PROGRAM EVALUATION OF A SCHOOL-BASED MENTAL HEALTH CENTER: IMPLICATIONS FOR COMMUNITY NEEDS AND CONNECTION

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Abstract

Across the country, nearly 80% of youth who need mental health services do not receive them. Perceived stigma, and structural barriers including lack of providers, long waiting lists, costs, lack of transportation, and temporal access remain profound challenges. The objective of this study was to conduct a program evaluation of how a school-based mental health center (SBMHC) can improve its services in a more inclusive, culturally sensitive, needs-based, and community-focused manner. Themes from existing theory, research, practice and policy were analyzed and informed a quantitative and qualitative survey for school faculty and community organizations (N=98). Perceptions of existing services and unmet community needs were addressed. One-way ANOVAs and post-hoc analyses were used to test the study's hypotheses, and showed that school staff and community members were largely unaware of the breadth of services at the SBMHC. Implications for increasing awareness and access are explored, and consistent with prior research, for increasing community connections and further collaboration with staff. Additionally, increased diversity training for school staff district-wide is suggested, with one of the aims being to encourage East and South Asian populations to seek mental health treatment. Results were used to develop recommendations to guide future developments and improvements for the program. Furthermore, the majority of the results could be generalized to help improve quality and access to other SBMHCs. This study was exploratory with limitations, and more research utilizing larger samples, more in-depth interviews, control groups, and long-term measured outcomes is recommended.

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Introduction

Background of Study

The Haven is a school-based mental health center located within Piscataway High School in Piscataway, New Jersey. The center expressed an interest in conducting a program evaluation to see how school and district personnel would rate and discuss the quality of the Haven's services after being in operation for seven years. There was also an interest from the researcher to see how closely the Haven is meeting the mental health care needs of students and their families in the community, as well as examining how much the Haven and the community interacts with one another. A survey was distributed that inquired about a variety of issues in the interest of obtaining information that would help understand the research objectives.

The Haven was developed in response to the increasing pressures and stress experienced by young people today, and its creation was spurred by several traumatic losses in the district. It helps students be more engaged in school, improve their academic functioning, and grow personally. The Haven is a partnership between the Piscataway Board of Education and the Rutgers University Center for Applied Psychology. The Haven strives to create a safe environment where students can speak freely about the difficulties they are encountering, and offer specific support and guidance on issues ranging from anxiety, depression and trauma to normal pressures of everyday life. Services offered include individual counseling, group counseling, family support, crisis intervention, and school consultation.

Role of School-based Mental Health Centers

School-based mental health centers (SBMHCs or SBHCs) serve as a crucial mechanism for providing diagnostic, preventative and treatment services to youth whose mental healthcare needs are underserved by other providers and perhaps would otherwise go unaddressed. SBHCs

also provide easy access to low-income families, and community members who face complex social and environmental risk. These centers can also have a positive impact on academic outcomes such as absences, tardiness, and grades. However, their presence in schools varies across communities. The SBHC model is unfamiliar to many providers and researchers with limited qualitative research to understand the working dynamics of successful centers. By assessing for and having a better understanding of these dynamics, it will better inform future developments and improvements to SBHCs.

Development and Function of SBHCs

Throughout the country, meeting students' mental health needs is a challenge due to perceived stigma associated with receiving care, and structural barriers including lack of providers, long waiting lists, costs, lack of transportation, and inconvenient hours. Nearly 80% of youth who need mental health services do not receive them (Amaral, Geierstanger, Soleimanpour, and Brindis, 2011). Adolescent males and other populations that are harder to reach such as minority groups, are more likely to receive mental health services at SBHCs than at community health network facilities. Students with access to SBHCs also make fewer visits to emergency rooms and urgent care centers. In the study by Amaral et al., (2011) the researchers gave out questionnaires to students in grades 9-11 in four different schools who do and not do provide mental health care. Despite the bias that is in the nature of self-reported measures, it was concluded that having access to SBHC increased reception of mental health services by 81% (Amaral et al., 2011).

In addition to reducing barriers to mental healthcare access, schools are the most common entry point into mental health services in the United States (Lai, Guo, Ijadi-Maghsoodi, Puffer, and Katakota, 2016). In this study, operations, partnerships, and engagement were chosen for

further review and analysis, as they were believed to determine the depth and quality of mental health care integration for underserved populations. Operations included organizational structures of sites and coordination of services, partnerships included collaborative strategies between different agencies within other sites, and engagement included efforts to engage parents and students in services.

Based on the interviews conducted, Amaral et al., (2011) found that services within an SBHC appeared to be related to more screening and detection of mental health problems. Partnership integration is representative of a health care team that includes school staff and wellness coordinators, who are responsible for supporting students' socioemotional cognitive development, and maintaining shared networks between school staff and community agencies. Finally, Amaral et al., (2011) found that engagement of parents and students in this setting can help to ensure that services are patient centered and remain relevant to the needs of the community. Community engagement can also improve wellness and reduce risk factors.

While Amaral et al., (2011) stated that nearly 80% of youth who need mental health services do not receive them, Paternite (2005) also provided the same statement, while also claiming that that number does not reflect the youth who are "at-risk" and could benefit from services. To emphasize how crucial of an entry point schools are for addressing educational, emotional, and behavioral needs, Paternite states that 52 million children attend 114,000 schools, with over 6 million adults working in those schools. If you combine students and staff, one fifth of the country's population can be reached in schools.

The rapid growth of SBMHC in the U.S. has been facilitated by important federal initiatives. For example, in 1999 the U.S. Surgeon General's report highlighted the youth mental health crisis and spoke of the importance of school-based approaches in improved mental health

care. In 2001, the National Institute of Mental Health stressed that effective interventions must be dispersed to clinics, schools, and other places where youth and parents can readily access services. Most recently, the President's New Freedom Commission on Mental Health drew attention to the fragmentation and gaps in mental health care for children and the lack of a national priority for mental health and for suicide prevention (Paternite, 2005).

Historically, mental health services in schools have been restricted, usually limited to assessment, clinical consultation, and treatment of students in or being referred to special education. However, with the heightened awareness of the potential advantages of SBMHCs and the help of federal initiatives, there have been more comprehensive programs and services emerging. Paternite (2005) states that the vital elements for success of SBMHC include partnerships between the school, family, and community, commitment to mental health education, early intervention, and treatment, and services for youth both in general and special education. There is an emphasis on collaboration between schools and communities agencies because it is being more widely recognized that schools cannot do all of the work alone, and that in many cases they are overwhelmed with demands that could and sometimes should be addressed by other community systems.

Role of Community

Paternite (2005) discusses the importance of a community-centered emphasis on SBMHCs, in an attempt to strengthen SBMHC functioning. It is meant to complement the research to practice model that is usually the main model for development of best practice programs. The community-centered emphasis focuses attention on local needs within the schools and the community, exhibiting more control, and making it easier to target the needs of the population.

There are many sociocultural variables that can inhibit and facilitate SBHC services, and some of these variables can be invaluable to school administrators in the implementation of service delivery. In a study by Bersamin, Fisher, Gaidus, and Gruenewald (2016), a greater number of SBHCs in California were found in cities (65.9%) and suburbs (23.9%) than in rural areas (6.8%) or towns (3.4%). Bivariate comparisons between schools with and without a SBHC found that schools with a SBHC had, on average, a higher percentage of students who received free or reduced-price lunch and minority students. Schools with a SBHC also were more likely to have at least one family planning clinic in the area, fewer teen pregnancies within the school district, as well as a smaller percentage of registered Republicans. The strongest predictor of schools having a SBHC on campus was the presence of a non-school-based family planning clinic within the school's estimated attendance zone (Bersamin et al., 2016).

This correlate likely indicates the collaboration with other general health community clinics, hospitals/medical centers, or nonprofit community-based health organizations. This correlation is not surprising, as community agencies often provide necessary resources, such as referrals, funding, and equipment, to support a SBHC. These findings suggest that schools looking to establish a SBHC may benefit from building strong relationships with local community agencies to help harness the necessary resources to meet the needs of youth in their neighborhoods and schools. According to Anyon, Ong, and Whitaker (2014), young people utilize community-based mental health centers often because of parental concern, where teachers and school staff can work together to identify students in need of additional support at school.

According to a Brief from the Center for Mental Health in Schools (2000), four key areas for collaboration between schools and their communities are 1) resource mapping and establishment of an integrated referral system, 2) providing staff development with respect to

prereferral interventions, 3) creating guidelines that protect confidentiality while still allowing for productive communication between the family and school staff, and 4) teaming with the family and key school community staff to enhance resource use.

The Brief states that it is essential to compile information about all existing resources within and outside a school system that are available to use by SBHCs. This helps to spread awareness of information and can increase chances of meeting students' and families' needs, as well as helping to empower the school community. Working on staff development is a way to minimize the amount of referrals by training teachers and other school personnel to help students whose problems are not so severe, by providing support and any classroom interventions possible. Guidelines about confidentiality and communication need to be established to protect students' and families' rights to privacy by making sure disclosed information is not relayed to others without informed consent. By doing this, it will hopefully increase student and family communication with schools. Finally, connecting with key personnel is important as well, in that the community and school staff are more likely to develop a working partnership if those to whom they are accountable have demonstrated a commitment to working together in policy and practice (Brief from the Center for Mental Health in Schools, 2000).

In order for programs at the school to improve, there must be both individual staff and group efforts to integrate efforts. Through these collaborative efforts, they can enhance program availability, access, and management of care, reduce wasted resources, reuse resources that are saved, and therefore, improve program results. Management of care and management of resources are two functions that play a key role in helping to integrate mental health center services in schools.

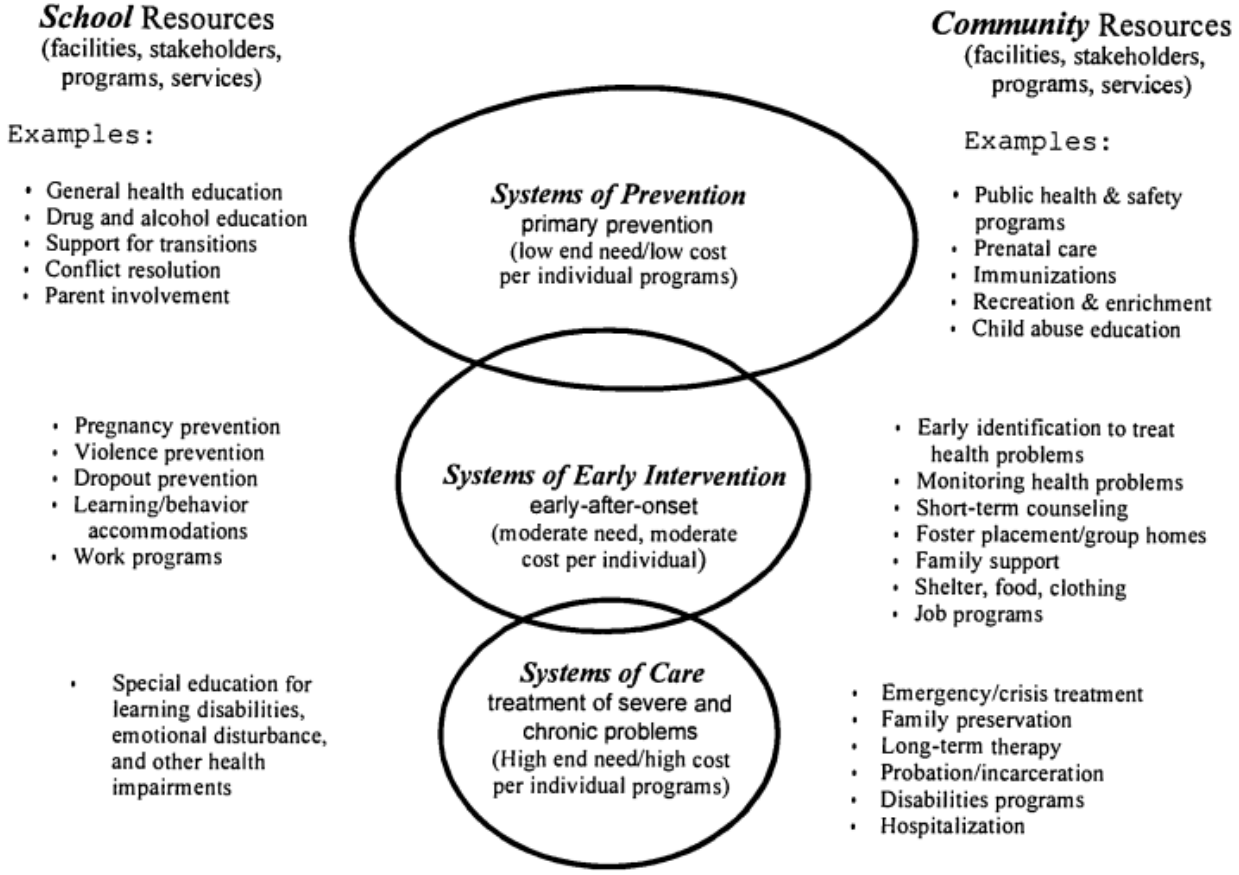

Figure 1. Providing a Continuum of School and Community Programs & Services Ensuring Use of the Least Intervention Needed. Knopf et al. (2016).

The diagram in Figure 1 shows the systemic collaboration of school resources and community resources to ensure intervention within each system, and among systems of prevention, systems of early intervention, and systems of care.

In a community guide systematic review, Knopf, Finnie, Peng, Hahn, Truman, Vernon-Smiley, and Johnson (2016) found that SBHCs are effective in improving many educational and health-related outcomes by addressing obstacles to educational achievement, including cultural, financial, and transportation-related barriers in order to have the potential to promote social

mobility and improve mental health care equity. In analyzing 46 studies of SBHCs operating for a number of years, trends show the centers have overall improved student academic expectations, safety and respect, school engagement, increased mental health awareness, and strengthened connections between the school and the larger community (Knopf et al., 2016). This is achieved primarily by having increased parental involvement in treatment and school activities, as well as the SBHC having increased involvement with community organizations.

Bains and Diallo (2016) also advocate for partnerships between schools and communities, and well as the sharing of existing resources, to be strengthened. Research by the authors yields that when adolescents had access to both the SBHC and community health centers, they were 21 times more likely to seek mental health services in the SBHC and more likely to access mental health services before medical services. Students said that they valued services in the SBHC because they could access the service easily, trusted the providers, found the providers helpful, and felt that the services were confidential.

In this study, the high number of students utilizing SBHC services and duration of visits was an encouraging indicator of patient access to mental health care, especially since adolescents are shown to not follow through with outpatient mental health services. Results of the study also show that students who exhibited high-risk behaviors, suicidal ideation, depression, and difficulty with sleep were more likely to have received services at the SBHCs as were students with no health insurance. School nurses in SBHCs often have partnerships and connections with community providers that may also provide additional resources to students and families that use SBHC mental health services (Bains & Diallo, 2016).

Connecting Teens to Caring Adults, School, and Academics

Mental health services are particularly important for teens during adolescence, where engaging in high-risk behaviors and the formulating adult habits is common. "An evolving concept in mitigating adolescent risk behaviors and in understanding how SBHCs work is the evolving concept of connectedness; that is, 'the belief by students that adults in the school care about their learning and about them as individuals'" (Blacksin & Kelly, 2015). The authors state that connectedness can serve as both a significant environmental protective factor for youth and a contributor to academic achievement. Despite how helpful teens feeling connected can be, knowledge about how SBHCs go about fostering this feeling of connectedness is minimally studied. By studying ways teens can feel more connected to caring adults in the SBHC and in the community, the research may contribute to new risk reduction strategies within SBHCs.

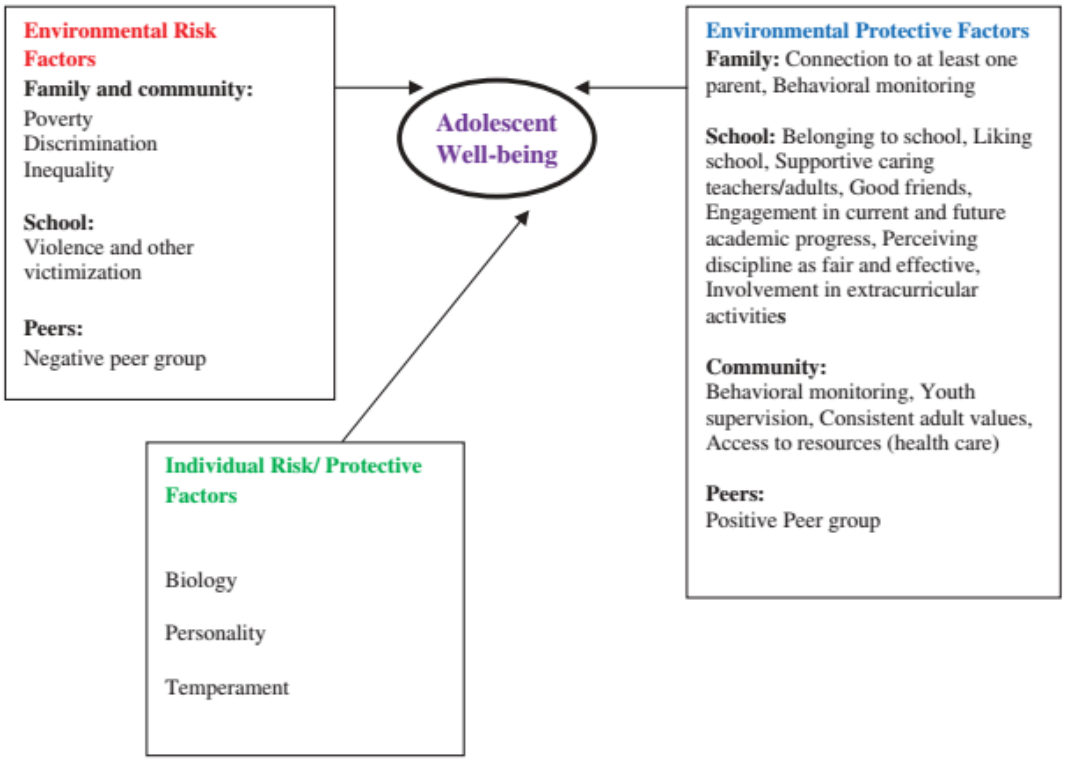

Figure 2. Ecological Model of Influence of a SBHC on the Lives of Urban Adolescents (Adapted from Blum & Blum, 2009l Bronfenbrenner, 1979).

In Figure 2, Adolescent Well-being is at the center of the diagram with environmental risk factors, protective factors, and individual risk and protective factors all influencing the feeling of well-being. These three categories are broken down into family, school, community, and peers, each being impacted by biology, personality, and temperament. Blacksin and Kelly (2015) conducted interviews with students, faculty and community members, and perused records in order to understand the history and programs of the SBHC. Out of the data that was collected, three themes emerged that demonstrated the positive effects of the SBHC that addressed the needs of the adolescent students and other users in the community. These three themes were the immediate access to adolescent-friendly services, providers as connectors, and focus on the whole adolescent (Blacksin & Kelly, 2015). These factors demonstrated specific aspects of primary care, which include first contact, continuous and comprehensive coordination, referral for specialized care, and cultural competency.

