services provided, barriers they perceive in providing services and alternative service delivery methods that could allow more children to receive assessment and services.

The final barrier identified as significant was transportation difficulties, but no urban school identified this as a barrier while 66.7% of rural schools identified this as a problem. Public transportation is available in urban areas and decreases this barrier while in rural areas there is no public transportation and transportation for low income families is often undependable with long waiting lists for services. In recent years, the Arkansas Department of Education has been forced to consolidate rural school districts due to legislation requiring equal

services for all children and a lack of financial resources to provide these services in all schools. Oftentimes children are now bused to a larger school that is located a distance from their home, and it is not uncommon for a child to travel fifty miles daily. In addition to the transportation of children to school, persons in rural areas must travel to larger towns to receive mental health services (“University of Arkansas,” 2008). This would require the parent to be motivated to assist in the child’s mental health treatment and require them to make arrangements for these services. Parents’ lack of available transportation would again hinder their child from receiving needed mental health treatment. Current politics regarding school consolidation are being met with a great deal of resistance (“University of Arkansas,” 2008). The addition of mental health services to all schools would provide another example of a positive outcome of these political initiatives and could improve public support for these decisions. As Mills et al. (2006) reported, the placement of mental health programs in schools provides a more naturalistic setting for families and children to seek services and decreases the number of barriers to these services.

#### Coordination of Mental Health Services

Coordination with community providers is essential for the survival of a school-based mental health program. Schools and providers are working together to ensure that all children receive the maximum number of services needed to complete their education. Data in this study found that most coordination of services is through staff making active referrals for services and staff completing follow-up with providers. These two activities require staff to make telephone calls at referral and to make certain that clients keep their appointments and that no other referrals are indicated. The act of communicating with these providers builds relationships and allows for back and forth communication that will strengthen the working relationship between people who are caring for the child and their family. Staff did not often attend team meetings and as mentioned in coordination of services this would be an area for the state to mandate who

should attend meetings and how often they should attend the meetings to continue to build positive working relations.

### Data Collection

Data collection is important to the continued evaluation of programs to ensure programs are providing adequate services and to assess the types of services needed by a school or a community. Schools identified areas where data were collected and results showed that 71 schools (91.0%) collected some type of data. Nationally, Foster et al. (2005) found that only 50% of the schools they surveyed collected data. Data were collected on types of mental health problems presented by students, types of school-based mental health services provided, demographic characteristics of students who receive services, the number of units of mental health services delivered, data on referrals to community mental health centers, referrals for students on medications, students referred for bullying, data on suspensions, data on students in seclusion, data on student expulsions, and youth suicide rates. Nationally, much larger amounts of individual data were collected but Weist et al. (2005) states that evaluation tools are still needed that will be easy to utilize and collect data that can be used for program improvement. Types of collected data were compared to school-based and non school-based programs. Collected data that were significant were types of school-based mental health services provided, demographics about students who receive mental health services, and information on the number of units of mental health services delivered. All three of these measures are required reporting for schools who participate in the Department of Education's school-based program. Not collecting this information could affect payment to schools or continued enrollment in school-based clinics. Other reasons for collecting data were reporting to district or state offices, developing training and professional development programs, planning and evaluation of school-based mental health programs, and planning and evaluation of community-based mental health providers.

Evaluation of current problems in schools is needed to evaluate current service delivery methods and to plan for new programs. Collection of the number of mental health problems presented, medication referrals, and behaviors that include bullying, expulsions, suspensions, seclusions and suicide will provide insight into the climate of our schools and allow development of programs that can decrease these behaviors and improve the mental health of the children in the schools, thus improving educational attainment for all students. If data are not collected on these problems, it will impede the evaluation and integration of new programs into the school system; however, the dissemination of information on what types of data to collect and reasons to collect the data is needed. Schools struggle with ways to collect this information and the person responsible for collection and recording of the information. Repie (2005) identified the need to identify a key informant for this job who could assist not only in data collection, but in overall coordination of these programs. The message must be clear from the state level that collection of this information has a justifiable cause (not just additional paperwork) and it will be used to create programs that will help the school provide a better atmosphere for the students. Nastasi et al. (2000) found that a collaborative approach works best when the staff members are identified as stakeholders, and the inclusion of principals and administrators will increase support and cooperation for the program (Guerra & Williams, 2003). Statewide measures will need to be determined and generalized for all schools so that all schools collect the same information. Data collection should not be perceived as merely a bureaucratic exercise involved with payments for services, but rather an integral component of effective service delivery.

