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SCHOOL-BASED MENTAL HEALTH SERVICES: ASSESSING CHARTER
SCHOOL PRINCIPAL PERCEPTIONS

By
Barry L. Ross

A Dissertation Submitted to the
Gardner-Webb University College of Education
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

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2021

Approval Page

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I dedicate this dissertation to my beloved wife Sharon without whose patience, encouragement, support, and dedication this dissertation would not have been possible.

Abstract

SCHOOL-BASED MENTAL HEALTH SERVICES: ASSESSING CHARTER SCHOOL PRINCIPAL PERCEPTIONS. Ross, Barry L., 2021: Dissertation, Gardner-Webb University.

The purpose of this quantitative study was to describe North Carolina charter school principal perceptions of school-based mental health services in their buildings. The research used an online survey instrument and descriptive statistics to gather and analyze data. Principals of all 182 North Carolina charter schools (excluding the state's two virtual schools) were asked to complete the survey. Through this study, 52 current North Carolina charter school principals completed a 36-question survey. The original survey instrument was designed jointly by the University of California San Francisco and the California Department of Education. It was modified for use with this study through permission granted by the survey's creators. The instrument measured principal perceptions of mental health care service availability, barriers to service provision, and staff professional development needs to identify and address student mental health issues. Four themes emerged from surveying principals: (a) students with mental health concerns are common in North Carolina charter schools, (b) charter schools lack adequate mental health staff, (c) significant barriers exist to the provision of mental health services, and (d) charter school teachers have a high need for professional development.

Keywords: quantitative study, principal perceptions, survey research, charter school, school-based mental health

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Chapter 1: Introduction

Background of the Study

Delivering effective mental health services for school-age youth is an important international issue. Eighty percent (approximately 58 million people) of the world's school-age people live in low-to-moderate-income countries, and more than 50% of them reside in sub-Saharan Africa, where they experience extremely stressful lives. The stressors that contribute to children's poor mental state include war, violence, famine, and poverty. Interestingly, even with this extreme stress, school attendance rates have risen steadily in these countries since 2000. The evidence indicates that the increased attendance of students with mental disorders is straining an already overburdened and under-resourced system of schools in these impoverished nations. To manage, these countries depend on nongovernmental organizations such as the United Nations Children's Fund and the World Health Organization (WHO) for financial assistance to provide school-based mental health care for young people. Finally, between 62% and 86% of the relief funds provided by such organizations go to supporting children's mental health during the day while they are at school (Fazel et al., 2014).

Evidence suggests that research on school-based mental health care in low-to-moderate-income countries is scarce. The few existing research studies have indicated similarities in student outcomes. Specifically, proactive interventions, rather than reactive treatment, provided students with mental health concerns the most benefit. Continents represented in these research projects included Africa, Europe, and South America. Most of the students treated during these studies were exposed to violence and conflict that manifested in mental conditions such as anxiety and posttraumatic stress disorder

(PTSD). Students treated for PTSD while at school showed the most improvement. Finally, providing school-based mental health care is an internationally accepted best practice for delivering mental health care to school-age children, regardless of a nation's wealth (Fazel et al., 2014).

Like their peers in poor nations, the school-age population in high-income countries such as Australia and the United Kingdom also experience mental health conditions that are most often treated at school. The quality of treatment and access to treatment are also far greater in wealthier nations. However, the most common location for student treatment is the same for both poor and rich countries. Students most often access mental health care while at school. Students in need of mental health care in wealthy countries are mostly treated for behavioral disorders and multiple forms of anxiety, with care provided by community- or school-based trained professionals. Finally, like poor countries, high-income nations approach school-based mental health care proactively through schoolwide preventative interventions by school staff, for example, promoting mentally healthy habits like developing coping skills to counteract stress (Fazel et al., 2014).

The United States, like all other nations of the world, has children and adolescents who experience mental health disorders. According to Foy et al. (2019), between 13% and 20% of American students experience mental health-related issues in any given year, but only 25% receive mental health care. The 25% of American students who receive treatment do so at school, just like their foreign counterparts. Like children in other countries around the world, the most common mental health conditions American students face include depression, anxiety, and behavioral disorders. Additionally, the

research indicates that if left untreated, these conditions typically lead to student aggression and disruptive behaviors that persist into adulthood. In their severest forms, untreated mental health conditions have led to teen suicide. WHO (2019) reported suicide as the second leading cause of death of young people 15–29 years old around the world. Finally, although the highest rates of mental health issues among American youth are in the poorest communities, affluent youth are experiencing the fastest rise in mental health disorders (Foy et al., 2019).

Like all other American states, North Carolina's traditional school districts and charter schools are facing serious problems responding to student mental health needs. Specifically, North Carolina's state legislature enacted a school-based mental health policy largely due to the School Mental Health Initiative report it commissioned in 2016. This report suggested that annually, approximately 76,000 students in North Carolina receive some degree of these services (North Carolina Department of Public Instruction [NCDPI], 2017); however, there is little evidence that the services have been effective. In a 2016 survey conducted by the North Carolina School Mental Health Initiative, more than 80% of community mental health agency providers indicated that no accountability system was in place to determine whether student program outcomes were achieved, nor was a system in place to assess program effectiveness.

Furthermore, more than 300,000 North Carolina students experience mental health disorders that require treatment, but only 76,000 receive it. Most of those 76,000 students receive services in the school setting (NCDPI, 2017). The legislation resulting from the School Mental Health Initiative's recommendations mandated a collaborative effort between NCDPI and the North Carolina Department of Health and Human Services

to develop (a) mental health training content standards, (b) evidence-informed or evidence-based mental health training programs, and (c) suicide risk referral standards (North Carolina Legislature, 2018).

Statement of the Problem

Students with mental health conditions lack the ability to build and maintain healthy relationships. There is an absence of well-developed coping mechanisms, which causes them to compensate for their difficulties in unhealthy ways, including drug and alcohol abuse. Also, these students lack the social-emotional skills necessary for school success, so poor school performance is a contributing factor to a bleak future (Centers for Disease Control and Prevention [CDC], 2016). Furthermore, the landmark federal report *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999) is often cited in the research for its claim that as much as 13% to 20% of this nation's youth have experienced mental health disorders. Two decades later, this figure of 13% to 20% is still commonly used in the literature. According to Foy et al. (2019), in any given year, 13% to 20% of America's youth experience mental health disorders. Finally, if students experiencing mental health disorders receive care, they are most likely only to receive said treatment at school (Costello et al., 2014).

Why Principal Perceptions Matter

For school-based mental health care to occur, it must have the support of building principals because they are the key influencers for school improvement and school reform. Effective principals seem to endorse and support collaborative leadership to build consensus for the necessary work. Furthermore, principal perceptions matter because principals are the ones who establish school culture and set the conditions for success for

both staff and students. Therefore, it is critical to uncover what principals think about the importance of nonacademic barriers to student achievement because their perceptions determine both the priority of effort for school personnel and the allocation of resources to address those perceived needs. Activities such as building teacher capacity through instructional coaching and collaborating with them to provide professional development based on their needs and those of their students, as well as providing a safe and orderly learning environment, are key to student academic achievement. Specifically, according to Iachini et al. (2015),

Principals can significantly influence school performance through setting directions for schools, building professional capacity for teachers, and managing school organizations to provide safe and orderly environments that foster school improvement.... These perceptions can highlight principals' implicit ideas regarding school improvement and the areas they may emphasize... [and the] resource allocation to promote academic achievement among students in their school. (pp. 40-41)

Purpose of the Study

The purpose of this study was to examine North Carolina charter school principal perceptions regarding the delivery of mental health care services in their schools. The instrument to examine principal perceptions was a survey, which I sent to all 182 North Carolina charter school principals. Specifically, the main aims of this research were to (a) describe what charter school principals think about student mental health care service delivery in their schools; (b) determine what barriers, if any, stand in the way of providing said services; and (c) examine the specific training needs of their staff to

facilitate school-based student mental health care. Additionally, I aimed to evaluate differences in principal perceptions based on geography (urban, suburban, or rural) and school level (elementary, middle, or high school). The final goal of this study was to add to the body of literature on principal perceptions of school-based mental health from a K–12 perspective.

Definitions of Terms

For this study, standard definitions of operational terms come from common usage and the relevant literature. The following definitions apply to this study.

Academic Functioning

This is a broad term that defines how students perform in school. It considers student performance in terms of both academic progress and meeting expected school behavioral norms (Hoagwood et al., 2007).

Comorbidity

The existence of two or more mental disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5). The purpose of the DSM–5 is to aid in the diagnosis of mental disorders (CDC, 2018).

DSM

Stands for Diagnostic and Statistical Manual of Mental Disorders. Mental health professionals use the DSM to define and classify mental health disorders in people to identify and treat patients. It is also used for research purposes (American Psychiatric Association, 2017).

Evidence-Based Practice

An evidence-based practice is one whereby a practitioner employs techniques and

methods according to the most recent and best available research (American Psychological Association, 2004).

Mental Health

“A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (Helping adolescents thrive toolkit, 2021, p. xi).

System of Care

An approach that supports youth in need of mental health care with a full spectrum of coordinated services provided by community-based agencies (Freeman et al., 2014).

School-Based Mental Health

“Any program, intervention, or strategy applied in a school setting that was specifically designed to influence students’ emotional, behavioral, or social functioning” (Rones & Hoagwood, 2000, p. 224).

Social-Emotional Learning (SEL)

The process by which “children and adults acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions” (Weissberg & Cascarino, 2013, p. 10).

Research Questions

The purpose of this research was to describe North Carolina’s charter school principal perceptions of student mental health needs in their schools. I used the following three questions to measure those perceptions.

1. What perceptions do charter school principals have of mental health care service availability, barriers to service provision, and staff professional development needs regarding mental health?
2. Are there statistically significant differences in perceptions of mental health care service, barriers to service provision, and staff professional development by grade level?
3. Are there statistically significant differences in perceptions of mental health care service availability, barriers to service provision, and staff professional development needs between school principals of urban, suburban, and rural communities?

Chapter 2: Literature Review

Introduction

The primary goal of this literature review is to trace the historical development and rationale for school-based mental health treatment programs in the United States. School-based mental health treatment emerged at the end of the 19th century and continued to evolve throughout the 20th century. Providing mental health care in schools was largely a local effort until the federal government began to become involved in the latter half of the 20th century through presidential executive orders and congressional legislation, as well as through the provision of financial grants to states. Moreover, federal funding sponsored longitudinal studies to establish the efficacy of school-based mental health. The results of these studies were stored in government-funded information databases that school systems could access free of charge. Finally, public schools have enabled families facing challenges in accessing mental health care to mitigate those obstacles.

The Evolution of School-Based Mental Health

The Historical Development of School-Based Mental Health

According to Jones (2002), the history of modern school-based mental health care began at the end of the 19th century when University of Pennsylvania psychiatrist Lightner Witmer established the country's first psychological clinic at the university in 1896. Witmer observed during patient evaluations how student physical impairments, such as the need for glasses, if left untreated may cause students to act out because of their inability to see the blackboard. He also observed in other studies that students' home environments and the nature of their relationships with their parents may impact student

learning and be a cause for disruptive behavior. Later, other scientists, like Sigmund Freud and his daughter Anna, would make similar assertions regarding the consequences of a child's negative relationship with a parent that would require psychiatric treatment. Furthermore, Witmer claimed that when students' medical conditions (e.g., a new pair of glasses) and home lives improved, so did their behavior and performance at school. Finally, Witmer's research had a profound impact on future child and adolescent mental health research because all that was known previously about young people's maldevelopment came from the observations of prison superintendents and their interactions with children inside the adult prison system (Jones, 2002).

Compulsory School Attendance

According to Katz (1976), school is where society first began to learn about the behavior and abilities of children and adolescents when the Massachusetts Bay colony passed the first compulsory attendance law in 1642. The purpose of the law was to ensure the colony's children were educated in religion, reading, and the laws of Massachusetts Bay. Additionally, the colony's educational supervisors were responsible for reporting parental child-rearing neglect to the colony's court. There was little change in how Americans were educated from the 17th century through the first half of the 19th century. The formal education of America's children was strictly a family responsibility; however, by the mid-19th century, once again, Massachusetts was the first state to develop public education. America's first educational reformer, Horace Mann, suggested a system of free public schools. While serving as Massachusetts's first state superintendent of education, Mann called for the establishment of free, nonsectarian public schools throughout the country. By 1890, 27 states had passed compulsory school attendance

laws; however, these compulsory attendance laws had little in common and varied in the length of the school year (impacted by farming and work), the curriculum, and attendance eligibility. The one thing they had in common, however, was the inability of states to enforce the laws (Katz, 1976).

The beginning of the 20th century gave rise to more states passing compulsory education laws along with an improving ability to enforce those laws. Still, the concept of compulsory school attendance was in its infancy, and it was rarely enforced. For the most part, this meant that school-age children continued to be left unattended and roaming the streets of America's largest cities day and night, where they could get into trouble with the law (Katz, 1976). Even though education laws mandated that children attend school, many millions of American children did not, for reasons such as gender, race, and socioeconomic status. Consequently, deplorable home environments, as well as obligations to contribute financially to provide for their families, made school attendance a low family priority. Tenuous family existence, combined with a lack of child labor laws, ensured that the poorest children did not attend public school, regardless of the law. On the other hand, thousands of children did attend school, and those numbers continued to grow throughout the first half of the 20th century. Ultimately, the "idea of sending one's child to school rather than to work not only was legislated and coercively implemented but also was promoted and voluntarily accepted by increasing numbers of people" (Katz, 1976, p. 23).

Although the concept of government involvement in family matters was generally anathema to the American psyche, the relationship between the government and the people began to change. The first 3 decades of the 20th century are referred to as the

Progressive Era. One of the leading figures of the time was America's second educational reformer, University of Chicago professor John Dewey. Among other ideas, Dewey called for both educational and societal reforms. While a professor at the University of Chicago, Dewey opened a school that was popular with both parents and students because it emphasized hands-on learning and the importance of children and the way they learned, rather than content and how it was taught ("John Dewey, philosophy and education," n.d.). His ideas were considered radical for the time, and Dewey was forced to resign from his position with the university, never opening another school; however, Dewey remained an educational philosopher and continued to promote educational and societal reform.

According to Hunt (2010), John Dewey outlined his educational philosophy in his year 1900 publication, *The School and Society*. In his book, Dewey promoted the idea that for American society to embrace its democratic nature, all students must be successful in school, and school must not simply be an institution to produce factory workers or a place to promote passive learning. Dewey believed the American education system of the time was designed to produce two classes, one that worked and one that managed, whereas Dewey believed America needed a system that fostered active learners who could think, build, and produce, rather than indifferent learners being force-fed information (Hunt, 2010). He also believed that the educational system needed to facilitate an environment in which students could be self-directed learners, exploring and creating. Finally, Dewey believed that traditional education failed to consider the social contexts in which children lived, and which influenced educational outcomes.

Societal Shift

The Progressive Era caused a monumental cultural shift from a primarily agrarian society to an industrial one. Additionally, mass European immigration and urbanization changed the American economy, resulting in poverty on such a large scale that it led to social problems the United States had never faced before (Osgood, 2008). This period was the first instance in American history where citizens, en masse, looked to the government for assistance; however, municipal governments found themselves woefully unprepared to fulfill this role and turned to local education agencies for assistance. Progressive leaders reasoned that because states had the power of law to compel school attendance, it seemed logical for schools to provide the necessary services to the impoverished and rapidly dissolving family unit, so schools were “charged to assume a greater role as social service and acculturation agencies...that ensured public safety, economic stability, and cultural integrity” (Osgood, 2008, p. 6).

Truant officers who enforced attendance laws were one-way progressives in government offices who improved school attendance (Pumariiega & Vance, 1999); however, this came at a price. First, many children who came to school for the first time had no formalized education. Consequently, they were academically unprepared for the rigors expected of them in school. Second, the 20th century also gave rise to America’s Industrial Age and rapid economic growth. Many jobs that were once done by hand were now done using machines, including farming; thus, an influx of displaced farmers to cities in search of work, coupled with waves of immigrants from Europe arriving and looking for economic opportunities in America’s largest cities, led to widespread poverty across the country because there was not enough work for all. Additional factors, such as

lacking necessary job skills, also contributed to poverty. Poverty, in turn, led to a rise in juvenile delinquency because parents could not adequately care for their children.

Before the Progressive Era, there were no alternatives to adult courts and prisons, so the rise in juvenile delinquency meant young people in legal trouble were tried in adult courts (Han, 2012). If they were convicted, these young offenders were then sent to adult prisons. Once inside an adult prison, juveniles faced harsh conditions and a bleak future when they got out. In response, major American cities like Chicago established separate justice systems for juveniles. This system was composed of newly established juvenile courts. Additionally, progressives recognized that the family circumstances and mental health statuses of juveniles impacted their behavior, so they created clinics to treat the mental health of young people. These clinics were called child guidance clinics. At these places, students and families received counseling to reduce delinquency, prevent jail time, and improve parenting skills. By 1922, child guidance clinics were established throughout the country through the philanthropic work of the New York City-based Commonwealth Foundation. The foundation's generosity throughout the 1920s and 1930s facilitated the expansion of the clinics to other major cities across the United States.

The facility staff of each child guidance clinic consisted of a psychiatrist, a psychologist, and a psychiatric social worker. The scientific framework for each clinic was Sigmund Freud's psychoanalysis model. Due to the Commonwealth Foundation's sponsorship, child guidance clinics established relationships with local colleges of social work where psychiatric social workers could be trained and placed in clinics where they were needed (Han, 2012). These social workers applied psychoanalytic techniques they

learned in school to discern the conscious and subconscious reasoning for the inappropriate behaviors of their child clients. Based on their experiences, psychiatric social workers made the argument that young people displayed inappropriate behaviors that were attributable to negative parent attitudes toward their children. In their view, a child's disruptive behavior was the result of their unmet needs for parental care and love.

America's first child psychiatrist, Leo Kanner, founded the Johns Hopkins University Children's Psychiatric Clinic in 1930 and later wrote the first English language child psychiatry textbook in 1935. Kanner's clinic was a sub-clinic within Johns Hopkins University's pediatric hospital. The original purpose of the child psychiatric clinic was to train pediatricians to treat children's behavioral problems because the prevailing medical reasoning of the time was that children's issues were simple and easily managed compared to adult psychiatry, especially if pediatricians were adequately trained (Han, 2012). In its first 15 years of existence, the clinic saw a 90% increase in referrals, rather than the expected decrease.

Differences in those clinical referrals ran along family socioeconomic status lines. Affluent families tended to be proactive and brought their children for consultative visits to the clinic when they noticed changes in behavior while at home or school. Their purpose for visiting the clinic was a personal consultation with Kanner. In many cases, affluent families traveled long distances just for the opportunity to meet with him, so they rarely actually engaged in treatment at the hospital (Han, 2012). The working poor, on the other hand, were referred to Kanner by school administrators because of student disruptive behaviors and truancy, among other causes. Mothers of these students engaged in treatment because they saw it as an opportunity to confide in someone about their

struggles at home regarding behaviors such as spousal abuse and alcoholism. However, these mothers risked a great deal by doing so, because if they confided too much and the clinic thought the children were at risk, the state could remove their children from the home.

Clifford W. Beers was another influential progressive who impacted children's mental health. Beers was a wealthy Wall Street banker who suffered from mental illness to the point that he attempted suicide. As a result of his actions, he was institutionalized for 3 years. During his involuntary commitment, he experienced the trauma associated with being an inpatient brought about by the poor, and sometimes cruel, treatment of his caretakers. After he was released, Beers founded the Mental Health America (MHA) organization in 1909. This action started a separate American mental health reform movement. Its purpose was to move the care of mentally ill people from institutions to the home and community. The movement had three goals: (a) improving societal attitudes toward mental illness and the mentally ill, (b) improving services for people with mental illness, and (c) working to prevent mental illness by promoting good mental health (MHA, n.d.). Over the course of the 20th century, MHA's support and influence continued to grow by supporting federal legislation that promotes mental health. MHA's most recent work was its lobbying efforts to pass the Student Support Act (2015–2016). The purpose of the bill was to “require...matching grants...so that additional school-based mental health and student service providers may be hired” (Student Support Act 2015–2016, p. 1).

