ADDRESSING SERVICE UNDERUTILIZATION AMONG MUSLIM YOUTH

ADDRESSING BARRIERS TO MENTAL HEALTH SERVICE UTILIZATION AMONG MUSLIM YOUTH AND FAMILIES USING A COMMUNITY-BASED PARTICIPATORY RESEARCH APPROACH

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY

OF

RUTGERS,

THE STATE UNIVERSITY OF NEW JERSEY

BY

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PSYCHOLOGY

NEW BRUNSWICK, NEW JERSEY AUGUST 2021

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ADDRESSING SERVICE UNDERUTILIZATION AMONG MUSLIM YOUTH

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ABSTRACT

Despite an identified need for treatment in this population, there continues to be a significant underutilization of formal mental health services among Muslim youth and families in the United States, due to a range of cultural, religious, and socioeconomic barriers. Consequently, traditional methods of engaging this population in clinical services and research have proven to be inadequate, whereas there is growing evidence to suggest that community-based participatory research (CBPR) approaches emphasizing collaboration with community stakeholders throughout the research process may be more acceptable and effective in addressing disparities in mental health care for racial/ethnic minority youth and families. The current study employs a CBPR approach to improve attitudes and stigma-related beliefs toward mental health services among “gatekeepers” to referrals in the local Muslim community. A community-academic partnership (CAP) was formed with a local religious Islamic school affiliated with a prominent Sunni mosque in Central New Jersey. A series of mental health psychoeducation and skills building workshops were developed with school leadership for teachers at the partnering school, and one workshop was implemented. Participants were attendees of the workshop who were invited to participate in a web-based survey following the attended workshop, in order to assess change over time in attitudes toward mental health services and treatment-seeking, barriers/facilitators to referrals for services, mental health stigma-related beliefs, and knowledge about services and local resources. Participants also provided qualitative and quantitative feedback about acceptability and suggestions for future workshops. Aims of the study included creation of a community-academic partnership, development and implementation of three gatekeeper training and education workshops, and evaluation of efforts to indirectly increase mental health service utilization among a local Muslim school community by influencing factors.
associated with teachers’ mental health referral propensity. Results demonstrated acceptable feasibility for both the CAP and workshops, and identified challenges to be addressed for improved feasibility and sustainability of efforts. Results also demonstrated high acceptability of workshops, as well as increased mental health knowledge and mental health referral propensity, and decreased mental health stigma-related beliefs as a result of attending the workshop. Survey responses were utilized to develop a list of recommendations for community clinics and clinicians seeking to increase access and utilization of formal mental health services for other underserved or difficult-to-reach youth populations.
ACKNOWLEDGEMENTS

First and foremost, I want to thank my dissertation chair, advisor, supervisor, and mentor: Dr. Brian Chu. I cannot even begin to express what your mentorship has meant to me. From the beginning, you have pushed and challenged me to grow, helped and encouraged me to pursue my (many) interests, and invested in me as a whole person. From the YADC to the ASA to the RCP and now to my dissertation, you have provided guidance and support at every step of my graduate career. I am so lucky to have joined the YAD-C and gotten the chance to learn from you. You taught me how to infuse fun and creativity into my work, develop confidence in my clinical skills, and build a professional identity that is rooted in my values. Thank you for supporting and helping me to navigate the challenges of graduate school, as both a new mother and student of color. Thank you for serving as a model for the kind of supervisor, leader, and mentor I hope to one day become for others.

I am also incredibly grateful for Dr. Shireen Rizvi who has been one of the best teachers, supervisors, and mentors I have ever worked with. Thank you for introducing me to a treatment that has helped me to grow and better myself as a person, connect with an incredible community of skilled and compassionate clinicians, and help clients through their suffering to build lives worth living. Thank you for empowering me to find my own voice, be radically genuine with others, and trust in my own wisdom. Thank you for teaching me by example how to be a “brassy broad” (in the words of a former client).

I want to thank several other faculty and staff members who have impacted my education, training, and graduate experience. I am fortunate to have Dr. Shalonda Kelly serve as a second member on my dissertation committee, in addition to her consistent support for my learning and growth with respect to racial and multicultural issues in therapy. I also want to
thank Dr. Angelica Diaz-Martinez for being an advocate for her students and always being available to offer guidance. Additionally, I want to thank Sylvia Krieger, Dolores Turchi, and Julie Skorny for their patience and warmth throughout the years as they work their magic behind the scenes – GSAPP wouldn’t be the same without you!

I would like to express my true appreciation for the Islamic school that has been partnering with us on this project for their graciousness, warmth, and enthusiasm throughout our collaborations. Although we did not share the same cultural or faith backgrounds, the principal welcomed us into her school and provided access to her staff, in the service of helping students and families in need achieve mental health and wellbeing. She and her teachers were incredibly kind and receptive to working with and learning from one another at every interaction. Getting to know you all has been the greatest honor and privilege, and I hope the RCP will be able to continue its relationship with your school for many years to come. Thank you for allowing us to partner with you.

I also want to thank the members of the RCP for tirelessly working alongside me to execute our mission of addressing disparities in care for local underserved youth and families. Despite their impossibly demanding schedules, Drs. Brian Chu and Andrea Quinn always devoted themselves to supporting its efforts, whether it be through countless edits of IRB and grant proposal drafts, or generously sacrificing time with their family to participate in meetings with community stakeholders or attend community events. I must also thank my fellow student members who are the heart and soul of this whole operation. They volunteered so much of their time conducting outreach to our local communities, meeting and collaborating with community stakeholders, implementing community events, and helping to disseminate our findings to the scientific community to assist others engaged in this work. Thank you to Cindy Chang, Sara
Ghassemzadeh, Mel Pedroza, Sheila Rouzitalab, and Maria Alba, with a very special thanks to Sheila for being my co-pilot during this particular partnership with the Islamic school. I am also grateful to the Family Youth Institute; Chaplain Kaiser Aslam of the Center for Islamic Life at Rutgers University (CILRU); and Drs. Maurice Elias, Anne Gregory, and Dr. Nadia Ansary for your generosity and willingness to advise and support our efforts.

Thank you to my YADC family, DBT Team, and cohort for your friendship, peer consultation and mentorship, and support over the years. There is no way I would have survived graduate school without you all, and it definitely would not have been as much fun.

Most importantly, I would like to thank my family for their patience, sacrifice, support, and encouragement throughout the long and arduous journey to earning my doctorate. Thank you, Neil, for helping me celebrate the highs, weather the lows, and supporting me throughout this process. Thank you to my daughter, Adelaide, for loving me, and inspiring me to live each with joy and gratitude. I love you best. I love you most. I love you forever and always. You are my motivation to do hard things and have the courage to keep growing, so I can become the kind of woman that you can feel proud to call your ummah. Thanks to my own ummah, Christina (HyeChung), for holding all my hopes and dreams, being my biggest cheerleader, and being the first to teach me about nonjudgmentalness, empathy, and humility. Nothing would have been possible without your love and faith.
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Introduction

Background

Despite the need for professional treatment, the underutilization of formal mental health services among racial/ethnic minority youth, particularly among immigrants and children of immigrants (Huang, Yu, & Ledsky, 2006), has been well documented (Alvarez, Vasquez, Mayorga, Feaster, & Mitrani, 2006; Kataoka, Stein, & Jaycox, 2003; May et al., 2007; Zayas, Hasumann-Stabile, & Pilat, 2009). This problem appears to be especially pronounced among American Muslims, a large and growing population most recently estimated at seven million (Pew Research Center, 2007). Understanding the factors that account for this underutilization can help the mental health field implement strategies to increase access to services for this critically underserved community.

The data on Muslims in the United States (U.S.) is limited and inconsistent, possibly owing to variance in research methods (e.g., information regarding religion not collected or unreported in published studies, data results filtered by race/ethnicity rather than religion, etc.) and limited participation by Muslims in research (Amri & Bemak, 2013). Further, findings from the little mental health research that has been done on this population are often not generalizable, given the diversity and heterogeneity among Muslims in the U.S., in terms of ethnicity and the ways in which the faith is practiced (e.g., sects within Islam). Approximately 75% of Muslims in the U.S. are estimated to be immigrants, and approximately half of American-born Muslims are children of immigrants (Council on American-Islamic Relations, 2006; Hodge, 2002). The majority of Muslim immigrants come from the Middle East, North Africa, and South Asia, and have settled in the country within the past 15-20 years (Pew Research Center, 2007 and 2011). Muslim immigrants and their children may face different challenges (e.g., acculturation
difficulties and stress, fewer social and family supports, limited English language proficiency, pre-migration trauma exposure related to persecution in their countries of origin) than American-born Muslims, converts to Islam, and those who have been in the U.S. for longer than one generation (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008; Erickson & Al-Tamimi, 2002). Thus, the Muslim community reflects a diverse set of peoples itself that may reflect diverse needs.

Nonetheless, the American Muslim community is generally reported to be experiencing a range of sociopolitical (e.g., emotional disturbances, substance abuse, unemployment, domestic violence, child abuse, immigration problems) and cultural (e.g., acculturation difficulties and stress) problems commonly associated with mental health problems (Abu-Ras, 2003; Erickson & Al-Timimi, 2002; Farrag & Hammad, 2002; Kulwicki, Miller, & Schim, 2000). Following the attacks of September 11, 2001, Muslims also appear to be at increased risk for victimization and violence, discrimination and marginalization (e.g., denial of religious accommodations, denial of employment; Cainkar, 2004), racial profiling (e.g., interrogation, travel restrictions, unjustified detentions, home raids) due to the Patriot Act and similar legislation (Ahmed & Reddy, 2007; Amri, Nassar-McMillian, Miesenhimer, & Bryan, in press; Ghaffari & Ciftci, 2010; Haddad, 2004), and discriminatory portrayals of Muslims and/or Islam in the media (Kira et al., 2010; Padela & Heisler, 2010), which have been associated with higher rates of depression and posttraumatic stress disorder (PTSD; Farrag & Hammad, 2002).

Muslim youth may be especially vulnerable to these challenges, due to the impact of peer pressure to conform to mainstream norms and values that may be in conflict with religious or cultural values, particularly for those also coping with acculturative stress and family differences in acculturation (Hodge, 2002). Canadian and American Muslim youth reported experiencing
frequent or daily discrimination in schools for observance of religious practices and religious clothing, such as the *hijab* or head covering worn by girls (Ahmed & Ezzeddine, 2009; Ajrouch, 2004; Zine, 2001). Such experiences of discrimination and acculturative stress have been found to predict psychological distress, anxiety, depression, and behavioral difficulties in Muslim American adolescents (Ahmed, Kia-Keating, & Tsai, 2011; Goforth, Oka, Leong, & Denis, 2014), highlighting the need for professional mental health intervention in Muslim youth and families.

Despite this, the literature indicates that there is a large discrepancy between identified need and services. There is a tendency for Muslims to avoid seeking out and utilizing formal mental health services, due to potentially malleable factors influencing Muslim attitudes toward help-seeking (Al-Adawi et al., 2002, Haque-Khan, 1997; Savaya, 1995, 1998). A large study of 459 ethnically diverse Muslim adults residing in Toledo, Ohio found that only 11.1% of the total sample utilized formal mental health services within the past two years, despite 15.7% reporting a perceived need for services (Khan, 2006). Studies of psychiatric inpatient facilities in Australia found that Arabic-speaking individuals were the least likely to receive community mental health services following discharge (Tobin, 2000). Individuals from the Middle East were also found to be 21%, 31%, and 50% less likely to be voluntarily admitted for psychiatric hospitalization for psychosis, depression, and anxiety, respectively, compared to other racial/ethnic groups (McDonald & Steel, 1997).

**Barriers to Help-Seeking and Service Utilization**

Muslims in the U.S. face many of the same socioeconomic and structural barriers to seeking professional psychological help as other racial/ethnic minority (e.g., lack of insurance coverage, transportation difficulties, lack of childcare, geographic proximity to service) and
immigrant (e.g., language barriers) populations (Alegria et al., 2007; Alvarez, Vasquez, Mayorga, Feaster, & Mitrani, 2006; Zayas, Hausmann-Stabile, & Pilat, 2009). Aswad (2001) found that approximately 20% of Arab Muslim families resided below the federal poverty level, impacting their ability to pay for formal mental health services. Muslims may also have limited knowledge or understanding about mental health services and resources. Arab individuals were reported to have a difficult time differentiating between the different roles of mental health professionals (e.g., psychiatrists, psychologists, clinical social workers) and the services (e.g., medication management, psychotherapy and assessment, counseling and assistance with social services) provided by them (Al-Krenawi & Graham, 1999), as well as little understanding about the general concept of Western models of psychotherapy (Al-Issa, 2000; Al-Krenawi, 2002; Al-Krenawi et al., 2000; Erickson & Al-Timimi, 2002) and where to find them (Youssef & Deane, 2006). Abu-Ras (2003) studied factors affecting service utilization in a sample of Arab female immigrants experiencing intimate partner violence (IPV) and found that 93% reported having no knowledge about how social services work. Limited English language proficiency was also found to impact decisions to seek and access services (Al-Krenawi, 2002; Haque-Khan, 1997; Kulwicki, Miller, & Schim, 2000; Savaya, 1998), due to fears of being misunderstood by mental health providers (Erickson & Al-Timimi, 2002).

