SCHOOL MENTAL HEALTH SERVICES: A STUDY OF CURRENT PRACTICES IN

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ABSTRACT

This study investigated current practices of school mental health services in central New Jersey public schools. Seven Directors of Special Education were interviewed to obtain information about mental health service providers, types of mental health services available, prevalence of school-based mental health centers, staff development on mental health issues, and the most effective services and programs. Participants also provided information about the gaps that still need to be filled to meet the mental health needs of students and how they would fill these gaps. All participants indicated that mental health services are provided within their school district. The most common service providers of mental health services were school counselors (100% of participants indicated mental health services are provided by school counselors), school social workers (100% of participants indicated mental health services are provided by school social workers), and school psychologists (85.7% of participants indicated mental health services are provided by school psychologists). Only two of the seven participants indicated there is a school-based mental health center within their district to provide expanded mental health services. Results suggested that school-based mental health centers, prevention programming, and specific individuals including school psychologists were the most effective at meeting students' mental health needs. Results also indicated that more prevention programming and staff training is needed to fully meet students' mental health needs. Additional findings as well as recommendations, limitations, and implications for school psychologists are discussed.

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CHAPTER I

INTRODUCTION AND RATIONALE FOR THE DISSERTATION

There is an increasing recognition for the need to promote the mental health needs of youth (President's New Freedom Commission on Mental Health, 2003). The World Health Organization (2004) has defined mental health as "a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." Mental health disorders, on the other hand, are defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual [which] is associated with present distress...or disability...or with a significant increased risk of suffering." Mental health disorders can lead to difficulties in social, emotional, family, and academic functioning and can be associated with long-term problems (Evans, Mullett, Weist, Franz, 2005).

Traditionally, mental health services have been delivered in outpatient clinics and inpatient units (Kiser, King, & Lefkovitz, 1999). More recently, mental health professionals have emphasized that schools can provide critical mental health services (Elias et al., 1997). The advantage of schools over community settings and clinics is that mental health professionals have more access to children and adolescents. Additionally, they have more opportunities to emphasize prevention approaches to mental health disorders as opposed to intervention once a problem has been identified, and are able to provide a variety of services to youth within the schools (Leaf, Schultz, Kiser, & Pruitt, 2003).

In order to address mental health problems, schools have been utilized as important settings to deliver mental health services. School-based mental health services refers to the broad spectrum of services delivered in a school setting with the collaboration of educators, including prevention, assessment of mental health issues, intervention, and consultation. Typically the goal of mental health services is to support students both academically and emotionally within school. Despite the support they offer students, mental health services often remain isolated from the goals of schooling and academic learning (Weist & Paternite, 2006). Adelman and Taylor (2010) suggest that mental health should be a focus in schools because schools can facilitate access to services for students and their families, and it is necessary to address mental health concerns for students to achieve effective school performance.

Federal initiatives including the 2000 Report of the Surgeon General on Mental Health of the Nation, the 2001 No Child Left Behind Act (2008) and the President's New Freedom Commission on Mental Health (2003) helped to propel the need for school mental health services for all children and adolescents. These initiatives focused attention on improving mental health and academic achievement in students and have helped to increase interest in school mental health services, but they have not supplied practitioners with recommendations to improve outcomes.

Although limited in scope, evidence indicates that school mental health services and programs have positive effects on student, family, and school outcomes (Foster et al., 2005). The complexities and differences among mental health programs make evaluations difficult (Nabors, Weist, and Reynolds, 2005).

This dissertation aimed to gain an understanding of current practices of mental health services in New Jersey public schools. Specifically, the study qualitatively investigated the different types of mental health services offered by school districts, the professionals that provide mental health services, the collaboration that exists among professionals in the school, funding for mental health services, as well as gaps that still exist in meeting the mental health needs of students. It also attempted to determine the gap between research and current practice, and helped to clarify what barriers exist to enhancing school mental health services.

CHAPTER II

REVIEW OF THE LITERATURE

School Mental Health Services: An Overview

Mental health services and programs in schools originated with the writings of 19th century educators such as John Dewey (Sarason, 1996). During the 1990s mental health programs gained much attention through a national movement and services evolved to what they are today. Mental health services and programs include assessment, intervention, consultation, and prevention activities designed to identify, treat, and reduce mental health disorders in children and adolescents. School settings include public schools, to public school-administered programs in hospitals and juvenile justice facilities. School mental health service programs may be staffed entirely by school-employed staff, such as school psychologists, social workers, and school counselors, or may include staff from community agencies, such as clinical, community, and counseling psychologists, social workers, and psychiatrists (Weist, Evans, & Lever, 2003).

When conceptualizing school mental health services, it is important to note that these are not just mental health clinics in schools, or providers operating independently delivering services. School mental health services are a more integrated component of the entire educational enterprise. Ideally, they are offered by school staff operating together to prioritize the promotion of health and prevention while working in cooperation with other community programs and services. One single profession cannot have full ownership over the field of school mental health because the field is interdisciplinary by nature (Weist, Evans, et al., 2003). Adelman and Taylor (2010) suggest that mental health should be a focus in schools because schools can facilitate access to mental health

services for students and their families. It is necessary to address mental health concerns for students to achieve effective school performance.

When conceptualizing mental health, there is a tendency for people to think of mental illness, mental disorders and problems due to the overuse of psychiatric labels (Adelman & Taylor, 2010). This suggests that mental health is the absence of these problems. However, mental health is not just the absence of mental problems, but is also the promotion of positive social and emotional well-being. The Surgeon General's Conference on Children's Mental Health (U.S. Public Health Service, 2000) began to address this issue by stating that "both the promotion of mental health in children and the treatment of mental disorders should be major public health goals." The statement uses the term mental health as a positive concept instead of a negative one. Since there is a tendency when discussing mental health to focus on mental illness, the attention of school policy makers has primarily been concerned with emotional disturbance, violence, and substance abuse, and not with promoting positive social-emotional well-being (Policy Leadership Cadre for Mental Health in Schools, 2001). Mental health, just like physical health, directly impacts children's learning and development. When children struggle with a mental health difficulty, or academic, social, and familial pressures, they may experience trouble learning in school (National Association of School Psychologists, 2006).

Need for Mental Health Services

There exists a growing need for mental health services for today's youth. Approximately one in five children and adolescents will have a mental health problem

during their years at school (U.S. Department of Health and Human Services, 1999). The U.S. Surgeon General has reported that within the course of a year, approximately 20% of children will experience signs and symptoms of a mental health problem, and approximately 5% experience extreme functional impairment (U.S. Department of Health and Human Services, 1999).

Recent studies have investigated prevalence and lifetime prevalence of mental health disorders. Connor and Meltzer (2006) suggested that depression has an incident rate of approximately 4.6% for children and 8.3% for adolescents. Merikangas, He, Burstein, et al. (2010) indicated that approximately 14.3% of adolescents experience a lifetime prevalence of a mood disorder, with about 11.2% experiencing severe impairment. Of these individuals, almost 3% are diagnosed with bipolar disorder by adolescence (Merikangas, He, Burstein, et al., 2010). Anxiety disorders occur in approximately 5% to 18% of children, 0.3% to 13% of preadolescents, and 0.6% to 7% of adolescents (Connor & Meltzer, 2006). Anxiety-related disorders have a lifetime prevalence rate as high as 31.9%, with approximately 8.3% experiencing severe impairment (Merikangas, He, Burstein, et al., 2010). The lifetime prevalence rate for behavior disorders is 19.6% with approximately 9.6% experiencing severe impairment (Merikangas, He, Burstein, et al., 2010). The prevalence of attention-deficit hyperactivity disorder ranges from 3% to 12%, while the prevalence of oppositional defiant disorder is between 1% and 13.3% (Connor & Meltzer, 2006). Merikangas, He, Brody et al. (2010) also found that approximately 55% of those with a mental disorder consulted with a mental health professional, which indicates an increasing trend in mental health service use for children.

The prevalence of mental health disorders in children and adolescents is a concern for both mental health professionals and educators. Mental health difficulties in children often are displayed through externalizing behavior that can result in a decrease in academic performance, or even in suspension or expulsion (Atkins et al., 2002). The dropout rate for students with extreme emotional and behavior problems is approximately double that of other students (Lehr, Johnson, Bremer, Cosio, & Thompson, 2004). These individuals are at risk for other school-related problems such as absenteeism, discipline troubles, retention, and or delinquency (Heathfield & Clark, 2004). Additionally, between 5% and 9% of individuals with mental health disorders may be classified as Emotionally Disturbed (ED) under the Individuals with Disabilities Improvement Act (IDEA 2004; Friedman, Katz-Leavy, Mandersheid, & Sondheimer, 1996) eligibility category, although the actual number of students who meet this criteria is lower than the amount of students with mental health difficulties (Heathfield & Clark, 2004). Part of this is related to the fact that the emotional difficulties cannot stem from social maladjustment according to the eligibility criteria (IDEA, 2004)

Despite the prevalence of mental health issues in children, many children do not receive the help they need. Weist, Goldstein, Morris, & Bryant (2003) reported that approximately four fifths of children and adolescents who need mental health services do not receive them. Of approximately 2.2 million youth ages 12-17 who reported a major depressive episode in the past year, only about 40% received any type of treatment (Foster et al., 2005). Of the students who reported receiving help, approximately two thirds of services were received in school (Foster et al., 2005). This same study (Foster et al., 2005) indicated that two thirds of U.S. school districts reported an increase in the

need for mental health services since the previous year. Given the increased prevalence of mental health disorders and the fact that the majority of mental health help students receive are provided by schools, there is support for schools as a primary place for mental health services.

