

Running Head: SCHOOL-BASED MENTAL HEALTH PRACTICES IN NEW JERSEY

SCHOOL-BASED MENTAL HEALTH PRACTICES IN NEW JERSEY:

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Abstract

New Jersey school mental health practitioners (school counselors, school psychologists, school social workers, and student assistance professionals) completed a survey regarding their role in the provision of school-based mental health services (SBMHS). Participants were recruited from a convenience sample of members of state professional organizations representing each of the four disciplines. A web-based survey was utilized to obtain information on barriers and facilitators to involvement in SBMHS, perspectives on training and professional development, the type of referrals practitioners receive, the type of services provided and practitioners' views concerning the quality of school-based mental health practice. A total of 179 participants out of approximately 2,078 potential respondents completed the survey representing an overall 8.6% response rate. SBMHS providers in New Jersey reported the most frequent referrals for concerns such as externalizing behaviors, academic and interpersonal problems, and anxiety. Practitioners reported providing a range of mental health services with the greatest percentage indicating providing services such as consultation (e.g., school staff, parents/caregivers, community providers), counseling, behavioral interventions, social/emotional/behavioral assessment, referrals to outside agencies and suicide assessment and intervention. Respondents rated the majority of facilitators as having a moderate to significant enabling effect on their ability to provide SBMHS. The facilitators with the highest ratings endorsed personal characteristics such as a desire to provide mental health services and systems-level factors, such as sufficient space and support from administrators. The largest barriers to the provision of services included role strain and inability to meet the needs of many students. The majority of didactic and applied training experiences that

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the practitioners attended were perceived as moderately to very helpful in preparation to provide SBMHS. Results indicated that participants view the quality of SBMHS practice in their schools as somewhat aligned with principles of best practice. The practices viewed as presently least developed in schools included ongoing training and supervision, use of screening to identify mental health concerns, intensive treatment services, and regular training on effective practice for students and families from diverse backgrounds. Limitations of this study as well as implications for future research and practice are discussed.

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Chapter I

Introduction and Rationale for The Dissertation

The introduction and rationale for this dissertation has been shaped by the events at Sandy Hook Elementary School on December 14, 2012. On that day, the dialogue on mental health, gun violence, and school safety issues grew substantially on a national level with many insistent upon action (Astor, et al., 2012; National Association of School Psychologists, 2012; Shah, 2013). In the weeks and months that followed, the conversation continued to bring to light the many faces affected by mental health concerns (Barry, McGinty, Vernick, & Webster, 2013; Swanson, 2013). Though the intensity of this dialogue has abated to some extent, the tragedy of that day has left an indelible impact on this country's consciousness regarding mental health (*Congressional Digest*, 2013; Khadaroo, 2013). The overall work of this dissertation is situated within this altered and pressing discussion on mental health and mental health services within schools.

The World Health Organization (2013) defines mental health as a “state of complete physical, mental and social well-being, and not merely the absence of disease. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.” The U.S. Surgeon General's *Report on Mental Health* (1999) characterizes mental health as a “state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity” (p. 4).

On June 3, 2013, President Barack Obama convened the first National Conference on Mental Health (Compton, 2013). This conference sought to increase understanding and awareness about mental health issues and was part of a larger plan by the president to reduce gun violence. Various stakeholders participated in this event with the goals of working to reduce stigma, raise awareness regarding the importance of seeking treatment, as well as address barriers to treatment.

Research has demonstrated the need for mental health services geared toward children and youth in the United States as well as New Jersey. Approximately 20% of children and adolescents in the U.S. experience signs of mental health problems and 5% experience extreme functional impairment (U.S. Department of Health and Human Services, 1999). Up to 60% of adolescents who reported a major depressive episode did not receive treatment (SAMHSA, 2005). In any given year, about 5% to 9% of children have a serious emotional disturbance (President's New Freedom Commission on Mental Health, 2003). In a summary of federal surveillance systems of mental health issues among children and youth, Perou, et al (2013) report data collected between 1994 and 2011 demonstrate the prevalence of mental disorders increasing in this population. This report documented attention-deficit/hyperactivity as the most prevalent diagnosis among children age 3 to 17 years old, followed by behavioral and conduct problems, anxiety, depression, autism spectrum disorders and Tourette's syndrome.

Statistics of overall mental health need in New Jersey are comparable to the national picture (SAMHSA, 2009). Based upon data collected by SAMHSA, between 2003-2006, approximately 31,000 adolescents in New Jersey needed but did not receive treatment for drug problems and 44,000 needed but did not receive treatment for alcohol

problems (SAMHSA, 2009). In New Jersey in 2004-2006, approximately 12.7% of adolescent females and 2.6% of adolescent males experienced a major depressive episode, which is similar to national prevalence patterns (SAMHSA, 2009). In 2008, sixty-eight individuals aged 24 and younger completed suicide. This places youth suicide as the fourth leading cause of death for New Jersey's youth (New Jersey Department of Children and Families, 2012).

Skalski and Smith (2006) assert that although there are various viewpoints concerning the specific mission of public schools, there is general agreement that schools should promote learning to create productive citizens. Mental health has been cited as an integral part of an individual's ability to achieve academically, as well as function as a member of society. The U.S. Surgeon General states, "from early childhood until death, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem. These are the ingredients of each individual's successful contribution to community and society" (U.S. Department of Health and Human Services, 1999, p. 5). Research has demonstrated a link between mental health programs and a range of positive student outcomes (Rones & Hoagwood, 2000). In regard to prevention, a 2009 Institute of Medicine report indicated that the "promotion of competence, self-esteem, mastery, and social inclusion can serve as a foundation for both prevention and treatment of mental, emotional and behavioral disorders" (Durlak, Weissberg, Dymnicki, Taylor & Schellinger, 2011).

There is consensus among governmental agencies and professional organizations that there exists an unmet need for mental health services among American children and youth (Cooper, 2008; NAMI, 2010; NASP, 2008; President's New Freedom

Commission, 2003). In recognition of the complexities of the current mental health system, the serious consequences of mental illness, and the growing evidence of effective school-based mental health services (SBMHS), the President's New Freedom Commission on Mental Health (2003) called for improving and expanding school mental health programs. Additionally, the American Academy of Pediatrics Policy Statement on School Based Mental Health Services (2004) identified SBMHS as a strategy to address barriers to and improve coordination of mental health services.

Schools have been identified as a logical setting for mental health services due to the length of time children spend in educational settings, as well as access to families (Brenner, et al, 2007; NASP date; U.S. Department of Health and Human Services, 1999). According to the National Survey on Drug Use and Health (SAMHSA, 2008a), approximately 12% of youth aged 12 to 17 received mental health services for emotional or behavioral problems in a school-based setting. In New Jersey, the Department of Children and Families (DCF) (n.d.), has recommended developing and improving school based mental health services, such as expanding School-Based Youth Services Programs in middle schools. DCF also identified schools and school personnel as key stakeholders in its formal state plan for youth suicide prevention (2010b).

Well-designed, well-implemented school-based mental health programs have been found in the literature to positively influence a wide range of academic and social-emotional outcomes (Charvat, 2012; Greenberg, et al., 2003; Rones & Hoagwood, 2000). Research over the last few decades has demonstrated that schools can have a significant positive impact on the utilization of mental health services and there is greater potential

for schools to address the unmet mental health needs of students, while concurrently improving academic outcomes.

Despite research demonstrating positive outcomes of SBMHS, and the call for expansion and improvement of SBMHS by federal and state government, changes in policy and practice are required in combination with further research in order for SBMHS to realize their potential. The first national survey of mental health services in a representative sample of elementary, middle and high schools, the *School Mental Health Services* study, (Foster, et al., 2005) found that “while schools are responding to the mental health needs of their students, [the findings] also suggest increasing needs for mental health services and the multiple challenges faced by schools in addressing these needs” (p. 2). Cooper (2008) writes that although the President’s New Freedom Commission stressed the importance of SBMHS, “school mental health services continue to be fragmented” and the “school-based mental health movement struggles to answer basic questions about its identity” (p. 4).

Furthermore, recent research has documented needs for training and research concerning school-based practitioners providing mental health services (Powers, et al, 2011; Splett & Maras, 2011; Suldo, Friedrich & Michalowski, 2010). Powers (2011) states that “it is imperative to understand from a practitioner perspective which resources schools currently have access to and what new resources would be most helpful to effectively intervene with youth as this information can guide critical next steps for school-based mental health intervention” (p. 33).

In an examination of current mental health practices in New Jersey, Gallegly (2012) interviewed Directors of Special Education in seven school districts in central

New Jersey. The data revealed that mental health programs are considered an important aspect of the school district. Prevention programs, as well as ongoing staff development, were identified as significant components to meeting the mental health needs of students. Additionally, participants in this study named school counselors, school psychologists, school social workers and student assistance professionals as among the effective components of their school based mental health services.

Recently, Suldo, Friedrich & Michalowski (2010) investigated factors that enhance and limit school psychologists' ability to provide SBMHS. In a qualitative study of 39 school psychologists from a state in the southeast, it was found that school psychologists perceived systems-level factors (e.g., space, resources, employee role descriptions) as creating more barriers to SBMHS provision than person-centered factors (e.g., professional preparation, role strain). In addition, internal factors (e.g., desire to provide counseling) were perceived as stronger facilitators to provision of SBMHS than systems-level factors.

Purpose of the Current Study

Previous research has found regional differences in school psychology and school counseling roles and practices (Carey & Dimmitt, 2012; Hosp & Reschly, 2002). In order to obtain a more comprehensive view of SBMHS specific to New Jersey, this study explored the perspectives of New Jersey school mental health practitioners (school counselors, school psychologists, school social workers, and student assistance professionals) regarding their role in the provision of SBMHS, the barriers and facilitators to involvement in SBMHS, and needs for training and professional development. This study gathered information on the types of referrals SBMH

practitioners receive and their perspectives on the resources available and necessary for effective SBMHS. This study also explored practitioners' perceptions concerning the quality of school-based mental health practice.

Chapter II

Review Of The Literature

Introduction to Mental Health and Overview of Need

The World Health Organization (2013) defines mental health as a “state of complete physical, mental, and social well-being, and not merely the absence of disease. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.” The traditional understanding of mental health as the presence or absence of psychopathology has evolved to include positive indicators of well-being as crucial to full understanding of one’s mental health status (Suldo & Shaffer, 2008). The U.S. Surgeon General’s *Report on Mental Health* (1999) characterizes mental health as a “state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity” (p. 4).

The topic of mental health is wide-ranging and extends across a number of professional disciplines (Skalski & Smith, 2006). Various professional organizations, such as the American Counseling Association (ACA), American School Counseling Association (ASCA), the National Association of School Psychologists (NASP), and the School Social Work Association of America (SSWAA), as well as several governmental agencies recognize the importance of mental health and support the development of effective SBMH programs to support diverse outcomes such as academic achievement, increased productivity, and economic advancement (ACA, ASCA, NASP, SSWAA, n.d.; American Academy of Pediatrics (AAP), 2004; Charvat, 2012; President’s New Freedom Commission on Mental Health, 2003).

According to the U.S. Department of Health and Human Services (2013), mental health problems are common. Statistics for 2011 reveal that 20% of American adults experienced a mental health issue, 10% of young people experienced a period of major depression and 5% of Americans had a serious mental illness, such as schizophrenia, bipolar disorder, or major depression. Additionally, suicide is noted as the 10th leading cause of death in the United States.

Alongside the increasing general awareness of mental health, there has been an increase in the attentiveness to the mental health issues of children and youth (Slade, 2003). Research has demonstrated the need for mental health services geared toward children and youth in the United States, as well as in New Jersey, and several sources point to the prevalence of mental health issues among children and youth (Behrens, Lear & Price, 2013; U.S. Department of Health and Human Services, 1999). Approximately 20% of children and adolescents in the U.S. experience signs of mental health problems and 5% experience extreme functional impairment (U.S. Department of Health and Human Services, 1999). In any given year, about 5% to 9% of children have a serious emotional disturbance (President's New Freedom Commission on Mental Health, 2003). Data has also shown there is a gap between children and youth that would benefit from mental health services, and those that receive it. As few as 15-20% of children and youth who need mental health services receive it (American Academy of Pediatrics Policy Statement, 2004; Macklem, 2011). Up to 60% of adolescents who reported a major depressive episode did not receive treatment (SAMHSA, 2005).

The statistics on mental health need in New Jersey are comparable to national data with approximately 4-5% the population living with serious mental conditions

(National Alliance of Mental Illness, 2010). Major Depressive Episodes (MDE) among adolescents in New Jersey has also been noted to occur at similar rates as the national level, with females more than four times as likely as males to have experienced an MDE between 2004-2006. Between 2003-2006, it is estimated that 31,000 adolescents in New Jersey needed but did not receive treatment for past-year drug problems; 44,000 needed but did not receive treatment for alcohol problems (SAMHSA, 2009). According to the New Jersey Department of Children and Families (NJ DCF), in 2008, sixty-eight individuals aged 24 and younger completed suicide. This places youth suicide as the fourth leading cause of death for New Jersey's youth (NJ DCF, 2012). Additionally, a brief from the Rutgers Center for State Health Policy (Scotto Rosato, Schneider, & Abramo, 2007) concerning mental health utilization in New Jersey concluded that residents of New Jersey's urban areas, particularly racial and ethnic minorities, as well as the poor and uninsured, are not receiving appropriate mental health services.

School-Based Mental Health

In light of the documented need for mental health services among children and youth, there has been an increasing focus on schools as a logical setting for delivering both prevention and intervention services (Weist, et al, 2012). A report by the Center for Health and Health Care in Schools (Behrens, Lear & Price, 2013) states "an emerging theme of the past 20 years has been the recognition that school-community partnerships can fill gaps in the delivery of children's mental health services." The President's New Freedom Commission (2003) recommended that federal, state, and local agencies recognize and address the mental health needs of youth in the education system. Notwithstanding the impetus of research and policy advocating more school-based

mental health services (SBMHS), there remains an unmet need among children and youth for consistent access to high-quality and evidence-based services (Brenner, Weist, Adelman, Taylor, & Vernon-Smiley, 2007; Paternite, 2005; Reinke, Nastasi & Varjas, 2008; Splett & Maras, 2011; Stormont, Herman, Puri, & Goel, 2011). This section will review the history and current status of SBMH, present an overview of outcome research on the effectiveness of SBMHS, and consider best practice, barriers to and future directions of SBMHS.

A History of and Rationale for School-Based Mental Health Services

The recognition of mental health concerns among children and youth, and efforts within schools to address these concerns, is not a recent phenomenon (Perfect & Morris, 2011). From the middle of the 20th century, practitioners and researchers highlighted disparities between the numbers of children who could benefit from mental health services and available resources, and called for additional prevention initiatives and integrated school-based mental health services (Baumgartner, 1946; Courtney, 1951; Knoblock & Garcea, 1965; Stevenson, 1947). Lambert's introduction to a 1965 U.S. Public Health Service monograph, *The Protection and Promotion of Mental Health in Schools*, discussed the apparent gap between the need for mental health services and financial and human resources:

We needed to start *before* the problems grew to full size and, if possible, *before*, they even had a foothold...preventive programs must aim at building the strengths in children that would help them avoid behavior problems... and where is the laboratory, the logical proving ground for this approach? It has been with us all

the time: the school is the strategic place in which to start building these strengths. (pp. vii).

Educators and mental health professionals have long recognized the reciprocal relationship between children's development, access to resources, health status, and their schooling (Atkins, Hoagwood, Kutash & Seidman, 2010). The early SBMH movement emerged from the larger mental hygiene movement of the early 20th century, as well rapid changes in education (e.g., compulsory attendance) and greater awareness and motivation to address public health issues impacting school attendance and educational outcomes (Dreyer, 1976; Fagan, 2000; Flaherty, Weist, & Warner, 1996; Sedlak, 1997).

Throughout the 20th century, the resolve to bring social services and mental health care into the schools was influenced by the pressing societal, political and economic concerns of the time (e.g., influx of immigration in the early 1900s, science and math education during space exploration in the 1960s). In the 1970s, the passage of PL 94-142 mandated the modern system of special education and schools were charged with the education and support services for students with disabilities, including emotional and behavioral disorders. During this time, services designed to promote positive behavior change for children and youth involved direct services (e.g., individual/group counseling, affective education, social problem-solving skill training), as well as efforts focused on primary prevention and altering the ecology of the school to prevent and treat learning and difficulties and mental health concerns (Conoley & Conoley, 1991).