Further, Muslims reported experiencing a mistrust of non-Muslim or American mental health providers and services, due to fears about cultural or religious stereotyping (Erickson & Al-Timimi, 2002), breaches in confidentiality (Youssef & Deane, 2006), and cultural misunderstandings (Erickson & Al-Timimi, 2002). Muslims reported believing that American doctors generally lacked familiarity with their cultural or religious backgrounds and did not trust their recommendations, fearing that they may advise them to engage in behaviors that would be
in conflict with their cultural/religious values and beliefs (Erickson & Al-Timimi, 2002; Inayat, 2007). Haroun et al. (2011) found that only 27.9% of Muslim adolescents believed that American doctors possessed sufficient cultural competency to adequately address their depressive symptoms.

Another barrier influencing help-seeking behaviors in this population may be culturally embedded beliefs about the causes of mental illness, specifically the attribution of mental health disorders and symptoms to supernatural entities like jinns (demons), Nahla (the evil eye), Seher (magic), etc. (Al-Adawi et al., 2002; Al-Issa, 2000; Al-Krenawi, Graham, & Kandah, 2000; Al-Subaie & Alhamad, 2000). Al-Adawi et al. (2002) found that Omani Muslims tended to attribute the cause of mental health disorders to spirits, rejecting genetic or biological explanations for etiology, even after controlling for demographic variables. Similarly, psychiatric outpatient clients in Kuwait were more likely to attribute psychiatric symptoms to supernatural versus biological causes, regardless of level of education (El-Islam & Abu-Dagga, 1992).

Cultural stigma about mental illness may negatively influence professional help-seeking, particularly among Arab Muslims. Arab Muslims were reported to associate psychological problems with personal weakness or lack of faith, regardless of level of education (Al-Issa, 2000; El-Islam & Abu-Dagga, 1992; Erickson & El-Tamimi, 2002; Vogel, Wade, & Hackler, 2007). The use of psychiatric medications, seeking help for psychological problems from those outside of one’s family or community, or receiving professional mental health services may be viewed as shameful, inappropriate, or actions only taken by “crazy” people (Abudabbeh & Aseel, 1999; Abu-Ras, 2003; Al-Adawi et al., 2002; Haque-Khan, 1997). Sharing personal information about one’s problems to “outsiders” may be perceived as disloyal to the family, due to the potential for portraying them in a negative light, thereby bringing shame to the entire family and affecting
their social standing within the community (Abudabbeh & Aseel, 1999; Abu-Ras, 2003; Al-Subaie & Alhamad, 2000). When examining barriers to service utilization in a sample of Arab female immigrants experiencing IPV, approximately 70% reported experiencing shame and 62.7% reported experiencing embarrassment about seeking formal mental health services (Abu-Ras, 2003). A review of the literature also indicated that many Muslims hold negative attitudes toward formal mental health services (Al-Adawi et al., 2002; Al-Krenawi & Graham, 1999, 2000, 2003; Haque-Khan, 1997; Savaya, 1995, 1998) and endorse the belief that they are ineffective in addressing their problems (Erickson & Al-Timimi, 2002), although levels of acculturation have been found to positively influence attitudes toward psychological help-seeking (Kim & Omizo, 2003; Kouyoumdjian, Zamboanga, & Hansen, 2001; Zhang & Dixon, 2003). For example, Haque-Khan (1997) found that Muslim women who were less acculturated to American culture were significantly less likely to seek formal mental health services compared to highly acculturated women.

When coupled with the under-representation of Muslim mental health providers in community and mental health settings in the U.S. (Al-Krenawi & Graham, 2003; Erickson & Al-Timimi, 2002; Haque-Khan, 1997; Kulwicki, Miller, & Schim, 2000; Savaya, 1998), it is no surprise that Muslims would prefer to seek out informal or religious services, rather than formal mental health services. Muslims have been found to over-utilize *Rugia* (traditional services) or religious services, often doing so before, or in place of, seeking help from primary care physicians or mental health providers (Al-Issa, 2000; Al-Krenawi, 2002; Al-Krenawi & Graham, 1999, 2000; Al-Krenawi et al., 2000; Al-Subaie & Alhamad, 2000; Tobin 2000). Al-Krenawi (2002) found that Muslims’ psychological help-seeking behaviors tended to follow a pattern, reaching out first to family members, followed by close friends, traditional healers, and then
primary care physicians. Formal mental health providers were often viewed as a last resort option. Khan (2006) examined attitudes toward professional mental health services among a large ethnically diverse sample of 459 Muslims residing in the Midwest. 68.2% of the total sample reported utilizing prayer most often to cope with difficulties, followed by the Qu’ran (44.9%) and comfort from family members (42%). Approximately 54.5% of the total sample reported seeking comfort from an imam. Indeed, Ali, Milstein, & Marzuk (2005) surveyed imams across the U.S. about their role in supporting the mental health of Muslims and found that they are often called upon to provide counseling for their congregants. However, they reported that they did not possess adequate mental health training, staffing, or resources at their mosques to support this endeavor. In a follow up study, on average, imams were found to recognize signs of mental illness and reported a willingness to refer congregants displaying psychiatric symptoms for formal mental health services. However, they endorsed a preference for continuing to counsel such congregants themselves, rather than having them receive counseling from formal mental health providers alone. They also reported that they tended not to consult with mental health providers while providing their own counseling, although greater contact with providers was associated with more willingness for collaboration and recognition of the utility of psychiatric medication (Ali & Milstein, 2012). These findings suggest the need for non-Muslim or American mental health providers to collaborate with religious leaders and other stakeholders within the Muslim community to improve attitudes toward mental health services and increase intent to refer for professional help.

Evidence for Community-Based Participatory Research Models

Increasingly, research aimed at addressing disparities in care for difficult-to-reach and underserved populations have turned to community-based participatory research (CBPR)
methods. Traditional models of research carried out in community settings typically entail academic researchers developing and implementing research projects on their own, with little to no involvement from the communities of interest. This has often resulted in information being produced that is useful for answering research questions generated by academics, but less likely to be relevant and meaningful for community stakeholders (Kasari & Smith, 2013), contributing to negative experiences with and increased mistrust of research among ethnic minorities and other underserved communities (Wells & Jones, 2009). CBPR methods represent a departure from traditional one-directional models of research, by collaborating with community stakeholders from the inception of a research project through what has recently been termed the Community-Academic Partnership (CAP; Drahota et al., 2016). CAPs emphasize the egalitarian, bidirectional nature of the relationship between community stakeholders and university researchers to collaboratively identify and address community needs while making use of university expertise. CAPs have been found to promote community engagement and investment in research (Suite et al., 2007) and treatment (Breland-Noble, 2012), as well as improving program development, implementation, and sustainability in community settings (Drahota et al., 2016).

Although the use of CBPR methods in mental health research is relatively new, a review of the literature has demonstrated success in using CBPR to address a variety of mental health related issues among underserved populations (Stacciarini, Shattell, Coady, & Wiens, 2011), including ethnic minorities (Michael et al., 2008; Reinschmidt & Chong, 2007; Shattell et al., 2008, 2009), low-income urban communities (Roberts et al., 2008), and faith communities (Epstein et al., 2007; Van Olphen et al., 2003). For instance, CBPR has been successfully used with ethnic minority participants to develop strategies to decrease mental health related stigma.
(Chung et al., 2006), provide education about mental health diagnoses and symptoms (Jones et al., 2006), and improve policies around mental health related issues (Stockdale et al., 2006). Additionally, CBPR has been successfully implemented in faith-based contexts to address mental health disparities among African Americans (Hankerson & Weismann, 2012; Molock et al., 2008).

Although its use with Muslim communities has not been well studied, some parallels can be made between Muslim and African American communities. The underutilization of formal mental health services among African Americans has been well documented, due to many of the same barriers to care (e.g., stigma, mistrust of mental health providers, demographic barriers to access) facing Muslims. Spirituality is highly important in African American culture, and African Americans were found to have the highest rates of church attendance compared to other racial/ethnic minority groups in the U.S. (Chatters, Taylor, Bullard, & Jackson, 2009). The social prominence of Black churches in African American communities, as well as the role of clergy in serving as “gatekeepers” for health, educational, and psychosocial services for its members (Bopp & Webb, 2012), also make them uniquely positioned to assist with referrals and mental health promotion. Thus, researchers have begun partnering with Black Christian churches to develop faith-based health promotion (FBHP; DeHaven, Hunter, Wilder, Walton, & Berry, 2004) programs aimed at improving health and mental health outcomes in these communities through psychoeducation, screening for mental health disorders, referrals for mental health treatment, and direct services.

A review of FBHP programs for mental health promotion among African Americans (Hankerson & Weissman, 2012) has demonstrated acceptability, feasibility, and success in utilizing CBPR to reduce disparities in mental health service utilization. Williams, Gorman, &
Hankerson (2014) utilized CBPR methods to develop and implement the Promoting Emotional Wellness and Spirituality (PEWS) Program, employing the “gatekeeper model” by partnering with clergy in Black Christian churches across New Jersey to provide psychoeducation about depression symptoms for church leaders, reduce depression-related stigma, and increase treatment-seeking for depression among African American congregants. The PEWS Program has also recently been adapted and implemented in the Muslim community, with results of this adaptation in press. However, while the results are promising for use with adult populations, there is limited research on CBPR and FBHP programs for mental health issues for youth, particularly for racial/ethnic minority youth. A recent review of the literature on CBPR with youth (Jacquez, Vaughn, & Wagner, 2013) across a range of content areas identified only one study focused on mental health outcomes for Cape Verdean adolescent participants (Christiansen, 2010), while a review of FBHP for mental health promotion (Hankerson & Weissman, 2012) identified only two such studies involving African American youth (Marcus et al., 2004; Molock et al., 2007). Thus, further research is needed to determine the feasibility, acceptability, and effectiveness of community-based mental health interventions for racial/ethnic minority youth in faith-based contexts.

School settings are increasingly being used for CBPR to address disparities in access and utilization of mental health services for low income and racial/ethnic minority youth (Gelberg, Andersen, & Leake, 2000; Weist, 2000). Studies have demonstrated success in using CBPR methods in schools to improve emotional/behavioral functioning and academic performance among ethnic minority youth (Mulvaney-Day, Rappaport, Alegria, & Codianne, 2006), influence mental health programming and policies for students (Soleimanpour, Brindis, Geierstanger, Kandawalla, & Kurlaender, 2008), and implement evidence-based trauma interventions for
recently immigrated youth (Stein et al., 2002). Ellis et al. (2010) found that school-based mental health services were the most likely type of formal mental health services to be accessed by a sample of Muslim Somali refugee adolescents, providing support for partnering with school personnel acting as gatekeepers for mental health referrals in this population. Further, Haroun et al. (2011) assessed the beliefs and attitudes of Muslim youth toward depression diagnoses and treatment, health providers, and mental health stigma. Results demonstrated acceptability and support for school-based depression interventions in influencing beliefs and attitudes toward depression diagnosis among those surveyed. Muslim adolescents who agreed that talking to school counselors about their feelings could help improve depression and feelings of sadness were found to be more likely to accept a physician’s diagnosis of depression, even when controlling for age, gender, and ethnicity. The same study found that 59.8% of Muslim adolescents agreed that taking a health class in school to learn about feelings and coping skills is useful, and endorsed a willingness to attend such a class. Endorsement of these beliefs and attitudes were also correlated with a higher likelihood of accepting a physician’s diagnosis of depression when controlling for demographic factors. Thus, partnering with schools to provide youth education about mental illness and treatment may be a particularly promising pathway to mental health services for Muslim youth and families.

Indeed, cultural beliefs about the causes of mental illness, knowledge and familiarity with formal mental health services, and mental health stigma were found to be the best predictors for Arab Muslim attitudes toward formal mental health services and treatment-seeking behaviors, whereas demographic variables (e.g., age, gender, level of education, household income) were not found to predict treatment-seeking behaviors and attitudes (Aloud & Rathur, 2009). Exposure to mental health services has also been found to influence cultural beliefs about the causes of
mental health disorders (Al-Adawi et al., 2002). Given that parental support for mental health treatment is typically required to utilize formal services for youth, and parents tend to seek guidance from schools when their children are confronted with mental health problems (Ellis et al., 2010), school settings may be particularly effective at addressing underutilization of mental health services among Muslim youth.

