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School-Based Mental Health Practices in Utah: A Descriptive Study

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ABSTRACT

School-Based Mental Health Practices in Utah: A Descriptive Study

by

Dina Hargrave, Educational Specialist
Utah State University, 2015

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As psychological well-being, or mental health, is a key factor to academic performance, schools are in a pivotal position to provide needed services to improve the well-being of individual students, parents, and teachers, as well as school-wide wellness. Research has shown positive outcomes related to psychological symptom reduction, but academic outcomes are less prevalent. Due to the increasing need for services, school-based mental health (SBMH) programs are being developed to combine the resources and expertise of SBMH professionals and community agency mental health professionals to serve these needs. In an effort toward developing a statewide Communities of Practice Model for the state of Utah, an internet survey was developed to identify the current practices that are being implemented with schools in Utah. This study explored the current and possible types of school based and community services within a multi-tier service system approach at each tier level (universal, at-risk, and intensive) delivered to elementary and secondary students, the outcomes expected to be impacted by these partnerships, and the barriers and key factors associated with effective program
implementation. The sample included 32 school district respondents from 21 districts and 19 community agency respondents from 18 agencies throughout the state. Results revealed that 18 of the 21 districts are involved in a SBMH partnership implementing a broad range of collaborative activities, assessments and interventions that vary between tier levels. Specific practices, barriers, and implications for SBMH services and future research are discussed.

(104 pages)
PUBLIC ABSTRACT

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As psychological well-being, or mental health, is a key factor to academic performance, schools are in a pivotal position to provide needed services to improve the well-being of individual students, parents, and teachers, as well as school-wide wellness. This study explored the current and possible types of school-based and community services within a multi-tier service system approach at each tier level (universal, at-risk, and intensive) delivered to elementary and secondary students, the outcomes expected to be impacted by these partnerships, and the barriers and key factors associated with effective program implementation. Results revealed that 18 of the 21 districts are involved in a school-based mental health partnership implementing a broad range of collaborative activities, assessments, and interventions that vary between tier levels.
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CHAPTER I

INTRODUCTION

Psychological well-being, or mental health (MH), is a key factor to academic performance. As many as 20% to 30% of children ages 9-17 have symptoms of a clinically diagnosable disorder over a 1-year period (U.S. Department of Health and Human Services [U.S. DHHS], 1999). Additionally, many students are at risk or experiencing school adjustment problems that can potentially lead to poor academic outcomes. Specifically, those who are suffering are at risk for: absenteeism, discipline problems, retention, poor grades, school dropout, and/or juvenile delinquency (Davis, Kruczek, & McIntosh, 2006). Unfortunately, only approximately one fourth of these children receive MH care, and 80% of these are receiving this care in the school setting (Roland, Ringel, Stein, & Kapur, 2001). There are several advantages to school-based services that include: proximity, cost, regular assessment, early identification, and continuum of services in a natural setting. Collaboration with community MH agencies, or a community of service model, is important to ensure access and continuity of care that helps maximize available support.

The current literature is limited primarily to descriptive information on a few MH service models in the schools as a guide to potential best practices. Most models consist of a multi-tier framework that provides multiple levels of interventions. Emerging research on school-based mental health (SBMH) outcomes, however, shows preliminary and promising outcomes for psychological disorder symptom reduction and improved psychological functioning (Rones & Hoagwood, 2000). Last, studies are beginning to
show positive associations between improved MH outcomes and improved educational outcomes (Becker, Brandt, Stephan, & Chorpica, 2014). Educational outcomes such as achievement scores, suspensions, and GPA also show improvements. Future research is still needed to systematically identify service options that can include a full range of services to provide an effective continuum of services, pinpoint important program evaluation outcomes for involved service programs and assessment procedures for effective decision making about student’s supportive programs, and how these may link to academic outcomes.

Since the IDEA-2004 supports response to intervention to support and identify students at-risk or with a learning disability as well as positive behavioral support, many schools are adopting a multi-tier approach with school personnel to provide systematic levels of support to improve academic and behavioral outcomes for the entire student populations. Thus, the aim of this research project is to explore the potential services that are currently or could be provided between schools and community services agencies when developing a statewide communities of practice, SBMH model in Utah.
CHAPTER II
LITERATURE REVIEW

Importance of Well-Being and Mental Health Issues in Schools

Students experiencing poor MH tend to struggle in the educational environment especially when MH issues are left untreated (Sznitman, Reisel, & Romer, 2011). MH can be defined as overall cognitive and/or emotional wellbeing that supports a student’s ability to positively interact and cope with daily stresses, work and relationships. MH falls on a continuum between “a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity” to “alterations in thinking, mood, or behavior associated with distress or impaired functioning” (U.S. DHHS, 1999, p. 4). MH status impacts a student’s thinking, communication skills, learning, emotional growth, resilience, and self-esteem (U.S. Department of Health and Human Services [U.S. DHHS], 1999). Thus, a person’s level of MH or well-being falls on a continuum from adaptive or constructive MH to maladaptive or destructive mental illness.

It is expected that most students within a school exhibit high levels of well-being, demonstrating successful academic skills and social relationships. Other students exhibiting lower levels of well-being may be experiencing problems in thinking abilities and/or emotional or social functioning, possibly due to mental illness or other conditions. Approximately 20% of children and youth are experiencing MH problems and 5%, or 15 million children in the U.S., between the ages of 9 and 17, have a diagnosable emotional
or behavioral health disorder (World Health Organization, 2004). Given that many students will experience stressful experiences at home or school, many students’ well-being may shift along the continuum during their school years that requires supportive MH services to return to functional emotional and well-being levels.

Children and youth tend to cope more successfully with many MH issues in school settings when receiving appropriate services by MH professionals (Costello, Egger, & Angold, 2005). Payton et al. (2008) reported that when social and emotional learning is a component of education, students’ standardized test scores—a hallmark of school accountability structures—increase between 11 and 17 points. And although emotional, behavioral, and social difficulties diminish a child’s ability to participate in the educational process (Rones & Hoagwood, 2000), schools are able to support learning by working in partnership with various service providers to offer ongoing academic and behavioral supports to individual students and to the whole school population (Weist & Evans, 2005). Furthermore, researchers are increasingly examining treatment effectiveness in the school setting (Kutash, Banks, Duchnowski, & Lynn, 2007; Kutash, Duchnowski, & Lynn, 2006) and narrowing the research-to-practice gap by focusing on school functioning as a key element of child well-being (Flaspohler, Anderson-Butcher, Paternite, Weist, & Wandersman, 2006). Students attending schools providing MH services and supports, therefore, benefit from efforts to promote MH in significant ways.
Mental Health Services and School Settings

Although many children and youth would benefit from MH services, a small percentage of these are served. Of this 20-30% of children with MH needs in the U.S., only 25% are receiving any treatment, and 80% of those are receiving treatment in the school setting (U.S. DHHS, 1999). Additionally, low income and minority children are at the greatest risk of not receiving treatment (Center for Health and Health Care in Schools, 2011).

There are several reasons why MH services for children and youth are primarily provided in school settings. First, a majority of referrals to school counselors and psychologists are due to emotional and/or behavioral problems that are interfering with academic performance (National Research Council, 2002; U.S. Department of Education, 2005). Second, students experience many academic and social stressors in school settings and approximately 30% students have difficulties managing and adjusting these stressors (Jepson, Juszczak, & Fisher, 1998). Lack of coping skills or unmet emotional and MH needs negatively affect many of these children’s ability to learn and function with both academic and social tasks. Consequences that may occur when students’ MH needs are unmet include: at-risk absenteeism, discipline problems, being retained, poor grades, school dropout, and/or juvenile delinquency (Davis et al., 2006; Gall, Pagano, Desmond, Perrin, & Murphy, 2000; Heathfield & Clark, 2004; Morris & Morris, 2006; Pekrun, 2006).

A third reason why the majority of children and youth who receive MH care receive services in the school setting is that access to MH services is limited by income,
insurance coverage, transportation, distance from providers, and the stigma associated with having a mental illness (Stephen, Malloy, & Brey, 2011). The school is usually located near the family, allowing for ease of access and reduced transportation issues. Schools provide these services at no cost to families, thus enabling them to receive care without regard to income or insurance status.

Fourth, given that 80% of children receiving MH services have services delivered in school settings, it is important that these services are effective. Becker et al. (2014) conducted a review of 88 studies between 1965 and 2012 that examined the effect of children’s MH treatment on outcome measures for academic performance, behavioral conduct and MH symptoms in the school setting (42%) and clinical setting. MH target problem areas were identified, in which externalizing (e.g., disruptive behaviors, and inattention/hyperactivity; 40.9%), internalizing (e.g., anxiety, depression, trauma; 26.6%), and social skills, adjustment problems (21.4%) were the most common. Results showed that 83.3% of studies had groups with better educational outcomes as compared to waitlist, no treatment or active comparison groups. These positive outcomes did not vary between school and clinic setting, $\chi^2 (1, N = 148) = 1.21, p = 0.27$, Cramer’s $V = 0.47$; or target external or internalizing problem, $\chi^2 (3, N = 144) = 2.76, p = 0.43$, Cramer’s $V = 0.32$. There was a significant positive correlation between positive outcomes on educational measures and positive outcomes on MH measures, $\chi^2 (1, N = 147) = 37.32, p < 0.001$, Cramer’s $V = 0.50$. Of the 83% studies with positive educational outcomes, 91.4% of treatment also showed better outcomes on MH measures. Well-being is an important aspect of academic performance, and as such, needs to become more of a
School-Based Mental Health Program Defined

Because of the need for increased services, various reports and professional associations (National Association of School Psychologists, No Child Left Behind Act, Reports from the New Freedom Commission on Mental Health, Reports of the Surgeon General on the Mental Health of the Nation) have focused attention on the potential of increasing the effectiveness of SBMH services to improve the emotional well-being of all children, as well as their academic achievement. There is also an increase in schools or districts considering or developing SBMH models aimed at combining the services and expertise of community MH providers and school based providers (e.g., school psychologists, school counselors, school nurses and school social workers). SBMH program has been loosely defined as any MH services conducted in a school setting (Kutash et al., 2006). SBMH services can include prevention, skills development, intervention, evaluation, referral, consultation, and counseling.

There are a number of advantages to SBMH services, including: implementation of systematic screening of entire student populations to identify at-risk and severe behaviors, the provision of continuum of services (prevention, early intervention, intensive interventions) and progress monitoring of services on behavior, interpersonal relationships, and academic performance. These activities are conducted in a convenient, natural setting on a daily basis. A continuum of MH services increases engagement, attendance (Masia-Warner, Nangle & Hansen, 2006) and academic performance and
lowers disruptions (Brener, Martindale, & Weist, 2001; Dryfoos, Brindis, & Kaplan, 1996; Flaherty & Weist, 1999; Foster et al., 2005; Kratochwill, 2007; Schaughency & Ervin, 2006). Therefore, schools are the logical choice for well-being and MH service delivery. However, this need requires a broader, more collaborative approach that may better serve more students and families to meet MH needs across the continuum of well-being. The inclusion of community MH providers would expand the current repertoire of services and reach more students. These would include a comprehensive system of interventions that addresses barriers to learning, which reduce problem behaviors, but more importantly re-engage students academically (Center for Mental Health in Schools at UCLA, 2006).

**Multi-Tier System of Support Model for SBMH Services**

Proposed SBMH models in the literature typically incorporate the multiple tiered system of support approach to provide an effective continuum of services and outcomes that support social, emotional, behavioral, and academic performance (Center for Mental Health in Schools at UCLA, 2006). The tier approach is typically conceptualized in terms of three levels noted by various terms in the literature: universal (or school-wide supports or Tier 1), tertiary (or secondary supports or Tier 2), and indicated (or intensive individual supports or Tier 3) interventions. Universal strategies promote a school environment that supports the positive development of all students—socially, emotionally, and academically. These strategies include prevention programs to support positive social and emotional learning (SEL) and positive behavior intervention and
supports (PBIS) that teach and support expected, appropriate school behaviors (e.g., respect, responsibility). These strategies address risk factors of vulnerable students with social and emotional needs and build on students’ strengths and resilience to stressors, and are designed to prevent the development of serious MH problems. Examples of school-wide preventive interventions address substance abuse, violence, or bullying. Other activities can also target school personnel by preparing them to provide effective supports for students with social and emotional needs and identify those who may need more intensive services.