Dryfoos (1995) highlighted the shifting, but steady, evolution of SBMH throughout the 20th century and described the climate of SBMHS in the 1980s: "the pendulum is swinging back to bringing outside health and social service programs into

schools in response to contemporary crises growing from poverty, immigration and community decay” (p. 151). During the 1980s there was great interest in expanding school-based health centers so that schools and communities could address physical and mental health concerns in one convenient and accessible location (Adelman, 1995). School-based health centers, one example of a movement toward *full service schools*, proliferated rapidly from about 10 in 1984 to over 500 locations in the mid-1990s. (Adelman, 1995; Dryfoos, 1995).

In recent decades, schools have become the de facto location for mental health services for children and adolescents (Evans, 1999; Kutash, Duchnowski, & Lynn, 2006). Among the reasons that schools are viewed as rational and advantageous locations to house mental health services include: ease of access, reduced stigma, and opportunities to support generalization (Paternite, 2005; Powers, Bower, Webber & Martinson, 2011; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). Lyon, Charlesworth-Attie, Vander Stoep & McCauley (2011), write that schools provide opportunity to measure mental health and academic indicators concurrently, which they argue provides a comprehensive view of youth functioning. Greenberg, et al (2003) highlighted the fundamental mission of pre-K through grade 12 education as a basis for supporting comprehensive social and emotional learning (SEL) prevention programs. That is, to foster engaged, productive and socially competent citizens, schools necessarily need to be a place where mental health prevention and promotion programs are part of the culture.

Past research has found that a majority of children with mental health care needs did not receive professional help for those needs, and those who did receive services did so mostly through schools. Burns, et al (1995) found:

Between 70 and 80 percent of children who received services for a mental health problem were seen by providers working within the education sector (mostly guidance counselors and school psychologists). For the majority of children who received any mental health care, the education sector was the sole source of care (pp. 152).

In a study examining service patterns in mental health care through various sectors, Farmer, Burns, Philip, Angold & Costello (2003) found 18 to 19 percent of children and youth utilized services from one or more sector. Of these children, approximately 11% used education services, compared with 7% specialty mental health services, and 4% general medical services. These researchers concluded that the education sector was a central provider of mental health services and in order to ensure children are receiving appropriate mental health care, more consistent linkages should be made between the education system and other sectors.

The Current Picture of School-Based Mental Health Services

According to Adelman & Taylor (2010), while the attempt by educators to address issues relating to mental health is not new, the drive to infuse school-based mental health services as a core component within education systems continues to be complex. In the last decade, an era of school accountability and a strong focus on academic achievement, in combination with an economic recession and its impact on school budgets, has resulted in SBMHS being characterized by fragmented, isolated programs, dependent on variable funding streams and commonly thought of as an adjunct to the true academic mission of schools (Brener, et al., 2007; Greenberg, et al., 2003; Paternite, 2005).

Foster, et al. (2005) conducted the first national study of school mental health services in a representative sample of elementary, middle and high schools. In this study, mental health services were defined as “those services and supports delivered to individual students who have been referred and identified as having psychosocial or mental health problems” and focused on those with existing mental health concerns rather than preventative services (p. 19). This study found on average 20% of students had received a school-supported mental health service in the year prior to the study. Additionally, the study found that more than 80% of schools provided services such as assessment for mental health problems, behavior management consultation, and crisis intervention, as well as referrals. School personnel reported interpersonal, social or family problems as the most frequent mental health problem for male and female students. Male students’ next most frequent mental health concerns were aggressive or disruptive behavior, while school staff reported the next most common mental health concerns of females as anxiety and adjustment issues. The authors concluded that while a majority of schools provide SBMHS, the findings suggest the need for mental health services is increasing and schools face multiple challenges addressing ongoing mental health concerns.

Although SBMHS have become increasingly widespread in recent decades, Stephan, et al. (2007) pointed out that schools do not have the same resources available to address non-academic barriers to learning, thus only a small percentage of students are offered mental health supports. A 2006 examination of school mental health practices and policies at the state, district and school level revealed that more than 75% of schools had at least a part-time counselor providing services to students, however “insufficient

numbers of mental health, and especially, social services providers are employed by schools, and connections between schools and related community systems, such as mental health, juvenile services and child welfare need to be strengthened” (Brenner, et al., 2007, p. 498).

SBMH programs can refer to a wide variety of services and programs including: assessment, case management, crisis intervention, individual/group counseling, mental health education, alcohol/drug abuse prevention programs, drop-out prevention programs, job readiness services and after-school counseling services (Foster, et al., 2005).

Researchers and practitioners have emphasized the need for comprehensive SBMHS to progress beyond traditional approaches of assessment, clinical consultation, and a focus primarily on students eligible for special education (Adelman & Taylor, 2004).

The term *expanded school mental health* (ESMH) refers to SBMHS that incorporate elements to build on existing services within schools and seek to collaborate with community agencies to more effectively serve larger numbers of students (Weist, et al., 2000). The elements of expanded school mental health include: (a) school-family-community agency partnerships, (b) commitment to a full continuum of mental health education, mental health promotion, assessment, problem prevention, early intervention, and treatment, and (c) services for all youth, including those in general and special education (Paternite, 2005; Weist, et al., 2000).

Best practice in School-Based Mental Health Services

Though there is not a sole best practice model, there are commonalities among recommendations for best practice in SBMHS. According to Nastasi & Varjas (2008), the existing unmet need in the mental health care of children and youth requires a shift

from the traditional medical model to a public health model of SBMH. This involves comprehensive service-delivery in an ecological-developmental approach in which personal, social, cultural, and physical environmental factors are addressed. The authors summarize the key components of effective mental health programs derived from “a decade of program development and evaluation research” (p.1354). These include: 1) integration of educational, mental health, and social services through interagency and interdisciplinary collaboration; 2) focus on the full complement of ecological contexts – school, family, peers, community, society – that influence child and adolescent development and functioning; 3) provide services that address individual, developmental, and social-cultural factors; 4) include a full continuum of services, including prevention, risk reduction, early intervention, and treatment; 5) systematically evaluate program process and outcome; and 6) offer services that are based on empirical evidence of the complex array of factors that influence mental health of children and adolescents.

Weist, et al. (2005), in an effort to advance quality assessment and improvement (QAI) of ESMH, developed a set of 10 principles for best practice in school mental health. These principles, developed through a literature review, consultation with national experts and research leading to the development of a survey, are as follows: 1) all youth and families are able to access appropriate care regardless of their ability to pay; 2) programs are implemented to address needs and strengthen assets for students, families, schools, and communities; 3) programs and services focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact; 4) students, families, teachers and other important groups are actively involved in the program's development, oversight, evaluation, and continuous

improvement; 5) quality assessment and improvement activities continually guide and provide feedback to the program; 6) a continuum of care is provided, including school-wide mental health promotion, early intervention, and treatment; 7) staff hold to high ethical standards, are committed to children, adolescents, and families, and display an energetic, flexible, responsive, and proactive style in delivering services; 8) staff are respectful of and competently address developmental, cultural, and personal differences among students, families, and staff; 9) staff build and maintain strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes all efforts; and 10) mental health programs in the school are coordinated with related programs in other community settings.

Barriers to School-Based Mental Health Services

Several barriers to effective SBMHS have been identified in the literature (Evans, 1999; Macklem, 2011; Powers, Bower, Webber, & Martinson, 2011; Slade, 2003; Weist, et al, 2000). These barriers include lack of material resources (e.g., finances, space, equipment), lack of trained staff to recognize symptoms and deliver interventions, school culture (e.g., attitudes regarding the responsibility of schools to address social-emotional functioning; high-stakes testing), and student and family issues (e.g., difficulty with home-school communication),

Weist, et al. (2012) argued that since SBMHS are often delivered through a diverse assortment of programs and disciplines, effective collaboration underpins the success of SBMHS at all levels of implementation. The authors delineate several challenges to collaboration in SBMHS including: the marginalization of SBMHS, limited interdisciplinary teamwork (e.g., between mental health professionals and with other

educational staff), inadequate coordination of services, and confidentiality concerns. It is essential, stated Weist, et al., to attend to how professionals are working together when developing program improvement initiatives.

Another significant impediment to SBMHS found in the literature is related to the utilization of evidence-based interventions (EBI). Schaeffer, et al. (2005) identified several barriers related to the use of EBI in school setting such as inadequate funding for training and quality assurance, logistical issues, reluctance on the part of professionals to use EBI, and concerns about the applicability of EBI with culturally and linguistically diverse youth.

Forman, Olin, Hoagwood, Crowe & Saka (2009) interviewed developers of EBI as to the factors related to implementation in school settings. Several areas were identified that could enhance successful implementation of EBI including: development of principal/administrator and teacher support; development of financial resources to sustain practice; high-quality training and consultation to ensure fidelity; ensuring that program outcomes and impact are visible to key stakeholders; and addressing turnover in school staff and administrators.

Access to SBMHS may be associated to demographic factors. Beehler, Birman & Campbell (2012) point out that immigrant status can significantly impact a child's access to mental health services, with barriers such as access, utilization, lack of familiarity with mental health services, stigma and validity of evidence-based treatments to this population. Additionally, Slade (2003) used data from the 1994-1995 National Longitudinal Study of Adolescent Health to estimate the proportion of middle and high schools that offer SBMHS. This research found substantial differences in mental health

counseling availability by region, with rural schools less likely to offer these services than suburban or urban schools.

Barriers to SBMHS have also been investigated at the practitioner level. Suldo, et al (2010), investigated factors perceived by school psychologists to impact their participation in SBMHS. In this study, systems-level barriers (e.g., time and space, clearly defined professional roles) were found to be more prevalent than person-centered factors. However the primary internal factor identified as a barrier was related to perceived insufficiency of professional preparation to provide SBMHS. Friedrich (2010) expanded on this study to include a national sample of school psychologists. In this study, external barriers to service provision were again found to occur in greater frequency than internal barriers, with significant to moderate barriers identified at the role level (e.g., caseload constraints), school-level (e.g., inconsistent treatment due to scheduling issues), and systems-level (e.g., lack of sufficient district funding).

Research on School-Based Mental Health Outcomes

Several meta-analytic and review-based research studies have demonstrated a link between mental health programs and positive student outcomes (Center for Health and Health Care in Schools, 2013). Rones and Hoagwood (2000) reviewed the evidence-base for mental health services delivered in the schools. For the studies included in their review, the target problems included a range of emotional and behavior problems, depression, conduct problems, stress management and substance use. The researchers found a strong group of programs that were found to have evidence of effectiveness. The authors also noted several key features of the implementation process that impact outcome and sustainability. These features include:

(i) consistent program implementation; (ii) inclusion of parents, teachers or peers; (iii) use of multiple modalities (e.g., the combination of informational presentations with cognitive and behavioral skill training); (iv) integration of program content into general classroom curriculum; and (v) developmentally appropriate program components (p. 237).

Building upon this study, Farahmand, Grant, Polo, Duffy and DuBois (2011), utilized the same methodology to examine the effectiveness SBMHS for low-income, urban youth. In contrast to the study by Roncs and Hoagwood (2000), the authors of this meta-analytic review of school programs between 1985-2009 found limited evidence of effective school-based interventions for low-income, urban youth, especially for those with externalizing concerns. The results of this study, according to the researchers, underline the importance of considering contextual factors when determining effectiveness and developing and implementing interventions.

In another meta-analysis, Reddy, Newman, De Thomas and Chun (2009), examined the effectiveness of school-based prevention and intervention programs for students with emotional disturbance. In this study, which included 29 studies spanning from 1988-2006, it was found that prevention programs generally yielded moderate effects, while intervention programs generally yielded larger effects, in reducing some symptoms associated with emotional disturbance. Though the authors noted that several factors, such as limited outcome research, indicated that findings should be interpreted cautiously, they also stated that “practitioners should be optimistic about the potential role” of prevention and intervention programs on academic and mental health outcomes for this population (p. 96).

The impact of social and emotional learning (SEL) was examined in a meta-analysis of 213 programs serving students in kindergarten through 12th grade (Durlak, Weissberg, Dymnicki, Taylor & Schellinger, 2011). Looking at universal interventions across multiple outcomes, it was found that SEL programs yielded the largest significant positive effects on social-emotional competencies, but also enhanced behavioral and internalizing outcomes, and improved academic achievement.

Hoagwood, et al. (2007) point out that most research has not examined the outcome of SBMHS on academic functioning. In their literature review on existing studies of EBI's that target both academic and mental health functioning in schools, the authors found only 24 of more than 2000 studies both met the inclusion criteria and examined academic and mental health outcomes concurrently. The most effective interventions were noted to be time-intensive, with a range of targeted participants (students, families, and teachers) and contexts. The authors found that most SBMHS interventions, particularly universal programs, had modest effects and called for careful consideration of the most appropriate and meaningful academic outcomes for SBMHS research (e.g., distal outcomes such as grades, vs. proximal factors such as academic engagement).

School-Based Mental Health Services in New Jersey

The statistics on mental health need in New Jersey is comparable to national data with (National Alliance of Mental Illness, 2010; SAMHSA, 2009). Relative to the national picture, there are some areas in which New Jersey fares well. On measures of past year serious psychological distress in adults and unmet need for treatment of drug or alcohol use among those 12 and older, New Jersey's rates have been found to be at or

below national rates on the National Survey on Drug Use and Health (NSDUH) (SAMHSA, 2008b). Additionally, New Jersey has ranked as one of the four lowest states for suicide rates. The New Jersey Department of Children and Families (2012) in their *New Jersey Youth Suicide Prevention Plan, 2011-2014* cited many efforts and policies in the state that are believed to contribute to effective prevention. These include laws restricting minors' access to firearms, mandated training for school staff in suicide prevention and detection of warning signs, and psychiatric screening centers in every county. Additionally cited in this report as the lead youth suicide prevention program in the state is the Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers University Behavioral Health Care. The TLC operates as a county-based collaborative system that provides training, outreach and direct on-site assistance for school staff and students.

Special education classification rates in New Jersey from 2013 document 8,316 students age 3-21 classified through the eligibility category "emotional disturbance." This accounts for approximately 3.8% of the total population eligible for special education (New Jersey Department of Education, 2013).

One program that has been cited in research as an innovative SBMH program is New Jersey's School-Based Youth Services Program (SBYSP) (Warren & Fanscali, 2000). This program, run through the Department of Children and Families, Office of School-Linked Services, began in 1987 as a way to address non-academic barriers to learning and assist schools in helping adolescents achieve successful outcomes. Governor Thomas Kean (1989) underscored the conditions which led to the creation of the SBYSP, including recognition that schools were struggling to tend to the needs of

adolescents, and that neither “education nor human services can do their jobs unless they work together” (p. 829). An outcome study of the SBYSP (Warren & Fanscali, 2000) concluded that SBYSP were reaching the most vulnerable students in the locations studied, participation in the program was related to positive effects on educational aspiration and credit accumulation, and may also have prevented further decline into negative behaviors. New Jersey continues to offer this program, which currently operates in 67 high schools, 18 middle schools and 5 elementary schools (NJ Department of Children and Families, n.d.). In the *New Jersey Child Abuse & Neglect Prevention Plan, 2010-2013: A Roadmap to Child and Family Well-being*, the New Jersey Task Force on Child Abuse and Neglect recognized SBYSP as a primary strategy to improve outcomes for youth and recommended expanding SBYSP in middle schools (NJ Department of Children and Families, n.d.).

In an examination of current mental health practices in New Jersey, Gallegly (2012) interviewed Directors of Special Education in seven school districts in central New Jersey. The data revealed that mental health programs are considered an important aspect of school districts. Prevention programs and ongoing staff development were identified as significant components to meeting the mental health needs of students.

The Role of School Practitioners

For SBMHS to realize their full potential, there is growing emphasis on workforce development to ensure high-quality services are implemented and outcomes assessed appropriately (Center for Mental Health in Schools, 2001; Flaherty, et al., 1998; Hanchon & Allen, 2013). Among the numerous professionals that have a role in SBMH programs (e.g., teachers, school nurses), school counselors, school psychologists and

school social workers have been consistently identified in the literature as having a critical function in SBMHS (Foster, et al, 2005; Splett, Fowler, Weist, McDaniel, & Dvorsky, 2013). In New Jersey, Gallegly (2012) found that administrators most frequently identified school counselors, school psychologists, school social workers and student assistance professionals as providers of school mental health services. The following sections will briefly present the historical nature and current function of several professions in SBMHS, and review current research on these practitioners as SBMHS providers.