### Implications

#### Implications for Intervention and Practice

The primary purpose of this study was to provide an initial review of the mental health services being provided in the public school systems in the state of Arkansas. Results will be

used to help ensure evaluation of existing programs and integration of new programs into the school system. Beyond the relevance of these findings for school systems in Arkansas, this study contributes to the broader literature on mental health services for school-children, generally by identifying the following specific needs: services barriers among rural children, specific mental health-related problems reported for boys, unmet service provision for Hispanic children; methodological strategies with respect to specific informants used for data collection; deficiencies in data collection among some schools; and lack of coordination of strategic planning across schools districts. Results show that while some schools are providing school-based mental health services, not all schools are providing services and many children are still not receiving the care they need. Barriers to these services were well identified in the literature and in current findings showing a disproportion of providers for rural areas, different types of providers for different areas, issues with lack of community mental health services, and transportation difficulties that prevent adequate service delivery.

With documented research that shows 11 million children come to school with significant mental health issues, it is estimated that less than one-third receive the mental health services they need (Richardson et al., 1996). Suicide rates among children ages 10 to 14 have doubled with suicide remaining the third leading cause of death of adolescents (Lazear et al., 1999), twenty percent of high school students report they have seriously thought about suicide, and 15.7% have made a specific plan to commit suicide (Centers for Disease Control and Prevention, 1997) emphasizes the need for schools to develop and implement programs that will provide mental health services.

The President's New Freedom Commission on Mental Health (Mills et al., 2006) has developed initiatives that programs should follow to provide the services that are needed. Some of these that need to be considered are reducing the stigma associated with mental illness,

developing individual plans for every child, protecting the rights of people with mental illness, and expanding school mental health programs. Schools provide the opportunity for access to children and with the proper, trained staff many more children could be served. This study's findings support that the services are warranted and that additional services and qualified providers are needed to assist in the service provision.

From a policy perspective, changes need to be effected in the delivery of mental health services in the state of Arkansas. This research should be used as a beginning exploration of mental health services and to advocate for services for rural and urban areas. Additional research should be conducted to investigate why more schools are not participating in the state's school-based mental health program, number of providers, service delivery, barriers, and data collection. Attention must be paid to make certain all social classes are eligible for services and can utilize the services.

#### Implications for Education

This study identified main issues that include services barriers among rural children, specific mental health-related problems reported for boys, unmet service provision for Hispanic children, lack of data collection among schools, and lack of coordination of strategic planning across school districts. These issues touch on core social work concepts that drive the field of social work and need to be imparted by social work educators. These include working with individuals and families to provide the best services possible for the client, knowledge of human behavior and developmental stages to provide age appropriate treatments for children, knowledge of community practice and ways to affect positive change for clients, and information to assist in program evaluation and change.

#### Implications for Research

While the current research project has added to the body of literature on school-based

mental health services, specifically in rural areas, there are still many areas that need to be explored. Future research projects will be needed to continue evaluation of the services that are provided by the different providers to ascertain which mental health services are being provided and if staff is qualified to provide these services. Questions will need to be explored about the amount of time providers are being kept from their primary job to complete these tasks and alternative ways of providing these services.

Current research has discovered information about the major problems presented by children in schools today. This information will be needed to deliver standardized programs to assist in treatment of these problems. To ensure that this information remains current and up to date, data collection on bullying, mental health problems exhibited by students, students on mental health medications, and suspensions/expulsions for behavior problems will need to be mandated. This will ensure that schools begin to collect pertinent information that will allow the system to plan for the type of students they will be required to educate. If no information is collected, then no program evaluation or implementation can be done.

Research will need to be conducted that includes input from the community providers so that their concerns and their roles in treatment can be identified. Additionally, focus groups could be conducted statewide to gather information from families who receive or have received these services to gather their input about barriers to treatment and problems with the mental health community. Research will also need to be conducted on the prevention programs that schools are providing and assess their relationship to mental health problems or treatment. Evaluation of these programs will need to be conducted by trained staff to ensure the quality of the research.

This research has established a baseline evaluation for current delivery of mental health programs in the public school system in Arkansas. This study builds on established national data by providing individualized data for the state of Arkansas, which was not previously available.



This research expands the knowledge base by presenting features unique to the delivery of mental health services in a rural area and barriers that prevent attainment of mental health services. The recruitment strategy used in this study was accomplished with less follow up than the national study and showed greater results were achieved when the study was conducted on a local level. This evaluation could be completed in other states to establish baseline information for comparison purposes and then used to begin to develop more standardized programs to provide mental health services.

#### Limitations of Study

Limitations of the present study begin with the administration of the instrument. The instrument was administered to the LEA in each school district at the recommendations of the Department of Education. The LEA is in charge of the Special Education programs in their district and mental health services are provided under the Special Education Program. To ensure adequate representation in the survey each LEA was chosen to receive the survey. Once a school was drawn from that LEA's district, no other schools from the district could be chosen for the study. The LEA was sent the survey and advised which school was to be included in the study. However, there was no mechanism in place to check for this or to be sure the LEA included only data from that school. The LEA was also the only person who completed the information, although they were allowed to ask other staff for assistance if needed. A great deal of the information can not be verified, so the researcher was dependent on the integrity of the LEA. While the LEA was viewed as the person with the most pertinent information for this study, this greatly reduced the number of responses. However, the use of the LEA as a request from the Department of Education and the formal supportive email from the LEA supervisor provided strength for the survey and a return rate of 56%.