Tertiary supports are typically offered to students who present with specific or pervasive MH or behavioral problems that interfere with their functioning at home, with peers, or in the classroom. These strategies may be delivered in a group format for targeted individuals with specific needs. Examples of tertiary supports include interventions that target social skills, anger management, or coping skills. When tertiary supports are not successful, indicated supports provide a more intensive level of support for an individual. These interventions may or may not include special education placement, are intensive in terms of frequency and duration, and usually require individualized administration. Examples of indicated supports include interventions that target a specific need of an individual child are: one-on-one reading instruction in fluency, individual counseling for a MH related concern, or specific court-related interventions.

With the recent attention on systematic multi-tier levels of prevention and intervention, many schools have started to implement programs targeting academic,
classroom behavior, and social-emotional performance for the entire school population. Currently, many schools are implementing systematic school-wide screenings for emotional and behavioral problems or disorders and implementing multiple levels of positive behavior supports (PBS) to address all students’ needs (Lassen, Steele, & Sailor, 2006; Osher, Bear, Sprague, & Doyle, 2010). PBS programs are designed to add systematic multiple tiers of interventions using general education teachers and other personnel to implement prevention and at-risk youth interventions to maximize student outcomes for most of the student population in a school. This allows more specialized personnel to implement intensive or individualized intervention with a small percent of students who need additional help. These frameworks are allowing for a more efficient and targeted approach to the selection and treatment of those most at need. However, PBS programs are implemented primarily by school professionals with few models involving collaboration with MH providers from community services (Kutash et al., 2006).

Collaborations between schools and community MH agencies are integral to successful SBMH programs. School and Agency partnerships formed to promote system-wide change is a combined effort of all individuals within both entities to purposely work towards transforming current system of MH services to meet a desired outcome (Curtis, Castillo, & Cohen, 2008). System change is a multifaceted process and systems theory in the field of psychology examines human behavior in relation to dynamic and complex systems (Bertalanffy, 1968). Huitt (2012) posited that system change requires knowledge of how each involved entities functions in isolation and as part of the relationship formed
between entities. Working with children in schools requires an understanding of the individual factors influencing and shaping a child’s behavior, as well as the environmental and relationships factors between that individual and peers, parents, teachers, and administrators. Due to the interconnectedness of these factors, system change can be difficult because as one part changes in a system, each of the other parts is affected and thus change themselves. Inclusion of community MH services with school services adds to the complexity of system change. Sometimes the goals of each stakeholder differ and may seem to be at cross purposes. School personnel goals are often aimed at increasing academic success while MH personnel goals are mainly aimed at symptom reduction (Suldo, Frederich, & Michalowski, 2010).

Changing a system requires leadership, goals, planning, implementation, and evaluation with consistent problem-solving to guide decision making (Ervin & Schaugency, 2008). School psychologists working within a dynamic, multi-tiered system of support (MTSS) for MH services are attempting to understand social systems, using data based decision making, and consultation strategies to support student well-being. Given that a MTSS includes various levels of service delivery managed by a myriad of providers, the school psychologist’s role may change during the course of a case from consultant, adviser, MH advocate, to mediator, diagnostician, or leader. By supporting educators, families, and communities, school psychologists can increase positive student outcomes (Thomas & Grimes, 2008).

SBMH multi-tiered programs are emerging to provide improved MH services to larger populations and models and procedures for system change have not been
Empirical Support for SBMH Programs

There are several recent reviews on the effect of SBMH on student outcomes that show promise. Hoagwood, Olin, Kerker, Kratchwill, Crowe, and Saka (2007) conducted a review of empirically based studies of SBMH programs in the U.S. from 1990-2006 to examine the effects of empirically based interventions that targeted both academic/educational and MH outcomes. Study inclusion was dependent on the following criteria: (a) prospective, longitudinal design, (b) random assignment or quasi-experimental comparison, and (c) the intervention had to take place in a public school. Of the more than 2,000 articles on SBMH, 64 met the criteria for the review, and 24 of the 64 studies (37.5%) reported both MH and academic outcomes, for which this review was based.

The target population for 17 of the 24 included outcome studies consisted of kindergarten and elementary students, and focused mainly on universal preventative programs only \((N = 8)\). Three also included an indicated level of interventions for more severe cases in addition to universal programs, whereas, six studies only focused on indicated programs. Seven studies included middle and high school students and targeted group and individual interventions to specific MH concerns: conduct \((N = 3)\), stress \((N = 3)\), and post-traumatic stress \((N = 1)\). Each of the 24 studies used several measurement methods to assess both academic and MH outcomes. Frequent measures of social or MH outcomes included standardized multiple informant reports (e.g., peer, teacher, parent, or
self), behavioral tracking systems, school climate, and discipline referrals. Measures of academic outcomes included: grades, reading and math scores, school attendance, special education placement, standardized school climate measures, standardized academic measures, and parent involvement. The academic and MH outcomes were measured in terms of decreased symptomatology, increased functioning (academic and behavioral), and academic progress.

Results of each study were examined to determine which intervention programs showed positive change in either MH or academic outcomes or both. Results revealed that 15 studies (62.5%), found statistically significant effects on both academic and MH outcomes; 8 (33.3%) found improvements in MH outcomes only; and 1 (4.2%) found no positive effects on either outcomes. Of the studies that found positive outcomes for both academic and MH domains, 11 were intensive (involving multiple domains) and complex, usually lasting a year or more. The remaining four were researcher implemented, lasting only a semester or less. In addition, 4 of the 15 studies that showed positive effects for both outcomes found that the academic effects were not steady over time. Specific items that seemed to lead to significant outcomes in MH only included: length of program (longer showed better outcomes), and complexity (multiple domains were more effective). The one study that did not show any significant outcomes did not use a true control group, and therefore may have impacted the results.

In summary, effects of SBMH services on both academic and MH are emerging in the literature. Limitations of the current studies include a primary focus on elementary students with most interventions applied to universal school populations as compared to
specific levels of interventions targeting at-risk or more specific populations. Although intervention effect was evaluated in the included studies on academic outcomes, few incorporated academic specific interventions, which may explain the lack of long-term effects on academic outcomes. Finally, few studies examined the effect on school-wide outcomes (e.g., school climate). The authors suggested a need for a multi-tiered approach to intervention in the schools, and especially for transition grades. These results reveal a need for more research in this area, specifically looking at academic and MH outcomes, and how outcomes work together.

SBMH effects are limited by the types of outcomes reported. Nonetheless, outcome data from studies examining effects of a SBMH program on outcome difference over time showed positive effects on educational outcomes (Becker et al., 2014), problem behavior (Sexton, Ryst, Gardner, & Bennett, 2011), antisocial behavior (Hoagwood et al., 2007), social competence (Hoagwood et al., 2007), office referrals (Bruns, Walrath, Glass-Siegal, & Weist, 2004), suspension rates (Bohanon & Wu, 2011; Bruns, Moore, Stephan, Pruitt, & Weist, 2005), referrals (Bruns et al., 2004), increased points on daily point cards (Puddy et al., 2007) and problem solving skills (Hoagwood et al., 2007). Teachers also reported higher ratings of school climate items indicating that teachers felt more MH support services for students with emotional and behavioral problems was helpful and had lower referral for special education in school with a SBMH program relative to no-program schools (Bruns et al., 2004). When focusing on secondary students, Walker, Kerns, Lyons, Bruns, & Cosgrove (2010), showed more positive results in attendance and grade point average (GPA) over time, for ninth-grade users of the
SBMH program compared to nonuser students.

In sum, positive outcomes in MH functioning and behavior have been consistently reported on multiple assessments. Although few studies specified batteries of assessments used at each tier in a multi-tier approach, this literature provides a rich sample of assessment options for SBMH programs to consider for screening and progress monitoring at each tier. In addition to outcome studies, given the complexity of SBMH programs, some researchers are employing a more qualitative approach, primarily describing their models, implementation procedures, and barriers (Catron & Weiss, 1994, Chuang & Lucio, 2011; Kelly & Luek, 2011). These studies will be discussed in the following section.

**Procedures**

Studies on statewide programs provide examples of implementation procedures as well as effects on various outcomes. Kelly and Luek (2011) conducted a survey to examine a state-level SBMH system in Illinois to describe practitioner characteristics, service population and practice content. Results from professionals from the four state SBMH associations indicated that most respondents worked in the public school elementary setting with teacher referrals for SBMH services. Most of the referred students were receiving Medicaid, SSI, or free/reduced lunch. School psychologists and school counselors reported mainly receiving referrals for academic concerns, school social workers and department of MH providers received referrals for behavioral concerns, and IEP related services were most often provided by school social workers.
The majority of respondents (83%) indicated that they spend a disproportionate time on Tier 2 and Tier 3 level activities, than on Tier 1 level services. Tier 1 level services were mainly comprised of parental involvement, community engagement, school culture improvement, and data-driven decision making activities. Tier 2 level activities mainly consisted of small group skills activities. Tier 3 activities entailed individual, small group and family based therapies. Program effectiveness was measured by teacher and student self-reports, observations, and whole school data (e.g., attendance, grades, and discipline referrals). Lastly, barriers to effective practice were cited as strict role restrictions, too many students on their caseloads requiring Tier 3 services, and heavy paperwork and administrative task requirements.

Bohanon and Wu (2011) further examined the effects of different combinations of SBMH, response to intervention (RTI), positive behavior intervention and supports (PBIS), and social and emotional learning (SEL) within the Illinois state model on suspension and expulsion rates in 60 schools that incorporated a three-tiered system of MH service approach. One of the 60 schools did not use any of the above initiatives, implementing SBMH alone. The remaining schools combined the four programs: 29% used PBIS, RTI, and SEL with SBMH, 38% used PBIS and SEL with SBMH, 25% used only SEL with SBMH, and 7% used only PBIS with SBMH. Twenty-five percent of schools reported using universal screening tools for Tier 1 to identify academic, behavioral, or emotionally at-risk students. Additionally, identification and progress monitoring data were gathered from several sources: individual, family, school, classroom, and community. Most schools appeared to use referrals and progress
monitoring data for identification and tracking progress. At Tier 2 (Tertiary), supports that were offered in participating schools included: academic instructional groups, crisis intervention (school or class-wide), teacher consults for classroom climate and/or individual needs, and peer mentoring. At the third tier (indicated) more intensive supports were utilized, such as: referral to outside agency, case management, and coordinated services across sites. By reviewing suspension and expulsion rates, the authors determined that those schools implementing more initiatives in combination with SBMH had significantly higher rates of zero expulsions \( z = 3.105, p < .001 \). Of the 13 schools with no suspensions, 53.8% were using SBMH in combination with all of the initiatives, and no school was using SBMH alone. Overall, the study suggests that SBMH may be more successful in conjunction with more initiatives. However, no progress monitoring data of academic or MH outcomes was reported.

A second SBMH program, the Maryland Initiative, was a state-mandated PBIS model, which also includes collaboration between The Maryland State Department of Education, the Shepard Pratt Health System, and John Hopkins University (Bradshaw et al., 2012). The collaborative partnership subsumes: mutually negotiated roles and responsibilities, common goals, knowledge sharing, and access to an interactive web-based data system to track implementation fidelity and student outcomes (www.PBISMaryland.org). Of the 1,465 schools in Maryland, 819 were trained in PBIS between 1999 and 2010. Within these schools, 594 coaches, 31% of whom were school psychologists, were also trained to provide support in program implementation and evaluation. This partnership allows for common collaboration (prevention of behavior
problems), as well as, agency specific collaboration such as: evidence-based practices, federal policies, and research studies.

Bradshaw, Mitchell, and Leaf (2010) conducted a longitudinal group randomized comparison study to examine the impact of the Maryland Initiative school-wide PBIS’s (SWPBIS) program on discipline problems, student achievement, and school environment. Thirty-seven Maryland public elementary schools were matched on baseline data for free or reduced lunch rates. Twenty-one schools were randomly selected to participation in the SWPBIS program group, and 16 schools were assigned to the comparison (no program) group. Implementation fidelity was measured using the Schoolwide Evaluation Tool (SET) and the Effective Behavior Support Survey (EBS) for the intervention group. Student outcomes in both groups were measured by Office Discipline Referrals (ODR), suspension rates, and the state’s standardized academic achievement test, the Maryland School Assessment (MSA), for third- and fifth-grade math and reading gain scores.