It would be prudent for providers to keep these three factors in mind as they function as connectors within the adolescent population and to referral networks within the school and external community. This relationship helps contribute to the feeling students have of care in the community. Providers also used therapeutic relationships to create meaningful connection with adolescents and were able to use feedback from the students to positively change the overall school environment. In order to address the focus on the whole adolescent, providers examined risk factors that contributed to overall adolescent health and wellness. Consistent and systemic use of comprehensive risk assessments was the mechanism used by providers to care for the whole adolescent in this study (Blacksin & Kelly, 2015). Questions included on the assessment included ones about liking school, problems at school, involvement in school and community activities, risk behaviors, substance use, self-injury, safety at home, trauma, bullying, and poor

academic grades. In addition, the notion of cultural competency is an important part of the model, and one that is integrally related to accessibility. Finally, a major component of care of the whole adolescent is the need to address the population's unmet needs for mental health services. Having a SBHC on site at the school decreased the stigma associated with mental health care, and several accounts of serious mental illness at this site would have gone unmet if onsite mental health care services were not available (Blacksin & Kelly, 2015).

There is an increased need to understand the relationship of SBHCs to performance and attendance in school. Previous studies support the theory that the benefits of SBHCs extend beyond just mental health benefits, and include academic outcomes. One previous study found an association between low to moderate SBHC use and reductions in dropout rates for high school students with higher risk for dropout. The current study by Strolin-Goltzman, Sisselman, Melekis, and Auerbach (2014) explored school connectedness and is relationship with SBHC usage, attendance, and academic performance.

According to Strolin-Goltzman et al., (2014), school connectedness is a key factor in examining the relationship between SBHC usage and academic outcomes. In 2009, the Center for Disease Control (CDC), defined school connectedness as "the belief held by students that adults and peers in the school care about their learning as well as about them as individuals". School connectedness has been shown to also be a protective factor against behavioral health problems as well as risky behaviors, such as tobacco use, substance use, delinquency, and early sexual behaviors (Strolin-Goltzman et al., 2014).

Students and parents from three schools (n=793) completed surveys on SBHC usage, satisfaction with SBHC usage, and school connectedness. The three variables being assessed to measure the level of school connectedness were school bonding, school attachment, and

commitment to educational future. Results indicate that users of SBHCs, compared with nonusers, have higher levels of school connectedness in each of the three variables listed above (Strolin-Goltzman et al., 2014). Overall, this article supports the theory that SBHCs not only improve mental health care and increase access to mental health care amongst students, but that a sense of school connectedness may also positively affect academic performance.

Types of Therapy as Interventions

School connectedness is an important factor to recognize as different types of therapeutic interventions are considered for use in SBHCs. There is a plethora of research showing that the more connected students and families feel on multiple levels to their school and community, the more effective these therapeutic interventions will be. What follows is a brief review of several therapy models that show promise for school-based mental health programs in general and the Haven in particular.

Multisystemic Therapy

Multisystemic Therapy (MST) is a family and community-based intervention originally developed for juvenile offenders. It is based on the theoretic model of Bronfenbrenner's social ecological framework, which illustrates that individuals' behaviors are influenced directly and indirectly by the multiple systems in which they are imbedded. Since MST was originally developed, it has been adapted and evaluated for a range of serious externalizing problems, including instances of violence and even substance abuse. There are specific factors such as school, family, achievement, peer, and neighborhood problems that increase risk for externalizing behaviors in youth. MST targets problems relating to these factors and can often prevent adolescents from being placed in out-of-district schools or even out-of-home placements.

Authors Zajac, Randall, Cupit, and Swenson (2015) explain that MST uses a home-based model to deliver services where problems most frequently occur (i.e. homes, schools, and neighborhoods). MST programs include a treatment team that is available to families 24 hours per day, 7 days per week through an on-call rotation. This allows for scheduling appointments at times that are convenient to families, effective crisis management, and high levels of direct service for each family (usually about 60 hours over the course of treatment).

There are nine core principles presented in Figure 2 that provide the underlying infrastructure of the MST model.

Box 1
Multisystemic therapy: 9 core principles

Principle 1: Finding the fit

The primary purpose of assessment is to understand the "fit" between the identified problems and their broader systemic context.

Principle 2: Focusing on positives and strengths

Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.

Principle 3: Increasing responsibility

Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members.

Principle 4: Present focused, action oriented, and well-defined

Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.

Principle 5: Targeting sequences

Interventions should target sequences of behavior within or between multiple systems that maintain the identified problems.

Principle 6: Developmentally appropriate

Interventions should be developmentally appropriate and fit the developmental needs of the youth.

Principle 7: Continuous effort

Interventions should be designed to require daily or weekly effort by family members.

Principle 8: Evaluation and accountability

Intervention efficacy is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.

Principle 9: Generalization

Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

Figure 3. Multisystemic Therapy: 9 Core Principles. Zajac et al. (2015).

According to this model, therapists first gather information about the referral behavior and desired outcomes from the youth, family, and other stakeholders. Then, the driving factors of the referral behaviors are identified so that the therapist can work with the family to develop evidence-based interventions to target each prioritized driver. These factors can include association with deviant peers, lack of prosocial activities, and school disengagement. This implementation is closely monitored, as well as any barriers that may arise. If treatment isn't successful, the therapist works with the family to determine new hypotheses and interventions. Thus, MST allows for learning about problems behaviors through treatment successes and failures (Zajac et al., 2015).

MST can also be used in cases of child abuse and neglect. MST-CAN (Child Abuse and Neglect) has been adapted for families who are under guidance of Child Protective Services and other related organizations. The aim of MST-CAN is to prevent out-of-home placements, assure safety, prevent reabuse and neglect, reduce mental health difficulties, and increase social supports. Zajac et al. (2015) outlined intervention strategies including conducting a functional analysis for physical abuse or family conflict in order to understand the sequence of events that lead to aggression. That way, interventions can more easily target triggers for aggression to deescalate children or parents. Other kinds of interventions include CBT for anger management, behavioral family treatment for communication difficulties and problem-solving, prolonged exposure therapy for parents with PTSD, and reinforcement-based therapy for adults for whom substance abuse puts child safety at risk. In order for these interventions to be effective, they must target risk factors at the individual, family, school, and community levels. Decades of research shows that if MST is carried out addressing problems at each of these levels, it significantly reduces serious clinical problems that put adolescents at risk for out-of-home

placement, serious externalizing behaviors, substance abuse, and parental physical abuse and neglect.

School-Based Trauma Intervention Program

It is known that multicultural, inner-city youth are more likely to be exposed to traumatic events, but less likely to receive mental health services. This is often because trauma treatment is often viewed as a "one size fits all" model, meaning that every student receives the same intervention. Of course, depending on the child and several other factors including their previous experiences and support systems, a "one size fits all" model may not always be appropriate. Brown, McQuaid, Farina, Ali, and Winnick-Gelles (2006) posit that because of this, there is little understanding of the ability for a school-based trauma program to address the different needs of students.

The authors support research that says how there should be a multi-tier model of assessment and intervention in school settings, where the program should match the intensity of therapy to symptom severity, resulting in different levels of intervention. Prior research indicates that a multi-step program is needed that would provide a comprehensive group for coping skills, an individualized intervention for children who remain symptomatic , and evaluations conducted before and after each step with all participants. Researchers in this study used measures to assess for trauma history (Traumatic Events Screening Inventory), PTSD (Child PSTD Symptom Scale), anxiety (Multidimensional Anxiety Scale for Children), depression (Children's Depression Inventory), externalizing symptoms (Behavioral Assessment of Children and Children's Inventory of Anger), and program satisfaction (Satisfaction Survey). The Haven sees numerous trauma cases every year, and the previously listed assessments in parentheses are included as possible resources for the Haven and its director.

The goals of the study were to implement an evidence-based, cognitive behavioral trauma intervention in a school setting, and to evaluate the effectiveness of the evidence-based intervention in the school setting. Cognitive Behavioral Therapy (CBT) was selected as the intervention because of its empirical evidence supporting the efficacy of CBT for symptoms of PTSD, anxiety, depression, and aggression following trauma exposure (Brown et al., 2006). Through CBT treatments, children learn to talk about the traumatic experience, while being provided with tools to control their behavioral responses and feel safe. Trauma-Focused CBT provides structure to treatment while allowing for developmental differences to be addresses. For example, different prompts are used with younger children than with older children while teaching coping skills.

Both classroom-based and individual interventions were informed by the work of child trauma and anxiety treatment outcome researchers. The goal of the classroom intervention was to educate the children, provide empathy for their experiences, normalize their reactions to traumatic events, and explain the intervention rationale. Affect regulation was included to help students identify emotions and link emotions to facial expression, language and tone and body stance (Brown et al., 2006). Coping strategies that were used included controlled breathing, progressive muscle relaxation, cognitive restructuring, positive imagery, problem-solving, and anger management. Individualized therapy consisted of six 45-minute sessions, usually providing exposure therapy, and reinforcing coping strategies in a more intimate setting.

In line with the goals of the study, consent, evaluation, and treatment processes were able to be incorporated into the school system, with the majority of the children reporting that the coping strategies worked and that they were likely to use those strategies outside the classroom. Students also experienced a significant reduction in PTSD, depression, and anger symptoms.

There was no reported decrease in anxiety symptoms, perhaps due to the effect of initially reporting anxiety symptoms in a classroom setting and not enough exposure therapy in the six individual sessions (Brown et al., 2006).

Group Cognitive Behavioral Therapy (GCBT)

Eiraldi, Power, Schwartz, Keiffer, McCurdy, Mathen, and Jawad (2016) conducted a study to examine the effectiveness of three group cognitive-behavioral therapy (GCBT) interventions for children with or at risk for externalizing behaviors problems, anxiety, and depression in two urban schools. The Coping Power Program (CPP) was used for behavioral problems, Friends for Life (FRIENDS) was used for anxiety, and Primary and Secondary Control Enhancement Training (PASCET).

The authors discuss that aggressive, defiant, disruptive, and antisocial behavior such as the behavior seen in children with, or at risk of, externalizing behavior disorders such as oppositional defiant disorder (ODD), conduct disorder (CD), and attention-deficit/hyperactivity disorder (ADHD) are highly prevalent in urban school settings. These disorders have been found to lead to academic underachievement, grade retention, suspension and expulsion, and later problems with the law. In fact, research also shows that early onset of aggressive and antisocial behaviors in elementary school children is related to a persistent and chronic trajectory of antisocial behavior into middle childhood and adulthood (Eiraldi et al., 2016).

Multi-tiered approaches are effective in reducing behavioral and emotional problems in children. Using CPP, FRIENDS, and PASCET include components for teaching social-emotional learning (SEL) skills such as self-awareness, social awareness, coping skills, and social skills. CPP offers eight sessions in the first year of intervention and 25 sessions in the second year of intervention. CPP includes units of anger management, goal setting, emotional

awareness, relaxation training, social skills training, problem solving, and handling peer pressure (Eiraldi et al., 2016). It is helpful to have school counselors participate in training workshops on CPP doing role-plays, watching video-recorded sessions, and demonstrating techniques to ensure quality of service delivery and the most effective outcomes.

Results of the study showed GCBT decreases externalizing behaviors. Specifically, 59% of children in CPP demonstrated symptom reduction. The results for CPP are especially noteworthy since the intervention that was used was briefer than the version validated by extensive previous research.

School-Based Mental Health Models

Middle and high schools that do not attend to their students' mental health needs are doing a great disservice to its students, given the fact that adolescence is a life stage where students experience developing issues relating to identity, intimacy, and individuation, as well as where most mental disorders have their onset. There are several articles in research today that suggest different models of mental health care that schools can follow and adapt to meet their own needs in order to best serve their student population. Multiple models are described in detail below.

According to Wei, Kutcher, and Szumilas (2011), mental health disorders that go unrecognized and untreated can lead to a variety of negative long and short-term outcomes, such as poor educational and vocational achievement, problematic social and personal functioning, and reduced life expectancy due to associated medical conditions and suicide. However, effective treatment of mental health issues and mental disorders can improve social and emotional behavioral difficulties, leading to a reduced number of school days missed (less suspensions and infractions with the law) and overall enhanced learning outcomes.

PracticeWise Managing and Adapting Practice system (MAP)

Mental health care services provided in schools doesn't always adequately integrate evidence-based practices (EBP), which could diminish the effectiveness of mental health interventions. There are often barriers that interfere with successful implementation of EBP, such as the training and support resources needed for implementation typically exceed those available in schools. Research by Lyon, Charlesworth-Attie, Stoep, and McCauley (2011) state that emerging implementation models attend closely to characteristics of the settings in which new practices are delivered, with the intent of facilitating the adaptation, adoption, and ongoing application of evidence-based care.

The authors posit that the Consolidated Framework for Implementation Research (CFIR) provides one model for conceptualizing program implementation that pinpoints crucial factors for successful adoption of new practices. The five major domains are: 1) *Intervention characteristics*, including core components and adaptable, peripheral elements; 2) *outer setting*, the broader economic, political, social context in which an organization exists; 3) *inner setting*, the immediate organizational context in which implementation occurs; 4) *individual characteristics of practitioners and team members*, such as personal and professional values, interests and affiliations; and 5) *the implementation process*, the steps and modes by which active change is undertaken (Lyon et al., 2015). In the current study, CFIR helped guide researchers' understanding of the unique challenges encountered when trying to implement practice changes in a school-based setting.

Research in schools show that modular psychotherapy may prove to be a better fit with the structure of a SBHC than more traditional models of evidence-based CBT practices in that it allows for greater flexibility in the length and frequency of sessions. It also breaks down

treatments into meaningful units that can be implemented independently or together to bring about a specific treatment outcome. One modular approach, the PracticeWise Managing and Adapting Practice system (MAP) carefully matches youth mental health problems and demographic characteristics to appropriate treatment modules of empirically supported interventions. Lyon et al. (2105) describes that MAP was originally developed to make treatment in a community-based setting more effective. One way it does this is by allowing therapists to choose specific elements of the treatment that are most likely to promote change.

MAP has three components to support clinical decision making: 1) A computerized database that has information showing which treatment models have the strongest evidence for being helpful; 2) A set of user-friendly practice guides for each module with step-by-step instructions for implementing its key elements, which helps therapists avoid searching through several treatment manuals; 3) A "dashboard" tracking system to monitor use of treatment elements and track a student's progress in therapy. Results from MAP suggest that it may be effective in increasing EBP delivery in the SBHC setting.

Elements of the MAP system address a broad range of internalizing (e.g., depression, anxiety) and externalizing (e.g., attention/hyperactivity, conduct) mental health problems	Specific focus on *depression and anxiety*; training focused on elements of effective interventions for internalizing problems	*Relevance:* Prioritization of elements related to the most common mental health problems treated in the SBHC setting (Walker et al., 2010) Preimplementation data indicated depression and anxiety accounted for 40% of all cases
Searchable EBS database is accessed by individual clinicians who use it to select practice elements for use with specific cases	Consultants accessed the online database and identified practice elements for training	*Efficiency and Acceptability:* Reduction of practitioner time demands—a key barrier to EBP implementation in schools (Langley et al., 2010) *Simplicity:* Reduction of intervention complexity to facilitate implementation success

Figure 4. Adaptations to the Map and Framework and Rationale. Lyon et al. (2015).

Traditional training model in which training in all elements occurs at the outset of implementation, followed by consultation	Gradual introduction of elements within existing consultation framework familiar to clinicians/ consultants	*Economy:* Implementation is facilitated by the appropriate use of existing resources and structures (Fixsen et al., 2005)

Note. MAP = Managing and Adapting Practice; SBHC = school-based health center; EBS = evidence-based service; EBP = evidence-based practice.

Figure 4- Continued. Adaptations to the Map and Framework and Rationale. Lyon et al. (2015).

Figure 4 shows how MAP can be adapted to different frameworks and rationales, depending on the needs of the target population. In this study, therapist attitudes, therapist knowledge, implementation, and progress monitoring were assessed. There are also structured therapist training sessions and consultation/support procedures for MAP implementation. Results of the study show that therapists who fully participated in the training were able to successfully use the modular psychotherapy with students, resulting in symptom change in 94% of their sessions (Lyon et al., 2015). There is a growing evidence for the feasibility of these approaches, which is encouraging as it suggests that clinical innovations can have an effect on mental health care delivered in schools.

School-based Pathway to Care Model

Canadian secondary schools (middle and high schools) have long been recognizing the importance of evidence-based promotion, prevention, and treatment approaches to mental health care. Wei, Kutcher, & Szumilas (2011) propose a comprehensive model to address mental health problems and promote effective care in school settings. Although this model was developed in Canada and has been in used in Canadian schools in line with national health care models in that country, it is important to emphasize that it has also been implemented in other

countries, and can easily be adapted to better fit with national health care policies of other nations, including the United States.

Wei et al. (2011) stated that the goals of the model include promoting mental health and reduce stigma by enhancing the mental health literacy of students, educators and parents, to promote appropriate and timely access to mental health care, enhance linkages between school and community health care providers, and to involve parents and the community at large to address the mental health concerns of youth.

The model is made up of interrelated domains that create an integrated pathway to care when put together. They include a mental health promotion through mental health literacy for youth, educators, and families; training for teachers, student services providers, and primary care providers, with knowledge upgrading for mental health professionals, to facilitate early identification, prevention, and intervention; processes for coordination and collaboration between schools and their communities; and evaluation.

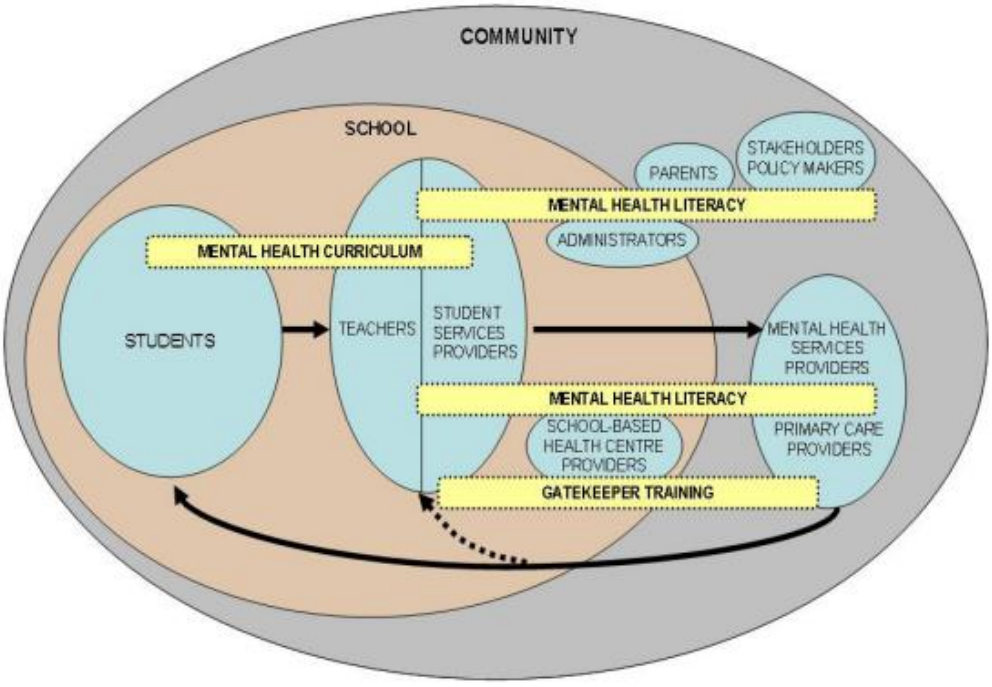

Figure 5. School-based Pathway to Care Model. Wei et al. (2011).