The generalizeability of the sample in this study is limited due to the small number of schools in the study and the overrepresentation of the rural populations. With the small number of schools in Arkansas and the convenience of a email surveys, future research could survey all schools to increase the strength of the research.

The survey was administered in March, near the end of the school year, and return rates could have been affected by the timing of the survey. Most demographic variables were completed in the first semester of school, so a more appropriate time for completion would have been late January or early February before the rush of the end of the school year could affect the study.

Funding of mental health services was deliberately left out of this study as data from the SAMHSA study and Bailey (2003) found that schools were more reluctant to answer questions about any services they provided if funding information was requested. In Arkansas, funding for mental health services has already been identified as an important political issue. Schools are allowed to bill Medicaid for services that are provided at the school and the increase in the cost of the Medicaid program has been a drastic event publicized on television and in the newspapers. Data will need to be collected about this sensitive issue to ensure that all aspects of the mental health program are evaluated, but this evaluation may be more effective if completed by an agency that cannot affect funding to the school.

### Conclusion

Children attend school for the primary purpose of attaining an education; however, social and behavioral problems often interfere with the attainment of this education. While the education system did not originally seek to solve the problems students bring to schools, they are no longer able to ignore the serious ramifications that result when mental health problems go untreated. This study established a baseline evaluation of current school-based mental health

services in Arkansas and provides valuable information that can increase the knowledge base on school-based mental health services, especially in rural areas. The research confirmed the need for continued mental health services in the schools to overcome barriers to treatment and ensure that all populations receive the treatment to which they are entitled.

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APPENDIX A: SCHOOL MENTAL HEALTH QUESTIONNAIRE

**Basic School Characteristics**

Before we ask you questions specifically about mental health services in your school, we would like some information about basic characteristics of your school. **You may have to ask someone in the school office for some of this information.**

1. **For the current school year (2008-2009), please check the box for each grade offered at your school.**

- Pre-kindergarten
- Kindergarten
- 1 st
- 2 nd
- 3 rd
- 4 th
- 5 th
- 6 th
- 7 th
- 8 th
- 9 th
- 10 th
- 11 th
- 12 th

2. **Of the total number of students enrolled in your school as reported in item 1, how many are:**

American Indian or Alaska Native	
Asian/Pacific Islander	
Black, not Hispanic	
Hispanic	
White, not Hispanic	

**3. Of the total number of students enrolled in your school as reported in item 1, how many are:**

Students identified as limited English proficient or English language learners	
Students with an Individual Education Plan (IEP) as defined by the Individuals with Disabilities Education Act	
Students eligible for a free or reduced price lunch	

**Delivery of Mental Health Services**

The next questions ask about delivery of mental health services in your school and relationships with the school district.

**Mental health services** are defined as:

o **Those services and supports delivered to individual students who have been referred and identified as having psychosocial or mental health problems.**

**4. Which students may receive these mental health services?**

- a. All students
- b. Special education students only

**5. How are mental health services managed in your school (who sets up the programs)?**

(Check all that apply)

- a. One person or team manages mental health services for all students (both general education and special education).
- b. One person or team manages mental health services for special education students only.
- c. One person or team manages mental health services for general education students only.
- d. No one manages mental health services at this school.
- e. Other \_\_\_\_\_  
(please describe)

**6. Does your school operate a mental health unit or clinic?**

- Yes
- No [SKIP to Item 9].

**7. Where is this MH unit or clinic located?**

- In this school
- Outside this school

**8. Does your school work with community agencies to provide mental health services for students in your school?**

- Yes
- No

**9. Who has responsibility for each of the following functions for mental health services provided to GENERAL EDUCATION students in your school? (Collaborative/Intermediate unit is a multidisciplinary unit that is district organized to provide services.) Check all that apply**

	N/A	School	District	Collaborative/ Intermediate Unit
Allocating funds for mental health services				
Establishing policies, guidelines, or standards on mental health service delivery				
Determining the number and types of mental health staff needed in your schools				
Hiring mental health staff				
Supervising mental health staff				
Planning in-service training and professional development for mental health staff				
Administering contracts or agreements with outside organizations or agencies providing mental health services				

**10. Who has responsibility for each of the following functions for mental health services provided to SPECIAL EDUCATION students in your school?  
(Collaborative/Intermediate unit is a multidisciplinary unit that is district organized to provide services.)**

**Check all that apply**

	N/A	School	District	Collaborative/ Intermediate Unit
Allocating funds for mental health services				
Establishing policies, guidelines, or standards on mental health service delivery				
Determining the number and types of mental health staff needed in your schools				
Hiring mental health staff				
Supervising mental health staff				
Planning in-service training and professional development for mental health staff				
Administering contracts or agreements with outside organizations or agencies providing mental health services				

**Mental Health Staff in School**

The next questions ask about the types of staff providing mental health services to students enrolled in your school.