Results showed that on both the SET and the EBS, there were significant effects. Specifically, the SWPBIS program group showed significantly greater SET fidelity scores ($d = 3.22$) than the comparison control group. EBS results showed significantly greater scores for the SWPBIS group on all four subscales: school-wide systems in place, $d = 1.71$; nonclassroom settings, $d = 1.47$; classroom settings, $d = 1.08$; and individualized student systems, $d = 1.46$. Outcome measures results were mixed. ODR data was obtained solely from the intervention group, thus providing no comparison, and without a baseline. Data from the first year indicated a rate of .201, well below the
national average of between .34 and .37. The fourth year rate was lower at .159. The authors suggest a ceiling effect may have been in effect and further study into specific school rates may have shown different rates. When ODR was broken down into major (e.g., abusive language, lying, fighting) and minor referrals (e.g., physical contact, disruption, property misuse), neither were significant over time across 4 years, but when combined, there was a significant decrease ($d = .08$). Results indicated that the intervention group had lower suspension rates at the end of the study as compared to the comparison group ($d = .27$). Although school level achievement data from the MSA showed no significant differences between groups for third- and fifth-grade gains in math or reading scores, the authors suggest that these nonsignificant effects may be due to the primary direct target of the PBIS program on behavior and not necessarily academics. Additionally, longer time periods may be necessary to see significant effects for academics because these would be due to mediation effects of school climate and/or overall behavior problem changes. Generally, the study suggests that the effects of training in PBIS and the collaboration of outside partners indicate preliminary improvements in suspension and ODR outcomes.

The Vanderbilt School-based Counseling Program (SBC) specifically targeted children in high-crime, impoverished neighborhoods, who needed MH services, but were not receiving them. This program was implemented in 1990 in nine Metro Nashville, Tennessee, public elementary schools (Catron & Weiss, 1994). The schools were randomly assigned to a treatment ($N = 6$) or comparison condition consisting of traditional community-based MH services ($N = 3$). Then, students in the treatment
condition were randomly assigned to either the SBC program or individual academic tutoring (AT). A matched group of students were selected from the comparison schools to a local community health center. Students in grades two through five were screened using: the Vanderbilt Depression Inventory, the State Trait Anxiety Inventory, the Child Externalizing Behavior Questionnaire, Peer Ratings, Teacher Scales (Teacher Behavior Questionnaire), and the Child Behavior Checklist; for inclusion on six problem domains: delinquency, aggression, anxiety, somatization, hyperactivity, and depression. Students receiving services through special education, including those identified as SED, were excluded. SBC program components included: onsite delivery of services, consulting, data sharing, prevention programs, medication management, inservice, liaison services, parent services, case management, individual, group and family therapy, and social and medical services. This model was evaluated and compared to traditional community based services in 1993 after 2 years of implementation. The attrition rate was 20% after the first rate due to families moving to unserved schools, and three families left the study voluntarily. Preliminary evaluation results of treatment participation data showed that 98% of students referred to the SBC program initiated services, whereas only 17% of those referred to the community health center initiated services. This was an important finding supporting the accessibility and utilization concerns many families face when trying to attain services. Unfortunately, change on MH outcomes measures was not presented.

Although some schools are implementing some form of SBMH, with many states developing models that incorporate some level of community support, gaps on specific
types of services and assessment procedures in the literature still exist. In a multi-tiered format, school wide universal programs can be supported by community agencies to provide wellness initiatives, drug and alcohol prevention, violence prevention, and crisis response (National Assembly on School Based Healthcare, 2007-2008). Tertiary supports could include: earlier identification of at-risk students, small group interventions, teacher consults, and parent programs. Indicated levels of support from community providers might include: case management, medication management, family therapy, individual therapy, and crisis coordination for severe students. Demands for data based decision making on behavioral, MH and academics at both the school and community clinic level, and what these mean for each agency, are logical next areas for exploration. Because schools are often the only point of contact for these families, SBMH programs serve as a logical place to manage multiple sources of services so that all children can benefit from a comprehensive SBMH program (Catron & Weiss, 1994). By exploring these programs, and defining the barriers to implementation, and keys to successes, we can move toward the development of an effective SBMH model.

**Barriers to Address**

Given that the majority of youth MH services are delivered in schools and the potential of SBMH to provide a continuum of MH care targeting prevention to severe problem, knowledge of barriers and challenges could be proactively addressed in current or future SBMH implementation (Short, Weist, Manion, & Evans, 2012). It is no surprise that funding system change is always a primary challenge to consider. Maag and
Katsiyannis (2010) cited the following funding sources available for SBMH: Medicaid and the State Children’s Health Insurance Program for low-income families and children with certain types of disabilities, Individuals with Disabilities Education Act, Title IV-E of the Social Security Act for children placed in out-of-home settings, and the Substance Abuse and Mental Health Services Administration (SAMHSA) of Health and Human Services for programs reducing the risk of substance abuse and mental illness.

Although there is available funding, careful budgeting and expertise on the effective services that will be paid through this funding is needed. Further, given the complexity of implementing services between schools and agencies, researchers have identified a number of barriers reported by schools and community agencies. For example, Chuang and Lucio (2011) cited differing agency priorities, confusion over funding, difficulty tracking cases across organizations, lack of empirical guidance, lack of mutual trust, and broad conceptualizations of interagency collaboration as reported barriers. Kelly and Luek (2011) and Friedrich (2010) reported time constraints, role strain, too many students to serve, and paperwork requirements. Reinke, Stormont, Herman, Puri, and Goel (2011) found that surveyed teachers report a need for training, specifically working with parents, recognizing MH issues in children, and classroom behavioral supports. In addition, Friedrich also identified difficulty collaborating with teachers, lack of money from districts, teachers unsupportive of counseling, student attrition, and insufficient professional preparation, especially for group therapy and crisis work. Langley, Nadeem, Kataoka, Stein, and Jaycox (2010) included unclear MH provider’s roles, lack of administration teacher, or family engagement, and need for
shorter sessions and briefer interventions as additional barriers.

Assessment of barriers specific to different partners, and planning to prevent these barriers, are key to sustainability of effective programs over time. Knowledge of specific, most intrusive barriers help brainstorm needed collaborative efforts to communicate, train, modify or develop new strategies.

**Utah Districts, Policy, and Funding Context**

The goal of SBMH is to increase access to MH services to improve psychosocial functioning (Hunter, 2004), but each state has its own policies, funding routes, and components that influence implementation of services. Moreover, MH school and community needs and resources play a role services provided across the entire continuum of prevention, at-risk and severe treatment services. Thus, investigating practices specifically within the state of Utah is needed to provide a rich description of practices being implemented or needed in the specific statewide context.

Utah’s Framework for school behavioral health services, developed in 2008, recommended consideration of several components to provide services to students within a multi-tiered system involving partnerships between community MH centers and schools (Utah State Office of Education, 2010). Specifically, readiness and implementation procedures, staff development and cooperation and collaboration with other agencies and resources, program evaluation and sustainability, and a continuum of MH and substance abuse services are key components.

School-level MH service providers in the state include school psychologists,
school counselors, and school social workers. National recommendations for student to school psychologist, school counselors, and school social worker ratios are indicated at 1000:1, 250:1, and 400:1, respectively (National Association of School Psychologists, 2009). Results on ratios by state indicate Utah’s average ratios for school psychologists between 2009-2010 and school counselors between 2010-2011 are 839:1 and 726:1, respectively (Castillo, Curtis, Chappel, & Cunningham, 2011; U.S. Department of Education, National Center for Education Statistics, 2012). However, school district ratios may differ, and school psychologist state ratios were derived from selected NASP members’ self-report. This suggests a trend in Utah toward increasing the number of available MH practitioners at the school level. This increase, combined with efforts to involve community MH agencies through this behavioral health framework, is a promising start toward full implementation of a statewide model for SBMH.

Preliminary results on the procedures and effect of one Utah model on student outcomes were reported in a nonpeer-reviewed journal. Robinson (2008) reported on the partnership between a Utah county MH provider, Valley Mental Health, and two of the county’s school districts, Salt Lake City and Granite districts during the 2007-08 school year. Valley Mental Health provided services to 11 classrooms across 7 public schools (6 elementary, 3 middle, 2 high school), 8 of which are self-contained special education classrooms and 3 are for youth in custody. Services include: onsite personnel (licensed clinicians, behavioral aides, and child psychiatrist), working knowledge and training in PBIS and least restrictive behavioral interventions (LRBI), social skills training, individual therapy, individual family therapy, functional analysis, 24-hour crisis
intervention services, and referral services. The classroom teachers used a multi-tier framework for service delivery including: clear rules and expectations as part of the PBIS initiative, a 5-point level system, and token economy. The Youth Outcome Questionnaire (YOQ) provided data on program outcomes, specifically changes in symptomatology over time. Data for 162 students was collected at admission, and every 30 days thereafter, for a total of 124 pre- and post-administrations. Improvement in YOQ scores were observed for 51% of the group, 29% maintained their scores, and 20% had worsening symptom scores over time. The strength of this model is that this partnership has been effective at reaching youth in their home environment, thus reducing access limitations and assuring continuity of care. The limitations to this model are the limited application of services to only self-contained and youth-in-custody classrooms, and outcome data only being reported for behavioral symptoms. For outcome data to be useful to school districts for SBMH widespread use, academic, behavioral, and social/emotional outcomes need to be tracked and reported. However, this is a promising step toward a larger model involving school and community-based MH partnerships in the state of Utah.

**Summary and Purpose of Study**

In a given year, 20-30% of children have clinically diagnosable symptoms of a disorder, and less than 50% of them receive any form of services (Center for Health and Health Care in Schools, 2003; U.S. DHHS, 1999). Of these who receive services, 80% are receiving them in the school setting (Roland et al., 2001). Given that many children and youth would benefit from mental services and school setting are a primary service
provider, the U.S. Surgeon General has emphasized the need for schools to begin addressing mental disorders in children (Davis et al., 2006), along with many other state and national associations. The state of Utah stated, “It is our goal ultimately to offer in schools a continuum of services from prevention through treatment, for both substance abuse and mental illness” (Utah State Office of Education, 2010, p. 6). Some of the advantages to SBMH are access and continuity of a wider variety of services targeting an array of concerns, resources to serve more children, and cost.

In Utah, the school partnerships with community agencies can help to alleviate some of these barriers. The above literature review provided guidance on various outcomes, procedures, and factors that have been previously used and evaluated in effective SBMH program. Although the use of a multi-tiered system for MH services will reduce the demand for intensive services, how each of these is being implemented or being assessed across the state will provide valuable insight on effective practices. Moreover, knowledge of MH provider roles, funding resources and treatment options for various populations or MH issues may enhance future planning. Thus, the aim of this thesis is to determine and describe the current and potential level of community/school partnerships and their implementation factors, necessary for developing a statewide Communities of Practice Model for the state of Utah. The identification of the current models that are being implemented in Utah is important to further clarify the development of a multi-tiered system of MH services. Thus, evaluation of models is not the intention, but to gather information about who is providing services, the specific service and procedural components of the models, including outcomes measures and
perceived service effectiveness. Key successful factors and barriers were also identified that may aid in further developing or refining SBMH programs in the state. This was accomplished by surveying practices, concerns and needs from both clinic and school providers. Specifically, this study attempted to answer the following questions.

1. What types of school based and community agency MH services at each tier level do schools and clinics report are provided at three tier levels of support (universal, at-risk, and intensive), for elementary and secondary students?

2. What school based and community outcomes are expected to be impacted by SBMH services?

3. What are successful key factors and barriers to SBMH programming that are reported by community and school personnel?
CHAPTER III
METHODS

Instrumentation

Two parallel online surveys (Appendices A and B) were designed to gather information on current and possible SBMH practices in the state of Utah. One survey was administered to school personnel to gather information about MH services provided by school personnel, collaborative work with the agencies, or services needed as part of the partnership. A similar survey was administered to community-based service program personnel to gather information about MH services provided by the agency, collaborative work with the schools, or additional services that could be provided by the agency.