Schools as a Place to Provide Mental Health Services

Bronfenbrenner's theory of human ecological systems suggests that children's development should be considered within the context of the system of relationships that comprise their environment (Bronfenbrenner, 1979). This would suggest that schools may be one of the most influential contexts on children's cognitive, social, and emotional development (Atkins, Hoagwood, Kutash, & Seidman, 2010), and are considered second only to families in terms of contributing to children's development (Evans, 1999).

Approximately 52 million youth attend 114,000 schools for at least six hours a day in the U.S, suggesting that about one fifth of the U.S. population can be served in schools (President's New Freedom Commission, 2003). Schools serve as a natural setting for mental health services and are a prime venue to connect parents and educators in the improvement of mental health functioning of children (Brener, Weist, Adelman, Taylor, Vernon-Smiley, 2007).

Actually, in many states, school systems are the major provider of mental health services to children (Rones & Hoagwood, 2000), and for some children, the school system provides the only source of mental health services (Burns et al., 1995). Educators have indicated that the unmet social and emotional needs of children can overwhelm school resources making their job of providing education difficult (Atkins et al., 2010).

Of the services that are provided, research suggests that students may be more likely to seek out mental health services when the services are available in schools (Slade, 2002).

Schools serve a critical role in the environment and promotion of the social and emotional well-being of youth. Resnick et al. (1997) suggested that academic failure and dropout are related to the development of anti-social behavior traits and emotional difficulties. Additionally, these authors indicated that increased levels of family and school attachment served as protective factors against behavior and emotional problems, indicating the importance of schools on emotional functioning (Resnick et al., 1997).

History of Mental Health Initiatives in Schools

School mental health services in the United States have their earliest roots in the late 1800s. During that time, known as the Progressive Era, the number of students in schools grew (Fagan, 2000). Schools were called upon to address issues that had previously been addressed at home such as mental health (Flaherty & Osher, 2003). During that time, the providers of mental health services were known as "visiting teachers," now known today as school social workers. Their role at the time was to prevent illness among youth with emotional and behavior difficulties (Sedlak, 1997).

Also during this time new organizational conceptualizations emerged. Granville Stanley Hall created the Child Study Team in the 1880s. This entity viewed learning as a child-centered activity versus a teacher-centered activity. The first U.S. psychological clinic serving to address students' difficulties in school was founded by Lightner Witmer in 1896 at the University of Pennsylvania. Together, these developments led to the evolution of the child guidance clinic which incorporated individual treatment and

collaboration among schools and community agencies (Fagan, 2000). The changes made during this time laid the groundwork for the future evolution of mental health in schools.

In the 1950s and 60s, public concern increased about the deficiency of mental health services. The Community Mental Health Centers Act of 1963 was created with an emphasis on mental health services in the community (Flaherty & Osher, 2003). At that time, the goal of mental health consultation to schools changed from assessment and treatment to working with the system as a whole. Prevention of mental health illnesses was seen as an ultimate goal by community mental health centers and schools were viewed as a place to implement prevention activities. The development of community mental health centers helped lead the way for future school-based mental health centers (Flaherty & Osher, 2003).

During the 1980s, comprehensive health services were established in schools in the form of school-based health centers that grew out of public health clinics (Flaherty & Osher, 2003). The movement to establish these centers in schools began with a need to address general concerns about adolescent health, with emphasis on psychological and educational risks associated with adolescent pregnancy and parenting. Nearly 20% of visits to these centers were related to mental health issues, establishing the need to expand health services to include mental health services (Lear, Gleicher, St. Germaine, & Porter, 1991).

In 1987, there were about 150 school-based health centers in middle and high schools in the United States and by 2002 there were about 1498 school-based health centers (Center for Health and Health Care in Schools, 2003; Dryfoos, 1988) offering an array of services to students. The staff of these school-based mental health centers varied

from school psychologists, social workers, counselors, clinical psychologists, and psychiatrists (Brown & Bolen, 2003). As school-based health centers expanded, there was a widespread recognition that mental health services were necessary to address problems of children and adolescents via the development of school-based mental health services (Flaherty, Weist, & Warner, 1996). In 2006, approximately 13.6% of districts nationwide had at least one school-based health center that offered mental health services to students (Brener et al., 2007) according to the School Health Policies and Programs Study 2006.

In New Jersey, the School-Based Youth Services Program (SBYSP) was developed in 1988 as the first statewide effort in the U.S. to put comprehensive services (including mental health) in secondary schools. Mental health services, including individual counseling, group counseling, and substance abuse counseling, are the most frequently used services in the program (Dolan, 1992). SBYSP now operates in 69 high schools, 18 middle schools, and 5 K-8 schools in urban, suburban, and rural New Jersey school districts to provide youth and families with comprehensive services on a "one-stop shopping" basis (Warren & Fancsali, 2000).

Similar mental health programs created to simulate community mental health clinics are now provided in schools throughout the U.S. in many other cities, such as Baltimore, Maryland, Denver, Colorado, New Haven, Connecticut, New York, New York, and Memphis, Tennessee (Flaherty et al., 1996). Additionally, collaborative school mental health training initiatives have developed such as the Center for School Mental Health Assistance at the University of Maryland, the Center for Mental Health in Schools at UCLA, Ohio Mental Health Network for School Success, New Mexico School Mental

Health Initiative, IDEA Partnership, School Mental Health Alliance, International Alliance for Child and Adolescent Mental Health and Schools (Paternite, 2005). These programs and training initiatives targeting integration of mental health services into schools are in alignment with recent reports and recommendations at the federal level.

National Reform and Policies on School Mental Health Services

The increased growth of school-based mental health services has been facilitated by numerous federal and professional initiatives. Recent national reforms have indicated there is federal support for an alignment between education and mental health. In particular, educational reform has heightened focus on accountability, outcomes, early intervention, and flexible learning supports (Lachat, 2001). State and federal mandates have required schools to increase their effectiveness. While schools are not responsible for meeting students' every need, they are responsible when the need directly impacts their learning (Carnegie Council Task Force on Education of Young Adolescents, 1989).

Public Law 94-142, the Education for All Handicapped Children Act (EHA or EAHCA) of 1975 was passed as a response to the exclusion of handicapped children from public school. The law mandated that handicapped students receive a free and appropriate education in the least restrictive environment. The law helped to strengthen schools' obligation to provide educational services to students with emotional and behavior problems, which led to expanded mental health services for students receiving special education (Thomas & Texidor, 1987). The law led to a range of agendas including full-service schools and school-based mental health programs as a means to integrate educational and mental health services.

The reauthorization of the Individuals with Disabilities Education Act (IDEA 2004) allocated funding for the use of evidence-based academic and behavioral supports. The Response to Intervention (RTI) framework developed as a response to following the IDEA mandates. RTI initiatives include a tiered framework ranging from prevention and early intervention to more targeted treatments and ongoing assessments to monitor improvement. This initiative allowed for the expansion of behavioral health services within the educational field (Reschly & Bergstrom, 2009).

The No Child Left Behind Act of 2001 emphasized accountability for academic achievement in schools, and suggested an increased use of scientifically-based programs and teaching methods. It also indicated that there is a need for "student access to quality mental health care by developing innovative programs to link the local school system with the local mental health system" emphasizing the link between schools and mental health.

The Surgeon General's Office has issued two reports that are relevant to school-based mental health. The *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* describes how mental health should be addressed for children and adolescents in the U.S (U.S. Public Health Service, 2000). The report indicated that mental health needs of children can be improved if schools and educators increase their ability to identify and respond to mental health needs, locate services in schools and coordinate with community agencies, develop a common language to describe children's mental health to facilitate service delivery, and increase the ability of parents and schools to collaborate in improving children's mental health. The report also described the importance of training school personnel to recognize and

manage mental health issues (U.S. Public Health Service, 2000). Similarly, another report issued by the Surgeon General's Office, *National Strategy for Suicide Prevention: Goals and Objectives for Action* (U.S. Public Health Service, 2001), indicated the importance of integrating suicide prevention into health, mental health, education, human service, and justice settings. It also suggested that the proportion of school districts and private schools with evidence-based programs to manage mental health issues and prevent suicide should be increased (U.S. Public Health Service, 2001).

The Policy Leadership Cadre for Mental Health in Schools (2001) emphasized that improving mental health in schools is more than expanding mental health services in schools. It indicated that improving mental health in schools should seek to make mental health in schools a multifaceted, systemic approach to strengthen students, their families, schools, and communities in a comprehensive way. The Cadre delineated a set of guidelines for implementing comprehensive mental health services in schools.

Another noteworthy report on school mental health is the President's New Freedom Commission on Mental Health (2003). This report emphasized the gaps in mental health services for children and focused attention on increasing awareness about children's mental health. The final report outlined a plan for transforming mental health service delivery by expanding and improving mental health in schools to meet the needs of youth.

Similarly, the American Academy of Pediatrics issued a *Policy Statement on School-Based Mental Health Services* (Committee on School Health, 2004) indicating that "school-based programs offer the promise of improving access to diagnosis of and treatment for the mental health problems of children and adolescents." The policy

statement also indicated that schools provide coordination of services and opportunities for prevention and intervention. The statement also included recommendations for collaboration among mental health providers, educators, and health care professionals in developing and implementing school-based mental health services (Committee on School Health, 2004).

The Mental Health in Schools Act of 2007 authorized local education agencies to use grant funding for providing comprehensive school mental health programs in schools across the U.S. This legislation resembled a public health approach and included prevention and promotion of mental health, support for positive behavioral supports, as well as targeted intervention services (Stephan, Weist, Kataoka, Adlesheim, & Mills, 2007).