The Influence of the Federal Government on School-Based Mental Health

World War II (WWII) unexpectedly helped the future of child psychiatry in the

United States by facilitating further understanding of the shaping of child and adolescent behavior. Additionally, the aftermath of the war led to the federal government's new role as a research sponsor and for providing grants to states to promote mental health (Schowalter, 2003). This new understanding began with America's entry into WWII. America did not have a large standing army, so the federal government initiated a military draft that conscripted young Americans from all walks of life into the country's armed forces. Draft boards received the records of millions of young people, including information about their mental and behavioral histories from childhood and adolescence. Consequently, information in these records rendered many of these draftees mentally and physically unfit for duty and led to their early discharges from military service.

For young civilians who were mentally ill and made it through the draft boards and into active military service, the stressors of war triggered underlying psychiatric issues. WWII military medical records indicate that from 1942 to 1945, over 1,000,000 of the 15,000,000 men and women serving in the war were discharged for some form of psychiatric disorder (Karpinos & Glass, n.d.). Furthermore, during the war, the army's medical leadership learned that mental fitness before service was just as important as soldiers' physical fitness in increasing their individual chances of survival. Moreover, mitigating casualties due to psychiatric factors depended on individuals' childhood and adolescent social and emotional conditioning, because "by the end of the war, it was obvious that soldiers who had behavior problems as children were much more likely to be prematurely discharged, disciplined, wounded or killed. It was a statistic that could not be ignored" (Schowalter, 2003, p. 1).

In the post-WWII era, the large number of early military discharges for

psychiatric reasons motivated the passage of the Mental Health Care Act (1946). This act was signed into law by President Harry Truman on July 3, 1946. It was the first federal law to address America's mental health needs. Its purpose was to improve the mental health of American citizens. The most significant piece of the legislation was the establishment and funding for a National Institute of Mental Health (NIMH), on April 15, 1949. The function of NIMH was to act as a national research institution by promoting and funding research to investigate the causes and treatment of mental disorders (National Institutes of Health, 2017). Today, NIMH is still the federal government's primary center for mental and behavioral health research.

Following the 1946 Mental Health Care Act, Congress passed the 1955 Mental Health Study Act, during the Eisenhower administration. The purpose of this act was to study the needs of America's mentally ill population and make recommendations for the development of a national mental health program (Joint Commission on Mental Illness and Health, 1961). The commission's final report, published in 1961, indicated that millions of children across the United States who had been diagnosed with mental illness were being neglected. Furthermore, report findings suggested that poverty, family conflict, fatherless homes, and emotional abuse all contributed to children's mental health issues. Significantly, the members of this joint commission were the first federal researchers to acknowledge the central role schools played in influencing the mental health of students.

Furthermore, the researchers reasoned that since classroom teachers have ongoing contact with students and their families, they are best suited to identify the early warning signs of mental illness. Consequently, they suggested teachers should be the ones to refer

suspected students in need of mental health care to trained professionals. To carry out this responsibility, the report recommended that teachers should be formally trained to make identifications and referrals, as well as to function as mental health care first aid attendants in cases where students were experiencing crises in the classroom. The Mental Health Study Act (1955) also called for placing professional guidance counselors and doctoral-level psychologists in schools to address student needs through counseling. Finally, the report recognized that support from school administrators and school boards was critical to promoting mental health care in schools (Joint Commission on Mental Illness and Health, 1961).

Recommendations resulting from the Mental Health Study Act (1955) eventually led to the passage of the Community Mental Health Centers Act (CMHCA) of 1963. This act was a major piece of federal legislation that would have a substantial and long-lasting impact on future mental health and educational policy. CMHCA formally asserted the federal government's influence in dispensing mental health care in the United States for the first time (Flaherty & Osher, 2003). The law reshaped America's mental health service delivery system. Whereas the child guidance clinics of the first half of the 20th century were financed through private-sector philanthropy, CMHCA used public financing to provide states with federal grants to fund community-based mental health clinics. The establishment of these clinics facilitated state efforts to deinstitutionalize mental health treatment by closing custodial-care psychiatric institutions. CMHCA laid the foundation for the landmark 1975 Education for all Handicapped Children Act by providing grants to colleges to prepare teachers of children with disabilities.

The federal government's growing influence over school-based mental health

continued with the passage of the Education for All Handicapped Children Act (1975). The purpose of this law was to ensure that students whose learning was impaired due to a handicapping condition would receive specialized instruction. In addition to academic support, the act required schools to provide any necessary specialized related services to students at no cost to their families. Specifically, students could be provided with individual, group, or family counseling services if they were eligible under the terms of the law. Moreover, the act provided parents and guardians with procedural safeguards to protect their children from being unfairly denied appropriate services.

The 1977 President's Commission on Mental Health was established by President Carter through Executive Order 11973 (President's Commission on Mental Health, 1978). The commission's purpose was to conduct a nationwide mental health needs assessment, accompanied by recommendations for national health care policy priorities. Like the 1961 Joint Commission report, the President's Commission on Mental Health recognized that schools were logical places to provide mental health functions for students. The commission asserted that America's fragmented mental health treatment delivery system was inadequate to meet patient needs. Consequently, it proposed a system-of-care model that would coordinate all available resources to provide improved mental health treatment. Additionally, the commission identified cultural barriers that impeded racial and ethnic minorities' access to care. Limited access to mental health care has often been cited in the research literature and other national reports as a rationale for supporting school-based mental health programs.

Mental Health: A Report of the Surgeon General (U.S. Department of Health and Human Services, 1999) is a seminal document in mental health research that is still often

cited in the school-based mental health literature. One of its key findings identified schools as suitable providers for parents seeking mental health care for their children. The report indicated that 21% of 9- to 17-year-old youth had some evidence of mental illness that impaired their school performance and that those youth were largely treated by school-based programs. Like prior reports, the 1999 Surgeon General's report recognized initial evaluation and referral to community-based mental health treatment as the primary role of schools. It also suggested that minorities were less likely to receive mental health treatment because of service access barriers. Finally, the Surgeon General's report stressed the effectiveness of a family-centered system of care using a treatment team approach as a best practice for providing mental health care services.

Like the Carter Administration, the George W. Bush administration's President's New Freedom Commission on Mental Health (Hogan et al., 2003) directed a research investigation into America's mental health status. The mental health commission worked within the parameters of six goals to guide its investigation:

- Americans understand that mental health is essential to overall health.
- Mental health care is consumer and family driven.
- Disparities in mental health services are eliminated.
- Early mental health screening, assessment, and referral to services are common practice.
- Excellent mental health care is delivered, and research is accelerated.
- Technology is used to access mental health care and information.

Of the six goals, Goal 4 specifically pertains to children and adolescents. Each goal was

given implementation recommendations from the commission.

In the final report to President Bush, the report's commissioners informed the president that schools would play a significant role in achieving Goal 4. They asserted that for America's youth to benefit from mental health services, school-age youth must be able to access these services. Even if students were able to access available services, they would encounter a system composed of seemingly disparate agencies that made seeking appropriate treatment a challenge, which is why the report called for a system of care model as the structure for mental health programming in schools (Hogan et al., 2003). Additionally, the commissioners recognized that addressing student mental health issues early leads to improved academic and behavioral functioning; thus, the schools were well suited to that endeavor. Finally, schools are in a "key position to identify mental health problems early and to provide a link to appropriate [community] services" (Hogan et al., 2003, p. 58).

Following the Bush Administration, two Obama Administration health care acts also impacted school-based mental health. The first of the two was the 2010 Patient Protection and Affordable Care Act (ACA), which directly funded school-based health services that included mental health care. Section 4101 of ACA provided financial aid to school districts to establish school-based health centers. The eligibility requirements of ACA required these centers to meet both the physical and the mental health needs of students. ACA's funding prioritized districts with large numbers of students enrolled in Medicaid and Medicare as well as those with large numbers of families who faced barriers to care. Additionally, it took parts of two federal laws to define a school-based health center. To be considered an official health care center, schools had to demonstrate

they provided health care to children and adolescents and that they provided services on school grounds during school hours. Additionally, school-based health centers under ACA were expected to be part of a cooperative effort among health providers, school personnel, and community agencies (Patient Protection and Affordable Care Act, 2010).

The most recent piece of federal legislation relating to school-based mental health is the 2015 Every Student Succeeds Act (ESSA). Like previous reports, ESSA promotes a system-of-care approach to student mental health care (National Association of School Psychologists, 2016). It also formally acknowledges the impact of the mental health status of students on their academic performance. Furthermore, ESSA was the first act to include school-based mental health funding to boost student academic achievement. Finally, ESSA provided professional development financing to train faculty and school leaders to address student mental health care needs effectively (Network for Public Health Law, 2017).

Student Access to Care

The school-based mental health research literature indicates that families have faced many barriers that hinder access to mental health services in the community. The barriers, therefore, have been a major contributing factor to the rise in care provided by America's schools. These obstacles include (a) lack of insurance coverage, (b) frequent appointment cancellations due to conflicting parent work schedules, (c) lack of transportation, (d) cultural stigmas, and (e) finances (American Academy of Pediatrics, 2004). Furthermore, there are cultural hindrances to mental health programs that are specific to minorities. In both the Latino and African American cultures, the spirit of machismo (male dominance) among the male heads of households is seen as a major

barrier to the family's ability to seek mental health treatment. Furthermore, mental health information and services are provided in English, which presents obstacles to Latino community members who have difficulty with the language and in places where translation services are limited (Gamble & Lambros, 2014).

The mandates associated with the Education for All Handicapped Children Act (1975) were another cause for an increase in school mental health services. Under the terms of the Individuals with Disabilities Education Act (IDEA), students whose academic progress is impeded by a recognized area of disability are eligible for related services to mitigate the disability. Typically, students diagnosed with emotional disturbances and other health impairments are eligible for mental health services (Kutash et al., 2011).

In 2013, George Washington University's Center for Health and Health Care in Schools conducted a study of 11 states, including North Carolina, on student access to school-based mental health services. The researchers uncovered several key findings in their investigation that are consistent with other research on school-based mental health. The top three commonalities were (a) funding is necessary to establish and maintain school-based mental health programs, (b) delivery of mental health services can be complex and distributed among many different agencies with different funding sources and purposes without the use of a system of care model, and (c) comprehensive services that include early intervention and prevention are the primary roles for schools (Behrens et al., 2013). Additionally, the study indicated that all the states had promising programs to build upon for other states to model.

Other organizations were conducting similar research at the same time. Data from

federal survey reports for 2011–2016 suggested that North Carolinians struggled to access care for their mental health needs. North Carolina ranked 10th among states for both youth and adult mental health treatment access in 2011; however, since 2011, access to mental health care for North Carolinians has dropped to 33rd overall and 39th for the under-18 population (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Since 2011, depression, illicit drug use, and alcohol abuse have been the leading causes of mental health disorders in North Carolinians aged 12–17 (SAMHSA, 2015). Moreover, roughly 60% of students diagnosed with depression and over 90% of students who are alcohol and substance abusers go untreated for their disorders. Last, the literature indicated that mental health issues in North Carolina go untreated because families find it a challenge to access mental health treatment for their children (North Carolina School Mental Health Initiative, 2016).

The Current State of National Adolescent and Teen Mental Health

In 2014, of the 24.9 million Americans between the ages of 12 and 17, 7.3 million (28%) had received mental health services in a school, a medical facility, or a mental health facility on an inpatient or outpatient basis (Lipari et al., 2016). In November 2016, when Blue Cross Blue Shield released a report on the overall health status of its 40 million subscribers, four of the top 10 issues impacting overall health and wellness related to mental health conditions, including major depression, drug abuse, alcohol abuse, and psychiatric disorders. The Blue Cross Blue Shield report indicated that North Carolina residents affected by major depression tended to be concentrated at opposite ends of the state. One heavy concentration was in the mountains of the state and the other group resided along North Carolina's coastline. The destructive impact on the overall

health of North Carolinians due to drug abuse ranged from 5% below the national average in Tyrell County to 167% above it in Carteret County. The inimical impact of alcohol abuse on the health status of New Hanover County residents was 84% higher than the national average. Finally, the detrimental health impact due to psychotic disorders on Wilson County residents was 218% above the national average.

The CDC conducts biannual Youth Risk Behavior Surveillance surveys. The purpose of these surveys is to inform the nation's policymakers on risky behaviors that have the most impact on America's youth. Data for these CDC surveys are obtained from high school students in Grades 9-12 in both public and private schools. CDC researchers surveyed over 15,000 students from various school districts, charter schools, and private schools across 46 states, including North Carolina, for the 2015 Youth Risk Behavior Surveillance. Data from that survey indicated teenage depressive symptoms were so severe that their physical and mental health statuses were at risk, with nearly 30% feeling sad and hopeless nationwide resulting in a cessation of routine activities for weeks at a time. Survey results also revealed 15% of respondents had made a plan about how they would attempt suicide. Furthermore, the surveillance findings indicated that at 17%, suicide for Americans between the ages of 10 and 24 was the second leading cause of death after car and motorcycle accidents. Moreover, African American females were 12.5% more likely to attempt suicide than any other group. Last, students who identified as gay, lesbian, or bisexual were approximately 24% more likely to attempt suicide than students who identified as heterosexual or unsure (Kann et al., 2016).

Other research shows that an unstable home environment in general, and being a youth of color specifically, can also be contributing factors to teenage depression and

drug abuse. The home-based factors that contribute to higher risks of mental health issues for all races and ethnicities include (a) being born to teenage parents, (b) living in poverty due to persistently unemployed or low wage-earning parents, (c) drug and alcohol abuse in the home, and (d) early involvement with the juvenile justice system. Youth of color, on the other hand, suffer more trauma than their White counterparts, which adds an additional layer to their mental health disorders. These other factors include (a) constant exposure to violence in their surroundings; (b) living in poverty; (c) living in segregated, inner-city neighborhoods; and (d) transient lifestyles resulting from the constant threat of homelessness. Consequently, youth of color are more apt to suffer from mental illness (Stagman & Cooper, 2010).

Categorizing School-Based Mental Health Service Delivery

According to the American Academy of Pediatrics (2004), school-based mental health program delivery models should be categorized into three service delivery tiers. Tier 1 interventions are based on preventative, universal care that (a) is designed to target all students in all schools, (b) is focused on decreasing risk factors, (c) builds relationships in schools with peers and adults, (d) provides instruction in healthy living, (e) provides for physical activity outlets, and (f) provides family support services. Tier 2 interventions are designed to accommodate the needs of students that are beyond the scope of Tier 1. Students in this category include those with one or more diagnosed mental health disorders but who can still function in a school environment with proper support. Proper supports are interventions that include individual therapy, group therapy, and other therapeutic models appropriate for this level of need. Finally, Tier 3 students are nonresponsive to the lower intervention tiers and therefore require intensified and

individualized strategies such as individual therapy and intensive in-home family therapy (American Academy of Pediatrics, 2004).

Since the American Academy of Pediatrics (2004) policy statement, school-based mental health care has commonly been delivered through a three-tiered approach consistent with the organization's recommendations in the form of multi-tiered systems of support (MTSS) structure. MTSS is a three-tier decision-making process widely used to address student academic and behavioral needs. Schools implementing the MTSS model use a battery of assessments, screening tools, and staff referrals to identify students at various stages of mental health care needs. This framework enables a coordinated, evidence-based, system-of-care effort. Teachers are the primary initiators of student referrals to the MTSS process. This referral process is in keeping with previously cited federal report recommendations calling for teachers to make referrals since they spend most of their day with students and typically have closer relationships with them than other school staff members (Kilgus et al., 2015). Last, in schools with high at-risk populations, the school nurse may be the de facto primary source of medical care for those students; therefore, school nurses serve as a major source of mental health referrals (National Association of School Nurses, 2013).

School-Based Mental Health Efficacy

Key Studies

The Primary Mental Health Project. The Primary Mental Health Project (PMHP) was the first large-scale program to implement mental health interventions in schools. PMHP was also one of the five exemplary prevention programs mentioned in the 1999 Surgeon General's mental health report. The initial 1957 PMHP pilot project was

implemented in Rochester, New York public schools and has been in continuous operation ever since. It was designed as an early identification and intervention program for students in Grades K–2. The program’s designers recognized that (a) psychiatric practices of the time were inadequate; (b) as children grew older, their mental illness became more difficult to treat; (c) early identification and intervention can prevent persistent mental illness; (d) untreated mental disorders lead to low teacher morale because of consistent disruptions of the learning process; (e) student records indicated that disruptive behaviors and academic failure began in the early years of elementary school; and (f) student problems were frequently ignored due to resource constraints. Accordingly, the project’s purpose was to reduce the need for persistent, long-term mental health services through effective early identification and intervention at the elementary level (Cowen, 1980).

Nationwide, PMHP operates in more than 300 elementary schools under different titles. Each school may make modifications in program implementation, but it must follow the program’s stipulated design to maintain fidelity. Aspects of program design include (a) focusing on K–2 students, (b) using a systematic screening and selection process, (c) staffing classrooms with trained mental health aides to provide immediate interventions, (d) program supervision by social workers or other professionals, (e) annual program evaluations, and (f) full integration into the school’s response to intervention system as a Tier 2 intervention (Smith & Lotyczewski, 2016).

In the decades following its 1957 inception, PMHP has undergone numerous research studies. Program evaluations were conducted from 1974–1981 using anonymous urban and suburban elementary schools. A total of 2,310 students received interventions

through PMHP. Evaluation teams used the Classroom Adjustment Rating Scales and the Health Resources Inventory to measure program outcomes. Cumulative evaluation data from the 1974–1981 annual cohorts suggested a significant improvement in acting out behaviors, shy or anxious behaviors, and learning difficulties among the 2,310 participants (Weissberg et al., 1983). Finally, the authors cited the lack of control groups as a research limitation but that this factor did not diminish the importance of the results.

California, where the program was called the Primary Intervention Program (PIP), sponsored evaluation research from 1988–1997 and did use control groups. The primary intent of California's PIP was to replicate school-based mental health early intervention programs and to evaluate participant outcomes against the control groups consisting of their nonparticipating peers. Two rural, K–6 central California elementary schools provided the PIP program interventions to students in Grades 1 to 4. The combined total student population for both schools was 550. Thirty-five of those students aged 5–10 years old were identified to participate in the PIP study. Additionally, to meet the child aide requirement, three aides were identified and selected through the district's human resources process. The research findings indicated that program participants showed improvements in the areas of (a) getting along with peers, (b) gaining confidence, (c) becoming more outgoing, and (d) improved learning and on-task behaviors. Moreover, the researchers associated student improvements with the development of relationships between students and the child aides assigned to them, as well as the safety they felt playing with other children where they could build social skills. Additionally, although the sample size was small, the researchers asserted that the skills of sharing, taking turns, and cooperating attained during the study are universal and therefore generalizable to the

whole school environment (Nafpaktitis & Perlmutter, 1998).

Currently, PMHP maintains a lead agency in Rochester, New York at the Children's Institute. PMHP operates as the PIP in this facility. The primary purpose of the PIP at the Children's Institute is to provide resources to schools throughout the United States to develop and maintain their own programs. Additionally, the Children's Institute consults with schools, districts, and community agencies to establish, support, and certify their programs. Finally, the Children's Institute provides access to program standards and implementation rubrics that, if followed to standard by school leadership and parents, will be certified for use by the institute (Children's Institute, 2018).

Head Start. Head Start was established in 1965 because child development research indicated that poverty negatively impacted the cognitive development, social-emotional well-being, and academic achievement of children. Head Start serves at-risk children from birth through age 5 and is an early identification and treatment program. It is designed to focus on breaking the poverty cycle for America's low-income families. Program interventions include preemptive mental health care to address children's social and psychological needs (U.S. Department of Health and Human Services, 2017). Finally, treating a child with the family and community environment in mind was infused into the program from its inception by the Head Start founders.