Figure 5 shows how the school-based pathway to Care model works. The circles show target groups within the educational system. The boxes show evidence-based mental health literacy and training program developed to meet the needs of target groups. Arrows show the integrated pathway to care for both students in general and students at risk of mental health problems. It also portrays how the model loop starts with and closes at students when different levels of both education and health systems work together.

As stated earlier, a strength of this model is that it is flexible, and can be conveniently adapted and customized to fit adolescent populations with differing needs in different educational settings. Another strength of this model is that it is embedded within the whole community, and has the potential to reach youth through outreach programs like community services, clubs, and sports teams.

Addressing mental health literacy during students' adolescent years has the potential to foster a better understanding of mental health and mental disorders that will help youth as they continue to progress through future life stages (Wei et al., 2011). Research shows that programs that promote mental health literacy have been successful in leading to an improved knowledge of mental health issues, changed attitudes among youth, parents, and educators, and reduced stigma in the community in general. A way to further reach parents and the community is to post the literacy curriculum online so it can be more easily accessible. This will help educate and empower school faculty and parents so that they can feel more comfortable discussing the material with their children both inside and outside the classroom.

	PROGRAM	TARGET AUDIENCE	PROJECT DESCRIPTION	PARTNERS
MENTAL HEALTH CURRICULUM	Mental Health & High School Curriculum	Students	Mental health curriculum for implementation in Canadian secondary schools. Topics include: stigma; mental health & mental illness; mental disorders; experience of mental illness; seeking help and support; positive mental health	Canadian Mental Health Association IWK Health Centre: Halifax, NS
MENTAL HEALTH LITERACY	Mental Health & High School Curriculum Teacher's Guide	Educators	Educational supplement to support teachers implementing Mental Health & High School curriculum.	Canadian Mental Health Association Laing House: Halifax, NS IWK Health Centre: Halifax, NS
	Transitions: Student Reality Check	Post-secondary students Student services providers Community health providers	Student resource includes topics such as time management, relationships, sexual activity, mental illness, suicide and addictions. Offers students self-help information and contains contacts to campus counseling services and other sources of help.	Orygen Youth Health :Australia
	MH-IN: Mental Health Identification and Navigation*	Educators Student services providers School health services providers School administrators Parents Community health providers Community stakeholders Policymakers	Training in topics including mental health, mental disorders, identification of at-risk students, navigation within mental health system	Nova Scotia Department of Education: Halifax, NS South Shore Regional School Board: Bridgewater, NS South Shore District Health Authority: Bridgewater, NS IWK Health Centre: Halifax, NS
GATEKEEPER TRAINING	Understanding Adolescent Suicide and Depression	Educators Student services providers School health services providers School administrators Community health providers	Training in topics including symptoms, physiology, causes, identification and treatment of depression and risk factors, prevention, and screening for suicide risk.	IWK Health Centre: Halifax, NS

Figure 6. Examples of School Mental Health Promotion Programs Corresponding to the Comprehensive School Mental Health Model. Wei et al. (2011).

Figure 6 depicts examples of these promotion programs that can be used within multiple school systems. Gatekeeper training programs provide training for teachers in the identification and support of young people experiencing mental health problems. It also informs teachers of student services in their own school, which increase the chances of them referring their students to appropriate mental health care, and eases the transition process for students to access this care.

Evaluation is another key component of the model to ensure quality and sustainability through evaluation of desired outcomes. Components of this evaluation can be included in quality assurance assessments conducted by educators, school psychologists, and can be customized to fit local needs. By doing this, the model can be adopted by schools and they can determine its fidelity. Wei et al. (2011) argues that qualitative program evaluations could be given at designated times (semi-yearly or yearly) in collaboration with all stakeholders including students, educators, health providers and policy makers to identify strengths and weaknesses, address barriers to treatment, and accordingly modify the model to best meet the communities' needs.

Implications for Culturally Sensitive Treatment

This section includes prior research that has been conducted amongst a variety of cultural/ethnic groups that discuss their involvement with mental health services, and include important findings and implications for working with such groups. This research was necessary and meaningful to review since the Haven services a broad range of cultural/ethnic diversity and can always learn more about culturally sensitive ways of improving treatment to these groups. The researcher focuses on Asian and African American populations since the Piscataway school district has a large number of these groups of students.

<u>East Asian populations</u>

Anyon, Moore, Horevitz, Whitaker, Stone, and Shields (2002) discuss research demonstrating that Asian youth's experiences with racial discrimination, stress, poverty, and cultural stigma result in lack of access and use of student mental health services in schools. The authors studied whether racial differences in SBHCs persist after accounting for student need or health risks. It examined if the varied prevalence of certain racial groups who use these school-based services can explain unique racial patterns of service use in schools. Using a random sample from nine schools, students (n=1755) were involved in this study (Anyon et al., 2002).

Within this school district, one of the most common ways through which students participate in SBHC services is through school staff referrals. In a program evaluation survey conducted by the SBHC staff, 49% of service users reported being referred by teachers, 29% reported being told by a friend, and 18% reported being told by another SBHC member. Anyon et al. (2002) says that based on this study's findings, the needs of Asian students may be overlooked by adults in the school community perhaps due to the strength of the "model minority" myth in educational settings, and the reality that Asian youth tend to experience lower risk factors than other youth of color.

In terms of implications for SBHCs and the future, the authors emphasize educating school staff on how to identify mental health risks among Asian students, increasing culturally specific programming, and if possible, improving SBHC providers' Asian language capacity in order to better help Asian youth. It is also important to document racial disparities in terms of SBHC use in schools, so that future research could expand on studies like this one, perhaps with the addition of measures examining other factors, such as exposure to trauma, service use outside school, contextual and cultural influences, and teacher referral practices (Anyon et al., 2002).

In a later article also by Anyon and other authors, it states growing evidence that Asian American youth are at a higher risk for depression, self-injury, and suicide than White or African American youth (Anyon, Ong, and Whitaker, 2014). This is, in part, due to culturally specific risks such as intergenerational family conflict and racial discrimination. To echo Blacksin & Kelly (2015), it has been found that school connectedness, support from family and peers, and living in a dual-parent household are general protective factors associated with positive mental health functioning for most adolescents. As a whole, Asian American underutilize mental health services, so it is crucial that attention be paid to issues of access and use to ensure that needs of underserved populations, such as Asian Americans, are met through prevention programs.

In the article by Anyon et al. (2014), a school-based mental health (SBMH) prevention program in an urban community with a significant Asian population was evaluated. Evidence suggests that teachers expect Asian youth to be perfectionist, anxious and shy, while also perceiving them to be less hostile, disruptive, and aggressive than Black or Latino youth. It is stereotypes such as these that may lead to the danger of teachers overlooking signs of psychological distress in Asian American students.

The study's service delivery approach is informed by the interconnected systems model which includes universal, selective, and indicated approaches to mental health prevention and early intervention, delivered by school personnel, often in partnership with community organizations. The measures examined in this study were race and ethnicity, universal risk factors, culturally unique risk factors, and protective factors. Results showed that in general, Asian youth tended to report lower risk factors and lower risk behaviors than peers of other racial backgrounds.

In this study, it was of concern that students who self-reported depressive symptoms also indicated that they rarely, if at all, utilized the services. It is hypothesized that barriers such as stigma and cultural norms may explain why depression among Asian youth is not associated with increased use of school-based services. An important takeaway from this study is that it cannot be assumed that students with the greatest need will find their way into services. There needs to be outreach efforts, enrollment strategies, and programming efforts made that are culturally and contextually responsive. In addition, it is important to emphasize that school-based screening for protective factors as well as culturally unique risk factors, may also help providers identify Asian American youth in need of services.

African American and Latino populations

Among African American and Latino adolescents, fewer than 10% utilize outpatient mental health services, and when they do, they are less likely to receive the needed care than their White peers (Bains, Franzen, and White-Frese, 2014). Unmet mental health needs contribute to a variety of problems, but specifically among adolescents in this population, it contributes to higher incarceration rates. According to Bains et al. (2014), one of the main strengths of SBHCs is that it provides mental health care that includes providing therapy in a culturally competent manner. For minority populations, such as African American and Latino, who are often challenged by poverty, limited access to healthcare, health care disparities, SBHCs offer a way to overcome those barriers. There is limited research on why African Americans and Latinos seek mental health services more often in SBHCs, so Bains et al., (2014) conducted research to understand the reasons behind it within a population of African American (45%) and Latino males (55%), ages 13-18, attending different high schools in Connecticut.

It was revealed that with this population of adolescents, managing anger was a major concern for them. Having someone they were comfortable talking with, could trust, and maintain confidentiality with was the most important factor in seeking mental health services in SBHCs. Moreover, five themes emerged from the analysis of data depicting the experiences of these adolescents with SBHC mental health services. The themes were "the burdens and hurdles in my life", "the door is always open", "sanctuary within chaos", "they get to know us", and "achieve my best potential" (Bains et al., 2014).

Within these themes, the adolescents included issues of managing anger, reducing risky behaviors, depression, and discussing family issues, such as parents not paying attention to them or not spending enough time with them. Many adolescents described being the primary caretakers for their younger siblings, and having to greatly help out with household chores so that their parents could work longer hours. Other topics included suicidal ideation and peer pressure. The adolescents reported always feeling welcome by providers and valued the easy accessibility of services. In addition, adolescent boys reported that talking to their counselors helped them avoid conflict, substance use, and stay in school. They felt understood and safe to share personal information. By conversing about their personal concerns, and home and school issues, adolescents reported feeling that the services received ultimately help them achieve their best academic potential.

The study shows the value and trust African American and Latino males place on mental health services in SBHCs. The easily accessible services were tailored to their needs and it allowed for them to have better social, emotional, and academic outcomes. The issues that males in this population face in urban, inner cities are challenging and the lack of access to adequate

care is resulting in disparities in their mental health and educational outcomes (Bains et al., 2014).

South Asian populations

Asians are currently the fastest growing ethnic group in the United States accounting for about 5.6% of the total US population, of which South Asians (i.e., people from India, Pakistan, Sri Lanka, Bangladesh, and Nepal) are the fastest growing subgroup. Despite the increasing size of the South Asian population in the country, they remain an understudied population in mental health research. Since cultural values and beliefs play an especially important role in psychiatric care, increased understanding of mental health perceptions within the South Asian community is needed (Rastogi, Khushalani, Dhawan, Goga, Hemanth, Kozi, and Sharma, 2014).

In the study by Rastogi et al. (2014), several South Asian participants disclosed their perspectives on topics such as abuse, gender issues, confidentiality, and psychoeducation about mental health and mental health treatment. Cultural stigma and denial of mental illness were identified by participants as the most common barrier for engaging in treatment of mental illness. "Participants noted that South Asian patients with mental illness are often concerned about being called "crazy," '"mad," or "insane." Young South Asian patients often did not feel comfortable discussing their emotional issues with their family even if the parents were well educated for fear of being misunderstood or considered weak. Obtaining family history of psychiatric illness was often challenging because patients did not want to discuss this" (Rastogi et. al., 2014).

Findings from this study discuss how the cultural stigma within the South Asian communities stems from consideration of mental illness as a weakness or shameful factor, which often leads to delay in seeking treatment, difficulties at work and problematic inter-personal relationships. Rastogi et al. (2014) posits that the evaluation and treatment of South Asians with

mental health issues requires understanding of the cultural values and beliefs that drive symptom presentation and attitudes toward treatment. Taking these findings into consideration, it is a goal for the Haven to increase its sensitivity to cultural issues within South Asian and other populations, and to address any barriers to treatment, in the hopes that it may facilitate better mental health care for students.

Evaluation of Programs

Conducting evaluations to measure the efficacy of SBHCs is helpful to both the staff working at the SBHC and the students obtaining services through it in order to maximize benefits. It is important to measure the impact on children's and adolescents' mental health, and how closely the population's needs are being met. It is also critical to secure ongoing and additional funding.

There is very sparse literature measuring outcomes within certain populations in SBHCs. The results of such literature yield inconsistent findings and discuss prominent challenges that researchers come across while evaluating programs. These challenges include selection bias, maturational and historical effects, sample size and statistical power, heterogeneity in services delivered or received, displacement effects, and accounting for clustering effects. In the article by Bersamin, Garbers, Gold, Heitel, Martin, Fisher, and Santelli (2015), the authors gather five innovative approaches to address these challenges that arise while conducting evaluations.

In response to the challenges, the first new approach to evaluating SBHCs' impact are to maximize participation to minimize self-selection. This included collaborative meetings with administrators and teachers, providing incentives to the school for increasing levels of participation, appending evaluation consent forms to required forms being sent to parents, and sending forms home with students rather than using mail. Using this approach, participating

rates exceeded 79%. Another approach is entering class proxy-baseline study design, which allows for the comparison among three groups: control group, treatment group-SBHC users, and treatment group-SBHC nonusers (Bersamin et al., 2015). The other approaches include propensity to score methods, linking data sets, and collaborative research. This will enable evaluators to test differences across SBHCs, enlist schools and/or clinics to create a more adequate comparison group similar to the demographics of the target population, develop shared measures for local, state and national comparisons, and provide the same sample size necessary to detect rare outcomes.

New approach	Problems addressed	Overview and key finding	Partial citation
Maximizing participation to minimize self-selection bias	• Self-selection bias in consent • Statistical power	In 29 middle schools, multiple approaches were used, including engaging teachers, providing incentives for both teachers and students, and integrating consent forms with required forms. Using this multipronged approach yielded an active consent rate of 79%, and a nonresponse rate of only 10%.	Esbensen et al. [47]. Active parental consent in school-based research: How much is enough and how do we get it?
Entering-class proxy-baseline study design	• Maturation • Selection • Dosage	Simulated cohort using cross-sectional design, with 9th graders in both SBHC and non-SBHC schools serving as unexposed baseline to examine impact over time. Although the proportion of sexually active females who ever used a hormonal method was similar among 9th graders in schools with and without an SBHC (21% vs. 20%), among 10th–12th grade sexually experienced females, it was substantially higher among those at SBHC schools (60% vs. 26%, $p < .001$).	Minguez et al. [31]. Reproductive health impact of a school health center.
Propensity score methods	• Systematic differences between youth who use and do not use SBHCs • Systematic differences between youth who go to schools that do and do not have SBHCs	A study using data from a survey modified from the California Healthy Kids from students in 15 schools used baseline (pre-SBHC treatment) data to model and statistically adjust for probability of using SBHC services. In adjusted linear regression models, compared to students who did not use the SBHC, those who ever did were significantly more likely to report caring relationships with adults (β = .09, 95% CI: .06–.13), high expectations of adults (β = .08, 95% CI: .03–.13), and meaningful participation in school (β = .11, 95% CI: .06–.15). The authors also found significant dose-response effect, with higher levels of school assets with increasing use of SBHC.	Stone et al. [53]. The relationship between use of school-based health centers and student-reported school assets.
Linking data sets	• Displacement of health services access/provision • Cost • Statistical power	A study in Baltimore linked pregnant teen mothers' medical records and their newborns' birth certificates to examine comprehensiveness of prenatal care and birth outcomes among teens receiving prenatal care in a school-based versus hospital-based setting. In regression models adjusting for baseline differences, teens receiving hospital-based prenatal care were more likely to deliver a low-birth-weight infant compared to teens who received school-based prenatal care (AOR = 3.75, 95% CI: 1.05–13.36). These findings were attenuated after adjusting for adequacy of prenatal care (AOR = 2.31, 95% CI: .65–8.24).	Barnet et al. [32]. Reduced low birth weight for teenagers receiving prenatal care at a school-based health center: Effect of access and comprehensive care.
Collaborative research	• Heterogeneity of services • Statistical power	Collection of nationally representative data from more than 9,000 students in 96 schools in New Zealand to allow sufficiently powered analyses stratified by SBHC staffing and hours of availability. An increased rate of staffing by doctors and nurses (hours per week per 100 students) at SBHCs was significantly related to fewer students reporting involvement in pregnancy (AOR = .94, 95% CI: .89–.99). In schools with more than 10 hours of staffing per 100 students, sexually active students had significantly lower odds of reporting involvement with pregnancy compared to sexually active students in schools with no school-based health services (AOR = .34, 95% CI: .11–.99).	Denny et al. [30]. Association between availability and quality of health services in schools and reproductive health outcomes among students: A multilevel observational study.

Figure 7. Summary of five recent innovations in SBHC evaluation work. Bersamin et al. (2015).

The table in Figure 7 depicts the challenges encountered and the new approaches to addressing the problems. Bersamin et al. (25) states that these new approaches can be used by clinicians, researchers, evaluators, school and SBHC stakeholders, and policymakers to address the limitations that have affected previous SBHC evaluations. When evaluating a SBHC, it is significant to fully consider that context, resources, potential partners, target population, and logistics to identify methodological approaches best suited to their specific research questions and settings (Bersamin et al., 2015).

Macpherson (2013) wrote a paper reporting the process, findings, and implications of a three-year evaluation of school-based integrated health centers (SBIHC). Data was collected using the Pupils Attitudes to Self and School (PASS) instrument to measure nine factors of student mental health, primarily relating to attitudes to self and school. These factors include feelings about school, perceived learning capacity, self-regard, preparedness for learning, attitudes to teachers, general work ethic, confidence in learning, attitudes to attendance, and response to curriculum demands.

The first SBIHC is The Haven in the Budehaven Community School. After evaluating students on multiple measures at the end of three years, it was recommended that schools continue to use PASS data with academic progress data. This can be used to plan interventions and school improvements, and work on developing more support for students in families that are from low SES areas, and therefore more vulnerable for becoming more at-risk for maladaptive behaviors. The second SBIHC that was evaluated is the Crayon in the Hayle Community School. By the end of the three year evaluation, it was found that widening the scope of services to more closely match student needs was most effective, as well as increasing the user-friendliness of the center, increasing accessibility, and building more partnerships with

neighboring schools and organizations. The third SBIHC is Bywva in the Penair School. Based on the collected data for the evaluation, it was recommended that community partnerships were strengthened, there would be an increase in workshops on domestic violence and on poverty awareness training. By the end of the three years, more professionals were involved in mental health care, and the center continued to utilize the results of the evaluations when addressing the needs of students (Macpherson, 2013).

Macpherson (2013) points out that there are nine themes regarding the SBIHC model of care that emerge from the evaluations of these three schools' SBIHC. They are important to identify as they were effective in contributing to the most effective change over the years in the school's center, and can be instrumental in making positive changes in other SBIHCs and SBMHCs in the country. The themes include the relationships between students and health care professionals, student' characteristics and expectations, professionals' personal beliefs and goals, structuration of services, delivery modes, selection of services, intended outcomes (aims and objectives), student health assessments, and formative evaluations of the IHC. These nine themes are crucial to identify so that special attention can be given to them in the future when looking to evaluate SBMHCs.

Summary

Ultimately, the results of this research are intended to improve school-based mental health services in the Haven to better fit the student population's needs. The research is also intended to create a collaborative effort to look at existing community data in conjunction with current Haven findings in an effort to further integrate student with community services and organizations. In addition, the results of this research will also help all school staff be more culturally competent in providing school-based mental health services. By having community

services and organizations involved in referral services to the Haven and having more interaction with students in the district, there is the aim to further reduce stigma that adolescents may experience regarding seeking school-based mental health services.