In 2008, the National Association of School Psychologists (NASP) released a position statement titled *The Importance of School Mental Health Services*, which supported the notion of coordinated, comprehensive, and effective school mental health services. In the statement, NASP advocated for the importance of prevention and intervention services and school reform to eliminate barriers to students' learning. In the statement, NASP indicated that "schools are the logical point of entry for services to promote the mental health and social and emotional competence of students," and that it is cost-effective to deliver mental health services in the schools.

School Mental Health Service Delivery

In the past, school mental health services were limited mainly to assessment, consultation, and treatment services for youth (Paternite, 2005). A study by Foster et al.

(2005) has suggested that the majority of school mental health programs provide "pull-out" services to children. These services can often be time and resource intensive, in addition to taking children out of instructional time. This "clinic within schools" framework does not allow for interdisciplinary collaboration among mental health providers and educators and can really only provide services for a small percentage of youth in need of services (Baker, Kamphaus, Horne, & Winsor, 2006).

However, recent awareness of the advantages of school mental health services is being recognized and a shift has been made toward more comprehensive services and programs (Flaherty & Osher, 2003). Federal reports including the President's New Freedom Commission on Mental Health (2003), the Surgeon General (U.S. Public Health Service, 2000; U.S. Public Health Service, 2001), and the American Academy of Pediatrics (2004) have suggested some key elements of the school mental health programs: a) partnerships among schools, families, and the community; b) commitment to a continuum of mental health education, promotion of mental health, assessment, prevention, intervention, and treatment; c) services for all children and adolescents in schools, including general education and special education (Paternite, 2005).

Integration of Schools and Mental Health Services

In order to maintain the partnership between schools and mental health to address the needs of youth, it is important that individuals support an agenda that not only enhances academic learning, but also "students' social-emotional competence, character, health, and civic engagement" (Greenberg et al., 2003, p. 466). There is evidence to suggest that emotional and behavioral problems can be significant barriers to learning,

indicating a strong link between mental health and academic success (Adelman & Taylor, 2010).

Lawson and Sailor (2000) reviewed mental health programs and suggested that although there are differences among programs, they share a need to include a broader agenda beyond academic achievement. Along those lines, the UCLA National Center for Mental Health in Schools (2001) suggested a need for integration among mental health and education.

Ecological models for school mental health services can serve as a model to unify research with practice. A positive effect of an ecological model would be the identification of mental health needs would result from assessment of children in their natural setting, the school. This would indicate an emphasis on improved mental health functioning as opposed to reducing symptoms (Hoagwood, Jensen, Pett, & Burns, 1996). Along those lines, learning occurs within the social environment of the school, so promotion of social-emotional development of children can be fundamental to educational learning (Atkins et al., 2010).

Schools do put forth an effort to implement a range of programs to address social and emotional development in children (Zins, Weissberg, Wang, & Walberg, 2004). However, these efforts are often parallel to the function of the schools, as opposed to being integrated within the core function of schools (Atkins et al., 2010). Historically, school-based mental health programs, services, and mental health staff have been viewed by educational professionals as "add ons" and are not considered core to the academic purpose of schools (Sedlak, 1997). Adelman and Taylor (2010) have suggested that mental health professionals and educators are viewed as coexisting in schools with

different agendas, values, and goals. Adelman and Taylor (2010) suggested that mental health professionals and educators should seek to obtain program integration beyond cooperation, where they are cooperatively working toward shared agendas, values, and goals. Weist et al. (2005) suggested some strategies to improve integration of mental health and education such as: a) ensuring strong coordination and collaboration among families of youth, educators, and mental health professionals; b) ensuring mental health professionals have proper training, supervision, and understand how to be a collaborative member within the culture of the school; c) ensure mental health services are evidence-based; d) position school mental health services as a way of reducing barriers to learning to promote academic success; e) collect data to support the outcomes of services being valuable to youth, their families, and their schools.

School-wide programs promoting mental health and social emotional learning can serve as a natural foundation that individualized programs can be developed from, as a way of reducing stigmatization when individualized programs are implemented in isolation (Kratochwill, 2007). Another school-wide approach is the Positive Behavior Intervention and Supports (PBIS; Lewis and Sugai, 1999) initiative. This model includes a tiered framework of universal, targeted, and intensive levels of support with the goal of improving student behavior and learning. With this model, mental health providers are able to work within the universal program at the different levels to most effectively meet student needs.

By conceiving mental health as part of the supports necessary for student learning, schools will better be able to address the goals and mission. This will also aid in

enhancing availability of resources, access to resources, and improve effective use of resources (Adelman & Taylor, 2004).

Outcomes of School Mental Health Services and Programs

School mental health services and programs provide an increased accessibility to students compared to the traditional mental health care setting. That is, some barriers to receiving services are not present, such as transportation, child care, and clinical inefficiency (Stephan et al., 2007). Also, there is reduced stigma associated with seeking mental health services, and the opportunity to promote generalization and maintenance of treatment gains (Evans, 1999).

Along with the advantages that school mental health services offer, evidence indicates that school mental health services and programs have positive effects on student, family, and school outcomes. The services have been associated with decreased emotional and behavioral problems, decreased discipline referrals, decreased special education referrals, improved pro-social behavior, increased family engagement, and improved school climate (Foster et al., 2005, Stephan et al., 2007; Bruns, Walrath, Glass-Siegel & Weist, 2004). School-based mental health services have also resulted in improvement in emotional and behavioral functioning of adolescents over time (Nabors & Reynolds, 2000).

Although schools may be considered the dominant provider of mental health services for children and adolescents (Farmer, Burns, Phillips, Angold, & Costello, 2003), there is limited research on specific services that are provided under the umbrella of mental health services and their effectiveness on current school performance (Rones &

Hoagwood, 2000; Kutash, Duchnowski, & Lynn, 2006). Additionally, there are mixed findings in terms of mental health services on academic outcomes. Recent educational literature has suggested that there is a reciprocal relationship between the academic functioning of children and adolescents and their social-emotional needs (Zins et al., 2004). However, a review by Hoagwood et al., 2007) has suggested the effects of mental health interventions on academic outcomes are modest and are often not sustainable. The impact of school mental health services on school performance has been poorly understood as educationally relevant outcomes in research are very limited, in part because there is limited variety and quality of academic measures used in researched studies (Hoagwood et al., 2007).

Previous research has suggested that several factors of the implementation of mental health programs are influential on the programs' outcomes. These factors include the culture and climate of the school, the cooperation of school leaders, availability of funding, and fidelity to the program (Rones & Hoagwood, 2000). Additionally, appropriate program facilitation included some successful strategies, including communication to staff of program goals, rationale and components, feedback on the effects of the program, plans to overcome barriers to implementation, and designation of individual responsibilities (Gottfredson, Gottfredson, & Hybl, 1993). Additionally, successful mental health program implementation also included specific expectations, creativity by individual schools, and ongoing feedback, consultation, and support to educators (Rones & Hoagwood, 2000). Just as successful program implementation can result in successful outcomes, poor implementation can impede program impacts (Rones & Hoagwood, 2000).

Interventions with the strongest evidence were considered those aimed at changing specific behaviors or improving skills (Rones & Hoagwood, 2000). Additionally, the use of multiple approaches to change behavior was linked to positive program effects (Rones & Hoagwood, 2000).

Rones and Hoagwood (2000) also suggested that program success was associated with the integration of mental health programs and services within the classroom curricula. Specifically, when mental health programs were delivered as an integral part of a school curriculum as opposed to a separate, targeted lesson, more positive outcomes resulted, indicating mental health services and programs need to be integrated within the school routine (2000).

Nabors and Reynolds (2000) examined the challenges in looking at outcome data of school mental health services and programs. The complexities and differences among mental health programs make comparisons of outcome data difficult. They found that outcome evaluations of school mental health programs are still in their infancy and tend to emphasize the short term impact of services on individuals. Future research may need to shift to explore long term impacts also. They suggest that outcome data should continue to be collected to build to the existing evidence base so over time, determinations can be made with more precision as to what types of services and programs are most effective in meeting mental health needs of youth. Also, continued program evaluation data can help to sustain programs, and possibly increase funding (Nabors & Reynolds, 2000).

Best Practices for School Mental Health Services

Despite many guidelines, standards and policies, there is not one best-practice model for school-based mental health programs and services (Paternite, 2005). Not all mental health services can be provided within the school. Mental health providers working in schools must collaborate with outside professionals to ensure that students receive the appropriate services they need. The UCLA Center for Mental Health in Schools suggests school staff should work in collaboration with families and providers of mental health services to create an integrated continuum of services to meet the needs of students (Adelman & Taylor, 2010).

While it has been suggested that the integration of mental health and education is the goal of many mental health professionals and educators, there is not a consensus on the optimal way to integrate these fields. Effective and efficient models for integrating promotion of mental health, prevention, and intervention within the ongoing practices of academic learning are still needed going forward. Adelman and Taylor (2010) suggest that in order to most effectively address the barriers to learning, schools need to integrate resources as part of a continuum of prevention and intervention services. It is critical to involve school-based professionals in the planning, implementation, evaluation, and sustainment phases of improving school mental health practices, based upon individual population's needs (Paternite, 2005).

Adelman and Taylor (2010) have proposed that comprehensive and multi-faceted school-wide approaches are part of initiatives to make schools part of systems of care. Schools are restructured so that student support services are woven together with instructional strategies, learning supports, and community resources. Efforts to promote

positive, healthy development, along with intervention services are part of a three-tiered approach that emphasizes the mental health needs of all students (Adelman & Taylor, 2010).