**11. How are MH services staffed in your school?**

**(Check all that apply)**

- Mental health staff are school-based. (i.e. employees of the district or school who are assigned to this school and work only in this school).
- Mental health staff are district-based. (i.e. employees of the district who are assigned to the district and travel to different schools, spending only part of their time in this school).
- A collaborative or intermediate unit provides the MH staff.
- A community provider or organization provides the MH staff.
- Other (please describe) \_\_\_\_\_

**12. On average, please indicate how frequently your school staff uses the following strategies to coordinate activities and services for students in your school.**

	Weekly	Monthly	Quarterly	Never
Interdisciplinary team meetings among mental health staff				
Joint planning sessions between mental health staff and regular classroom teachers				
Joint planning sessions between mental health staff and special education teachers				
Professional development on mental health topics for regular school staff				
Sharing of mental health resources among staff (e.g. printed material, videos, exchange of referral info)				

**13. How many of the following staff provide mental health services to students in your school? Include both school-based and district-based staff.**

In **column 1** indicate the total number of staff that your school has. Put in '0' for none. Of the total, indicate the number who are fulltime (**column 2**) or part-time (**column 3**). In **column 4** indicate the percent of time (on average) each type of staff spends providing mental health services to students.

Type of Staff	Total Number of Staff	Full time staff	Part time staff	Percent of time providing mental health services
School Counselor				
Mental Health Counselor				
School Social Worker				
School Psychologist				
Alcohol/Substance Abuse Counselor				
PhD level Clinical Psychologist or Counseling Psychologist				
Psychiatrist				



**14. Of the total staff in each category reported in column 1 of item 14, indicate in column 1 the number with a master’s degree or higher in their field. In column 2 indicate the number with licensure or certification in their field.**

Type of Staff	Number with Master’s Degree or Higher	Number with Licensure/Certification
School Counselor		
Mental Health Counselor		
School Social Worker		
School Psychologist		
Alcohol/Substance Abuse Counselor		
PhD level Clinical Psychologist or Counseling Psychologist		
Psychiatrist		

**Arrangements with Community Organizations and Individual Providers**

**15. Does your school or district have formal or contractual agreements with any community-based organizations or individual providers to provide mental health services to students enrolled in your school?**

- Yes
- No

**16. What are your general practices for routine referrals to and coordination with community-based organizations or providers?**

- Staff make passive referrals (staff give brochures, lists, phone numbers of providers)
- Staff make active referrals (staff completes form with family, makes phone calls or appointments, assists with transportation)
- Staff follow-up with student/family (calls to ensure appointment kept, assures satisfaction with referral, need for follow-up)
- Staff follow-up with provider (phone, fax, or email)
- Staff attends team meetings with staff of community providers
- Other (please describe) \_\_\_\_\_

**17. Using the code list below, rank the 3 most frequent problems for each group:**

(Use the letter codes a. to n. to indicate the problem.)

Most Frequent Problem	Males	Females
#1 Problem		
#2 Problem		
#3 Problem		

**18. Overall, which problem uses most of your school's mental health resources (e.g. staff time, materials)?**

( Use letter code to indicate the problem.)

\_\_\_\_\_

**Code list of psychosocial or mental health problems for questions 19 and 20.**

**Use the letter code to indicate the problem.**

- a. Adjustment issues (e.g. difficulty managing transition to new school, new grade or class)
- b. Social, interpersonal or family problems
- c. Anxiety, stress, school phobia
- d. Depression, grief reactions
- e. Aggressive/disruptive behavior, bullying
- f. Behavior problems associated with neurological disorders (e.g., attention deficit disorder with or without hyperactivity, epilepsy, Tourette's syndrome)
- g. Delinquency and gang-related problems
- h. Suicidal or homicidal thoughts or behavior
- i. Alcohol/drug problems
- j. Eating disorders
- k. Concerns about gender or sexuality
- l. Experience of physical or sexual abuse
- m. Sexual aggression, including harassment
- n. Major psychiatric or developmental disorders (e.g., psychosis, bipolar disorder, Autism)

**Mental Health Services Provided to Students in your School**

**19. Does your school provide the following services, either directly or through a community based organization with which you have a formal arrangement? If YES, also indicate who provides the service.**

Service Provided	Yes	No	Provided by School	Provided by Community Agency
Assessment for emotional or behavioral problems (including behavioral observation, psychosocial assessment and psychological testing)				
Behavior management consultation (with teachers, students, families)				
Case management (monitoring and coordination of services)				
Referral to specialized programs or services for emotional or behavioral problems or disorders (e.g eating disorders)				
Crisis Intervention				
Individual Counseling or Therapy				
Group Counseling or Therapy				
Substance Abuse Counseling				
Medications for emotional or behavioral problems				
Referral for medication management				
Family Support Services				