Since there is sparse literature on the evaluation of SBMHCs, the current study contributes significantly to the current literature on the topic. Macpherson's paper highlights nine factors of student mental health and nine themes regarding the SBIHC model of care that emerged from the evaluations of these three schools' SBIHC. These factors and themes helped to guide the effective recommendations made for the SBMHC, and helped inform the current study's research questions and hypotheses. Taking this information into consideration, the study's researcher and the Haven's director collaborated to figure out what potential findings would be the most useful and the most meaningful to improving services at the Haven. The formulated research questions and hypotheses were carefully chosen, as they address specific identified mental health factors and themes from previous program evaluation studies, as well as existing concerns about the nature of the Haven's services and role within the school/larger community. The most common theme to materialize from all of the relevant literature discussed in earlier sections of this paper is that establishing connections between schools and community organizations and facilities is crucial for providing the most comprehensive and effective mental health care for students within schools.

This study seeks to use the following research questions and hypotheses to contribute to future school-based mental health center program development and performance and improvement, as well as connecting to community referral agencies and organizations:

Research Question 1: How well do the available school resources address the needs of a variety of mental health issues (presenting problems, effectiveness, and cultural competence)?

Hypothesis 1: The mean ratings of available school resources will be below average in meeting the needs of the mental health services identified, and comments will generally indicate that school services can improve their service delivery.

Research Question 2: How well do the available Haven resources address the needs of a variety of mental health issues (presenting problems, timeliness and appropriateness, and cultural competence)?

Hypothesis 2: The available Haven resources do not adequately meet the needs of a variety mental health services according to ratings (Adequately = rated 5 and above on the Likert Scale) and comments will state that services can be improved to more appropriately match needs.

Research Question 3: Which types of presenting problems are we doing well with according to our stakeholders?

Hypothesis 3: The Haven is less effective with family problems at the high school level (since the Haven does not have enough family involvement).

Research Question 4: Is the Haven culturally competent in general and with specific groups?

Hypothesis 4: The Haven is less competent with Asian students (perhaps a reflection of less involvement from this group) than with other cultural/ethnic groups.

Research Question 5: How effective is the Haven's communication, collaboration, and integration with various staff, community members, and community organizations?

Hypothesis 5: The mean ratings by teachers regarding the Haven's communication, collaboration, and integration with various staff, community members, and community organizations will be lower than the mean ratings of administrators and support staff. Comments will also indicate that there needs to be stronger connections between the Haven, the schools, and the community.

Research Question 6: How positively do school faculty perceive their school's climate?

Hypothesis 6: There will be significant variations in ratings and comments of perception of school climate. Specifically, administrators and support staff perceive their school's climate more positively than teachers will.

Methods

Participants

This study surveyed a sample of 98 Administrators, School Psychologists, Counselors, Behaviorists, Teachers, Learning Disabilities Teacher Consultants (LDTCs), Social Workers, Medical Professionals, and Law Enforcement officers from all over the Piscataway School District in Piscataway, New Jersey. Respondents were excluded from the research if they do not work in the Piscataway district, do not work directly with students or adolescent services of any nature, and/or decide to not participate in the research. Due to the qualitative nature of the study, the sample will be small and a control group will not be utilized. All participants will receive the same survey questions (see Appendix B).

Materials

Steps were taken to ensure the distributed survey reached a representative sample of people who work directly with adolescent youth services in varying capacities. In order to maximize these efforts, Dr. Patrick Connelly, Director of the Haven, sent out the surveys to a listserv of the aforementioned Piscataway school staff. Furthermore, support was also garnered from Margaret Drozd and Zachary Taylor, who work as a manger and coordinate of community health at Saint Peter's University Hospital, and Robert Wood Johnson Hospital, respectively. They helped to distribute the survey to people they work with involved in community health that could help collaborative efforts integrating the Haven students with community resources.

However, upon examination of the completed surveys, there were disproportionate numbers in regards to the type of participants (role/job title) who completed the survey, and therefore, there was not an evenly distributed representative sample. Nevertheless, this study sought to improve the quality of services at the Haven and to add to the growing body of literature through qualitative means by assessing the information provided by school faculty and community stakeholders who work directly with adolescent youth.

Procedures

Participants completed an online survey/questionnaire with qualitative features that the researcher developed through Qualtrics, an online software that enables users to do many kinds of online data collection and analysis including market research, customer satisfaction and loyalty, product and concept testing, employee evaluations and website feedback. Before disseminating the survey, the researcher received approval from the Institutional Review Board after completing a request for exemption from full IRB review form. The researcher qualified for the exemption review because they had minimal risk involved and did not use Rutgers students in the survey. As this is an introductory investigation, an email with a link to the consent form and the survey/questionnaire was disseminated to district school psychologists, teachers, administrators, and community stakeholders who had the option to participate in the survey. This study is completely voluntary and all data collected was de-identified.

The survey contained multiple choice questions, Likert scale questions, and open-ended questions that would inform the researcher of school staff and community stakeholder perception of the quality Haven services, the extent of staff and community interaction with students, and which aspects of student services the researcher can help the Haven improve upon when seeking to improve overall services and better match the student and family population's needs.

Underneath each multiple choice or Likert scale question on the survey, there is space for comments that gave the respondents an opportunity to anonymously report any additional knowledge they have about a certain question, any concerns they may have, and any suggestions they may have.

This research is designed as a needs assessment. Lower ratings on Likert scale questions, as indicated upon scoring, as well as areas highlighted by the survey, demonstrated a need for further training Haven staff on culturally sensitive evidence-based models, as well as a need for further student connection and integration with community resources and organizations.

Consent Form

I will be notified of the completed consent forms from each potential participant. The consent form explains the purpose and procedures for participation, risk and benefits of the study, confidentiality and limits to confidentiality, and provides contact information for all individuals affiliated with the study (see Appendix A). The consent form explains that the study is completely voluntary and participants have the right to decline participation at any time during the survey. Additionally, each participant was informed that they can contact the researcher if they had any concerns or questions about the study.

Survey

At the start of the survey, which is the community needs assessment section, participants were be informed to please select the answer (multiple choice) that is the best choice and not to answer any questions for which they felt they didn't have the knowledge to answer. The next section of the survey deals with what knowledge participants have regarding the Haven and schools in the Piscataway district. Participants were asked to please select the number (Likert scale) which best represents their opinion, and to feel free to add any additional comments in the

spaces provided underneath each question. Again, participants were reminded to not answer any questions for which they felt they didn't have the knowledge to answer. The last section of the survey is an open ended question asking for suggestions to improve the Haven. The survey has open ended questions as well as a scenario that participants will be asked to respond to (see Appendix B). The length of time it took participants to complete the survey was 10-20 minutes. Finally, once the survey was complete, participants were thanked for taking the time to complete the survey and told that their feedback was greatly appreciated.

Treatment of Data

Consent Forms

The consent forms will be kept in a locked storage file cabinet at the home of the researcher. Background data received from the demographic section of the survey will be used to categorize participants based on number of years teaching, ethnicity, and the school district to which they belong. Each participant will be assigned a code in order to keep his or her name confidential.

Survey Data

Hard copies of survey data will be stored in a secure location (locked file cabinet) in the researcher's home and no one other than the researcher will have access to this information. Once the data is transcribed, the information will be transferred into a password protected computer database at the researcher's residence. Three years after the completion of the research, all documents with identifying information will be shredded.

Data Analytic Plan

This study utilized the surveys as the method for obtaining data from participants. For the quantitative analysis the researcher ran frequencies to obtain the descriptive statistics on all

survey questions. Then one-way ANOVAs were run to see if differences between the answers provided in the survey generated by the three groups pertaining to a specific hypothesis were significant. Then post-hoc comparison were run to examine significant differences between the three groups. Once all of the surveys have been completed, the researcher coded the responses "A" for administrator, "SS for Support Staff, and "T" for teacher, included the grade levels they worked with. This coding process is known as selective coding, in which the researcher generates themes based on all of the responses and coding procedures (Corbin & Strauss 2014). Data for the current study was analyzed by a process called constant comparisons, where the data is broken down into manageable pieces and was compared and contrasted for similarities, differences, and any emerging themes. These comparisons were then developed into more refined categories and were tremendously informative in shaping recommendations for future studies.

Results

Teachers, administrators, and support staff working in the Piscataway school district, as well as various other positions working in the Piscataway community, filled out a survey examining their knowledge of the Haven's services, and how well the Haven meets the needs of various types of students and their presenting problems. Specifically, there were 14 administrators, 42 support staff, 34 teachers, and 8 community members, tallying a total of 98 respondents. All participants completed the survey, looking at variables such as prevalence of issues, communication and collaboration with the Haven, meeting needs of cultural/ethnic groups, school climate, and crisis intervention. Questions that measured the dependent variables were designed so that the answer choice to the question was a point on a Likert Scale. The answer choices were 1 (Unmet), 2 (Poor), 3 (Fair), 4 (Average), 5 (Good), 6 (Very Good), and 7

(Excellent). Each question also had an additional option of leaving a comment in the box below the Likert Scale answer choices.

This chapter begins with examining the quantitative data. Frequencies were run to obtain descriptive data statistics for the three participant groups, Administrators, Support Staff (School Psychologists, Counselors, Behaviorists, LDTCs, and Social Workers), and Teachers (see Table 1). One-way ANOVAs were conducted to see if differences between the answers provided in the survey generated by the three groups pertaining to a specific hypothesis were significant ($p<.05$) or not. These results also include data yielding from post-hoc analyses, which were conducted in order to further understand and interpret the significant data, using the Bonferroni Correction. Independent variables were coded 1 for Administrator, 2 for Support Staff and 3 for Teacher. The chapter concludes by examining the qualitative data, looking at the participants' comments throughout the survey, and discussing any common themes that emerged from the survey responses.

Quantitative Results by Hypotheses

One-way ANOVAs were conducted to test hypotheses to compare group means on the survey items of interest (see Table 2). Independent variables were coded 1 for Administrator, 2 for Support Staff and 3 for Teacher. Post-hoc comparisons, using a Bonferroni Correction, were performed for survey questions that yielded significant results in the One-Way ANOVA in order to examine significant differences between the three groups (see Table 3).

Hypothesis 1

Significant findings were found on multiple items that addressed Hypothesis 1, "The mean ratings of available school resources will be below average in meeting the needs of the

mental health services identified, and comments will generally indicate that school services can improve their service delivery."

An ANOVA revealed groups differed on the question, "How well does your school meet the needs of students with academic underachievement?", F (2, 66) =12.43, p= .000. Post-hoc analyses showed that teachers (M= 3.45, SD= 1.04) believe their school does not meet the needs of students with academic underachievement as well as administrators (M= 5.50, SD= .58), p=. 000, and support staff (M= 4.50, SD= .89), p= .001, think their school does. There is no significant difference between how administrators and support staff rated this item (M= .74, SD= .42), p= .242.

Groups differed on the question, "How well does your school meet the needs of students having issues with peers?", F (2, 66) =6.67, p=.002. Post-hoc analyses showed that teachers (M=4.45, SD=1.30) believe their school does not meet the needs of students having issues with peers as well as administrators (M= 6.00, SD= .82), p= .003, and support staff (M= 5.00, SD= 1.10), p= .037, think their school does. There is no significant difference between how administrators and support staff rated this item (M= .69, SD= .42), p= .306.

Hypothesis 2

Significant findings were found on multiple items that addressed Hypothesis 2, "The available Haven resources do not adequately meet the needs of a variety mental health services according to ratings (Adequately = rated 5 and above on the Likert Scale) and comments will state that services can be improved to more appropriately match needs."

Groups differed on the question, "How well does the Haven meet the needs of internalizing students?", F (2, 63) =4.53, p= .015. Post-hoc analyses showed that teachers (M= 5.27, SD= 1.19) believe the Haven does not meet the needs of internalizing students as well as

administrators (M= 5.75, SD= .50), p= .045, and support staff (M= 5.63, SD= .62), p= .030, think the Haven does. There is no significant difference between how administrators and support staff rated this item (M= .159, SD= 3.23), p= 1.00.

Between the three groups of respondents, answers differed on the question, "How well does the Haven meet the needs of students with academic underachievement?", F (2, 52) =5.94, p= .005. Post-hoc analyses showed that teachers (M= 3.55, SD= 1.44) believe the Haven does not meet the needs of students with academic underachievement as well as administrators (M= 5.25, SD= .96), p=. 008, and support staff (M= 4.50, SD= 1.27), p= .032, think the Haven does. There is no significant difference between how administrators and support staff rated this item (M= .57, SD= .49), p= .745.

The question, "What is your perception of the Haven's provision of appropriate and timely mental health care?", F (2, 63) =4.92, p= .010, yielded differences between groups. Post-hoc analyses showed that teachers (M= 4.91, SD= 1.38) believe their perception of the Haven's provision of appropriate and timely mental health care is worse than both the perception of administrators (M= 6.25, SD= .96), p=. 012, and the perception of support staff (M= 5.63, SD= .81), p= .113. There is no significant difference between how administrators and support staff rated this item (M= .57, SD= .35), p= .331.

Groups differed on the question, "What is your perception of the level of effectiveness of counseling services provided at the Haven?", F (2. 59) =3.564, p= .035. Post-hoc analyses showed that teachers (M= 5.36, SD= 1.362) believe their perception of the level of effectiveness of counseling services provided at the Haven is lower than both the perception of administrators (M= 5.75, SD= .50), p= .163, and the perception of support staff (M= 5.63, SD= .89), p= .044.

There is no significant difference between how administrators and support staff rated this item (M= .02, SD= .39), p= 1.000.

There were differences in the answers between groups on the question, "How well does the Haven respond to crisis intervention?", F (2, 58) =3.932, p= .025. Post-hoc analyses showed that teachers (M=5.45, SD=1.128) believe the Haven does not respond to crisis intervention as well as administrators (M= 6.50, SD= .58), p=. 043, and support staff (M= 6.19, SD= .75), p= .090, think the Haven does. There is no significant difference between how administrators and support staff rated this item (M= .40, SD= .43), p= 1.000.

Finally, there were also group differences in the answers to the question, "How well does the Haven meet the needs of students and families with trauma histories?", F (2, 56) =3.26, p= .046. Post-hoc analyses showed that teachers (M=5.18, SD=1.08) believe the Haven does not meet the needs of students and families with trauma histories as well as administrators (M= 6.00, SD= .82), p= .043, and support staff (M= 5.44, SD= .73), p= 1.000, think the Haven does. There is no significant difference between how administrators and support staff rated this item (M= .61, SD= .31), p= .155.

Hypothesis 5

Significant findings were found on multiple items that addressed Hypothesis 5, "The mean ratings by teachers regarding the Haven's communication, collaboration, and integration with various staff, community members, and community organizations will be lower than the mean ratings of administrators and support staff. Comments will also indicate that there needs to be stronger connections between the Haven, the schools, and the community."

Respondent groups answers differed on the question, "How would you rate your general communication with the Haven (referrals, setting up appointments, etc.)?", F (2, 61) =9.67,

p=.000. Post-hoc analyses showed that teachers (M= 5.18, SD= 1.66) believe their general communication with the Haven is worse than both administrators' (M= 6.25, SD= .96), p=. 025, and support staff's (M= 6.38, SD= .72), p= .000, communication with the Haven. There is no significant difference between how administrators and support staff rated this item (M= .18, SD= .45), p= 1.000.

Groups also differed on the question, "How would you rate the Haven's collaboration with you on meeting students' needs (this includes planning and coordinating interventions, etc.)?", F (2, 60) =7.97, p= .001. Post-hoc analyses showed that teachers (M= 4.91, SD= 1.58) believe their collaboration with the Haven is significantly worse than both the collaboration of administrators (M= 5.75, SD= .50), p=. 034, and support staff (M= 5.94, SD= .85), p= .001, with the Haven. There is no significant difference between how administrators and support staff rated this item (M= .18, SD= .48), p= 1.000.

There were also group differences in response to the question, "How well is community involvement integrated into students' lives (ex: what is the level of student involvement with community programs and recreational activities?", F (2, 63) =4.25, p= .019. Post-hoc analyses showed that teachers (M= 3.91, SD= 1.30) believe community involvement is less integrated into students' lives than both administrators (M= 5.50, SD= .58), p= .016, and support staff (M= 4.44, SD= 1.46), p= .295, believe it is. There is no significant difference between how administrators and support staff rated this item (M= .80, SD= .46), p= .252.

Respondent groups also differed on the question, "What is your perception of administrator collaboration with the Haven?", F (2, 60) =3.248, p= .046. Post-hoc analyses showed that teachers (M=4.00, SD=1.34) believe their perception of administrator collaboration with the Haven is worse than the perception of administrators' (M= 5.75, SD= .50), p= .041, and

the perception of support staff (M= 4.75, SD= 1.07), p= .919). There is no significant difference between how administrators and support staff rated this item (M= .92, SD= .50), p= 204.

Hypothesis 6

Significant findings were found on an items that addressed Hypothesis 6, "There will be significant variations in ratings and comments of perception of school climate. Specifically, administrators and support staff perceive their school's climate more positively than teachers will."

Groups differed on the question, "What is your perception of the school climate within your school?", F (2, 69) =10.452, p= .000. Post-hoc analyses showed that teachers (M=3.73, SD=1.104) believe their perception of the school climate within their school is worse than the perception of both administrators (M= 5.75, SD= .96), p=. 000, and support staff (M= 4.63, SD= 1.15), p= .032, regarding the school climate within their schools. There is also a significant difference between how administrators and support staff rated this item (M= 1.11, SD= .41), p= .025.

Table 1

Descriptive Statistics for Administrators, Support Staff, and Teachers

N=90

Variables	*Administrators* $\bar{x}$ (*SD*)	*Support Staff* $\bar{x}$ (*SD*)	*Teachers* $\bar{x}$ (*SD*)
Haven related:			
Internalizing Students	5.75 (.50)	5.63 (.62)	5.27 (1.19)
Academic Underachievement	5.25 (.96)	4.50 (1.27)	3.55 (1.44)
Response to Crisis	6.50 (.58)	6.19 (.75)	5.45 (1.13)
Trauma	6.00 (.82)	5.44 (.73)	5.18 (1.08)
Timely Services	6.25 (.96)	5.63 (.81)	4.91 (1.38)
School related:			
Peer Issues	6.00 (.82)	5.00 (1.10)	4.45 (1.29)
Academic Underachievement	5.50 (.58)	4.50 (.89)	3.45 (1.04)
School Climate	5.75 (.96)	4.63 (1.15)	3.73 (1.10)
Haven (other):			
Communication with Haven	6.25 (.96)	6.38 (.72)	5.18 (1.66)
Collaboration with Haven	5.75 (.50)	5.94 (.85)	4.91 (1.58)
Effectiveness of Counseling	5.75 (.50)	5.63 (.89)	5.36 (1.36)
Community Involvement	5.50 (.58)	4.44 (1.46)	3.91 (1.30)
Admin Collaboration with Haven	5.75 (.50)	4.75 (1.07)	4.00 (1.34)

Note. ($\bar{x}$) = mean; SD = standard deviation; 7-point scale ranging from “Unmet” (1), “Poor” (2), “Fair” (3), “Average” (4), “Good” (5), “Very Good” (6), to “Excellent” (7).