Developmental psychologists Urie Bronfenbrenner and Edward Zigler were the cofounders of Head Start. Bronfenbrenner claimed that the most effective early-childhood interventions actively included members of the child's family. According to the American Psychological Association (2004), family involvement as a component of program design is at the foundation of Head Start's success. Zigler's forte was as a

research scientist; therefore, he was responsible for ensuring that program evaluations were conducted in accordance with rigorous research standards (American Psychological Association, 2004). Zigler went on to become the first federal official in charge of Head Start. There has been extensive Head Start research since the program's 1965 inception. Findings from those studies consistently indicate that children who participated in Head Start improved academically and behaviorally. Additionally, Head Start participants have been able to sustain that progress in later years, which is one of the reasons why the program continues to receive funding from the federal government.

The 1998 congressional reauthorization of Head Start required the U.S. Department of Health and Human Services to conduct the first national evaluation of Head Start (Phillips et al., 2016). The study's goals were to (a) determine the impact of Head Start on children's school readiness, (b) determine which parental practices best support children's development, (c) determine under what circumstances Head Start achieves its greatest impact, and (d) determine which children make the most gains as a result of program participation (U.S. Department of Health and Human Services, 2005). The research study was a randomized controlled trial involving 4,000 children across 23 states. The children were randomly assigned to either a Head Start treatment group or a control group. Three hundred eighty-three Head Start locations participated in the study. The researchers asserted the sample size was significant and was highly generalizable nationally to the Head Start program.

Other congressionally mandated evaluations followed. A 5-year longitudinal research study was launched in 2005 and ended in 2010. The evaluation consisted of four research domains: (a) cognitive development, (b) social-emotional development, (c)

health status and services, and (d) parenting practices. There were several findings from the research:

- Children demonstrated improvements in the domains of cognitive development, social-emotional development, and health status.
- Parent spanking decreased, and the number of incidents of reading to their children increased.
- Participation in family cultural activities increased.
- Children of parents diagnosed with depression showed no improvements in any of the domains.
- Participants in Head Start improved across all domains relative to the control group (Puma et al., 2010).

The sustainability of student improvements resulting from Head Start participation is an important area of research. Oklahoma was the second state to implement universal preschool access. The Tulsa, Oklahoma school district had two preschool programs: One was administered by the district and open to all children of preschool age, and the other was only for Head Start-eligible children. In 2016, the Tulsa Public School District conducted an evaluation of the long-term impact of its Head Start program. The study compared the academic progress of middle school students who attended Head Start in the 2005–2006 school year to students who did not attend a preschool program. Research data indicated that there was a positive, sustainable impact associated with Head Start attendance as a 4-year-old. Specifically, participating students were less likely than the nonparticipating group to repeat a grade, have high levels of

chronic absence, or demonstrate low math achievement (Phillips et al., 2016).

Methods for the Epidemiology of Child and Adolescent Mental Health

Disorders Study. The 1979 Epidemiologic Catchment Area program was a federal government-sponsored mental health survey. Due to a lack of reliable youth survey instruments at the time, the survey could only be used with adults. The NIMH, therefore, needed to develop a reliable survey instrument for use with children and adolescents. The NIMH entered into a cooperative agreement with Columbia University, Emory University, the University of Puerto Rico, and Yale University to create an instrument and conduct the methodological study. The work resulted in the 1989 Methods for the Epidemiology of Child and Adolescent Mental Health Disorders Study (MECA survey). The purpose of the survey was to assess for mental disorders, risk factors, and service utilization in youths 9 through 17 (Lahey et al., 1996).

The MECA study was designed to accomplish specific aims: (a) attaining adequate survey response rates, (b) developing assessment criteria based on the DSM–III, (c) differentiating between levels of functioning based on severity of mental disorder, (d) developing measures for access and use of mental health services, (e) developing measures for demographic risk factors, (f) developing protocols for conducting large sample surveys, and (g) determining the prevalence of youth mental disorders for future research studies. MECA resulted in the creation of reliable and valid large-scale assessment instruments for use with youth aged 9–17, enabling subsequent researchers to conduct adolescent and teen mental health research projects (Lahey et al., 1996).

Epidemiologists, such as those in the MECA study, seek to understand the prevalence (the number of existing cases), incidence (number of new cases), and

distribution of a disease or disorder among specific population groups (Merikangas et al., 2009). Epidemiologists also attempt to identify risk factors, or characteristics within the population, that make some people more susceptible to disease and disorders than others. Examples of risk factors include family dynamics, living in poverty, and exposure to violence. Additionally, researchers can examine the association between risk factors and the existence or nonexistence of disorders among the sample population (Goodman et al., 1998). MECA study researchers also developed and defined risk factors relating to the onset of psychiatric disorders in children and adolescents. The risk factors were organized into six general categories:

- sociodemographics (parental employment status)
 - family management (discipline practices)
 - parental discord and quality of family environment (arguments between parents or other family members)
 - negative life events (exposure to violence)
 - the child's illness history
 - history of psychiatric disorder in parents or other family members
- (Merikangas et al., 2009).

Finally, the MECA study indicated connections between risk factors and psychiatric disorders in children and adolescents, such as between sociodemographic factors and depression or between family management practices and conduct disorders (Goodman et al., 1998).

The Great Smoky Mountains Study. The Great Smoky Mountains Study was

the first large-scale longitudinal mental health survey to be performed in the rural southeastern United States. Its purpose was to study the development of childhood psychiatric disorders and the subsequent need for mental health treatment services. The study's sample population consisted of children aged 9, 11, and 13 living in western North Carolina. This area of North Carolina has one major urban center where half of the sample resided, surrounded by an extensive rural area where the other half lived. It is also home to the 8,000-member Cherokee Indian Nation. This geographic and cultural dynamic provided the opportunity to make comparisons between the development of mental disorders and mental health service use among both urban and rural youth. Additionally, the participation of the children from the Cherokee nation gave unique access to their culture's tribal-based mental health treatment system. The pilot project started in 1992 and continued through to 2016. It followed the study's 4,500 participants from youth into adulthood (Costello, 2010).

Participants in the Great Smoky Mountains Study were identified and recruited using student information culled from 11 North Carolina county school district student information management system databases. Researchers used two different survey instruments to collect data. One was the Child and Adolescent Psychiatric Assessment for data on psychiatric disorders, and the other was the Child and Adolescent Services Assessment for mental health service usage (Burns et al., 1995). Data from the first wave (1992–1993) of participants indicated that the predominant risk factors for receiving a mental health disorder diagnosis and subsequent treatment services were being male and living in poverty (Costello et al., 2003). Other factors that led to child and adolescent mental health disorders included fractured family relationships, poor parenting skills, and

a history of parental drug and alcohol abuse. Children and adolescents exposed to these risk factors were commonly diagnosed with (a) serious emotional disturbance, (b) anxiety disorder, (c) conduct disorder, (d) oppositional defiant disorder, (e) hyperactivity, and (f) depression. Finally, of the children and adolescents who participated in mental health treatment, 80% reported that school-based mental health services were their only source of care.

The Cherokee nation study sample consisted of 450 students who attended either reservation schools or county public schools near the reservation. They completed the same surveys as their non-Cherokee counterparts, and the results indicated that the Cherokee children generally had the same mental health disorder diagnoses as the other groups of students. There was one exception, however; Cherokee students were much more likely to abuse drugs and alcohol than their non-Cherokee peers (Costello, 2010). Additionally, although both groups shared similar risk factors, the Cherokee students had protective factors unavailable to the other participants. The financial resources provided by the federal government, coupled with tribal benefits such as subsidized housing and free medical care, helped to mitigate the direct consequences of poverty on student mental health disorders (Costello et al., 1997). Moreover, a casino was built on Cherokee land in 1996, and the income supplements generated from casino revenue helped to lift Cherokee families out of poverty. Finally, the positive change in economic status that led to the long-term reduction of mental disorder symptoms in Cherokee youth, as opposed to the other participants who remained in poverty and continued to suffer from mental health disorders that persisted into adulthood, seems to suggest a causal relationship between socioeconomic status and mental health need (Costello, 2010).

The National Comorbidity Survey–Adolescents. Comorbidity is the presence of two or more disorders or conditions occurring simultaneously in one person (CDC, 2019). The National Comorbidity Survey–Adolescents (NCS–A) was developed after Congress directed the NIMH to gather and present data on the prevalence of, and interconnections among, mental health disorders in America’s youth. Over 10,000 young people aged 13–17 completed the 3-year national survey between 2001 and 2004 (Kessler et al., 2009).

The primary method of administration was face-to-face interviews. Professional interviewers from the University of Michigan administered the computerized Composite International Diagnostic Interview using laptops. Simultaneously, parents took a self-administered paper-and-pencil questionnaire. School-based surveys were conducted at 320 randomly selected middle, junior high, and senior high schools using the same instrument as the home surveys. Like parents in the home survey, principals and school-based mental health workers at these locations completed a self-administered paper-and-pencil survey. The survey’s broad sample size of socioeconomic, school, and geographic characteristics facilitated a representative sampling of America’s general adolescent population (Kessler et al., 2009).

The NCS–A was the first research project to provide data on the prevalence of mental health disorders in children and adolescents. It distinguished four general classifications of early-onset mental disorders: (a) anxiety disorders by age 6, (b) behavior disorders by age 11, (c) mood disorders by age 13, and (d) drug and alcohol abuse by age 15 (Merikangas et al., 2010). Forty percent of adolescents reported co-occurring mental disorder diagnoses. Mood disorder was the affliction most reported in

combination with another disorder. Finally, though mental disorders are prevalent among American youth, only one fourth of those with mental disorders are debilitated due to the severity of their disorders and can still function with little impairment.

The NCS–A psychiatric researchers categorized mental health disorders as either internalizing or externalizing behavior. Additionally, each category was further divided into two subcategories. Internalizing behaviors were subdivided into distress disorders and fear disorders, while externalizing behaviors were subdivided into behavior disorders and substance disorders. The challenge with distress disorders is that the signs of these mental health disorders may not be outwardly apparent and therefore may go unnoticed by educators. Fear disorders such as social anxiety or panic disorders, on the other hand, can be triggered by certain events and may be more recognizable to staff and teachers because of how the disorders manifest. Externalizing behaviors are clearly recognizable to educators due to the disruptive behaviors that follow. Common substance disorders, such as drug or alcohol abuse, are also easy to detect due to changed behaviors and attitudes (Blanco et al., 2015). Last, the NCS–A’s findings revealed that if left untreated, early-onset mental disorders linger through adulthood; therefore, early intervention is advisable (Merikangas et al., 2010).

Depositories of Empirically Supported Programs

Practitioners and school staff seeking empirically supported mental health programs, practices, or strategies for use in schools can find them in several well-known and federally supported databases. These are (a) SAMHSA, (b) the Collaborative for Academic, Social, and Emotional Learning (CASEL), and (c) the Center for School Mental Health (CSMH) at the University of Maryland School of Medicine.

SAMHSA. The U.S. Congress established SAMHSA to provide mental health stakeholders, including state-level policymakers, with research and data analysis pertaining to drug and alcohol dependence. The agency also provides regular reports on America's mental health status, as well as other factors regarding behavioral and mental health. Additionally, SAMHSA created a national registry of evidence-based programs and practices to promote effective mental health interventions for use with students. This database is readily available for use by educators and other professionals. Before a program can be included in this registry, it must meet SAMHSA's standards, including (a) rigor as determined by the strength of the study's methodology, (b) effective sample size sufficient for generalizability, (c) implementation fidelity, and (d) the research must demonstrate the causal relationship between the interventions and program outcomes (SAMHSA, 2016). The programs that are accepted into the registry receive an outcome-based rating system. The results allow for positive ratings on outcomes, even if the overall program is considered relatively ineffective; thus, potential program users must use caution when determining if the program is the right one for their student needs. The outcome-based classification categories are as follows:

- **Effective.** The evaluation evidence demonstrates strong methodological rigor and short-term outcomes were positive.
- **Promising.** The evaluation evidence demonstrates adequate methodological rigor and short-term outcomes are likely to be positive.
- **Ineffective.** The evaluation evidence demonstrates adequate methodological rigor, but there is no evidence of positive short-term outcomes.
- **Inconclusive.** There is not enough evidence to determine methodological rigor

(SAMHSA, 2016).

CASEL. CASEL was founded in 1994 to advance the science and practice of SEL in schools. One of its core functions is to establish standards for evidence-based programs designed to help students (a) build their capacity, (b) manage their emotions, (c) develop positive peer and adult relationships, and (d) make responsible decisions (Fundamentals of SEL, 2021). Furthermore, CASEL only accepts programs with demonstrated effectiveness using randomized controlled trials and follow-up longitudinal studies. Multiple replications and successful field implementation by classroom teachers are also required. Moreover, like SAMHSA, effective outcome-based programs are accepted into CASEL's registry. The evidence-based categories are as follows:

- Improved academic performance. Program participation demonstrates significant improvement in student achievement.
- Improved positive social behaviors. Program participation demonstrates significant improvement in social interactions with peers and adults.
- Reduced conduct problems. Program participation demonstrates a significant reduction in student disruptive behaviors.
- Reduced emotional distress. Program participation demonstrates a reduction in the symptoms of emotional distress; i.e., depression (About the program guide, 2021).

CSMH. CSMH, established by the Maternal and Child Health Bureau of the Health Resources and Services Administration, is a technical assistance center for evidence-based school mental health policies, practices, programs, and strategies, both nationally and abroad. CSMH coined the term *enhanced school-based mental services* to

describe the effective core functions of mental health services in schools. These functions include (a) developing early identification, intervention, and treatment programs through school and mental health agency partnerships; (b) sharing knowledge and resources through interagency collaborations; and (c) promoting the development of a system-of-care continuum (University of Maryland School of Medicine, 2017).

The CSMH website provides the user with access to a broad database. Its purpose is to provide the evidence-based data and resources that school and mental health agency personnel need to assist students in improving their academic performance and behavior. Resources available through CSMH provide current data on effective and innovative programs. Additionally, CSMH sponsors annual conferences to advance the knowledge base related to improving school mental health, culture, and climate. Through CSMH, educators can avoid costly and time-consuming mistakes by accessing lessons learned from other program implementations. Additionally, CSMH provides schools with two resources to enhance their capacity to deliver effective school-based mental practices. One program allows schools and districts to conduct self-assessments and measure themselves to (a) assess the comprehensiveness of their school-based mental health system, (b) prioritize their quality improvement efforts, and (c) track systems and program improvement. Finally, CSMH provides schools with a curriculum on how to plan and implement a school-based mental health program curriculum (University of Maryland School of Medicine, n.d.).

Key School-Based Mental Health Programs

Two nationally recognized and extensively researched school-based mental health programs are the Baltimore City School Mental Health Initiative and the Dallas

Independent School District Initiative. Each program was established with federal funding and is a collaborative enterprise that partners with other agencies in its respective community. These partnerships provide additional funding, training, and qualified professionals who deliver services. Each program has been in existence for decades, with Dallas's initiative being one of the first school-based mental health programs in the country.

Dallas Independent School District Youth and Family Centers

In collaboration with the University of Texas Southwestern Medical Center, the Dallas, Texas public school system was one of the first districts in the United States to establish a school-based mental health program. This collaborative effort began with two elementary schools in 1969 and expanded to include one high school in 1971. By 1993, two school principals (one elementary and one middle school) contacted the city's Community Mental Health Center (CMHC) to request an evaluation of the impact student mental health issues may have had on academic functioning in the areas of school attendance, test scores, and discipline. Based on their assessment findings, CMHC provided each school with a child psychiatrist who could meet with referred students and their families. Subsequently, a multidisciplinary team composed of the CMHC-provided psychiatrist and district-provided mental health care professionals came together to create a procedural system for (a) referrals, (b) intake processes, (c) conducting evaluations, (d) developing treatment plans, and (e) delivering services (Jennings et al., 2000).

By 1995, a partnership was formed between the school district, CMHC, and the city's hospitals to establish 10 Youth and Family Centers (YFCs) that would provide mental health care services to all district students who needed them. The program's goals

were to (a) provide school-based physical and mental health services to students and their families, (b) promote academic success, and (c) promote family engagement in student educational and health care needs (Megan, 2018). Each YFC served one or more high schools along with their feeder middle and elementary schools. Each site was organized in an identical fashion. Specifically, each site (a) had a standalone district-funded and district-constructed facility; (b) was managed by a licensed, district-employed mental health professional; and (c) was advised by a local board of parents, school staff, and community stakeholders (Jennings et al., 2000). Professional development was provided for principals and faculty about their unique roles in student health care treatment, and school-based student support teams were established to screen and refer students in need.

Currently, the YFCs remain the Dallas Independent School District's primary mode of delivering mental health treatment to students and their families; however, the district added an 11th YFC in 2012. YFCs provide initial evaluations and assessments; psychiatric consultations; and individual, group, and family therapy. According to data for the 2017–2018 school year, there were 5,710 diagnoses of mental health disorders in 4,855 participants, including an unspecified number of comorbid diagnoses (Megan, 2018). Most students receiving treatment were male, and the most common diagnoses were attention deficit hyperactivity disorders (ADHDs, 40%), adjustment disorders (27%), and depressive disorders (11%). The largest population group receiving services was Hispanics at 63%, followed by African Americans at 28% and European Americans, or Whites, at 7%. Comparatively, 70% of the district is Hispanic, so they are slightly underrepresented in the program. African American and White students comprise 22% and 5% of the district respectively, and they are overrepresented in the district's mental

health care program at 28% and 6%, respectively.

The Dallas YFCs provided 13 different types of mental health services; however, the most common services were individual therapy sessions lasting between 30 and 60 minutes, which constituted 54% of clinic visits, followed by psychiatric follow-ups at 20% of clinic visits; other services such psychological evaluations and family therapy comprised the rest (Megan, 2018). Additionally, nine diagnoses were prevalent among program participants. The top three diagnoses were ADHDs at over 40% of the participants, adjustment disorders at slightly more than 27%, and depression at almost 11.5%. Finally, although obsessive compulsive disorders made up less than 1% of the student diagnoses, these students saw clinicians 27 times for therapy during the school year as compared to the slightly more than eight times for ADHD-diagnosed students, which is indicative of a more challenging disorder to treat.

The Baltimore City School Mental Health Initiative

The Baltimore City Public Schools school-based mental health program was established in 1985 when the city's health department placed health centers in seven of the district's high schools. The primary purpose of these centers was to provide student health care; however, 22% of the students coming to the health centers were seen for mental health issues (Flaherty & Weist, 1999). Consequently, the health department infused additional funds to enable the centers to hire mental health professionals. An expansion of school-based mental health services soon followed. Mental health care in Baltimore has grown from the initial seven schools to more than 100 district schools using various models: (a) mental health services within school health clinics, (b) standalone mental health care clinics that are satellites of community-based clinics, and

(c) school-based clinicians provided by an outside mental health care agency. Regardless of the model used, funding for these programs comes from a collaborative effort that involves multiple local and state agencies.

Beginning in 1995, the University of Maryland partnered with the Baltimore City Public School District to support a school-based mental health program. In that year, the U.S. Department of Health and Human Services Maternal and Child Health Bureau established CSMH to support school-based mental health programs nationwide. Baltimore's program is referred to as an enhanced program model because of its success in augmenting school district staff with community-based agency staff to deliver a full continuum of mental health services to students and their families (Weist et al., 2009).

In coordination with CSMH and other agencies, a 1998 agency provider research survey was conducted to assess (a) school-based provider characteristics (such as the intensity of services provided), (b) the types of services provided in schools, (c) student participant characteristics, and (d) whether the providers believed their services were beneficial. The survey results indicated that the students receiving services were more likely to come from families in economic need (75.8% of students, compared to 66.8% of the district as a whole; Walrath et al., 2004). Middle school students were more likely to receive a mental health referral (an average of 140 students per year, per school) than either elementary (43 per year, per school) or high school (93 per year, per school) students. At the elementary level, most recipients were male; in high schools, females were more likely to receive services than males. The students who received mental health care were reflective of the district's majority African American student population (75% of elementary school recipients, 79% of middle school recipients, and 80% of high school

recipients). Agencies offered both individual and group therapy with students of all grades, but at the middle and high school levels, family therapy was emphasized more strongly than with elementary students. Finally, providers indicated that increased mental health awareness and access to services were the biggest benefits they provided to students and their families.