**20. How many students in your school received one or more of the above mental health services during the last school year (2007-2008)?**

\_\_\_\_\_ (number) OR \_\_\_\_\_ (%)

**21. Using the following scale from 1 to 4 where “1” is “not a barrier” and “4” is a “serious barrier”, please indicate the extent to which each of the following is a barrier in delivering mental health services to your students.**

	Rank 1, 2, 3, 4
School mental health resources are inadequate to meet student needs (waiting list, limited space or staff availability)	
Competing priorities take precedence over mental health services	
Protecting student confidentiality	
Gaining parental cooperation and consent	
Financial constraints of family	
Language and cultural barriers of students or families	
Community mental health resources inadequate to meet student needs	
Inadequate coordination/collaboration between school staff and community providers	
Transportation difficulties for students to travel to service providers	

### **Data Collection and Reporting**

The next questions ask about data your school collects and reports on mental health services for students.

**22. Does your school collect or have access to data on mental health services provided to students in your school?**

\_\_\_\_\_ Yes for all students

\_\_\_\_\_ Yes for special education students only

\_\_\_\_\_ No data collected (skip to end of survey)

**23. What data are collected? (Check all that apply)**

\_\_\_\_\_ Types of mental health problems presented by students

\_\_\_\_\_ Types of school-based mental health services provided

\_\_\_\_\_ Demographic characteristics of students who receive services

\_\_\_\_\_ Number of units of mental health services delivered

\_\_\_\_\_ Referrals to community mental health providers

\_\_\_\_\_ Referrals for students on medication

\_\_\_\_\_ Bullying referrals

\_\_\_\_\_ Expulsions

\_\_\_\_\_ Seclusion Data

\_\_\_\_\_ Suspensions

\_\_\_\_\_ Youth Suicide Rates

**24. How does your school use these data? (Check all that apply)**

\_\_\_\_\_ Reporting to district or state offices

\_\_\_\_\_ Developing training and professional development programs for various school staff

\_\_\_\_\_ Planning and evaluation of school-based mental health services and resources

\_\_\_\_\_ Planning and evaluation of arrangements with community-based mental health providers

\_\_\_\_\_ Other uses for the data (please describe)

\_\_\_\_\_

**Please provide the name, title and contact information of the person who completed this survey.**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

**If more than one person was involved in completing this survey, please indicate who.**

Principal

Assistant Principal

Director of Mental Health Services (or Student Support Services)

School secretary \_\_\_\_\_

School counselor, school psychologist, school social worker or other mental health staff

Other (Please provide title)\_\_\_\_\_

**If you have any comments you would like to make about this survey, please use the space below.**

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*Thank you very much for completing this survey!*

APPENDIX B: SAMPLE LIST

<b>SCHOOL NAME</b>	<b>DISTRICT NAME</b>	<b>LEA NUMBER</b>
1. Rose City Middle School	North Little Rock	6002077
2. Sulphur Rock Elementary	Batesville	3201042
3. Benton High School	Benton	6302012
4. Armorel High School	Armorel	4701002
5. Barton-Lexa High School	Barton-Lexa	5401003
6. Arkadelphia High School	Arkadelphia	1002010
7. Bay High School	Bay	1601002
8. Williford Elem School	Twin Rivers	6806018
9. Southside Elem School	Southside	3209038
10. Alpena High School	Alpena	501002
11. Caddo Hills High School	Caddo Hills	4901003
12. Gosnell Elem School	Gosnell	4708028
13. Beebe Middle School	Beebe	7302011
14. James Tate Elementary	VanBuren	1705029
15. Central Elem School	Cabot	4304002
16. Pocahontas Upper Elem	Pocahontas	6103011
17. Waldron Elem School	Waldron	6401001
18. Greenbriar Eastside Elem	Greenbriar	2303016
19. Yellville Summit Elem	Yellville-Summit	4502005
20. Evening Shade Elem	Cave City	6802005
21. Morrilton High School	South Conway Co.	1507036
22. Elkins High School	Elkins	7201002
23. Bearden Elem School	Bearden	5201001
24. Southside High School	Fort Smith	6601025
25. L.L. Owen Elem School	Watson Chapel	3509064
26. Florence Mattison Elem	Conway	2301004
27. Mountainberg High	Mountainberg	1703013
28. Atkins Middle School	Atkins	5801003
29. Warren High School	Warren	602014
30. Cedar Ridge High School	Cedar Ridge	3212027
31. Heber Springs Middle Sch	Heber Springs	1202007
32. Mountain Pine Elem	Mountain Pine	2607046
33. Blytheville Middle Sch	Blytheville	4702012
34. Forrest City High School	Forrest City	6201011
35. Dover Middle School	Dover	5802008
36. Bethel Middle School	Bryant	6303028
37. L.F. Henderson Int School	Ashdown	4101001
38. Mulberry High School	Mulberry	1704017
39. Monticello Middles Sch	Monticello	2203011
40. Dollarway High School	Dollarway	3502010
41. Marmaduke High School	Marmaduke	2803017
42. Mansfield Elem School	Mansfield	6606060
43. Central Elem School	Corning	1101005