Table 2

One-way Analysis of Variance (ANOVA) between Dependent Variables

Variables	*F*	*df*	*p*
Haven related:			
Internalizing Students	4.53	(2, 63)	.015*
Response to Crisis	3.93	(2, 58)	.025*
Timely Services	4.92	(2, 63)	.010*
Academic Underachievement	5.94	(2, 52)	.005**
Trauma	3.26	(2, 56)	.046*
School related:			
Peer Issues	6.67	(2, 66)	.002**
Academic Underachievement	12.43	(2, 66)	.000**
School Climate	10.45	(2, 69)	.000**
Haven (other):			
Communication with Haven	9.67	(2, 61)	.000**
Collaboration with Haven	7.97	(2, 60)	.001**
Effectiveness of Counseling	3.56	(2, 59)	.035*
Community Involvement	4.25	(2, 63)	.019*
Admin Collaboration with Haven	3.25	(2, 60)	.046*

Note. F= F Statistic; df= degrees of freedom; p= significance; * = p <.05, ** = p <.01; 7-point scale ranging from “Unmet” (1), “Poor” (2), “Fair” (3), “Average” (4), “Good” (5), “Very Good” (6), to “Excellent” (7).

Table 3

Bonferroni Post-Hoc Comparisons of Means for Administrators, Support Staff, and Teachers

Variables	*MD (SE)*	*p*
Haven related:		
Internalizing Students		
1 vs. 3	.87 (.35)	.045*
2 vs. 3	.71 (.27)	.030*
1 vs. 2	.16 (.32)	1.000
Academic Underachievement		
1 vs. 3	1.62 (.51)	.008**
2 vs. 3	1.05 (.40)	.032*
1 vs. 2	.57 (.49)	.745
Timely Services		
1 vs. 3	1.11 (.37)	.012*
2 vs. 3	.54 (.26)	.113
1 vs. 2	.57 (.35)	.331
Response to Crisis		
1 vs. 3	1.15 (.46)	.043*
2 vs. 3	.75 (.34)	.090
1 vs. 2	.40 (.43)	1.000
Trauma		
1 vs. 3	.83 (.33)	.043*
2 vs. 3	.22 (.26)	1.000
1 vs. 2	.61 (.31)	.155
School related:		
Peer Issues		
1 vs. 3	1.56 (.45)	.003**
2 vs. 3	.87 (.34)	.037*
1 vs. 2	.69 (.42)	.306
Academic Underachievers		
1 vs. 3	2.03 (.44)	.000**
2 vs. 3	1.29 (.34)	.001**
1 vs. 2	.74 (.42)	.242
School Climate		
1 vs. 3	1.96 (.43)	.000**
2 vs. 3	.85 (.32)	.032*
1 vs. 2	1.11 (.41)	.025*

Haven (other):

Communication with Haven		
1 vs. 3	1.28 (.47)	.025*
2 vs. 3	1.46 (.34)	.000**
1 vs. 2	.18 (.45)	1.000
Collaboration with Haven		
1 vs. 3	1.34 (.51)	.034*
2 vs. 3	1.51 (.39)	.001**
1 vs. 2	.18 (.48)	1.000
Effectiveness of Counseling		
1 vs. 3	.83 (.42)	.163
2 vs. 3	.81 (.32)	.044*
1 vs. 2	.02 (.39)	1.000
Community Involvement		
1 vs. 3	1.42 (.49)	.016*
2 vs. 3	.61 (.37)	.295
1 vs. 2	.80 (.46)	.252
Admin Collaboration with Haven		
1 vs. 3	1.35 (.53)	.041*
2 vs. 3	.43 (.42)	.919
1 vs. 2	.92 (.50)	.204

Note. MD= mean difference; SE= standard error; p= significance; 1= Administrator, 2= Support Staff, 3= Teacher; * = p <.05, ** = p <.01; 7-point scale ranging from "Unmet" (1), "Poor" (2), "Fair" (3), "Average" (4), "Good" (5), "Very Good" (6), to "Excellent" (7).

Summary

The ANOVA results were statistically significant for thirteen dependent variables within the survey. These statistically significant results yielded that across all variables, the respondents who are teachers scored items consistently lower than respondents who are administrators and support staff. This implicates that teachers have a distinctly different perspective on a variety of issues and concerns, which the survey questions addressed, than administrators and support staff do. The post-hoc analyses conducted revealed many statistically significant mean differences between survey answers from administrators, support staff, and teachers. These results informed

the researcher where specific differences lie between the independent variables. An analysis of these results will be discussed in detail in the next chapter.

Qualitative Results by Hypotheses

Survey respondent's comments relating to specific survey questions were sorted according to their relevance to the hypotheses generated for the study. They were then coded as either "A" for administrator, "SS" for support staff, and "T" for teacher, as well as "K-5", "6-8", "9-12", or "all grades" based on the range of grade levels the respondents work with in the school district, in accordance with Corbin & Strauss' selective coding process (2014). However, the teachers that participated in the survey only work with grades 9-12 at the high school level. Finally, these grouped comments were analyzed for any emerging themes, commonalities, or distinct answers that would help improve the quality of service delivery at the Haven, as well as improve the Haven's communication with other faculty and community members.

Hypothesis 1

Hypothesis 1 posited, "The mean ratings of available school resources will be below average in meeting the needs of the mental health services identified, and comments will generally indicate that school services can improve their service delivery."

In response to the question, "How well does your school meet the needs of internalizing students?", a support staff who works with grades 6-8 commented, "Some students go unnoticed until something significant develops."

According to the comments in response to the question, "How well does your school meet the needs of students having issues with peers?", support staff who work with all grades

reported, “A social skills group for children with Autism would be phenomenal” and “Conflict resolution sessions; classroom lessons; lunch groups.”

As a response to the question, "How well does your school meet the needs of students with academic underachievement?”, a teacher said, “It is not the goal of the school to meet the needs of the student, it is the goal of the school to give opportunity so the student can fill their need. We are measuring by results, not opportunity whether taken or not.”

Hypothesis 2

Hypothesis 2 conjectured, “The available Haven resources do not adequately meet the needs of a variety of mental health concerns according to ratings (Adequately = rated 5 and above on the Likert Scale) and comments will state that services can be improved to more appropriately match needs.”

In response to the question, “How well does the Haven meet the needs of internalizing students?”, an administrator who works with all grades responded, “For students who we are aware of, we provide good services.” A support staff who works with grades 6-8 said, “The Haven has been great about getting students in for counseling this year. Sometimes parent follow through falls short in getting the students ongoing support.” One teacher said, “They need to look at students’ performance in classes and not take them out of classes where they are performing low. It has also become a "play" time. The students are using them for "play time", and another teacher working with the same grades said, “Unaware. This information isn't given to the teachers to my knowledge.”

According to the comments in response to the question, "How well does the Haven meet the needs of students having issues with peers?", an administrator who works with grades 4-5 reported, “Not sure any of the students have attended the haven due to peer issues”, and a

support staff who works with grades 4-5 reported, “Because the Haven doesn't offer group counseling, it is difficult to rate it on peer issues.”

As a response to the question, "How well does the Haven meet the needs of students with academic underachievement?", an administrator working with grades 4-5 replied, “Students with low academics have not attended the haven.” Additionally, support staff working with grades ranging from 4-8 provided statements such as, “The Haven does an excellent job meeting the needs of students who struggle with the contributing factors to low academic achievement such as low self, esteem, poor motivation, etc.”, “The Haven has helped students work out intrapersonal and family issues which has helped students get back on track in school”, and “We have many students, particularly in 6th grade, who come to us with low skills. We don't always have the resources to help them make up huge gaps.”

The question, “What is your perception of the Haven’s provision of appropriate and timely mental health care?" generated a comment from an administrator who works with grades 6-8 who said, “Whenever we have a student or family in need the Haven works with us to assist in a timely fashion.” A teacher responded, “The Haven is great, but they cannot serve everyone who needs counseling because there are only so many counselors and only so many hours and many, many teenagers.”

According to the comments in response to the question, "What is your perception of the level of effectiveness of counseling services provided at the Haven?”, an administrator said, “Students who attend the Haven regularly invariably demonstrate improved behavior and well-being along with academic performance in school. The only concern that I have is summer recidivism.” Three teachers commented, “Good on the giving, questionable on the receiving”, “The few students that I know seek counseling at the Haven seem to be coping well with their

challenges", and "I believe that the haven is a good place for students and that they feel safe going there. It is also easy to send students when they feel that they need to go."

In response to the survey question, "How well does the Haven respond to crisis interventions?", an administrator who works with grades 6-8 replied, "Dr. Connelly and his staff are extremely responsive in a crisis situation and they respond ASAP with a high level of competence and compassion." A support staff working with the same grade levels replied, "Very quick with response time", and a teacher replied, "I do have one student who has been repeatedly "in crisis". There has been little improvement, but I believe that the family is not supportive of crisis intervention."

The final question on the survey inquired, "Are there groups that you think the Haven could offer that would be helpful?" This question generated comments that ranged from suggestions for new groups around topics that the staff felt are needed, suggestions for groups that the Haven already runs, positive feedback about continuing the Haven's work, and statements around not knowing about the groups offered, or stating that there are students who do not know about the groups that are offered. Some suggestions for new groups included comments such as, "Summer program and after school rec program" from an administrator working with grades 6-8, "Mental health groups for students who immigrated to this country" from a support staff working with all grades, and "Appropriate classroom behavior, importance of self-control, cell phone addiction, strategies for focusing attention" from a teacher.

Several staff administrators, support staff, and teachers who work with a range of grade levels made comments such as, "I would like to see, if possible, groups that address how parents can better balance their lives to meet the needs of their children", "Parent support for trauma students", "Divorce processing groups for students", "Groups for children of divorce; groups for

students with a trauma history; afterschool groups for elementary and middle school students with ADHD", "Children of Divorce", "In house afterschool groups: Peer relations, navigating the internet, divorce etc.", "Students who are dealing with trauma such as parents who are incarcerated and are drug addicted", "Groups for students who have experienced trauma", "Students who are dealing with trauma such as parents who are incarcerated and are drug addicted", "In conjunction with behaviorist/substance counselor, substance abuse groups", and "A group for internalizing/depressed African American males."

Four teachers commented, "The academic underachievers. This year I have more freshmen than ever who are failing. It seems like they give up before even trying, in spite of my open availability before school, during HR and lunch periods, and after school", "The under the radar students", "Groups that address students with 2 or more F's in a marking period", and "Under Achievers, Student who are absent frequently."

Several support staff working with all grades and teachers commented, "Positive Image-for girls", "Social skills groups for children with ASD", "Social skills, family counseling", "Social Skills, Siblings with autism, coping skills/ self-regulation", "Self-esteem for middle school boys and girls, LGBTQ support groups for middle school students and families", "Anxiety, stress-management group", "Gender issues especially for middle school", "Grief and loss groups and parenting groups", "Social skills; anger management", and "Anger management, anxiety, stress management, self-esteem."

Two teachers replied, "I don't know all the groups they offer, but they are thorough" and "I think that there are a good number of students who don't know about the services offered by the Haven." Support staff who work with all grades encouraged, "I think most of the existing groups are helpful (social skills, LGBT, etc.)" and "Continue doing what you do."

Hypothesis 3

Hypothesis 3 speculated, “The Haven is less effective with family problems at the high school level (since the Haven does not have enough family involvement).”

The question, “How well does the Haven meet the needs of family problems?” was met with two comments. A support staff who works with grades 6-8 replied, “More school access after school would broaden the reach”, and a teacher said, “I do not know how the Haven interacts with families”.

Hypothesis 4

Hypothesis 4 hypothesized, “The Haven is less competent with Asian students (perhaps a reflection of less involvement from this group) than with other groups.”

In response to the question, "How well does your school meet the social, emotional, and behavioral needs of the following cultural/ethnic groups in your school/district?” two support staff who work with grades 6-8 commented, “Language is often a barrier in meeting the needs of students whose first language is not English”, and “I believe that sometimes we do not meet the needs of our East Asian and South Asian populations as much because they tend to typically do well academically and sometime fall under the radar.”

According to the comments in response to the question, "How well does the Haven meet the social, emotional, and behavioral needs of the following cultural/ethnic groups in your school/district?”, two support staff who work with grades 6-8 voiced, “I find that it's challenging to get families from ethnic groups to go to counseling”, and “The only reason I rated poor for the East Asian and South Asian populations is because typically we see less families agree to outside counseling services.”

As a response to the question, "What is your perception of the level of cultural competence among district staff?" an administrator who works with grades 6-8 stated, “I think that people over-estimate their cultural competence. I think people mean well although they do not have the level of understanding that they may need to improve their cultural competence.”

Hypothesis 5

Hypothesis 5 posited, “The mean ratings by teachers regarding the Haven’s communication, collaboration, and integration with various staff, community members, and community organizations will be lower than the mean ratings of administrators and support staff. Comments will also indicate that there needs to be stronger connections between the Haven, the schools, and the community.”

In response to the survey question, "How would you rate your general communication with the Haven?”, an administrator who works with grades 4-5 said, “I, personally have no contact with the Haven.”

According to the comments in response to the question, "How would you rate the Haven’s collaboration with you on meeting students’ needs?”, a support staff who works with all grades replied, “Implementing support groups as well as willingness to address specific student concerns”, and a support staff who works with grades 6-8 said, “It is sometimes difficult to collaborate with Haven staff due to scheduling conflicts. It would be very helpful to not only collaborate at the start of therapy but throughout the course of treatment as well.”

The survey question, "How well connected are students to community health care providers?" generated one comment from a support staff who works with grades 9-12 who said, “Some are connected others not at all.”

As a response to the question, "What is your perception of teacher collaboration with the Haven?", an administrator who works with grades 4-5 reported, “Teachers do not collaborate with the Haven.”

In a response to the question, “What is your perception of administrator collaboration with the Haven?”, one administrator who works with grades 4-5 commented, “The behaviorist collaborates with the haven more so than other staff members.”

Other Findings

The survey yielded additional findings beyond the scope of the six hypothesis above, which are described below.

The rated responses to the question, “How well does the Haven meet the social, emotional, and behavioral needs of the following cultural/ethnic groups in your school/district?”, broken down by different cultural/ethnic groups, are displayed in Table 4, according to administrators, support staff, and teachers.

Table 4

Descriptive Statistics Regarding Cultural Competence

Variables	*Administrators* $\bar{x}$ *(SD)*	*Support Staff* $\bar{x}$ *(SD)*	*Teachers* $\bar{x}$ *(SD)*
East Asian	5.50 (.58)	5.50 (1.16)	5.45 (1.04)
African American	5.50 (.58)	5.63 (.81)	5.36 (1.36)
Latino	5.50 (.58)	5.63 (.81)	5.45 (1.29)
European/Caucasian	5.50 (.58)	5.63 (.81)	5.18 (1.47)
South Asian	5.50 (.58)	5.50 (1.16)	5.45 (1.04)

Note. ($\bar{x}$) = mean; SD = standard deviation; 7-point scale ranging from “Unmet” (1), “Poor” (2), “Fair” (3), “Average” (4), “Good” (5), “Very Good” (6), to “Excellent” (7).

While the results of this question were not found to be statistically significant, the data still yields important information to help the researcher understand how respondents view the

Haven's mental health care of various cultural/ethnic groups. According to survey respondents, the Haven is doing well meeting the needs of the various cultural/ethnic groups.

The program director expressed interest in the relative ratings of different types of presenting problems, which are presented in Table 5. The rated responses to questions, "How well does the Haven meet the needs of internalizing students?" (Internalizing Students), "How well does the Haven meet the needs of family problems?" (Family), "How well does the Haven meet the needs of students and families with trauma histories?" (Trauma), "How well does the Haven meet the needs of students having issues with peers?" (Peer Issues), and "How well does the Haven meet the needs of students with academic underachievement?" (Academic Underachievement) are displayed in Table 5.

Table 5

Descriptive Statistics for Haven's Prevalent Presenting Problems

Variables	*Administrators* $\bar{x}$ *(SD)*	*Support Staff* $\bar{x}$ *(SD)*	*Teachers* $\bar{x}$ *(SD)*
Internalizing Students	5.75 (.50)	5.63 (.62)	5.27 (1.19)
Family	5.75 (.50)	5.56 (.73)	5.18 (1.17)
Trauma	6.00 (.82)	5.44 (.73)	5.18 (1.08)
Peer Issues	6.00 (.82)	5.00 (1.10)	4.45 (1.29)
Academic Underachievement	5.25 (.96)	4.50 (1.27)	3.55 (1.44)

Note. ($\bar{x}$) = mean; SD = standard deviation; 7-point scale ranging from "Unmet" (1), "Poor" (2), "Fair" (3), "Average" (4), "Good" (5), "Very Good" (6), to "Excellent" (7).

While some of these questions were not found to be statistically significant, examining the data will produce important information to help the researcher understand how respondents view the Haven's mental health care of various prominent issues.

The rated responses to questions, "How would you rate your general communication with the Haven?" (Communication with Haven), "How would you rate the Haven's collaboration with

you on meeting students' needs?" (Collaboration with Haven), "What is your perception of the Haven's provision of appropriate and timely mental health care?" (Timely Services), "What is your perception of administrator collaboration with the Haven?" (Admin Collaboration with Haven), "What is your perception of teacher collaboration with the Haven?" (Teacher Collaboration), "How well does the Haven respond to crisis interventions?" (Response to Crisis), and "What is your perception of the level of cultural competence among district staff?" (Cultural Competence) are displayed in Table 6.

Table 6

Descriptive Statistics for Haven's Other Related Concerns

Variables	*Administrators* $\bar{x}$ *(SD)*	*Support Staff* $\bar{x}$ *(SD)*	*Teachers* $\bar{x}$ *(SD)*
Communication with Haven	6.25 (.96)	6.38 (.72)	5.18 (1.66)
Collaboration	5.75 (.50)	5.94 (.85)	4.91 (1.58)
Timely Services	6.25 (.96)	5.63 (.81)	4.91 (1.38)
Admin Collaboration with Haven	5.75 (.50)	4.75 (1.07)	4.00 (1.34)
Teacher Collaboration	4.75 (.96)	4.38 (1.20)	3.91 (1.38)
Response to Crisis	6.50 (.58)	6.19 (.75)	5.45 (1.13)
Cultural Competence	4.75 (.96)	4.44 (.96)	4.55 (1.57)

Note. ($\bar{x}$) = mean; SD = standard deviation; 7-point scale ranging from "Unmet" (1), "Poor" (2), "Fair" (3), "Average" (4), "Good" (5), "Very Good" (6), to "Excellent" (7).

While some of these questions were not found to be statistically significant, examining the data will yield important information to help the researcher understand how respondents view various types of communication, collaboration, and overall quality of the Haven's mental health services.

The rated responses to the question, "Please use the following scale points to rate how prevalent each of the listed issues are. Using points 1-7, assign the number of the scale that most

closely pertains to each issue.", broken down by various prevalent issues, are displayed in Table 7, according to administrators, support staff, teachers, and community members.