There were several phases to the design of each survey. The first phase consisted of a systematic literature review to determine definitions for SBMH, program implementation components, and associated outcome factors. Second, based on the examination of the literature, two survey drafts were developed to target school-setting providers and community-based providers. Each survey first presents a definition of a SBMH program. Questions on the survey were separated into six sections: (1) program description (number of schools and grades receiving services, types of services (504, idea), collaboration activities, funding, and training); (2) targeted problems and service effects, (3) tier interventions, (4) school and well-being outcome assessments, (5) barriers and successful key factors rankings, and (6) district and respondent demographics. Targeted problems and service effects section listed MH challenges requiring services
that were checked if targeted in the SBMH programs. An estimation of the SBMH service effect on each checked target was reported using a 4-point Likert scale (1 = not effective at all to 4 = highly effective). The tier intervention section began with definitions of the three levels, universal, tertiary, and indicated, and then responders checked type of services implemented or desired from a list. Third, the surveys were piloted by having three professors, two out-of-state school personnel and two out-of-state community services providers complete the survey for clarity and feedback. Feedback was incorporated into a final draft that took approximately 20 minutes to complete.

**Participants**

Participants that completed study survey included one to two personnel from each of the 41 school districts and community MH agencies throughout Utah. Of the 41 school districts, personnel (n = 34) from 24 districts responded to the study survey to be described below. Those districts with two participants (52%) were aggregated by using information from the one of two reporting having knowledge about the SBMH partnership. If both participants reported having a SBMH partnership, then responses from the two participants were aggregated into one dataset per district. Of the 24 district participants, 21 school districts reported being involved in a school-community partnership but only 18 completed the survey and 3 school districts reported not being involved in such partnerships and completed the survey (see Figure 1).

Of the school district personnel who participated in the study, the majority were MH service providers (school counselors (40%), social workers (20%), administrators
Figure 1. Contacted school district and agency personnel for study participants.
(15%), school psychologists (20%), and special education teacher (5%) with a masters’
(33%), masters’ + 30 units (52%), or Ph.D. (15%) degrees. The number of years working in
the districts ranged from 6 years to 35 years (median = 15.5 years). All school
personnel reported working with one or more of the five grade settings: preschool (5%),
elementary (57%), middle (48%), high school (67%), and alternative school (24%).
School respondent partnered roles included team member (28%), liaison (28%), team
member + liaison (16%), consultant (22%), or director (6%).

Community-based personnel were recruited from a list of community partners
participating in the Utah State School Behavioral Health Implementation Program ($n = 38$)
and from Substance Abuse and Mental Health Centers or Behavioral Health Services
($n = 7$) within the Utah Intermountain Healthcare network for children and adolescents.
Of the 45 agencies contacted, 16 agency personnel reported being involved in a school-
community partnership and 2 agencies reported not being involved. Approximately 70% of
the community MH providers were social workers (28%), MH counselor (22%) and
RN (6%), with a Masters or Masters + 30 units. The remaining respondents reporting
having a Bachelor degree (44%) with no reported title. The number of years working at
the agency ranged from 1 year to 20 years (median = 15 years). All agency personnel
reported in schools primarily in one or two grade levels: elementary (38%), middle
(50%), and high school (38%). In addition, one agency worked in preschool (6%) and
another in an alternative school (6%). Agency respondent partnered roles included team
member (28%), liaison (17%), administration (17%), or no partnered role reported (38%).
**Procedures**

Following approval of the study by the university Institutional Review Board (IRB), participants were recruited by first calling the district special education director and MH agency program director to give a brief description of the project and name and e-mail of the personnel who would have the most information about the provision of children’s MH service programs in their district or clinic. Each recommended participant was sent an email that described the study and an IRB approved informed consent cover letter. Following the acceptance of the informed consent, the participants were redirected to a secured link to the online survey. A follow-up email was sent 2 to 3 weeks later to those who had not yet completed surveys. A second follow-up occurred 4 weeks after the first email by making a phone call to nonresponders with an offer to complete the survey together. Incentives were provided by offering participants the opportunity to be one of two winners who were randomly selected in a raffle to earn an electronic certificate to an Internet store.
CHAPTER IV
RESULTS

Description of Partnerships

Table 1 presents the descriptive of partnered SBMH programs as reported from participating school districts ($n=21$) and community agencies ($n=18$). Three of the 21 partnered districts that did not complete the survey will not be included in these results. In general, school districts with partnerships tended to work with one agency partner in two to five schools, with the highest percentage of schools located in rural settings. School psychologists and counselors provided school services to students in all grades in 90% or more of the schools and social workers were the primary providers of agency services.

Services

Information on the type of SBMH services provided by schools and community agencies are described below. Specifically, funding, problem types targeted for intervention, interventions for each tier level, collaborative services and collaborative activities are presented.

Funding

Percentages of partnered districts reported funding sources for SBMH services as 72% ($n=13$) from grants, 44% ($n=8$) from Medicaid and 17% ($n=3$) from private monies. Additional funds written in by one district included district funds, school
Table 1

*Descriptive Information of Partnered Schools and Agencies*

<table>
<thead>
<tr>
<th>Description</th>
<th>School (n = 18)</th>
<th>Agency (n = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Number of agency partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>50</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>27</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>25</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Number of participating schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5</td>
<td>61</td>
<td>11</td>
</tr>
<tr>
<td>6-10</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>11-20</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Grade</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;20 district-wide</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Elementary</td>
<td>62</td>
<td>13</td>
</tr>
<tr>
<td>Middle</td>
<td>67</td>
<td>14</td>
</tr>
<tr>
<td>High</td>
<td>57</td>
<td>12</td>
</tr>
<tr>
<td>Professional providing services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School psychologist</td>
<td>67</td>
<td>14</td>
</tr>
<tr>
<td>School/mental health counselor</td>
<td>62</td>
<td>13</td>
</tr>
<tr>
<td>School/social worker</td>
<td>44</td>
<td>8</td>
</tr>
<tr>
<td>Nurse</td>
<td>28</td>
<td>6</td>
</tr>
<tr>
<td>Licensed psychologist</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Location*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban principal city</td>
<td>33</td>
<td>5</td>
</tr>
<tr>
<td>Suburb</td>
<td>44</td>
<td>8</td>
</tr>
<tr>
<td>Town</td>
<td>27</td>
<td>5</td>
</tr>
<tr>
<td>Rural</td>
<td>61</td>
<td>11</td>
</tr>
</tbody>
</table>

Vouchers, or paid by agency. The three unpartnered districts also predicted that funding sources would be grants (67%, n = 2), Medicaid (67%, n = 2), or private monies (33%, n = 1).

Percentages of partnered agencies reported that 81% (n = 13) from grants, 63% (n = 10) from Medicaid grants, or and 12% (n = 2) from private monies funded partnered
services. Two partnered agencies wrote private insurance and district funds as additional funding sources. One of the two nonpartnered agencies predicted that grants and private monies could help fund SBMH services.

**Intervention Targets**

Table 2 indicates problem target areas reported by schools and agencies that are currently addressed with partnered services. Although services are targeting a variety of concerns, most services reported are being implemented for internalized problems (i.e., anxiety, school refusal, depression, and motivation) and externalized problems (i.e., disruptive, defiant, aggressive, conduct disorder [CD], oppositional defiant disorder [ODD], attention deficit hyperactivity disorder [ADHD], and bullying). Addiction/substance abuse and dropout prevention were additional concerns for unpartnered schools. Table 3 also shows unpartnered ratings of needed targets to address with SBMH services. Additionally, partnered school endorsement of additional need of services for these concerns and agencies ability to further address these concerns are presented.

**Targeted Interventions by Tiers**

Figure 2 depicts the services provided for student populations at each of the three tier levels: universal, at-risk students, and severely symptomatic students. At the Tier 1 level, unpartnered schools would include all treatments as part of SBMH service with the exception of Classroom based reward system programs. Likewise, all treatments were selected at the Tier 2 and Tier 3 level, however only one district endorsed teacher training at Tier 2 and medical management and day treatment at Tier 3.
Table 2

*Ratings of Partnered District, Unpartnered Districts, and Partnered Agencies*

<table>
<thead>
<tr>
<th>Intervention target</th>
<th>Partnered districts (n = 18)</th>
<th>Unpartnered districts (n = 3)</th>
<th>Partnered agencies (n = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Should consider</td>
<td>Very needed</td>
<td>Possibly helpful</td>
</tr>
<tr>
<td>Externalizing problems</td>
<td>39% 7</td>
<td>100% 3</td>
<td>0% 0</td>
</tr>
<tr>
<td>Internalizing problems</td>
<td>33% 6</td>
<td>100% 3</td>
<td>0% 0</td>
</tr>
<tr>
<td>Dropout prevention</td>
<td>33% 6</td>
<td>100% 3</td>
<td>0% 0</td>
</tr>
<tr>
<td>Addiction/substance abuse</td>
<td>33% 6</td>
<td>100% 3</td>
<td>0% 0</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>50% 9</td>
<td>67% 2</td>
<td>33% 1</td>
</tr>
<tr>
<td>Peer problems</td>
<td>44% 8</td>
<td>67% 2</td>
<td>33% 1</td>
</tr>
<tr>
<td>Medical</td>
<td>28% 5</td>
<td>67% 2</td>
<td>33% 1</td>
</tr>
<tr>
<td>Attendance/truancy</td>
<td>44% 8</td>
<td>33% 1</td>
<td>67% 2</td>
</tr>
<tr>
<td>Immigration cultural adjustment</td>
<td>56% 10</td>
<td>33% 1</td>
<td>33% 1</td>
</tr>
<tr>
<td>Trauma</td>
<td>28% 5</td>
<td>33% 1</td>
<td>33% 1</td>
</tr>
<tr>
<td>Family stressors</td>
<td>28% 5</td>
<td>33% 1</td>
<td>100% 3</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>56% 10</td>
<td>0% 0</td>
<td>100% 3</td>
</tr>
<tr>
<td>Academic deficits</td>
<td>50% 9</td>
<td>0% 0</td>
<td>67% 2</td>
</tr>
<tr>
<td>Court referrals</td>
<td>39% 7</td>
<td>0% 0</td>
<td>67% 2</td>
</tr>
</tbody>
</table>

*Note.* Additional intervention target outcome needs-respondents allowed multiple responses
### Table 3

**Collaborative Involvement Sharing of Services Information and Process**

<table>
<thead>
<tr>
<th>Type of collaboration</th>
<th>Partnered school</th>
<th>Unpartnered school</th>
<th>Partnered agency</th>
<th>Unpartnered agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Involved</td>
<td>Needed</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Case management</td>
<td>78</td>
<td>14</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Consulting with teachers</td>
<td>61</td>
<td>11</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td>Attending team meetings</td>
<td>55</td>
<td>10</td>
<td>33</td>
<td>6</td>
</tr>
<tr>
<td>Collecting data to monitor progress on school progress</td>
<td>55</td>
<td>10</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td>Data sharing</td>
<td>50</td>
<td>9</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td>Conducting record reviews of school outcomes</td>
<td>28</td>
<td>5</td>
<td>44</td>
<td>8</td>
</tr>
<tr>
<td>Providing written reports to schools</td>
<td>28</td>
<td>5</td>
<td>44</td>
<td>8</td>
</tr>
<tr>
<td>Consulting with parents</td>
<td>28</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Figure 2. Interventions implemented for Tier 1, 2, and 3 services.
Collaboration of School Program Services

Interestingly, 14 (64%) of the partnered school districts reported community agencies as the service provider of alternative school services whereas only 3 (19%) of the agencies reported and 1 of two agencies reported they would be willing to serve in alternative school settings. Seven districts (32%) and agencies (44%) reported that services were part of related services to meet IEP goals. Six districts (27%) and agencies (38%) reported that services were part of 504 accommodations. Two of the unpartnered districts (67%) could envision SBMH services as part of 504 accommodations, related services to meet IEP goals, and/or alternative school services.

Collaboration Activities

Table 3 presents the types of collaborative sharing activities that currently exist or are needed. Partnered school districts reported highest percentage of the collaboration efforts in consulting with parents and no schools reported that community agencies needed to be more involved. Schools, however, reported that more collaboration was needed in the areas of conducting record reviews of school outcomes and providing written reports. At least half of the schools and agencies reported collaborative activities that included case management, teacher consultation, team meetings, and data monitoring and sharing. More agencies than districts reported parent consultation and record reviews as collaborative activities.