Difficulties in Advancing the Field Forward

Despite national initiatives such as the reports of the Surgeon General (U.S. Public Health Service, 2000) and the President's New Freedom Commission on Mental Health (2003), mental health services in schools still remain marginalized (Taylor & Adelman, 2004; Weist, 2005). Weist, Goldstein, et al. (2003) described how mental health services in schools can consist of limited evaluation and treatment services primarily for youth being referred for special education, and that schools have poor links to community mental health resources. Rones and Hoagwood (2000) suggested that the majority of school-based mental health programs are not supported by research and are not systematically evaluated, which can compromise advocacy and policy enhancing efforts (Weist, 2005).

Federal initiatives call for a public mental health promotion approach to address the mental health of youth in the U.S. The public mental health approach, a model used by the World Health Organization and other groups, is a tiered model of service delivery, including broad mental health promotion (primary prevention), mental health prevention and early intervention (secondary prevention), and treatment of severe mental health problems (tertiary prevention; Rowling & Weist, 2004). However, the majority of mental health services are provided to individuals with serious mental health problems and there

are significant gaps in the services that are provided (President's New Freedom Commission, 2003; U.S. Public Health Service, 2000).

Current Practices of School Mental Health Services

Brener et al. (2007) reported on the School Health Policies and Programs Study 2006 and discussed the discrepancy among current practices for school mental health services and programs. Although an integrated model of service delivery has been recommended, current practices often do not align with this model. Most school districts have a range of services and programs for student needs. Some school districts may implement mental health service delivery district-wide, whereas other districts may only deliver mental health services within specific schools. Some programs are delivered by school-employed professionals, such as school psychologists, school counselors, and school social workers. Other programs may be delivered in conjunction with community agencies. In some schools and districts, interventions are for all students, whereas in other schools or districts, interventions may only be for targeted students, or those considered at-risk (Brener et al., 2007). Despite the amount of mental health services being provided, it has been suggested that the implementation and evaluation of services is fragmented and marginalized (Adelman & Taylor, 2010).

The first national survey related to mental health in the schools was reported in *School Mental Health Services in the United States, 2002-2003* (Foster et al., 2005). The study sampled approximately 83,000 public elementary, middle, and high schools to determine the most frequently occurring mental health problems and the services delivered, types of arrangements for service delivery, type of staff providing services, and

issues relating to funding of mental health services. The key findings of the study suggested that nearly 73 percent of schools indicated that social, interpersonal, or family problems were the most frequent mental health issues for both male and female students. Both general education and special education students were eligible to receive mental health services in approximately 87 percent of schools. Nearly all schools had at least one staff member who was responsible for providing mental health services to students, and the most common school mental health providers were school counselors, nurses, school psychologists, and social workers. Schools reported that the most common funding sources were the Individuals with Disabilities Education Act (IDEA 2004), state education funds, local funds, and Medicaid. The findings suggested that schools are addressing some of the mental health issues of students, but also that there is an increased need for mental health services in schools (Foster et al., 2005).

Brener et al. (2007) conducted a more recent study to investigate the characteristics of school mental health and social services in the U.S. They suggested that states and local school districts generally do not have policies indicating that schools will provide mental health services. However, they found that approximately 77.9% of schools employed at least a part-time school counselor as a mental health service provider. Fewer schools (61.4%) had at least a part time school psychologist who provided mental health services, and approximately 41.7% of schools had at least a part-time school social worker who provided mental health services to students (Brener et al., 2007). Approximately more than 75% of schools provide counseling for emotional or behavioral disorders, crisis intervention, identification of emotional or behavioral disorders, identification and referral for students with family problems, and stress

management programs (Brener et al., 2007). Only about 13.6% of schools nationwide had a school-based health center that provided mental health services, but almost 50% of schools had an agreement with a mental health provider not located on school property (Brener et al., 2007). Brener et al. (2007) provided positive data supporting the need and prevalence of school mental health services, however, more recent and specific information is needed on how schools are addressing mental health needs of children and adolescents (Brener et al., 2007).

To investigate specifically how schools are addressing mental health needs of youth in central New Jersey, the current study aimed to investigate current practices in central New Jersey. The current study interviewed Directors of Special Education to determine who are providers of mental health services, what types of mental health services are offered, which services and programs are most effective, and what still needs to be in place to meet students' mental health needs.

CHAPTER III

METHOD OF INVESTIGATION

Interviews with a sample of Directors of Special Education (or equivalent

position) in central New Jersey were conducted in order to obtain information regarding

current practices of mental health services in New Jersey public schools.

Participants

Seven Directors of Special Education or an equivalent position were chosen from

24 possible school districts within two counties in central New Jersey. The Director of

Special Education (or individual of equivalent position) at the district level is the

individual who oversees special education and mental health services for school districts.

Six of the participants represented K-12 school districts, and one participant

represented a K-8 school district. Three of the participants represented districts with

sending/receiving relationships, meaning districts will send some or all of their students

to another school district as a means of financial saving for districts. Two of the

participants represent districts that accept students from other districts at the high school

level, while one of the participants represents a district that sends students to a high

school in a different district.

Participants represented districts of various sizes of enrollment (small = <1,500;

medium = 1,501-6,000; large = 6,001-10,000; very large = >10,000). Table 1 provides

the breakdown of participating districts and the size of their districts. Enrollment data

were obtained from the National Center for Education Statistics (2011).

Table 1

Participating district by district size

District	Small	Medium	Large	Very Large
A			x	
B			x	
C	x			
D		x		
E		x		
F				x
G	x			
Total	2	2	2	1

Setting

County Demographics

The county (County A) that employs the six out of the seven of the study's participants is located in central New Jersey. It is approximately over 300 square miles and contains 24 municipalities. According to the U.S. Census Bureau (2011a), this county's population was approximately 809,858 in 2010, making it the second most populated county of the 21 counties in New Jersey. The approximate 2010 demographic information on the county's population is as follows: White, Non-Hispanic: 49.2%; Asian: 21.4%; Hispanic or Latino: 18.4%; Black: 9.7%; American Indian or Pacific Islander: 1.3%. Approximately 39.5% of the county's population speaks a language other than English at home and approximately 29.4% of the population is estimated to be foreign born (U.S. Census Bureau, 2011a). County A was chosen because it is a representation of the state's population.

The county (County B) that employs one of the seven of the study's participants is also located in central New Jersey. It is approximately over 220 square miles and contains 13 municipalities. According to the U.S. Census Bureau (2011b), the county's population was approximately 366,513 in 2010. The 2010 demographic information on the county's population is as follows: White, Non-Hispanic: 54.5%; Black: 20.3%; Hispanic or Latino: 15.1%; Asian: 8.9%; American Indian or Pacific Islander: 1.2%. Approximately 26.2% of the county's population speaks a language other than English at home and approximately 19.7% of the county's population is estimated to be foreign born (U.S. Census Bureau, 2011b).

District Factor Grouping

Each of New Jersey's school districts has a District Factor Grouping (DFG) category which is based on 2000 census data and is determined by the socioeconomic status of the districts. There are six factors used to determine a DFG category: Percent of adults with no high school diploma, percent of adults with some college education, occupational status, unemployment rate, percent of individuals in poverty, and median family income (New Jersey Department of Education, 2004).

There are eight DFG categories (A, B, CD, DE, FG, GH, I, and J). Districts with the lowest socioeconomic status are classified as DFG A, while districts with the highest socioeconomic status are classified as DFG J.

The participants in the study represented districts from DFG DE-J. Table 1 illustrates the breakdown of participants by DFG.

Table 2

Number of participants by DFG

DFG	Participants
A	0
B	0
CD	0
DE	1
FG	1
GH	2
I	2
J	1

County Educational Information

County A is home to 24 public school districts and two charter schools. According to the National Center for Education Statistics (2011), County A enrolled approximately 111,400 students in 172 public primary and secondary schools during the 2009-2010 school year. The mean district enrollment in 2009-2010 was approximately 4,432 students per district, with a maximum enrollment of approximately 14,277 students per district and a minimum enrollment of approximately 668 students per district (National Center for Education Statistics, 2011).

County B is home to nine public school districts and nine charter schools. The National Center for Education Statistics (2011) reported that County B enrolled approximately 62,781 students in 215 public primary and secondary schools during the 2009-2010 school year. The mean district enrollment in 2009-2010 was approximately 6,395 students per district, with a maximum enrollment of approximately 13,013 students per school district and a minimum enrollment of approximately 2,761 students per district (National Center for Education Statistics, 2011).

Procedures

Recruitment Procedures

All 24 Directors of Special Education from County A were e-mailed by the County Supervisor of Child Study in April 2011 an overview of the proposed study and were invited to respond to this investigator if interested in participating. Participants were notified that prior to participating in the interview, a letter of permission from a school administrator (i.e.: Superintendent) would be required to grant permission to conduct the interview at their offices of employment.

Of the 24 Directors that were e-mailed, two volunteered to participate. The remaining 22 Directors were sent a follow-up e-mail regarding participation in the study. Of the 22 that were e-mailed, five additional Directors volunteered to participate. One director from County B was contacted by this investigator directly to participate in the study because a participant from County A is part of a sending-receiving relationship with the district in County B. Of the eight volunteers, only seven returned a letter of permission from a school administrator.

Once letters of permission from a school administrator were received, in person interviews were scheduled via e-mail or phone at participants' place of employment during May and June 2011.

Interview Protocol Development

The interview protocol was developed from previous research, including the School Health Policies and Programs Study (Brener et al., 2007), which is currently the most comprehensive assessment of school health programs in the U.S. The interview

protocol was developed to obtain qualitative information regarding school mental health services and can be found in Appendix C. The interview also includes two checklists that can be found in Appendixes D and E.