Table 7

Descriptive Statistics for Issue Prevalence Rated by Administrators, Support Staff, and Teachers

Variables	*Administrators* $\bar{x}$ *(SD)*	*Support Staff* $\bar{x}$ *(SD)*	*Teachers* $\bar{x}$ *(SD)*	*Community Members* $\bar{x}$ *(SD)*
Internalizing	5.21 (1.25)	5.43 (1.15)	5.07 (1.28)	5.25 (.50)
Externalizing	5.14 (1.10)	5.28 (1.04)	5.30 (1.18)	5.00 (.82)
Family Problems	5.14 (1.03)	5.30 (1.09)	5.24 (1.35)	4.50 (.58)
Trauma	4.50 (1.02)	4.26 (1.18)	3.83 (1.39)	4.25 (1.50)
Peer Issues	5.21 (1.67)	5.21 (1.22)	5.00 (1.26)	3.75 (1.89)
Academic Underachievement	5.57 (1.22)	5.03 (1.35)	5.23 (1.25)	3.75 (1.89)

Note. ($\bar{x}$) = mean; SD = standard deviation; 7-point scale ranging from "Not Prevalent" (1), "Not very prevalent" (2), "Slightly Prevalent" (3), "Somewhat Prevalent" (4), "Prevalent" (5), "Very Prevalent" (6), to "Extremely Prevalent" (7).

While some of these questions were not found to be statistically significant, examining the data will yield important information to help the researcher understand how both school and community respondents view how prevalent a range of issues are that students face.

Table 8

Percentages of Racial Demographics of Haven Referrals (2016-2017) and Community Populations (2016)

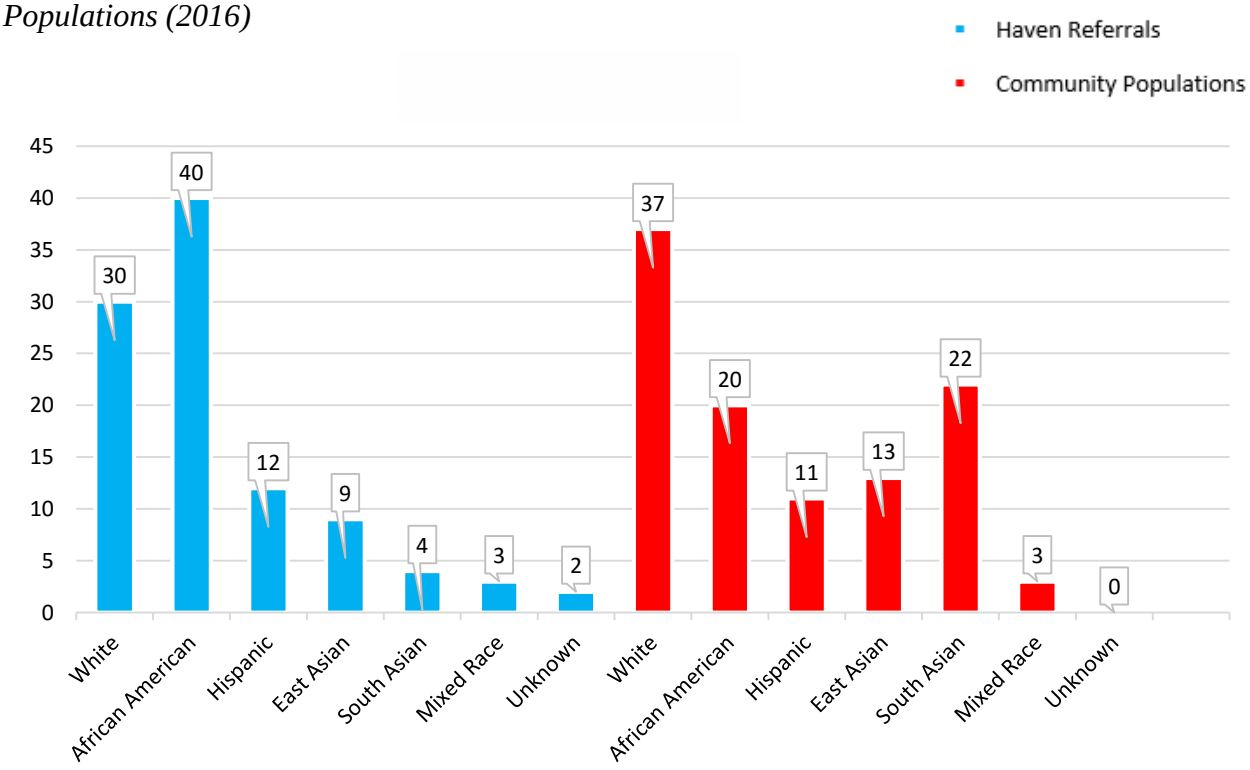

Table 8 shows the percentages of racial demographics of Haven referrals during the 2016-2017 school year, and the percentages of 2016 community populations of the same demographic groups. Haven data was collected from the Haven's records and community data was obtained from https://factfinder.census.gov. This chart illustrates some interesting comparisons, specifically confirming the results that East and South Asians do not avail themselves enough of mental health services, especially given their large community representation. The data shows that East and South Asian populations together make up 34% of the community's population in terms of demographics, but in terms of Haven referrals, this population only makes up 12%. In looking at this statistic, it is important to keep in mind that

the people within these populations may define "mental health" in different cultural terms than what is usually recognized, and that in some cases, religious affiliations are a community source for support. So, East and South Asian community members may be visiting other facilities for support of their "mental health" needs.

Another surprising statistic that stands out upon examining the data in the chart is that the African American population makes up 20% of the community population, while it makes up 40% of the Haven's caseload. These findings can be conceptualized in multiple ways. In looking at the literature previously discussed, the study by Bains et al. (2014) shows the value and trust African American students place on mental health services in SBHCs. In their study, the easily accessible services were tailored to meet this population's needs and it allowed for them to have better social, emotional, and academic outcomes. The data in Table 8, supported by the quantitative data in the current study, shows that the Haven is doing a good job of getting African American students to utilize its services. However, some qualitative data indicated there should be additional services, such as "a group for internalizing/depressed African American males". The data in the table could show that there is already a positive shift in attitudes towards mental health care by the African American youth in Piscataway, seeing that there is a larger proportion of its students using the Haven's services than is represented in the larger community population. This statistic is an excellent indicator for African American students' continued utilization of the Haven's services, and is an encouraging statistic for the Haven to keep up their work and expand further on meeting the needs of this population.

It is also important to keep in mind that the amount of students that are self-referred versus referred by teachers to the Haven is unknown to the researcher, so it may be possible that teachers are recommending African American students at a much higher rate to the Haven than

perhaps East or South Asian students. It is possible that teachers are looking at the more overt presenting problems (externalizing) of the African American students as they experience them, versus the less overt presenting problems (internalizing) typical within the Asian student population. This conjecture is supported by Rastogi et al. (2014) as the authors postulate that the evaluation and treatment of South Asians with mental health issues requires understanding of the cultural values and beliefs that drive symptom presentation and attitudes toward treatment. Multiple comments within the qualitative data, such as, "I believe that sometimes we do not meet the needs of our East Asian and South Asian populations as much because they tend to typically do well academically and sometimes fall under the radar", also support this interpretation of disparate data in the table between the community percentage of this population and the population of Haven referrals.

Summary

The comments generated for the these questions provided a diversity of perspectives by administrators, support staff, and teachers regarding the availability, accessibility, and quality of mental health care within the Piscataway school district. The comments also provided numerous suggestions for how the Haven can work to improve a variety of aspects of their mental health care, including its communication and collaboration with schools and community organizations, and types of services offered. These perspectives and suggestions will highlight strengths and perceived weaknesses of the Haven, and inform the researcher on how to make adjustments to the Haven in order to better meet the district's mental health care needs.

Discussion

School-based mental health centers (SBHCs) fulfill a vital need in the well-being of youth. These centers can function as providing diagnostic, preventative and treatment services to

youth whose mental health needs are underserved by other providers and perhaps would otherwise go unaddressed. SBHCs also provide easy access to low-income families, and community members who face complex social and environmental risk. These centers can also have a positive impact on academic outcomes such as absences, tardiness, and grades. However, their presence in schools varies across communities. The SBHC model is unfamiliar to many providers and researchers with limited qualitative research to understand the working dynamics of successful centers. A program evaluation of a successful program was seen as a potential contribution to the existing literature. It was also intended to provide meaningful feedback to the program to help it improve, both in terms of making recommendations based on the literature and based on the study's findings. A survey was distributed to administrators, support staff, teachers, and community members within the Piscataway school district to see how they viewed the quality of mental health services both at the Haven and in the district, as well as communication between the schools and larger community.

Hypothesis 1

It was predicted that the mean ratings of available school resources would be below average in meeting the needs of the mental health services identified, and comments would generally indicate that school services can improve their service delivery. Actual results were inconsistent with the hypothesis, showing that the majority of the mean ratings of available school resources were above average in meeting the students' mental health care needs. Administrators, support staff, and teachers found that schools were doing well overall in meeting the needs of students in terms of internalizing issues, meeting the needs of families meeting the needs of students and families with trauma histories, meeting the needs of peer issues, and meeting the needs of students with academic underachievement. While the majority of

respondents' answers yielded that school resources were doing a good job meeting the mental health needs of the students, there were some outliers in responses.

In the question asking, "How well does your school meet the needs of students and families with trauma histories", the mean support staff rating was below average. This could mean that support staff, who often work with students more directly than administrators or teachers to address trauma, have seen how prevalent trauma histories are within the student population and feel that the school is not doing as good of a job as they could be addressing these issues. Nationally, there is growing effort to make schools "trauma informed" and this may benefit Piscataway. The question about schools meeting the needs of students with academic underachievement yielded a mean rating of in the "Fair" range from teachers, which is much lower than the above "Average" ratings from administrators and support staff on the same question. This could be because teachers are more aware of students' academic performance than administrators or support staff are, and think that the school is not doing enough to help improve the academic performance of students. Within the quantitative results, there was a significant difference on the question regarding how well school meet the needs of students having issues with peers. The data showed that teachers believe their school does not meet the needs of students having issues with peers as well as administrators and support staff think their school does. This could be because teachers spend the most time with students in the classrooms and in the hallways, and observe more conflict with peers than do administrators or support staff. In addition, a comment from a teacher implicated that there could also be an issue of the students not availing themselves of the opportunities that school provides to improve their academic performance. The Haven's Director, Dr. Patrick Connelly, stated that he has found that administrators and support staff are less burnt out than high school teachers and are more

positive overall. Another plausible explanation for administrator ratings being so high is that they will want the school to look like it is functioning well, so they are more likely to overrate survey items.

It is recommended that psychologists and other educational experts, and perhaps a shared Professional Education program, spend more time consulting with teachers on how to more closely address students' various mental health needs. It is also recommended that more administrators and support staff attend school programming, extracurricular activity meetings, and be more heavily involved in classroom interventions. The more school personnel integrates themselves into student life, the more they will be connected to the student population and their needs. The increased presence of faculty in student programming activities and in classrooms may also lead to a decrease in a variety of symptoms since students are more likely to approach administrators, support staff, and teachers for help if they see them taking more of an interest in their school life.

Hypothesis 2

Given the Haven's limited budget, it was predicted that the available Haven resources would not adequately meet the needs of a variety mental health services according to ratings (Adequately = rated 5 and above on the Likert Scale) and comments would state that services can be improved to more appropriately match needs. Actual results were inconsistent with the hypothesis, showing that the majority of the ratings indicated Haven resources did meet the needs of a variety of mental health services. Administrators, support staff, and teachers found that schools were doing well overall in meeting the needs of students in terms of internalizing issues, meeting the needs of family, meeting the needs of students and families with trauma histories, meeting the needs of peer issues, and meeting the needs of students with academic

underachievement. While the majority of respondents' answers yielded that school resources were doing a good job meeting the mental health needs of the students, there were some outliers in responses.

Quantitative results showed that teachers believe the Haven does not meet the needs of internalizing (anxiety, depression, etc.) students as well as administrators and support staff think the Haven does, teachers believe the Haven does not meet the needs of students with academic underachievement as well as administrators and support staff think the Haven does, and teachers believe their perception of the Haven's provision of appropriate and timely mental health care is worse than both the perception of administrators, and the perception of support staff. Teachers also believe their perception of the level of effectiveness of counseling services provided at the Haven is lower than both the perception of administrators and the perception of support staff think the Haven does, that the Haven does not respond to crisis intervention as well as administrators and support staff, and that the Haven does not meet the needs of students and families with trauma histories as well as administrators and support staff think the Haven does.

The predominant theme across the quantitative results above is that teachers consistently rated those particular survey items lower than administrators and support staff did. Administrators and support staff have a better impression of how the Haven is meeting a variety of needs than the teachers. Such a discrepancy could indicate that the people who do not work as closely with students, including administrators and some support staff, are not as aware of the issues that students face. Teachers may be more aware of these issues since they spend more time with students throughout the day and observe a variety of these issues. Therefore, there is a need to build closer relations between administrators, support staff, and teachers in order to

increase awareness of issues students face and to more comprehensively aid in getting them into appropriate treatment.

This theme for Hypothesis 2 is supported by several comments in the qualitative analysis as well. A teacher commented that there has been little improvement with one of her students who come to the Haven, but believes that this could be due to the student's family not being supportive of crisis intervention. Several administrators and support staff (School Psychologists, Counselors, Behaviorists, LDTCs, and Social Workers) commented on the same question saying that they felt the Haven is "extremely responsive" and displays a high level of "competence and compassion". This discrepancy is perhaps due to teachers seeing students more regularly than administrators and support staff do, and are able to see other factors that may negatively impact a student's slower progress in treatment, such as an uncooperative family. Administrators and support staff are also less likely to be impacted by a student's low or disruptive performance than teachers are since they are not with students on a day to day basis. Dr. Connelly believes that, "administrators and support staff focus on troubled students, and their experience tells them that change is slow, whereas teachers may have unrealistic views of what progress means."

Moreover, a few teachers also responded that they were unaware of how well the Haven meets certain mental health needs, and one stated that they have felt students should not be taken out of class for therapy since some students view coming to the Haven as a "play" time. In contrast there were a few teachers who gave positive feedback about the Haven, specifically how it helps students cope with challenges, that students feel safe going there, and that the referral process is easy. It is also easy to send students when the students themselves feel that they need to go. This shows there is a discrepancy in teachers' awareness and perception of services offered. One teacher is saying going to the haven becomes "play time", another might not have a

sense of how well the Haven is doing to meet students' issues, and some teachers have positive things to say and find the Haven effective. As an implication to this data, more teacher Professional Development time would be useful to understand and increase patience with struggling students.

Despite both administrators and support staff, on average, rating the survey question about meeting the needs of peer issues "Good" and above, there was a comment from an administrator stating they did not know students attend the Haven due to peer issues, and a comment from a support staff admitting they did not know the Haven offered group counseling. These comments shows that administrators and support staff in the elementary schools are not aware of the services the Haven offers, or what kinds of issues students attend counseling for at the Haven.

The question soliciting feedback about what kinds of groups the Haven could offer that would be helpful to students generated a wide array of responses. Many responses included suggestions for new groups around topics that the staff felt are needed, suggestions for groups that the Haven already runs, positive feedback about continuing the Haven's work, and statements about faculty and students both not knowing about the groups offered. Taking the useful suggestions for new groups into consideration, potentially helpful groups for students can be an ADHD support group, children of immigrants and/or a group for students who are immigrants, a group for children whose parents are divorced or getting divorced, a group for students of color, a group to assist with and improve with academic underachievement, and a LGBT group for middle schoolers potentially to be held at the Haven in the evening. There were several comments by administrators, support staff, and teachers with suggestions for groups that

already exist such as anger management, LGBT issues, grief and loss, emotional regulation, and social skills.

There were also a few comments from people unsure of the groups offered and a few comments encouraging the Haven to continue their good work. This large discrepancy between types of answers provided, especially the myriad of comments suggesting groups that already exist further prove that there are so many faculty members across disciplines that are not aware of the services the Haven offers, including the types of groups. This could be a disservice to several students and families in the district. If faculty do not know the kinds of groups that exist, they cannot refer students and families to the Haven for services or adequately advocate for the Haven's services, which would contribute to increased mental health issues among students and families. Dr. Connelly suggested, "The Haven also needs to determine a way to prioritize the most needed groups. Offering groups reduces available individual counseling spots, so this is a dilemma." It also further supports a teacher's perspective, saying, "The Haven is great, but they cannot serve everyone who needs counseling because there are only so many counselors and only so many hours and many, many teenagers." This issue can be viewed as an argument to increase staffing at the Haven, which would require an increased budget.

Eiraldi et al. (2016) discussed how a variety of group cognitive-behavioral therapy (GCBT) techniques significantly decreases externalizing behaviors through working on anger management, goal setting, emotional awareness, relaxation training, social skills training, problem solving, and handling peer pressure. The authors state that it is helpful to have school counselors participate in training workshops on the Coping Power Program CPP doing role-plays, watching video-recorded sessions, and demonstrating techniques to ensure quality of service delivery and the most effective outcomes.

It is recommended that there are efforts made throughout the district to increase awareness about the Haven's services, which will help increase referrals to its services or appropriate outside mental health care providers. To address this the issue of spreading awareness of Haven services, it is important to reach teachers, administrators, and support staff. Teachers are required to attend professional development days during the summer and the school year. A representative from the Haven could give a presentation during these professional development days on mental health with a heavy psychoeducational component in training faculty on what aspects of behavior or performance to pay attention to in order to better see if students may need a referral to the Haven. These meetings or seminars can incorporate statistics about mental health care in Piscataway (perhaps derived partly from this dissertation) to make information more relevant and readily available to show faculty where the district is deficient in meeting certain groups' mental health care needs or in treating specific issues. Meetings can also provide a description of what the Haven offers and how to contact the Haven for further resources.

For administrators and support staff, it would be prudent to have a mandatory meeting for key decision makers in the district, such as principals. At this meeting, principals would be asked who the key decision makers are in different roles within the schools in the district. Once these individuals are identified, there should be a meeting where they are given the same presentation as the teachers on mental health. This longer-term perspective will help to change the culture of communication within the school if the Haven becomes more of an increased presence in meetings with teachers, administrators, and support staff.

A second way to address awareness of Haven services in the short-term is to appropriately market the Haven. An easy way to accomplish this is to expand the Haven's

online presence through advertising on the front page of Piscataway school district's website. Every parent visits the district's website site, if the Haven is clearly advertised on there, parents will consciously or subconsciously be exposed to Haven information, along with administrators and support staff. Currently, the Haven is the last item on a general "Counseling" drop-down list with other information such as SAT prep and college planning. If someone does not know what the Haven is they will not click on the link. It is recommended that there be a website for the Haven with specific information about individual counseling, specific groups offered, and family services, as well as accessible links for parents to learn more about mental health resources. Creating a website can be implemented in the short-term, perhaps even before the next school year.

Additionally, it is recommended that there are efforts made to negotiate obtaining increased funds to hire more Haven staff. It is also recommended that there could be a seminar for parents similar to this in structure, but more tailored to family needs, instead of the focus on the district's needs as a whole. Lastly, it is recommended that more time is spent deciding how to most efficiently allocate resources to further help specific student populations.

These recommendations can be supported by the relevant literature. In a community guide systematic review, (Knopf et al., 2016) found that SBHCs are effective in improving many educational and health-related outcomes by addressing obstacles to educational achievement, including cultural, financial, and transportation-related barriers in order to have the potential to promote social mobility and improve mental health care equity. In analyzing 46 studies of SBHCs operating for a number of years, trends show the centers have overall improved student academic expectations, safety and respect, school engagement, increased mental health awareness, and strengthened connections between the school and the larger community. This is

achieved primarily by having increased parental involvement in treatment and school activities, as well as the SBHC having increased involvement with community organizations. The more faculty and parents are aware of Haven services and educated about the benefits of them, the more they can work together to help decrease mental health concerns amongst students.