In addition, training and training needs were queried. The majority of school district respondents had received training in SBMH (86%), while only 38.9% of community agencies respondents had received training. More than half of school district
respondents (67%) but fewer community agency respondents (44.4%) were interested in additional training.

**Outcomes**

**Assessments**

Figure 3 depicts the type of outcome assessments used to determine the impact of SBMH services on overall school and MH functioning at each Tier level. Additionally, all three schools without a school/community partnership (100%) reported dropout rates and suspensions, one district reported office referrals (33%) and two school districts (967%) reported the remaining assessments could be used to determine overall school functioning.

**Service Effectiveness**

Figures 4 and 5 presents the school and community agency participants’ ratings of the effectiveness of services on outcomes per targeted areas of concern. Although internalizing and externalizing problems were most served, these services are rated by schools as moderately effective. In fact, most services are reported by schools to be mainly moderately effective. Specifically, 1%, 11%, 59%, and 29% of the total ratings were indicated to be, not effective, slightly effective, moderately effective, or highly effective, respectively. Moreover, 0%, 5%, 51%, and 44% of the total agency ratings were indicated to be, not effective, slightly effective, moderately effective, or highly effective, respectively.
Figure 3. Assessments for Tier 1, 2, and 3 to determine the impact of SBMH services on mental health and school functioning.
Figure 6 presents the average ratings of barriers from most (i.e., 10 is the biggest barrier/struggle) to least (i.e., 1 is least barrier/struggle). Schools and agencies showed differences in reported barriers; however, burden of too many students who required services was a highly rated barrier. Agencies also wrote in two other items as barriers to successful SBMH programs: “no juvenile court system to support substance abuse treatment” (n = 1) and “lack of parent follow through” as barriers. One school district wrote in “providers not showing up” when promised (n = 1). All unpartnered districts (n = 3) endorsed paperwork, two of three (67%) endorsed too many students and budget,
one of three (3%) endorsed time, roles, collaboration, attrition and training as possible struggles or barriers. No district endorsed unsupportive staff with the counseling service as a barrier.

**Key Factors**

Figure 7 presents average ratings on key factors needed for successful SBMH program implementation from most (i.e., 7 is the most important factor) to least (i.e., 1 is
Figure 6. Partnered schools ($n=18$) and agencies ($n=16$) endorsement of possible barriers/struggles.
least important key factor) for partnered agencies and schools. Partnered schools and agencies rated regular feedback, effective teams, and data sharing as an important key factor. All three unpartnered schools rated training, data sharing, and effective teams as key factors to implementation and two of three (76%) endorsed regular feedback, roles and shard priorities.

*Figure 7. Partnered schools (n = 18) and agencies (n = 16) endorsement of key factors to successful programs.*
CHAPTER V
DISCUSSION

The purpose of this study was to provide a rich description of the current and potential level of community/school partnerships as related to SBMH, and their implementation factors in one state. The majority of responders from both school and community personnel reported currently working within a SBMH partnership; working with between two and five schools per agency; working with grades K-12; working mainly in rural communities; and working with school counselors, school psychologists, and social workers primarily providing the services. Because of the scarcity of resources in many rural communities in this state, it was not surprising that most services were directed in this location. Thus, this study provides a contrasting perspective of services with prior studies that had frequently examined SBMH services in urban areas.

Determining how to fund SBMH services is an ongoing challenge. Several federal funding sources are available including: Medicaid, State Children’s Health Insurance grants, Title IV of the Social Security Acts, Substance Abuse and Mental Health Administration of Health and Human Services, and IDEA (Maag & Katsiyannis, 2010). In this present study, respondents reported that funding for SBMH services came primarily from grants and Medicaid, and respondents whose schools did not have partnerships also thought that if they were to implement SBMH services the funding would likely come from these two sources as well. Throughout the 1980s and 1990s, IDEA funds were the primary source of funding for services aimed at students with IEPs with accompanying MH problems requiring related services (Maag & Katsiyannis, 2010).
With the expansion of Medicaid under the Patient Protection and Affordable Care Act (2010), more students are now able to receive coverage for MH.

The majority of current collaboration efforts that were reported differed between schools and agencies. Schools reported that partnership services were or needed to target alternative school services whereas few agencies reported such supports. Few agencies also reported services to meet IEP goals and 504 accommodations. Plausible explanations for lower agreement on IEP and 504 services may be due to actual greater IDEA and 504 support by school professionals, less training for agency providers on students with disabilities and legal requirements, or due to difficulties with collaborations of services that meet all federal and state legal requirements for students with disabilities.

When examining collaborative efforts to share service support and information, all schools and a high percentage of agencies endorsed consultation with parents as an important active component of the partnership. Agencies ability to focus on work with parents may address the need for schools to use community agencies to address a communication barrier with parents often reported in prior studies (Catron & Weiss, 1994; Kutash, Duchnowski, Green, & Ferron, 2011; Suldo et al., 2010). Many respondents in both groups also reported implementation of consultation with teachers, school based team meetings, data sharing and progress monitoring. This may reflect careful attention to effective planning of partnered services to meet school needs, given that these are key components cited in the literature on multi-tier system service models such as RTI or PBS programs (Kutash et al., 2006; Rones & Hoadwood, 2000; Suldo et al., 2010). These activities were also rated as needed by schools without partnerships. Interestingly, all schools reported that partnerships were assisting with case management
while only half of the agencies reported implementing this support. Schools also expressed an interest in having partnerships assist with written reports—although few agencies provided this service.

Service Target Outcomes and Effectiveness

Service target outcomes were examined to determine the span of problems address and whether the collaborative school based interventions aimed at specific MH challenges were perceived to be effective. Overall, the majority of targeted outcomes were rated as moderately effective by school districts and highly effective by agencies. This difference may be due to differences in data collected or different emphasis on the importance of certain outcomes. School personnel have the ability to observe the degree that treatment effects generalize or are maintained across situations, people and time.

Although academics was the most frequent outcome monitored by schools, few interventions targeted academic deficits suggesting lack of awareness of the relationship between school adjustment, well-being and academic engagement (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Not surprisingly, externalizing behaviors were being addressed by the majority of the partners but internalizing problems were also a major target for intervention followed by trauma. Although the literature suggests that students with internalizing disorders are under served (Browne, Gafni, Roberts, Byrne, & Majumdar, 2004; Hoagwood et al., 2007; Reinke et al., 2011), there appears to be an awareness of the need for partnered services to target this outcome. Unfortunately, additional results from the current study correspond with prior findings in the literature that few services address immigration and cultural adjustment issues (Lustig et al., 2004).
Although family consultation was reported, few interventions targeted family stressors. Additional research is warranted to identify why and what could be implemented to increase this need in schools (Kia-Keating & Ellis, 2007).

**Tier Interventions and Assessments**

Results of this study reveal that intervention services are being implemented at all three tier levels. The majority of services were provided by schools, which was expected given that the purpose of Tier 1 was to have the largest personnel resource, educators, providing preventative services to most students (Bradshaw et al., 2012). As fitting with the multi-tiered system support framework with increasing intensity of services and specialized personnel at more advanced tier supports, more services are being reported by agencies at Tier 2 relative to Tier 1 (Hawkin, Adolphson, MacLeod, & Schumann, 2009).

Services aimed at at-risk students at the Tier 2 level consisted mainly of behavior modification plans implemented by schools and counseling implemented by agencies and schools. Behavior plans is consistent with the literature on evidence based intervention for decreasing social and disruptive behavior problems when implementing teacher prompts, feedback and positive reinforcement strategies in classroom settings (Anderson & Borgmeier, 2010). This is an appropriate first attempt to add an extra intervention level of support to improve student performance under Tier 1 performance expectations and settings. Schools also report implementing small group interventions to explicitly teach pro-social skills that may be practiced and positively reinforced as part of behavior planning in school settings. Finally, teachers are receiving training and consultation in schools possibly to help implement classroom behavior plans.
Two additional services in Tier 3 was crisis management reported by both partners and alternative settings by schools. A few agencies and school added medical management, day and residential treatment. The lower reported treatment options may possibly due to cost or lower need. Although few services addressed medication, schools tend to struggle with medication trials, timing and effect on classroom behavior (Anderson, Walcott, Reck, & Landau, 2009). Forming this type of service in SBMH partnerships may benefit students who receive services in more restrictive classroom settings. Research shows that combined environmental and medication services are most effective for reducing social emotional and behavioral problems than either alone which may increase the possibility of transitioning into a less restrictive environment (Kendall, 2012). Only slightly over one third of schools and agencies provide parent training at Tier 3, although the smaller population of students may make this a more feasible option that would help generalize effects to home settings. Alternatively, parent training was the most common Tier 2 and 3 level services that nonpartnered schools would consider for implementation, possibly because the system does not support the effort or lacks the time and resources.

An important part of services are assessment and findings from this study shows promising assessment practices are in place at the universal level of services. All but four districts reported use of one or more well-being assessments to monitor prevention services and/or to screen for the identification of students requiring more intense services. Schools reported more assessments at all tier levels than agencies and schools are primarily using observation and teacher completed scales suggesting these may be more useful, acceptable or feasible options (Catron & Weiss, 1994; Hoagwood et al., 2007;
Given that school outcomes are a primary focus of school based services, schools reported a number of outcomes of school functioning. Review of these outcomes may be related to education state department annual performance plan and report requirements. Surprisingly, few districts rely on standardized tests, which are critical indicators of an effective school. Environmental factors, that schools could potentially target as intervention support, such as school climate and student relationships, were also not frequently monitored, as was found by Kutash et al. (2006) and Gall et al. (2000). A promising result was the number of school functioning outcomes that were monitored by a number of agencies. Given that these agencies also participated on teams, it appears that this collaboration is supporting agencies understanding of the importance of these factors for youth and children.

One noteworthy finding was that academic performance was an important assessment monitored at Tier 1 but not at Tier 2 and 3. Use of observation as an assessment method continued to be the primary method in schools at Tier 2 and Tier 3. Moreover, parent report scales and interviews, which may take more time and resources, are being increasingly administered in the more advanced Tier 2 and 3 service support levels. A higher percentage of schools reported using interviews than agencies which may be due the daily availability of teacher and student in a school setting. Agencies relied on self-report measures that may be useful to evaluate the individual targeted symptom change related to MH disorders. Surprising, a low percentage of MH agencies reported using the well-being assessments and less than half of the agencies used more than two types of assessments.
Barriers and Successful Key Factors

Barriers and successful key factors were reported to determine what elements would be necessary and which elements needed attention for successful implementation of SBMH services. Key factors and barriers identified in this study were similar to the ones found in the literature (Chuang & Lucio, 2011; Friedrich, 2010; Johnson, 2010; Kelly & Luek, 2011; Kutash et al., 2006; Langley et al., 2010; Lever, Chambers, Stephan, Page, & Ghunney, 2010). Key factors varied between school and agencies. A clear prescribed role was critical for both groups and reported as a major barrier for schools. Time constraints, budget constraints, and too many students to serve were also presented as greater barriers to schools than agencies. This may reflect the added benefit of conjoined efforts between entities to provide additional services to students. However, it is important to note that the consistency in provision of these services was a critical key factor and an existing barrier to partnered schools. Possibly related to consistency, addressing key elements and existing barriers (i.e., training and shared priorities), may result in more consistent services. Agencies also rated lack of effective teams as a potential barrier; thus, an increased agency role in teams may be beneficial for problem solving some of the reported barriers. Overall, it was interesting how the schools and agencies have different priorities about what is necessary for successful programs, in fact, understanding this dichotomy and effectively taking actions to meet differences may actually be the key.
Strengths and Weaknesses of the Current Programs

System change is a complex process that takes time. Thus, we explored current practices to identify key successful components to include, investigated current strengths to build on, and targets or barriers. One strength of the partnerships was the multiple assessment tools to monitor academic outcomes as well as MH outcomes with an increase in reported types of assessment for more intense tiers. Programs were utilizing a tiered approach to service identification, delivery, and assessment, which appeared to be very effective in symptom reduction and funding sources are becoming more varied to support services. Current programs are utilizing several different types of MH practitioners, especially school psychologists, as they have been previously underrepresented as being MH practitioners (Friedrich, 2010; Suldo et al., 2010). Consultation services between practitioners, parents and teachers, are on the rise, which usually leads to more effective identification and treatment of students. Lastly, most practitioners have received training in SBMH, which was cited in the literature as a barrier to effective implementation (Friedrich, 2010; Kelly & Luek, 2011).