The Development and Current Practice of School Practitioners

The profession of school counselors arose during the early 1900s as part of the vocational guidance movement (Flaherty, et al., 1998). Throughout the 20th century, the role grew to include working with mental health issues of students, social and development issues and prevention (Agresta, 2004). The American School Counselor Association (ASCA) (n.d.) describes school counselors as “uniquely qualified to address the developmental needs of all students through a comprehensive school counseling program addressing the academic, career and personal/social development of all students” (p. 2).

Early influences on the profession of school psychology include the child guidance clinics of the late 19th century and the IQ testing movement in the early 20th century (Merrell, Ervin & Peacock, 2012). The passing of PL 94-142 drastically increased the need for professionals trained to assess students for special education eligibility, thus further solidifying the “gatekeeper/sorter” role of school psychologists (Merrell, et al., 2012, p. 30). Through the 20th century, the profession of school

psychology developed from its initial emphasis on psychometric testing to include roles in counseling, consultation, behavioral supports, violence prevention and, more recently, within models of Response to Intervention (RTI)/Multi-Tiered System of Supports (MTSS) (Agresta, 2004; Flaherty, et al., 1998). The National Association of School Psychologists (NASP) (n.d.) describes school psychologists as “highly trained in both psychology and education” who help students “succeed academically, socially, behaviorally, and emotionally” by collaborating with stakeholders to “create safe, healthy, and supportive learning environments” (p. 1).

Phillippo & Blosser (2013) write that school social work arose as a profession, then known as “visiting teachers,” in the early 20th century as a response to “schools’ perceived failure to address” rapid changes in regard to compulsory education laws, industrialization and immigration (p. 22). From these early roles, school social workers focused on home-school connection, mobilization of community resources, and direct service to children and families (e.g., individual and group counseling), around mental health and social-behavioral adjustment (Flaherty, et al., 1998; Merrell, et al., 2012). The School Social Work Association of America (n.d.) states “school social work is a specialized area of practice within the broad field of the social work...school social workers are trained in mental health concerns, behavioral concerns, positive behavioral support, academic and classroom support, consultation...[and] individual and group counseling techniques” (para. 1).

According to the Association of Student Assistance Professionals of New Jersey (ASAP-NJ) (n.d.), Student Assistance Programs were modeled after Employee Assistance Programs and developed throughout the 1970's and 1980's as a way to assist

elementary, middle and secondary schools in dealing with alcohol and other drug problems. Since that time, Student Assistance Programs have “evolved to focus...on all barriers to learning that impact student success including substance use, mental health issues, violence, as well as a host of other individual and environmental problems that interfere with student achievement” (p. 1).

The New Jersey Department of Education (2010) has set the current minimum qualifications to obtain certification for each role are as follows: 1) School Counselor: Master’s Degree with 48 credits including a 6-credit supervised internship in a school setting; 2) School Psychologist: Master’s degree with 60 credits including a 300-hour supervised practicum and a 1200-hour supervised externship (600 hours of which must be in a school setting); 3) School Social Worker: Master’s degree with 30 credits including 6 credits in introductory and advanced level social case work; and 4) Student Assistance Coordinator: Bachelor’s degree with 21 to 27 graduate credits in specified areas and a supervised six month full time or equivalent school residency.

School Practitioners and Need for Future Research

Research has examined the roles of school counselors, school psychologists and school social workers and their involvement with SBMHS (Agresta, 2004; Phillippo & Blosser, 2013, Suldo, et al., 2010). Agresta (2004) surveyed these groups regarding their actual and ideal time spent on various professional role functions. The results showed that school social workers and school counselors devoted the greatest proportion of their time to individual counseling, group counseling and administrator/teacher consultation. School psychologists reported the greatest time spent in psychometric testing, report writing and administrator/teacher consultation. All groups expressed a desire to spend

increased time engaged in individual and group counseling. Agresta (2004) also examined the degree of role overlap and feelings of competitiveness between the disciplines. According to the author, the results of this study suggest “relatively little duplication of function or role overlap” and do not support the idea of “turf wars” between the professional roles (p. 161-162).

Several researchers in the field have called for a transformation of the traditional roles of school practitioners in relation to SBMHS (Keys, Bemak, & Lockhart, 2001; Lyon, Charlesworth-Attie, Perfect & Morris, 2011; Stoep & McCauley, 2011). Flaherty, et al. (1998) asserted that for SBMHS to be optimally effective, a shift in the approach of the various SBMH disciplines to more effective collaboration is necessary. Barriers to collaboration were identified such as isolated programs and services, logistics, organizational structure and differences between the background and norms of each discipline (Flaherty, et al., 1998). Perfect and Morris (2011) proposed that state agencies or professional groups develop task forces to outline specific competencies related to the delivery of SBMHS. They also suggest research on factors such as pre-service didactic and training experiences and barriers to service delivery as valuable next steps to advance the field.

In a qualitative study examining the perspectives of multidisciplinary school practitioners on resources needed to promote mental health among students, Powers, et al. (2011) found that participants viewed mental health needs as increasing and described critical school needs, (e.g., access to outside colleagues for consultation, more time to utilize specialized training) in order to effectively support students.

Friedrich (2010) surveyed a national sample of school psychologists on their role in providing SBMHS. In this study, school psychologists reported receiving referrals for a variety of student issues and providing a wide array of mental health services. Identified barriers to provision of SBMHS included caseload constraints, role strain, and lack of funding for services. The highest rated facilitators to SBMHS provision involved personal characteristics (e.g., personal desire to provide mental health services), having adequate training and confidence, and school-related factors (e.g., availability to consult with other mental health professionals). Friedrich asserted that such information could be utilized to expand and improve SBMHS and identify pre-service and in-service training needs.

In a national survey of regular and special education teachers, school counselors, and school psychologists on a range of issues related to SBMHS, Repie (2005) found differences among these professional groups regarding their perception of the most problematic mental health issues, as well as barriers to services. The author recommended that future research utilize such a survey as part of a needs assessment. Further, the author states:

Targeting key informants such as regular and special education teachers, school counselors, school psychologists, administrators, and even parents and students may glean a broad and accurate perspective of need and guide the development of school-based programs to address district-specific mental health needs of students. The data provided by these assessments may also spotlight areas of problem and need, thus promoting community and school receptiveness and support for services (p. 295).

To obtain more detailed information regarding SBMHS in New Jersey, Gallegly (2012) recommended gathering information from providers of mental health services, such as school psychologists, school counselors, and school social workers. For a comprehensive view of SBMHS at the state level, Gallegly also suggested investigating service-delivery programs and methods and evaluation of the effectiveness of SBMHS.

Chapter III

Method Of Investigation

The aim of the current study was to gather nominal descriptive information about a sample of school-based mental health services (SBMHS) providers in New Jersey and investigate their perceptions on mental health problems encountered and treated in schools, facilitators and barriers to the provision of SBMHS, and training and education needs. The methodology used in this study, including the research design, participants, instrumentation development, and procedure are discussed in this chapter.

Research Design

This study sought to extend the survey of school psychologists developed by Friedrich (2010) to include perspectives of multiple professional disciplines involved in SBMHS in New Jersey. To develop an inclusive overview of SBMHS in the state it was decided to survey four distinct groups of professionals most closely aligned with direct service provision: school counselors, school psychologists, school social workers and student assistance professionals. Kerlinger and Lee (2000) stated that survey research is well suited to “obtaining personal and social facts, beliefs, and attitudes” (p.611). A survey method was chosen in order to explore and describe current conditions of SBMHS in New Jersey, as well as the perceptions and characteristics of practitioners. Greenlaw and Brown-Welty (2009) asserted that a survey design allows for collection of demographics and perceptions in an efficient and cost-effective manner.

Participants

Setting. As of 2013-2014, there were 591 operating school districts serving 1.37 million students in New Jersey (Department of Education, n.d.). A search of

DataUniverse (Asbury Park Press, n.d.), a database of New Jersey public government data, revealed that the number of school counselors, school psychologists, school social workers and student assistance professionals (categorized as “Coordinator Substance Abuse”) employed in the state during the 2012-2013 academic year was 7,847.

Sample. This investigator attempted to obtain a random sample of current members of the four professional organizations in New Jersey representing practitioners in SBMHS. However, after discussions with the leadership of each organization, it was determined that random sampling would be impossible due to the privacy policies of each group. After further discussion, it was decided to draw participants from a convenience sample (those who were available). The investigator was aware that the use of a convenience sample would place limits on any major generalizations that could be drawn from this research. All four organizations agreed to participate and be named in this dissertation: the Association of Student Assistance Professionals of New Jersey (ASAP-NJ) (personal communication, April 10, 2015), the New Jersey Association of School Psychologists (NJASP) (personal communication, April 10, 2015), the New Jersey Association of School Social Workers (NJASSW) (personal communication, April 13, 2015) and the New Jersey School Counselor Association (NJSCA) (personal communication, April 12, 2015). Inclusionary and exclusionary criteria for participants were developed to focus on soliciting professionals currently working in school settings (i.e., only professional members were included in the survey vs. students/retired/affiliated). Current membership data, as provided by the four professional organizations, are shown in Table 1.

Ethical considerations. Prior to data collection, permissions and approval from

each of the four professional groups that were to be surveyed, as well the Institutional Review Board (IRB) at Rutgers University were obtained. Prior to participation in the survey, all potential participants read an informed consent letter describing the study, their rights, potential risks and the researcher's contact information (see Appendix A). The identities of participants were kept confidential and IP addresses were not collected.

Instrumentation Development

Survey. A web-based survey was developed following a literature review and adapted from Friedrich's (2010) *School Based Mental Health Survey for School Psychologists*. The response options from Friedrich's survey were derived from prior qualitative research (Suldo, Friedrich & Michalowski, 2010) investigating a range of factors school psychologists perceived to impact the provision of SBMHS. Additionally, for an initial examination of quality indicators of SBMHS in New Jersey as perceived by practitioners, a set of survey questions were also derived from *The School Mental Health Quality Assessment Questionnaire (SMHQAQ)* (Weist, Stephan, Lever, Moore, & Lewis, 2006) which connects to 10 research-based principles for best practice in SBMH (Weist, et al., 2005). Permission to use and adapt both instruments was granted by their respective authors (A. Friedrich, personal communication, August 28, 2012; M. D. Weist, personal communication, April 20, 2014).

Selected items from the original survey for school psychologists were revised to be inclusive of other professional disciplines. The sections of the survey (see Appendix B) were designed to gather information on six areas: (1) nominal descriptive characteristics of the sample of practitioners, (2) referral concerns, (3) mental health services provided, (4) barriers and enablers to mental health service provision, (5)

training in school-based mental health, and (6) indicators of quality of SBMHS. A web-based survey format, using SurveyMonkey (www.surveymonkey.com) was selected after discussions with the leadership of each professional organization regarding the parameters of distribution (i.e., this researcher was not granted direct access to members' contact information). It was decided that an electronic survey was the optimal method to gather information across multiple groups. Research conducted by Greenlaw & Brown-Welty (2009), showed that when administered to an educated population with access to computers, web-based surveys could produce higher response rates with less cost and effort than paper-based surveys.

Field test. A field test study to determine the utility of the survey was conducted. Four individuals, one of each of the four professional disciplines, were asked to participate in the field test. The researcher knew these individuals personally and three (a school psychologist, a school social worker and a student assistance professional) agreed to participate in the field test. The field test participants were asked to complete the web-based survey followed by a brief interview to gather information on survey length, clarity of questions, and potential impediments to survey completion. The explanation provided to the field test participants and follow-up interview questions can be found in Appendix C. Each participant was provided the survey link to complete independently. All three participants reported completing the survey at their workplace. The researcher then interviewed each field test participant using the questions shown in Appendix C. Results from field testing revealed the average length of time for survey completion was approximately 35 minutes. It was noted by two of the three participants that several work-related interruptions prolonged survey completion time. Additionally, a section of

the survey in which participants indicated the number of hours spent providing various mental health services in a typical work week was cited by all field test participants as notably time-consuming. Field test participants also reported that rating full lists of factors (e.g., barriers, enablers and training areas), followed by rank ordering the top five from each category, was cumbersome in the web-based format. In an effort to maximize the response rate for this study, the original field test survey was revised to shorten completion time and improve the web-based interface. The section regarding frequency of SBMHS provision was modified to provide participants with response options (e.g., indicate if provide service daily, weekly, monthly) as an alternative to indicating number of hours. The questions in which participants were asked to rank order the top five barriers, enablers and training experiences in SBMHS were eliminated. Two of the field test participants agreed to complete the revised survey. The average completion time for the revised survey was 16 minutes.

Procedure

The link to the web-based survey was disseminated to participants by a representative within each professional organization. Each organization was provided with a cover letter appropriate for introducing the survey (see Appendix D). Two of the organizations (NJASP, NJASSW) distributed the survey link to their members via direct e-mail. One organization (ASAP-NJ) distributed the survey to County/Regional Chairs, who subsequently e-mailed the survey link to their respective regional members. The fourth organization (NJSCA) distributed the survey link to members as an item within their regularly published bi-weekly electronic newsletter. Each professional organization disseminated the survey during late September through October 2014. All four

organizations reported sending at least one survey reminder to participants through the methods listed above. Informed consent (see Appendix A) for the survey was provided through the electronic cover letter. The participants completed the survey (see Appendix B) online. Participants were given an opportunity to provide an e-mail address to be entered in a drawing for one of two \$25 Amazon.com gift cards. The e-mail address, if provided, was stored separately from the survey data.

Response Rate. Though past research has indicated that response rates of paper vs. web-based surveys could be comparable, other evidence pointed to lower response rates for web-based surveys (Hayslett & Wildemuth, 2004). The increased use of web-based surveys, owing to low cost and ease of delivery, has led researchers to examine factors affecting response rate (Laguilles, Williams & Saunders, 2011). High-salience topics and length (approximately 15 minutes) have been associated with higher response rates in both mail and web-based surveys (Fan & Yan, 2010). The evidence regarding the impact of incentives on response rates in web-based surveys is mixed; for instance, some research shows no effect, other studies show post-survey raffles can have a positive effect on response rate, and yet other data indicates lottery incentives of perceived high value are most likely to influence response rates, and may also impact subgroups differently (Laguilles, Williams & Saunders, 2011).

Attempts to maximize response rate were made through instrumentation development as described above. Additionally, a raffle drawing accompanied the survey as an incentive to participants. A total of 179 out of 188 completed surveys met the inclusionary criteria and were further analyzed. Each professional organization provided the researcher with data on current membership numbers. The total number of potential

respondents (i.e., the number of professional members across all four organizations) equaled 2,078 leading to an overall response rate of 8.6%. Table 1 summarizes the response rate for each professional group.

Table 1

Response Rate by Professional Role

Professional Role	<i>n</i>	Number of Professional Members in Organization	Response Rate
School Counselors	15	1,020	1.5%
School Psychologists	89	469	19.0%
School Social Workers	30	220	13.6%
Student Assistance Professionals	38	369	10.3%
Total ^a	179	2,078	8.6%

^aIncludes “Other” Professional Role (n = 7)

Data Analysis

Data collected from the web-based survey were coded and entered into a database using SPSS, version 22. Descriptive statistics were used to provide information relevant to each research question. Frequencies, percentages and measures of central tendency of the overall sample, as well as the four professional groups, were used to examine nominal descriptive characteristics and referral concerns. With respect to the data collected on barriers, enablers and training in SBMHS, frequencies, percentages, mean ratings and standard deviation for each item were obtained. Descriptive statistics, including the mean and standard deviation, were also used to summarize data gathered from the final section of the survey regarding quality indicators of SBMHS.

Research Questions

This study sought to gather information on the following research questions:

1. What are the nominal descriptive characteristics of the sample of SBMHS practitioners in New Jersey, including: years of experience, background and training?
2. What types of mental health issues and problems are seen by school practitioners in New Jersey?
3. What types of school-based mental health services are provided by school practitioners in New Jersey?
4. What factors (system level (district, school, state); individual; other) do school practitioners perceive as facilitators in the provision of SBMHS in New Jersey?
5. What factors (system level (district, school, state); individual; other) do school practitioners perceive as barriers in the provision of SBMHS in New Jersey?
6. What content areas and experiences are perceived by practitioners in New Jersey as important to prepare school practitioners to provide SBMHS?
7. What are the perceptions of school practitioners in New Jersey on the quality of mental health services available in their schools?