44. Dumas Jr. High School	Dumas	2104020
45. Jonesboro High School	Jonesboro	1608025
46. Highland Middle School	Highland	6804011
47. Drew Central High School	Drew Central	2202005
48. Viola High School	Vilonia	2307034
49. Dunbar Middle School	Earle	1802006
50. Valley View High School	Valley View	1612048
51. Izard Co. Middles School	Izard County	3306016
52. Cabe Middle School	Gurdon	1003017
53. University Heights Elem	Nettleton	1611040
54. Acorn High School	Ouachita River	5706002
55. Murfreesboro Elem School	Murfreesboro	5504014
56. Greene Co. Jr. High	Greene Co Tech	2807008
57. Leslie Elem School	Searcy County	6502001
58. Bradley Elem School	Bradley	3701001
59. Centerton-Gamble Elem	Bentonville	401014
60. Magnolia High School	Magnolia	1402009
61. Greenwood High School	Greenwood	6602043
62. Booneville High School	Booneville	420102
63. Central High School	Helena	5403019
64. Redfield Jr. High School	White Hall	3510077
65. Searcy High School	Searcy County	7311052
66. Alma High School	Alma	1701002
67. Jessieville Elem School	Jessieville	2604029
68. Lakeside Elem School	Lakeside LV	903016
69. Lavaca Elem School	Lavaca	6605056
70. St. Paul Elem School	Huntsville	4401011
71. Ramay Jr. High School	Fayetteville	7203018
72. Stuttgart Jr. High School	Stuttgart	104026
73. Marion Int. School	Marion	1804017
74. Norphlet Elem School	Norphlet	7006035
75. Beryl Henry Elem School	Hope	2903008
76. Willis Shaw Elem School	Springdale	7207066
77. Fullbright Elem School	Little rock	6001048
78. Pine Bluff High School	Pine Bluff	3505042
79. Jones Elem School	Rogers	405049
80. Union Elem School	Texarkana	4605022
81. Camden-Fairview Middle	Camden-Fairview	5204023
82. West Jr. High School	West Memphis	1803034
83. Norman Jr High Schoo	Crossett	201008
84. Scott Elem School	Pulaski Co Special	603111
85. Norfolk Elem School	Norfolk	304021
86. Green Forest Elem Sch	Green Forrest	803011
87. Clinton Int School	Clinton	7102007
88. Stephens Elem School	Stephens	5206032
89. Bald Knob High School	Bald Knob	7301003



90. Ouachita Elem School	Ouachita River	3005029
91. Des Arc High School	Des Arc	5901002
92. Washington Middle Sch	El Dorado	7001011
93. Paris High School	Paris	4203012
94. Carlisle Elem School	Carlisle	4303012
95. Cedarville Middle School	Cedarville	1702010
96. Centerpoint High School	Centerpoint	5502010
97. Fordyce High School	Fordyce	2002007
98. Gravette High School	Gravette	404022
99. Luxora Elem School	South MS County	4706039
100. Russellville Middle Sch	Russellville	5805022
101. DeQueen Middle School	DeQueen	6701004
102. Gillett High School	Dewitt	101009
103. Harmony Grove High	Harmony Grove Benton	6304030
104. Lonoke Elem School	Lonoke	4301027
105. Mammoth Spring High	Mammoth Springs	2501002
106. Marked Tree High Sch	Marked Tree	5604017
107. Laekside Int School	Lakeside Hot Springs	2606042
108. Osceola Middle School	Osceola	4713050
109. Omaha High School	Omaha	504023
110. Quitman Elem School	Quitman	1203010
111. McCrory High School	McCrory	7403013
112. Mt. Pleasant High Sch	Melbourne	3302011
113. Siloam Springs Middle	Siloam Springs	406049
114. Saratoga High School	Mineral Springs	3104022
115. Riverview Jr. High Sch	Riverview	7307033
116. Sheridan Middle School	Sheridan	2705021
117. Mayflower Elem School	Mayflower	2305025
118. West Fork High School	West Fork	7208062
119. Lee High School	Lee County	3904008
120. Wynne Int. School	Wynne	1905015
121. Hoxie High School	Hoxie	3804010
122. Horatio High School	Horatio	6703013
123. Mount Ida Elem School	Mount Ida	4902006
124. Paragould High School	Paragould	2808043
125. Pinkston Middle School	Mountain Home	303014
126. Perryville High School	Perryville	5303011
127. Pea Ridge Middle Sch	Pea Ridge	407028
128. Rector High School	Rector	1106023
129. Bismarck Middle School	Bismarck	3001002
130. Magnet Cove High Sch	Magnet Cove	3003014
131. Newport Jr. High Sch	Newport	3403012
132. Forest Heights Elem Sch	Harrison	503012
133. Berryville Middle Sch	Berryville	801003
134. Kraus Middle School	Clarksville	3601002
135. Prescott Elem School	Prescott	5006022

136. Kirby High School	Kirby	5503011
137. Lake Hamilton Int Sch	Lake Hamilton	2605036
138. Mt. Vernon-Enola Elem	Mount Vernon-Enola	2306029
139. Nevada Elem School	Nevada	5008013
140. Jonesboro Elem Sch	Jonesboro	1608019

## APPENDIX C: PRE-SURVEY NOTICE

March 5, 2009

Dear Colleague,

Based on your role as a LEA with the school district, you have been selected to participate in a descriptive survey about school-based mental health practice.