Today, although the University of Maryland Medical School's school-based mental health program has been replicated nationally, the university's primary focus remains in Baltimore. The university and Behavioral Systems Baltimore collaborate to support school administrators and teachers in promoting healthy school climates and building their capacity to serve students with mental health concerns. Additionally, these organizations still provide school-based prevention, intervention, and therapeutic treatment services to students. Furthermore, the Baltimore City Schools program also emphasizes partnerships between the school, family, and community (University of Maryland School of Medicine, 2018).

The Primary Role of Schools

Precedent for School-Based Mental Health

The first federal report to acknowledge a need for student mental health care was the 1955 Congressional Joint Commission on Mental Illness. In 1961, the commission published a 6-year assessment of America's mental health care needs, which highlighted the importance of providing mental health care in schools. The report described schools as the best place for early identification and referral of youth needing mental health care (Joint Commission on Mental Illness and Health, 1961). Subsequently, the 1999 Surgeon General's mental health report also acknowledged the role of schools in delivering mental

health care. Specifically, it identified schools as primary providers for parents seeking mental health care for their children. The report stated that the main role of schools in this regard should be initial evaluation and referral to community-based mental health treatment (U.S. Department of Health and Human Services, 1999). Finally, the 2003 President's New Freedom Commission on Mental Health affirmed the other two reports by identifying public schools as the primary point of access to mental health care for young people (Hogan et al., 2003).

The Primary Role of Teachers in School-Based Mental Health

The role of teachers as mental health counselors grew along with society's expectations of America's public schools. Early stages of industrialization in the United States led to a rise in both juvenile delinquency and poverty. Around the same time, compulsory attendance laws were beginning to gain ground, compelling local governments to build and staff public schools. These two converging forces placed an enormous burden on district staff and administration. Additionally, public schools began to encounter student nonacademic issues for the first time. Teachers had little understanding of the daily realities of their impoverished students or of how living in squalor impacted academic achievement. Consequently, they were unprepared to address classroom disruptions stemming from their students' home environments (Hunter, 1905).

Expectations for teachers to address students' expanding mental health needs grew as student enrollment increased. By the mid-20th century, teachers were identified as the logical choice for assisting students in need of mental health care. Furthermore, the 1961 Congressional Joint Commission on Mental Illness and Health report was the first federal report to state that teachers were the people best suited to identify students who

may need mental health care. Moreover, this report suggested that teachers were best suited for early identification and early applications of interventions because of their frequent contact with students (Joint Commission on Mental Illness and Health, 1961).

System of Care

No single treatment or delivery system can provide all the services to a student in need of mental health care. Best practices in service delivery call for a coordinated effort between many agencies, both public and private, which is commonly referred to in the literature as a system of care. A system of care approach intends to access and fund mental health care treatment cost-effectively and efficiently. The system-of-care model was accepted as a best practice by the federal government in 1984 when Congress established the Child and Adolescent Service System Program (CASSP). CASSP was a reaction to a 1982 national study finding that over two thirds of children and adolescents diagnosed with severe emotional disturbances did not receive treatment. Additionally, CASSP advanced the notion that children's mental health needs should be a coordinated effort between multiple agencies and should take place as close to home as possible with full family involvement (Pumariega & Vance, 1999).

CASSP established a set of values and principles to guide systems of care. As with treatment and service delivery, there is no one-size-fits-all approach to systems of care; however, CASSP has suggested two overarching values and a set of 10 principles that communities may use to guide their processes. The first core value envisions a family-oriented and child-centered system. It is a system that emphasizes children's needs in treatment planning and implementation. The other core value is that mental health care be community-based and as close to the family home as possible. The 10

guiding principles for systems of care are as follows:

- Access to a large scope of services.
- Individualized treatment to meet student needs.
- Treatment provided in the least restrictive setting.
- Integration of families into the treatment planning and service delivery process as full partners.
- Coordination of services between agency providers via case managers.
- No rejection or removal of patients from treatment based on a belief that they are untreatable.
- Identifying and treating disorders as early as possible.
- Development of a youth-to-adult transition plan.
- Effective patient advocacy.
- Providing culturally sensitive services (Stroul & Friedman, 1988).

The system of care principles guided state health and human services agencies to create their models. North Carolina developed its model in 2003, and this model is consistent with CASSP's core values and principles. North Carolina's system of care

is a comprehensive network of community-based services and supports organized to meet the needs of families who are involved with multiple child service agencies, such as child welfare, mental health, schools, juvenile justice, and health care. The goal is for families and youth to work in partnership with public and private organizations, ensuring supports are effective and built on the individual's

strengths and needs. (What is system of care, 2019)

Furthermore, North Carolina's model has 15 guiding principles of its own mental health service delivery:

- Families are immersed in all phases of treatment planning and implementation.
- Families are provided with educational services to facilitate their program engagement.
- Children and their families are the focus of attention.
- Collaboration among and between agencies is the model's cornerstone for planning and implementation.
- Services are accessible and close to home.
- Services aim to meet the needs of the whole child.
- Professional development is provided to staff members at multiple levels to foster a competent and functional system.
- Enough financial resources are available for service support.
- Up-to-date and consistent information for the family is emphasized.
- Services are culturally sensitive.
- Services are community-based, consistent, and predictable across the state.
- Evidence-based treatment services are applied by qualified professionals.
- Continuity of care is maintained during transition periods, such as from high

school to adulthood.

- Early identification and prevention services are emphasized.
- Families should not have to give up custody as a condition of receiving services (North Carolina Department of Health and Human Services, 2003).

Finally, the state's education legislation, enacted by the North Carolina General Assembly in 2018, is also consistent with the system-of-care values and principles of cooperation. Specifically, the NCDPI Developmental Health Training Program and Suicide Risk Referral Protocol Law, Section 5, requires the North Carolina Departments of Public Instruction and Health and Human Services to address mental health care and suicide prevention jointly (North Carolina Legislature, 2018).

Persistence of Mental Illness

Most adults who have mental health disorders developed them while they were children or adolescents. Using similar research methodologies, two national surveys, the National Comorbidity Survey (NCS) and the NCS–A, indicated that youth and adults share the same disorders at the same rates; therefore, researchers suggested that mental illness emerges before adulthood. Additionally, NCS–A findings also indicated that persistent disorders could vary by gender and/or parental education levels. For instance, males are more likely to be diagnosed with substance abuse and mood disorders, whereas females are more likely to be diagnosed with anxiety and mood disorders. On the other hand, children and adolescents whose mothers were not college graduates were at greater risk than those with mothers who held at least a bachelor's degree. Finally, notwithstanding the high prevalence rates of lifetime mental disorders, results from the two national studies revealed that only one in five affected persons met the criteria for

impaired functioning due to their mental illness. For instance, impaired people cannot maintain a job or a household unassisted (Merikangas et al., 2010).

Persistence findings from the National Comorbidity Survey–Replication (NCS–R) also indicated that childhood and adolescent mental health disorders tend to continue into adulthood. The NCS–R was a 2-part national survey of adults conducted from 2001–2003. Part 1 elicited data on mental disorders using a diagnostic assessment, and Part 2 assessed risk factors for mental disorders and their consequences. As in the NCS and the NCS–A, NCS–R mental health diagnoses were classified into the four general domains of (a) mood disorders (e.g., depression), (b) anxiety disorders (e.g., panic disorder), (c) behavior disorders (e.g., ADHD), and (d) substance abuse. Additionally, the study’s diagnostic tool, the Composite International Diagnostic Interview, contained questions that specifically addressed the age of onset of the respondents’ mental health disorders (McLaughlin et al., 2011).

One primary predictor of the lifetime persistence of mental health disorders identified by these surveys is growing up in poverty. Financial hardship affects diagnoses across all four domains of mental disorders above all other indicators. Other factors, some of which are often derivatives of financial hardship, are also associated with persistent mental illness. They are (a) the loss of a parent due to death, divorce, or breaking off contact; (b) parental dysfunction in the form of mental illness, substance abuse, violence, or criminal behavior; (c) parental maltreatment in the form of neglect, physical abuse, or mental abuse; and (d) persistent childhood physical illness. Finally, research suggests that although there is a strong correlation between poverty and persistent mental illness, there is insufficient evidence in the literature to determine that

there is an actual causal relationship between the two (McLaughlin et al., 2011).

Another important mental health persistence research study is the 2009 NIMH-funded, Philadelphia Neurodevelopmental Cohort. In this study, roughly 9,500 people between the ages of 8 and 21 from the greater Philadelphia tri-state area (Pennsylvania, Delaware, and New Jersey) were subjects. The purpose of the research was to study how mental disorders persist from childhood into adulthood, as well as the degree to which those disorders impair a person's functioning (e.g., school and job performance). Participants completed an assessment to document their psychiatric or psychological treatment history, as well as the frequency and duration of mental disorders across all four psychiatric domains. Additionally, a history of exposure to traumatic mental disorder triggers was collected. These included (a) experience of natural disasters, (b) witnessing violent acts, (c) witnessing violent acts resulting in death, (d) being physically or sexually assaulted, (e) being threatened by somebody with a weapon, (f) being in a serious accident, or (g) seeing a dead body (Calkins et al., 2017).

Furthermore, participants in the Philadelphia Neurodevelopmental Cohort were assessed twice, once for the baseline measurement and again 2 years later to assess progress. Of the respondents who were diagnosed with psychotic symptoms at the initial assessment, approximately 52% were either just as bad or worse off 2 years later, whereas the remaining 48% who were diagnosed with psychotic symptoms at the initial assessment were symptom free 2 years later (Calkins et al., 2017). Finally, the findings revealed that people with persistent mental disorders were more likely (a) to seek continued treatment for their disorders, (b) to have comorbid diagnoses, (c) to be substance abusers, and (d) to be exposed to triggering events.

School-Based Mental Health Research Gap

Mental health care agency staff assigned to schools are professionally trained therapists who diagnose and treat the symptoms of students who present at various stages of mental illness. The therapists' treatment priority is to reduce the observable symptoms of mental disorder(s) in their clients. The core priority of schools, however, is student academic achievement. These conflicting priorities are not equally reflected in the school-based mental health care literature, because most of the studies have been conducted by mental health professionals. Hence, the literature has focused primarily on the effectiveness of interventions designed to reduce the symptoms of mental health disorders in students to the detriment of evaluations of their impact on educational outcomes.

North Carolina Public Charter Schools

North Carolina has a total of 184 charter schools. Some 182 schools are physical structures built to house students, and two are for 100% online virtual learning. I only surveyed the principals of the 182 buildings because this research focuses on mental health services provided at school. Virtual schools do not have physical building structures where mental health care can be delivered; therefore, they were excluded from this study. Of the state's more than 1,490,000 students, nearly 110,000 attend charter schools. This represents almost 7.5% of North Carolina's school population (NCDPI, 2019). Table 1 illustrates statewide demographic differences between North Carolina public charter schools and traditional public schools.

Table 1*Charter School Student Demographics, 2017–2018 School Year*

	Charter schools		Traditional public schools		All	
Race/ethnicity/ gender	Students	Percentage	Students	Percentage	Students	Percentage
Total White	55,401	54.9%	686,652	47.9%	742,053	48.4%
Total Black	26,349	26.1%	361,746	25.2%	388,095	25.3%
Total Hispanic	10,040	9.9%	256,848	17.9%	266,888	17.4%
Other	9,196	9.1%	128,000	8.9%	137,196	8.9%
Male	50,543	50%	736,972	51.4%	787,415	51.3%
Female	50,543	50%	696,274	48.6%	746,817	48.7%
Total enrollment	100,986	100%	1,433,246	100%	1,543,232	100%

Note. Source: Charter Schools Annual Report to the North Carolina General Assembly (NCDPI, 2020).

Like traditional schools, charter schools are also public schools. They are tuition free and they receive local, state, and federal funds to operate. Charter schools are autonomous and incorporate nonprofit corporations with their own boards of directors. The boards of directors enter into a contractual agreement with the North Carolina State Board of Education to function independently of the local city or county school district, and they must abide by the articles of the charter agreement signed by both the charter school's board chairperson and the state's superintendent of public education. Charter schools are designed to be innovative and to provide choice for families looking for alternative educational placements outside their county or city placement. NCDPI, 2019, p.1 defined charter schools as,

public schools of choice that are authorized by the State Board of Education to be operated by independent non-profit boards of directors. State and local tax dollars are the primary funding sources for charter schools, which have open enrollment and cannot discriminate in admissions, associate with any religion or religious

group, or charge tuition. Charter schools operate with freedom from many of the regulations that govern district schools, but charter schools are held accountable through the state assessment and accountability system

Charter schools were authorized to operate in North Carolina beginning with the passage of the 1996 Charter School Act. The act gave the North Carolina State Board of Education the power to approve or deny applications and to grant charters. Additionally, the Charter School Act limited the number of charter schools in North Carolina to just 100. In 1997, the State Board of Education approved the state's first 27 charter schools. By 2011, the North Carolina Legislature had lifted the 100-charter-school cap. Since then, the number of charter schools has risen to 184, two of which are online virtual schools. Furthermore, the 1996 Charter School Act requires all charter schools to meet one or more of six legislative purposes for opening a school. These purposes are

- Improve student learning.
- Provide increased learning opportunities for at-risk youth.
- Promote innovation and reform in teaching methods.
- Promote new professional opportunities for teachers.
- Expand educational choice for students and their families.
- Be accountable for improving student achievement (NCDPI, 2020).

To oversee the operations of the state's charter schools, the legislature created the North Carolina Charter School Advisory Board (CSAB). The function of CSAB is to (a) advise the State Board of Education on all charter school operations, (b) review new charter school applications and make approval recommendations to the State Board of

Education, (c) monitor existing charter schools and make periodic recommendations to the State Board of Education regarding renewing school charters, and (d) perform other duties as assigned by the State Board of Education (North Carolina General Statute 14A—Charter Schools, 2019). Additionally, an Office of Charter Schools was created to conduct the daily business of the CSAB. The Office of Charter Schools assists the CSAB by (a) serving as the CSAB's staff and performing assigned tasks, (b) providing guidance and assistance to the state's charter schools, (c) providing training for new charter schools approved for opening, (d) assisting charter schools with coordinating activities among other NCDPI departments, and (e) other duties as assigned by the Office of Charter Schools.

Charter schools are public schools; therefore, any student who is a resident of North Carolina and eligible to attend the state's traditional public schools is also eligible to attend the state's public charter schools. The number of students attending an individual charter school is limited to the number of open seats in each grade. North Carolina mandates all charter schools to use a randomized lottery system when selecting students to ensure all applicants have an equal chance of being accepted. For instance, if a charter high school has 150 ninth-grade openings and 150 or fewer students apply, then all the applicants are accepted. However, if that same ninth-grade class has 151 applicants or more, a public lottery is held to select students randomly for each available opening until all seats are filled. The remaining students are placed on a waiting list, where they are randomly selected if seats become available. Furthermore, North Carolina charter school policy allows schools to assign enrollment priority seating for selected groups, such as the children of the school's faculty (North Carolina General Statute

14A—Charter Schools, 2019).

Like traditional public schools, charter school performance is evaluated against accountability standards established by the North Carolina legislature. All North Carolina public schools receive A–F performance grades based on student academic achievement on state accountability exams in the areas of English, mathematics, and science (80%) and for student academic growth (20%). Charter schools must also comply with all aspects of IDEA and Section 504 accommodations for all its students with 504-eligible disabilities. Finally, charter schools have the freedom and flexibility to carry out their mission as approved in their charter by the North Carolina State Board of Education (North Carolina General Statute 14A—Charter Schools, 2019).

The Role of Principals in School-Based Mental Health

A school-based mental health program cannot take root without strong leadership from the principal, nor can it take place in a vacuum. For school-based mental health to flourish, principals must demonstrate their support for the program by making it a priority within the school improvement process. To do so, principals must be influencers, supporters, and collaborators. All three of these leadership skills are necessary, and they do not occur in a vacuum. In the influencer role, principals exert their leverage within the school improvement process where they carry the most weight in determining to what extent, if any, mental health care services are provided at school. Because principals facilitate an established school culture in which routines and organizational structures are in place to support a program, faculty and staff can feel safe to embrace discussing issues and developing plans for the creation of a school-based mental health program. In this

environment, principals recognize that SEL is a key component to student academic achievement and lend their support to its launch (Skalski & Smith, 2006). Likewise, Frabutt and Speech (2012) asserted that the principal-as-influencer is necessary for establishing a school-based mental health program. By conveying how SEL fits into their vision for academic achievement, principals can develop goals and set the conditions for success necessary to create a mental health program. These principal influencers recognize that SEL does not detract from the focus on student academic success. Rather, they understand that sound mental health fosters it.

To support their vision for SEL, principals must also fully develop the infrastructure to support it because “the success of any project or initiative started in schools is strengthened considerably when school leadership has a vested interest coupled with the expectation and desire for a successful initiative” (Blackman et al., 2016, p. 247). For this reason, CASEL provided advice and assistance to principals so they can build the systems necessary to support their students’ schoolwide social-emotional needs. To create a program, principals should (a) create a highly functioning SEL leadership team, (b) dedicate the time to engage school-community stakeholders, (c) lead the effort for a shared buy-in into the vision, (d) collaboratively set goals and develop an implementation, (e) resource the leadership team enough to implement the plan properly, and (f) frequently communicate the SEL plan as a priority. Furthermore, North Carolina is a CASEL Collaborating States Initiative SEL partner. One benefit of this partnership for the state’s principals is access to CASEL’s school leadership resources (Schlinger et al., 2019).

Schools with involved SEL principal leadership are distinguishable from those

with none because well-developed SEL strategies can easily be seen in highly effective schools and can be led by both internal staff and community-based experts. A 2015 study conducted by the American Educational Research Association with an emphasis on the impact of SEL on academic achievement found that principal leadership was at the core of highly effective high schools (Rutledge et al., 2015). Results from the study indicated there was one primary difference between highly effective high schools and ineffective ones. Students in the effective schools considered themselves successful, in large part due to a culture of personalization. These students believed their success was based on both a shared community connection to the school and genuine, personal relationships between themselves and the adults in the building. Conversely, students in the ineffective schools saw themselves as isolated, where few adults cared about them (Rutledge et al., 2015).

In both scenarios, principals were front and center in establishing and fostering these cultures. Additionally, principals of highly effective schools created organizational structures that supported both academics and student mental health. For example, each of the effective high schools in the study structured their guidance departments as student-centered hubs where they received both academic support and assistance with nonacademic concerns related to their social-emotional needs. Moreover, although ineffective schools also provided support for students, their programs were built for crisis management and lacked universal or proactive interventions. In sum, it is imperative to have the total support of the principal for SEL in general, and in school-based mental health care specifically, to succeed (Rutledge et al., 2015).

Principal Perception Research: Key Studies

School Survey on Crime and Safety

The U.S. Department of Education’s National Center for Educational Statistics (NCES) administers the School Survey on Crime and Safety. NCES has sent this survey to over 4,000 K–12 public school principals nationwide periodically since 2003. The authority to conduct the survey derives from the Education Sciences Reform Act of 2002. The purpose of the survey is to collect data on school crime and safety. The survey covers nine safety-related topics, one of which is school-based mental health. The school-based mental health section asks principals if (a) their schools provide diagnostic mental health assessments, (b) their schools provide treatment to students, and (c) mental health services are provided in school or outside school. The intent of these questions is to inform researchers on how well-equipped schools are to deal with students who have mental health disorders and to mark trends over time.

Findings from the most recent principal survey (2017–2018 SY) indicated that 51.2% of all schools conduct mental health diagnostic assessments to evaluate for mental disorders; of those, only 33% provide school-based mental health care. Additionally, 51.1% of traditional public schools conduct diagnostic assessments; of those, 32.6% provide mental health care. Moreover, 54.2% of charter public schools conduct diagnostic assessments for mental disorders; of those, 39.4% provide school-based mental health services (Diliberti et al., 2017). Finally, when both in-school and out-of-school mental service provisions are combined, 55.2% of traditional public schools provide services compared to 45.2% of charter public schools.