Teachers, in particular, appear to play an important role in supporting youth mental health within schools, as they are often the individuals asked to refer youth in need of services (Reinke, Stormont, Herman, Puri, & Goel, 2011). Improving teachers’ attitudes toward mental health services via “gatekeeper” training and education may be warranted to increase their willingness to refer and encourage treatment-seeking among youth and families. Additionally, it may be important to educate teachers about mental illness and the mental health system, as well as address mental health stigma-related beliefs, in order to increase mental health referral propensity. According to Ajzen’s theory of planned behavior (1985), willingness to refer for mental health services is not only influenced by attitudes toward mental health services, but also by perceptions about one’s ability to adequately refer for professional psychological help and perceptions about approval for mental health referrals from important others (Ajzen, 1985). Related to perceived ability to adequately refer for professional help is perceived knowledge about mental illness, mental health services, and the referral process. Teachers who do not feel that they have adequate knowledge about such matters may be less willing or likely to refer a person in need of psychological help for services, even if they generally hold positive attitudes toward them. Likewise, teachers who believe that mental illness or help-seeking for psychological problems is shameful, and who endorse a lack of acceptance and support for mental health services within their cultural, social, and/or religious communities may be less
willing or likely to refer for mental health services, even if they held positive attitudes toward the services themselves. For instance, some studies have demonstrated that, despite having more positive attitudes toward mental health services compared to Caucasians, African Americans were still less likely to seek out or utilize mental health services (Anglin, Alberti, Link, & Phelan, 2008; Diala et al., 2010). Thus, we may see similar discrepancies between attitudes toward mental health services and actual referral behaviors among teachers. Gatekeeper trainings and workshops aimed at addressing these factors through the provision of psychoeducation about mental health and services, assistance with navigating the mental health referral process, and normalization of mental health problems and treatment may indirectly increase mental health referral propensity among school personnel.

The Current Study

As outlined, Muslim youth and families in the U.S. tend to underutilize formal mental health services, despite an identified need for treatment in this population. There are multiple factors contributing to this problem, including socioeconomic barriers to access, lack of knowledge and understanding about mental health services and available resources, mistrust of and lack of confidence in non-Muslim mental health providers and services, culturally embedded beliefs about the causes of mental illness, and the over-utilization of informal/religious services when confronted with mental health problems. Traditional methods of engaging this population in treatment have proven to be inadequate, whereas there is growing evidence to suggest that CBPR approaches may be more acceptable and effective in addressing factors that may be contributing to the underutilization of services for racial/ethnic minority youth and families. Embedding community-based mental health interventions in faith-based contexts have
demonstrated success for addressing disparities in care for racial/ethnic minority adults, which may also prove true for youth populations, although this has not been well-studied.

Community-based interventions in school settings have shown to be effective in addressing disparities in care among racial/ethnic minority youth. Thus, the current study aims to employ a CBPR approach to form a CAP between youth- and family-oriented specialty mental health clinics within the Psychological Services Clinic at Rutgers University and a local private Islamic school for grades K-12 affiliated with a prominent Sunni mosque in Central New Jersey. The CAP was part of a broader existing initiative called the Rutgers Community Partners in Youth Mental Health (RCP) to alleviate disparities in mental health care for underserved youth and families in the local Rutgers communities. The primary goal of this CAP is to improve mental health stigma-related beliefs, and attitudes toward mental health services and referrals among school personnel acting as “gatekeepers” to mental health referrals, as attitudes towards mental health services have been shown to influence the actual intent to refer for professional help and encourage treatment-seeking (Ajzen & Fishbein, 1980, 2000; Leaf et al., 1988). The CAP collaboratively developed a series of three workshops for school personnel (e.g., teachers, administrators). One of the primary purposes of these workshops was to educate teachers about the causes of mental illness, types of mental health settings and services, types and roles of different mental health providers, local mental health resources, issues of confidentiality, and psychotherapy.

**Aims and Hypotheses**

*Aim 1*: Create a community-academic partnership (CAP) with the Islamic school.

*Aim 2*: Collaboratively develop and implement three gatekeeper training and education workshops for school personnel at the Islamic school.
**Aim 3:** Gather and review both qualitative and quantitative data related to:

* **Aim 3a:** Acceptability and feasibility of a CAP, and gatekeeper training and education workshops for school personnel.
* **Aim 3b:** Participant characteristics (e.g., religiosity, mental health education/training, demographics) associated with attitudes toward mental health services, mental health stigma-related beliefs, and willingness to refer youth and families for formal mental health services.
* **Aim 3c:** Change over time in school personnel attitudes toward mental health services and treatment-seeking, barriers/facilitators to referrals for services, mental health stigma-related beliefs, and knowledge about services and local resources.
* **Aim 3d:** Participants’ referral history, and change over time in reasons for referrals and referral sources.

**Aim 4:** Develop a list of recommendations for community clinics and clinicians seeking to utilize CBPR methods to increase access and utilization of formal mental health services for underserved or difficult-to-reach youth populations.

**Hypothesis 1:** Attendance of workshops will result in improved attitudes toward mental health referral among school personnel.

**Hypothesis 2:** Attendance of workshops will result in a reduction in mental health stigma-related beliefs among school personnel.

**Hypothesis 3:** Attendance of workshops will result in greater perceived knowledge of mental illness, mental health services, and available mental health resources in the community among school personnel.
Hypothesis 4a: Attendance of workshops will result in greater intent to refer youth and families confronted with mental health problems for formal mental health services compared to other sources of help or informal services.

Methods

Community Setting

The partnering school is a private religious Islamic school serving grades K-12 that is affiliated with a prominent local Sunni mosque located in Central New Jersey. School staff includes a principal, administrative staff, and 50 faculty. The school does not provide any mental health or social services, with the exception of one part-time staff member who comes to the school once per week to provide academic supports for students who are classified with an Individualized Education Plan (IEP). The school does not have child study team personnel or perform any psychoeducational evaluations for its students.

Workshop Participants

Faculty and staff (N = 50) at the partnering school attended a mental health training and education workshop designed for school personnel (e.g., teachers, administrators). Participant demographics are reported in Results and listed in Table 1. Inclusion criteria were access to the Internet and an electronic device with web connectivity (e.g., computer/laptop, smartphone, tablet) to complete web-based surveys, English language proficiency to be able to understand and respond appropriately to survey items, and informed consent to continued participation in the study. There were no other exclusionary criteria, as the sample strove to be representative of individuals interfacing with youth and their caregivers in Muslim school settings.
Measures

The Community Leaders Survey is a 19-item measure designed for the current study completed by all study participants following completion of each attended workshop. The survey was developed for this study, in collaboration with community partners at the partnering Islamic school. The survey assessed the following domains:

Participant demographics

- Age (item 13)
- Sex (item 14)
- Race/Ethnic Identity (item 15)

Participant training and role within the partnering Islamic school

- Role or title (item 16)
- Highest degree obtained in mental health related profession (item 18)
- Level of training or education in working with youth mental health (item 19)

Beliefs/attitudes toward mental health services and treatment

- Endorsed facilitators of mental health referrals (item 1)
  - Belief that counseling/therapy is as effective as/more effective than medication or faith alone in treating mental health problems and related difficulties (item 11)
- Barriers to mental health referrals (item 2)
  - Belief that mental health treatment would not be helpful (item 2k)
  - Belief in solving problems within the family or with guidance from faith leaders (item 2l)
Belief that having strong faith and being very diligent in prayer or recitation of the Holy Koran can treat or cure mental illness more effectively than mental health services (item 2m)

Mental health-related stigma beliefs

- Facilitators to mental health referrals (item 1)
  - Support/encouragement from faith leaders around mental health issues and services (item 1h)
  - Social acceptance or approval from peers/colleagues in this community for discussing mental health concerns or services with youth/families (item 1j)
  - Support/encouragement from place of work/organization around mental health issues and services (item 1k)

- Barriers to mental health referrals (item 2)
  - Belief that people should be given the privacy to work out their own problems (item 2g)
  - Concerns that referring a youth/family for mental health services would be embarrassing or shameful for them (item 2h)
  - Fear of negative social consequences for the youth/family if others in their community were to learn of the mental health referral (item 2i)
  - Lack of cultural, social, or religious acceptance for mental health services (item 2j)

- Degree of comfort speaking openly about mental health difficulties to various individuals (e.g., youth, parents/caregivers, peers/colleagues, leaders) in the partnering school community (item 6a-d)
• Beliefs about the causes of mental illness (item 9)

Knowledge of mental health and services (item 5)

• Knowledge about common mental health problems and disorders affecting children and adolescents (item 5a)
• Knowledge about the types of emotional or behavioral problems one could benefit from seeking counseling for (item 5b)
• Knowledge about different types of mental health practitioners and their various roles in mental health settings (item 5c)
• Knowledge about the location and means of contacting local mental health providers (item 5d)
• Knowledge about common mental health interventions and what is involved in the counseling process (item 5e)
• Knowledge about the rules of confidentiality, as it applies to counseling (item 5f)

Referral history, referral behaviors, and intent to refer

• Referral history (item 3)
• Reasons for referral (item 4)
• Likelihood of referring youth/families for services through Rutgers or elsewhere in the community (items 7c-d)
• Referral preferences (item 8)

Participant satisfaction and acceptability

• Likelihood of attending or encouraging peers/colleagues to attend similar mental health-related events in future (items 7a-b)
• Overall satisfaction with attended workshop (item 10)
• Open-ended response assessing the workshop impact on work with youth in need of services (item 11)

Remaining survey items assessed religiosity (item 17), additional facilitators (item 1) and barriers (item 2) to mental health referrals, and other questions of interest identified by community partners. Questions assessing potential change in attitudes/beliefs or knowledge over time were assessed on a 5-point Likert scale, as the literature indicates that rating scales with 5-7 points demonstrate greater reliability and validity than those with fewer than five points (Krosnick & Fabrigar, 1997). Higher ratings indicated greater change for relevant constructs.

Items assessing participant beliefs/attitudes toward mental health services and treatment (items 1l; 2m) and beliefs about the causes of mental illness (item 9) were adapted from survey items developed for a study assessing attitudes/belief about depression and depression treatment, as well as social norms and stigma in a sample of Muslim adolescents residing in the Midwest (Haroun et al., 2011). Items assessing referral preferences (item 8) were adapted from the Preferred Coping Scale (Ward & Heidrich, 2009), which is a 14-item scale used to assess the likelihood of employing a specific coping method if faced with a mental illness using a 4-point Likert scale. The scale was simplified into one item to reduce participant burden.

In developing the Community Leaders Survey, steps were taken to incorporate feedback from community partners to ensure acceptability of survey items. For instance, language or phrasing was changed, and survey items were removed altogether in some instances, as community partners indicated they were incompatible with cultural or religious values. Community partners also included additional items of interest. Survey responses were shared with community partners.
Procedures:

All study procedures were informed by previously completed CAPs conducted with other local underserved youth communities, within the broader context of the RCP initiative. Specifically, a CAP was successfully formed in 2018 between Rutgers and a local nonprofit organization aimed at providing education and support services for LGBTQ+ youth and young adults (Chang, Laurine, Alba, Rouzitalab, & Chu, 2020), resulting in a collaboratively developed “Youth Mental Wellness Day” event focused on providing psychoeducation about signs and symptoms of psychological distress; facilitating in-person referrals to local mental health services; providing separate parent and youth mental health programming consisting of Q&A, psychoeducation and skills-based workshops, and practice of evidence-based coping skills for anxiety and depression. Surveys were administered to both youth and parent attendees following the event to assess feasibility, acceptability, and other variables of interest. The knowledge obtained from the establishment of this CAP; collaborative development and implementation of the intervention (i.e., joint community-academic event) and associated research procedures; methodological, sociocultural, and economical challenges related to the CBPR approach; and survey data collected from the joint event were utilized to guide study procedures for the current study, which was planned to occur in seven phases.

Phase I: Establish contact and relationship with community partner to form the community-academic partnership, including preliminary assessment of the schools’ mental health needs.

Phase II: Develop joint formulation of format and curriculum for intervention, research questions, and study recruitment and procedures.

Phase III: Implement initial workshop, obtain baseline data, and provide survey results to the community organization.
Phase IV: Review survey results obtained from initial workshop, and incorporate into workshop curriculum and survey revisions.