Data Collection

Individual interviews took place at participants' office of employment and lasted 20 to 50 minutes. Before the interviews took place, participants were asked to sign an informed consent form (Appendix A) and an audiotape addendum to the consent form (Appendix B) to grant permission to audio record the interviews. Interviews were administered by this investigator using the interview protocol (Appendix C). Participants completed the Checklist of School Mental Health Services (Appendix D) and the Checklist of Collaboration (Appendix E) as indicated in the interview protocol. Although the interview protocol was used for each interview, this investigator asked additional follow-up questions on an individual basis to clarify responses. Some participant responses answered more than one research question.

Data Analysis

All interviews were transcribed verbatim for purposes of qualitative analyses. Each transcribed interview was labeled with a participant code and contained no personal or identifying information. The data were aggregated so no individual or school district was able to be identified in the results.

Transcribed interviews were reviewed by this investigator three times. Each time transcriptions were read, the investigator made notes to describe the content. Notes were

aggregated and summarized question by question in order to identify similarities and differences. Common themes were identified through qualitative content analysis and will be discussed in the following chapters.

CHAPTER IV

RESULTS

The purpose of the following qualitative analysis was to identify common themes from the interviews and discuss how the results reflect current mental health practices in school mental health. All seven participants responded to each of the questions included in the analysis. The results are presented in a more concise format than the interview protocol for analysis purposes.

Question 1. *Does this school district have a school-based mental health center that offers mental health services to students?*

- 28.6% of participants reported their district has a school-based mental health center.

- 71.4% of participants reported there is not a school-based mental health center in their district.

Question 2. *Is there someone in this district designated to coordinate/oversee mental health services?*

- 57.1% of participants reported they as the Director of Special Education, or similar version of this title were responsible for coordinating and overseeing mental health services in their district.

- 42.9% of participants reported that as the Director of Special Education, they have involvement in the coordination/oversight of mental health services, but this responsibility is shared with other professionals, such as

the Assistant Superintendent, the Director of Guidance, and the Supervisor of Student Services.

Question 3. *Who provides school mental health services?*

Participants listed the following individuals as providers of school mental health services:

- School counselor
    - 100% of participants reported that mental health services are provided by School Counselors.
- Clinical Psychologist
    - 57.1% of participants reported that mental health services are provided by a Clinical Psychologist.
- School Psychologist
    - 85.7% of participants reported that mental health services are provided by a School Psychologist.
- School Social Worker
    - 100% of participants reported that mental health services are provided by a School Social Worker.
- Counselor
    - 28.6% of participants reported that mental health services are provided by a Counselor receiving doctoral supervision.
- Behaviorist or similar version of this title

- o 71.4% of participants reported that mental health services are provided by a Behaviorist or a version of this title.

- Student Assistance Counselor or similar version of this title
  - o 85.7% of participants reported that mental health services are provided by a Student Assistance Counselor or a version of this title.

- Dean of Students
  - o 14.3% of participants reported that mental health services are provided by a Dean of Students.

- Consulting psychiatrist
  - o 14.3% of participants reported that mental health services are provided by a consulting psychiatrist.

- Consulting behaviorist
  - o 14.3% of participants reported that mental health services are provided by a consulting behaviorist.

Question 4. *How many professionals provide mental health services in this district?*

Table 3 illustrates the number of service providers in each of the seven districts that were surveyed. Table 4 illustrates the number of students enrolled in each of the seven districts that were sampled. Table 5 illustrates the ratio of service providers to students in each of the seven districts that were surveyed.

Table 3

Number of service providers by school district

Service Provider	District A	District B	District C	District D	District E	District F	District G
School Counselor	21	33	5	19	14	17*	1
Clinical Psychologist	1	0	1	2	1	0	0
School Psychologist	8	9*	2	9	6	10	1
School Social Worker	8	9*	1	5	6	10	1
Counselor	6	0	6	0	0	0	0
Behaviorist	1	0	1	2	1*	1	0
Student Assistance Counselor	1	1	1	1	1	1	0
Dean of Students	0	0	0	0	1	0	0
Consulting Psychiatrist	0	1	0	0	0	0	0
Consulting Behaviorist	0	0	0	0	0	0	1

Note. * Indicates approximate number.

Table 4

Number of students enrolled per district

Service Provider	District A	District B	District C	District D	District E	District F	District G
Students Enrolled	7,190.5	8,517.5	1,451.0	5,649.0	3,396.0	13,032.0	586.0

Note. Enrollment data provided by New Jersey Department of Education (2010).

Table 5

Ratio of students to service provider

Service Provider	District A	District B	District C	District D	District E	District F	District G
School Counselor	342	258	290	297	243	Unknown	586
Clinical Psychologist	7,191	N/A	1,451	2,825	3,396	N/A	N/A
School Psychologist	899	Unknown	726	628	566	1,303	586
School Social Worker	899	Unknown	1,451	1,130	566	1,303	586
Counselor	1,198	N/A	242	N/A	N/A	N/A	N/A
Behaviorist	7,191	N/A	1,451	2,825	Unknown	13,032	N/A
Student Assistance Counselor	7,191	8,518	1,451	5,649	3,396	13,032	N/A
Dean of Students	N/A	N/A	N/A	N/A	3,396	N/A	N/A
Consulting Psychiatrist	N/A	8,518	N/A	N/A	N/A	N/A	N/A
Consulting Behaviorist	N/A	N/A	N/A	N/A	N/A	N/A	586

Note. Number of students enrolled from Table 4.

Question 5. *Indicate which types of mental health services are available in your school.*

All services that were indicated as available were also indicated as ongoing. The actual providers of services and programs varied based on district, and individual schools within each district.

- Assessment for emotional or behavioral problems

  o 100% of participants reported assessment services are available in their school district.

- Behavior management consultation

  o 100% of participants reported behavior management consultation is available in their school district.

- Case management

  o 100% of participants reported case management is provided in available in their school district.

- Referral to specialized programs

  o 100% of participants reported their district makes referrals for specialized programs or services.

- Crisis intervention

  o 100% of participants reported crisis intervention services are available in their district.

- Sudden traumatic event counseling

  o 100% of participants reported their district provides sudden traumatic event counseling.

- Individual counseling

- o 85.7% of participants reported that individual counseling is available in their district.

- Group counseling

    - o 100% of participants reported that group counseling is available in their district.

- Substance abuse counseling

    - o 85.7% of participants reported that substance abuse counseling is available in their district.

        - The one participant who reported that substance abuse counseling is not available is from a district that only includes kindergarten through eighth grade.

- Family counseling services

    - o 71.4% of participants reported that family counseling services are available in their district.

        - One of the participants who reported that family support services are not available in their district indicated that outside referrals are made for family support services.

- Job readiness skills programs/services

    - o 71.4% of participants reported that job readiness skills programs/services are available in their district.

        - One of the participants who reported that job readiness skills programs/services are not available in their district

available is from a district that only includes kindergarten

through eighth grade.

- Student mental health education

    o 71.4% of participants reported that student mental health education

    is available in their district.

- Violence prevention programs

    o 71.4% of participants reported that violence prevention programs

    are available in their district.

- Alcohol/drug abuse prevention programs

    o 100% of participants reported that alcohol/drug abuse prevention

    programs are available in their district.

- Dropout prevention programs

    o 57.1% of participants reported that dropout prevention programs

    are available in their district.

- After-school counseling programs

    o 57.1% of participants reported that after-school counseling

    programs are available in their district.

Question 6. *Is there backup or after hours coverage for school mental health services?*

- 28.6% of participants reported their district offers additional after hour

coverage for school mental health services.

    o 100% of participants with after hour coverage also have a school-

    based mental health center in district.

Question 7. *Describe the collaboration that occurs among mental health service providers*.

- 42.6% of participants reported that collaboration takes place at Child Study Team meetings and Intervention and Referral Services meetings.
- 28.6% of participants reported that collaboration takes place at staff meetings.
- 14.3% of participants reported that e-mail is a tool utilized for collaboration.
- 14.3% of participants indicated that collaboration depends on the individuals involved and their collaboration style.

Question 8. *Describe the district's staff development on the issue of mental health*.

- 42.9% of participant's responses were related to district-wide suicide prevention for all staff that takes place on an annual basis.
- 57.1% of participants indicated their district provided staff development relates to students' behavior.
  - 42.9% of participants reported that de-escalation was a topic of staff development.
  - 14.3% of participants reported that conducting functional behavior assessments and behavior intervention plans were topics of staff development.
- 28.6% of participants reported their district provided staff development on the topic of bullying.

- 28.6% of participants reported their district provided staff development on specific student mental health issues.

- 14.3% of participants indicated they were unaware of the staff development taking place district-wide as it relates to mental health. This participant was only aware of the staff development done within their department.

- 14.3% of participants reported that there was not any ongoing professional education provided to the staff by the district and that staff members sought out professional development opportunities independently outside of the district.

- 28.6% of participants reported staff development takes place at staff meetings.

- 57.1% of participants reported that staff development takes place at in-services.

- 28.6% of participants reported staff development and trainings are provided to staff members by outside behavioral consultants.

Question 9. *How do individuals learn about available mental health services and programs?*

- 14.3% of participants reported their district does not provide written descriptions of their mental health programs and services.

- 42.9% of participants reported their districts provide written descriptions for students, staff and parents.

- 42.9% of participants reported information about mental health programs and services is available in student handbooks.

- 42.9% of participants reported information about mental health programs and services is available through their district website.

- 14.3% of participants reported their district provides parent trainings to discuss mental health programs and services that are available within the district.

Question 10. *What is the referral process for students to gain access to mental health services?*

- 42.9% of participants reported that students are referred for mental health services by the school counselor.

- 42.9% of participants that students are referred for mental health services by the Intervention and Referral Services committee.

- 28.6% of participants reported that students are referred for mental health services by the school psychologist.