“Now is the Time” Project AWARE State Educational Agency Grants

In 2014, the U.S. Department of Health and Human Services, SAMHSA, and the Center for Mental Health Services received more than \$34,000,000 in “Now is the Time”

Project AWARE State Educational Agency Grants. These grants covered 5 years from 2014–2019. According to SAMHSA’s announcement, the grant’s purpose was to build and expand the capacity of State Educational Agencies to increase awareness of mental health issues among school-aged youth, provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues in children and young adults, and connect children, youth, and families who may have behavioral health issues with appropriate services. The intent of NITT-AWARE-SEA is to develop a comprehensive, coordinated, and integrated program for advancing wellness and resilience in educational settings for school-aged youth. (p. 1)

Twenty states were awarded 5-year Project AWARE State Educational Agency Grants in 2014. California was the largest state to receive one of those grants and, seemingly, the only recipient to survey principals. The state’s education department named its grant-funded program Project Cal-Well and contracted with the University of California San Francisco to conduct a program evaluation. The evaluation included two statewide principal surveys, one in the 2015–2016 school year and the other in 2016–2017. The most recent report of survey findings was published in March 2018. The purpose of those surveys was to “assess principal perceptions of availability of existing mental health services, barriers to service provision, and staff professional development needs related to student mental health in California schools” (Philip R. Lee Institute for Health Policy Studies, 2018, p. 5).

The first Cal-Well principal perception survey was conducted in 2015 with 1,010 California principals. Their responses indicated that the most commonly implemented

school-based mental health care practices were individual therapy at 67% and group therapy at 57%. Additionally, inadequate funding at 55% and a lack of trained professionals at 43% presented the biggest challenges principals faced in providing mental health services for their students (Philip R. Lee Institute for Health Policy Studies, 2018). Furthermore, 43% of principals responded that their teachers needed professional development on how to support their students' needs, and 39% of principals said their teachers needed information on how to address their own stress to serve their students better. For the second survey conducted the following year in 2016, 1,376 principals participated in the research. At 72%, individual counseling was the most common mental health service they provided to California students. Like the prior year's survey, group counseling was also a frequently applied practice; however, crisis intervention was added to the 2016 survey at 56%. The top two barriers to providing school-based student mental health care were again low funding at 58% and a lack of qualified service providers at 42%. Like the 2015 survey, supporting both their own needs and those of their students were the two highest-rated teacher professional development categories. Specifically, 42% of staff rated the need for professional development to support their own needs as moderately high, and 43% rated the need for training to address their students' needs as high.

International Principal Perspectives on Student Well-Being

The International Survey of Principals Concerning Emotional and Mental Health and Well-Being (International Association of Child and Adolescent Mental Health and Schools, 2009) was a landmark international survey conducted in 25 countries with 1,215 principals. It was sponsored by the International Alliance for Child and Adolescent

Mental Health and Schools and the International Confederation of Principals. Like other principal perception surveys, the purpose of the international survey was to gain insight into principal thinking about (a) the link between emotional and mental health and academic achievement; (b) the major emotional and mental health issues facing their students and staff; (c) the types of professional development, education and training materials, and other resources needed for support; and (d) national policies that might be most supportive and useful to them in addressing these perceived issues (Rowling et al., 2009).

Most respondents came from countries that were members of the International Confederation of Principals. These nations were Ireland, Australia, the United Kingdom, Canada, the United States, and New Zealand. There were other countries represented that were not necessarily International Confederation of Principals members, such as Ghana, Brazil, and India. Fifty-one percent of participants were principals of pre-K to Grade 6 schools, 27% were principals of middle or high schools, and 22% represented outlier school grade and student age combinations. Fifty-seven percent of the participants were female, while 43% were male. Additionally, 50% of the principals responded that their students were either mixed race or diverse. Finally, most principals (40% each) reported being a principal for 7–14 years or 6 years or less. The remaining 20% had been principals for 15 or more years (International Association of Child and Adolescent Mental Health and Schools, 2009).

The survey results indicated that most principals believe that (a) student social-emotional health is very important to academic achievement; (b) the top three student issues needing attention are bullying/harassment, impulse control, and anger

management; (c) the top three staff issues needing attention are stress, anxiety, and depression; (d) national policies need to be established that address student and staff mental health well-being; (e) socioeconomic status has a profound impact on student well-being across all issues; and (f) professional development training resources are necessary to train staff to address student social-emotional issues (International Association of Child and Adolescent Mental Health and Schools, 2009). Finally, the findings from this survey are consistent with those from similar surveys of American principals.

The Conceptual Framework of Differences in the Mental Health Care Needs of Students in the Elementary School, Middle School, and High School Settings

The early life relationships of children form the basis from which students will experience school at various stages of their development. Urie Bronfenbrenner developed the Bioecological Systems Theory to explain human development. Briefly stated, these relationships typically occur regularly, continue throughout life, and grow more complex and dynamic over time. Bronfenbrenner refers to human interactions as proximal processes, and they are the primary influencers on human development. Proximal processes vary according to the characteristics of the developing person. These include individual student characteristics such as parent-child or student-teacher interactions. Proximal processes also include how a student engages within the school context. Last, these processes vary with different periods of human development (Bronfenbrenner & Morris, 2006).

A student's environment also shapes their proximal processes and contributes to a healthy or delayed form of human development. Environment influences growth through

the level of stability or instability a student may experience. Childhood experiences such as living in poverty with its proximity to violence, homelessness, and abuse have a direct impact on the physical and mental maturation of a child. These types of proximal processes may lead to stunted academic functioning at school. In contrast, if a child is shaped by experiences of an affluent life and family stability, they will be more likely to conform to the expected social norms of academic functioning and positive self-image (Bronfenbrenner & Morris, 2006).

Furthermore, the bioecological theory breaks time down into three phases, each of which affects human development. These phases are known as micro-time, meso-time, and macro-time. Micro-time is made up of a series of episodes in a child's life. The length of time these episodes last is connected to the influence of proximal processes. For example, after a classroom incident, a student may be ready to return immediately following the meeting with a counselor, but the teacher may still be experiencing the episode and may not be ready for the student's return. Meso-time carries these episodes over longer periods lasting days, weeks, or more; e.g., the effects of a violent neighborhood interaction could continue long after it has ended and manifest itself in chronic inappropriate student behaviors in school. Macro-time reflects a society's constantly shifting expectations from one generation to the next over an extended period of human development (Bronfenbrenner & Morris, 2006).

The bioecological systems theory also suggests several layers define a child's environmental interactions. The first layer is the microsystem. This is the layer closest to a developing child and from which all direct contact occurs; e.g., parent to child, brother to sister. Layer 2 is the mesosystem. This layer connects the child's microsystems to one

another; e.g., parent to sibling interactions. Finally, the third layer is the exosystem. This layer connects the child to their larger community. Although the exosystem does not afford any direct contact between the child and the systems within that exosystem, it still exerts a positive or negative impact upon the child; e.g., a parent becomes unemployed and the family consequently becomes homeless (Paquette & Ryan, 2001). Last, Bronfenbrenner's bioecological systems theory can act as the core concept to differentiate school-based mental health needs between elementary, middle, and high school-age students because there are multiple levels of interacting influences on development that impact people's mental health and how they connect with their environment (Sallis et al., 2008).

Elementary School Setting

The elementary school is a highly concentrated microsystem setting for human development because of the multiple, direct daily contacts between people. At any given time during the day, a child's microsystem interactions could include child to parent, child to child, child to teacher, or child to school principal. For children, therefore, strong relationships with these members of the microsystem are imperative to providing support for their mental health care needs, especially when it comes to the student-principal relationship. According to Mendoza (2018), teacher and counselor survey responses indicated that principals best support them when principals know their students and have positive relationships with them. Furthermore, the research indicates that principals themselves believe they must actively get to know their students by "understanding their background or what they are bringing with them emotionally to the school...to allow for a...strong principal–student relationship" (Mendoza, 2018, p. 97).

Most of the school-based mental health literature is dedicated to the elementary school setting and is primarily focused on preventing antisocial behaviors because the onset of mental health disorders can be identified in children by the time they enter kindergarten. Additionally, the literature spotlights student externalizing behavior (e.g., disorderly conduct) versus internalized behavior (e.g., depression). Furthermore, research studies on middle school and high school students receive much less attention, and therefore it is an area within the school-based literature that is lacking (Hoagwood et al., 2007).

Middle School Setting

Adolescence and the middle school setting give rise to an expanded student

microsystem resulting from a change in student proximal processing. As mentioned earlier, Bronfenbrenner's bioecological theory refers to proximal processors as people-to-people and people-to-environment interactions that grow more complex and dynamic over time. Consequently, these proximal processors become the primary influencers of human development; therefore, as students transition from childhood to adolescence, the anxiety stemming from the naturally occurring changes in with this age group (e.g., growth spurts and puberty) leads to new behaviors. Depending on the experiences and relationships from elementary school, these behaviors can either develop into well-adjusted adolescence or, conversely, follow a self-destructive path into adulthood (Stormshak et al., 2011).

The behavioral risk that comes with adolescence is reflective of the changes to the proximal processor influencers. The child-to-parent relationship can give way to child-to-a-new-group-of-peers relationships if there is a decrease in parent involvement and an increase in unsupervised time. Consequently, this risk period can lead to problem behaviors such as substance abuse, aggression, absenteeism, and violence. Furthermore, middle schoolers who exhibit these behaviors as adolescents follow the pathway to academic failure, poor mental health, and increased antisocial behavior in high school (Stormshak et al., 2011). Last, the research literature indicates that the mental health issues that develop during these middle school years persist into adulthood (McLaughlin et al., 2011).

High School Setting

High schools operate within a complex structure of social systems. Bronfenbrenner's bioecological theory of human development aids in providing an

understanding of the impacts those systems have on students. As a recap, the bioecological theory asserts certain factors shape the identity of a developing person. These factors are known as proximal processes and take the form of people-to-people and people-to-environment interactions. These direct interactions occur regularly, increasing in complexity over a long period within the microsystem; e.g., the connection between students in a varsity football team. Moreover, high school students are less impacted by the decreasing value in relationships within the mesosystem; e.g., parent-teacher communication frequency. High school exosystem interactions, on the other hand, begin to grow in influence because of the wide array of options open to them in this setting, which they may find more alluring; e.g., the school's drug use counterculture (Wood et al., 2017).

Consistent with the bioecological theory, stability of development, rather than changes in development, is the pattern in high school. As cited previously in this chapter, untreated mental illness in adolescence leads to mental disorders that persist into adulthood. The ultimate manifestation of dysfunctional human development in high school is for a student to drop out of school. The research literature indicates that the factors that distinguish students at risk for dropping out from their peers who graduate occur before the 10th grade, which is consistent with an ecological theory of human development. Additionally, these at-risk students do not perceive the consequences that come with not completing high school (Wehlage, 1986). Last, the literature suggests that to mitigate losing at-risk high school students, exosystem-based organizations (i.e., community-based mental health agencies) need to engage them as direct contact microsystems. "Community partners who were located in the exosystem, and only

indirectly (and weakly) connected to student development, found various ways to attain direct, face-to-face microsystem-level relationships with students to better promote student development” (Leonard, 2011, p. 997).

Geographic Classification: Urban (Metropolitan), Suburban (Micropolitan), and Rural Communities

School-based mental health service delivery varies by both school level and geographic locale because students at different school levels are at different stages of development and conform to disparate geographically based cultural norms. For instance, children raised in an urban area are likely to encounter different stressors than children raised in a rural area, and high school students have different coping skills than middle school and elementary students. Furthermore, urban children are exposed to more violence and poverty than suburban children and therefore present different mental health needs; e.g., PTSD versus heavy drug and alcohol abuse in suburban children. Finally, children who live in rural communities do not have the same access to service delivery as urban and suburban children because rural communities lack service providers and organized programs or their communities are just too sparsely populated (Weist et al., 2000).

Urban, suburban, and rural are formally defined and categorized by the federal government. According to the U.S. Office of Management and Budget, a metropolitan statistical area has at least one urbanized area with a minimum of 50,000 people.

Metropolitan areas are also home to 86.3% of America’s school-age children.

Micropolitan areas are urban clusters with populations of at least 10,000 people but less than 50,000. Residents of micropolitan areas typically commute to the urban center for

work. Additionally, 8.3% of America's youth live in these suburban clusters. The Office of Management and Budget defines rural areas as being neither metropolitan nor micropolitan. Instead, they can contain small urban areas of less than 10,000 people or be completely rural. Last, 5.4% of children live in rural communities (Childstats.gov, n.d.). Finally, the U.S. Department of Agriculture refines these Office of Management and Budget definitions even further. It uses an urban-rural system that codifies geographic locations on a scale of 1–8 to describe where each community falls in the continuum from urban to rural. For example, Mecklenburg County, North Carolina is a 1 because its metropolitan area has a population of over 1 million people, whereas Warren County, North Carolina is an 8 because it is completely rural with an urban population of fewer than 2,500 people (U.S. Department of Agriculture, 2019).

School-Based Mental Health in Urban Communities

The highest concentrations of youth under 18 who have mental health issues reside in America's poorest communities (Foy et al., 2019). So, while America's poverty rate is only 10.5%, 14.4% of youth under the age of 18 live in poverty. Geographically, most of these impoverished young people live in the southern United States (12%), reside in the city centers of metropolitan statistical areas (13.1%), and are children of color (African American 18.8%; Hispanic 15.7%). Furthermore, North Carolina is ranked 11th of the 50 states and the District of Columbia, with 12.9% of children under age 18 living in poverty. Finally, Americans living below the poverty level are likely to be high school dropouts, female, and have a disability of some kind (U.S. Census Bureau, 2020).

Even though urban youth are the most likely to need mental health care, they are also the least likely to receive it for a variety of reasons including social stigma,

inaccessibility, transportation challenges, and a lack of information in the community; thus, low-income students who do receive mental health services, do so during the day while at school. (Farahmand et al., 2011). In addition to family instability and poverty, urban youth of color are traumatized by their frequent exposure to violence in the community and at home. These students face violence and victimization in such forms as “abuse and neglect, witnessing family violence, discrimination based on race/sex/sexual orientation/religion, or having a close friend/family member murdered” (Larson et al., 2017, p. 676). Additionally, urban youth of color experiencing trauma incidents are most likely to be diagnosed with mental health disorders such as PTSD, depression, anxiety, and behavioral disorders. Last, these children experience chronic absenteeism and poor academic performance because their untreated mental health conditions manifest themselves in classroom disruptions and other infractions of school policies, which causes them to be removed from school.

School-Based Mental Health in Suburban Communities

A 2016 study of high school guidance counselor perceptions of school-based mental health services in two suburban Philadelphia school districts indicated that suburban students presented with common mental disorders (Babbins, 2016). These disorders included anxiety, depression, eating, misconduct, personality disorders, and suicidal ideations. Additionally, these suburban guidance counselors reported that student mental health issues were increasing, and the survey responses suggested that counselors in both county school districts felt they lacked the training necessary to provide their students with therapeutic services. Interestingly, however, survey results found that although they lacked the formal training, school guidance counselors nonetheless

reported that they spent much of their day attending to student mental health needs (Babbins, 2016).

A study of the perceptions of teachers, counselors, and principals on school-based mental health was conducted in a suburban Los Angeles elementary school district in 2018 (Mendoza, 2018). Principals reported that one of the key elements necessary to provide mental health services in their elementary schools is a proactive system of structured support at the district level. Specifically, principals looked to the district to provide qualified mental health professionals to administer services such as universal student screenings. School counselors indicated that for structured support systems to work, principals need to be able to develop relationships within and without the school district (e.g., with community-based agencies) to gain the resources necessary to deliver mental health services. Counselors also reported that it is imperative for principals to be skilled collaborators with the express purpose of building a qualified team to develop and implement the mental health program. Finally, teachers agreed with counselors on the importance of principals as collaborators and partners in dealing with student mental health issues as they arise (Mendoza, 2018).

The state of California has many high-performing suburban school districts. One mental health research project studied two such districts (Meadows, 2018). Like their east coast suburban colleagues, these California high school educators found their students experienced anxiety, depression, and suicidal ideations. The antecedent triggers for these disorders were academic competition and high parent expectations. Additionally, over 50% of the school leaders who participated in the study's survey indicated their concern over rising student anxiety and depression disorders, along with increasing substance

abuse. Furthermore, nearly 40% of school leader respondents reported that they were extremely concerned about the negative impact of student mental health needs on academic achievement. Finally, like their suburban Philadelphia high school colleagues, California school counselors reported the scope of their duties changing from academic counselor to addressing student mental health needs as the school counselor's top priority.

School-Based Mental Health in Rural Communities

The highest concentrations of Americans living in poverty are those who reside in the most remote and isolated sections of rural America. Children living in these impoverished communities are more likely to experience mental health issues and less likely to receive care than either their urban or suburban contemporaries. Additionally, rural areas are small and close-knit, which can lead families not to seek out mental health care for their children because of their fear of public shaming and rejection. Conversely, rural school facilities tend to be the center of community activities, which builds connectedness to the school and fosters resilience in students that can help to compensate for a lack of mental health resources (Nichols et al., 2018).

However, children in rural communities and urban areas share certain common mental health concerns. Like their counterparts in urban areas, many rural regions across the United States are composed of a majority population of African Americans and Latinos and are less likely to receive mental health services for their children than the largely Caucasian suburbs. Additionally, rural residents of color tend to have lower levels of academic attainment and greater levels of poverty than their Caucasian suburban counterparts. Furthermore, rural residents of all races and ethnicities who identify outside

the mainstream (for example, as people who are gay or transgender) experience hostility and bullying at school at far greater rates than their urban or suburban counterparts. Finally, the cultural norms and beliefs of prominent leaders and members of rural communities have a greater influence on community and school district mental health policies than their counterparts in metropolitan or suburban school districts (O'Malley et al., 2018).

Tu (2018) compared the perspectives of rural and urban Kentucky high school students on their mental health concerns. Tu identified four overarching themes that impacted the mental health of the participants: (a) family dynamics, (b) peer interactions, (c) a lack of resources, and (d) high stress levels. Both urban and rural students stated that the relationships with their parents were sources of mental health issues, and they were concerned about the stigma associated with mental health care needs. The stress was particularly keen when parents compared them to their high-performing siblings or to the mistakes of siblings who did not perform according to parental expectations. The stigma surrounding seeking mental health care is exacerbated by a lack of parental empathy attributable to generation gaps. Whereas students saw no shame in seeking help, their parents did because of their own upbringing, which disapproved of family members seeking assistance outside the home.

Urban and rural Kentucky youth recognized that their peers can be both good and bad influences on their mental health (Tu, 2018). These high school students believed that their close friends would be considerate if they faced mental health issues but thought others would use the knowledge to hurt them emotionally through verbal bullying. They also believed that once the situation was known, their peers would treat

them as outcasts or judge them, which can lead to social isolation and loneliness. Furthermore, rural students indicated that their school's lack of mental health care resources and the absence of formal student mental health education at school contribute to stigmatization and lack of empathy on the part of their peers. Rural and urban students reported that they experience anxiety and high levels of stress because of conflicting priorities such as competing academically, sports, holding jobs, and meeting family expectations (Tu, 2018). Finally, as mentioned previously, students at high-performing suburban schools identified with these same mental health stressors.

Summary

This chapter has revealed several consistent themes across the school-based mental health care literature. These themes included the following:

- Since students spend most of their day in school, it is a logical entry point into mental health care: The primary role of schools in mental health care is early identification and referral of students.
- Schools can mitigate barriers to care, and teachers are best suited for early identification and referral due to their frequent contacts and close relationships with students.
- System-of-care is the ideal approach to mental health care delivery.
- Mental health disorders that occur in childhood are likely to persist into adulthood if left untreated.
- The influence of the federal government on mental health care policy has grown steadily since the 1960s.

Sponsoring research is an important aspect of the federal government's influence

on school-based mental health (“Value, importance, and oversight,” n.d.). Research included survey studies with emphasis on the perceptions of school-based leaders, faculty, and student support personnel such as nurses. One of the two major principal perception survey research studies cited here is the 5-year California study which is the research basis for this study. Like the Cal-Well project, this study involved a statewide study of principals. In the two Cal-Well surveys, findings indicated that lack of funding and lack of qualified personnel were the two major hurdles to providing school-based mental health. The difference between this study and other studies was the population sample. Whereas in the previous research all principals were included on a wide scale, this study only surveyed North Carolina charter school principals.