Phase V: Conduct second and third workshops, administer survey at the end of each workshop, and iteratively incorporate participant feedback from surveys into each subsequent workshop.

Phase VI: Data analysis and written report of recommendations for CBPR methods to engage underserved youth and families in psychological services and research.

Phase VII: Provide final results and feedback to community organization.

Results

Phases I and II: Establishing Contact and Developing Community-Academic Partnership

Outreach to the Islamic school was conducted by select study staff affiliated with the RCP, based on information gleaned from past meetings with the imam of the associated mosque about mental health need in this community. The RCP had previously attempted to partner with the imam to improve youth mental health within the congregation, resulting in two meetings focused on relationship-building, informal mental health needs assessment, and brief discussion of ideas for mental health programming at the mosque during Ramadan. However, despite an identified need for mental health education among congregants, the RCP was unsuccessful in establishing an ongoing relationship with the mosque, due to scheduling difficulties and cultural/religious barriers (e.g., imam’s English language proficiency, religious practices regarding private meeting between two members of the opposite sex, imam’s mental health literacy and stigma-related beliefs). In response, the RCP pivoted to establish contact with leadership at the Islamic school, as it was directly affiliated with the mosque and better aligned with the RCP’s focus on youth and families.
RCP staff first established contact via email with the principal of the Islamic school, followed by two face-to-face meetings to orient her to the structure and activities of RCP, its mission of improving youth mental health in local communities, and to determine interest in future collaboration. The principal expressed a strong desire to partner with the RCP to bring mental health education and training to the school, particularly given the lack of school resources for mental health support/services for students. Thus, meetings focused on mental health needs assessment, identification of shared goals, and discussion of a mental health intervention and delivery model (i.e., mental health education workshops for teachers during professional development days) to achieve those goals.

Select RCP study staff met with the principal to collaboratively develop and implement mental health workshops and research measures for all school personnel in direct contact with students. Due to factors that were hypothesized to hinder school personnel’s willingness to attend mental health-related programming (e.g., cultural mistrust, mental health-related stigma), particularly when conducted by study personnel of differing cultural/religious backgrounds, the first workshop was embedded into existing professional development programming with mandatory attendance required to ensure first contact with all relevant school personnel. Once the relationship between study personnel and the partnering Islamic school personnel was established at this first workshop, attendance at all subsequent workshops were planned to be optional. Thus, participation was expected to vary across workshops. Each workshop was expected to run for approximately 1-3 hours and was designed to be self-contained, focusing on unique mental health-related topics of interest identified by school personnel participating in the initial workshop. Study personnel conducted the workshops, utilizing the assistance of relevant community and academic consultants when proposed workshop topics fell outside the scope of
study personnel’s knowledge, experience, and/or training. Examples of consultants included licensed doctoral-level psychologists with expertise in school-based mental health and bullying interventions, Muslim chaplains, and nonprofit organizations dedicated to Muslim mental health. Consultants were expected to conduct workshops alongside study personnel when appropriate. Approval and feedback was sought from school leadership before implementation for all content for workshops, communications with outside consultants, and survey questions.

Quantitative and qualitative assessment of participant attitudes and reactions to workshops was desirable to both university and community staff. The school principal desired feedback from staff to determine proficiency level in mental health issues and to plan future professional training. Due to potential concerns about confidentiality, mental health-related stigma, discomfort with study personnel, and cultural/religious beliefs and practices around mixed-gender communications, mixed-method surveys allowing for open-ended qualitative responses were utilized in lieu of alternative methods (e.g., focus groups) to increase acceptability for participants. The web-based survey was administered via Qualtrics and was anonymous. That is, participants were not asked for any identifying information that could connect them with their survey responses, in order to increase the likelihood of participation in research procedures and encourage respondent honesty. Participants were also asked to label each completed survey with the same four-digit numerical code of their own choosing, in order to track changes in attitudes, knowledge, and stigma over time without obtaining any identifying information. Electronic consent forms were written in English, as translation of study materials were not feasible, given limited study resources and the racial/ethnic diversity of Muslim school personnel. Time was allotted at the end of each workshop to answer survey questions, in order to increase the likelihood of participation in research procedures and encourage survey completion.
Participants were provided with a link to an electronic consent form that could be completed using any electronic device with web connectivity (e.g., computer/laptop, smartphone, tablet). For the purposes of the study, tablets were provided for participants who did not have immediate access to an electronic device with web connectivity. Participants were provided opportunities to ask questions or raise concerns, and study personnel were available to respond to questions or address issues. Signed electronic consents were obtained from each participant before survey administration. Participants who provided consent were then guided to complete the web-based survey. Participants who denied consent were not precluded from participation in any subsequent workshops and would be asked to provide consent before each workshop. All procedures were approved by the Institutional Review Board (IRB) of Rutgers University.

**Phases III-VII: Workshop Development, Implementation, and Evaluation**

All results pertain to observational and survey data related to the initial workshop only, as subsequent workshops were unable to be implemented as expected. Workshop development and barriers to implementation for additional workshops are described in feasibility and acceptability sections of results.

**Participant Demographics**

Fifty school staff attended the initial workshop, and 27 completed a post-workshop survey (Table 1). Participants’ background revealed that the sample was predominately female (88.9%), fairly young with a mean age of 34.2 years (range = 23 - 56 years), and ethnically diverse (14.8% White, non-Hispanic). The majority of participants (55.6%) identified as Asian or Asian American (e.g., Afghanistan, Pakistan, Iran), followed by Middle Eastern or North African (14.8%), Other (11.1%), Multiracial (7.4%), and Black or African American (3.7%).
Unsurprisingly, the sample was highly religious, with 80.8% of participants reporting their faith was “extremely” important in their lives and 19.2% reporting it was “very” important.

All participants identified as teachers at the school. Participants’ education and training experiences revealed that the majority of the sample had received at least a bachelors level education, and possessed limited mental health education or training. Of those who responded, 29.4% of respondents endorsed that they had obtained their BA, 17.7% endorsed they had obtained their MA, and one participant reported they had obtained their EdD. 37% of participants did not provide any information regarding their education level. Most participants reported having minimal mental health education or training. Of those who responded, 47.6% or respondents reported that they had either not received any mental health education/training or relied only on informal consultation with peers/colleagues for mental health issues. 47.6% of respondents reported they had either received brief professional mental health training (e.g., day-long or multi-day workshops, webinars) or completed some formal coursework in a mental health related field (e.g., psychology, school counseling, special education). 14.3% of respondents reported having earned a bachelors degree in a mental health related field.

All 50 teachers within the school attended the workshop and stayed until the end, and 27 teachers (54% of staff) consented to participate in the survey. Completion rates for individual survey items varied, with item non-completion rates typically ranging from 3.7% to 7.4%. One item assessing educational attainment demonstrated 37% non-completion. There was full completion for all questions related to participant satisfaction and acceptability. With the exception of one item assessing change over time in knowledge about types of mental health practitioners and their various roles in mental health settings (96.3% completion rate), there was
full completion for all questions related to change over time in primary variables of interest (i.e., mental health knowledge, referral propensity).

**Feasibility of Community-Academic Partnership and Partnered Interventions/Research**

Workshop completion and attendance, participation in research procedures, and frequency of communications were used as metrics to assess the feasibility of interventions (i.e., gatekeeper workshops) developed by the CAP. Workshop content and online surveys were collaboratively developed with the school principal who served as the primary point of contact with the partnering school. The initial 90-minute workshop was successfully implemented in August 2019, during a professional development day for the school. The workshop provided psychoeducation, case vignettes to demonstrate concepts discussed in the presentation, and modeling and participant role-play of presented skills and strategies (Appendix: Workshop Objectives and Activity Outline).

As this was a private school with extremely limited resources, there was no mental health presence (e.g., guidance counselor, school psychologist) or designated persons on staff whose role was to provide emotional support or assist with referrals. Students would often turn to individual teachers for help and support, and teachers reported feeling ill-prepared to respond effectively in these situations. Consequently, workshop content focused on behavioral indicators of psychological distress across the developmental spectrum, risk and protective factors for anxiety and depression, active listening and validation skills, and safety planning. Additionally, a mental health referral directory of local providers with cultural expertise in working with Muslim youth/families and adults was also developed, with an emphasis on including clinicians providing low-cost services (e.g., insurance or Medicaid accepted, slots for pro bono cases,
sliding scale fee structure). This resource was provided to all teachers during the workshop, in addition to assistance making referrals as needed.

University partners encountered substantial barriers to development and implementation of the second workshop, due to communication difficulties and the unexpected impact of the COVID-19 pandemic. This is a commonly identified challenge associated with engaging in community work, given the level of competing demands on community partners, often limited availability of resources within partnering community organizations, and high burden associated with partnership activities (e.g., excessive time commitment, administrative tasks) that frequently hinder consistent partner communication and participation (Drahota et al., 2016). Thus, persistence is necessary for the success and sustainability of community-academic partnerships. To give the reader a sense of the perseverance required to work within the demands of a community organization, on average, the wait period between communication attempts was approximately 9-14 weeks. Four to six emails, two phone messages, and one to two in-person visits were conducted before receiving responses during each wait period. The principal’s responsiveness increased in the two weeks prior to scheduled face-to-face planning meetings and workshop dates, typically responding on the same day or within eight days of communication attempts. She did not attend a scheduled face-to-face meeting at the school in November 2019 to plan for the second workshop, and she did not respond to four emails to reschedule. She followed up via phone in February 2020 to request a face-to-face meeting to discuss planning for the second workshop, in response to multiple reported requests for further mental health education and training from teachers who had attended the first workshop. See Discussion section for more detailed analyses of the implementation challenges associated with community-academic partnerships.
The second two-hour workshop was scheduled for March 2020. Teachers did not have access to traditional school supports and services (e.g., behavioral aides or co-teachers, child study team for evaluation and accommodations) at the school, and experienced significant difficulties in managing students’ behaviors in the classroom. Teachers requested help learning strategies for behavior management and bullying. Thus, content for the second workshop was expected to focus on teaching strategies for general classroom behavior management during the first hour, followed by psychoeducation about bullying and strategies to provide emotional support for victims of bullying during the second hour. Content for the third workshop was expected to focus on strategies for bullying prevention and intervention without resorting to punishment, in order to align with Islamic beliefs and values. University partners were in collaboration with non-RCP faculty at Rutgers with expertise in social, emotional, and cognitive learning (SECL) and restorative justice practices in schools, as well as a consultant at Rider University with expertise in both Muslim/Arab American mental health and bullying prevention/intervention to develop content for the third workshop.

Unfortunately, these workshops were cancelled following school closures, due to increasing public health concerns regarding the rise of COVID-19 in New York/New Jersey. Given the uncertainty of school re-openings and cancellation of all remaining professional development days, workshops were cancelled for the remainder of the 2019-2020 school year. University partners offered to provide workshops in webinar format, in addition to providing a webinar on strategies for coping and talking to students about COVID-19. The school principal indicated that webinars would be unlikely in the period following school closures, as faculty were overwhelmed with efforts to shift classroom instruction to distance learning. She expressed
interest in a webinar focused on responses to COVID-19 but failed to respond to emails attempting to coordinate logistics.

**Participant Satisfaction and Acceptability of Partnered Interventions**

Overall, results suggested that teachers found the introductory workshop to be generally acceptable and helpful for understanding how to recognize and respond to students experiencing psychological distress (Table 2). Participants provided feedback on rating scales of 1 (Extremely Unlikely) to 5 (Extremely Likely), regarding their likelihood of both attending and encouraging peers/colleagues to attend similar mental health related events in the future, after attending the workshop. Ratings were analyzed for mean scores. Participant ratings on likelihood of attending similar mental health related events in the future ranged from 1 (extremely unlikely) to 5 (extremely likely), with a mean rating of 4.33 (SD = 0.83). Participant ratings on likelihood of encouraging peers/colleagues to attend similar mental health related events in the future ranged from 2 (somewhat unlikely) to 5 (extremely likely), with a mean rating of 4.48 (SD = 0.7). When asked to report on their overall satisfaction with the workshop on a scale of 1 (Extremely Dissatisfied) to 5 (Extremely Satisfied), participants reported that they were “somewhat satisfied” to extremely satisfied” (M = 3.96, SD = 1.29).