In the next couple of days, you will be receiving a link to complete an online survey entitled, "Survey of School Mental Health Services in Arkansas."

This research is being conducting for my dissertation at Louisiana State University in Baton Rouge, Louisiana and has received approval from Marcia Harding, Director of Special Education, Arkansas Department of Education.

If you participate in this descriptive study, the information you provide will be presented in aggregate form. Individual responses will not be distributed. The internet technology has set the survey to flush internet addresses of the participants so only the aggregate data is available from your school. An internet research informed consent form that you may print for your records will accompany the survey.

Thank you in advance for your time and assistance. If you have any questions, please feel free to contact me at (870) 265-1151.

Sincerely,

*Lisa B. Moon, MSW, LCSW*

Lisa B. Moon, MSW,LCSW  
Doctoral Candidate, Louisiana State University  
Instructor of Social Work  
Delta State University  
Cleveland, MS  
(870) 265-1151  
Email: smoon99@ipa.net

APPENDIX D: CONSENT FOR PARTICIPATION/SURVEY LINK

March 1, 2009

Dear Colleague,

Based on your role as a LEA in the school system, as identified by the Arkansas Department of Education, you have been selected to participate in a descriptive survey about school-based mental health services.

I am conducting this research for my dissertation at Louisiana State University, Baton Rouge, Louisiana.

If you participate in this study, the information you provide will be presented in aggregate form and no individual responses will be described.

By completing the survey you are agreeing to participation in this study and indicating that you have read and understand the purpose of the study. Please see the informed consent on the next page.

Thank you for your willingness to complete the survey.

Sincerely,

Lisa B. Moon, MSW LCSW  
Doctoral Candidate, Louisiana State University  
Instructor of Social Work  
Delta State University  
Cleveland, MS  
(870) 265-1151  
Email: [smoon99@ipa.net](mailto:smoon99@ipa.net)

## Informed Consent Form for Participation in Dissertation Research

Louisiana State University, Baton Rouge, LA

Investigator Name: Lisa B. Moon, MSW, LCSW  
Doctoral Program, Louisiana State University School of Social Work  
Instructor of Social Work, Delta State University, Cleveland, MS

Contact Address: 4787 E Hwy 82  
Lake Village, AR 71653

Contact Phone: (870)265-1151

E-Mail Address: [smoon99@ipa.net](mailto:smoon99@ipa.net)

Project Title: "Survey of Mental Health Programs in the Arkansas Public School System"

### Invitation to Participate

I am asking you to take part in a research study conducted in partial fulfillment of the requirements of the PhD. Program in Social Work at Louisiana State University, Baton Rouge, LA. Participation is voluntary and refusal to participate will involve no negative consequences to you.

### Project Purpose and Design

This research explores the mental health services that are being provided in the public school system in Arkansas. Participants have been randomly selected from a list of all public schools in the state of Arkansas provided by the Arkansas Department of Education.

### Potential Risks

There are no known risks for participation in this research project.

### Potential Benefits

There are no benefits gained by the participants. There is no financial incentive. Participants will be offered an "Executive Summary" of the findings.

### Precautions to Safeguard Identifiable Information

The information obtained in this survey will be aggregate data collected by individual school. The survey will be coded with an identifier for the school known only to the researcher and the researcher's supervising professor. No individual data will be collected or reported. All reported information will be in aggregate form. Confidentiality will be maintained by storage of all survey instruments in a locked cabinet in the researcher's office.

#### Institutional Review Board Approval

This study has been approved by the LSU Institutional Review Board. For questions about participant rights please contact the chair, Dr. Robert Mathews, (225)578-8692 or [irb@lsu.edu](mailto:irb@lsu.edu).

Your completion and return of the survey indicates that you have read and understand the above information and 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. Again, your participation is voluntary. If you have any questions, please contact:

Lisa B. Moon at (870) 265-1151 or Dr. Tim Page at (225)578-1358

APPENDIX E: THANK YOU/REMINDER NOTICE

Dear LEA,

About a week ago, you received an invitation to participate in a survey about school-based mental health practice. I would like to thank you for your time and assistance. Your responses will be used to learn more about mental health services in the school.