Chapter IV

Results

The purpose of this study was to explore the perspectives of New Jersey school mental health practitioners (school counselors, school psychologists, school social workers, and student assistance counselors) regarding their role in the provision of school-based mental health services (SBMHS), the barriers and facilitators to involvement in SBMHS, and needs for training and professional development. Additionally, this study gathered information on the type of referrals SBMH practitioners receive and their perspectives on the resources available for effective SBMHS. Data were collected from 179 SBMHS professionals in New Jersey via a web-based survey. However, some participants did not complete all items on the survey. The number of participants who responded to an item is noted. On an a priori basis, the research methods were not designed to determine group differences. Post hoc analyses were considered and deemed unlikely to contribute meaningfully to interpretation of this research. Therefore, only descriptive methods were used in data analysis. The results of the survey data corresponding to the research questions presented in Chapter 3 are reported in this chapter.

Research Question 1: What are the nominal descriptive characteristics of the sample of SBMHS practitioners in New Jersey, including: years of experience, background and training?

To answer this research question, responses from questions 1 through 14 on the survey were analyzed. These questions gathered information on the characteristics of SBMH practitioners as well as the schools in which they currently work. Frequency

counts and percentages were calculated based on the number of participants that completed each item. Additionally, the mean, standard deviation and the range of responses were calculated. The data gathered on gender, ethnicity, professional role, school type (private, public, parochial), school setting (rural, suburban, urban) and the ratio of students to professional role in their school are presented in Table 2. Information on the average age of respondents, years practicing, number of school buildings served and time spent serving each grade level (preschool, elementary, middle school and high school) are presented in Table 3. Participants consisted of 153 female (85.5%) and 26 male (14.5%) school based mental health practitioners in New Jersey. Most respondents were Caucasian ($n = 157$; 89.2%) with an average age of 45.01 and 13.23 years of experience in their current professional role. Additional ethnicities reported by respondents included: Black/African American (3.4%), Hispanic/Latino (2.3%), Asian/Pacific Islander (0.6%), and Other (4.5%). The responses obtained from the other ethnicity category included: American Indian/White, Black/White, Hispanic/White, South Asian and White/Jewish.

The majority of participants worked in public schools (95.9%) and were school psychologists ($n = 89$, 49.7%), followed by student assistance professionals ($n = 38$, 21.2%), school social workers ($n = 30$, 16.8%), school counselors ($n = 15$, 8.4%) and other professional role ($n = 7$, 3.9%). The responses given for other professional role included Assistant Superintendent of PPS, Director of School Counseling, School Counselor/School Social Worker, Supervisor of Mental Health team, Supervisor of School Psychologists. Most participants reported their highest degree as Specialist/Post-Masters (42.5%). Other participants reported holding Masters degrees (36.9%),

Doctorate degrees (16.8%), Post Bachelors certification (3.4%) and Bachelors degrees (0.6%). The school settings reported by respondents were suburban (77.1%), urban (17.1%) and rural (5.7%).

Table 2

Nominal Descriptions of the Sample

Variable	<i>n</i>	Percentage
Gender (<i>n</i> = 179)		
Female	153	85.5
Male	26	14.5
Ethnicity (<i>n</i> = 176)		
American Indian or Alaskan Native	0	0
Asian or Pacific Islander	1	0.6
Black or African American	6	3.4
Hispanic or Latino	4	2.3
White/Caucasian	157	89.2
Other	8	4.5
Professional Role (<i>n</i> = 179)		
School Counselor	15	8.4
School Psychologist	89	49.7
School Social Worker	30	16.8
Student Assistance Professional	38	21.2
Other	7	3.9
Highest Degree Earned (<i>n</i> = 179)		
Bachelors	1	0.6
Post-Bachelors Certification	6	3.4
Masters	66	36.9
Specialist/Post-Masters	76	42.5
Doctorate	30	16.8
Type of School Served (<i>n</i> = 170)		
Private	6	3.5
Public	163	95.9
Parochial	1	0.6

Table 2 Continued

School Setting (<i>n</i> = 175)		
Rural	10	5.7
Suburban	135	77.1
Urban	30	17.1
Professional Role to Student Ratio (<i>n</i> =175)		
1: <500	95	54.3
1: 500-999	49	28.0
1: 1000-1499	18	10.3
1:1500-2000	8	4.6
1: >2000	5	2.9

More than half (54.3%) of participants reported a 1:500 professional role to student ratio in their school while less than a third (28.0%) indicated a 1:500-999 ratio. Fewer respondents reported ratios of 1:1000-1499 (10.3%), 1:1500-2000 (4.6%) or 1:>2000 (2.9%). The average number of school buildings served by respondents was 2.07. The average percentage of time reported serving students at each grade level was calculated: high school (32.10%), elementary school (30.53%), middle school (26.56%), preschool (20.83%) and other (0.39%).

Table 3

Participant Job Related Information

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	Min	Max
Age in years	170	45.01	12.92	25	85
Years practicing in current professional role	178	13.23	9.77	1	51
Number of school buildings served	175	2.07	1.70	1	13
Percentage of time serving preschool students	167	9.82	20.83	0	100

Table 3 Continued

Percentage of time serving elementary students	167	30.53	35.50	0	100
Percentage of time serving middle school students	167	26.56	35.26	0	100
Percentage of time serving high school students	167	32.10	43.89	0	100
Percentage of time serving students at other school level	166	0.39	2.70	0	25

The frequencies, percentages and means of the nominal descriptive and job-related information for each of the four professional roles are delineated in Tables 4 through 8. Participants who selected “other” professional role were not included in these analyses. The composition of the groups are described here but further interpretation is not presented. The investigator considered doing a post hoc analysis to compare groups but due to differences in the sample size of each group this would have provided very limited data.

Table 4

Nominal Descriptions by Professional Role

Variable	School Counselors		School Psychologists		School Social Workers		Student Assistance Professionals	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Gender								
Female	14	93.3	72	80.9	29	96.7	33	86.8
Male	1	6.7	17	19.1	1	3.3	5	13.2
Ethnicity								
American Indian or Alaskan Native	0	0	0	0	0	0	0	0
Asian or Pacific Islander	0	0	1	1.1	0	0	0	0
Black or African American	0	0	2	2.3	3	10.0	1	2.8
Hispanic or Latino	0	0	2	2.3	1	3.3	0	0
White/Caucasian	15	100.0	77	87.5	25	83.3	34	94.4
Other	0	0	6	6.8	1	3.3	1	2.8
Highest Degree Earned								
Bachelors	0	0	0	0	0	0	1	2.6
Post-Bachelors Certification	0	0	0	0	0	0	6	15.8
Masters	9	60.0	17	19.1	23	76.7	13	34.2
Specialist/Post-Masters	6	40.0	45	50.6	7	23.3	16	42.1
Doctorate	0	0	27	30.3	0	0	2	5.3
Type of School Served								
Private	1	7.1	3	3.7	1	3.3	1	2.6
Public	13	92.9	78	96.3	28	93.3	37	97.4
Parochial	0	0	0	0	1	3.3	0	0
School Setting								
Rural	1	6.7	3	3.4	3	10.3	3	8.1
Suburban	13	86.7	66	75.9	20	69.0	30	81.1
Urban	1	6.7	18	20.7	6	20.7	4	10.8

Table 4 Continued

Professional Role to Student Ratio								
1: <500	12	80.0	43	49.4	25	86.2	11	29.7
1: 500-999	3	20.0	30	34.5	4	13.8	10	27.0
1: 1000-1499	0	0	9	10.3	0	0	8	21.6
1:1500-2000	0	0	4	4.6	0	0	4	10.8
1: >2000	0	0	1	1.1	0	0	4	10.8

Table 5

Participant Job Related Information by Professional Role – School Counselors

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	Min	Max
Age in years	14	43.07	12.38	27	64
Years practicing in current professional role	15	10.40	7.03	1	25
Number of school buildings served	15	1.87	3.09	1	13
Percentage of time serving preschool students	14	6.07	14.30	0	50
Percentage of time serving elementary students	14	27.64	41.34	0	100
Percentage of time serving middle school students	14	41.29	47.38	0	100
Percentage of time serving high school students	14	24.29	42.38	0	100
Percentage of time serving students at other school level	14	0.71	2.67	0	10

Table 6

Participant Job Related Information by Professional Role – School Psychologists

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	Min	Max
Age in years	89	44.99	14.44	25	85
Years practicing in current professional role	89	13.50	11.33	1	51
Number of school buildings served	88	2.20	1.49	1	8
% of time serving preschool students	84	12.89	24.16	0	100
% of time serving elementary students	84	41.93	36.09	0	100
% of time serving middle school students	84	23.24	29.85	0	100
% of time serving high school students	84	20.21	36.42	0	100
% of time serving students at other school level	83	0.54	3.49	0	25

Table 7

Participant Job Related Information by Professional Role – School Social Workers

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	Min	Max
Age in years	25	44.44	9.47	26	66
Years practicing in current professional role	30	12.80	6.18	2	28
Number of school buildings served	29	2.10	1.15	1	5
% of time serving preschool students	27	15.74	24.01	0	75
% of time serving elementary students	27	33.15	33.17	0	100
% of time serving middle school students	27	26.48	33.71	0	100
% of time serving high school students	27	24.26	41.53	0	100
% of time serving students at other school level	23	0.37	1.93	0	10

Table 8

Participant Job Related Information by Professional Role – Student Assistance Professionals

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	Min	Max
Age in years	35	44.54	10.29	25	62
Years practicing in current professional role	37	13.35	7.94	1	27
Number of school buildings served	36	1.61	1.44	1	6
% of time serving preschool students	36	0.14	0.83	0	5
% of time serving elementary students	36	3.03	13.42	0	80
% of time serving middle school students	36	29.75	43.69	0	100
% of time serving high school students	36	67.08	45.30	0	100
% of time serving students at other school level	36	0.00	0.00	0	0

Question 13 on the survey asked participants to indicate how prepared they felt provide mental health services in schools after completion of graduate training. The number and percentages corresponding with the answer options for the questions, for both the overall sample as well as by professional group are presented in Table 9. Overall, the largest number of respondents felt adequately prepared to provide SBMHS with 28.5% selecting *Satisfactorily Prepared* and 26.8% indicating they felt *Well Prepared* to provide SBMHS upon completion of graduate training. A number of respondents (31.8%) felt *A Little Prepared* by their graduate school training to provide SBMHS. Only 9.5% respondents felt *Extremely Prepared* by their graduate training experience while very few respondents (0.6%) indicated they felt *Not at All Prepared* to provide mental health services in schools.

Question 14 on the survey asked participants to indicate the amount of time they would prefer to spend providing mental health services. The number and percentages corresponding with answer options for the overall sample, as well as by professional group are presented in Table 10. Overall, the majority of participants (55.3%) indicated they would prefer to spend *More time* providing mental health services. Over a third of respondents (37.4%) preferred to spend *The same amount of time* and few respondents (4.5%) indicated they would prefer to spend *Less time* providing mental health services.

Table 9

Perception of Level Prepared to Provide Mental Health Services after Graduate School

Level Prepared	Overall (<i>n</i> =174) <i>n</i> (%)	School Counselors (<i>n</i> =15) <i>n</i> (%)	School Psychologists (<i>n</i> =87) <i>n</i> (%)	School Social Workers (<i>n</i> =29) <i>n</i> (%)	Students Assistance Professionals (<i>n</i> =36) <i>n</i> (%)
Not at all prepared	1 (0.6)	0 (0)	1 (1.1)	0 (0)	0 (0)
A little prepared	57 (32.8)	2 (13.3)	35 (40.2)	9 (31.0)	10 (27.8)
Satisfactorily Prepared	51 (29.3)	2 (13.3)	30 (34.5)	8 (27.6)	7 (19.4)
Well prepared	48 (27.6)	9 (60.0)	15 (17.2)	10 (34.5)	12 (33.3)
Extremely prepared	17 (9.8)	2 (13.3)	6 (6.9)	2 (6.9)	7 (19.4)

Table 10

Participants' Preference for Amount of Time Providing Mental Health Services

Amount of Time	Overall	School Counselors	School Psychologists	School Social Workers	Student Assistance Professionals
	<i>(n = 174)</i> <i>n (%)</i>	<i>(n = 15)</i> <i>n (%)</i>	<i>(n = 87)</i> <i>n (%)</i>	<i>(n = 29)</i> <i>n (%)</i>	<i>(n = 36)</i> <i>n (%)</i>
More time	99 (56.9)	12 (80.0)	45 (51.7)	21 (72.4)	17 (47.2)
Less time	8 (4.6)	0 (0)	7 (8.0)	0 (0)	1 (2.8)
Same amount	67 (38.5)	3 (20.0)	35 (40.2)	8 (27.6)	18 (50.0)

Research Questions 2: What type of mental health issues and problems are seen by school practitioners in New Jersey?

To answer this research question, responses from question 15 on the survey were analyzed. This question asked respondents to review a list of 32 problems for which children are commonly referred for mental health services and rank order the five types of problems referred most frequently. The results for the participants who responded to this question ($n=163$) are presented in Table 11. Analyses on this item included calculating the number and percentages of respondents who ranked each problem in their top five, as well as the percentage of respondents who did not rank a given referral problem. All referral problems were ranked by at least two respondents as among the top five most common problems referred for SBMHS. The most commonly ranked items, (i.e., ranked by the highest percentages of respondents as one of their top five) were (1) interpersonal problems (57.7%), (2) academic problems (57.1%), (3) general anxiety (42.9%), (4) Attention Deficit Hyperactivity Disorder (ADHD) (41.7%), (5) anger/aggression (31.3%) and (6) general externalizing concern (31.3%). The least

commonly ranked problems referred to respondents for mental health services include (1) romantic relationship problems (1.2%), (2) Obsessive Compulsive Disorder (OCD) (1.2%), (3) eating problems (1.2%), (4) school-wide tragedy (1.8%), and (5) adolescent sexuality (1.8%). Responses generated by the “Other” referral problem category (5 respondents) included academic pressure, debilitating conditions in community, developmental delays, and school refusal/school anxiety.

Table 11

School-Based Mental Health Referral Concerns

Referral Problem (n=163)	% Ranked in Top 5	% 1 st	% 2 nd	% 3 rd	% 4 th	% 5 th	% Not Ranked
Interpersonal problems	57.7	11.0	11.0	9.8	14.1	11.7	42.3
Academic problems	57.1	32.5	9.8	9.2	3.7	1.8	42.9
General anxiety	42.9	8.0	7.4	11.7	8.0	8.0	57.1
ADHD	41.7	8.6	17.8	6.1	6.1	3.1	58.3
Anger/aggression	31.3	6.7	7.4	8.0	5.5	3.7	68.7
General externalizing concern	31.3	4.9	7.4	8.0	8.0	3.1	68.7
Autism/Asperger's	23.3	4.3	2.5	5.5	6.1	4.9	76.7
Bullying	21.5	2.5	3.7	6.1	4.9	4.3	78.5
Depression	21.5	1.2	5.5	4.9	5.5	4.4	78.5
Threat to harm self	20.2	3.1	4.9	1.2	4.9	6.1	79.8
Lack of Motivation	19.0	0.6	2.5	3.7	6.1	6.1	81.0
Substance use	17.8	8.6	3.1	2.5	1.2	2.5	82.2
Atypical or odd behaviors	13.5	2.5	3.1	2.5	3.1	2.5	86.5
Low self-esteem/self concept	12.3	0	1.2	1.2	4.9	4.9	87.7
Cutting	11.7	0.6	2.5	3.1	1.2	4.3	88.3
ODD	11.7	0.6	1.8	3.1	3.1	3.1	88.3
Grief or loss	10.4	0	0	1.8	4.3	4.3	89.6
General internalizing concern	9.2	0.6	0.6	2.5	1.2	4.3	90.8
Trauma	5.5	1.2	0	1.2	1.2	1.8	94.5
Truancy	4.3	0	0.6	1.8	0.6	1.2	95.7
Bipolar Disorder	3.7	0.6	1.2	0.6	1.2	0	96.3
Caregivers' mental health issues	3.7	0	0	2.5	1.2	0	96.3
Divorce in family	3.7	0	0.6	0.6	0	2.5	96.3
Specific phobia	3.7	0	1.2	0.6	0.6	1.2	96.3
Problems/conflict with caregivers	3.1	0	1.2	1.2	0	0.6	96.9
Other (please specify)	3.1	0	1.2	0	0	0	96.9
Threat to harm others	2.5	0.6	0.6	0	0.6	0.6	97.5
Adolescent sexuality	1.8	0.6	0	0	0	1.2	98.2
School-wide tragedy	1.8	0	0.6	0	0	1.2	98.2
Eating Problems	1.2	0	0.6	0	0	0.6	98.8
OCD	1.2	0.6	0	0	0	0.6	98.8
Romantic Relationship Problems	1.2	0	0	0.6	0	0.6	98.8

Further analysis on this item computed the most commonly ranked mental health problems referred for each professional group. Among school counselors (n=14), the most common problems were (1) interpersonal problems (71.4%), (2) academic problems (50.0%), (3) general anxiety (50.0%), (4) anger/aggression (35.7%), (5) general externalizing concern (35.7%), and (6) grief or loss (35.7%). Among school psychologists (n=80), the most commonly ranked were (1) academic problems (72.5%), (2) ADHD (41.7%), (3) interpersonal problems (53.8%), (4) general externalizing concern (43.8%), (5) general anxiety (37.5%), and (6) Autism/Asperger's (37.5%). The most commonly ranked referral problems reported by school social workers (n=27) include (1) academic problems (66.7%), (2) interpersonal problems (63.0%), (3) general anxiety (40.7%), (4) anger/aggression (40.7%), and (5) ADHD (40.7%). Finally, among student assistance professionals (n=36) the most commonly ranked items were (1) substance use (75%), (2) general anxiety (50.0%), (3) interpersonal problems (50.0%), (4) depression (44.4%) and (5) threat to harm self (38.9%).