Qualitative feedback was also obtained, by inviting participants to answer open-ended prompts about how (if at all) attending the workshop would impact their work with youth in need of mental health services and their caregivers (Table 3). A grounded theory approach (Corbin, 2017) was used to code and analyze responses for themes. Themes that emerged included skills acquisition and enhancement (40% of comments), confidence and preparedness to manage difficulties effectively (25% of comments), openness to mental health issues and services (10% of comments), and utility of content (25% of comments). Feedback was largely positive. 90% of
all comments were positively valenced, 5% were neutral, and 5% were negatively valenced. Participants generally reported that they learned new skills and concepts as a result of attending the workshop, and the presentation enhanced and refined their understanding of previously learned skills/concepts. Specific feedback included, “[It helped me know] how to be more aware and reactive to my students,” be “more aware of how to deal with mental behaviors,” and “be more open to use good contact techniques and refer students for help.” Participants also reported that the workshop increased self-confidence and self-efficacy related to their ability to recognize and respond effectively to students in distress. One participant did report that the content was not helpful, as she was already using the presented skills and strategies with her students. Another reported that there were “certain [recommended] reactions [to student distress] that [she] would not agree with,” stating “I think the practitioners/students were well versed in their standards, however, I found my qualms to actually be with the standards not the students.” In other words, the participant felt that the workshop leaders demonstrated their professional skills well, but did not agree with the skills.

Participants were also invited to provide open-ended suggestions for improvements to future programming (Table 4). Feedback was primarily positive and suggested that participants found the workshop to be useful and relevant. Themes that emerged included demonstration of concepts and skills (47.1%), frequency of workshops (11.8%), workshop topic suggestions (17.6%), psychological theory and support (11.8%), and presentation of materials (11.8%). The most commonly received feedback involved requests for more frequent workshops and topic ideas for future workshops. Specific topics included, “dealing with issue of [students’] guilt of having problems because seen as a weakness in faith” and “techniques on how to deal with mental illness and appropriate referral process.” Participants also commonly commented on the
helpfulness of role-plays and examples, asking for more opportunities to practice and more role-play situations focused on younger children (i.e., Kindergarten to 5th Grade). One participant did suggest including more evidence for psychological concepts and interventions, stating “some people come from a different time and find them useless. Perhaps [include] statistics or reasons why these methods work better than the traditional methods.” One participant commented, “I don’t think the presentation/event was lacking in any way, however I found the standards to be binary and not complex.” Other general suggestions for improvement included having more breaks and larger font on printouts of PowerPoint presentation slides.

Perhaps the best indicators of participant satisfaction and acceptability were the teachers’ persistent requests for further programming. According to the school principal, multiple teachers “kept asking about the next workshop and when it was going to be,” which resulted in resumed communications between university and community partners in February 2020. The principal requested a face-to-face meeting to discuss scheduling and content development for the second workshop in March 2020. The principal extended an open invitation to any interested teacher at the school to attend the meeting to provide input and to serve a leadership role in program development for student mental health needs. Fourteen teachers in total (28% of all faculty) attended the one-hour meeting, with eleven teachers attending in person and three teachers attending remotely via conference call. Following this meeting, a committee of teachers was formed specifically to address professional development around mental health issues.

**Barriers and Facilitators to Mental Health Referrals**

Overall, mental health knowledge and affordability were the most frequently endorsed barriers to mental health referrals, whereas cultural factors were the most frequently endorsed facilitators for referrals (Table 5).
Beliefs/attitudes toward mental health services and treatment

When asked about factors that might have prevented or hindered teachers in the past from referring youth/families dealing with mental health difficulties for specialized mental health services in the community, 7.4% of participants endorsed the “belief that mental health treatment would not be helpful” and 14.8% endorsed “belief in solving problems within the family or with guidance from faith leaders.”

Mental health-related stigma beliefs

When asked about factors that might have prevented or hindered teachers in the past from referring youth/families dealing with mental health difficulties for services, 37% of participants endorsed “concerns about getting involved in someone else’s private business,” and 37% identified a “lack of cultural, social, or religious acceptance for mental health services.” Participants also endorsed negative word-of-mouth about mental health services and/or providers from religious leaders in the community (7.4% of participants), other members of the community (7.4% of participants), and work place colleagues in the community (3.7% of participants) as barriers to referrals.

When asked about factors that might have encouraged teachers in the past to refer such youth and families for services, participants most commonly endorsed the “family’s openness to discussing mental health issues and services” (51.8% of participants) and “social acceptance or approval from peers/colleagues in the community for discussing mental health concerns or services with youth/families” (44.4% of participants). Participants also identified “positive word-of-mouth about their experiences with mental health providers and services from trusted person in the community” (37% of participants), “support/encouragement from their place of work”
(33.3% of participants), and “support/encouragement from faith leaders” (25.9% of participants) around mental health issues and services” as facilitators for referrals.

*Mental health knowledge*

Participants most frequently (48.1% of participants) reported that their own lack of knowledge about mental illness or mental health services, generally speaking, served as a barrier to mental health referrals, and 40.7% identified no assistance with or knowledge about navigating the referral process as a barrier to referrals. Participants also identified assistance with navigating the referral process and initiating services (22.2% of participants) as a facilitator for referrals.

*Cultural factors*

Participants identified a “lack of providers who are knowledgeable about and/or share the youth/family’s racial/ethnic or religious background” (37% of participants) and “lack of providers who speak the youth/family’s language” (33.3% of participants) as barriers to referrals for mental health services. Similarly, participants reported that providers who are knowledgeable about and/or share the youth/family’s background (51.8% of participants) and speak the youth/family’s language (48.1% of participants) would encourage them to refer youth and families facing psychological difficulties for formal services.

*Socioeconomic or logistical factors*

Participants identified high appointment cost (44.4% of participants), location (33.3% of participants), and limited hours of availability or scheduling difficulties (25.9% of participants) as barriers to referrals for mental health services. Similarly, participants reported that low appointment cost (37% of participants), flexible hours (29.6% of participants), and convenient location (25.9% of participants) would serve as a facilitator for referrals.
Change in Mental Health-Related Stigma Beliefs

Participants provided feedback about changes in their degree of comfort speaking openly about mental health difficulties with various members of their community, as a result of attending the workshop (Table 6). Participants generally reported that they would feel more comfortable speaking openly with youth (74.1% of participants), parents/caregivers (63% of participants), and peers/colleagues (66.7% of participants) within the school community after attending the workshop. Participants were least likely to endorse feeling more comfortable speaking openly about mental health difficulties with faith leaders in this community (33.3% of participants).

Change in Mental Health Knowledge

Participants provided feedback about changes in their perceived knowledge about mental health, services, and systems as a result of attending the workshop on rating scales of 1 (negative valence) to 5 (positive valence). Ratings were analyzed for mean scores (Table 7). Overall, participants generally reported increases in mental health knowledge in domains corresponding to the content areas covered in the initial workshop. Participant ratings on increase in knowledge about common mental health problems and disorders affecting children and adolescents ranged from 1 (Not True at All) to 5 (Very True), with a mean rating of 4.07 (SD = 0.83). Ratings on increase in knowledge about the types of emotional or behavioral problems one could benefit from seeking counseling for ranged from 1 (Not True at All) to 5 (Very True), with a mean rating of 4.15 (SD = 0.82).

Participant ratings on domains of mental health knowledge that were not covered in the initial workshop demonstrated no change or minimal change. Ratings on increase in knowledge about different types of mental health practitioners and their various roles in mental health
settings ranged from 1 (Not True at All) to 5 (Very True), with a mean rating of 3.35 (SD = 1.36). Ratings on increase in knowledge about the location and means of contacting local mental health providers ranged from 1 (Not True at All) to 5 (Very True), with a mean rating of 3.11 (SD = 1.42). Ratings on increase in knowledge about common mental health interventions and the counseling process ranged from 1 (Not True at All) to 5 (Very True), with a mean rating of 3.44 (SD = 1.42). Ratings on increase in knowledge about the rules of confidentiality as it applies to counseling ranged from 1 (Not True at All) to 5 (Very True), with a mean rating of 3.56 (SD = 1.37).

Referred History, Behaviors, and Propensity

Referral history

Participants provided feedback about referrals they had made in the past for youth and families in need of help for mental health problems (Table 8). The most frequently endorsed referrals were faith-based programs or leaders (37% of participants), followed by therapists in a private practice setting (29.6% of participants), and pediatricians or family physicians (14.8% of participants). Participants also referred equally (7.4% of participants) to each of the following: psychiatrist or psychiatric nurse practitioner, community mental health clinic, and school-based services. It is unclear where youth/families were referred for “school-based services,” as the partnering school did not have any formal mental health related practitioners (e.g., guidance counselor, school psychologist) on site. Approximately a quarter of participants (25.9%) indicated that they had not referred any youth/families for professional help or services in the past.
Reasons for referral

Participants were asked to identify the types of mental health issues for which they would most likely refer youth and families for mental health services (Table 8). The most frequently endorsed reasons for referrals were problems considered to be “taboo” or haram (sinful) in this community, such as depressed mood (70.4% of participants), self-harm behaviors (70.4% of participants), thoughts about death and suicide (66.7% of participants), and substance abuse (63% of participants), as compared to other symptoms or problems.

Participants also reported that they would make referrals for eating disorders (55.6%); problems with peer relations, social isolation, or bullying (51.9%); attention problems and impulsive behaviors (51.9%); anxiety (48.1%); family conflict and functioning (40.7%); rule breaking and aggression (29.6%); and poor academic performance (25.9%).

Referral preferences

Participants were asked to rank, in order of most to least likely, where they would be most likely to refer youth/students who may be struggling with emotional or behavioral difficulties for help (Table 9). Of those who responded, participants most frequently ranked family members (40% of participants) as their first choice, with 28% of participants ranking mental health practitioners first, and 20% ranking pediatricians or family doctors first. Participants most frequently ranked schools second (24% of participants) for referral preference, followed by religious leaders like an imam or sheik (20% of participants) and mental health practitioners (20% of participants). Participants most frequently ranked close neighbors (36% of participants) as their least preferred referral.
Referral propensity

Results suggest that teachers would generally be more likely to encourage youth and families to seek out mental health services, as a result of attending the initial workshop (Table 2). Participants provided feedback on rating scales of 1 (Extremely Unlikely) to 5 (Extremely Likely), regarding their likelihood of encouraging youth/families in their community to seek out formal services after attending the workshop. Ratings were analyzed for mean scores. Participant ratings on likelihood of encouraging youth/families to seek out mental health services through Rutgers clinics ranged from 1 (extremely unlikely) to 5 (extremely likely), with a mean rating of 4.22 (SD = 0.85). Participant ratings on likelihood of encouraging youth/families to seek out mental health services elsewhere in the community ranged from 1 (extremely unlikely) to 5 (extremely likely), with a mean rating of 3.81 (SD = 1.04).

Referral behaviors

Following completion of the initial workshop, four teachers reached out to study personnel to request assistance with referrals. Study personnel conducted brief assessments over the phone, in order to identify the most appropriate mental health settings and services to address relevant needs. Referral options were discussed, and study personnel provided psychoeducation about the overall referral and therapy process (e.g., intake process, confidentiality, payment options, structure of therapy sessions). Study personnel were available to troubleshoot and facilitate all teacher referrals, in addition to following up to ensure families had been connected to care. Four families were successfully engaged in services for youth depression/anxiety, interpersonal problems, and trauma.
Discussion

The current study examined the effectiveness of a community-based participatory research (CBPR) model to develop and implement mental health education and literacy programming for teachers at a local parochial Islamic school, with the aim of improving factors related to referral propensity among local “gatekeepers” to youth mental health services. The goals of this project were to (a) describe and discuss the process of establishing and sustaining a community-academic partnership (CAP) with an underserved and under-resourced school community, (b) develop a list of recommendations to enhance feasibility, acceptability, and sustainability of CAPs and their interventions to address disparities in access and utilization of services among local underserved communities, (c) evaluate the feasibility and acceptability of interventions developed and implemented by the CAP, and (d) gather and review both quantitative and qualitative data related to changes in teachers’ attitudes toward mental health services, stigma-related beliefs, mental health knowledge, and referral propensity and behaviors as a function of attending the workshops.

In terms of forming the collaboration, community outreach efforts by university partners at Rutgers quickly resulted in two face-to-face meetings with the principal of the partnering school to define shared values and goals, conduct a brief informal mental health needs assessment, and discuss potential interventions and delivery models. The CAP was easily established, but as is typically the case, the process of sustaining the relationship proved to be more difficult. There are a number of possible explanations for identified challenges to sustainability.