Several potential areas of improvement were found in the current SBMH programs. Academics were rarely identified as a target for intervention. Additionally, the methods used by schools and agencies, namely assessments and intervention types, do not address academics directly for individuals. Instead of incorporating agency support for IEP goals, which inasmuch as IDEA requirements mandate that these related services be tied to, most collaborative services are related to more restrictive alternative school services. The literature suggests a need for more school climate assessments to assess
need for proactive tier 1 services, and these are clearly lacking in the current programs (Gall et al., 2000; Kutask et al., 2006). Despite the strengths, several barriers still exist and these differ between school and agencies which may jeopardize future efforts for continued collaboration without attention and planning towards these issues. Training and ongoing professional development is an important factor for addressing barriers as SBMH partnerships develop and maintain system change. Even though the majority of schools had received training for SBMH services, over half were interested in additional training, and similar needs were found for agencies. Further, schools reported this as a major barrier. This is consistent with results found by Suldo et al. (2010), that even when provided with training, most school practitioners felt it was insufficient and left them unprepared to implement services adequately.

**Limitations**

There several limitations to this study. First, 27 of the 41 districts and 18 of 45 the agencies contacted did not respond. Southern and southeastern areas of Utah had the least amount of information reported; whereas, the northern and northeastern regions had the most. Because of the voluntary nature of the study, it is difficult to determine why some programs did not respond.

Second, the current study relied on self-report data and from one to two respondents per school or agency. Although efforts were made via phone calls and e-mails to identify the person most knowledgeable about the SBMG program, job duties limited the knowledge about the actual day-to-day aspects of the program as perceived by all involved professionals. Additionally, data based on self-report has potential
interpretation problems such as respondents being subject to response sets in his or her answers or reluctance to disclose or risk perceived negative information due to limited confidentiality issues.

Limited question items also limited conclusions about current services. For example, school-wide screeners for identification, individual academic assessment, and program acceptability or integrity measures were not included in the survey. Setting of services was not assessed, which might have indicated more about the types of services provided and if indeed it was more advantageous for parents due to onsite service. In addition to identified well-supported behavior modification and consultation services, more specific items would have defined types of skills training, counseling, therapeutic strategies, or well-supported manualized treatments being conducted with individuals and groups.

**Summary and Future Research**

Given the emerging development of SBMH program, future research should further examine the broad components of SBMH components that are not solely based on self-report. Effective assessment strategies may be further explored in future research by examining the utility of school climate assessment, school wide screenings, and individual academic outcome assessments for treatment planning that is linked to MH supports. Knowledge about treatment options may be more specific by researching the effect of flexible manualized treatment or strategies that are practical and feasible yet remain effective when used in various types of settings for SBMH. And finally, given limited time, resources, and the many students who need services, studies on methods
that promote system wide training, team work and consultation that results in improved or maintained positive well-being outcomes for student populations is warranted.

In sum, the literature review revealed a need for more research, specifically on academic and MH outcomes. The responders indicated a present SBMH partnership in 68% of the school districts in the state suggesting an increasing awareness of the need for these types of collaborations. These partnerships are working with a variety of target problems, within a multi-tiered system, utilizing many different practitioners, and engaging in a variety of collaborative activities. The few responders who did not have partnerships indicated a need for services in several areas and these data can be used to refine new and current programs.
REFERENCES


Mental Health Promotion, 3(4), 38-50.


Appendix A

School Survey
School Survey

Introduction/ Purpose

(Dr./Professor) Donna Gilbertson and Dina Hargrave, a graduate student in the Department of Psychology at Utah State University are conducting a research study to explore the potential services that are currently or could be provided between schools and community service agencies when developing a statewide Communities of Practice - School Based Mental Health model in Utah. You have been asked to take part because you are involved in the provision and organization of mental health services. There will be 45 to 70 total participants in this research.

Procedures

If you agree to be in this research study, you will complete an online questionnaire. You will be asked about services that are or could be provided by community mental health services for elementary and secondary students in school settings. This questionnaire is expected to be take 15 to 20 minutes. If you prefer, a second option may be to complete the questionnaire during a phone call from a researcher. Risks Participation in this research study may involve a small risk for loss of confidentiality but we will take steps to reduce this risk as described below.

Benefits

A possible benefit from participation in this study is the awareness of local and statewide community and school based mental health services. The key benefit of this study is that the collected information collected may provide guidance on mental health needs and effective practices to developing at state-wide school and community mental health partnership model.

Explanation and Offer to Answer Questions

If you have other questions or research-related problems, you may reach Donna Gilbertson at (435) 797- 2034 or by e-mail at donna.gilbertson@usu.edu

Payment/Compensation

Upon completion of the survey, you may choose to follow another link to submit your email address for a chance to win one of two $50 gift certificate to Amazon.com. In no way will your personal information be connected with your survey responses.

Voluntary nature of participation and right to withdraw without consequence Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence or loss of benefits. You may skip any questions that you
choose not to answer.

Confidentiality

Research records will be kept confidential, consistent with federal and state regulations. FERPA and HIPPA regulations are met by the survey using Qualtics online survey software that is a secure and free program offered at Utah State University. No names will be written on any surveys. A code will be used to replace your district or agency name. The code and agency list will be kept separate from the data throughout the study and it will be destroyed immediately after all data is collected. Only the investigators will have access to the coded data, which will be downloaded from the survey provider’s secure database, and stored on a password-protected computer.

IRB Approval Statement

The Institutional Review Board for the protection of human participants at Utah State University has approved this research study. If you have any questions or concerns about your rights or a research-related injury and would like to contact someone other than the research team, you may contact the IRB Administrator at (435) 797-0567 or email irb@usu.edu to obtain information or to offer input.

Investigator Statement

“I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered.”

I consent (1)
I do not consent (2)

If I do not consent Is Selected, Then Skip To End of Survey

Q1 A school-community partnership to provide School based mental health services is a collaboration of school personnel (e.g., school psychologists, school social workers, school counselors) and community mental health personnel (e.g., social workers, psychiatrists, psychologists) working together to provide services for students and families. These services can range from consultation to on site care at the school. Are you currently partnering with an outside agency to provide School based mental health (SBMH) services for students?

Yes
No
Q3 How many community service agencies are partnered with a school for mental health services in your district?

Q5 How many schools are participating in a SBMH partnership(s)?

Q6 Check all grades being served by a SBMH partnership(s):

K
1
2
3
4
5
6
7
8
9
10
11
12
not sure

Q2 Check all the locations of the schools that are participating in a SBMH partnership with outside agencies?

Urban Principal City
Suburb (outside a principal city and inside an urbanized area)
Town(territory inside an urban cluster)
Rural(> 5 miles from an urbanized area)

Q7 Are the mental health services provided by the outside agency part of (check all that apply):

504 accommodations
related services to meet IEP goals
alternative school services
not sure
Q8 Check all the types of funding used for the services provided by the SBMH partnership?
   Medicaid
   Grants
   Private monies
   Other ________________
   not sure

Q10 What activities are the community personnel engaged in at the schools? (check all that apply)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Currently doing this</th>
<th>No, but needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending team meetings</td>
<td>Answer 1</td>
<td>Answer 1</td>
</tr>
<tr>
<td>Consulting with teachers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collecting data to monitor progress on school progress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conducting record reviews of school outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing written reports to schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consulting with parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data sharing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q54 What activities would you like community personnel to be engaged in at the schools? (check all that apply)

Attending team meetings
Consulting with teachers
Collecting data to monitor progress on school progress
Conducting record reviews of school outcomes
Providing written reports to schools
Consulting with parents
Data sharing
Case management
Other ____________________
Q9 If a partnership with a mental health community agency was formed in the future, could the SBMH services provided by the agency be part of (check all that apply):
   - 504 accommodations
   - related services to meet IEP goals
   - alternative school services
   - not sure

Q10 How could the SBMH services be funded (check all that apply)?
   - Medicaid
   - Grants
   - Private monies
   - Other ____________________
   - not sure

Q12 What school employed professionals provide mental health services in your district (check all that apply)?
   - School psychologists
   - Nurses
   - School counselors
   - School social workers
   - Other ____________________
   - Unsure

Q13 Have the above personnel had training in school based mental health?
   - Yes
   - No
   - not sure

Q15 Would your school or district be interested in additional training?
   - Yes
   - No
   - Not sure

Q17 Below is a list of 3 levels of problem severity and corresponding services that could be addressed with a school/ community collaboration. Although each level have various titles, in general, services addressing the 3 levels of problems are defined as: Tier 1, Prevention or Universal services: Given to all students to address risk factors in entire school populations without attempting to discern who are at-risk (e.g., education). Tier 2, At-risk, Secondary, or Selective Targeted services for at-risk symptoms: Provided to at-risk students who share a significant risk factor that may be a lifetime risk or beginning to exhibit signs of more serious problems (e.g., small group training). Tier 3, Severe, Tertiary, or Indicated Intensive services(Tier 3, Tertiary) for severe symptoms: Given to
those students with severe problems or symptoms that may meet diagnostic disorder/classification criteria, that may be harmful to self or others, and/or not responding to other levels of support (e.g., individual therapy).

**Answer**

A school-community partnership to provide School based mental health (SBMH) services... Yes Is Selected

Q18 First, check if a type of problem is currently being addressed by SBMH partnership services OR, if no partnership is in place for that problem, indicate whether the problem is a concern that could potentially be considered for a SBMH partnership for services. Second, check the levels of support (Universal, Selective, Indicated) that are currently being implemented or which levels could be implemented with SBMH community services. Third, if a program is being implemented, rate the effectiveness of the SBMH services.

<table>
<thead>
<tr>
<th>Partnership level</th>
<th>Indicate level in place or needed (check all that apply)</th>
<th>Effectiveness if Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Deficits</td>
<td>Implemented with a partnership</td>
<td>Universal (for ALL students)</td>
</tr>
<tr>
<td>Externalizing Problems (disruptive, defiant, aggressive, CD, ODD, ADHD, bullying)</td>
<td>Would consider for collaboration</td>
<td>Selective (for AT-Risk students)</td>
</tr>
<tr>
<td>Internalizing Problems (anxiety, school refusal, depression, motivation)</td>
<td></td>
<td>Indicated (for SEVERELY SYMPTOMATIC students)</td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
<td>Not at all effective</td>
</tr>
<tr>
<td>Court Referrals</td>
<td></td>
<td>Slightly effective</td>
</tr>
<tr>
<td>Attendance/Truancy</td>
<td></td>
<td>Moderately effective</td>
</tr>
<tr>
<td>Addiction/Substance abuse/Dropout prevention</td>
<td></td>
<td>Highly effective</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Family stressors (e.g., parent death, divorce)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immigration and cultural adjustment issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q55 First, check if a type of problem could be considered for SBMH partnership services. Second, check the levels of support (Universal, Selective, Indicated) that are needed and could be implemented with SBMH community services.

<table>
<thead>
<tr>
<th>Consideration for Partnership</th>
<th>Indicate level needed (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Deficits</td>
<td>Very needed</td>
</tr>
<tr>
<td>Externalizing Problems</td>
<td>Possibly helpful</td>
</tr>
<tr>
<td>(disruptive, defiant, aggressive, CD, ODD, ADHD, bullying)</td>
<td>Not Needed</td>
</tr>
<tr>
<td>Internalizing Problems</td>
<td>Universal(for ALL students)</td>
</tr>
<tr>
<td>(anxiety, school refusal, depression, motivation)</td>
<td>Selective(for AT-RISK students)</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Indicated(for SEVERELY SYMPTOMATIC students)</td>
</tr>
<tr>
<td>Court Referrals</td>
<td></td>
</tr>
<tr>
<td>Attendance/Truancy</td>
<td></td>
</tr>
<tr>
<td>Alcohol/ Substance abuse/</td>
<td></td>
</tr>
<tr>
<td>Dropout prevention</td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>Family stressors (e.g., parent death, divorce)</td>
<td></td>
</tr>
<tr>
<td>Peer problems</td>
<td></td>
</tr>
<tr>
<td>Immigration and cultural</td>
<td></td>
</tr>
<tr>
<td>adjustment issues</td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Q19 In this section we will ask questions to find out about specific services that are being provided or could be provided for each level of support: Tier 1 (prevention services), Tier 2 (addressing at-risk factors), Tier 3 (addressing severe problems).