Chapter 3: Methodology

Introduction

The purpose of this research study was to investigate North Carolina charter school principal perceptions of school-based mental health service delivery using survey questions to collect data that describe what these principals think about (a) the availability of school-based mental health services, (b) barriers to service provision, and (c) staff professional development needs. I also investigated the differences in perceptions between principals from different grade levels as well as principals from different geographical regions of North Carolina. To answer the research questions, I used the Cal-Well instrument developed by the California Department of Education for its statewide principal survey. While the results only characterized the views of a single principal, collectively, the data can be generalized to North Carolina's charter school principal population.

Research Questions

To avoid redundancy in the conduct of quantitative research, the researcher should choose either research questions or hypotheses but not both (Creswell, 2014). Therefore, three research questions guided this quantitative study.

1. What perceptions do charter school principals have of mental health care service availability, barriers to service provision, and staff professional development needs regarding mental health?
2. Are there statistically significant differences in perceptions of mental health care service, barriers to service provision, and staff professional development by grade level?

3. Are there statistically significant differences in perceptions of mental health care service availability, barriers to service provision, and staff professional development needs between school principals of urban, suburban, and rural communities?

Research Design

There are three research approaches for collecting data: (a) quantitative methods, (b) qualitative methods, and (c) mixed methods. I used a quantitative approach to this survey research study. Quantitative methods use numerical information to organize, test, compare, and statistically analyze data relationships between variables. Quantitative research is also a means of testing relationships among numerically measurable variables either to describe those relationships or to infer cause-and-effect relationships among them using statistical methods (Howell, 2012). Additionally, I used a descriptive research design to examine perceptions among charter school principals and to assess for differences by grade level and community. I established the distributions of school principals among grade levels and urban, suburban, and rural communities before the data collection.

Participants

I sent surveys via email to all North Carolina public charter school principals except for the two virtual charter school principals. I collected contact emails using the Educational Directory and Demographical Information Exchange (EDDIE). This online exchange lists each charter school in alphabetical order along with all the school's leadership contact information and therefore is more convenient than searching each individual school webpage. This sampling method precluded the inclusion of the state's

two charter virtual school principals in the study.

To determine the adequate sample size for participants, I used the Qualtrics sample size calculator. Qualtrics is a statistical analysis program provided by Gardner-Webb University free of charge for student use. There are three numbers a researcher must know in addition to the actual number of potential research participants. These numbers are the (a) margin of error, also known as the confidence level (converted to a z score), (b) the confidence interval (the confidence level of the mean falling within the margin of error), and (c) the standard deviation (how much do responses vary from each other and also from the mean number). According to the Qualtrics calculator, the appropriate sample size for this quantitative research study at a 90% confidence level, a $\pm 5\%$ margin of error, and a Qualtrics recommended safe number of $.5 - SD$, is 109 participants of the total sample population of 182. The figure graphically depicts the math the calculator used to determine this optimal number.

Figure

Qualtrics Sample Size Formula

$$\text{Necessary Sample Size} = \frac{(\text{Z-score})^2 \times \text{StdDev} \times (1-\text{StdDev})}{(\text{margin of error})^2}$$

Surveys

Surveys provide quantitative data that describe a population's beliefs, attitudes, opinions, and behaviors by studying a fraction of that population. The researcher then uses the sample survey data to draw inferences about the population. Surveys typically have several components in common:

- They make inferences about a whole population with data collected from a population sample;
- they demonstrate why the survey data collection method is preferred;
- they indicate whether the survey is designed to collect data over a long period of time (longitudinal) or a single point in time; and
- they specify how the data will be collected (Creswell, 2014).

Survey Instrument

I contacted Samira Soleimanpour via email to request permission to use the Cal-Well Survey Statewide Principal Survey. Soleimanpour is the Senior Researcher on the School Health Services Research & Evaluation Team at the Philip R. Lee Institute for Health Policy Studies of the University of California, San Francisco. The instrument (Appendix A) was used to survey California's principals on their perceptions of mental health care service delivery and staff professional development needs in their buildings. As mentioned previously, 1,376 California school principals participated in the research in the summer and fall of the 2015–2016 and 2016–2017 school years. Soleimanpour granted permission to use the survey at no cost. Her only request was that I acknowledge that it was created and is owned by the California Department of Education and the University of California San Francisco. Finally, Soleimanpour and her team did not test the psychometrics of the survey. Instead, her team based the survey on “existing tools and final versions were reviewed by members of the California Department of Education’s Student Mental Health Policy Workgroup and other experts in the school mental health and education fields” (S. Soleimanpour, personal communication, April 29, 2019).

Survey Administration

The purpose of this research study was to describe North Carolina charter school principal perceptions of school-based mental health service delivery using survey questions to describe what these principals thought about (a) school-based mental health availability, (b) barriers to service provision, and (c) staff professional development needs. Accordingly, I surveyed principals via the internet. Additionally, I collected data using an instrument created by the California Department of Education and modified slightly for use with North Carolina's charter school principals.

Data-Collection Procedures

I collected data over a short period (1 month) using an internet-based, multiple-choice survey instrument. A survey is the preferred data collection method because it can be administered efficiently to many people over a short period, and the resulting data are well suited to describe the population (Aaron, 2012). Multiple choice questions are preferred over other forms of questioning because over time, multiple choice questions have proven to be more efficient and more reliable than other models of research (Fink, 2009). Finally, besides providing affordable, quick, and reliable responses, internet-based survey research is an ideal method because charter school principals are easily identifiable and accessible via email addresses displayed in North Carolina's online EDDIE, as well as on their school websites. Except for the state's two virtual charter schools, all North Carolina charter school principals received an email requesting their participation in the study. The survey included questions pertaining to their perceptions of school-based mental health service delivery, barriers to said delivery, and the professional development needs of their staff.

This study followed the protocols established by Gardner-Webb University's

Institutional Review Board regarding research with human subjects. I fully informed survey participants of the purpose of this study and informed them that their participation would be completely voluntary. I used SurveyMonkey (Appendix B) to host the survey and collect the data and then transferred the data to the Statistical Package for Social Sciences (SPSS) program to conduct the relevant tests for data analysis. All data collected through SurveyMonkey were confidential; thus, no other security measures were necessary.

Table 2

Variables, Research Questions, and Items on the Survey

Variable name	Research question	Survey items
Perceptions of existing school mental health services, barriers to service provision, and staff professional development needs.	Descriptive research question: What perceptions do principals have of existing mental health service availability, barriers to service provision, and staff professional development?	See Survey Questions 3–42
Independent variable: Grade level	Inferential research question: Are there statistically significant differences in perceptions of mental health care service, barriers to service provision, and staff professional development by grade level?	See Survey Questions 1, 3–25, 26–34, and 35–42
Dependent variable: Perceptions of mental health care service, barriers to service provision, and staff professional development		
Independent variable: Communities	Inferential research question: Are there statistically significant differences in perceptions of mental health care service availability, barriers to service provision, and staff professional development needs between school principals of urban, suburban, and rural communities?	See Survey Questions 2, 3–25, 26–34, 35–42
Dependent variable: Perceptions of mental health care service, barriers to service provision, and staff professional development		

Data Analysis

I downloaded and extracted the data from SurveyMonkey and uploaded the data into SPSS Version 26.0 for Windows. Participants who did not respond to most of the questionnaire ($> 50\%$) were removed from further analysis. To address the descriptive research questions, I used exploratory data analysis to examine the trends in the survey responses. I analyzed the collected data through frequency distribution and percentages. Frequency distribution yields information about the different categories of measurement and the number of occurrences of each category, which is then organized and displayed within a frequency distribution table. A frequency distribution table display enables the researcher to see patterns in the data across the whole scale of measurement; i.e., data may be concentrated in one area of the scale or equally distributed across the whole scale. To do this, a researcher uses the statistical method of measure of central tendency (Manikandan, 2011a, 2011b).

According to Manikandan (2011b), the measure of central tendency is “the statistical measure that identifies a single value as representative of an entire distribution with the aim of providing an accurate depiction of all the collected data” (p. 140). These measures of central tendency are the mean, median, and mode. The median is the exact middle point along a scale. One side of the median is the lower half of occurrences, and the other side is the upper half of occurrences. For example, if a student’s grade point average is in the 50th percentile, that means 50% of students did better and 50% did worse than the student. The mode is the number that occurs most frequently. Of the three elements, the mean is the most common measure of central tendency (Manikandan, 2011b).

I also used chi-square tests of independence and analyses of variance (ANOVAs)

to investigate whether there were differences in perceptions of mental health care service availability, perceptions of barriers to service provision, and perceptions of staff professional development needs by geographic location and school grade levels. A chi-square test of independence is appropriate when assessing for the strength of the association between two nominal-level variables (Howell, 2012). An ANOVA is appropriate when testing for differences in continuous dependent variables between groups (Tabachnick & Fidell, 2013). The dependent variables corresponded to perceptions of mental health care service availability, barriers to service provision, and staff professional development needs. The independent grouping variables corresponded to school level and geographic location. For the nominal-level comparisons, I conducted chi-square tests of independence. For the continuous-level data, I conducted ANOVAs. Prior to analysis, I tested the assumptions of normality and homogeneity of variance. I assessed normality using Kolmogorov-Smirnov tests. Significance on the Kolmogorov-Smirnov test means that the data significantly deviate from a normal distribution. I assessed homogeneity of variance using Levene's tests. Significance on Levene's test means that the data are not spread equally between the groups of school level or geographical location.

Summary

As previously stated, the purpose of this study was to examine the perceptions of charter school principals regarding mental health care service provision and teacher professional development needs in their buildings. I used a survey instrument to collect data for this research project. I received permission from the creator of the Cal-Well principal survey to use the instrument in my study. I asked 182 principals to participate in

the survey. I used exploratory data analysis to describe principal perceptions, and I used chi-square tests and ANOVA statistical measures to investigate whether differences in perceptions existed between principals at different grade levels and between urban, suburban, and rural communities around the state.

Chapter 4: Results

Introduction

As described in Chapter 1, the purpose of this study was to examine North Carolina charter school principal perceptions regarding the delivery of mental health care services in their schools. Specifically, the main aims of the research were to (a) describe what charter school principals think about student mental health care service delivery in their schools; (b) determine what barriers, if any, stand in their way to provide said services; and (c) examine the specific training needs of their staff to facilitate school-based student mental health care. Additionally, I aimed to evaluate differences in principal perceptions based on geography (urban, suburban, or rural) and school level (elementary, middle, or high school). The final goal of this study was to add to the body of literature on principal perceptions of school-based mental health care from a K–12 perspective. This study involved a research survey administered over a 3-week period from January 9–31, 2021 employing quantitative methods. A 38-question survey was used to gather the data. This North Carolina Charter School Principal Survey questionnaire was based on the Cal-Well Survey, with permission for use from both the sponsor, The California Department of Education, and the survey creator, The University of California, San Francisco.

Principal responses to each of the following research questions were examined:

1. What perceptions do charter school principals have of mental health care service availability, barriers to service provision, and staff professional development needs regarding mental health?
2. Are there statistically significant differences in perceptions of mental health

care service, barriers to service provision, and staff professional development by grade level?

3. Are there statistically significant differences in perceptions of mental health care service availability, barriers to service provision, and staff professional development needs between principals of urban, suburban, and rural communities?

Data-Analysis Procedures

The SurveyMonkey research survey instrument was administered over a 3-week period from January 9–31, 2021, which provided automatic data download to the SPSS software program for analysis. Of the 182 charter school principals emailed, a total of 51 principals provided consent to participate in the survey, for a response rate of 28%.

Among these individuals, six left most of the survey questions unanswered. These cases were subsequently removed from further analysis. Consequently, the final sample consisted of 45 charter school principals for an actual response rate of 24.7%. The survey data were first cleaned to account for principal nonresponses. Then, to address the three research questions, exploratory data analysis was utilized, along with a series of ANOVAs. Frequencies and percentages were used to identify trends in the nominal-level variables. Means and standard deviations were used to examine trends in the continuous-level variables.

Research Question 1

What perceptions do charter school principals have of mental health care service availability, barriers to service provision, and staff professional development needs regarding mental health?

Data Summary. The results of the surveys were analyzed to determine whether differences exist in principal perceptions based on school location or grade levels served. The first two survey questions asked participants to identify the grade levels they were responsible for and their school's geographic community location. All 45 principals answered these two questions. Some 21 of the 45 principals led K–8 schools, representing nearly half the participants at 46.67%. The largest number of respondents identified as being the principal in a rural school (42.22%). The results in Table 3 indicate the frequency distributions and percentages for participant school levels and geographic community locations.

Table 3

Frequency Table for Type of School and Location

Variable	n	%
Type of school		
I am principal of an elementary school	7	15.56
I am principal of a middle school	2	4.44
I am principal of a high school	2	4.44
I am principal of a K–8 school	21	46.67
I am principal of a K–12 school	13	28.89
Location		
My school is in a rural area	19	42.22
My school is in a suburban area	16	35.56
My school is in an urban area	10	22.22

Q4: How common are the following issues among students at your school?

The frequencies and percentages are in Table 4.

Table 4*Frequency Table for Q4*

Variable	n	%
How common are student social, emotional, and mental health problems?		
A little	5	11.11
Moderate	28	62.22
Very common	12	26.67
Missing	0	0.00
How common is student substance use/abuse?		
Not at all	18	40.00
A little	21	46.67
Moderate	6	13.33
Missing	0	0.00
How common is student exposure to trauma/violent events in the home or community?		
A little	27	60.00
Moderate	15	33.33
Very common	2	4.44
Missing	1	2.22
How common is student truancy?		
Not at all	5	11.11
A little	23	51.11
Moderate	16	35.56
Very common	1	2.22
Missing	0	0.00

Note. Due to rounding errors, percentages may not equal 100%.

Q5: Please provide the number and full-time equivalent (FTE) of staff in the following categories that worked at your school during the 2018–19 school year. If you have no staff in any category, please state none. The frequencies and percentages are in Table 5.

Table 5*Frequency Table for Q5*

Variable	n	%
Guidance counselor		
0	12	26.67
1	16	35.56
2	10	22.22
3 or more	6	13.33
No response	1	2.22
Mental health counselor		
0	32	71.11
1	10	22.22
2	1	2.22
3 or more	2	4.44
School nurse		
0	19	42.22
1	21	46.67
2	5	11.11
School social worker		
0	37	82.22
1	8	17.78
School psychologist		
0	26	57.78
1	18	40.00
No response	1	2.22
Mental health service provider employed by an outside community-based agency		
0	19	42.22
1	19	42.22
2	4	8.89
3 or more	2	4.44
No response	1	2.22
Graduate or undergraduate school interns in the mental health or related field.		
0	37	82.22
1	7	15.56
2	1	2.22

Note. Due to rounding errors, percentages may not equal 100%.

Q6: What types of services do school-based mental health providers offer at your school? The frequencies and percentages are in Table 6.

Table 6

Frequency Table for Q6

Variable	n	%
What types of services do school-based mental health providers offer at school during the school day? Mark all that apply.		
None—we don't offer school-based mental health services	9	20.00
Assessment/screening for mental health needs	20	44.44
Behavior management consultation	21	46.67
Case management	10	22.22
Crisis intervention	23	51.11
Family support services (including family counseling)	14	31.11
Individual counseling/therapy	31	68.89
Group counseling/therapy	21	46.67
Medication management	6	13.33
Substance abuse counseling	3	6.67
Missing	42	93.33

Note. Due to rounding errors, percentages may not equal 100%.

Q7: Do you conduct school-wide, universal screenings of ALL students to identify general education students with mental or behavioral health issues who may need support from school-based mental health providers? The frequencies and percentages are in Table 7.

Table 7*Frequency Table for Q7*

Variable	n	%
Do you conduct universal screenings to identify students with mental or behavioral health issues who may need support from a mental health provider?		
Yes	16	35.56
No	29	64.44
Missing	0	0.00

Note. Due to rounding errors, percentages may not equal 100%.

Q9: During the 2018–2019 school year, approximately how many students were referred to.... The frequencies and percentages are in Table 8.

Table 8*Frequency Table for Q9*

Variable	n	%
During the 2019–2020 school year, how many students were treated by a mental health provider at school during school hours?		
None	16	35.56
1–10	14	31.11
11–20	2	4.44
21 or more	12	26.67
Do not know	1	2.22
During the 2019–2020 school year, how many students were treated by a community-based mental health service provider in the community during non-school hours?		
None	10	22.22
1–10	16	35.56
11–20	1	2.22
21 or more	3	6.67
Do not know	14	31.11
No response	1	2.22
During the 2019–2020 school year, how many students received mental health services provided by a school employee at school during school hours?		
None	15	33.33
1–10	11	24.44
21 or more	15	33.33
Do not know	4	8.89
During the 2019–2020 school year, how many students received mental health services at school, during school hours, by a community-based mental health provider?		
None—community-based mental health services are not offered	13	28.89
1–10	15	33.33
11–20	1	2.22
21 or more	3	6.67
Do not know	10	22.22
Missing	3	6.67
During the 2019–2020 school year, how many students received mental health services by providers in the community during non-school hours?		
None	11	24.44
1–10	15	33.33
11–20	1	2.22
21 or more	3	6.67
Do not know	15	33.33

Note. Due to rounding errors, percentages may not equal 100%.

Q12: To what extent are the following factors barriers to the delivery of mental health services at your school? The frequencies and percentages are in Table 9.

Table 9*Frequency Table for Q12*

Variable	n	%
Lack of qualified school-based employee mental health providers		
Not a barrier	9	20.00
Minor barrier	13	28.89
Moderate barrier	13	28.89
Serious barrier	10	22.22
Missing	0	0.00
Lack of community-based mental health providers who can provide services at our school		
Not a barrier	14	31.11
Minor barrier	13	28.89
Moderate barrier	13	28.89
Serious barrier	5	11.11
Missing	0	0.00
Lack of funding for school-based mental health services		
Not a barrier	5	11.11
Minor barrier	2	4.44
Moderate barrier	14	31.11
Serious barrier	24	53.33
Missing	0	0.00
Limited school space/facilities for mental health professionals to work		
Not a barrier	10	22.22
Minor barrier	11	24.44
Moderate barrier	14	31.11
Serious barrier	10	22.22
Missing	0	0.00
Stigma associated with mental health services		
Not a barrier	17	37.78
Minor barrier	15	33.33
Moderate barrier	9	20.00
Serious barrier	4	8.89
Missing	0	0.00

(cont.)

Variable	n	%
Lack of parental cooperation and consent		
Not a barrier	12	26.67
Minor barrier	20	44.44
Moderate barrier	10	22.22
Serious barrier	3	6.67
Missing	0	0.00
Language and cultural barriers		
Not a barrier	22	48.89
Minor barrier	19	42.22
Moderate barrier	4	8.89
Missing	0	0.00
Concern about students missing classroom time to receive services		
Not a barrier	19	42.22
Minor barrier	18	40.00
Moderate barrier	7	15.56
Serious barrier	1	2.22
Missing	0	0.00

Note. Due to rounding errors, percentages may not equal 100%.

Q13: To what extent does your school staff need more professional development, training, mentorship, or other support in the following areas? The frequencies and percentages are in Table 10.

Table 10*Frequency Table for Q13*

Variable	n	%
Ways to identify students with social, emotional, and/or mental health needs		
Minor need	15	33.33
Moderate need	22	48.89
High need	8	17.78
Ways to support students with social, emotional, and/or mental health needs		
Minor need	8	17.78
Moderate need	27	60.00
High need	10	22.22
Ways to refer students with social, emotional, and/or mental health needs to support services		
No need	2	4.44
Minor need	14	31.11
Moderate need	16	35.56
High need	13	28.89
Ways to support staff/teachers' own social, emotional, and/or mental health needs as they support students		
Minor need	12	26.67
Moderate need	19	42.22
High need	14	31.11

Note. Due to rounding errors, percentages may not equal 100%.

Q14: Have you or your school staff ever attended a Youth Mental Health

First Aid (YMHFA) Training? These trainings introduce common mental health challenges for youth, review typical adolescent development, and teach a 5-step action plan for how to help young people in both crisis and non-crisis situations. The frequencies and percentages are in Table 11.