Research Question 3: What type of school-based mental health services are provided by school practitioners in New Jersey?

To answer this question, responses from survey questions 16 and 17 were analyzed. Question 16 asked respondents to select “yes” or “no” for a list of items to indicate which services they provide to children with mental health problems. For all items marked “yes”, respondents indicated the frequency they provide the service (e.g., 1=*Daily*, 2=*Several days per week*, 3=*Weekly*, 4=*Several days per month*, 5=*Monthly*, 6=*Less than monthly*). For each item, the percentage of respondents providing the service was calculated. The number of missing responses varied by item, thus

percentages were calculated for each item based on the valid responses. The mean rating of the frequency was calculated for each service. The results from this question in order of descending mean rating of frequency are presented in Table 12.

Table 12

Mental Health Services Provided by School Practitioners by Frequency

Service	<i>n</i>	% Provide	<i>M</i>			
			Frequency Rating	<i>SD</i>	Min	Max
Consultation with School Staff	157	100	1.92	1.10	1	6
Other	54	22.2	2.10	1.45	1	5
Individual Counseling	155	87.1	2.64	1.32	1	6
Brief Counseling	153	83.7	3.40	1.68	1	6
Consultation with Parent/Caregiver	150	98.7	3.44	1.60	1	6
Group Counseling	152	66.4	3.58	1.30	1	6
Consultation with Problem-Solving or I&RS Team	154	90.3	3.77	1.29	1	6
Behavioral Interventions	154	81.2	4.22	1.50	1	6
Social/Emotional/Behavioral Assessment	152	75.7	4.53	1.27	1	6
Prevention Programs	151	49.0	4.67	1.36	1	6
Consultation with Community Service Providers	151	89.4	4.78	1.28	2	6
Referrals to Outside Agencies	153	89.5	4.94	1.14	1	6
Counseling Adults	147	37.4	5.04	1.09	2	6
Family Counseling	149	21.5	5.22	1.04	2	6
Suicide Assessment and Intervention	154	81.8	5.36	0.90	3	6
Threat Assessment	152	71.7	5.62	0.91	2	6
Schoolwide/Classwide Screening	149	18.1	5.64	0.91	3	6
Inservice Training for School Staff	154	63.0	5.78	0.51	3	6
Inservice Training for Parents	151	44.4	5.90	0.35	4	6

A substantial majority of respondents (i.e., more than 75%) indicated they provide the following services to children with mental health problems: consultation with school staff (100%), individual counseling (87.1%), brief counseling (83.7%), consultation with parent/caregiver (98.7%), consultation with problem-solving or Intervention and Referral Services (I&RS) team (90.3%), behavioral interventions (81.2%), social/emotional/behavioral assessment (75.7%), consultation with community service providers (89.4%), referrals to outside agencies (89.5%), and suicide assessment and intervention (81.8%). A moderate amount of respondents (i.e., 35 to 75%) reported providing group counseling (66.4%), prevention programs (49%), counseling adults (37.4%), threat assessment (71.7%), and inservice trainings for school staff (63%) and parents (44.4%). Less respondents (i.e., less than 25%) indicated they provide family counseling (21.5%) or schoolwide/classwide screenings (18.1%). Fifty-four respondents (22.2%) indicated they provide an “other” service to children with mental health problems. Of this group 17 respondents specified the type of “other” service. Responses elicited included (1) services related to bullying (3 respondents), (2) case management (3 respondents), (3) special education assessment (2 respondents), (4) substance use/abuse services (2 respondents), (5) clinical staffings, (6) crisis intervention, (7) meetings with community resources, (8) planning and preparation for programs/groups, (9) services to homeless students, and (10) parenting assistance/training.

In regard to the frequency of mental health service provision, five services were reported to occur on average on at least a weekly basis (i.e., mean frequency rating ≥ 3.5): (1) consultation with school staff, (2) individual counseling, (3) brief counseling, (4) consultation with parent/caregiver and (5) other. As is shown in Table 14, ten services

were reported to occur on average at least several times per month (i.e. mean frequency ratings between 3.1 and 5.49). Respondents reported engaging in four services on a less than monthly basis (i.e., mean frequency ratings >5.5): (1) threat assessment, (2) schoolwide/classwide screening, (3) inservice training for school staff and (4) inservice training for parents.

Answers from survey question 17 were analyzed to identify the types of group counseling services provided by respondents. Of the 101 respondents who indicated they provide group counseling, 99 further specified the types of groups. The most frequently identified group among this subsample was social skills (82.8%) followed by anger management (51.5%). Additional group types reported by respondents included anxiety (38.4%), grief (26.3%), study skills (23.2%), and divorce (19.2%). In addition, 28 respondents (28.2%) indicated they provide one or more “other” type of group. These responses were tabulated and included (1) substance abuse and related issues (16 respondents), (2) gender, sexuality and relationship related topics (5 respondents), (3) self-esteem (3 respondents), (4) motivation (2 respondents), (5) stress management (2 respondents), (6) teenage parenting (2 respondents), (7) ACT/CBT, (8) ADHD, (9) attendance, (10) cutting, (11) organization, (12) peer support, (13) smoking cessation, (14) social skills and yoga, (15) transition, and (16) general groups.

Research Question 4: What factors (system level (district, school, state); individual; other) do school practitioners perceive as facilitators in the provision of SBMHS in New Jersey?

To answer this research question, responses from question 19 on the survey were analyzed. Respondents rated various factors that enable provision of mental health

services. The factors were rated as follows: *1=Not an enabler, 2=Slight enabler, 3=Moderate enabler, 4=Significant enabler, 5=Extreme enabler and 6= N/A, Have not personally experienced this factor.* Each factor was reviewed to determine the number of respondents per item followed by computing the percentage of respondents rating the item N/A. The mean rating (excluding N/A) and standard deviation for each factor were calculated as well as the range of scores. Results of the analysis, including the number of respondents for each factor, are presented in Table 13 in order of descending mean factor rating.

Table 13

Ratings of Possible Enablers to the Provision of School-Based Mental Health Services by All Practitioners

Possible Enabler	<i>n</i>	% <i>reported</i>		<i>SD</i>	Min	Max
		<i>N/A</i>	<i>M</i>			
Personal desire to provide mental health (m.h.) services	136	1.5	3.51	1.35	1	5
Sufficient knowledge/skills relevant to m.h. service provision	135	3.0	3.41	1.16	1	5
Ability to remain objective with a student	134	3.7	3.41	1.22	1	5
Access to adolescents	135	21.5	3.39	1.41	1	5
Adequate confidence in ability to provide m.h. services	136	2.2	3.38	1.25	1	5
Ability to maintain personal boundaries	136	6.6	3.32	1.35	1	5
Availability to consult with other school m.h. professionals	135	5.9	3.31	1.31	1	5
Sufficient space	134	5.2	3.24	1.41	1	5
Sufficient support for m.h. services from building-level administrator	137	4.4	3.06	1.32	1	5
Access to/linkages with community resources	135	3.0	3.05	1.32	1	5
Sufficient time and integration into your site	137	6.6	3.02	1.50	1	5
Teachers are supportive of mental health services/interventions	136	2.2	3.02	1.16	1	5
Teachers expect your role to include m.h. services	136	2.2	3.01	1.32	1	5
Personal experiences as a parent	136	28.7	2.99	1.34	1	5
Sufficient support from parents for m.h. services	134	3.7	2.67	1.24	1	5
Manageable number of children in need of m.h. services	135	3.0	2.62	1.33	1	5

Table 13 Continued

Department gives explicit permission to provide m.h. services	137	16.8	2.60	1.31	1	5
District Support for m.h. services provision	137	6.6	2.53	1.33	1	5
Department provides relevant professional development	136	5.1	2.49	1.24	1	5
Manageable number of children who require psychoeducational evals	135	3.0	2.41	1.39	1	5
Other enabler to m.h. service provision in schools	24	8.9	2.00	1.41	1	4

The vast majority of respondents (i.e., >90%) reported having personally experienced most of the items listed as possible enablers. Three enabling factors were rated by more than 10% as respondents as N/A: (1) personal experiences as a parent (28.7%), (2) access to adolescents (21.5%) and (3) department gives explicit permission to provide mental health services (16.8%). The factors personally experienced by the greatest number of respondents (i.e., >97%) included (1) personal desire to provide mental health services (98.5%), (2) adequate confidence in ability to provide mental health services (97.8%), (3) teachers are supportive of mental health services/interventions (97.8%) and (4) teachers expect your role to include mental health services (97.8%).

All factors but one (“Other”) received ratings from the minimum of one to the maximum of five. None of the factors received a mean rating corresponding to *Extreme Enabler* (i.e., mean rating of 4.51 to 5.00) or *Not an Enabler* (i.e., mean rating of 1.00 to 1.50). One factor, a personal desire to provide mental health services, received a mean rating corresponding to *Significant Enabler* (i.e., mean rating of 3.51 to 4.50). As can be seen in Table 15, the large majority of factors received a mean rating corresponding to

Moderate Enabler (i.e., mean rating of 2.51 to 3.50). Three factors received a rating corresponding to *Slight Enabler* (i.e., a mean rating of 1.51 to 2.50): (1) department provides relevant professional development, (2) manageable number of children who require psychoeducational evaluations, and (3) “Other” enabler.

Eight respondents selected the “Other” category and one respondent specified an “Other” type of enabler: Responses elicited from the “Other” category included: district administration supportive of mental health services to the extent that we have partnered with a private agency to provide quality mental health services to our students and their families.

Research Question 5: What factors (system level (district, school, state); individual; other) do school practitioners perceive as barriers in the provision of SBMHS in New Jersey?

To answer this research question, responses from question 18 on the survey were analyzed. Respondents rated various factors that present a barrier in their provision of mental health services. The factors were rated as follows: *1=Not a barrier, 2=Slight barrier, 3=Moderate barrier, 4=Significant barrier, 5=Extreme barrier and 6= N/A, Have not personally experienced this factor.* Each factor was reviewed to determine the number of respondents per item followed by computing the percentage of respondents rating the item N/A. The mean rating (excluding N/A) and standard deviation for each factor were calculated as well as the range of scores. Results of the analysis, including the number of respondents for each factor, are presented in Table 13 in order of descending mean factor rating.

Table 14

Ratings of Possible Barriers to the Provision of School-Based Mental Health Services by All Practitioners

Possible Barrier	<i>n</i>	% <i>reported</i>		<i>SD</i>	Min	Max
		<i>N/A</i>	<i>M</i>			
Role strain	150	2.7	3.35	1.32	1	5
Inconsistent treatment	148	7.4	2.96	1.17	1	5
Problems accessing students during the day	150	4.7	2.88	1.17	1	5
Too many students in need of mental health (m.h.) services	149	4.7	2.80	1.32	1	5
Too many psychoeducational evaluations	149	12.1	2.63	1.49	1	5
Lack of time and integration into site	149	4.7	2.61	1.48	1	5
Cumbersome department procedures	149	6.0	2.47	1.47	1	5
Difficulty collaborating with teachers to implement services	150	2.0	2.47	1.16	1	5
Lack of funds	147	8.2	2.39	1.46	1	5
Overlapping responsibilities among m.h. staff	148	2.7	2.37	1.18	1	5
Lack of support from parents during m.h. intervention efforts	148	5.4	2.37	1.24	1	5
Schools accountable for students' academic success only	148	8.1	2.29	1.27	1	5
Burnout	149	6.7	2.27	1.25	1	5
Lack of support from building level administrator	147	8.8	2.08	1.30	1	5
Lack of space	148	8.1	2.08	1.38	1	5
Lack of support from teachers	150	4.0	2.03	1.17	1	5
Concerns with liability	150	6.0	2.03	1.15	1	5
Narrowly defined department assigned role	150	6.7	1.97	1.18	1	5
Teachers unaware of m.h. services that school professionals can provide	150	6.0	1.92	1.17	1	5
Difficulty maintaining students' privacy	150	6.7	1.90	1.03	1	5

Table 14 Continued

Unplanned/premature termination	148	9.5	1.89	1.05	1	5
Personal desire to provide traditional services such as assessment	148	10.1	1.88	1.20	1	5
Student attrition	150	9.3	1.82	1.06	1	5
Lack of knowledge/skills relevant to m.h. services provision	149	5.4	1.69	0.82	1	5
Lack of confidence in ability to provide m.h. services	150	4.7	1.63	0.84	1	5
Other barrier to provision of m.h. services in schools	28	28.6	1.50	1.24	1	5
Off-putting student characteristics	150	6.0	1.30	0.65	1	5
Personal mental health problems	150	10.7	1.30	0.73	1	5

The majority of respondents (i.e., >90%) reported having personally experienced most of the items listed as possible barriers. Four potential barriers were rated by more than 10% of respondents as N/A: (1) too many psychoeducational evaluations (12.1%), (2) personal mental health problems (10.7%), (3) personal desire to provide traditional services such as assessment (10.1%), and (4) “Other” barrier (28.6%). The factors personally experienced by the greatest number of respondents (i.e., >97%) included difficulty collaborating with teachers to implement services (98.0%), role strain (97.3%), and overlapping responsibilities among mental health staff (97.3%).

All factors received ratings from the minimum of one to the maximum of five. As can be seen in Table 16, the large majority of factors received a mean rating corresponding to *Slight Barrier* (i.e., mean rating of 1.51 to 2.50). None of the factors received an average rating corresponding to *Extreme Barrier* (i.e., mean rating of 4.51 to 5.00) or to *Significant Enabler* (i.e., mean rating of 3.51 to 4.50). Six factors received a

rating corresponding to *Moderate Barrier* (i.e., a mean rating of 2.51 to 3.50): (1) role strain, (2) inconsistent treatment, (3) problems accessing students during the day, (4) too many students in need of mental health services, (5) too many psychoeducational evaluations, and (6) lack of time and integration into site. Three factors received a rating corresponding to *Not a Barrier* (i.e., mean rating of 1.00 to 1.50): (1) off-putting student characteristics, (2) personal mental health problems and (3) “Other” barrier.

Twenty respondents selected the “Other” category, however only 3 of these respondents provided a rating higher than *Not a barrier*. Responses elicited from the “Other” category included: insufficient funds, securing parental permission, and teachers intervening instead of referring students for help.

Research Question 6: What content areas and experiences are important to prepare school practitioners to provide SBMHS?

To answer this research question, responses from questions 20 through 22 were analyzed. Respondents rated various types of content area, experiential activities and professional development opportunities on their importance in preparing them to provide SBMHS. The items were rated as follows: 1=*Not helpful*, 2=*Somewhat helpful*, 3=*Moderately helpful*, 4=*Very helpful*, 5=*Extremely helpful* and 6= *N/A, Did not receive training in content area or Did not receive/incur this experience*. Content and training items were reviewed to determine the number of respondents per item followed by computing the percentage of respondents rating the item N/A. The mean rating (excluding N/A) and standard deviation for each item were calculated as well as the range of scores.