Establishing consistent communications with the school principal was difficult for a variety of reasons, a common challenge when engaging with community partners. First, she
served as the only point of contact with the school, which contributed to difficulties in establishing a timeline and receiving input related to intervention development and implementation. Further, there was limited access to her contact information. Initially, the only available communication modality was the principal’s school email address, in addition to a secondary email address that was provided at a later date. Her phone number was not publicly available on the school website or faculty directory, and both the principal and school administrators appeared uncomfortable with sharing it with university partners, likely to build boundaries and avoid being inundated with work-related calls from multiple sources. Ultimately, the principal did share her phone number just prior to the second scheduled workshop to facilitate ease of communications, but it was difficult to assess its impact as the second workshop was cancelled shortly thereafter due to COVID-19 related school closures. Second, the principal had finite availability and resources to devote to the collaboration, which was likely related to apparent limited funding and understaffing at all levels of the organization. Thus, despite her interest in collaborating with the RCP, it may have been difficult to attend or respond to communications from university partners given her other competing demands and myriad responsibilities. In her communications, she consistently apologized for delays in responding due to workload, expressed appreciation for our efforts to reach out, and emphasized her continued interest in project involvement.

Finally, it is also possible that it was difficult to arrange scheduling or prioritize workshop implementation, due to lack of teacher buy-in for mental health workshops. During the initial needs assessment, the principal had expressed some concerns about the acceptability of interventions and perceived cultural competency of workshop presenters, as university partners did not visibly appear to share the same cultural or faith background as that of the school
community. Cultural mistrust toward non-Muslim university partners were likely exacerbated by stigma related to mental health interventions and research, as well as lack of access to and opportunities for direct relationship-building between teachers and university partners in the early stages of establishing the CAP.

To address these challenges, we have outlined a list of specific recommendations to enhance the feasibility, acceptability, and sustainability of CAPs and their interventions among local underserved communities:

1. **Identify multiple points of contact** within a community organization to increase:
   
   (a) consistency of communication between community and university partners, (b) validity of needs assessments, and (c) acceptability and relevance of interventions. These contacts should represent a range of identities, perspectives, and roles within the community organization, in order to increase validity. For this study, an open invitation was extended to all interested teachers at the school to participate in a face-to-face meeting with university partners and the principal, in order to discuss planning for the second workshop. As stated earlier, 14 teachers attended the meeting and were representative of faculty from each educational stage (e.g., elementary school, middle school, high school), although it may have been helpful to diversify teacher demographics (e.g., age, sex, race/ethnicity). This meeting functioned as an informal focus group to discuss the school’s most urgent mental health needs from teachers’ perspectives and determine content for the next three upcoming workshops. The self-selected group of teachers who presented to this meeting were the most invested in mental health education for faculty, electing to create a committee to take on a larger role in workshop development and the CAP.
Following this meeting, they were included in all subsequent emails with the school principal. Outcomes resulted in: (a) more consistent communication between community and university partners leading up to the second workshop, (b) deeper and more thorough understanding of systemic barriers to students’ mental health and related needs, and (c) increased nuance and relevance of content for upcoming workshops, and development of a tiered approach to workshop implementation. Teachers provided the feedback that workshops focused specifically on psychoeducation about the mental health system and navigating the referral process would not be relevant for all faculty, as most teachers referred students with suspected emotional/behavioral difficulties to the principal or this smaller group of teachers for assistance. Thus, it was requested that these workshops be implemented only for this newly formed committee of teachers, for transfer-of-knowledge to other colleagues/peers who might be more receptive to receiving this information from trusted persons within their own community. Workshops providing psychoeducation and skills relevant to teachers’ daily occupational functioning (e.g., classroom behavior management, bullying prevention/intervention) were planned to be implemented for all staff.

2. **Develop and implement a structured check-in system** (e.g., bi-weekly phone/videoconference calls, bi-monthly face-to-face meetings) to maintain reliable and consistent contact with community partners, obtain ongoing feedback about strengths and weaknesses of the CAP and its processes, and provide greater opportunities for university partners to address feedback and concerns in a timely fashion. Relatively, it may be beneficial to **clearly define each stakeholder’s role**
within the CAP, in order to avoid diffusion of responsibility, encourage active participation of all community stakeholders, and reduce burden. For example, creating subgroups of teachers (e.g., elementary school) to discuss relevant ideas and concerns pertaining to group interests, and identifying one spokesperson per subgroup tasked with participating in weekly/monthly check-in meetings and organizing subgroup activities. Implementing an anonymous feedback mechanism (e.g., Qualtrics survey) where teachers at the school could provide direct feedback to university partners at any time would encourage honesty, without fear of negative social or professional consequences.

3. Be proactive! Establish timelines for completion of action steps, and schedule important dates in advance when engagement and motivation is high. It is easier to adjust or modify existing plans, rather than mobilizing group efforts at times when there may be less momentum and increasing demands on all partners.

Further, it may be necessary to engage community partners in collaborative problem-solving for anticipated challenges early on in the research process (e.g., communication lapses, school cancellations), in order to be aware of potential cracks in the system and address them effectively. This process may also serve to identify organizational strengths or existing systems to support effective communication and prevent barriers to implementation. For instance, it may have been possible for RCP meetings to be naturally incorporated into existing monthly staff or curriculum meetings for improved sustainability, rather than developing new mechanisms for communication/participation and increase partner burden.

This process may also function as a self-check for community stakeholders,
regarding their readiness and capacity for participation in the community-academic partnership.

4. **Demonstrate that we value their feedback, by addressing concerns quickly and communicating our efforts to do so.** Not unexpectedly, there were initial concerns about cultural competency and, although university partners consistently worked to build cultural competency and engage the assistance of cultural brokers, these efforts were not well communicated to community partners. For instance, university partners recruited the help of several consultants at Rutgers, including a chaplain of the Center for Islamic Life at Rutgers University and a clinician specializing in Muslim mental health at the university counseling center. Non-Rutgers consultants were also recruited to co-lead workshops and contribute to content development, including the Communications Manager at the Family Youth Institute for Muslim mental health and a Professor at Rider University with clinical/research expertise in school bullying interventions for Muslim youth. Rather than merely updating community partners about these developments via email, it may have been helpful to “e-introduce” and include consultants in email communications, include consultants in phone calls and meetings, etc.

5. **Invest in more relationship building** to foster rapport and trust between community and university partners! In order to emphasize the bidirectional nature of the CAP, it is helpful to engage in a **consistent exchange of knowledge and tangible resources** with community stakeholders. Some easy ways to do this are by providing relevant resources (e.g., COVID-19 resources for schools, community-specific referral lists etc.), sharing all survey results with stakeholders,
and sending small tokens of appreciation following events or meaningful interactions (e.g., fruit basket of figs and apples).

The current study also gathered and reviewed quantitative and qualitative survey data to assess feasibility and acceptability of the CAP and mental health education workshops, identify strengths and weaknesses of workshops and the CBPR process with an underserved community, and gain an improved understanding of factors related to mental health referral propensity and behaviors. 50 teachers attended the first workshop, and 27 participated in research procedures following completion of the first workshop. The second workshop was scheduled but not implemented.

Results generally demonstrated acceptable feasibility for both the CAP and workshops, and identified challenges to be addressed for improved feasibility and sustainability of efforts. Of note, only one workshop was fully implemented, due to persistent communication difficulties with community partners involving an average of 9-14 weeks between communication attempts. As discussed, changes were being implemented between the first and second workshops to address communication and related difficulties, and the second workshop had been successfully scheduled for March 2020. However, university partners were unable to evaluate the impact of these changes or successfully implement subsequent workshops, due to the unexpected impact of COVID-19 on school procedures in March 2020. Moderate research participation was evidenced from the first workshop, with 54% of teachers participating in the online survey. Among those who did participate, there were high survey completion rates with only 3.7 to 7.4% item non-completion on average.

Overall, results also demonstrated high acceptability of workshops, based on review of quantitative and qualitative data obtained from the online survey. Teachers generally reported
being “somewhat satisfied” or “extremely satisfied” with the workshop, and several teachers were reported to make frequent requests for further mental health programming following this workshop. On average, teachers reported that they would be “somewhat likely” or “extremely likely” to both attend and encourage colleagues/peers to attend similar mental health related events in the future. 90% of all open-ended comments pertaining to the usefulness of workshop content were positively valenced, with teachers generally reporting that they learned or refined their understanding of skills/concepts presented in the workshop, and experienced improved confidence and self-efficacy related to their ability to recognize and respond effectively to students experiencing psychological distress. Similarly, feedback pertaining to areas for improvement was primarily positive, with the majority of comments related to requests for increased frequency of workshops, suggested content for future workshops, and helpfulness of role plays and examples. Suggested improvements included requests for larger font on materials, more frequent breaks, more role plays and examples geared toward early childhood and elementary school aged youth, and more research supporting the efficacy of skills/concepts presented in the workshop.

Overall, results indicated that lack of knowledge about mental illness, mental health services, and the referral process was the greatest barrier within this sample to mental health referrals, rather than attitudes toward mental health services or mental health stigma-related beliefs. Social approval of mental health services from members of their community (e.g., students’ families, peers/colleagues, religious leaders, other trusted persons) and support/encouragement from their place of work emerged as important facilitators to referrals among this sample, along with cultural competency of providers which emerged as the most frequently endorsed facilitator. These findings are consistent with previous theories of planned behavior (Ajzen, 1985), which
posits that the intention to engage in a particular behavior (i.e., referrals for mental health services) is a function of one’s perceived ability to execute that behavior effectively and social approval of the behavior from important others, as much as it is a function of attitudes toward the behavior itself. Findings also provide support for study interventions aimed at improving factors related to mental health referral propensity. By increasing mental health knowledge via gatekeeper workshops, and providing instrumental support and assistance with referrals, teachers’ willingness to refer youth and families for services was hypothesized to increase. Similarly, referral propensity was expected to increase following gatekeeper workshops, by normalizing mental health problems and services and increasing institutional/peer support for referral behaviors and services.

Although only one workshop was implemented, preliminary survey data shows promise for the effectiveness of these interventions in improving factors related to mental health referral propensity. Specifically, results indicated that the gatekeeper workshop increased mental health knowledge and decreased stigma-related beliefs. Teachers generally endorsed increased knowledge about common mental health problems affecting youth and the types of emotional/behavioral problems that could benefit from treatment, as a result of attending the gatekeeper workshop. Although there is limited data on Muslim mental health, results are consistent with the burgeoning literature on the effectiveness of mental health education and training programs for gatekeepers in faith-based contexts with other cultural groups (Williams, Gorman, & Hankerson, 2014). For instance, Anthony et al. (2016) found that a depression-specific training workshop for African American clergy resulted in changed beliefs about the causes of depression and helpfulness of health/mental health providers in treating depression, as well as increased knowledge about depressive symptoms and effective methods of treating
depression. More than 75% of teachers also endorsed greater comfort with openly discussing mental health issues with students and their parents/caregivers, and two-third of teachers reported feeling more comfortable discussing mental health issues with peers/colleagues as a function of attending the workshop. These findings are significant, as teachers in this sample identified lack of mental health knowledge, and social approval and institutional support for referrals/services as the greatest barrier and facilitator to mental health referrals, respectively. Teachers must feel that discussion of mental health problems and services with both youth/families and peers/colleagues in the workplace is an acceptable and supported behavior, in order to be willing to make referrals for students and their families. Preliminary data also demonstrate that mental health workshops may be effective in increasing teachers’ mental health referral propensity. On average, teachers reported that they would be more likely to encourage youth and families to seek out mental health services through Rutgers clinics, and to a lesser degree, elsewhere in the community as a result of attending the workshop.

In terms of referral preferences and history, teachers generally indicated a preference for informal services or family help/support for students suspected of experiencing mental health difficulties. Teachers who had referred youth/families for help in the past reported that they had most commonly referred youth/families to faith-based programs or leaders (e.g., imam), and teachers most frequently endorsed that they would be most likely to refer youth with mental health problems to family members for help over formal health/mental health services. Results are consistent with the literature on patterns of help-seeking behaviors among Muslims that indicate a preference for family and religious resources (Al-Krenawi, 2002). The most frequently endorsed reasons for referrals were problems considered to be “taboo” or haram (sinful) in this community, such as suicidality/self-harm and substance abuse, as compared to other mental
health problems or disorders. This is also consistent with previous findings, which demonstrate tendencies to attribute psychiatric symptoms to personal weakness or religious failings within the Muslim community (Vogel, Wade, & Hackler, 2007). It is possible that the presence of stigma-related beliefs and/or negative attitudes about mental health services contribute to a belief that most other emotional/behavioral problems are more appropriately addressed within the family or cultural/faith community.