Table 11*Frequency Table for Q14*

Variable	n	%
Have you or another school leader ever attended a Youth Mental Health First Aid Training? These trainings introduce common mental health challenges for youth, review typical adolescent development, and teach how to help young people in both crisis and non-crisis situations.		
I have attended	10	22.22
No	32	71.11
Do not know	3	6.67
Have any of your faculty ever attended a Youth Mental Health First Aid Training? These trainings introduce common mental health challenges for youth, review typical adolescent development, and teach how to help young people in both crisis and non-crisis situations?		
Some or all of my staff have attended	14	31.11
No	19	42.22
Do not know	12	26.67

Note. Due to rounding errors, percentages may not equal 100%.

Q15: Does your school implement any of the following curricula/programs to improve student mental health and wellness? (Circle all that apply). The frequencies and percentages are in Table 12.

Table 12*Frequency Table for Q15*

Variable	n	%
Does your school implement any of the following curricula/programs to improve student mental health and wellness?		
Character Counts	8	17.78
National Alliance on Mental Illness (NAMI) on Campus High School	2	4.44
Positive Behavioral Interventions and Supports (PBIS)	26	57.78
Restorative Justice	15	33.33
Second Step	6	13.33
SEL	32	71.11
None—we do not offer student mental health service	2	4.44
Do not know	1	2.22

Note. Due to rounding errors, percentages may not equal 100%.

Q16: Does your school's Comprehensive School Safety Plan specifically outline how to address any of the following topics? (Circle all that apply). The frequencies and percentages are in Table 13.

Table 13*Frequency Table for Q16*

Variable	n	%
Does your school's Comprehensive School Safety Plan specifically outline how to address any of the following topics?		
Student mental health policies and services	16	35.56
Suicide prevention and post-vention (i.e., support after a suicide attempt has occurred)	28	62.22
Wellness policy	18	40.00
Restorative practices	13	28.89
SEL	30	66.67
Do not know	5	11.11
Does not address student mental health	2	4.44

Note. Due to rounding errors, percentages may not equal 100%.

Q17: Does your school conduct suicide risk assessment for students? Q20:

Were there any deaths by suicide in your school community in the 2019–2020 school year? The frequencies and percentages are in Table 14.

Table 14

Frequency Table for Q17 and Q20

Variable	n	%
Does your school conduct suicide risk assessment for students?		
Yes, for individual students as needed.	36	80.00
Yes, through universal screenings of ALL students	3	6.67
No	5	11.11
Do not know	1	2.22
Were there any deaths by suicide in your school community in the 2019–2020 school year?		
No	44	97.78
Do not know	1	2.22
Missing	0	0.00

Note. Due to rounding errors, percentages may not equal 100%.

Composite scores were generated for the survey items pertaining to issues among students (Q4), barriers (Q12), and needs (Q13). Scores for issues among students ranged from 1.75 to 3.25, with $M = 2.40$ and $SD = 0.42$. Scores for barriers ranged from 1.00 to 3.50, with $M = 2.25$ and $SD = 0.55$. Scores for needs ranged from 2.00 to 4.00, with $M = 2.96$ and $SD = 0.62$. The means and standard deviations for the variables are in Table 15.

Table 15

Means and Standard Deviations for Issues Among Students, Barriers, and Needs

Variable	Min	Max	M	SD
Issues among students	1.75	3.25	2.40	0.42
Barriers	1.00	3.50	2.25	0.55
Needs	2.00	4.00	2.96	0.62

Research Question 2: Are there statistically significant differences in perceptions of mental health care service, barriers to service provision, and staff professional development by grade level?

A series of ANOVAs were conducted to analyze for differences in issues among students, barriers, and needs by grade level. The findings of the ANOVA were not significant for issues among students ($F [4,40] = 1.64, p = .183$, partial $\eta^2 = .141$), indicating there were no significant differences in issues among students by grade level. The findings of the ANOVA were not significant for barriers ($F [4,40] = 1.44, p = .239$, partial $\eta^2 = .126$), indicating there were no significant differences in barriers by grade level. The findings of the ANOVA were not significant for needs ($F [4,40] = 0.50, p = .737$, partial $\eta^2 = .047$), indicating there were no significant differences in needs by grade level. The findings of the ANOVAs are in Table 16. The means and standard deviations for the variables are in Table 17.

Table 16

ANOVA Findings for Issues Among Students, Barriers, and Needs by Grade Level

Variable	F (4, 40)	p	Partial η^2
Issues among students	1.64	.183	.141
Barriers	1.44	.239	.126
Needs	0.50	.737	.047

Table 17

Means and Standard Deviations for Issues Among Students, Barriers, and Needs by Grade Level

Grade level	Issues			Barriers		Needs	
	n	M	SD	M	SD	M	SD
Principal of elementary school	7	2.15	0.32	2.54	0.66	2.79	0.42
Principal of middle school	2	2.63	0.88	2.75	0.35	3.50	0.71
Principal of high school	2	2.88	0.53	1.88	0.35	3.00	0.00
Principal of K–8 school	21	2.37	0.45	2.13	0.41	2.96	0.67
Principal of K–12 school	13	2.48	0.26	2.27	0.67	2.94	0.68

Research Question 3: Are there statistically significant differences in perceptions of mental health care service availability, barriers to service provision, and staff professional development needs between principals of urban, suburban, and rural communities?

A series of ANOVAs were conducted to analyze for differences in issues among students, barriers, and needs by location. The findings of the ANOVA were not significant for issues among students ($F [2,42] = 1.30, p = .284$, partial $\eta^2 = .058$), indicating there were no significant differences in issues among students by location. The findings of the ANOVA were not significant for barriers ($F [2,42] = 2.15, p = .130$, partial $\eta^2 = .093$), indicating there were no significant differences in barriers by location. The findings of the ANOVA were not significant for needs ($F [2,42] = 3.03, p = .059$, partial $\eta^2 = .126$), indicating there were no significant differences in needs by location. The findings of the ANOVAs are in Table 18. The means and standard deviations for the variables are in Table 19.

Table 18*ANOVA Findings for Issues Among Students, Barriers, and Needs by Location*

Variable	F (2, 42)	p	Partial η^2
Issues among students	1.30	.284	.058
Barriers	2.15	.130	.093
Needs	3.03	.059	.126

Table 19

Means and Standard Deviations for Issues Among Students, Barriers, and Needs by Location

Grade level	Issues			Barriers		Needs	
	n	M	SD	M	SD	M	SD
Rural area	19	2.31	0.37	2.39	0.59	2.72	0.50
Suburban area	16	2.53	0.35	2.03	0.54	3.03	0.74
Urban area	10	2.38	0.57	2.33	0.40	3.28	0.49

Chapter 5: Discussion

Introduction

Chapter 5 presents a review of the study's purpose, methodology, key findings, and how they relate to the research literature explored in Chapter 2. It also discusses the limitations of the study, provides implications for practice, and provides recommendations for future studies on the perceptions of principals of school-based mental health services and delivery. Last, this chapter is organized around the three research questions and the findings associated with each one. These questions were

1. What perceptions do charter school principals have of mental health care service availability, barriers to service provision, and staff professional development needs regarding mental health?
2. Are there statistically significant differences in perceptions of mental health care service, barriers to service provision, and staff professional development by grade level?
3. Are there statistically significant differences in perceptions of mental health care service availability, barriers to service provision, and staff professional development needs between school principals of urban, suburban, and rural communities?

Background

Between 13% and 20% of students, both in the United States and abroad, require mental health services for various reasons that impede their academic progress. The research literature indicates that some of the common factors contributing to student mental health concerns include substance abuse, poverty, physical and mental abuse, and

exposure to violence and trauma in the home and community. The literature also demonstrates students rarely receive mental health services except when they are provided at school, but schools struggle to fill the needs for a variety of reasons including a lack of funding and competing school priorities in the form of academic versus nonacademic needs. While principals may not have total control of the funding to establish a school-based mental health program, as cited in Chapter 2, principals are the key influencers to school improvement and reform. Therefore, principals can assert their influence by prioritizing the resources allocated to support the school's academic and nonacademic needs. Specifically, by virtue of their leadership roles and responsibilities, principals (a) set the tone for the school's culture, (b) prepare budgets, (c) prioritize the allocation of resources, and (d) set the conditions of success for all school stakeholders (Iachini et al., 2015, pp. 40–41). Therefore, to resource, establish, and implement a school-based mental health program, its stakeholders must secure their principal's leadership and support.

Purpose

The purpose of this quantitative study was to describe North Carolina's charter school principal perceptions of school-based mental health. Specifically, the main aims of my research were to (a) describe what charter school principals think about student mental health care needs and service delivery in their schools; (b) determine what barriers, if any, stand in their way to provide said services; and (c) examine the specific training needs of their staff to facilitate school-based student mental health care. Additionally, I aimed to evaluate differences in principal perceptions based on geography and school level (elementary, middle, or high school). Last, I aimed to add to the body of

literature on principal perception research.

Methodology

My research was a quantitative study of North Carolina charter school principal perceptions of school-based mental health services. With permission from the California Department of Education and the University of California San Francisco, I used their Cal-Well statewide principal survey (Appendix C) to conduct my survey. I used questions from the Cal-Well questionnaire to create a survey tailored to North Carolina's charter school principals that was delivered online using a Survey Monkey template. Last, the North Carolina charter school survey was conducted from January 9 to January 31, 2021.

Surveys were sent via email to all of North Carolina's 182 public charter school principals except for the two virtual charter school principals. I collected their contact emails using EDDIE. Fifty-two of 182 surveys were answered by seven elementary school principals, three middle school principals, two high school principals, 24 K–8 principals, and 16 K–12 principals. The study followed the protocols established by Gardner-Webb University's Institutional Review Board regarding research with human subjects. The email explained the nature of the study and defined informed consent. Additionally, the email contained a hyperlink to a secured SurveyMonkey.com survey instrument. Once the respondents completed and submitted the survey, their participation in the research was done.

Survey Monkey provided an automatic data download to the SPSS software program for analysis. As cited in Chapter 4, means and standard deviations were used to examine trends in the nominal-level variables. The means provided the central tendency, while the standard deviations helped to explain potential variations in the distributions. A

series of ANOVAs were also used for data analysis. ANOVAs measured the influence of an independent variable (in this case, grade levels and communities) on the dependent variables (in this case, perceptions of existing school mental health services, barriers to service provision, and staff professional development needs). Finally, the results of the surveys were analyzed to determine if differences existed in principal perceptions based on a school's location or grade levels served by a school.

Summary of Key Research Findings

My study sought to assess North Carolina charter school principal perceptions of availability of existing mental health services, barriers to service provision, and staff professional development needs related to student mental health in their schools. The questions were designed to find out if differences existed between the perceptions of principals based on their geographic location or the grade levels served by their school. Findings from my study are interesting because while certain responses to questions are consistent with the research literature, other responses are not. Several themes emerged from the principal survey: (a) students with mental health concerns are common in North Carolina charter schools, (b) charter schools lack adequate mental health staff, (c) significant barriers exist to the provision of mental health services, and (d) charter school teachers have a high need for professional development.

Findings for Research Question 1: What perceptions do charter school principals have of mental health care service availability, barriers to service provision, and staff professional development needs regarding mental health?

Students' Mental Health Needs in the Forefront

Research Question 1 was informed by Survey Questions 3 to 36. Findings from my study indicated most principals reported that social, emotional, and mental health

problems are a significant issue, with 64% of principals responding it is a moderate problem and 24% indicating it is a very common problem among students in their schools; yet their responses to the questions presenting known contributing factors to student mental health concerns challenge their own perceptions. Specifically, most principals (63.27%) reported exposure to trauma and violent events in the home or community to be only a small problem, and more than half (54%) of the principals indicated student truancy to be only a small problem as well. Moreover, principals do not perceive substance use and abuse as a common problem in their schools. Forty percent of participants responded that substance use is not a problem at all, and another 46% perceived it to only be a minor problem; hence, the responses they provided do not align with their own perceptions that student mental health issues are a common concern.

Mental Health Staffing in North Carolina Charter Schools is a Concern

For those North Carolina charter schools that offer school-based mental health services, survey results indicate those schools are not adequately staffed to perform the functions. Only 25% of charter school principals report having a trained mental health counselor on staff, and more than half (58%) report that they do not cooperate with a community-based agency to provide any school-based mental health services.

Additionally, only 40% of principals responded they had a guidance counselor on staff who could provide mental health support to students, and only 44.99% of charters have a school nurse who could. Furthermore, most (80%) of principals responded that their schools do not have a social worker. Last, no principals at all (0%) reported collaborating with local universities to provide interns at school who could provide or expand student mental health support.

Significant Barriers to School-Based Mental Health Service Provision

Consistent with the research literature, the three most reported barriers to the delivery of school-based mental health services by North Carolina charter school principals are a lack of funding, a lack of mental health care providers, and a lack of office space in the building to provide treatment. Specifically, more than half (54.35%) of principals responded that insufficient funding was a serious barrier to school-based mental health services provision; and at 21.74% each, both a lack of access to qualified service providers and a lack of office space inside the school for mental health care staff members were both reported as serious barriers to providing school-based mental health services. Last, not one principal (0%), indicated that language or culture was a serious barrier. This is very interesting because it contradicts the research literature that clearly suggests language and cultural differences are major barriers to mental health care treatment in school because students from ethnic minority backgrounds are far less likely to receive school-based mental health services than Caucasian students (Wang et al., 2018).

Charter School Teachers Have a High Need for Professional Development

Nearly all principals reported a moderate or high need for teacher professional development to better support their students with social, emotional, and mental health issues. Specifically, nearly 68% of principals perceived training their staff to identify students with social, emotional, and/or mental health concerns as a moderate to high professional development training need. Additionally, most principals (82.61%) identified providing teachers with the skills to support their students with mental health issues as a moderate to serious professional development staff training need.

Furthermore, many principals (63.04%) identified training teachers in the student services referral process as a moderate to high training need. Last, 73.91% of charter school principals perceived ways to support their staff's own social, emotional, and mental health self-care to be a moderate to high professional development training need.

Findings for Research Question 2: Are there statistically significant differences in principal perceptions of mental health care service, barriers to service provision, and staff professional development by grade level?

Research Question 2 sought to determine if there were statistically significant differences in principal perceptions of school-based mental health care service, barriers to service provision, and staff professional development needs between grade levels served by the school. A series of ANOVA tests were used to analyze differences in principal perceptions of mental health issues among students, barriers to delivering mental health services, and teacher professional development needs. Participant responses to Research Question 2 indicated that the differences were statistically insignificant. Specifically, the insignificant ANOVA findings for mental health issues among students were ($F[4,40] = 1.64, p = .183, \text{partial } \eta^2 = .141$), for barriers to service provisions they were ($F[4,40] = 1.44, p = .239, \text{partial } \eta^2 = .126$), and for teacher development needs they were ($F[4,40] = 0.50, p = .737, \text{partial } \eta^2 = .047$).

According to Fazel et al. (2014), mental disorders vary with age. Elementary school students aged 4 to 10 years old, typically display external disruptive behaviors resulting from mental health issues such as separation anxiety and oppositional defiant disorder, while middle and high school students aged 11 to 18 years old commonly experience internalizing behaviors such as depression or eating disorders (Fazel et al.,

2014). Therefore, students at these distinctly different developmental levels naturally would present different mental health symptoms and thereby receive different, age-appropriate interventions. Principal participants in my study identified themselves as leading a K–8 school (46.20%) and a K–12 school (30.80%). Additionally, there were principals who identified themselves as leading a traditional elementary school (13.5%), a middle school (5.8%), and a high school (3.8%). However, data from my study indicate age and developmental levels have no bearing on mental health service provision because there were no differences in perceptions between leaders with students at the elementary, middle, or high school levels. Consequently, my data run counter to the school-based mental health research literature which asserts there should be distinguishable differences.

Findings for Research Question 3: Are there statistically significant differences in perceptions of mental health care service availability, barriers to service provision, and staff professional development needs between school principals of urban, suburban, and rural communities?

Research Question 3 sought to determine if there were statistically significant differences in principal perceptions of school-based mental health care service; barriers to service provision; and staff professional development between urban, suburban, or rural geographic school locations. A series of ANOVAs were conducted to analyze principal perception differences in issues among students, barriers, and teacher professional development needs by geographic location. Participant responses to Research Question 3 indicated that the differences were statistically insignificant. Specifically, the insignificant ANOVA findings for mental health issues among students were ($F[2,42] =$

1.30, $p = .284$, partial $\eta^2 = .058$), for barriers to service provisions they were $F[2,42] = 2.15$, $p = .130$, partial $\eta^2 = .093$), and for teacher professional development they were ($F[2,42] = 3.03$, $p = .059$, partial $\eta^2 = .126$).

Mental disorders in young people vary by both developmental level and by differences in the urban, suburban, or rural locales in which they reside. For instance, urban youth generally encounter more crime and violence than suburban or rural students, and rural communities do not have the same access to care as urban or suburban areas (Weist et al., 2000). Therefore, students residing in these distinctly different communities, each with its own set of unique social conditions experienced by the youth, are not the same. Therefore, students in each community naturally would present different mental health symptoms and thereby receive different, age-appropriate interventions accordingly. The principal participants in my study identified as 42.31% rural, 34.60% suburban, and 23.10% urban, yet data from my study indicate no differences in perceptions of school-based mental health provision between principals. Consequently, as with Research Question 2, my data for Research Question 3 runs counter to the school-based mental health research literature.

Delimitations

My study was delimited in its focus to only charter school principals; therefore, the results from the study may not necessarily represent the perceptions of non-charter school principals in North Carolina. This delimitation prevents investigating whether charter school principal perceptions are aligned with their non-charter school colleagues because I did not collect data from these other groups. Additionally, I recognize that the study's singular focus on principal perceptions did not allow for other influential school

staff members' perceptions to be included in the research. Specifically, teachers spend the most time with students and therefore have a unique perspective on the influence of school-based mental health care on students; however, there are so many potential charters for a teacher survey that it makes a statewide survey unfeasible. Finally, like surveying charter school faculty members, surveying parents statewide was beyond the scope of this study.

Implications for Practice

The results of this study have education and training implications for school administrators who wish to address the mental health needs of their students. The perceptions of the 52 charter school principals who participated in this study provide a foundational starting point for the planning, resourcing, and establishment of a school-based mental health program. The responses of the principals clearly indicate that teachers need training to facilitate successful program outcomes. The participants identified common barriers that impede the development and implementation of school-based mental health programs. School administrators may benefit from the viewpoints of school leaders with real-world experience in establishing and sustaining student mental health programs by taking into account teacher training needs and barriers to implementation.

This study affirms the notion that the efficacy of school-based mental health service delivery depends on building the capacity of teachers through appropriate education and continuous training. Principals indicated that teachers require professional development in the following areas: (a) identifying students who may need school-based mental health services, (b) knowing the necessary procedures to refer students to higher

levels of care, (c) learning how to support their students with mental health problems, and (d) identifying ways to self-manage the stress resulting from their desire to support their students.

Specifically, 50% of principals responded that training to identify students with mental health problems was a moderate need, and 17% perceived it as a high need. However, just 34.78% of principals responded that training teachers the referral procedures for students needing mental health support was a moderate need, and 28.26% of principals perceived it as a high need. By contrast, 60.87% of principals identified training teachers on how to support their students with mental health issues as a moderate need, and 21.74% of them perceived it as a high need. In addition, 43.48% of principals indicated teacher self-care training as a moderate need, and 30.4% perceived self-care training as a high need.

There are multiple sources of training material to address such teacher professional development needs, and school administrators can access training resources from several open-source websites. These sources include CASEL, MentalHealth.gov, SAMHSA, the National Center on Safe Supportive Learning Environments, and the Mental Health Technology Transfer Center (MHTTC):

- CASEL offers training material dedicated to SEL professional development focusing on planning for training and identifying students with social, emotional, and learning needs (<https://casel.org/state-resource-center/professional-development/>).
- MentalHealth.gov provides federal government resources on mental health research and practice, with material dedicated to educators

(<https://www.mentalhealth.gov/talk/educators>). This material explains the warning signs of mental health problems and the behaviors associated with mental illness.