The results regarding content areas viewed as important preparation for SBMHS are shown in Table 15. Results of the analysis, including the number of respondents for each item, are presented in Table 15 in order of descending mean item rating. A substantial majority of respondents (i.e., $\geq 80\%$) reported having received training in all but four content areas. The content areas rated by 20% or more of respondents as N/A: (1) counseling adults (28.0%), (2) substance abuse prevention and treatment (26.5%), (3) advanced counseling/psychotherapy (22.1%), and (4) systems consultation (20.0%). The content areas in which the greatest number of respondents (i.e., $>97\%$) reported having received training were (1) developmental psychology (99.3%), (2) Ethics/Law (99.3%), (3) social-emotional-behavioral assessment (98.5%) and (4) psychopathology/behaviors disorders/abnormal psychology (98.5%).

Table 15

Ratings of Content Areas in School-Based Mental Health Preparation

Content Area	<i>n</i>	% <i>reported</i>		<i>SD</i>	Min	Max
		<i>N/A</i>	<i>M</i>			
Therapeutic relationship skills	135	3.0	4.15	0.92	2	5
Social-emotional-behavioral assessment	135	1.5	4.13	0.89	2	5
Crisis intervention	135	10.4	4.02	0.98	2	5
Developmental psychology	135	0.7	4.01	0.92	2	5
Consultation with teachers or parents	136	5.1	3.95	1.02	2	5
Learning skills needed to be a lifelong learner	135	4.4	3.92	1.06	1	5
Techniques/strategies for working in school environments	135	11.1	3.91	1.00	2	5
Behavior interventions	135	6.7	3.85	0.96	2	5
Psychopathology/behaviors disorders/abnormal psychology	135	1.5	3.82	1.01	2	5
Advanced counseling/psychotherapy	136	22.1	3.81	1.16	1	5
Information on mental health agencies and resources in the community	135	9.6	3.80	1.07	1	5
Group therapy approaches and techniques	136	11.0	3.73	1.12	1	5
Counseling adults	132	28.0	3.63	1.23	1	5
Ethics/Law	136	0.7	3.61	1.15	1	5
Empirically supported treatments	135	11.9	3.54	1.11	1	5
Substance abuse prevention and treatment	136	26.5	3.52	1.33	1	5
Case documentation	135	9.6	3.51	1.11	1	5
Treatment planning	136	13.2	3.50	1.05	1	5
Family therapy approaches and techniques	135	17.0	3.47	1.19	1	5
Systems consultation	135	20.0	3.40	1.07	1	5
Multicultural education/therapy techniques	136	5.1	3.39	1.12	1	5

Table 15 Continued

Prevention of mental health problems	136	14.7	3.37	1.14	1	5
Survey course covering multiple therapeutic orientations	136	8.8	3.27	1.15	1	5
Psychopharmacology	136	16.9	3.25	1.15	1	5
Advanced study of a single therapeutic orientation	136	19.1	3.09	1.27	1	5

Eight content areas did not receive a rating of less than two (*Somewhat Helpful*) by any respondent. These content areas were therapeutic relationship skills, social-emotional-behavioral assessment, crisis intervention, developmental psychology, consultation with teachers or parents, techniques/strategies for working in school environments, behavior interventions, and psychopathology/behaviors disorders/abnormal psychology. The remaining content areas received ratings from the minimum of one and all content areas received ratings to the maximum of five.

The majority of content areas received a mean rating corresponding to “Very Helpful” (i.e., mean rating of 3.51 to 4.50). No content area received a mean rating corresponding to *Extremely Helpful* (i.e., mean rating of 4.51 to 5.00), *Somewhat Helpful* (i.e., mean rating of 1.51 to 2.50) or *Not Helpful* (i.e., mean rating of 1.00 to 1.50). The remaining eight content areas received a mean rating corresponding to *Moderately Helpful* (i.e., mean rating of 2.51 to 3.50).

Results of the participants’ ratings of experiential activities and professional development opportunities as preparation for providing SBMHS, including the number of respondents for each item, are delineated in Tables 16 and 17, in order of descending mean item rating. As shown in Table 16, three experiential activities were reported as

personally experienced by a vast majority of respondents (i.e., >90%): (1) supervised practicum/externship/internship (97.1%), (2) work on a multidisciplinary team (94.8%) and (3) in-class role plays (93.4%). In contrast, four experiential activities were reported by more than 20% of respondents as *N/A, Did not receive/incur this experience*: (1) receive own counseling (39.3%), (2) self-review and critique of counseling (35.8%), (3) observe master therapist(s) (34.1%), and (4) co-lead counseling group(s) (21.3%).

Table 16

Ratings of Experiential Training Activities in School-Based Mental Health Preparation

Content Area	<i>n</i>	% <i>reported</i>		<i>SD</i>	Min	Max
		<i>N/A</i>	<i>M</i>			
Supervised practicum/externship/internship	136	2.9	4.30	0.91	1	5
Work on a multidisciplinary team	135	5.2	4.12	1.00	1	5
Co-lead counseling group(s)	136	21.3	3.96	0.97	1	5
Self-review and critique of counseling	134	35.8	3.60	1.20	1	5
Observe master therapist(s)	135	34.1	3.56	1.10	1	5
Receive own counseling	135	39.3	3.44	1.37	1	5
In-class role plays	136	6.6	3.12	1.31	1	5

As shown in Table 17, three professional development opportunities were reported as personally experienced by a vast majority of respondents (i.e., >90%): (1) consultation with colleagues (100.0%), (2) self-study (99.3%) and (3) participate in professional organization (99.3%). More than 20% of respondents reported they had not personally experienced one professional development opportunity: work with interns (26.5%).

Table 17

Ratings of Professional Development Opportunities in School-Based Mental Health Preparation

Content Area	n	% reported		SD	Min	Max
		N/A	M			
Consultation with colleagues	136	0	4.32	0.85	2	5
Self-study	135	0.7	3.83	1.02	2	5
Participate in professional organization	134	0.7	3.47	1.15	1	5
Formal supervision of services	135	14.8	3.44	1.24	1	5
Applied experiences following an in-service	135	14.8	2.90	1.28	1	5
Work with interns	136	26.5	2.84	1.29	1	5
In-services offered through one's district	136	11.0	2.55	1.20	1	5

All experiential areas and most professional development opportunities received ratings from the minimum of one to the maximum of five. Two professional development opportunities were not rated less than two (“Somewhat Helpful”) by any respondent: (1) consultation with colleagues and (2) self-study. All mean ratings of experiential areas and professional development opportunities corresponded to either *Moderately Helpful* (i.e., mean rating of 2.51 to 3.50) or *Very Helpful* (i.e., mean rating of 3.51 to 4.50). No items received mean ratings corresponding to *Extremely Helpful* (i.e., mean rating of 4.51 to 5.00), *Somewhat Helpful* (i.e., mean rating of 1.51 to 2.50) or *Not Helpful* (i.e., mean rating of 1.00 to 1.50).

Research Question 7: What are the perceptions of school practitioners in New Jersey on the quality of mental health services available in their schools?

To answer this question, responses from question 23 on the survey were analyzed. Respondents rated 17 items relevant to several SBMHS quality indicators. The

respondents were asked to rate the item according to the degree it is currently developed and/or implemented in their school(s) on a 5-point Likert scale from 1=*Not at all in place* to 5=*Fully in place*. Analyses determined the number of respondents per item. The mean rating and standard deviation for each quality indicator were calculated as well as the range of scores. Results of the analysis, including number of respondents for each indicator, are presented in Table 18 grouped by the relevant best practice principle.

Table 18

Ratings of Degree of Implementation of School-Based Mental Health Quality Indicators

Principle of Best Practice and Quality Indicators	<i>n</i>	<i>M</i>	<i>SD</i>	Min	Max
Evidence Based-Practice					
Receive ongoing training and supervision on: effective diagnosis, treatment planning and implementation, clinical decision- making	134	1.98	1.11	1	5
Conduct screening and follow-up assessments to identify mental health concerns	132	2.33	1.07	1	5
Continually assess whether ongoing services provided to students are appropriate and helping to address presenting problems	133	2.99	1.12	1	5
A clear and effective protocol in district to assist clinical decision making and care for more serious situations (e.g., abuse and neglect reports, self-reporting of suicidal/homicidal ideation)	133	3.47	1.40	1	5
Actively using the evidence-base (practices and programs) to guide preventive and clinical interventions	132	2.99	1.05	1	5
Continuum of Care and Referral Process					
District offers activities promoting school-wide mental health	133	2.55	1.16	1	5
Faculty and staff trained on the identification, referral, and behavior management of social/emotional/behavioral problems in students	133	2.71	1.04	1	5
District offers prevention activities (e.g., group, classroom, and/or school-wide)	133	2.87	1.20	1	5
District offers intensive treatment services to youth and families (e.g., individual, group, and family therapy)	133	2.11	1.24	1	5
Referral procedures utilized by stakeholders (e.g., educators, other mental health staff, health staff, administrators, parents and students)	133	3.02	1.09	1	5
Clinician Training and Support					
Feel sufficiently trained, supported, and supervised to handle the unique demands of school-based practice in an ethical and effective manner	133	3.33	1.13	1	5

Table 18 Continued

Competence in Cultural, Developmental and Personal Differences					
Receive regular training on effectively providing care for students and families who present diverse developmental, cultural, ethnic, and personal backgrounds	133	2.44	1.18	1	5
Caseload reflects the diversity of the school population	133	3.63	1.08	1	5
District makes effort to ensure that school mental health programs and services are welcoming and respects students and families	133	3.05	1.30	1	5
Interdisciplinary Collaboration					
District coordinates mental health efforts in the school to ensure that youth who need services receive them, while avoiding service duplication	132	2.71	1.24	1	5
Actively collaborate with other professionals in school (other health/mental health providers, educators, administrators)?	131	3.91	0.96	1	5
Community Coordination					
District works with other community health and mental health providers to improve and coordinate and expand resources	133	3.03	1.22	1	5

All quality indicators received ratings from the minimum of one to the maximum of five. No items received a rating corresponding to *Not at all in place* (i.e., mean rating of 1 to 1.5) or *Fully in place* (i.e., mean rating of 4.51 to 5.00). As seen in Table 20, the majority of items received ratings corresponding to “*Somewhat in Place*” (i.e., mean rating of 2.51 to 3.5). For items relevant to evidence-based practice, two out of five received average ratings of less than *Somewhat in place* (i.e., mean rating <2.51): (1) ongoing training and supervision on: effective diagnosis, treatment planning and implementation, clinical decision- making; and (2) conduct screening and follow-up assessments to identify mental health concerns. In regard to continuum of care practices, one of five items received an average rating less than *Somewhat in place* (i.e., mean

rating <2.51): district offers intensive treatment services to youth and families (e.g., individual, group, and family therapy). Of three items relevant to cultural competence and diversity, one item received an average rating less than *Somewhat in place* (i.e., mean rating <2.51): receive regular training on effectively providing care for students and families who present diverse developmental, cultural, ethnic, and personal backgrounds.

Overall, two quality indicators received average ratings corresponding to greater than *Somewhat in place* (i.e., mean rating >3.5): (1) caseload reflects the diversity of the school population and (2) actively collaborate with other professionals in school.

Chapter V

Discussion

The purpose of this study was to examine perceptions of practitioners from multiple disciplines regarding school-based mental health services (SBMHS) in New Jersey. This research gathered information regarding nominal descriptive characteristics of providers, types of mental health problems and services provided in schools, perceived facilitators and barriers to the provision of mental health services, and practitioners' views on helpful content and experiences for preparation to provide SBMHS. This study also examined the perceptions of practitioners regarding the quality of SBMH practices in New Jersey. A web-based survey was administered to a sample derived from members in professional organizations of school counselors, school psychologists, school social workers, and student assistance professionals currently working in New Jersey. This chapter provides a summary of the important findings of the current study and the relationship of the results to other research on this topic. Implications for the practice of school-based mental health services, limitations of the study, and recommendations for further research are also discussed.

Nominal Descriptive Characteristics of School-Based Mental Health Practitioners

One of the primary goals of this research was to add to current knowledge regarding the characteristics of SBMH practitioners in the state of New Jersey as well as the schools in which they provide service. Similar to past research concerning SBMH practitioners and school psychologists at a national level (Agresta, 2004; Curtis, Castillo & Gelley, 2012), the majority of respondents in this study were women (85.5%), White/Caucasian (89.2%), with Masters level (36.9%) or Specialist/Post-Masters level

(42.5%) graduate degrees. Also consistent with prior research is that a higher percentage of school psychologists reported having a doctorate degree compared with other SBMHS providers. However, in contrast with prior research (Agresta, 2004) the majority of this sample of NJ-based practitioners reported suburban schools as their work setting (77.1%), with urban (17.1%) and rural settings (5.7%) indicated much less frequently.

In regard to the professional designations of SBMH practitioners in New Jersey, it is important to take into consideration the membership numbers and disparate response rates of the professional organizations. In this study school psychologists are overrepresented having made up 22.6% of the number of possible responders and 49.7% of actual respondents. Conversely, school counselors composed only 8.4% of respondents but 49.1% of the possible responders.

SBMH providers in New Jersey reported spending, on average, the largest percentage of time at the high school level, closely followed by elementary and middle. However, differences in averages between professional roles were observed. School psychologists reported spending the largest percentage of time serving elementary students (41.9%), school counselors spent the most time in middle school (41.3%), student assistance counselors reported spending a majority of their time at the high school level (67.1%), and school social workers appeared to spend a comparable amount of time among elementary, middle and high school levels. As might be expected given their roles in special education eligibility determination and case management in New Jersey, school psychologists and school social workers reported spending a higher percentage of time on average serving preschoolers compared to the other professional groups.

It is a notable finding that the majority of professionals (66.7%) reported their graduate school training as sufficient to provide SBMHS. However, one-third of participants overall (33.3%) reported feeling less than satisfactorily prepared, suggesting there may be opportunities at the pre-service level to bolster perceptions of preparedness. Among the professional roles, school psychologists had the largest proportion of respondents (41.2%) report feeling less than satisfactorily prepared to provide mental health services.

The majority of respondents (56.9%) indicated they would prefer to spend more time providing mental health services. However, it is not known if respondents believe more time is necessary to adequately address the mental health need of the students in their school(s), or if the desire to spend more time providing SBMHS is associated with a preference for a particular function (e.g., counseling) versus other tasks (e.g., administrative duties). Very few practitioners (4.6%) indicated they would prefer to spend less time providing mental health services.

Mental Health Problems and Services Provided

This study extended Friedrich's (2010) survey of school psychologists to include multiple professional disciplines. Results suggest practitioners in New Jersey encounter a diverse range of mental health problems in schools. The problems reported by practitioners in New Jersey as most frequently referred for mental health services are generally consistent with previous research (Brener, 2007; Kelly & Lueck, 2011; Reinke, et al, 2011; Repie, 2005). Interpersonal and academic concerns were the most commonly cited among practitioners' top five referrals. Disruptive behavioral concerns (e.g.,

general externalizing, anger/aggression, ADHD) were also frequently reported as primary referrals.

Viewed alongside Friedrich's study (2010) of school psychologists, the inclusion of multiple professional disciplines in this research appears to contribute to a broader depiction of mental health concerns seen in schools. As a top referral concern, general anxiety was cited by more New Jersey practitioners overall (42.9%), as well as more school psychologists (37.5%), than reported by the national sample of school psychologists in Friedrich's study (16.4%). Additionally, referrals for concerns such as bullying and threat of self-harm were reported by a greater percentage of practitioners in New Jersey than by school psychologists nationally. As might be predicted with the inclusion of student assistance professionals, substance use was reported as a top referral by a greater percentage of participants in this study (17.8%) than in Friedrich's research (1.82%). Three-quarters of student assistance professionals in the current study ranked substance use within the top five referrals.

Results of this study suggest there may be distinctions regarding the types of mental health problems referred to the various SBMH professionals in New Jersey. Referrals for interpersonal problems and general anxiety were among the most frequently identified concerns for each professional group. However, whereas referrals for academic problems were ranked by 57.1% of all respondents, only 13.9% of student assistance counselors ranked this in their top five. Similarly, while 10.4% of practitioners overall ranked grief or loss as a top referral, over a third (35.7%) of school counselors reported this as a main referral. School psychologists (37.5%), reported referrals for Autism/Asperger's more frequently, compared to counselors (7.1%), social workers

(11.1%) and student assistance professionals (2.8%). Differences observed in the types of mental health referrals reported by different professional roles may be an artifact of the position (e.g., practitioners who are chiefly involved in special education procedures) or may be influenced by the grade level of the students with whom they work. For example, the student assistance professionals in this study were more likely to work with high school students. This group also reported higher rates of referrals for substance use, depression, and threat to harm self than participants overall which is consistent with prior research finding these concerns more prevalent among adolescents (Repie, 2005).