Answer If A school-community partnership to provide School based me... Yes Is Selected
Q21 For Tier 1/ Universal level(for ALL students), what school-community partnership services are provided to support well-being of the entire school population or that the district would like to implement as part of a school-community partnership (check all that apply)?

<table>
<thead>
<tr>
<th>Implemented by School Personnel</th>
<th>Implemented by Community Agency Personnel</th>
<th>Not currently partnered for this service, but would consider for partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psycho-educational knowledge for teachers, parents, and/or students</td>
<td>Check if Yes</td>
<td>Check if Yes</td>
</tr>
<tr>
<td>Classroom based social emotional or social skill training</td>
<td>Check if Yes</td>
<td></td>
</tr>
<tr>
<td>Classroom based reward system programs</td>
<td>Check if Yes</td>
<td></td>
</tr>
<tr>
<td>Teacher training</td>
<td>Check if Yes</td>
<td></td>
</tr>
<tr>
<td>Crisis prevention</td>
<td>Check if Yes</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Check if Yes</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Check if Yes</td>
<td></td>
</tr>
</tbody>
</table>

Answer If A school-community partnership to provide School based me... No Is Selected

Q56 For Tier 1/ Universal level(for ALL students), what school-community partnership services could be provided to support well-being of the entire school population (check all that apply)?

- Psycho-educational knowledge for teachers, parents, and/or students
- Classroom based social emotional or social skill training
- Classroom based reward system programs
- Teacher training
- Crisis prevention
- Other

Q26 Selective Services (Tier 2) provided to at-risk students

Answer If A school-community partnership to provide School based me... Yes Is Selected

Q27 For Selected Tier 2 level(for AT-RISK students), what services are provided to support at-risk students with community support or that the district would like to implement as part of a school-community partnership (check all that apply)?
<table>
<thead>
<tr>
<th>Implemented by School Personnel</th>
<th>Implemented by Community Agency Personnel</th>
<th>Not currently partnered for this service, but would consider for partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student (parent, teacher) psycho-educational Counseling</td>
<td>check if Yes</td>
<td>check if Yes</td>
</tr>
<tr>
<td>Small groups social skill training</td>
<td>check if Yes</td>
<td>check if Yes</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior modification plans (e.g., contracts, tokens, home-school notes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent skill training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher Consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Answer**

If A school-community partnership to provide School based mental health support... No Is Selected

Q57 For Selected Tier 2 level, what services could be provided to support at-risk students with community support as part of a school-community partnership (check all that apply)?

- Student (parent, teacher) psycho-educational Counseling
- Small groups social skill training
- Cognitive Behavioral Therapy
- Behavior modification plans (e.g., contracts, tokens, home-school notes)
- Parent skill training
- Parent consultation
- Teacher Consultation
- Teacher Training
- Other ____________________

Q32 Indicated Services (Tier 3) for severe Mental Health issues

**Answer**

If A school-community partnership to provide School based mental health support... Yes Is Selected
Q33 For Indicated Tier 3 level (for SEVERELY SYMPTOMATIC students), what services are provided to address high levels of symptoms that may meet diagnostic disorder/classification criteria with community support or that the district would like to implement as part of a school-community partnership (check all that apply)?

<table>
<thead>
<tr>
<th>Service</th>
<th>Implemented by School Personnel</th>
<th>Implemented by Community Agency Personnel</th>
<th>Not currently partnered for this service, but would consider for partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student (parent, teacher) psycho-educational Counseling</td>
<td>check if Yes</td>
<td>check if Yes</td>
<td>check if Yes</td>
</tr>
<tr>
<td>Small groups social skill training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior modification plans (e.g., contracts, tokens, home-school notes,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent skill training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher Consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis response</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Treatment (i.e. Therapeutic day program part of school district services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternative School Placement/Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Treatment (Therapeutic day program provided by an outside agency not part of school district services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Answer: If a school-community partnership to provide School-based mental health services is not selected... No is selected.
symptoms that may meet diagnostic disorder/classification criteria with community support as part of a school-community partnership (check all that apply)?

Student (parent, teacher) psycho-educational Counseling
Small groups social skill training Individual Therapy
Behavior modification plans (e.g., contracts, tokens, home-school notes, ) Parent skill training Parent consultation Teacher Consultation Teacher training Crisis response Medication management Residential Day Treatment (i.e. Therapeutic day program part of school district services) Alternative School Placement/Services Day Treatment (Therapeutic day program provided by an outside agency not part of school district services)
Other ____________________
Other ____________________

Q38 It is important that services promote important outcomes that help students be academically successful.

Answer If A school-community partnership to provide School based me... Yes Is Selected

Q39 What assessments are used by the school personnel to determine the impact of community services on school functioning (check all that apply)?

Attendance Grades Standardized tests Academic screening outcomes Suspensions Teacher relationships Peer relationships School climate assessment (i.e., overall safety, quality and character of school life) Drop-out rates Other data are collected and reviewed? ____________________

None

Answer If A school-community partnership to provide School based me... No Is Selected
Q59 What assessments could be used by the school personnel to determine the impact of community services on school functioning (check all that apply)?
- Attendance
- Grades
- Standardized tests
- Academic screening outcomes
- Suspensions
- Teacher relationships
- Peer relationships
- School climate
- Drop-out rates
Other data are collected and reviewed? ____________________
None

Q36 What type of additional assessments are currently being used by schools to determine who is responding to each level of services (check all that apply)?

<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>Universal or Tier 1</th>
<th>Selective or Tier 2</th>
<th>Indicated or Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-report scales</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent report scales</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher report scales</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surveys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interviews</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardized Interviews</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Answer If A school-community partnership to provide School based me... Yes Is Selected

Q42 Rank from 1 to 10, by dragging and dropping, the following barriers/struggles to manage and obtain outcome data within a SBMH program where 1 is NOT a barrier/struggle, and 10 is the biggest barrier/struggle)?

____ Time Constraints
____ Problems with prescribed role
____ Too many students to serve
____ Paperwork requirements
____ Collaboration difficulties
____ Budget constraints
____ Staff unsupportive of counseling
____ Student attrition
____ Insufficient professional preparation
____ Other
Q60 Check all the possible barriers/struggles that you foresee to managing and obtaining outcome data within a SBMH program.

- Time Constraints
- Problems with prescribed role
- Too many students to serve
- Paperwork requirements
- Collaboration difficulties
- Budget constraints
- Staff unsupportive of counseling
- Student attrition
- Insufficient professional preparation
- Other ____________________

Q43 Rank the following key factors from 1 to 7, by dragging and dropping, to successful programs that promote positive education, social, behavioral, mental health well being outcomes for all students (where 1 is NOT an important key factor, and 7 is the most important key factor).

1. Training
2. Data sharing
3. Effective teams
4. Shared priorities between school and agency
5. Regular feedback
6. Clear definition of inter-agency roles
7. Other

Q61 Check which key factors you believe are important for successful programs that promote positive education, social, behavioral, mental health well being outcomes for all students.

- Training
- Data sharing
- Effective teams
- Shared priorities between school and agency
- Regular feedback
- Clear definition of inter-agency roles
- Other ____________________

Q52 What grade level do you typically work with (check all that apply):

- Preschool
- Elementary
- Junior High/Middle School
High School

Q45 Your School District

Q49 Alternative School setting?
yes(Please indicate: Learning Center, Middle, High School, Youth-in-Custody, etc) ______________________

No

Answer If A school-community partnership to provide School based me... Yes Is Selected

Q50 What is your role with school-community partnership?
  Team member
  Liaison
  Other ______________________

Q47 Your Educational Level (highest degree obtained)
  B.S.
  M.S./M.A.
  M.S./M.A. + 30 or Ed.S.
  Ph.D./ Ed.D/ Psy.D.
  Other ______________________

Q48 Your Licensed Professional title

Q49 Number of years you have been working with your district
Appendix B

Community Survey
Community Survey

Introduction/ Purpose

(Dr./Professor) Donna Gilbertson and Dina Hargrave, a graduate student in the Department of Psychology at Utah State University are conducting a research study to explore the potential services that are currently or could be provided between schools and community service agencies when developing a statewide Communities of Practice - School Based Mental Health model in Utah. You have been asked to take part because you are involved in the provision and organization of mental health services. There will be 45 to 70 total participants in this research.

Procedures

If you agree to be in this research study, you will complete an online questionnaire. You will be asked about services that are or could be provided by community mental health services for elementary and secondary students in school settings. This questionnaire is expected to be take 15 to 20 minutes. If you prefer, a second option may be to complete the questionnaire during a phone call from a researcher. Risks Participation in this research study may involve a small risk for loss of confidentiality but we will take steps to reduce this risk as described below.

Benefits

A possible benefit from participation in this study is the awareness of local and statewide community and school based mental health services. The key benefit of this study is that the collected information collected may provide guidance on mental health needs and effective practices to developing at state-wide school and community mental health partnership model.

Explanation and Offer to Answer Questions

If you have other questions or research-related problems, you may reach Donna Gilbertson at (435) 797-2034 or by e-mail at donna.gilbertson@usu.edu

Payment/Compensation

Upon completion of the survey, you may choose to follow another link to submit your email address for a chance to win one of two $50 gift certificate to Amazon.com. In no way will your personal information be connected with your survey responses.

Voluntary nature of participation and right to withdraw without consequence
Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence or loss of benefits. You may skip any questions that you
choose not to answer.

Confidentiality

Research records will be kept confidential, consistent with federal and state regulations. FERPA and HIPPA regulations are met by the survey using Qualtics online survey software that is a secure and free program offered at Utah State University. No names will be written on any surveys. A code will be used to replace your district or agency name. The code and agency list will be kept separate from the data throughout the study and it will be destroyed immediately after all data is collected. Only the investigators will have access to the coded data, which will be downloaded from the survey provider’s secure database, and stored on a password-protected computer.

IRB Approval Statement

The Institutional Review Board for the protection of human participants at Utah State University has approved this research study. If you have any questions or concerns about your rights or a research-related injury and would like to contact someone other than the research team, you may contact the IRB Administrator at (435) 797-0567 or email irb@usu.edu to obtain information or to offer input.

Investigator Statement

“I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered.”

I consent (1)
I do not consent (2)

If No, I do not agree Is Selected, Then Skip To End of Survey

A school-community partnership to provide School based mental health services is a collaboration of school personnel (e.g., school psychologists, school social workers, school counselors) and community mental health personnel (e.g., social workers, psychiatrists, psychologists) working together to provide services for students and families. These services can range from consultation to on site care at the school. Are you currently partnering with schools to provide School Based Mental Health (SBMH) services for students?

Yes
No

Answer If A school-community partnership to provide School based me... Yes Is Selected
How many schools are you partnered with for mental health services?

**Answer** If a school-community partnership to provide school-based mental health services exists...

Selected

How many school districts are you partnered with for mental health services?

**Answer** If a school-community partnership to provide school-based mental health services exists...

Selected

Check all grades being served by the SBMH partnership(s):

- K
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- not sure

**Answer** If a school-community partnership to provide school-based mental health services exists...

Selected

Check all the locations of the schools that are participating in the SBMH partnership?