Bains and Diallo (2016) also advocate for partnerships between schools and communities, such as the Public Health Department, and well as the sharing of existing resources, to be strengthened. Research by the authors yields that when adolescents had access to both the SBHC and community health centers, they were 21 times more likely to seek mental health services in the SBHC and more likely to access mental health services before medical services. Results of the study show that students who exhibited high-risk behaviors, suicidal ideation, depression, and difficulty with sleep were more likely to have received services at the SBHCs as were students with no health insurance. These results can be generalized to fit the goals of the Haven in terms of strengthening its connections to community organizations. If more high school students are aware of community resources and know that they have strong ties to the Haven for collaborative care, there will likely be an increase in the number of students utilizing the Haven's services. It is useful to note that the Haven consistently has a waiting list of 15 or more students from December to June, so increasing community connections would most definitely help reduce students' wait time for services.

Hypothesis 3

It was predicted that the Haven is less effective with family problems at the high school level. Actual results were inconsistent with the hypothesis, with ratings indicating that the Haven is more effective in working with family problems at the high school level as opposed to other schools being effective working with families in younger grade levels.

Quantitative results showed that when answering the survey question about how well schools meet the needs of family problems, administrators, support staff, and teachers all had mean ratings between 4.45 and 4.75, which is in the "Average" range according to the Likert Scale. The question asking how well the Haven meets the needs of family problems yielded ratings between 5.18 and 5.75, which is in the "Good" range of the Likert Scale. This shows that across all types of responders, it is perceived that that Haven does a better job of meeting the needs of families than the high school and other schools in the district.

This question also yielded a couple of comments in the qualitative analysis from a support staff and a teacher that implied the Haven can improve their access to services. The support staff voiced that having more access to school resources for families after school would broaden the Haven's abilities of being able to help families. A teacher commented that they did not know the Haven interacted with families. This shows that some faculty members feel that the Haven could be doing a better job providing additional access for families after school and a better job advocating the Haven's services that work with families.

Consistent with prior recommendations, it is recommended that the Haven work to increase efforts promoting their resources so more district faculty can be aware of what types of services are offered and can better communicate this to the students and families they work with. Paternite (2005) states that the vital elements for success of SBMHC include partnerships between the school, family, and community, commitment to mental health education, early intervention, and treatment, and services for youth both in general and special education. Just as a teacher commented that they were unaware the Haven worked with families, it is likely that many parents in the district are also unaware the Haven works with parents and families as well. According to the literature, it is extremely important to work to get families more involved in

their student's treatment and increase collaboration efforts. According to a Brief from the Center for Mental Health in Schools (2000), two out of four key areas for collaboration between schools and their communities are "creating guidelines that protect confidentiality while still allowing for productive communication between the family and school staff", and "teaming with the family and key school community staff to enhance resource use". Dr. Connelly stated, "On a positive note, we are getting many more parent referrals in the last couple of years. I think there is a lot of word of mouth. We did a family program last spring which was open to the public, but attendance was low. I don't think we'll have the time to do that this year due to limited resources being a challenge. Prioritizing needs and spreading out resources is not easy." This anecdote supports prior recommendations to try and have the Haven's budget increased to obtain more funds so that future valuable programs can be added to the services and more advertising can be done for it.

Hypothesis 4

It was predicted that the Haven is less competent with Asian students (perhaps a reflection of less involvement from this group) than with other cultural/ethnic groups, which is a concern that was raised by Dr. Connelly. Actual results were mostly inconsistent with the hypothesis, showing that the majority of the ratings indicated the Haven is not less competent treating Asian students as opposed to students from other cultural/ethnic groups. While the majority of respondents' answers yielded that the Haven was not less competent in treating Asian students than other groups (African American, Latino, and Caucasian), there were some outliers in responses. The most dramatic finding in this regard is the difference between the Haven's referrals and the community demographics.

Quantitative results showed that when answering the survey question rating how well the Haven meets the social, emotional, and behavioral needs of specific cultural/ethnic groups in the schools/district, administrators all had a ranking of 5.50, which is in the "Good" range on the Likert scale. This does not show any evidence that administrators feel the Haven is less competent with Asian students than other groups. However, the consistent mean rating across all specific groups mentioned indicates that there was a very small number of administrators responding to this question as opposed to support staff and teachers, who had more of a variety of ratings for this question. Consistent with the hypothesis, support staff had a mean rating for Asian students that was lower than their rating of the other cultural/ethnic groups, indicating that they feel the Haven is less competent with that particular student population. In contrast to this and inconsistent with the hypothesis, teachers' mean rating for this population had a mean rating (in the "Good" range) that was equivalent to the Latino population, but higher than African American populations and Caucasian populations. This indicates that teachers feel that the Haven is more competent with Asian students than with those other groups. This may be because Asian students typically exhibit less externalizing behaviors, which are therefore less noticeable to teachers, and are less likely to come to therapy due to cultural stigma. Anyon, Moore, Horevitz, Whitaker, Stone, and Shields (2002) discuss research demonstrating that Asian youth's experiences with racial discrimination, stress, poverty, and cultural stigma result in lack of access and use of student mental health services in schools. Anyon et al. (2002) says that based on this study's findings, the needs of Asian students may be overlooked by adults in the school community perhaps due to the strength of the "model minority" myth in educational settings, and the reality that Asian youth tend to experience lower risk factors than other youth of color.

Comments within the qualitative analysis are in alignment with the notion that cultural barriers may prevent Asian students from seeking mental health care. Support staff from the middle school addressed that the Haven does not meet the needs of the East Asian and South Asian populations as much as other groups because they "tend to typically do well academically and sometime fall under the radar." This concern is supported by the growing evidence that Asian American youth are at a higher risk for depression, self-injury, and suicide than White or African American youth (Anyon, Ong, and Whitaker, 2014). Evidence from a school-based mental health (SBMH) prevention program evaluation in an urban community suggests that teachers expect Asian youth to be perfectionist, anxious and shy, while also perceiving them to be less hostile, disruptive, and aggressive than Black or Latino youth. It is stereotypes such as these that may lead to the danger of teachers overlooking signs of psychological distress in Asian American students (Anyon, Ong, and Whitaker, 2014). The support staff also suggested that language is often a barrier in meeting the needs of students whose first language is not English, and that it is challenging to get families from Asian populations to go to counseling. In addition, a support staff said they rated this item "Poor" on the Likert Scale and emphasized, "The only reason I rated poor for the East Asian and South Asian populations is because typically we see less families agree to outside counseling services." This comment speaks to the cultural barrier of Asian populations seeking mental health treatment, and can imply that the rating was "Poor" not due to lack of competence on the part of the Haven, but because families are not as likely to come into therapy.

Interestingly, an administrator from the middle school stated, "I think that people over-estimate their cultural competence. I think people mean well although they do not have the level of understanding that they may need to improve their cultural competence." This comment

speaks to people overestimating their cultural competence, yet, when individually rating specific cultural/ethnic groups, administrators rated each group in the middle of the "Good" range. It is poignant that the administrator also says that "although people mean well, they do not have the level of understanding that may be needed to improve their cultural competence", as this is the view that is shared with the researcher and the director of the Haven. There is always a strong need for school faculty to increase their cultural competence as much as possible to best accommodate the needs of the highly diverse Piscataway school district. People are often unaware of their lack of cultural competence, which necessitates more seminars on diversity training for all faculty. There are dangers to lacking cultural competence, such as coming off as insulting, offensive, or uncaring, which would push someone further away from mental health treatment. It is an ongoing process to gain cultural competency, and it is important to strive to collaborate with others to openly process clinical diversity issues and engage in powerful discussions in the interest of becoming more self-aware and better serving the students.

It is recommended that that more training seminars be held in the district to increase cultural competency. It may be helpful for these seminars to be engaging and interactive so that there is greater buy-in from the staff. Often times, the topic of diversity makes people uncomfortable or nervous, but it is essential to communicate that these types of forums are necessary to learn more about what the students experience in their everyday lives, what cultural factors could be potential barriers to therapy and classroom learning, and how the staff can use this knowledge of diversity to enhance and tailor learning experiences to best fit student needs. In addition, it is recommended that perhaps there should be specific outreach to get more East Asian and South Asian students and families into counseling. In accordance with the relevant literature, Anyon et al. (2002) emphasizes educating school staff on how to identify mental

health risks among Asian students, increasing culturally specific programming, and if possible, improving SBHC providers' Asian language capacity in order to better help Asian youth. The authors also say that it is also important to document racial disparities in terms of SBHC use in schools, so that future research could expand on studies like this one, perhaps with the addition of measures examining other factors, such as exposure to trauma, service use outside school, contextual and cultural influences, and teacher referral practices. The large discrepancy between community populations and Haven referrals of disparate cultural/ethnic demographics is further evidence for the need for more culturally competent trainings and further advocacy to get these more marginalized groups to utilize mental health resources.

Hypothesis 5

It was predicted that mean ratings by teachers regarding the Haven's communication, collaboration, and integration with various staff, community members, and community organizations will be lower than the mean ratings of administrators and support staff. Comments will also indicate that there needs to be stronger communication and collaboration between the Haven, the schools, and the community. Actual results were consistent with the hypothesis, showing that the ratings from teachers were lower than the mean ratings from administrators and support staff for questions inquiring about respondents' general communication with the Haven, the Haven's collaboration with respondents on meeting students' needs, perception of teacher collaboration with the Haven, perception of administrator collaboration with the Haven, and the level of students' knowledge in terms of mental health literacy. Results indicated that teachers feel the Haven could improve its communication and collaboration with school personnel, as well as with community to further integrate community programming and recreational activities into students' lives.

Quantitative results showed that teachers believe their general communication with the Haven is worse than both administrators', and support staff's communication with the Haven, teachers believe their collaboration with the Haven is significantly worse than both the collaboration of administrators and support staff with the Haven, teachers believe community involvement is less integrated into students' lives than both administrators and support staff believe it is, and teachers believe their perception of administrator collaboration with the Haven is worse than the perception of administrators' and the perception of support staff.

There have been comments examined in the qualitative analysis in response to other questions, such as teachers saying many students view going to the Haven as "play time" and that students miss classes to go to the Haven. This negative view from teachers towards the Haven's communication and collaboration efforts appears to be a theme across this survey in both quantitative and qualitative answers. These sentiments from teachers are certainly reflected in the responses to questions in relation to Hypothesis 5 as well. Qualitative results only yielded one comment from a teacher that supported the quantitative findings of teacher rating being the lowest of the respondents, which was that they believed teachers did not collaborate with the Haven. Teachers may be under this impression because they might think the Haven does not spend enough time working with them to formulate interventions for their students. According to Dr. Connelly's comments, when he originally started the Haven, he focused on his connection with the Guidance department and Child Study Team (CST) first, followed by administrators, and was careful about getting "flooded" by teacher referrals. "In developing the program, our emphasis was on fitting into the school system organizationally and systemically. The larger community was not a focal point as I was concerned about being overwhelmed by referrals," Dr. Connelly contributed. "Maybe it's time to link more with teachers. We have nurses that we

could probably connect better with, as we also have a good connection with the supervisor of the nurses. It is also a turf issue – we let guidance and CST take the lead on working with teachers", added Dr. Connelly. Increased communication and collaboration between these departments and the Haven would be useful in formulating more comprehensive interventions for students informed by multiple viewpoints as a result of their respective interactions with the students.

An administrator corroborated this belief from teachers with a comment stating teachers do not collaborate with the Haven. Administrators also made comments about having no personal contact with the Haven, how it is sometimes difficult to collaborate with Haven staff due to scheduling conflicts, and how it would be "very helpful" to not only collaborate at the start of therapy but throughout the course of treatment as well. Dr. Connelly stated, "This is something we could definitely work on, but we would have to take that time from somewhere else. For example, if we increase regular communication, we might have to take fewer cases." Despite these comments, it was interesting to see that the mean administrator rating for the question asking for perception of administrator collaboration with the Haven was at the high end of the "Good" range. This could mean that administrators wanted to appear like they collaborate well or often with the Haven, or that the majority of administrator respondents do believe they are doing a good job with their collaboration with the Haven. There is a discrepancy with the support staff and teacher ratings for this question, as they are significantly lower than the administrator rating. This indicates that administrators have an inflated perception of how well they collaborate with the Haven as compared to how well the support and staff and teachers think they do.

Although this recommendation has become a theme throughout the quantitative and qualitative analyses, it is worth stating again and is applicable again that the Haven work to build

and strengthen partnerships with community members for more collaborative and comprehensive mental health care for students. Paternite (2005) emphasizes collaboration between schools and communities agencies because it is being more widely recognized that schools cannot do all of the work alone, and that in many cases they are overwhelmed with demands that could and sometimes should be addressed by other community systems. The research by Amaral et al., (2011) also supports this recommendation in that they found that engagement of parents and students can help to ensure that services are patient centered while remaining relevant to the needs of the community, and that community engagement can also improve wellness and reduce risk factors. Facilitating communication between the PTA in the High School would be a good source for collaboration between parents and all school faculty and administrators as well.

It is also recommended to create a similar model for the Haven in relation to the greater Piscataway community, based off the research and model of the School-based Pathway to Care model that was developed in Canada. Wei et al. (2011) stated that this model includes promoting mental health literacy for youth, educators, and families; training for teachers, student services providers, and primary care providers, with knowledge upgrading for mental health professionals, to facilitate early identification, prevention, and intervention; processes for coordination and collaboration between schools and their communities; and evaluation. As Wei et al. (2011) highlights, strengths of this model is that it is flexible, can be conveniently adapted and customized to fit adolescent populations with differing needs in different educational settings, it is embedded within the whole community, and has the potential to reach youth through outreach programs like community services, clubs, and sports teams.

It is also recommended that the Haven take steps to hold interactive and engaging seminars for students to increase their knowledge of mental health literacy. Administrators,

support staff, and teachers all rated this survey item in the "Fair" range. Addressing mental health literacy during the adolescent years has the potential to foster and understand of mental health and mental disorders that will help youth as they continue to progress through future life stages (Wei et al., 2011). Research shows that programs that promote mental health literacy have been successful in leading to an improved knowledge of mental health issues, changed attitudes among youth, parents, and educators, and reduced stigma in the community in general. A way to further reach parents and the community is to post the literacy curriculum online so it can be more easily accessible. This will help educate and empower school faculty and parents so that they can feel more comfortable discussing the material with their children both inside and outside the classroom. Dr. Connelly also suggests collaborating with the health teachers on this issue since they are already familiar with promoting mental health literacy as part of their curriculum. Another way to increase education on mental health literacy is to creatively increase efficiency of treatments by using more evidence-based practices.

There are several ways of addressing trauma treatment for students at the Haven. Brown, McQuaid, Farina, Ali, and Winnick-Gelles (2006) posit that because there is no "one size fits all" model, there is little understanding of the ability for a school-based trauma program to address the different needs of students. The authors support research that says how there should be a multi-tier model of assessment and intervention in school settings, where the program should match the intensity of therapy to symptom severity, resulting in different levels of intervention. Prior research indicates that a multi-step program is needed that would provide a comprehensive group for coping skills, an individualized intervention for children who remain symptomatic , and evaluations conducted before and after each step with all participants. Researchers in this study used measures to assess for trauma history (Traumatic Events Screening Inventory), PTSD

(Child PSTD Symptom Scale), anxiety (Multidimensional Anxiety Scale for Children), depression (Children's Depression Inventory), externalizing symptoms (Behavioral Assessment of Children and Children's Inventory of Anger), and program satisfaction (Satisfaction Survey). The Haven sees numerous trauma cases every year, and the previously listed assessments in parentheses are included as possible resources for the Haven and its director. Additionally, further use of these efficient practices may free up time for staff to engage in educating students on mental health literacy. Dr. Connelly added, "Our informal way of bringing in EBP is by having current trainees bring their learning from GSAPP to their cases."

Zajac et al. (2015) discusses the relevance of building community connections in saying that in order for these interventions to be effective, they must target risk factors at the individual, family, school, and community levels. Decades of research shows that if Multisystemic Therapy (MST) is carried out addressing problems at each of these levels, it significantly reduces serious clinical problems that put adolescents at risk for out-of-home placement, serious externalizing behaviors, substance abuse, and parental physical abuse and neglect.

A specific intervention backed by research that is known for its effectiveness in decreasing externalizing disorders is School-Wide Positive Behavioral Interventions and Supports (SWPBIS), which could be useful to the Haven and implemented to improve classroom behavior as well. Authors McIntosh, Ty, and Miller (2013) define SWPBIS as a comprehensive approach for the prevention and treatment of problem behavior that is designed to change ineffective practices in schools with the goal of creating positive and predictable environments that support improved behavior and academic outcomes. Existing research has shown significant reductions in negative externalizing behavior such as disruptive behaviors, as well as a reduction in discipline referrals and suspensions.

Since there are some limitations to behavior measures used in schools, the authors describe using the research-validated measure, Systematic Screening for Behavior Disorders, which helps integrate existing data of school discipline referrals with multiple screening measures designed to address specific students concerns (McIntosh et al., 2013). It also aids in identifying students with both externalizing and internalizing problems, which would maximize both the effectiveness and the efficiency of screening efforts to identify the greatest number of students at risk of school failure in each area. The authors emphasize that SWPBIS can provide an effective framework for implementing, monitoring, and sustaining evidence-based practices in schools to address maladaptive externalizing behavior, and promote prosocial behavioral and adaptive emotional skills (McIntosh et al., 2013).

Hypothesis 6

It was predicted that there will be significant variations in ratings and comments of perception of school climate. Specifically, administrators and support staff perceive their school's climate more positively than teachers will. Actual results were consistent with the hypothesis, showing that the mean ratings from administrators and support staff were higher than ratings from teachers.

Quantitative results yielded that teachers believe their perception of the school climate within their school is worse than the perception of both administrators and support staff regarding the school climate within their schools. There was a large discrepancy between the answers from administrators, support staff, and teachers. Administrators produced a mean rating that fell in the "Good" range, support staff had a mean rating in the "Average" range, and teachers generated a mean rating in the "Fair" range. Teachers' perception of school climate might be rated lower than the other two groups of respondents because they spend the most time

directly engaging with students in classrooms and in the hallways. They are able to see how students relate to one another and likely have more of a feel for how the environment of the school feels than administrators or support staff who do not work directly with students as much as teachers do during the day, if they even engage with students at all. This low rating for school climate implies that teachers have witnessed aspects of interpersonal communication and general environmental factors within their school that they have found to be a negative influence, dysfunctional, unsafe, unwelcome, or unconducive to the overall effectiveness of healthy social and emotional learning.