In regard to the types of services provided by practitioners, consultation services with various stakeholders (e.g., school staff, parents/caregivers, community providers) were reported by the vast majority of respondents as one of the most common and frequently provided service. Other activities provided by a large majority of SBMH professionals in New Jersey include social-emotional-behavioral assessment, inservices for staff, counseling (e.g., individual, group, and brief), behavioral interventions and referrals to outside agencies.

In comparison to the mental health services provided by the national sample of school psychologists in Friedrich's study (2010), a higher percentage of this transdisciplinary sample reported providing suicide assessment and intervention and threat assessment. This is consistent, however, with Repie's (2005) finding that showed the most frequently available mental health services available on school grounds included emotional/behavioral assessment, individual counseling and crisis intervention.

Services least frequently provided by SBMH practitioners in New Jersey included family counseling (21.5%) and schoolwide/classwide screening (18.1%). Family

counseling has not been found to be a widely available SBMH service in other studies (Repie, 2005). Furthermore, although screening has been mentioned often as a critical element in comprehensive SBMHS (Levitt, Saka, Romanelli & Hoagwood, 2006), routine use of screening in schools as an integrated service for early identification and prevention of mental health problems remains limited (Dowdy, et al 2014; Essex, et al, 2009).

Facilitators and Barriers to Mental Health Service Provision

This research surveyed SBMH practitioners in New Jersey with a comprehensive list of personal and systems-level barriers and facilitators developed through prior qualitative and quantitative research (Friedrich, 2010; Suldo, et al., 2010). Through an examination of issues that hinder or promote provision of SBMHS, implications may result for training and professional development as well systems-level considerations.

Although the barriers and enablers included in this survey were developed through research with school psychologists, the vast majority of SBMH practitioners in this study reported having experienced most of these factors. This suggests there is an amount of shared experiences between professionals providing mental health services in schools. In this study, practitioners more often reported school or district level factors (e.g., problems accessing student during the day, lack of time and integration into site) as moderate barriers to service provision. The majority of items related to personal or internal characteristics (e.g., personal mental health problems, lack of confidence/knowledge) were among the lowest rated barriers, however role strain and burnout were reported as slight to moderate barriers to SBMHS.

Systems-level factors were also reported as slight to moderate enablers of SBMH service provision. Among the highest rated systems-level enabling factors were items such as availability to consult with other school mental health professionals and having sufficient space to provide SBMHS. Thus, although there are challenges providing mental health services in schools, some features of the school setting may also serve to facilitate SBMHS. Similar to prior research (Friedrich, 2010; Suldo, et al., 2010), enabling factors received higher ratings by the practitioners in this study than factors serving as barriers. Also comparable was the finding that the highest rated enabling factors tended to be personal characteristics (e.g., personal desire to provide mental health services, sufficient knowledge and confidence in ability), while systems-level factors tended to be the higher rated barriers.

Preparation for School-Based Mental Health Practice

In regard to the perceived helpfulness of various didactic and experiential training areas for SBMH practitioners, all items were rated as moderately to very helpful, suggesting current pre-service offers substantive preparation for provision of SBMHS. Several items contained in this section of the survey, particularly the experiential training items, had not been experienced by a relatively greater percentage of respondents (e.g., receive own counseling, self-review and critique of counseling). Just over a quarter of respondents indicated that they had not personally experienced working with interns as a professional development activity. Roughly the same percentage of participants (23.6%) reported having five years of less of experience, suggesting that the lower rate of relevance for this item could be associated with the qualifications typically required of internship supervisors (e.g., 3 or more years experience). The content areas rated most

helpful for preparation for SBMHS provision (e.g., therapeutic relationship skills, social-emotional-behavioral assessment, crisis intervention, developmental psychology, consultation) appear to coincide well with the mental health services reported as most frequently provided by practitioners. Practitioners viewed supervised practicum/externship/internship, work on a multidisciplinary team, consultation with colleagues and self-study as the most helpful experiential and professional development training opportunities. Participation in professional organization was reported as personally experienced by the vast majority of respondents (99.3%), which could be anticipated given the sample was derived from current members of such organizations. This item also received one of the highest helpfulness ratings, suggesting that respondents perceive their respective state organizations as valuable to their professional development and ability to provide mental health services in schools. This finding is less likely to be able to be generalized to SBMH professionals who are not members of state organizations.

Quality of School-Based Mental Health Services in Schools

The purpose of this area of research was to gain insight into the perception of the quality of SBMHS in New Jersey. The range of responses for all quality indicators ranged from the minimum to the maximum rating, suggesting a degree of variability in the quality of services. Only two of the items obtained an average rating greater than somewhat in place, suggesting that there are improvements required among school districts in New Jersey to better align their SBMHS with best practice. Among the lowest rated quality indicators were items relevant to evidence-based practice and cultural diversity. Respondents perceived active collaboration with other school professionals as

the most developed and established of the quality indicators. The emphasis on transdisciplinary collaboration as a strength within New Jersey schools is supported by respondents ratings on the services they provide and the training experiences they perceive as most helpful for service provision.

Implications for Training

Several implications for SBMH practitioners in New Jersey arise from the results of this study. In the area of training, it is encouraging that a clear majority of respondents felt at least satisfactorily prepared to provide mental health services after graduate school. This is consistent with the finding that didactic and experiential training activities in graduate programs are generally reported as helpful preparation for SBMHS provision. However, one-third of overall respondents reported feeling less than prepared to provide mental health services in the schools. Furthermore school psychologists in this study more reported feeling less than satisfactorily prepared more often than other professional roles. Further inquiry may be warranted to determine if this perceptions relates to factors such required coursework for the professional degree (e.g., number of courses on assessment vs. mental health interventions), the extent to which school psychology graduate students engage in mental health service provision as part of their pre-service experiential training experiences, or other factors.

Collaboration and consultation with colleagues were noted as important enablers to service and professional development. Training programs may want to consider what can be done to support and extend this at the pre-service level. Although mental health practitioners often work collaboratively within school districts, at the graduate level the opportunities for transdisciplinary dialogue appears limited. Faculty across disciplines

may consider developing partnerships designed to support collaborative research projects and experiential training opportunities in SBMHS.

Another implication relevant to training is the substantial lack of diversity among SBMH practitioners in this study. Prior research (Lewis, Truscott, & Volker, 2008) of members and non-members of the National Association of School Psychologists (NASP) has found that non-members may be more culturally diverse than members, thus using professional organization data may underestimate the degree of diversity in the field. However it is not clear if this may also be true of state-level organizations. While almost 90% of respondents in this study were White/Caucasian, according to the New Jersey Department of Education (2014) enrollment data, in 2013-2014, less than half (48.9%) of the almost 1.4 million students enrolled were White. Hispanic students made up the next largest group of students by ethnicity (24.2%), followed by Black (16.1%) and Asian (9.3%). There is a need for training programs in New Jersey to work toward meaningful progress to create a diverse field of practitioners. Castillo, Curtis & Gelley (2013) recommend training programs use the available literature to evaluate and strengthen their efforts at recruitment (e.g., financial support, marketing efforts) and retention (e.g., faculty support, fostering community) of diverse candidates.

Other potential implications for training emanate from findings on personal and systems-level barriers and enablers to service provision. SBMH professionals rated items such as sufficient knowledge and skills, confidence in ability, and personal desire to provide mental health services as moderate to significant enablers to service and only slight barriers to service. Training programs could utilize this information by aligning training goals and activities with outcomes on these personal factors. Systems-level

factors were often identified as barriers to service and respondents reported having received less training in systems consultation relative to other areas. Taken together, this suggests that augmenting training opportunities related to systems-level concerns may be another viable area for training programs to impact the readiness of practitioners to effectively deliver SBMHS.

Implications for Practice

The results of the survey in regard to facilitators, barriers and perceived quality of services can inform potential next steps to improve the delivery of SBMHS in New Jersey. Practitioners reported they are not commonly involved in efforts to screen students at the school or classroom level. The routine use of screening to identify mental health concerns was also reported as one of the quality indicators currently least in place in schools. At the practitioner level, it is important for professionals to become educated on the available methods for universal screening and best practice models for implemented screening efforts as part of a comprehensive SBMHS program. Dowdy, et al. (2015) indicated that universal screening models require practitioners who understand the need for a planned response to screening data (e.g., who will utilize the data, a protocol linking screening to intervention) and awareness of how to consult with stakeholders. Practitioners with skills and knowledge in these areas can become effective advocates for the development of such programs, as well as assist in the implementation and evaluation of these efforts.

The challenges of implementing evidence-based interventions in schools have been often discussed in the literature (Schaeffer, et al., 2005). Results from this study suggest that this is also true for practitioners in New Jersey. Recent literature (Lyon et

al., 2014; Weist et al., 2014) points to the potential of a modular approach to treatment. Practitioners can use the growing research on this approach to assist them in using components of evidence-based interventions. These components can then be integrated into programs that also take into account school-based factors that could impact treatment.

Organizations in New Jersey that support the professional development of SBMHS practitioners could take results from this study to further develop targeted programming related to SBMHS. In regard to enhancing the practice of SBMH providers, potential topics for which to offer advanced training and/or ongoing workshops are diagnosis and treatment planning concerns and the provision of appropriate services for individuals and families from diverse cultural, linguistic and developmental backgrounds.

The final area implication for practice arising from this research comes from a consideration of the consistent endorsement by participants in this study of the importance and utility of collaboration and consultation in providing SBMHS, as well as the systems-level factors which both contribute and detract from service provision in schools. Collaboration at the district level can be supported through the use of district teams, but also has potential to occur on a wider level. SBMHS in New Jersey may benefit from an approach found in other states (e.g., Ohio's Center for School-Based Mental Health and Network for School Success) to build a multidisciplinary network designed to influence training, research, policy, and support school-community collaborations. These networks may be best situated at a state or regional (e.g., county) level, or by school setting (e.g., rural, urban, etc.).

Limitations

There are limitations that affect the generalizability of these results. The first relates to the use of a convenience sample of practitioners belonging to professional organizations. Attempts were made to use a random sample of professional members, but due to privacy regulations this was not feasible. Thus, the characteristics of participants in this study are unlikely to be representative of SBMH practitioners in New Jersey as a whole and, moreover, may not be representative of the total population of members of professional organizations.

The use of a web-based survey requires consideration of several limitations inherent to survey methodology. All professional members had an opportunity to participate in the survey and the number of participants who completed the survey resulted in a low overall response rate. The participants in this study may possess characteristics that differ in meaningful ways from professional members who chose not to respond. For example, participants in this study may have self-selected due to their level of interest in or affiliation with mental health services and this could affect the findings (e.g., ratings of personal desire to provide mental health services as an enabler).

The survey results may also be susceptible to the effect of social desirability, or the tendency of respondents to answer questions in a way they feel is more acceptable to others. For example, some personal characteristics that received low ratings as barriers to SBMH service provision (e.g., personal mental health problems), may have been affected by an unwillingness of participants to reveal potentially sensitive information.

The method of survey distribution in this study specifically may have influenced the response rate. Higher response rates were observed within the groups that received

the survey link as a direct e-mail versus other means (e.g., the link included within a newsletter). Additionally, although field test results were used to simplify and shorten the survey, respondent fatigue was observed through the rate of missing data. Results from the field test underscored the notion that school-based practitioners are subject to frequent interruptions at work. To improve response rates and reduce the rate of missing data, the survey could be further abridged and the formatting further enhanced for an online platform. Finally, another factor to consider is the timing of distribution of the survey. This survey was distributed within the first two months of the academic year and respondents were instructed to base their answers on experiences of the current school year. To the extent that the involvement of practitioners in SBMHS may vary over the course of a school year (e.g., as the needs of individual students become more apparent or referrals are processed), this data may provide a limited picture of the overall scope of practice.

Directions for Future Research

This study provides an initial overview of the current state of SBMHS in New Jersey from the perspective of practitioners. Further lines of research can add to this understanding in a number of meaningful ways. This was the first study to ask professionals other than school psychologists to rate this particular list of barriers and facilitators to SBMH service provision. Qualitative studies of school counselors, school social workers, and student assistance professionals in regard to this topic would contribute depth (e.g., in what ways do these barriers/facilitators function) and potentially identify additional role-specific factors not included in this study. To obtain a more extensive view of SBMHS, it is recommended that future studies include the perspective

of additional stakeholders in New Jersey, such as teachers, parents, and students. It may be especially valuable to include the perspective of school nurses, as they have been identified as holding a key role in comprehensive school-based health services, including identification, screening, and referral services related to mental health concerns (Foster et al., 2005).

Though beyond the scope of this study, future research could explore meaningful distinctions between professional disciplines and other school factors. For example, an investigation of differences between the types of referrals and services provided within a given grade level (e.g., high school or elementary) or within a particular school setting (e.g., suburban or urban) among the various disciplines. Additionally, it may be useful to examine more closely the relationship between demographic variables (e.g., years practicing, ethnicity, gender) and the factors perceived to be barriers and enablers to service. This additional information could be useful for developing a more informed action plan to improve mental health services for students.

This study provided an overview of the perception of practitioners on the quality of SBMHS in New Jersey. The findings suggest there is significant variability between school districts regarding alignment of SBMHS with best practice. Future research could explore further through qualitative research with practitioners or through in-depth case studies and assessment of need within individual school districts. Furthermore, although this study contributed to an increased understanding of the barriers to and facilitators of SBMHS, it is not known by what mechanism and to what extent these factors influence efficacy or outcomes. A future study may be designed to gather information on the perceptions of practitioners on factors which impact measurable outcomes in SBMHS.

The field of school-based mental health is complex and obstacles to service delivery abundant. Despite the challenging reality, schools offer a logical setting to address the needs of a large percentage of children and youth. One advantage to a school setting is the opportunity for meaningful interdisciplinary collaboration. For the field to advance and witness measurable improvement in existing unmet mental health needs, practitioners require ongoing training, district support and a system which fosters their ability to coordinate and develop integrated and comprehensive approaches to school based mental health.

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Appendix A

Informed Consent

Principal Investigator: Meredith Cregg-Wedmore

Project Title: School-Based Mental Health Practices in New Jersey: A Transdisciplinary Perspective

INFORMED CONSENT FORM

You are invited to participate in a research study being conducted by Meredith Cregg-Wedmore, a doctoral candidate in the Graduate School of Applied & Professional Psychology, Rutgers University. The purpose of this research is to gain information about current practices of school-based mental health services (SBMHS) in NJ from the perspective of school-based practitioners.

You are being asked to participate in this study because you are a member of one of the following professional associations: Association of Student Assistance Professionals of NJ (ASAP-NJ), the NJ School Counselor Association (NJSCA), the NJ Association of School Psychologists (NJASP), or the NJ Association of School Social Workers (NJASSW). Participation in this study involves completing an online survey. Each individual's participation will last approximately 15-20 minutes. The survey includes questions about your role and experience in the provision of SBMHS. There are no foreseeable risks to participation in this study. The benefits of taking part in this study are contributing to the knowledge about SBMHS in NJ. In addition, you may choose to enter a drawing for 1 of 2 \$25.00 Amazon.com gift cards. However, you may receive no direct benefit from taking part in this study.

This research is confidential. Confidential means that the research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. The information collected about you includes your email address to enter you in the drawing for a gift certificate. I will not know your IP address when you respond to this survey. Please note that I will keep this information confidential by limiting access to the research data and storing it in a password protected electronic format. Your email address, should you choose to provide it, will not be stored with data from your survey. You will be assigned a participant number and only the participant number will appear with your survey responses.

The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. When the research study is published as a dissertation, or if the results are presented at a professional conference, only group results will be stated. All study data will be kept for three years. Participation in this study is voluntary. You may choose not to participate, and you may withdraw at any time during the study procedures without any penalty to

you. In addition, you may choose not to answer any questions with which you are not comfortable. If you have any questions about the study or study procedures, you may contact Meredith Cregg-Wedmore at 732-320-1999 or creggm@aol.com, or you may contact my advisor Dr. Kenneth Schneider, at 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, the State University of New Jersey
Institutional Review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: 848-932-0150
Email: humansubjects@orsp.rutgers.edu

By beginning the survey, you acknowledge that you have read this information and agree to participate in this research, with the knowledge that you are free to withdraw your participation at any time without penalty. If you choose not to participate, you may close the link to this survey.