- Urban City
- Suburb (outside a principal city and inside an urbanized area)
- Town (territory inside an urban cluster)
- Rural (> 5 miles from an urbanized area)

**Answer** If a school-community partnership to provide school-based mental health services exists...

Selected

Are the mental health services provided part of (check all that apply):

- 504 accommodations
- Related services to meet IEP goals
- Alternative school services
- Not sure
- Other ______________________

**Answer** If a school-community partnership to provide school-based mental health services exists...

Selected

Check all the types of funding used for the services provided by the SBMH partnership?
Medicaid
Grants
Private monies
Other ____________________
not sure

Answer If A school-community partnership to provide School based me... Yes Is Selected

What activities are your personnel engaged in at the schools? (check all that apply)

<table>
<thead>
<tr>
<th>Currently doing this</th>
<th>Not currently, but could be</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending team meetings</td>
<td>Check if yes</td>
</tr>
<tr>
<td>Consulting with teachers</td>
<td>Check if Yes</td>
</tr>
<tr>
<td>Collecting data to monitor progress on school progress</td>
<td></td>
</tr>
<tr>
<td>Conducting record reviews of school outcomes</td>
<td></td>
</tr>
<tr>
<td>Providing written reports to schools</td>
<td></td>
</tr>
<tr>
<td>Consulting with parents</td>
<td></td>
</tr>
<tr>
<td>Data sharing</td>
<td></td>
</tr>
<tr>
<td>Case management</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Answer If A school-community partnership to provide School based me... No Is Selected

As part of mental health services, what activities would you like to be engaged in at the schools? (check all that apply)

- Attending problem solving team meetings
- Consulting with teachers
- Collecting data to monitor progress on school progress
- Conducting record reviews of school outcomes
- Providing written reports to schools
- Consulting with parents
- Data sharing
- Case management
- Other ____________________

Answer If A school-community partnership to provide School based me... No Is Selected

If a partnership with a school or district was formed in the future, could the SBMH services provided by your agency be part of (check all that apply):

- 504 accommodations
related services to meet IEP goals
alternative school services
not sure
other ____________________

Answer If A school-community partnership to provide School based me... No Is Selected

How could the SBMH services be funded (check all that apply)?
Mediaid
Grants
Private monies
Other ____________________
not sure

Answer If A school-community partnership to provide School based me... Yes Is Selected

Who provides SBMH services(check all that apply)?
APRN (Advanced Practice Registered Nurse)
Psychologist
Social worker
Psychiatrist
Nurse Practitioner
Other ____________________
Unsure

Answer If A school-community partnership to provide School based me... No Is Selected

Who could provide SBMH services(check all that apply)?
APRN (Advanced Practice Registered Nurse)
Psychologist
Social worker
Psychiatrist
Nurse Practitioner
Other ____________________
Unsure

Have the above personnel had training in school based mental health?
Yes
No
not sure

Would your agency be interested in additional training?
Yes
No
Not sure
Below is a list of 3 levels of problem severity and corresponding services that could be addressed with a school/community collaboration. Although each level has various titles, in general, services addressing the 3 levels of problems are defined as: Tier 1, Prevention or Universal services: Given to all students to address risk factors in entire school populations without attempting to discern who are at-risk (typically delivered in the general education setting). Tier 2, At-risk, Secondary, or Selective Targeted services for at-risk symptoms: Provided to at-risk students who share a significant risk factor that may be a lifetime risk or beginning to exhibit signs of more serious problems (typically delivered in the small group setting). Tier 3, Severe, Tertiary, or Indicated Intensive services (Tier 3, Tertiary) for severe symptoms: Given to those students with severe problems or symptoms that may meet diagnostic disorder/classification criteria, that may be harmful to self or others, and/or not responding to other levels of support (typically delivered in the individual setting).

**Answer**

If a school-community partnership to provide School based mental health... Yes is Selected

First, check if a type of problem is currently being addressed by SBMH partnership services OR, if no partnership is in place for that problem, indicate whether the problem is a concern that could potentially be considered for a SBMH partnership for services. Second, check the levels of support (Universal, Selective, Indicated) that are currently being implemented or which levels could be implemented with SBMH community services. Third, if a program is being implemented, rate the effectiveness of the SBMH services.

<table>
<thead>
<tr>
<th>Partnership level</th>
<th>Indicate level in place or needed (check all that apply)</th>
<th>Effectiveness if Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implemented with a partnership</td>
<td>Would consider for collaboration</td>
<td>Not Implemented and would not consider</td>
</tr>
<tr>
<td><strong>Academic Deficits</strong></td>
<td><strong>Externalizing Problems</strong> (disruptive, defiant, aggressive, CD, ODD, ADHD, bullying)</td>
<td><strong>Internalizing Problems</strong> (anxiety, school refusal, depression, motivation)</td>
</tr>
</tbody>
</table>

<p>| Academic Deficits | Externalizing Problems (disruptive, defiant, aggressive, CD, ODD, ADHD, bullying) | Internalizing Problems (anxiety, school refusal, depression, motivation) | Pregnancy | Court Referrals | Attendance/Truancy | Implemented with a partnership | Would consider for collaboration | Not Implemented and would not consider | Universal (for ALL students) | Selective (for AT-Risk students) | Indicated (for SEVERELY SYMPTOMATIC students) | Not at all effective | Slightly effective | Moderately effective | Highly effective | N/A |</p>
<table>
<thead>
<tr>
<th>Consideration for Partnership</th>
<th>Indicate level of services needed (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Deficits Externalizing Problems (disruptive, defiant, aggressive, CD, ODD, ADHD, bullying) Internalizing Problems (anxiety,</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Consideration for Partnership

<table>
<thead>
<tr>
<th>Indicate level of services needed (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

- school refusal, depression, motivation
- Pregnancy
- Court Referrals
- Attendance/Truancy
- Addiction/Substance abuse
- Eating Disorder
- Medical
- Family stressors (e.g., parent death, divorce)
- Peer problems
- Immigration and cultural adjustment issues
- Trauma
- Drop out prevention
- Other

In this section we will ask questions to find out about specific services that are being provided or could be provided for each level of support: Tier 1 (prevention services), Tier 2 (addressing at-risk factors), Tier 3 (addressing severe problems).

Answer If A school-community partnership to provide School based me... Yes Is Selected

For Tier 1/ Universal level (for ALL students), what school-community partnership services are provided to support well-being of the entire school population or that the agency would like to implement as part of a school-community partnership (check all that apply)?
Answer If A school-community partnership to provide School based me... No Is Selected
For Tier 1/ Universal level(for ALL students), what school-community partnership services could be provided to support well-being of the entire school population (check all that apply)?
- Psycho-educational knowledge for teachers, parents, and/or students
- Classroom based social emotional or social skill training
- Classroom based reward system programs
- Teacher training
- Crisis prevention
- Other ____________________

Selective Services (Tier 2) provided to at-risk students

Answer If A school-community partnership to provide School based me... Yes Is Selected

For Selected Tier 2 level provided to AT-RISK students, what services are provided to support at-risk students with community support or that the agency would like to implement as part of a school-community partnership (check all that apply)?

<table>
<thead>
<tr>
<th>Implemented by Community Agency Personnel</th>
<th>Not currently partnered for this service, but would consider for partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student (parent, teacher) psycho-educational Counseling Small groups social skill training</td>
<td>check if Yes</td>
</tr>
</tbody>
</table>
Individual Therapy
Behavior modification plans (e.g., contracts, tokens, home-school notes)
Parent skill training
Parent consultation
Teacher Consultation
Teacher Training
Other

Answer If A school-community partnership to provide School based me... No Is Selected
For Selected Tier 2 level provided to at-risk students, what services could be provided to support at-risk students with community support as part of a school-community partnership (check all that apply)?

- Student (parent, teacher) psycho-educational Counseling
- Small groups social skill training
- Cognitive Behavioral Therapy
- Behavior modification plans (e.g., contracts, tokens, home-school notes)
- Parent skill training
- Parent consultation
- Teacher Consultation
- Teacher Training
- Other ____________________

Indicated Services (Tier 3) for severe Mental Health issues

Answer If A school-community partnership to provide School based me... Yes Is Selected
For Indicated Tier 3 level provided to SEVERELY SYMPTOMATIC students, what services are provided to address high levels of symptoms that may meet diagnostic disorder/ classification criteria with community support or that the agency would like to implement as part of a school-community partnership (check all that apply)?
<table>
<thead>
<tr>
<th>Implemented by Community Agency Personnel</th>
<th>Not currently partnered for this service, but would consider for partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student (parent, teacher) psycho-educational Counseling Small groups social skill training Individual Therapy Behavior modification plans (e.g., contracts, tokens, home-school notes) Parent skill training Parent consultation Teacher Consultation Teacher training Crisis response Medication management Residential Day Treatment (i.e. Therapeutic day program part of school district services) Alternative School Placement/Services Day Treatment (Therapeutic day program provided by an outside agency not part of school district services) Other Other</td>
<td></td>
</tr>
</tbody>
</table>

**Answer**

If A school-community partnership to provide School based me... No Is Selected For Indicated Tier 3 level provided to severely symptomatic students, what services could be provided to address high levels of symptoms that may meet diagnostic disorder/classification criteria with community support as part of a school-community partnership (check all that apply)?

- Student (parent, teacher) psycho-educational Counseling
- Small groups social skill training
- Individual Therapy
- Behavior modification plans (e.g., contracts, tokens, home-school notes)
- Parent skill training
Parent consultation
Teacher Consultation
Teacher training
Crisis response
Medication management
Residential
Day Treatment (i.e. Therapeutic day program part of school district services)
Alternative School Placement/Services
Day Treatment (Therapeutic day program provided by an outside agency not part of school district services)
Other ____________________
Other ____________________

Answer If A school-community partnership to provide School based me... Yes Is Selected
What assessments are used by your agency to determine the impact of community services on school functioning (check all that apply)?
  Attendance
  Grades
  Standardized tests
  Academic screening outcomes
  Suspensions
  School climate assessment (i.e., overall safety, quality and character of school life)
  Drop-out rates
  Other data are collected and reviewed? ____________________
  None

Answer If A school-community partnership to provide School based me... No Is Selected
What assessments could be used by your agency to determine the impact of community services on school functioning (check all that apply)?
  Attendance
  Grades
  Standardized tests
  Academic screening outcomes
  Suspensions
  School climate
  Drop-out rates
  Other data are collected and reviewed? ____________________
  None

What type of assessments are currently being used by your agency to determine who is responding to treatment for each level of services (check all that apply)?
<table>
<thead>
<tr>
<th></th>
<th>Universal or Tier 1</th>
<th>Selective or Tier 2</th>
<th>Indicated or Tier 3</th>
</tr>
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</tr>
<tr>
<td>Interviews</td>
<td></td>
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<td>Observations</td>
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<td>Other</td>
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</tbody>
</table>

**Answer** If a school-community partnership to provide School based... Yes is selected

Rank from 1 to 10, by dragging and dropping, the following barriers/struggles to manage and obtain outcome data within a SBMH program (where 1 is NOT a barrier/struggle, and 10 is the biggest barrier/struggle).

-   __________ Time Constraints
-   __________ Problems with prescribed role
-   __________ Too many students to serve
-   __________ Paperwork requirements
-   __________ Collaboration difficulties
-   __________ Budget constraints
-   __________ Staff unsupportive of counseling
-   __________ Student attrition
-   __________ Insufficient professional preparation
-   __________ Other

**Answer** If a school-community partnership to provide School based... No is selected

Rank from 1 to 10, by dragging and dropping, the following possible barriers/struggles that you foresee to managing and obtaining outcome data within a SBMH program (where 1 is NOT a barrier/struggle, and 10 is the biggest barrier/struggle).

-   __________ Time Constraints
-   __________ Problems with prescribed role
-   __________ Too many students to serve
-   __________ Paperwork requirements
-   __________ Collaboration difficulties
-   __________ Budget constraints
-   __________ Staff unsupportive of counseling
-   __________ Student attrition
-   __________ Insufficient professional preparation
-   __________ Other
Rank the following key factors from 1 to 7, by dragging and dropping, to successful programs that promote positive education, social, behavioral, mental health well being outcomes for all students (where 1 is NOT an important key factor, and 7 is the most important key factor).

_____ Training
_____ Data sharing
_____ Effective teams
_____ Shared priorities between school and agency
_____ Regular feedback
_____ Clear definition of inter-agency roles
_____ Other

Rank the following key factors from 1 to 7, by dragging and dropping, you believe are important for successful programs that promote positive education, social, behavioral, mental health well being outcomes for all students (where 1 is NOT an important key factor, and 7 is the most important key factor).

_____ Training
_____ Data sharing
_____ Effective teams
_____ Shared priorities between school and agency
_____ Regular feedback
_____ Clear definition of inter-agency roles
_____ Other

What grade level do you typically work with (check all that apply):
- Preschool
- Elementary
- Junior High/Middle School
- High School

Your Agency

Alternative School setting?
yes(Please indicate: Learning Center, Middle, High School, Youth-in-Custody, etc)

No

Answer If A school-community partnership to provide School based me... Yes Is Selected

What is your role with school-community partnership?
Team member
Liaison
Other ____________________

Your Educational Level (highest degree obtained)
B.S.
M.S./M.A.
M.S./M.A. + 30 or Ed.S.
Ph.D./ Ed.D/ Psy.D.
Other ____________________

Your Licensed Professional title

Number of years you have been working with your agency