It is recommended that teachers, support staff, and administrators work together to infuse more social-emotional learning into the existing curriculums in the district. Research has shown that increased social-emotional learning is proven to enhance attitudes towards school, help students understand and manage their emotions, incorporate more adaptive behaviors, increase social skills, and improve interpersonal relationships with one another. All of these improved aspects contribute to students having an increased academic performance in schools. In an article by Kress and Elias (2013), there are three illustrated trends in common that lead to successful implementation of SEL programming: (a) creating systems that allow integration of the intervention at multiple levels of the school and across risk levels, (b) developing an infrastructure for progress monitoring, and, most significantly for our concerns, (c) ongoing support systems for professional development that often includes coaches external to the school system. It is also emphasized that external consultants played a key role in most of the interventions and implementation efforts. New Brunswick, New Jersey schools have been incorporating social-emotional learning into the curriculum for years under the direction of Dr. Maurice Elias, a professor at Rutgers University, and one of the prominent and leaders in the

field of Social-Emotional Learning and Character Development. He would be an excellent resource to consult with for any future direction that the Haven or any school in the Piscataway school district might need. The article stresses that assessing fidelity of implementation also yields benefits in terms of increasing the chances for sustainability of this programming. Ongoing feedback about the implementation process can provide a springboard for the site based leaders' ongoing and realistic shaping of any initiative (Kress and Elias, 2013).

As is mirrored by the current study, assessing fidelity through program evaluation and incorporating district-wide and community feedback are extremely useful catalysts for the positive change that is needed in schools. Increasing SEL in Piscataway through collaboration with experts such as Dr. Elias would undoubtedly over time lead to decreased negative mental health symptoms amongst students, as was evident as a result of these efforts in the New Brunswick public schools. It is recommended that after the initiation and implementation of more SEL efforts that another program evaluation be conducted that surveys school and community perspective to measure the effectiveness of how well the Haven is addressing Piscataway's identified mental health concerns.

Limitations

There are several limitations to this study that inhibit generalizability to other school-based mental health centers and community contexts. Upon tallying the number of each type of survey respondent, there were 14 administrators, 42 support staff, 34 teachers, and 8 community members. The majority of the questions on the survey were only filled out by school faculty, which include administrators, support staff, and teachers. It must be taken into account that there was a more limited number of both administrator and teacher respondents to the study than support staff, and an extremely limited number of community members. Bersamin, Garbers,

Gold, Heitel, Martin, Fisher, and Santelli (2015), say that an innovative approach to address challenges that arise while conducting evaluations is to have "collaborative meetings with administrators and teachers, providing incentives to the school for increasing levels of participation, appending evaluation consent forms to required forms being sent to parents, and sending forms home with students rather than using mail. Using this approach, participating rates exceeded 79%, with a cost of only $7.93 per participant." It would be more informative and increase generalizability if there were more administrators and teachers participating in future program evaluations and needs assessments so that responses more accurately reflect school personnel.

The low number of administrators participating in certain questions, specifically the one regarding how well the Haven meets the needs of East and South Asian students, could have affected the outcome of results since there was no variation in the administrators' ratings. If there had been more administrators answering that question, there would be more of a variety in mean response ratings, indicating more clear answers for which groups they felt the Haven was more or less competent in treating. This emerging information would have been helpful to the Haven in its program evaluation, as well as for guidance in improving its responsiveness and culturally sensitive treatment to specific cultural/ethnic groups.

The low number of community members responding to the survey shows that either community members chose not to participate in this survey, felt they did not have the knowledge to answer the questions in the survey, or a combination of both answers. Seeing such a low number of community members who responded to the survey highlights the importance of community involvement and collaboration with school-based mental health centers. The low

number of community respondents indicates that there might not be enough collaboration and communication between schools, which is further discussed in the recommendations.

The fact that all data in the survey was self-reported presents another limitation to the study. There was no objective data to compare and contrast responses to, which would have strengthened this study and been helpful overall. Due to the nature of self-reporting, it could be likely that there was responder bias, and respondents provided more desirable answers since that may have been more comfortable for them. This would prevent the researcher from obtaining more truthful information and skew the accuracy of the study.

Another limitation to this study is that there is a lack of concurrent validity. The Haven was a convenience sample and was chosen for a program evaluation by the researcher and Haven's program director, making it the sole source for obtaining data. The prior working relationship between the researcher and Haven director facilitated the process of obtaining permission for and conducting the study.

Lack of in-depth qualitative data, such as staff interviews, is a further limitation to this study. If there had been more time available to collect research and conduct interviews with a variety of staff and community members throughout the district, it would undoubtedly yield much more rich and meaningful data that could be used to make more specific changes to the Haven. It is recommended that future studies collect more in-depth interviews with survey respondents to get a more comprehensive picture of their views and attitudes towards school-based mental health centers and the changes they want to see that would more closely meet community needs. To explore this further, the Haven could also conduct a focus group.

The study would also benefit from a follow-up in the future, as the nature of the study was short-term. Data was collected within a few months span, and therefore, the information in

the study could very well evolve going forward. It would be important to conduct a study in the future where the survey questions are administered again to monitor the Haven's growth and any change.

Finally, the study was both enhanced and limited by the dual roles of the dissertation chair, Dr. Patrick Connelly. He also serves as the director of the Haven. He provided useful information and insights about the program, but there may have been some pressure to provide positive perspectives on the data due to his role.

Threats to Internal and External Validity

As briefly mentioned earlier, the working relationship between the Haven's director and the researcher could have impacted internal validity. Both the researcher and Haven director had an idea of how interpreting qualitative comments would best serve the Haven, and thus, could skew interpretations to more closely fit their goals for the study. Steps were taken to minimize researcher biases throughout the analysis process as a third party provided their interpretation of the qualitative comments in addition to the researcher's interpretation. Steps were also taken to minimize researcher bias as the one-way ANOVA was run for a second time by a third party who is a statistician and had no personal connection to the data, the researcher, or the study in any way. Although the survey was widely distributed to various school staff and community members and the identities of the respondents were not known, a third party could have been involved in the distribution process to further minimize researcher bias.

In addition to the limitations described above, some of the external threats to validity in the current study was the potential problem of not being able to reach potential respondents from a variety of the respondent groups, such as administrators and community members that would have had important input in the survey. The population of respondents per group that the survey

reached was not proportionally representative of those groups in the district/community, which may prevent results from being generalizable across different settings. While survey questions were constructed as unambiguously as possible, it is possible that some participants did not understand all questions. Also, the sample sizes for some respondent groups were smaller than ideal, and so may not be statistically reliable to generalize to future studies of this nature.

Suggestions for Future Researchers/ Future Directions

There are several further recommendations that have implications for future research, policy, and practice. Future research conducting another program evaluation of the Haven would be very useful to use to compare to the current study. This would provide a measure to examine the growth the Haven has had, if there are any changes in various staff perception of certain school aspects, as well as examining if the main presenting problems within the student population have decreased over the years. This would reveal if the increased efforts by the Haven have been found to be efficacious and enduring. Furthermore, the results of the future study would show how well the schools were communicating and collaborating with the larger community. A concurrent approach would be to send families and referral sources a "satisfaction survey," geared to the audience, to evaluate on a case by case basis aspects of the referral and treatment process.

The findings in the current study indicate that school-based mental health centers cannot assume that students with the greatest need will find their way into utilizing mental health services. Therefore, more research needs to be done to see how clinicians and school personnel can more effectively get minorities into treatment, specifically Asian populations. There needs to be an increase in community outreach, culturally sensitive school programming, and diversity training opportunities for staff to more fully understand what cultural factors keep certain ethnic

groups from coming to therapy and learn how to work around those barriers. Culturally tailored therapy needs to be researched and implemented in order to maximize minority students and underserved student populations utilizing the Haven's services. This will hopefully reduce racial and ethnic disparities of mental health service use.

Findings from Rastogi et al. (2014) discuss how the cultural stigma within the South Asian communities stems from consideration of mental illness as a weakness or shameful factor, which often leads to delay in seeking treatment, difficulties at work, and problematic inter-personal relationships. The authors posit that the evaluation and treatment of South Asians with mental health issues requires understanding of the cultural values and beliefs that drive symptom presentation and attitudes toward treatment. Further research is needed to develop and evaluate strategies to improve acceptance of and compliance with mental health treatment in this population, in particular in school based mental health settings.

A theme that was omnipresent in this study was that school staff, community members, and students and their families are not aware of the extent of the Haven's services. It is vital for the Haven to advertise themselves more, build more community relationships, and be more of a presence in schools. The Haven can do this by doing classroom interventions educating students and their families on mental health literacy, contributing to social-emotional learning, and increasing positive school climate.

There needs to be much increased efforts to establish partnerships with community organizations that interact with the school district's students. As the literature shows, having open communication and collaborative partnerships with community members and organizations will lead to decreased negative mental health symptoms. There are many hospitals in the area who report increased rates of Emergency Department (ED) visits that are because of mental

health concerns. If medical doctors and hospital personnel build relations with the Haven, it is likely that more students would be aware of the Haven's services and redirect their concerns to mental health professionals rather than medical professionals.

The data from the 2016 Community Health Needs Assessment (CHNA) conducted for St. Peter's University Hospital and Robert Wood Johnson University Hospital shows that African American and Latino communities are the ethnic groups that are utilizing ED visits more than other ethnic demographics for mental health concerns. The study describes these ED visits as "avoidable hospitalizations" and states that these mental health concerns could have been avoided with 'high quality community-based primary care". The data of the rates of these avoidable ED visits can serve to inform communities and future researchers as to the availability of primary care and more generally the quality of community level health services within an area (Brownlee, Farnham, Chatravarty and Zhang, 2016). These measures identify unmet community health care needs and provide a good starting point for assessing quality of health services in the community. The study also addresses how various groups of people are unaware of the availability of mental health services in their area, and how there is often inability to access these resources due to financial limitations (i.e., no internet in their home to research mental health care centers, or method of transportation). This is another factor that urges the Haven to advertise and advocate more about their services. It also shines a light on the importance of forging, strengthening, and maintaining school and community partnerships for increased availability and access to mental health resources for students and their families. Since the CHNA is limited in adolescent focus, a recommendation for the future is that perhaps there could be a joint study between both the current CHNA data and the findings from this dissertation about the Haven's services which does examine adolescent data. This would encompass a

broader and more comprehensive look at the entire community's consumption of mental health services. Upon examination of the collective data, there should be specific actions steps formulated to more closely bridge the gap between the community's identified mental health needs and availability, accessibility, and quality of services.

As the researcher writes this dissertation, the country has experienced another tragic school shooting in Florida, where the shooter was a student with known cognitive impairments and various mental health issues. It has been made known that there was a lack of collaboration between the school's Child Study Team and community agencies in efforts to help this individual whose issues were well known to others. According to Naples Daily News, t is cited as a contributing factor to the horror that occurred terrible outcome with student known to school officials. At the policy level, Secretary DeVos has championed school choice proposals, which take funds away from underperforming public schools and reallocate the funds to charter and private schools. Most recently in an interview on 60 Minutes (March 11, 2018), the Secretary stated that she is unaware if her actions have actually improved public schools, admitted she has not visited these underperforming schools, and appears out of touch with the current problems affecting the education system. Her actions and the policies she is looking to enact would significantly impact diverse communities and have implications for how agencies like the Haven need closer collaboration with the other schools in the district, community agencies, and Rutgers University as its source of support for funding. If more community organizations were invested and had working alliances with the Haven, there would be opportunity for potentially increased funding, additional resources, and more students and families accessing its services.

In a journal article that speaks directly to this issue, Elias, Nayman, Duffell, and Kim (2017) state that because the benefits of Social-Emotional Character Development (SECD)

extend to areas that fall under the jurisdiction of several government agencies (e.g., the departments of Health and Human Services, Housing, and Justice), federal budgeting guidelines should be flexible enough to allow those agencies to make allocations in partnership with the Department of Education. The authors also make a poignant and moving statement directed at Secretary DeVos without mentioning her name: "To our new secretary of education, and to all those who play a role in shaping the nation's priorities for school improvement, we offer a pair of suggestions: You should identify and call attention to effective, school-based approaches to social-emotional and character development, and you should advocate for structures, supports, and incentives that will allow such high-quality approaches to be implemented at scale" (Elias et. al, 2017).

Overall, the present study demonstrates that the survey can be generalized to other school-based mental health centers to yield useful information necessary to facilitate positive changes within schools and communities. It would be prudent for future researchers to address the current study's limitations and further explore the research questions and hypotheses, which would strengthen the evidence base of the study and potentially produce additional useful information. It is imperative to remember that schools are the most common entry point into children's mental health services in the United States (Lai et al., 2016). All of these factors would benefit a middle class community such as Piscataway, and act as preventative measures for students who are at-risk of developing negative mental health symptoms. It would also help transform school-based mental health centers into more welcoming, culturally competent, and well-connected establishments for excellent comprehensive mental health care for all students.

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Appendix A: Consent Form

CONSENT FORM
FOR ANONYMOUS DATA COLLECTION

You are invited to participate in a research study that is being conducted by Sheri Balsam, who is a Doctoral Student at the Rutgers Graduate School of Applied and Professional Psychology. The purpose of this research is to conduct a program evaluation of the Haven, and to determine how services at the Haven can be improved for students and families in the Piscataway school district by surveying school staff and community stakeholders.

This research is **anonymous**. Anonymous means that I will record no information about you that could identify you. There will be no linkage between your identity and your response in the research. This means that I will not record your name, address, phone number, date of birth, etc.

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. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated. All study data will be kept for three years in a locked cabinet in a secured office.

There are no foreseeable risks to participation in this study. In addition, you may receive no direct benefit from taking part in this study, other than being part of a collaborative effort for a community needs assessment to help the students and their families in the Piscataway school district.

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. It is estimated that it will take between 15 to 20 minutes to complete the study materials.

If you have any questions about the study or study procedures, you may contact me at 152 Frelinghuysen Road, Piscataway, NJ, 08854, by phone at 516-732-1735, or by e-mail at sheri.balsam@rutgers.edu.

You can also contact my faculty advisor Dr. Patrick Connelly by mail at The Haven, Piscataway High School, 100 Behmer Road, Piscataway, NJ 08854, by phone at (732) 981-0700 x2250, or by e-mail at: pconnelly@pway.org.

If you have any questions about your rights as a research subject, please contact an IRB Administrator at the Rutgers University, Arts and Sciences IRB:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-2866
Email: humansubjects@orsp.rutgers.edu

Please retain a copy of this form for your records. By participating in the above stated procedures, then you agree to participation in this study.

If you are 18 years of age or older, understand the statements above, and will consent to participate in the study, click on the "I Agree" button to begin the survey/experiment. If not, please click on the “I Do Not Agree” button which you will exit this program.

I Agree I Do Not Agree

Thank you in advance for your participation in this research study.

_____

Sheri Balsam, Psy.M.

Appendix B

Piscataway Community Stakeholder Survey

Instructions: For the questions below, please select the answer that is the best choice. ***Do not answer any questions for which you feel you don't have the knowledge to answer.***

1. What is your role in the community?
    a) Administrator
    b) School psychologist
    c) Counselor
    d) Behaviorist
    e) LDTC
    f) Social Worker
    g) Medical professional
    h) Other (specify): _____

2. What is your agency/organization?
    a) School
    b) Community organization
    c) Hospital
    d) Outpatient Clinic
    e) Recreation Center
    f) Other: _____

3. What grade levels do you work with?
    a) K-3
    b) 4-5
    c) 6-8
    d) 9-12
    e) All grades
    f) Other: _____

4. Please use the following scale points to rate how prevalent each of the listed issues are. Using points 1-7, assign the number of the scale that most closely pertains to each issue.

7	**6**	**5**	**4**	**3**	**2**	**1**
Extremely Prevalent	Very Prevalent	Prevalent	Somewhat Prevalent	Slightly Prevalent	Not very Prevalent	Not Prevalent

_____ Internalizing (anxiety, depression, etc.)
_____ Externalizing (behavioral issues, aggression, violence)
_____ Family Problems (fights/tension/relationship difficulties between people
_____ Trauma (deeply distressing/disturbing life experience)
_____ Peer issues (in person bullying, cyber bullying, physical or verbal attacks)
_____ Academic underachievement (low grades)
_____ Other (specify)_____

5. What supports/interventions are being provided?
   a) Individual counseling
   b) Behavior management
   c) Group counseling
   d) Classroom support
   e) Adolescent clinics
   f) Law enforcement
   g) Parks and recreation
   h) Social Services
   i) Other: _____

Instructions: This next part of the survey deals with what knowledge you have regarding the Haven and schools in the Piscataway district. Please select the number which best represents your opinion. Feel free to add any additional comments in the spaces provided underneath each question. ***Do not answer any questions for which you feel you don't have the knowledge to answer.***

6. How well does your school meet the needs of internalizing students?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

7. How well does the Haven meet the needs of internalizing students?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

8. How well does your school meet the needs of family problems?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

9. How well does the Haven meet the needs of family problems?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

10. How well does your school meet the needs of students and families with trauma histories?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

11. How well does the Haven meet the needs of students and families with trauma histories?

7	**6**	**5**	**4**	**3**	**2**	**1**

EXCELLENT VERY GOOD GOOD AVERAGE FAIR POOR UNMET

Comments:_____
_____
_____

12. How well does your school meet the needs of students having issues with peers?

7 **6** **5** **4** **3** **2** **1**

EXCELLENT VERY GOOD GOOD AVERAGE FAIR POOR UNMET

Comments:_____
_____
_____

13. How well does the Haven meet the needs of students having issues with peers?

7 **6** **5** **4** **3** **2** **1**

EXCELLENT VERY GOOD GOOD AVERAGE FAIR POOR UNMET

Comments:_____
_____
_____

14. How well does your school meet the needs of students with academic underachievement?

7 **6** **5** **4** **3** **2** **1**

EXCELLENT VERY GOOD GOOD AVERAGE FAIR POOR UNMET

Comments:_____
_____
_____

15. How well does the Haven meet the needs of students with academic underachievement?

7 **6** **5** **4** **3** **2** **1**

EXCELLENT VERY GOOD GOOD AVERAGE FAIR POOR UNMET

Comments:_____
_____
_____

16. How would you rate your general communication with the Haven (referrals, setting up appointments, etc.)?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

17. How would you rate the Haven's collaboration with you on meeting students' needs? This includes planning and coordinating interventions, etc.

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

18. How well does your school meet the social, emotional, and behavioral needs of the following cultural/ethnic groups in your school/district?

a) East Asian populations

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

b) African American populations

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

c) Latino populations

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

d) European/Caucasian populations

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

e) South Asian American populations

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

19. How well does the Haven meet the social, emotional, and behavioral needs of the following cultural/ethnic groups in your school/district?

a) East Asian populations

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

b) African American populations

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

c) Latino populations

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

d) European/Caucasian populations

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

e) South Asian American populations

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

20. What is your perception of the level of cultural competence among district staff?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

21. What is your perception of the level of cultural competence among Haven staff?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

22. What is your perception of the school climate within your school?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

23. How well is community involvement integrated into students' lives (Ex: what is the level of student involvement with community programs and recreational activities)?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

24. How well connected are students to community health care providers?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

25. What is the level of students' knowledge in terms of mental health literacy?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

26. What is your perception of the Haven's provision of appropriate and timely mental health care?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

27. What is your perception of teacher collaboration with the Haven?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

28. What is your perception of administrator collaboration with the Haven?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

29. What is your perception of the level of effectiveness of counseling services provided at the Haven? Please respond to this question based on your grade level affiliation.

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

30. How well does the Haven respond to crisis intervention?

7	**6**	**5**	**4**	**3**	**2**	**1**
EXCELLENT	VERY GOOD	GOOD	AVERAGE	FAIR	POOR	UNMET

Comments:_____
_____
_____

Instructions: Fill in the blank for the question below with the most appropriate suggestions.

31. Are there groups that you think the Haven could offer that would be helpful?

_____
_____
_____