- 14.3% of participants reported that students are referred for mental health services by the behavior specialist.

Question 11. *What community agencies does your district have a formal relationship with?*

Participants listed various local agencies ranging from universities, mental health clinics, state agencies, counseling services, and substance abuse services. Of the ten agencies that were named:

- 20% were state universities

- 20% were inpatient/outpatient mental health treatment centers

- 10% were statewide child protection agencies

- 10% were behavioral health managed care agencies

- 10% were community counseling agencies

- 10% were outpatient substance abuse agencies

- 10% were agencies promoting health and wellbeing

- 10% were statewide agencies for inclusive education

Question 12. *Indicate if your school district collaborates with community agencies for the following services:*

(Collaboration refers to communication between the school district and the agency or referrals.)

- Mental health clinic services

  o 85.7% of participants reported that their district collaborates with community agencies for mental health clinic services.

- Counseling

  o 100% of participants reported that their district collaborates with community agencies for counseling services.

- Crisis hotlines

    - 42.9% of participants reported that their district collaborates with community agencies for crisis hotline services.

- Substance abuse

    - 100% of participants reported that their district collaborates with community agencies for substance abuse services.

- Violence prevention

    - 71.4% of participants reported that their district collaborates with community agencies for violence prevention services.

- Gang alternatives

    - 42.9% of participants reported that their district collaborates with community agencies for gang alternative services.

- Pregnancy prevention

    - 28.6% of participants reported that their district collaborates with community agencies for pregnancy prevention services.

- Child abuse/domestic violence prevention

    - 85.7% of participants reported that their district collaborates with community agencies for child abuse/domestic violence prevention services.

Question 13. *How are school mental health services and programs in your school funded?*

- 100% of participants reported that mental health services and programs are funded by district funds.

- 85.7% of participants reported that mental health services and programs are funded by federal, state, or county grants.

- 28.6% of participants reported that mental health services and programs are funded by federal funds.

Question 14. *In your opinion, which programs and services are most effective?*

The following were responses articulated by the individual participants.

1. The district-wide developmental counseling program and the school-based mental health center.

2. The Student Assistance Counselors, School Psychologists, and social skills instruction.

3. The school-based mental health center and the elementary social problem solving curriculum.

4. Building-based school-psychologist, school counselor, and social worker in every school to address concerns immediately, behavior specialists to follow on implementation and treatment integrity, and staff programs and staff trainings.

5. Services of school psychologists and Intervention and Referral Services team, and open communication among staff and students.

6. The expertise of the Child Study Team members in assessing the needs of the child and finding ways to meet the needs, and the communication among staff members.

7. Key individuals such as the behavior consultant and the school social worker, and the school crisis committee.

Question 15. *Are there gaps that still need to be filled to meet the mental health needs of students?*

100% of participants indicated there are still gaps that need to be filled to meet the mental health needs of students. Below are summaries of individual participant responses with the gaps that need to be filled:

- Need to change children's behavior or help them develop skills.

- Need for more parent education and family support, need for more assistance, and transitioning to school from out-of-district programs.

- Lack of primary prevention.

- Need for more staff understanding of mental health needs, and meet needs of alternative education students.

- Need for more primary prevention at the middle school level.

- Need for more education for administrators and new teachers about children who have mental illnesses or emotional problems.

- More primary prevention and a proactive approach on behavior issues and mental health issues, and a need for better collaboration among staff.

Question 16. *How would you fill the gaps to meet the mental health needs of students?*

Several participants had multiple responses. Below is a list of responses:

- 42.9% of participants indicated more primary prevention as a way of meeting
  needs. These responses were:
  - o Place school psychologists in every building to serve as change agents
    by providing behavioral intervention and teacher consultation.
  - o More primary prevention to promote mental health education and
    awareness, and creating a positive supportive environment.
  - o Shift focus from academics to recognize the social, emotional, and
    behavioral welfare of children to have more preventative services in
    place.
- 42.9% of participants indicated that more training as a way of meeting needs.
  These responses were:
  - o More parent training, more intensive services to prevent relapses.
  - o More staff training on student mental health needs, and alternative
    education program within district.
  - o Ongoing professional development for administrators and teachers to
    address mental health issues of students.
- 14.3% of participants indicated an expansion of existing services would help
  meet mental health needs. This response was:
  - o Expand support services for students experiencing mental health issues
    from the high school to the middle school level.

Summary

In sum, all participants indicated that mental health services are provided within their school district. Only two of the seven participants have a school-based mental health center that provides mental health services. The majority of the directors indicated that mental health services are provided by mental health professionals, including school counselors, school social workers, school psychologists, counselors, and behaviorists. The number of service providers directly relates to the size of the district. The majority of participants reported mental health services provided include assessment, behavior management consultation, case management, referral to specialized programs, crisis intervention, individual and group counseling, and alcohol/drug abuse prevention programs. The majority of participants reported that staff development on the issue of mental health relates to students' behavior. Participants reported that the majority of individuals in their district learn about mental health services by written descriptions, student handbooks, and through the district website. The majority of participants indicated that mental health services are funded through district funds and grants. All participants reported that there are still gaps in meeting mental health needs of students. The majority of participants felt their districts needed more primary prevention and more staff training as a means to filling these gaps.

CHAPTER V

DISCUSSION

Interpretation of the Findings

The primary purpose of the current study was to examine current practices of mental health services in New Jersey public school districts. Information was obtained regarding current services, programs, service providers, and funding through individual interviews with from Directors of Special Education or individuals of equivalent positions. A qualitative content analysis was conducted on a question by question basis through intensive review of each answer. The following discussion summarizes key findings and common themes of the interviews. Limitations, future directions for research, and implications for school psychologists are also discussed.

Participants

All of the participants (100%) identified themselves as a Director of Special Education as having some part in overseeing and coordinating the mental health service delivery for their district. The majority of participants (57.1%) indicated that they were the one individual responsible for overseeing these services while the rest of the participants indicated that their responsibility is shared with some other professionals in their district.

This suggests that mental health delivery is linked to the department of Special Education in most districts. Directors of Special Education tend to have many responsibilities as part of their role, including implementation and delivery of special education programs and services and supervision of child study teams, in addition to mental health services. Mental health services, such as counseling, can be mandated as a

related service in an Individualized Education Plan for students eligible for special education and related services.

Some of the participants have a professional background in mental health as school psychologists or school social workers from their previous employment before being Director of Special Education. However, the position of Director of Special Education does not require individuals to have a background in mental health and some directors may not have specific training in mental health.

Mental Health Service Providers

School counselors and school social workers provided mental health services in 100% of participant's school districts. School psychologists also provide mental health services in a majority (85.7%) of districts. However, in 6 out of the 7 districts, school psychologists and school social workers only provide mental health services to students eligible for special education and related services. In those districts, students who are not eligible for special education and related services are provided mental health services by school counselors.

Despite the fact that job titles, such as School Counselor, may indicate that an individual has knowledge of mental health, there is not a credential requirement for mental health-related positions in schools. The training among mental health professionals varies greatly. One participant described this phenomenon and while referring to the training of mental health providers said, "Are they really trained to provide mental health services? If you have a licensed psychologist, yes they have training. But even a school psychologist may get two classes on counseling, a group and

individual course in process, and some training in some theoretical models, but you don't really understand and know how to work with people with severe mental health illnesses. The guidance counselors have very little training. They get a couple of classes in counseling, so to call it mental health, is it really appropriate to call it mental health services?" This speaks to some of the disparity within the field of school mental health in terms of the training of the providers, and to what extent the services being provided are really reflective of school mental health service delivery best practices.

As expected, the number of mental health service providers in each district was dependent on the size of the district as indicated in Table 3. The smallest districts had the fewest number of mental health service providers, while the district that was labeled as very large had the most mental health service providers. This indicates that the number of mental health professionals in each district is dependent on the student enrollment. The ratio of school counselor to students was somewhat consistent across district size. In the small districts was 1 to 290 and 1 to 586. In medium size districts, the ratio ranged from 1 to 243 to 1 to 297. The large districts had a ratio of 1 to 258 to 1 to 243. The ratio was much more discrepant for more specialized positions, such as clinical psychologists and behaviorists. For example, of the districts that employed clinical psychologists, the ratio of clinical psychologists to students was 1 to 1,451 and ranged to 1 to 7,191. Of the districts that employed or contracted behaviorists, the ratios of behaviorists to students ranged from 1 to 586, to 1 to 1 to 13,032. This suggests that some of the more specialized mental health service providers are employed to work with students with more severe mental health needs because they would not efficiently be able to serve the entire student population.

Current Practices of Mental Health Service Delivery

Participants described a variety of mental health services that were provided within their districts. Mental health assessment, consultation for behavior management, case management, and counseling were the most common types of services offered. Some of the more developmentally dependent mental health services, such as substance abuse counseling, job readiness skills programs, and dropout prevention programs were less common types of mental health services. Part of this may be due to the fact that one of the participants represented a K-8 school so the need for some of these services is not present at that developmental level. Although many services are being provided, the actual types of treatments and programs being utilized are not known.

Consistent with previous research, the majority of the mental health services that participants indicated are provided in their districts are considered to be "pull-out" services (Foster et al., 2005). That is, children are taken out of instructional time to receive mental health services as opposed to being integrated within the core function of the school.

Two of the seven participants represented districts that had school-based mental health centers. These centers provided mental health services that extended beyond the typical school day hours to expand services to families of students, suggesting that school-based mental health centers are able to provide expanded mental health services than what is available through the school. Both of these districts employed clinical psychologists and counselors as part of the school-based mental health centers' service delivery. The services that are provided at these school-based mental health centers are

provided parallel with other school mental health services. This dichotomy supports the importance of mental health service delivery within the school.