**Limitations**

Several limitations were identified for the current study. First, the sample size was small, due to low research participation and the inability to implement more than one workshop. The sample was also predominately female, which further limits the generalizability of results, although the sample was diverse in terms of racial/ethnic identity and education level. Additionally, the over-representation of female teachers in this sample was reflective of the overall faculty demographics at the school. (Only 4 out of 50 teachers in the school were male.) Future studies may benefit from further diversifying their sample populations. Second, responses were self-reported, which may have been impacted by various biases (e.g., sampling bias, social desirability) and decreased validity. Third, consideration of other study settings (e.g., mosque, other Muslim community organizations) may have increased generalizability of results to broader Muslim populations.

Many of the known barriers to service utilization among Muslim Americans may also have hindered research participation in this sample, including mental health stigma, cultural mistrust of mental health research, and concerns about confidentiality. Teachers may have been concerned about their survey responses being identifiable to peers/colleagues, as well as any potentially negative professional or social consequences associated with their participation in the
survey. For future workshops, it may be helpful to spend more time discussing confidentiality issues and protections of data throughout the consent process, in addition to reiterating that survey data will only be shared in aggregate with school leadership to mitigate some of these issues. Research participation may also have increased over the course of multiple workshops, as teachers received greater exposure to mental health concepts and strengthened relationships with university partners. Some teachers were also observed translating written materials for others and/or assisting with web connectivity during the workshop. Thus, limited technology and English language proficiency may have impacted survey participation for a small subset of teachers. Options to complete online or paper versions of the survey may increase future research participation. Given the cultural heterogeneity of the sample and lack of information about teachers’ preferred languages, Arabic translation may not be the most efficient use of study resources.

Conclusions and Future Directions

Although only preliminary data was collected, the current study provides a thorough description of the CBPR process and contributes to the literature, by demonstrating the utility and value of CBPR in engaging underserved populations in research and services. Unlike traditional methods of research, study personnel are able to obtain ongoing feedback from participants at each stage of the research process, allowing for the unique opportunity to make iterative procedural adjustments to increase the acceptability and cultural appropriateness of interventions. Further, while a common challenge associated with CBPR in the mental health arena is a lack of psychological researcher expertise within community settings/contexts (Stacciarini, Shattel, Coady, & Wiens, 2011), the current study was able to draw upon university resources and expertise to develop and implement culturally appropriate interventions with
community partners. Although collaborations are still in its infancy, preliminary results contribute to the burgeoning literature on the feasibility, acceptability, and effectiveness of CBPR methods to address disparities in access and utilization of child mental health services with minority populations (Breland-Noble, 2011; Mehta et al., 2019). Findings also add to the dearth of mental health research with Muslims who represent a significantly understudied, underserved, and vulnerable population in the United States. Future studies should make use of the above recommendations to further refine, implement, and evaluate the CBPR model in school/child contexts with Muslim and other underserved populations.
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### Table 1.

**Participant Demographics**

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<td>6</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

Notes: “Other” racial/ethnic backgrounds were not specified by respondents; “Other” responses for degrees obtained in a mental health related profession included completion of 14 psychology credits and BA in progress; responses for religiosity were rated on a scale of 1 (extremely important) to 4 (not at all important).
Table 2.

*Participant Satisfaction and Referral Propensity*

<table>
<thead>
<tr>
<th></th>
<th>M (SD)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall satisfaction with workshop</td>
<td>3.96 (1.29)</td>
<td>1-5</td>
</tr>
<tr>
<td>Likelihood of attending similar event in future</td>
<td>4.33 (0.82)</td>
<td>1-5</td>
</tr>
<tr>
<td>Likelihood of encouraging colleagues/peers to attend similar event in future</td>
<td>4.48 (0.69)</td>
<td>2-5</td>
</tr>
<tr>
<td>Likelihood of encouraging youth/families to seek out services through Rutgers clinics</td>
<td>4.22 (0.83)</td>
<td>1-5</td>
</tr>
<tr>
<td>Likelihood of encouraging youth/families to seek out services elsewhere in community</td>
<td>3.81 (1.02)</td>
<td>1-5</td>
</tr>
</tbody>
</table>

Notes: responses for overall satisfaction with workshop were rated on a scale of 1 (extremely dissatisfied) to 5 (extremely satisfied); responses for likelihood of attending or encouraging others to attend similar programming were rated on a scale of 1 (extremely unlikely) to 5 (extremely likely).
Table 3.

*Themes of Qualitative Feedback related to Workshop Impact*

<table>
<thead>
<tr>
<th></th>
<th>Total number of comments</th>
<th>Percent of total comments</th>
<th>Positive valence</th>
<th>Neutral valence</th>
<th>Negative valence</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills acquisition and</td>
<td>8</td>
<td>40%</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>Make me better at responding to students and validating their behaviors</td>
</tr>
<tr>
<td>enhancement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidence and preparedness</td>
<td>5</td>
<td>25%</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>It would prepare me to deal with concerning situation</td>
</tr>
<tr>
<td>to manage difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Openness to mental health</td>
<td>2</td>
<td>10%</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>I’ll be more open to use good contact techniques, and refer students for</td>
</tr>
<tr>
<td>issues and services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>help.</td>
</tr>
<tr>
<td>Utility of content</td>
<td>5</td>
<td>25%</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>I already know the methods of active listening from a book I read and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>apply them in my dealings with students.</td>
</tr>
<tr>
<td>Total number of comments</td>
<td>20</td>
<td></td>
<td>18</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.

*Themes of Qualitative Feedback related to Suggested Improvements*

<table>
<thead>
<tr>
<th></th>
<th>Total number of comments</th>
<th>Percent of total comments</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstration of concepts and skills</td>
<td>8</td>
<td>47.1%</td>
<td>Role play is very helpful. Creating a situation gives us a more clear picture.</td>
</tr>
<tr>
<td>Frequency of workshops</td>
<td>2</td>
<td>11.8%</td>
<td>Have more frequent workshops on classroom-related issues</td>
</tr>
<tr>
<td>Workshop topic suggestions</td>
<td>3</td>
<td>17.6%</td>
<td>Bullying issues, how to help students overcome the stress</td>
</tr>
<tr>
<td>Psychological theory and support</td>
<td>2</td>
<td>11.8%</td>
<td>Some people come from a different time and find this useless. Perhaps statistics or reasons why these methods work better than the traditional methods.</td>
</tr>
<tr>
<td>Presentation of materials</td>
<td>2</td>
<td>11.8%</td>
<td>Slides printout has really small print, can’t read comfortably</td>
</tr>
<tr>
<td>Total number of comments</td>
<td>17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5.

**Barriers and Facilitators to Mental Health Referrals**

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family’s openness to discussing mental health issues/services</td>
<td>14</td>
<td>51.9%</td>
</tr>
<tr>
<td>Providers who speak family’s language</td>
<td>14</td>
<td>51.9%</td>
</tr>
<tr>
<td>Providers who are knowledgeable about and/or share family’s background</td>
<td>13</td>
<td>48.2%</td>
</tr>
<tr>
<td>Social acceptance/approval from peers/colleagues</td>
<td>12</td>
<td>44.4%</td>
</tr>
<tr>
<td>Positive word-of-mouth from trusted persons in community</td>
<td>10</td>
<td>37.0%</td>
</tr>
<tr>
<td>Low appointment cost</td>
<td>10</td>
<td>37.0%</td>
</tr>
<tr>
<td>Support/encouragement from workplace</td>
<td>9</td>
<td>33.3%</td>
</tr>
<tr>
<td>Flexible hours</td>
<td>8</td>
<td>29.6%</td>
</tr>
<tr>
<td>Support/encouragement from faith leaders</td>
<td>7</td>
<td>25.9%</td>
</tr>
<tr>
<td>Convenient location</td>
<td>7</td>
<td>25.9%</td>
</tr>
<tr>
<td>Assistance navigating referral process and initiating services</td>
<td>6</td>
<td>22.2%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Barriers</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant’s lack of knowledge about mental health issues/services</td>
<td>13</td>
<td>48.2%</td>
</tr>
<tr>
<td>High appointment cost</td>
<td>12</td>
<td>44.4%</td>
</tr>
<tr>
<td>No assistance with/knowledge about navigating referral process or initiating services</td>
<td>11</td>
<td>40.7%</td>
</tr>
<tr>
<td>Concerns about getting involved in someone’s private business</td>
<td>10</td>
<td>37.0%</td>
</tr>
<tr>
<td>Lack of cultural/social/religious acceptance or support</td>
<td>10</td>
<td>37.0%</td>
</tr>
<tr>
<td>Lack of providers who are knowledgeable about and/or share family’s background</td>
<td>10</td>
<td>37.0%</td>
</tr>
<tr>
<td>Location</td>
<td>9</td>
<td>33.3%</td>
</tr>
<tr>
<td>Lack of providers who speak family’s language</td>
<td>9</td>
<td>33.3%</td>
</tr>
<tr>
<td>Limited hours/scheduling issues</td>
<td>7</td>
<td>29.6%</td>
</tr>
<tr>
<td>Belief in solving problems within family or with faith leaders</td>
<td>4</td>
<td>14.8%</td>
</tr>
<tr>
<td>Belief that mental health treatment would not be helpful</td>
<td>2</td>
<td>7.4%</td>
</tr>
<tr>
<td>Negative word-of-mouth from religious leaders</td>
<td>2</td>
<td>7.4%</td>
</tr>
<tr>
<td>Negative word-of-mouth from other members of community</td>
<td>2</td>
<td>7.4%</td>
</tr>
<tr>
<td>None (would refer regardless of any of these issues)</td>
<td>2</td>
<td>7.4%</td>
</tr>
<tr>
<td>Negative word-of-mouth from workplace colleagues in community</td>
<td>1</td>
<td>3.7%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
Table 6.

*Increased comfort with speaking openly about psychological difficulties with members of school community as a result of attending workshop (select all that apply)*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth/students</td>
<td>20</td>
<td>74.1%</td>
</tr>
<tr>
<td>Peers/colleagues or leaders</td>
<td>18</td>
<td>66.7%</td>
</tr>
<tr>
<td>Parents/caregivers</td>
<td>17</td>
<td>63.0%</td>
</tr>
<tr>
<td>Religious leaders</td>
<td>9</td>
<td>33.3%</td>
</tr>
</tbody>
</table>
Table 7.

*Change in Mental Health Knowledge*

<table>
<thead>
<tr>
<th></th>
<th>M (SD)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common youth mental health problems/disorders</td>
<td>4.07 (0.81)</td>
<td>1-5</td>
</tr>
<tr>
<td>Types of emotional/behavioral problems that could benefit from counseling</td>
<td>4.15 (0.80)</td>
<td>1-5</td>
</tr>
<tr>
<td>Types of mental health practitioners and roles</td>
<td>3.35 (1.33)</td>
<td>1-5</td>
</tr>
<tr>
<td>Location and means of contacting local mental health providers</td>
<td>3.11 (1.40)</td>
<td>1-5</td>
</tr>
<tr>
<td>Common mental health interventions and what is involved in counseling process</td>
<td>3.44 (1.40)</td>
<td>1-5</td>
</tr>
<tr>
<td>Rules of confidentiality as it applies to counseling</td>
<td>3.56 (1.34)</td>
<td>1-5</td>
</tr>
</tbody>
</table>

Note: responses rated on a scale of 1 (not true at all) to 5 (very true).
Table 8.

Referral History and Behaviors

<table>
<thead>
<tr>
<th>Past referrals (select all that apply)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faith-based program or leaders</td>
<td>10</td>
<td>37.0%</td>
</tr>
<tr>
<td>Therapist in private practice setting</td>
<td>8</td>
<td>29.6%</td>
</tr>
<tr>
<td>Have never referred youth/families for professional help or services</td>
<td>7</td>
<td>25.9%</td>
</tr>
<tr>
<td>Pediatrician or family physician</td>
<td>4</td>
<td>14.8%</td>
</tr>
<tr>
<td>Community mental health clinic</td>
<td>2</td>
<td>7.4%</td>
</tr>
<tr>
<td>Psychiatrist or psychiatric nurse practitioner</td>
<td>2</td>
<td>7.4%</td>
</tr>
<tr>
<td>School-based services</td>
<td>2</td>
<td>7.4%</td>
</tr>
<tr>
<td>Intensive Outpatient Program (IOP) or Intensive Day Treatment (IDT)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Partial Hospitalization Program (PHP)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Residential treatment program</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Inpatient hospital program</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health issues most likely to refer for services (select all that apply)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-harm behaviors</td>
<td>19</td>
<td>70.4%</td>
</tr>
<tr>
<td>Depressed mood</td>
<td>19</td>
<td>70.4%</td>
</tr>
<tr>
<td>Thoughts about death and suicide</td>
<td>18</td>
<td>66.7%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>17</td>
<td>63.0%</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>15</td>
<td>55.6%</td>
</tr>
<tr>
<td>Peer relations, social isolation, or bullying</td>
<td>14</td>
<td>51.9%</td>
</tr>
<tr>
<td>Attention problems or impulsive behaviors</td>
<td>14</td>
<td>51.9%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>13</td>
<td>48.1%</td>
</tr>
<tr>
<td>Family conflict and family functioning</td>
<td>11</td>
<td>40.7%</td>
</tr>
<tr>
<td>Rule breaking and aggression</td>
<td>8</td>
<td>29.6%</td>
</tr>
<tr>
<td>Poor academic performance</td>
<td>7</td>
<td>25.9%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
Table 9.