This informed consent form was approved by the Rutgers University Institutional Review Board for the Protection of Human Subjects on 9/22/14. Currently, there is no expiration on the approval of this form

Appendix B

Survey

School-Based Mental Health Survey for Practitioners

Please answer all questions based on your experiences since the beginning of the 2014-2015

Demographic Information

1. Gender: Male or Female
2. Age: _____
3. What is your ethnicity:
 - a. American Indian/Alaskan Native
 - b. Asian or Pacific Islander
 - c. Black or African American
 - d. Hispanic or Latino
 - e. White/Caucasian
 - f. Other, please specify: _____
4. Professional Role
 - a. School Counselor
 - b. School Psychologist
 - c. School Social Worker
 - d. Student Assistance Professional
 - e. Other, please specify: _____
5. Years practicing in a school setting in your current professional role (include present year): _____
6. State in which employed
 - a. NJ
 - b. Other, please specify
7. Highest degree earned
 - a. Bachelors
 - b. Post-Bachelors Certification
 - c. Masters
 - d. Specialist/Post-Masters
 - e. Doctorate
8. How many different school buildings do you serve in your current position?

9. What type of school(s) do you serve in your current position?:
 - a. Private
 - b. Public

- c. Parochial
10. How would you describe the setting of the school(s) you currently serve?
- Rural
 - Suburban
 - Urban
11. What percentage of your time is assigned to serving students at each school level?: (e.g., 25%, 50%, total should equal 100%)
- ____ Preschool
 - ____ Elementary School
 - ____ Middle/Jr. High School
 - ____ High School
 - ____ Other, please specify: _____
12. In your current position, what is the ratio of other professionals in your role to students (e.g., school counselor:student, school psychologist:student, etc)?
- 1: <500
 - 1: 500-999
 - 1: 1000-1499
 - 1: 1500-2000
 - 1: > 2000
13. After completing your graduate school training (e.g., courses, practicum, internship), how prepared did you feel to provide mental health services (e.g., counseling, crisis intervention, etc.) in the schools?
- 1=Not at All Prepared
2= A Little Prepared
3=Satisfactorily Prepared
4= Well Prepared
5= Extremely Prepared
14. Please indicate the amount of time you would prefer to spend providing mental health services:
- More time
 - Less time
 - The same amount of time

Referral Concerns

The following is a list of problems for which children are commonly referred for mental health services.

Referral Concerns	
A. Academic problems (e.g., poor study skills, failure to complete work)	Q. Grief or loss
B. Adolescent sexuality (e.g., pregnancy, sexual preference)	R. Interpersonal problems (e.g., poor social skills, social isolation, peer rejection)
C. Anger/aggression	S. Lack of motivation
D. Attention Deficit Hyperactivity Disorder (ADHD)	T. Low self-esteem/self-concept
E. Atypical or odd behaviors (e.g., bizarre or inappropriate comments)	U. Obsessive Compulsive Disorder (OCD)
F. Autism/Asperger's	V. Oppositional Defiant Disorder (ODD)
G. Bipolar Disorder	W. Problems/conflict with caregivers
H. Bullying (i.e., victims or aggressors; physical or verbal)	X. Romantic relationship problems
I. Caregivers' mental health issues (e.g., parental depression or substance use)	Y. School-wide tragedy (e.g., teacher or student dies)
J. Cutting	Z. Specific Phobia (e.g., school, tests)
K. Depression	AA. Substance use
L. Divorce in family	BB. Threat to harm others (e.g., threatens to kill other students, brings weapon to school)
M. Eating problems	CC. Threat to harm self (suicidality)
N. General anxiety	DD. Truancy
O. General externalizing concern (e.g., disrespect, talking back, conduct problems)	EE. Trauma (e.g., emotional, physical, or sexual abuse)
P. General internalizing concern (e.g., withdrawn, shy, flat/negative affect)	FF. Other (please specify): _____

15. Please list the letters (e.g., A, T, FF) that correspond to the five types of student problems that are referred to you most frequently for mental health services (in rank order):

If you are choosing FF-Other, please specify below:

1st. _____

2nd. _____

3rd. _____

4th. _____

5th. _____

Mental Health Services Provided

16. Do you provide any of the following services below to children with mental health problems?

**select “yes” or “no” for each service. For each service you do provide, select the frequency (e.g., daily, weekly, monthly) that best describes how often you engage in that service in a typical month.

	Service Provided Yes/No	Frequency
Individual counseling	_____	_____
Family counseling	_____	_____
Consultation with parent/caregiver	_____	_____
Consultation with school staff (e.g., teacher, administrator)	_____	_____
Consultation with problem-solving or I&RS teams	_____	_____
Consultation with community service providers (e.g., psychiatrists, therapists, juvenile justice)	_____	_____
Referral to outside agencies for follow-up care	_____	_____
Suicide assessment and intervention	_____	_____
Threat assessment (i.e., with students who pose threat to safety of others or school)	_____	_____
Brief counseling (i.e., address specific problem in 1-2 meetings)	_____	_____
Behavioral interventions (e.g., FBA, behavior contracts, behavior intervention plans)	_____	_____
In-service training for parents/caregivers	_____	_____
In-service training for school staff	_____	_____
Prevention programs	_____	_____
School/classwide screening	_____	_____
Social-emotional-behavioral assessment	_____	_____
Group counseling	_____	_____
Counseling adults (e.g., brief counseling with school staff)	_____	_____
Other (please specify): _____	_____	_____

17. If you selected “Group Counseling” as a service you provide, please check which types of groups you provide (select all that apply during the current school year):

Social Skills

Grief

Divorce

Anger Management

Anxiety

Study Skills

Other (please specify type of group)

Barriers to Mental Health Service Provision

18. To what extent do you feel each of the following factors presents a **BARRIER** in your provision of mental health services in your school(s)?

1 = *Not a Barrier*

2 = *Slight Barrier*

3 = *Moderate Barrier*

4 = *Significant Barrier*

5 = *Extreme Barrier*

N/A = Have not personally experienced this factor

- A. Inconsistent treatment (miss scheduled sessions due to other responsibilities)
- B. Problems accessing students during day (e.g., pulling students from class for sessions; finding a common time to hold a group)
- C. Unplanned/premature termination of services due to school calendar
- D. Difficulty maintaining students' privacy due to inquiries from school staff
- E. Insufficient space to provide m.h. services (e.g., no room to meet with students)
- F. Overlapping responsibilities among mental health professionals (e.g., school counselors, school psychologists, social workers, student assistance counselors)
- G. Schools are accountable for students' academic success only (vs. behavioral or social wellness)
- H. Student attrition (e.g., drop-out, moving during school year)
- I. Narrowly defined department-assigned roles and responsibilities
- J. Cumbersome department procedures and requirements (e.g., extensive paperwork)
- K. Concerns with liability and legal problems related to providing m.h. services
- L. Insufficient funds for mental health services from district administration
- M. Insufficient support for m.h. services from building-level administration
- N. Insufficient support for mental health services from teachers (e.g., don't value mental health treatment)
- O. Teachers are unaware of mental health services that school based practitioners can provide
- P. Difficulty collaborating with teachers to implement interventions
- Q. Too many students in need of mental health services
- R. Too many psychoeducational evaluations to complete
- S. Insufficient time and integration into your school site
- T. Role strain (i.e., having too many responsibilities in your professional role)
- U. Burn out (i.e., emotional/physical toll incurred by providing m.h. services)
- V. Personal desire to provide traditional services such as assessment
- W. Personal mental health problems (i.e., dealing with issues in one's own life)
- X. Insufficient knowledge/skills relevant to mental health service provision (i.e., not enough didactic training or applied experiences)
- Y. Insufficient confidence in your ability to provide mental health services
- Z. Off-putting student characteristics (e.g., poor hygiene, immature behavior)
- AA. Insufficient support from parents during mental health intervention efforts
- BB. Other (please specify) _____

Enablers to Mental Health Service Provision

19. To what extent do you feel that each of the following factors serves to ENABLE your provision of mental health services in your school(s)?

1 = *Not an Enabler*

2 = *Slight Enabler*

3 = *Moderate Enabler*

4 = *Significant Enabler*

5 = *Extreme Enabler*

N/A = Have not personally experienced this factor

A. Department gives explicit permission to provide mental health services and creates assignments consistent with this expectation

B. Department provides relevant professional development (i.e., in-services about mental health interventions, behavior disorders, etc.)

C. District support for mental health service provision (e.g., initiatives that prioritize mental health, sufficient funding and personnel resources)

D. Personal desire to provide mental health services

E. Ability to maintain personal boundaries (e.g., use preventive strategies to avoid becoming too attached to a child or overwhelmed by multiple demands)

F. Personal experiences as a parent helps you handle similar problems with students

G. Ability to remain objective with a student (e.g., avoid involvement with school discipline matters, avoid being influenced by teachers' opinions of the student)

H. Sufficient time and integration into your school site (e.g., assigned to one school for multiple days; high availability to school staff or students)

I. Sufficient support for m.h. services from building-level administration

J. Teachers are supportive of mental health services/interventions

K. Teachers expect your role to include mental health services

L. Sufficient knowledge/skills relevant to mental health service provision

M. Adequate confidence in your ability to provide mental health services

N. Availability to consult with other school mental health professionals

O. Sufficient space to provide mental health services

P. Manageable number of children who require psychoeducational evaluations

Q. Manageable number of children in need of mental health services

R. Access to adolescents (i.e., working in a middle or high school setting)

S. Sufficient support from parents for mental health services

T. Access to/linkages with community resources

U. Other (please specify) _____

Training in School-Based Mental Health

20. To what extent do you feel each content area below was important in preparing you to provide mental health services in your school(s)?

1 = Not Helpful

2 = Somewhat Helpful

3 = Moderately Helpful

4 = Very Helpful

5 = Extremely Helpful

N/A = Did not receive training in content area

A. Psychopathology/behavior disorders/abnormal psychology

B. Developmental psychology

C. Social-emotional-behavioral assessment (e.g., interview techniques, rating scales)

D. Advanced study of a single therapeutic orientation (e.g., Rogerian, Gestalt, CBT)

E. Survey course covering multiple therapeutic orientations

F. Advanced counseling/psychotherapy (i.e., how to conduct individual psychotherapy)

G. Family therapy approaches and techniques

H. Substance abuse prevention and treatment approaches and techniques

I. Group therapy approaches and techniques

J. Crisis intervention (e.g., suicide assessment/ intervention, threat assessments)

K. Behavior interventions (e.g., relaxation training, behavior analysis)

L. Consultation with teachers or parents

M. Systems consultation

N. Multicultural education/therapy techniques

O. Ethics/Law

P. Psychopharmacology

Q. Empirically-supported treatments (i.e., identifying evidence-based interventions)

R. Prevention of mental health problems

S. Treatment planning (identifying goals, tracking progress)

T. Case documentation (progress notes, intake summaries)

U. Therapeutic relationship skills (e.g., interpersonal skills, listening skills)

V. Information on mental health agencies and resources in the community

W. Techniques/strategies for working in school environment

X. Learning skills needed to be a lifelong learner (i.e., to stay abreast of mental health literature)

Y. Counseling adults (i.e., what to say, techniques)

21. To what extent do you feel each of the following types of experiential activities was important to preparing you to provide mental health services in your school(s)?

1 = Not Helpful

2 = Somewhat Helpful

3 = Moderately Helpful

4 = Very Helpful

5 = Extremely Helpful

N/A = Did not receive/incur this experience

A. In-class role plays

B. Supervised practicum/externship/internship

C. Co-lead counseling group(s)

D. Observe master therapist(s) (e.g., live through mirror, videotapes available commercially)

E. Self-review and critique of counseling (e.g. watch audio or videotapes of own sessions)

F. Receive own counseling

G. Work on a multidisciplinary team (i.e., opportunity to interact with other mental

22. To what extent do you feel each of following types of professional development opportunities was important in preparing you to provide mental health services in your school(s)?

1 = Not Helpful

2 = Somewhat Helpful

3 = Moderately Helpful

4 = Very Helpful

5 = Extremely Helpful

N/A = Did not receive/incur this experience

A. In-services offered through one's district

B. Applied experiences following an in-service

C. Work with interns

D. Participate in professional organization (e.g., national or state professional organization)

E. Self-study (e.g., reading books on mental health interventions, psychopathology, etc.)

F. Formal supervision of services

G. Consultation with colleagues

23. To the best of your knowledge, please answer each item that follows based on your current practice in your school(s). Please select the rating that best reflects the degree that the item is developed and/or implemented. (Rate from 1 to 5; 1 = Not at All in Place; 3 = Somewhat in Place; 5 = Fully in Place)

Do you receive ongoing training and supervision on: effective diagnosis, treatment planning and implementation, clinical decision making?
Do you conduct screening and follow-up assessments to identify mental health concerns?
Do you continually assess whether ongoing services provided to students are appropriate and helping to address presenting problems?
Is there a clear and effective protocol in your district to assist your clinical decision making and care for more serious situations (e.g., abuse and neglect reports, self-reporting of suicidal/homicidal ideation)?
Does your district offer activities promoting school-wide mental health?
Does your district offer prevention activities (e.g., group, classroom, and/or school-wide)?
Are referral procedures being utilized by stakeholders (e.g., educators, other mental health staff, health staff, administrators, parents and students)?
Are you receiving regular training on effectively providing care for students and families who present diverse developmental, cultural, ethnic, and personal backgrounds?
Does your caseload reflect the diversity of the school population?
Does your district make efforts to ensure that your school mental health program and services are welcoming and respect the students and families served?
Do you actively collaborate with other professionals in your school (other health/mental health providers, educators, administrators)?
Are you actively using the evidence-base (practices and programs) to guide your preventive and clinical interventions?
Are faculty and staff trained on the identification, referral, and behavior management of social/emotional/behavioral problems in students?
Does your district offer intensive treatment services to youth and families (e.g., individual, group, and family therapy)?
Do you feel sufficiently trained, supported, and supervised to handle the unique demands of school based practice in an ethical and effective manner?
Does your district coordinate mental health efforts in the school to ensure that youth who need services receive them, while avoiding service duplication?
Does your district work with other community health and mental health providers to improve and coordinate and expand resources?

Appendix C

Field Test MaterialsExplanation to field test participants:

“I am going to ask you to complete an online survey as a field test to assist with survey development. Please fill it out the same way you would if this was the actual study. When you are finished, I will ask you some questions about your experience taking the survey. Your answers will remain confidential and no identifying information about you will be used in the survey development or published research. Please take note of the time you begin and end the survey to assist me in understanding how long it will take participants to complete.”

Post-Survey Interview Questions:

1. How long did it take you to complete the survey?
2. Were there any words in the informed consent or survey that you did not understand?
3. If you were a prospective participant, what would make you more likely to participate in this study?
4. Was there any information in the informed consent that made you not likely to participate in the study?
5. Did any of the questions make you feel uncomfortable to answer?
6. Did you find any of the questions extremely difficult to answer?
 - a. If so, please tell me about the question and your experience answering it.
7. Tell me about aspects of the survey that would make you more or less likely to fully complete it if you were a participant in this study.
8. Was there anything in the survey that you felt should have been included and wasn't?
9. Was there any question you left blank? If so, was there a particular reason for that?
10. Do you have anything else you would like to tell me that you haven't had a chance to mention?

“Thank you for your time and feedback!”

Appendix D

Cover Letter

Dear Members of [Professional Organization],

My name is Meredith Cregg-Wedmore and I am a doctoral candidate at Rutgers University. I invite your participation in a survey focusing on **school-based mental health services in New Jersey**.

My study examines school-based mental health services (SBMHS) in NJ from the perspective of school practitioners (school counselors, school psychologists, school social workers and student assistance coordinators). The survey explores the role of practitioners in the provision of SBMHS, facilitators and barriers to best practice, and areas for professional development. This survey will take approximately 15-20 minutes of your time.

If you are willing to participate, please click on this link, or copy and paste into your web browser: https://www.surveymonkey.com/s/NJ_SBMHS

If you choose to complete the survey and provide an email address, you will be entered into a drawing to win one of two \$25 Amazon gift cards.

If you have any questions or concerns, you may contact me at creggm@aol.com or my dissertation chair, Dr. Kenneth Schneider (schneid@rci.rutgers.edu). Thank you for your time and consideration!

This study has been approved by Rutgers University's IRB #E14-827, effective 9/22/2014