Participants have indicated there is a range in terms of services that are provided as well as the range of professionals that are providing those services.

Communication, Collaboration, and Development among District Staff

The majority of staff collaboration for mental health issues was reported to take place at meetings (Child Study Team, Intervention and Referral Services, and staff meetings). This suggests that collaboration takes place on a time-limited basis as opposed to being ongoing. Collaboration appears to take place when needed, or on a case-by-case basis instead of the consultation and communication that mental health professionals could be doing to help integrate services within the general education classroom environment.

Staff-development falls into a similar pattern. Staff-development took place in the form of brief topical workshops or trainings on various issues, or was lacking altogether. Staff-development also tended to take place on a departmental level, as opposed to school-wide development. One participant even indicated that he/she was unaware of staff-development relating to mental health outside of their department. Another participant indicated that there was not any staff-development to their knowledge on the topic of mental health that was provided by the district. That participant indicated that if he/she wanted to obtain more information or education about mental health, they would need to do so independently outside of the district. The topics pertaining to mental health at staff development trainings varied as well. The majority of participants reported that

professional development related to students' behavior, and suicide prevention, but bullying and specific mental health issues of students were also addressed.

This finding points to the fragmentation and inconsistency that takes place within the field of school mental health. School districts do not seem to have an overarching mental health framework they are using to educate staff about important issues. Instead, staff development seemed to be an area that is underdeveloped in many districts. The approach to staff development and collaboration varies among districts. The existing discrepancy makes it difficult for mental health services to be a core component of a school's mission when staff do not have ongoing professional development in the area of school mental health services.

Funding

Funding of mental health services does not come from one single source. Instead, services are funded through a combination of district funds (local taxes), grants at the federal, state, or county level, as well as federal funds that are disseminated to local school districts. Districts budget different amounts for the provision of mental health services and programs in their schools.

Most Effective Services and Programs

Participants named a variety of services, programs, and individuals as being most effective in their individual districts. It is evident that school-based mental health programs and collaboration among staff members have contributed to the meeting of mental health needs in some districts.

The two participants that had school-based mental health centers in their districts named these programs as some of the most effective in their districts. One participant stated "I think we absolutely needed the [school-based mental health center] because we just don't have the school staff nor do we have the time to address the problems [in the scope of traditional school mental health services]. This participant also indicated that although the school-based mental health center is meeting a district need, the need is still great in that "the problems are almost beyond our capacity." The other participant with a school-based mental health center also reported that this program is one of the most effective in the district. The participant said "I think the [school-based mental health center] has been a 'Godsend.' We rely heavily on them, maybe sometimes too much." This participant went on to note that "just the number of resources and the people [at the school-based mental health center] there to support…you can work with them directly and provide them with resources which has been the biggest help." This further supports the value of the school-based mental health center in meeting the mental health needs of students, but also indicates that some of the mental health needs of students are beyond the capacity of school mental health providers.

Prevention programs were also highlighted by participants as effective programs within their districts. One participant described the district's developmental counseling program and indicated that it is "the foundation for the district." This participant suggested that prevention is important because there are "too many problems in the community for us to be effective with interventions." The participant indicated described the effect of the program by reporting that "when new students move in, especially in fourth and fifth grade, you can see the difference between our students and how they

manage conflicts and solve problems and how they can talk their way through situations versus someone who moved in."

Another participant reiterated the effectiveness of prevention programs within their district by commenting on a school-wide positive behavior support program at the elementary level. "I think it is the building-wide interventions that really make a huge difference. Just that ongoing, cultural verbiage, focusing on the positive, and teaching kids how to act and what to say instead of 'don't do this, don't do that.'" This participant commented that the district has seen positive impacts of the program and is looking to expand it to the primary level within the district.

Other participants commented on various mental health professionals themselves as being the most effective in terms of meeting mental health needs of students. One participant named the school psychologists and student assistance counselors as being effective. Another participant also named school psychologists and the services they provide as effective. Another participant commented that the behavior consultant and social worker are identified key people at meeting the mental health needs of students. Although they have been described as effective at meeting mental health needs of students, these professionals are also limited by the other duties their job has mandated.

Communication among staff members was also highlighted as an effective part of meeting mental health needs of students. In particular, one participant identified the communication among child study team members about needs of students is valuable in terms of matching services and programs to best address students' needs. Another participant identified communication of observations regarding student needs as an effective means to meeting mental health needs.

Along those lines, another participant identified that having building-based child study team members in each school to address mental health needs is effective. Having mental health professionals in each school allows for quick response to student concerns and the ability to follow up and monitor plans put in place to address student needs.

Gaps in Meeting Mental Health Needs of Students

All participants indicated that there are still gaps that need to be filled in order to meet the mental health needs of students. Several participants indicated that there is a lack of prevention programming in their district. One participant stated that reactionary type work is not effective and prevention is needed to address this. Another participant indicated there still is a need to proactively help children develop skills to help change their behavior as opposed to only intervening when there is a crisis. Another participant indicated that there is a need for more prevention at the middle school level. This participant found that a prevention program at the high school in their district has been effective at meeting the mental health needs of high school students, but the middle school needs are still unmet. A fourth participant also reported similar gaps and indicated their district could "use a more proactive approach" for behavioral and mental health issues among students. Overall, participants recognized that prevention is a valuable means to addressing their current deficits in meeting student mental health needs.

Another noticeable gap in meeting student mental health needs is a lack of staff training. One participant stated that staff understanding, including administration, child study team, and teaching staff, need a firmer understanding of mental health needs and the needs of alternative education students. One other participant remarked that public

school employees "feel ill equipped to handle [mental health or behavioral issues]." This participant specifically stated "I think there's not enough education out there for both administrators and new teachers coming out of college. They can tell you every strategy for a reading problem and can tell you every program available for that, but give them a child who does not fit the norm, does not sit quietly, or is experiencing deep emotional problems, or mental illness, or is medicated, then they don't understand." This implies the fact that training programs may not be highlighting the importance of addressing student mental health needs and districts are left to develop this area within their staff, but as previously mentioned, staff development on the topic of mental health has been inconsistent among districts.

Ways to Fill Gaps

Participant responses revealed two areas that would help to meet and strengthen student mental health needs. As previously discussed, the inclusion of prevention has been recognized by participants as an important way to assist and support students. One participant indicated that they would include school psychologists in every school building to use their training to provide prevention services to support the social-emotional and behavioral development of students. Another participant remarked that "creating an environment that's supportive and positive is probably the better approach than going into reaction mode and sending kids out," further strengthening the support for the use of prevention in schools.

Training was also highlighted as the second area in need of improvement to meet mental health needs of students. One participant spoke about the economic changes that

are impacting school districts and how training is salient at this time. "If school districts are going to go the route that they're going, especially with these difficult financial times, and if they're going to force students to stay in district and they're going to stop sending out…especially our emotionally disturbed populations and even our autistic population, they're going to need more professional development and training to understand how to manage and handle the behaviors and emotions, and severe mental illness [within schools]."

Another participant spoke about the importance of ongoing training. They commented "we often get these one shot deals where we talk about the issue and then it's gone. I think we need ongoing professional development. [Teachers and administrators] need to know what's happening out there and why. They need to know the effects of the environment….I don't think we keep abreast of the mental illness and where it's going, and why, and other factors that play into that." These comments supports the value that districts place on the education and professional development of school staff to improve their understanding of student mental health, and the importance of ongoing training as a means to aid in prevention.

This investigation also revealed that there is not a direct administrator responsible for solely overseeing mental health in school districts. Providers are responsible for serving the mental health needs of students, but the providers lack a dedicated administrator to serve as a champion to bridge the gap between research and practice. What is needed is an administrator to assess the mental health needs of students and develop, implement, and evaluate a program that has been specifically designed to meet those needs in line with the core mission of the school. This is not current practice of

schools and mental health services are overseen as a component of other student services. Mental health has been an adjunct to education in schools and is not part of an integrated model where mental health services are interwoven with the educational development of students.

Summary

Participants of this study have commented on their impressions of mental health services and current practices within their district. Although providers and services vary by district, mental health professionals such as school counselors, school psychologists, and school social workers play critical roles in addressing mental health needs through intervention and prevention services. Primary prevention and ongoing staff development and training have been identified as significant components to successfully meeting the mental health needs of students in schools.

Overall, participants have recognized the importance that mental health of students plays in the school system. If these needs are not addressed, they will create barriers to academic learning as Adelman and Taylor (2010) have indicated. One participant commented on this phenomenon and said, "I think sometimes you need a philosophical shift. There's so much emphasis in school these days on scores and academics…I think sometimes you need to take a step back [from the academic aspect] and say 'Okay, that's good, but the social, emotional, and behavioral welfare of our children merits attention as well.'"

Limitations

This study has several limitations. The study is qualitative in nature and may lack reliability and validity data known to quantitative quasi-experimental studies. The content analysis used is subjective, and a more objective system may provide more reliability. The study has a small sample size, consisting of the seven participants who agreed to participate out of a possible 24. The results of the study are specific to central New Jersey and should not be generalized to other geographic regions. The study was also limited by lack of previous research models on current practices of school mental health services.

Additionally, it should be acknowledged that self-report bias may be evident in the results as participants may have responded in a way that made them appear more positive despite being told their responses would be anonymous. It should also be noted that findings may be influenced by the characteristics of participants who volunteered to participate in this study. It may be the case that their characteristics or views differ from those individuals that did not volunteer to participate in this study.

Future Directions

In order to obtain more comprehensive information regarding school mental health services in central New Jersey, interviews with providers of mental health services would provide more insight at the service-delivery level. Specifically, individuals like school psychologists, school counselors, and school social workers as providers of intervention and prevention programs should be interviewed to gain more knowledge about current practice of school mental health.