*Teacher preferences for mental health referrals*

<table>
<thead>
<tr>
<th>Source</th>
<th>First (most likely)</th>
<th>Second</th>
<th>Third</th>
<th>Fourth</th>
<th>Fifth</th>
<th>Sixth (least likely)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family members</td>
<td>10 (40%)</td>
<td>4 (16%)</td>
<td>3 (12%)</td>
<td>7 (28%)</td>
<td>1 (4%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Mental health practitioners</td>
<td>7 (28%)</td>
<td>5 (20%)</td>
<td>4 (16%)</td>
<td>3 (12%)</td>
<td>3 (12%)</td>
<td>3 (12%)</td>
</tr>
<tr>
<td>Pediatric or family doctor</td>
<td>5 (20%)</td>
<td>2 (8%)</td>
<td>4 (16%)</td>
<td>6 (24%)</td>
<td>2 (8%)</td>
<td>6 (24%)</td>
</tr>
<tr>
<td>School</td>
<td>2 (8%)</td>
<td>6 (24%)</td>
<td>4 (16%)</td>
<td>5 (20%)</td>
<td>4 (16%)</td>
<td>4 (16%)</td>
</tr>
<tr>
<td>Religious leaders</td>
<td>1 (4%)</td>
<td>5 (20%)</td>
<td>7 (28%)</td>
<td>2 (8%)</td>
<td>7 (28%)</td>
<td>3 (12%)</td>
</tr>
<tr>
<td>Close friends or neighbors</td>
<td>0 (0%)</td>
<td>3 (12%)</td>
<td>3 (12%)</td>
<td>2 (8%)</td>
<td>98 (32%)</td>
<td>9 (36%)</td>
</tr>
</tbody>
</table>
Appendix

Community Leaders Survey

Thank you so much for participating in today’s events!

Please remember that all of your answers will remain strictly confidential, and there will be no identifying information (e.g., name, contact information) connecting your responses to you.

Code #: __________

1. In the capacity of your job, you may have worked with a youth/student whom you thought was dealing with issues related to mental health (e.g., anxiety, stress, depressed mood, behavioral issues). What factors might have encouraged you to refer the youth/family to seek specialized mental health services in the community? Select all that apply.
   a. Convenient location
   b. Flexible hours (e.g., weekends, evenings)
   c. Low appointment cost (e.g., accepts insurance, sliding scale payment)
   d. Providers who speak the youth/family’s language
   e. Providers who are knowledgeable about and/or share the youth/family’s background (e.g., race/ethnic identity, religion, gender/sexual orientation)
   f. Assistance with navigating the referral process and initiating services
   g. Family’s openness to discussing mental health issues and services
   h. Support/encouragement from faith leaders around mental health issues and services
   i. Positive word-of-mouth about their experiences with mental health providers/services from trusted persons in my community
   j. Social acceptance or approval from peers/colleagues in this community for discussing mental health concerns or services with youth/families
   k. Support/encouragement from my place of work/organization around mental health issues and services
   l. Belief that counseling/therapy is as effective as medication or faith alone in treating mental health problems and related difficulties.
   m. Other ________
2. In the capacity of your job, you may have worked with a youth/student whom you thought was dealing with issues related to mental health (e.g., anxiety, stress, depressed mood, behavioral issues). What factors might have prevented or hindered you to refer the youth/family to seek specialized mental health services in the community? Select all that apply.

a. Location (e.g., long distance from where I live, inaccessible via public transportation)
b. Limited hours/scheduling issues (e.g., no weekends or evenings)
c. High appointment cost
d. Lack of providers who speak the youth/family’s language
e. Lack of providers who are knowledgeable about and/or share the youth/family’s background (e.g., race/ethnicity, religion, gender/sexuality)
f. No assistance with or knowledge about mental illness or mental health services generally speaking
g. Belief that people should be given the privacy to work out their own problems
h. Concerns that referring a youth/family for mental health services would be embarrassing or shameful for them
i. Fear of negative social consequences for the youth/family if others in their community were to learn of the mental health referral
j. Lack of cultural, social, or religious acceptance for mental health services
k. Belief that mental health treatment would not be helpful
l. Belief in solving problems within the family or with guidance from faith leaders
m. Belief that having strong faith and being very diligent in prayer or recitation of the Holy Koran can treat or cure mental illness more effectively than mental health services.

n. Negative past experiences with or negative word-of-mouth about mental health services and/or providers from religious leaders in my community
o. Negative past experiences with or negative word-of-mouth about mental health services and/or providers from other members of my community
p. Negative past experiences with or negative word-of-mouth about mental health services and/or providers from work place colleagues in my community
q. Other ________________
r. None (I would refer youth/families for mental health services, regardless of any of these issues.)

3. Where (if any) have you referred youth/families in this community for help with mental health problems in the past? Select all that apply.

a. Pediatrician or family physician
b. Faith-based program or leaders (e.g., imam)
c. Therapist in a private practice setting
d. Psychiatrist or nurse practitioner
e. Community mental health clinic
f. Intensive Outpatient Program (IOP) or Intensive Day Treatment (IDT) program
g. School-based services (e.g., guidance counselor, school psychologist, etc.)
h. Partial Hospitalization Program (PHP)
i. Inpatient hospital setting
j. Residential treatment program (RDT)
k. Other: ________________
l. I have not referred any youth/families for help or services.
4. For what mental health issues are you most likely to make referrals for mental health services in the community? Select all that apply:
   a. Anxiety
   b. Depressed mood
   c. Thoughts about death or suicide
   d. Self-harm behaviors (e.g., cutting)
   e. Substance abuse
   f. Family conflict and family functioning
   g. Peer relations, social isolation, or bullying
   h. Attention problems and impulsive behaviors
   i. Poor academic performance
   j. Rule breaking or aggression
   k. Eating disorders (e.g., food restriction, binging and purging, etc.)
   l. Other: ______________

5. After today’s event, I feel more knowledgeable about… [LIKERT SCALE 0-5, 0= NOT TRUE AT ALL TO 5= VERY TRUE]
   a. …common mental health problems and disorders affecting children and adolescents
   b. …what types of emotional or behavioral problems one could benefit from seeking counseling for
   c. …different types of mental health practitioners and their various roles in mental health settings
   d. …the location and means of contacting local mental health providers
   e. …common mental health interventions and what is involved in the counseling process
   f. …the rules of confidentiality, as it applies to counseling

6. After today’s event, I feel more comfortable speaking openly about mental health difficulties to (select all that apply)…
   a. …youth in this community
   b. …parents/caregivers in this community
   c. …peers/colleagues in this community
   d. …leaders in this community

7. After today’s events, I would be more likely to: [LIKERT SCALE 0-5, 0= EXTREMELY UNLIKELY TO 5= EXTREMELY LIKELY]
   a. …attend a mental health related event like this in the future
   b. …encourage colleagues/peers to attend a mental health related event like this in the future
   c. …encourage youth/families in this community to seek out mental health services through the Rutgers clinics
   d. … encourage youth/families in this community to seek out mental health services elsewhere in the community
8. When confronted with a youth/student who may be struggling with emotional or behavioral difficulties, where would you be most likely to refer them for help? Please rank, in order of most to least likely.
   a. Pediatrician/family doctor
   b. Family members
   c. Religious leaders (e.g., imam)
   d. Mental health practitioners
   e. Close friends/neighbors
   f. Youth’s school

9. What do you believe causes youth to experience psychological problems or emotional/behavioral difficulties? Please select all that apply.
   a. Evil spirits cause such problems and difficulties.
   b. These problems and difficulties are inherited.
   c. Biological changes in the brain cause such problems and difficulties.
   d. These problems and difficulties are the outcome of sinful acts or moral weakness.

10. How satisfied were you with today’s events? [LIKERT SCALE 0-5, 0= EXTREMELY SATISFIED TO 5= EXTREMELY DISSATISFIED]

11. How will attending this event impact your work with youth in need of mental health services and their caregivers? [OPEN TEXT BOX]

12. In what ways (if any) could we improve events like this in the future? [OPEN TEXT BOX]

13. Age: ___

14. Sex:
   a. Male
   b. Female

15. Race/Ethnic Identity (select all that apply):
   a. American Indian or other Native American
   b. Asian, Asian American, or Pacific Islander
   c. Black or African American
   d. Caribbean/West Indian
   e. Middle Eastern or North African
   f. White (non-Hispanic)
   g. Hispanic or Latino
   h. Multiracial
   i. Other: __________
16. How would you describe your role or title within the specific community that is participating in this event today? [OPEN TEXT BOX]

17. How important is faith/spirituality in your life? [LIKERT SCALE 0-5, 0= EXTREMELY IMPORTANT TO 5= NOT AT ALL IMPORTANT]

18. What is your highest degree obtained in a mental health related profession (if applicable)?
   a. AAS/AA/AS/ABS/AAT
   b. BA/BS/RN
   c. MA/MS/MSW/MHC/LMFT/LCSW/LPCC
   d. EdS
   e. APN/NP
   f. PhD
   g. PsyD
   h. EdD
   i. MD/DO
   j. Other ___________________

19. Please describe any training or education you have received in working with youth/students around the issues of mental health (e.g., anxiety, stress, depressed mood, behavioral issues):  
   a. I have earned an advanced degree (masters, doctorate) in a mental health, counseling, or related field 
   b. I have earned a bachelors degree in a mental health, counseling, or related field (e.g., psychology, school counseling, special education, psychiatric nursing). 
   c. I have taken some formal coursework but have not earned any degree in a mental health, counseling, or related field (e.g., psychology, school counseling, special education, psychiatric nursing). 
   d. I have received brief professional mental health training (e.g., day-long or multi-day workshops, webinars) in a mental health, counseling, or related field (e.g., psychology, school counseling, special education, psychiatric nursing). 
   e. In the capacity of my job, I have had to manage mental health issues in the youth I work with, and have relied on informal consultation with my peers and colleagues. 
   f. I have not received any training or education in mental health issues in youth/students.

Thank you for taking the time to complete this survey! Your feedback is very important to us.
# Workshop 1: Objectives and Activity Outline

| Title: Teacher Support for Student Distress |
| Speakers: Christine J. Cho, Psy.M., Sheila Rouzitalab, B.A. |
| Setting: School |
| Duration: 2 hours |

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Content (Topics)</th>
<th>Time Frame</th>
<th>Teaching Method</th>
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</thead>
<tbody>
<tr>
<td>Participants will be able to: 1.</td>
<td>Behavioral indicators of distress in children vs. adolescents</td>
<td>15</td>
<td>Case vignettes with Q&amp;A; PowerPoint; lecture</td>
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<td></td>
<td>Risk and protective factors for mental health problems</td>
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<td>Range of emotional experiencing, functional impairments, and threshold for clinical symptoms</td>
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<td>2. Define validation and invalidation, describe the impact of validation on emotional reactivity and rapport building, and describe how and what to validate with students.</td>
<td>What validation is and isn’t</td>
<td>30</td>
<td>Role plays with Q&amp;A; PowerPoint; lecture</td>
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<td></td>
<td>What to validate and what not to validate</td>
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<td>Functions and effects of validation</td>
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<td>3. Describe and practice the components of active listening and validation skills to facilitate effective communication with students experiencing emotional/behavioral difficulties.</td>
<td>Verbal and nonverbal demonstrations of active/reflective listening</td>
<td>30</td>
<td>Role plays with Q&amp;A; group skills practice exercises; PowerPoint; lecture</td>
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<tr>
<td></td>
<td>Identifying and labeling emotions</td>
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<td></td>
<td>Levels of validation</td>
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<td>4. Practice generating a short-term coping plan with students in psychological distress.</td>
<td>Identify current strengths and adaptive coping skills</td>
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<td>Role play; PowerPoint; lecture</td>
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<td>Identify peer and adult social supports</td>
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<td>Identify new coping strategies that can be immediately utilized</td>
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<td>Identify “warning signs” of worsening distress or crisis</td>
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<td>Identify action steps for crisis situation</td>
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<td>5. Open discussion, Q&amp;A, provide handouts of local referral directory</td>
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<td>Optional survey</td>
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