If you did not have time to complete the survey and would like to participate, you can access the survey at: [http://www.surveymonkey.com/s.aspx?sm= 2f7O5YO3XCD5bprHsxEzPNQ\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=2f7O5YO3XCD5bprHsxEzPNQ_3d_3d)

If you have questions, please feel free to contact me at (870) 265-1151.

Sincerely,

*Lisa B. Moon*

Lisa B. Moon, MSW LCSW  
Doctoral Candidate, Louisiana State University  
Instructor of Social Work  
Delta State University  
Cleveland, MS  
(870) 265-1151  
Email: [smoon99@ipa.net](mailto:smoon99@ipa.net)

## APPENDIX F: EXPERT PANEL LIST

### School Mental Health Services in the United States 2002-2003

Michael Curtis, Ph.D.  
Research and Training Center for Children's  
Mental Health  
Louis de la Parte Florida Mental  
Health Institute  
University of South Florida

Kevin Dwyer  
Bethesda, MD

Elizabeth Farmer  
Assistant Professor  
Duke University  
Department of Psychiatry and  
Behavioral Science  
Durham, NC

Ted Feinberg  
National Association of  
School Psychologist  
Bethesda, MD

Lisa Hunter, Ph.D.  
Center for the Advancement of  
Children's Mental Health  
Columbia University NYSPI

Julia Graham Lear, Ph.D.  
The Center for Health and  
Health Care in Schools (RWJ)  
Washington, DC

Adelaida Montemayor  
Lubbock, Texas

Angela M. Oddone, MSW  
Mental Wellness Program Coordinator  
NEA Health Information Network  
Alexandria, VA

Diane Oglesby  
National Association of State Directors of  
Special Education  
Alexandria, Virginia

David Osher, Ph.D.  
Center for Effective Collaboration and  
Practice  
Washington, DC

Robin Rosenthal  
Rosalynn Cater Institute for Human  
Development  
Georgia Southwestern State University  
Americus, GA

John Schlitt  
National Assembly on School-Based  
Health Care  
Washington, DC

Mark Weist, Ph.D.  
UMB Center for Mental Health Assistance  
Baltimore, MD

Joan Wodiska  
American School Counselors Association  
Alexandria, VA

Jo Anne Grunbaum, Ed.D.  
Chief, Surveillance Research Section  
Division of Adolescent and School Health  
Atlanta, GA

Tom V. Hanley  
U. S. Department of Education  
Washington, DC



Isadora Hare, MSW  
Health Resources and Services  
Administration  
Maternal and Child Health Bureau  
Division of Child, Adolescent, and  
Family Health  
Rockville, MD

Jeffrey A. Buck, Ph.D.  
Associate Director  
Office of Organization and Financing  
CMHS/SAMHSA  
Rockville, MD

Eileen Cronin, Ph.D.  
Office of Organizing and Financing  
CMHS/SAMHSA  
Rockville, MD

Malcolm Gordon, Ph. D.  
Special Programs Development ranch  
Center for Mental Health Services  
Rockville, MD

Kevin Hennessy, Ph.D.  
Office of the Assistant Secretary for  
Planning and Evaluation  
Department of Health and Human Services  
Washington, DC

Kimberly Hoagwood, Ph.D.  
Associate Director of Child and Adolescent  
Research  
National Institute of Mental Health  
Bethesda, MD

Shelagh Smith, MPH, CHES  
Office of Organization and Financing  
CMHS/SAMHSA  
Rockville, MD

Roseann R. Rafferty  
U.S. Department of Education  
Washington, DC

Judith L. Teich, MSW  
Social Science Analyst  
Office of Organization and Financing  
CMHS/SAMHSA  
Rockville, MD

Kelly Henderson  
U.S. Department of Education  
Washington, DC

Michele Edwards, M.A., ACSW  
Special Programs Development Branch  
Center for Mental Health Services  
Rockville, MD

LaVoyce Reid  
Senior Staff Associate  
Children, Families, and Schools  
National Association of Social Workers  
Washington, DC

## VITA

Lisa is a native of Lake Village, Arkansas, and will receive her Doctor of Philosophy in Social Work in August, 2009. Lisa completed her bachelor's degree in social work from the University of Louisiana-Monroe, in August, 1985, and was awarded her master's degree in social work from the University of Southern Mississippi, Hattiesburg, Mississippi, in August, 1986. She spent ten years working in the field of medical social work in Mississippi and Louisiana before returning to her hometown in Arkansas. She worked with children in the school system and the Division of Family Services as a practitioner and then as an instructor at the University of Arkansas-Monticello. She served as a Field Instructor before being promoted to Social Work Field Director and then Director of the Social Work Program. After five years at the University of Arkansas-Monticello she moved to Delta State University as the Director of the IV-E Program. She continues to teach in the Social Work Program at Delta State and is a Licensed Certified Social Worker in Louisiana, Arkansas, and Mississippi. She lives in Lake Village with her husband, two children, and her mother.