Additionally, school mental health services and programs in other parts of New Jersey, as well as throughout the U.S. should be investigated to get a comprehensive picture of mental health services at the state and national level. It would also be helpful to investigate actual service delivery treatments and programs being utilized within districts to compare across districts. This would provide insight on the extent to which mental health services are actually addressing mental health needs. Further research is also needed to evaluate the effectiveness of all mental health services and programs to better understand their utility in terms of future school mental health service planning. Finally, future research is needed on administrators of school mental health services and their training in this area. Their role should be examined to determine if a district-wide champion is needed to link the mental health services within the overall educational system.

Implications for School Psychologists

Previous research and results of this study have named school psychologists as service providers of school mental health services. Participants in this study named school psychologists specifically as valuable and effective individuals because of their training and unique position that integrates education and mental health fields. Specifically, doctoral school psychologists have unique skills in program planning and evaluation and have training in systems and organizational theory that are critical working within a school context. These skills may be helpful when investigating mental health and assessing the mental health needs of students, as well as designing, implementing, and evaluating mental health programs as part of the school context.

The National Association of School Psychologists (NASP) released a position paper (2008) supporting the importance of school mental health services. NASP advocates for the provision of mental health services within the context of schools and the utilization of school psychologists as mental health service providers. NASP stated that "school psychologists are uniquely qualified to provide comprehensive, cost-effective, mental health because as change facilitators, they engage in systems consultation and the promotion of public policies to support the education and mental health of children."

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APPENDIX A: INFORMED CONSENT

Allison Gallegly
Graduate School of Applied and Professional Psychology
Rutgers, The State University of New Jersey
152 Frelinghuysen Road
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gallegly@eden.rutgers.edu

INFORMED CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

School Mental Health Services: A Study of Current Practices in Central New Jersey
Public Schools

You are invited to participate in an interview that will be conducted by Allison Gallegly, a doctoral candidate in the school psychology program at the Graduate School of Applied and Professional Psychology at Rutgers University. The purpose of this interview is to gather detailed information about school mental health in New Jersey public schools. For clarification, school mental health is a school's promotion of positive social and emotional development among students as well as the treatment of students' psychosocial concerns and mental disorders.

Before you agree to participate in this interview, please read the information below, and provide your signature and date of signature at the bottom of the page if you understand the statements and freely consent to participate in the study.

Approximately six New Jersey Directors of Special Services and six school mental health professionals will be selected to participate in this interview. This interview will include a series of questions about school mental health services in your school district. Your participation will last approximately 30 minutes. Participation in the interview is voluntary. You can choose not to participate and you can withdraw at any time without penalty. You can also choose to not answer questions with which you are not comfortable.

The interview will be audiotaped for transcription purposes only. Neither your name nor your district will be recorded on the audio tape. I will advise you and request your consent before I begin audiotaping. You can request that the audiotape of your interview be destroyed at any time.

This research is anonymous. Anonymous means that I will record no information about you that could identify you. This means that I will not record your name, address, phone number, date of birth, etc. If you agree to take part in the study, you will be assigned a random code number that will be used on each test and the questionnaire. Your name will appear only on a list of subjects, and will not be linked to the code number that is assigned to you. There will be no way to link your responses back to you. Therefore, data collection is anonymous.

This interview will be conducted in accordance with Board of Education and school policies of your district.

By participating in this interview, you are helping to contribute to the understanding of school mental health in New Jersey. There are no foreseeable risks to participate in this interview.

If you have any questions about this study, please contact me, Allison Gallegly, at gallegly@eden.rutgers.edu or 973-896-1705. You may also contact my faculty advisor, Dr. Kenneth Schneider, at:

Graduate School of Applied and Professional Psychology
Rutgers, The State University of New Jersey
152 Frelinghuysen Road
Piscataway, NJ 08854
Tel: 732-445-2000 x107
Email: schneid@rci.rutgers.edu

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Rutgers University Institutional Review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: 732-932-0150
Email: humansubjects@orsp.rutgers.edu

Please keep a copy of this consent form for your records.

Sign below if you agree to participate in the interview.

Subject: _____ Date: _____

Principal Investigator: _____ Date: _____

Thank you for your participation.

Sincerely,

Allison Gallegly
Principal Investigator

Revised 5/12/2011

APPENDIX B: AUDIOTAPE ADDENDUM TO CONSENT FORM

Allison Gallegly
Graduate School of Applied and Professional Psychology
Rutgers, The State University of New Jersey
152 Frelinghuysen Road
Piscataway, NJ 08854
gallegly@eden.rutgers.edu

AUDIOTAPE ADDENDUM TO CONSENT FORM

School Mental Health Services: A Study of Current Practices in Central New Jersey Public Schools

You have already agreed to participate in a research study entitled "A Study of New Jersey Public High Schools' Mental Health Services" conducted by Allison Gallegly. I am asking for permission to allow me to audiotape as part of that research study. You do not have to agree to be recorded in order to participate in the main part of the study. The recording will be used for analysis by the Principle Investigator only. The recording will not include your name, district, or other identifying information. The recording will be stored in a locked cabinet and linked to a subject code. Only the Principle Investigator will have access to the subject code data. The subject code information will be stored in a separate secure location in a locked filing cabinet from the recordings. Audio tapes will be destroyed upon completion of the study. Transcriptions will be destroyed one year after the completion of the study.

Your signature on this form grants the investigator named above permission to audiotape you as described above during participation in the above-referenced study. The investigator will not use the recording for any other reason than that stated in the consent form without your written permission.

Please sign below if you agree to permit audio taping of your participation in this research study:

Subject: _____ Date: _____

Principal Investigator: _____ Date: _____

APPENDIX C: INTERVIEW PROTOCOL

<u>School Mental Health Services: A Study of Current Practices in Central New Jersey Public Schools</u>

1. Does this school have a school-based mental health center that offers mental health services to students?

2. Is there someone in this school designated to coordinate/oversee mental health services?

3. Is someone at this school designated to meet with members of the other schools in the district to enhance coordination among the schools?

4. Who provides school mental health services?
   a. School counselor
   b. School psychologist
   c. School social worker
   d. Psychologist
   e. Other

5. How many professionals (of each position, part-time and full-time) provide mental health services at this school?

6. Look at the Checklist of School Mental Health Services (Attachment D). Please indicate whether or not the following mental health services are available in your school by placing an "X" in the Available column. If the service is available, indicate if the service is ongoing or not by placing a "Y" for yes or "N" for no. Indicate who the provider of the service is (i.e.: psychologist, school psychologist, school counselor, school social worker).

7. Is there backup or after hours coverage when school mental health services are not available (After school or weekends)?

8. Describe the kind of collaboration that occurs among mental health service providers within the following staff in the school:
   a. Health education
   b. Physical education
   c. Nutrition/food services
   d. Health services

9. Describe the school's staff development on the issue of mental health.

10. Are there written descriptions of mental health programs available to give to
    a. Staff
    b. Families
    c. Students
    d. Community members

11. Are there written descriptions available to give to staff and others about
    a. How to make referrals
    b. What to do in a crisis situation
    c. The process for case monitoring

12. Are there processes for which staff and families can learn
    a. About programs and services at school
    b. About programs and services in the community
    c. About how to access programs and services

13. What community resources does your school have a formal relationship with?

14. Look at the Checklist of Collaboration Among School and Community (Attachment E). Please indicate if your school collaborates with community agencies for the following services by placing a "Y" for yes or "N" for no. Collaboration refers to communication between the school and the agency, referrals, and representatives from the school going to the community agency or vice versa.

15. How are school mental health services and programs in your school funded?

16. In your opinion, which programs/services are most effective?

17. Are there gaps that need to be filled to reach the mental health needs of students? If so, how would you fill these gaps?

APPENDIX D: CHECKLIST OF SCHOOL MENTAL HEALTH SERVICES

School Mental Health Services: A Study of Current Practices in Central New Jersey Public Schools

Checklist of School Mental Health Services

Please indicate whether or not the following mental health services are available in your school by placing an "X" in the Available column. If the service is available, indicate if the service is ongoing or not by placing a "Y" for yes or "N" for no. Indicate who is the provider of the service (i.e.: psychologist, school psychologist, school counselor, school social worker).

Service	Available	Ongoing? (Y or N)	Provider of Service
Assessment for emotional or behavioral problems or disorders (including behavioral observation, psychosocial assessment, and psychological testing)			
Behavior management consultation (with teachers, students, family)			
Case management (monitoring and coordination of services)			
Referral to specialized programs or services for emotional or behavioral problems or disorder			
Crisis intervention			
Sudden traumatic event counseling			
Individual counseling/therapy			
Group counseling/therapy			
Substance abuse counseling			
Medication for emotional or behavioral problems			
Referral for medication management			
Family support services (e.g., child/family advocacy, counseling			
Job readiness skills programs			
Mental health education			
Violence prevention programs			
Alcohol/drug abuse prevention programs			
Dropout prevention programs			
Job readiness skills services			
Mental health education			
After-school programs			
Other:			

APPENDIX E: CHECKLIST OF COLLABORATION

School Mental Health Services: A Study of Current Practices in Central New Jersey Public Schools

Checklist of Collaboration Among School and Community

Please indicate if your school collaborates with community agencies for the following services. Place "Y" for yes and "N" for no. Collaboration refers to communication between the school and the agency, referrals, and representatives from the school going to the community agency or vice versa.

Service	Collaboration (Y or N)
Mental health clinics	
Counseling	
Crisis hotlines	
Substance abuse	
Violence prevention	
Gang alternatives	
Pregnancy prevention	
Child abuse/domestic violence prevention	