- SAMHSA's School Mental Health Referrals Pathway Kit provides educators with the guidance they need to create and support a school-based referral infrastructure

(https://www.escneo.org/Downloads/NITT%20SMHRP%20Toolkit_11%2019%2015%20FINAL.PDF).

- The National Center on Safe Supportive Learning Environments provides access to professional development source material for teacher self-care (<https://safesupportivelearning.ed.gov/sites/default/files/BuildResilToolkit-Mod-3-508.pdf>).
- The MHTTC online library includes self-care training modules for teacher use (<https://mhttcnetwork.org/search/node?keys=self-care+for+teachers>).

Participants indicated that administrators could also benefit from addressing the common barriers to building a school-based mental health program. Specific problems that need attention include (a) a lack of funding for school-based mental health services, (b) a lack of qualified school-based employee mental health providers, (c) a lack of community-based mental health providers, and (d) the impact of language and cultural differences on service provision.

Some 30.43% of principals perceived a lack of funding as a moderate barrier to service provision, and 54.35% saw it as a severe barrier. Just 28.26% of principals indicated that a lack of qualified school employees to deliver mental health services was a

moderate barrier, and 21.74% perceived it as a serious barrier. Moreover, 28.26% of principals identified a lack of community-based providers as a moderate obstacle, and 10.87% of them perceived it as a severe challenge. Interestingly, only 8.9% of principals indicated that language and culture was a moderate barrier, and none of them (0%) perceived this issue as a severe barrier to school-based mental health service delivery. Given that these perceptions contradict the research literature, administrators would be well advised to attempt to mitigate the barriers arising from differences in language and culture to school-based mental health service delivery.

To compensate for these barriers, school administrators should consider the following options:

- Administrators can examine current staff roles to determine what support existing school staff can provide. They can also rethink the functions of existing staff to find positions they can fill with mental health providers such as mental health counselors or school social workers.
- School leaders can request assistance from their local county commissions, county health departments, or community-based agencies to seek funding or to fill needs. One example is forming partnerships with community-based mental health agencies because they can claim reimbursement from state and local Medicaid programs. Community agencies can also receive payments from insurers for the provision of mental health services.
- Administrators can apply for additional funds using online grant websites such as <https://www.grantwatch.com>.
- School leaders can use online-only businesses such as Dotcom Therapy

(<https://www.dotcomtherapy.com/schools>). Web-based companies such as these provide a full array of school-based student mental health services.

- Administrators can approach schools of higher learning and other community-based agencies to recruit supervised student interns to provide school-based mental health services.
- School leaders can provide universal mental health interventions without the need for mental health professionals. School leaders can implement schoolwide programs such as Positive Behavioral Interventions and Supports (PBIS). PBIS is a data-driven program designed to prevent inappropriate behaviors (<https://www.pbis.org/pbis/getting-started>). PBIS's program outcomes include addressing student social/emotional needs and reducing substance use and abuse.
- Administrators can implement restorative justice, which is a program designed to build school culture by recognizing the importance of relationships and the interconnectedness of all members of the school community (<http://www.triadrj.org/>). Restorative justice is a way to build connections between students, faculty, and administration and to foster healthy relationships. Schools that implement restorative practices seek to understand the reasons behind inappropriate behaviors and to refer students to proper care.
- School leaders can use CASEL's equity-based SEL curriculum and staff training (<https://casel.org/state-resource-center/culturally-and-linguistically-responsive-practices/>).

- Administrators can consult the webpage of the National Center for School Mental Health on developing culturally responsive school-based mental health programs (<https://www.schoolmentalhealth.org/Cultural-Responsiveness--Equity/>).
- School leaders can use MHTTC's asynchronous culturally based mental health training options to train their faculty and staff (<https://mhttcnetwork.org/centers/global-mhttc/webinars-videos>).

Recommendations for Further Research

The research field on school-based mental health warrants further study because of the increasingly mandated requirement of schools to support student mental health; therefore, the following research suggestions are offered to assist with advancing the research:

1. Although principals are vital to supporting and establishing any school-based program, the faculty is closest to any implementation. Therefore, gaining the perspective of teachers can give insight into the daily practice of school-based mental health service delivery.
2. Many variables impact the mental health status of students. Student socioeconomic status was not a variable considered in the Cal-Well study, nor was it considered in mine; however, the mental health literature clearly and consistently cites the impact of poverty on the mental health status of young people. Therefore, future research should focus on the principal perceptions of socioeconomic status on their students' mental health, especially for students of color who experience poverty and trauma at significantly higher rates than

Caucasian students.

3. This study was limited to 52 North Carolina charter school principals who participated in the online survey research. Future researchers should consider including other charter school leaders such as assistant principals and directors such as Exceptional Children's directors to increase the participation rate.
4. This study did not focus on student demographics. The literature indicated students of color, particularly African Americans, experience mental health issues at a higher rate than White students. Future researchers should consider studying principal perceptions of this phenomenon.

Conclusions

The findings from my study are meaningful because they provide an important contribution to the field of school-based mental health for the following reasons:

1. North Carolina's charter school principal survey responses acknowledge that mental health needs of students are significant issues in their schools. Respondents were presented with common contributing factors of truancy, substance use/abuse, and exposure to violence/trauma to help support these perceptions. However, principal responses indicated these contributing factors to be only minor problems in their schools. Therefore, the data do not adequately explain why principals perceive student mental health issues as a significant problem in their schools.
2. Data from my research regarding barriers to establishing and maintaining a school-based mental health program are consistent with the research literature. Participants in my research responded that funding is the primary barrier to

school-based mental health service provision. Principals also perceived two other barriers as significant obstacles to service provision. One is a lack of qualified mental health providers, and the other is a lack of office space to provide mental health care treatment. Last, although the research literature is clear on language and culture being significant barriers to student participation in school-based mental health services, the principals in my study perceived it to be only a minor problem.

3. Teachers are typically the first people in school to observe differences in their students and therefore, they are the first to identify students in need of mental health services. The findings from my research clearly demonstrate that principals perceive teacher professional development to be a critical component to the establishment and sustainment of a school-based mental health program. Principals indicated professional development in both identifying students in need and developing the skills necessary to provide care to those students as significant professional development training needs. Moreover, principals responded that teachers also need training in the process of referring their students to a higher level of care than they can provide. Last, principals acknowledged providing teachers with training for their own emotional and mental health well-being as a high need.

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Appendix A

Project Cal-Well Statewide Principals Survey

Project Cal-Well Statewide Principals Survey

This survey asks about your perceptions of students' social and emotional wellness and mental/behavioral health needs (referred to as **mental health** needs) and your school's efforts to identify and address these needs.

Please answer the survey based on the 2018–19 school year.

School Information

The following questions will help us link your responses to data on school type, enrollment, and student demographics from other sources. We will not share responses by school name with anyone outside of the University of California San Francisco Research Team.

1. In which county do you work?
2. In which school district do you work?
3. In which school do you work?

Common Issues Faced by Students

4. How common are the following issues among students at your school?	Not at all	A little	Moderate	Very common
a. Social, emotional, and mental health problems				
b. Substance use/abuse				
c. Exposure to trauma/violent events in the home or community				
d. Truancy				

Support Staffing

5. Please provide the number and full-time equivalent (FTE) of staff in the following categories that worked at your school during the 2018–19 school year. If you have no staff in any category, please state none. If you have multiple staff in any category, please add their FTE together and enter the total.	Total number of staff	Total FTE of staff
a. School/guidance counselors, excluding social workers and psychologists	<ul style="list-style-type: none"> • ____ staff • None • Do not know 	<ul style="list-style-type: none"> • ____ FTE of staff • None • Do not know
b. Credentialed school nurses	<ul style="list-style-type: none"> • ____ staff • None • Do not know 	<ul style="list-style-type: none"> • ____ FTE of staff • None • Do not know
c. School social workers	<ul style="list-style-type: none"> • ____ staff • None • Do not know 	<ul style="list-style-type: none"> • ____ FTE of staff • None • Do not know
d. School psychologists	<ul style="list-style-type: none"> • ____ staff • None • Do not know 	<ul style="list-style-type: none"> • ____ FTE of staff • None • Do not know
e. Mental health service providers employed by community-based agencies	<ul style="list-style-type: none"> • ____ staff • None • Do not know 	<ul style="list-style-type: none"> • ____ FTE of staff • None • Do not know
f. Graduate or undergraduate school interns in the mental health or related fields (i.e., social work, psychology, marriage, and family therapy)	<ul style="list-style-type: none"> • ____ staff • None • Do not know 	<ul style="list-style-type: none"> • ____ FTE of staff • None • Do not know

-
- | | | |
|---|---------------|---------------------|
| g. Other mental health support staff, please specify: | • ____ staff | • ____ FTE of staff |
| | • None | • None |
| | • Do not know | • Do not know |
-

School-Based Mental Health Services

The following questions (6–11) ask about services provided by **school-based mental health providers** including:

- School social workers
- School psychologists
- Graduate or undergraduate interns in mental health related fields on the school campus
- Community-based mental health providers on the school campus

Note: Please do not include services provided by school/guidance counselors or school nurses.

6. What types of services do school-based mental health providers offer at your school? (Circle all that apply)
- a. None
 - b. Assessment/screening for mental health needs
 - c. Behavior management consultation
 - d. Case management
 - e. Crisis intervention
 - f. Family support services (including family counseling)
 - g. Individual counseling/therapy
 - h. Group counseling/therapy
 - i. Medication management
 - j. Referrals to specialized programs/services in the community
 - k. Substance abuse counseling
 - l. Other, please specify:
7. Do you conduct school-wide, universal screenings of ALL students to identify general education students with mental or behavioral health issues who may need support from school-based mental health providers? (Circle your answer)
- a. Yes
 - b. No
 - c. Do not know

7a. If yes, what instruments or tools do you use to conduct universal screenings?

8. How are general education students referred to mental health services at your school?
(Circle all that apply)

- a. Does not apply—we do not have school-based mental health services
- b. Teachers/school staff send students to the school-based mental health providers' office
- c. Designated staff person (e.g., Wellness Coordinator) receives all referrals
- d. Students in need of services are discussed at school meetings, such as Coordination of Service Team (COST) or Student Success Team (SST) meetings, and referred to appropriate services
- e. Parents refer students to school-based mental health providers
- f. Students self-refer/drop into the school-based mental health providers' office
- g. Positive Behavioral Interventions and Supports (PBIS) system for referral to Tier 2 interventions
- h. Other, please specify:

9. During the 2018–19 school year, approximately how many students were referred to...	# Referred to services	# Received services
a. School-based mental health services (services on your campus) provided by school mental health staff, such as school social workers and school psychologists (excluding school/guidance counselors and school nurses)?	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know
b. School-based mental health services (services on your campus) provided by community-based mental health providers?	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know
c. Community-based mental health services (services in the community)?	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know

10. During the 2018–19 school year, approximately how many students received...	# Referred to services	# Received services
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a. School-based mental health services (services on your campus) provided by school mental health staff, such as school social workers and school psychologists (excluding school/guidance counselors and school nurses)?	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know
b. School-based mental health services (services on your campus) provided by community-based mental health providers?	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know
c. Community-based mental health services (services in the community)?	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know	<input type="checkbox"/> ____ students <input type="checkbox"/> None <input type="checkbox"/> Do not know

11. Did your school have a waitlist for students who needed school-based mental health services this school year? (Circle your answer)

- a. Does not apply—we do not have school-based mental health services
- b. No, we did not have a waitlist
- c. Yes, we had a waitlist

11a. If your school had a waitlist for students who needed school-based mental health services, approximately how many students were on the waitlist, on average? (Circle your answer)

- a. 1–5 students
- b. 6–10 students
- c. 11–20 students
- d. 21 or more students
- e. Do not know

11b. If your school had a waitlist, approximately how long did students have to wait to receive school-based mental health services on average? (Circle your answer)

- a. 1–2 days
- b. 3–6 days
- c. 1–2 weeks
- d. 3 or more weeks
- e. Do not know

Barriers to Service Provision

12. To what extent are the following factors barriers to the delivery of mental health services at your school?	Not a barrier	Minor barrier	Moderate barrier	Serious barrier
a. Lack of school-based mental health providers				
b. Lack of community-based mental health providers who can provide services at our school				
c. Lack of funding for school-based mental health services				
d. Limited school space/facilities for mental health professionals to work				
e. Competing demands/priorities (e.g., Local Control Funding Formula, Common Core, Every Student Succeeds Act)				
f. Stigma associated with mental health services				
g. Parental cooperation and consent				
h. Language and cultural barriers				
i. Concern about students missing classroom time to receive services				
j. Other, please specify:				

Trainings, Programs, and Policies

13. To what extent does your school staff need more professional development, training, mentorship, or other support in the following areas?	No need	Minor need	Moderate need	High need
a. Ways to identify students with social, emotional, and/or mental health needs				
b. Ways to support students with social, emotional, and/or mental health needs				

-
- c. Ways to refer students with social, emotional, and/or mental health needs to support services
 - d. Ways to support staff/teachers' own social, emotional, and/or mental health needs as they support students
-

14. Have you or your school staff ever attended a Youth Mental Health First Aid (YMHFA) Training? These trainings introduce common mental health challenges for youth, review typical adolescent development, and teach a five-step action plan for how to help young people in both crisis and non-crisis situations.	Yes	No	Do not know
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- a. I have attended
 - b. Some or all my staff have attended
-

15. Does your school implement any of the following curricula/programs to improve student mental health and wellness? (Circle all that apply)

- a. Character Counts
- b. Directing Change
- c. National Alliance on Mental Illness (NAMI) on Campus High School
- d. Positive Behavioral Interventions and Supports (PBIS)
- e. Restorative Justice
- f. Second Step
- g. Other, please specify: _____
- h. Do not know
- i. None of the above

16. Does your school's Comprehensive School Safety Plan specifically outline how to address any of the following topics? (Circle all that apply)

- a. Student mental health policies and services
- b. Suicide prevention and post-vention (i.e., support after a suicide attempt has occurred)
- c. Wellness policy
- d. Restorative practices
- e. Other, please specify: _____
- f. Do not know
- g. None of the above

17. Does your district have a written policy to address student suicide prevention, intervention, and post-vention? (Circle your answer)

- a. Yes

- b. No
 - c. Do not know
18. Which of the following trainings do you provide school staff on student suicide prevention, intervention, and post-vention? (Circle all that apply)
- a. Question Persuade Refer (QPR)
 - b. SafeTALK
 - c. Applied Suicide Intervention Skills Training (ASIST)
 - d. More than Sad
 - e. Kognito At-Risk
 - f. Youth Mental Health First Aid
 - g. Do not know
 - h. None of the above
 - i. Do not know

19. Does your school conduct suicide risk assessments for students (Circle your answer)?

- a. Yes, for individual students as needed
- b. Yes, through universal screenings of ALL students
- c. No
- d. Other, Please Specify: _____
- e. Do not know

20. Have there been any deaths by suicide in your school community in the current school year (Circle your answer)

- a. Yes,
- b. No
- c. Do not know

20a. If, yes, how many? _____

20b. If it was a student(s), what grade(s)? _____

Do you want more support for your school and staff on how to handle crises in your school community, such as suicide, gun violence, or natural disasters? (Circle your answer)

- a. Yes (my email address is: _____)
- b. No
- c. Do not know

21. Would you like to share any additional comments or feedback?

Thank you for completing this survey!

If you would like additional information on any of the following topics, please follow the links below.

- Addressing student mental health services in your Comprehensive School Safety Plan. Please visit the CDE Safe School Planning web page at <https://www.cde.ca.gov/ls/ss/vp/safeschlplanning.asp>.
- Addressing suicide prevention, intervention, and post-vention services. Please visit the CDE Youth Suicide Prevention web page at <https://www.cde.ca.gov/ls/cg/mh/suicideprevres.asp>.
- CDE Model Youth Suicide Prevention Policy (intervention and post-vention policy). Please visit the CDE Mental Health web page at <https://www.cde.ca.gov/ls/cg/mh/>.

- Training your school staff on **Youth Mental Health First Aid** at NO COST to you. Please visit the CDE Project Cal-Well web page at <https://www.cde.ca.gov/ls/cg/mh/projectcalwell.asp>.
- Results from the 2016–17 Statewide Principal Survey. Please visit the CDE Project Cal-Well Evaluators' web page at <https://healthpolicy.ucsf.edu/school-health-services-evaluation#currentprojects>.

If you have questions or would like additional information, please contact:

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Appendix B**North Carolina Charter School Statewide Principal Survey**

North Carolina Charter School Statewide Principal Survey

Charter School Principal Perceptions of School-Based Mental Health Service Delivery

Q1 This survey asks about your perceptions of students' social and emotional wellness and mental/behavioral health needs (referred to as mental health needs) and your school's efforts to identify and address these needs. This survey will take approximately 15 minutes to complete.

Q2 I am principal of

- ☐ an elementary school
- ☐ a middle school
- ☐ a high school
- ☐ a K-8 school
- ☐ a K-12 school

Q3 My school is in a _____ community.

- ☐ Urban
- ☐ Suburban
- ☐ Rural

Q4 How common are these issues faced by your students?

Q5 Social, emotional, and mental health problems

- ☐ Not at all (1)
- ☐ A little (2)
- ☐ Moderate (3)
- ☐ Very common (4)

Q9 Substance use/abuse

- ☐ Not at all (1)
- ☐ A little (2)
- ☐ Moderate (3)
- ☐ Very common (4)

Q10 Exposure to trauma/violent events in the home or community

- ☐ Not at all (1)
- ☐ A little (2)
- ☐ Moderate (3)
- ☐ Very common (4)

Q11 Truancy

- ☐ Not at all (1)
- ☐ A little (2)
- ☐ Moderate (3)
- ☐ Very Common (4)

Q12 Supporting Staff: Please provide the number of full-time staff in the following categories that worked at your school. If you had no staff in any category, please mark 0.

Q13 School counselors such as guidance or mental health

- ☐ 0 (1)
- ☐ 1 (2)
- ☐ 2 (3)
- ☐ 3 or more (4)

Q14 School nurse

- ☐ 0 (1)
- ☐ 1 (2)
- ☐ 2 (3)
- ☐ 3 or more (4)

Q15 School social worker

- ☐ 0 (1)
- ☐ 1 (2)
- ☐ 2 (3)
- ☐ 3 or more (4)

Q16 School psychologist

- ☐ 0 (1)
- ☐ 1 (2)
- ☐ 2 (3)
- ☐ 3 or more (4)

Q17 Mental health service providers employed by community-based agencies.

- ☐ 0 (1)
- ☐ 1 (2)
- ☐ 2 (3)
- ☐ 3 or more (4)

Q18 Graduate or undergraduate school interns in the mental health or related fields.

- ☐ 0 (1)
- ☐ 1 (2)
- ☐ 2 (3)
- ☐ 3 or more (4)

Q19 School-Based Mental Health Services:

Q20 What types of services do school-based mental health providers offer at your school (excluding school guidance counselors or school nurses)? Please mark all that apply.

- ☐ None (1)
- ☐ Assessment/screening for mental health needs (2)
- ☐ Behavior management consultation (3)
- ☐ Case management (4)
- ☐ Crisis intervention (5)

- Family support services (including family counseling) (6)
- Individual counseling/therapy (7)
- Group counseling/therapy (8)
- Medication management (9)
- Referrals to specialized programs/services in the community (10)
- Substance abuse counseling (11)

Q21 What types of school-based mental health services are provided by a school nurse or a school guidance counselor at your school? Please mark all that apply.

- None (1)
- Nurse only (2)
- Guidance counselor only (3)
- Both a nurse and a guidance counselor (4)
- Assessment/screening for mental health needs (5)
- Behavior management consultation (6)
- Case management (7)
- Crisis intervention (8)
- Family support services (including family counseling) (9)
- Individual counseling/therapy (10)
- Group counseling/therapy (11)
- Medication management (12)
- Substance abuse counseling (13)

Q22, Do you conduct school-wide, universal screenings of ALL students to identify general education students with mental or behavioral health issues who may need support from school-based mental health providers?

- Yes (1)
- No (2)
- Do not know (3)

Q23 How are general education students referred to mental health services at your school? Please mark all that apply

- Does not apply—we do not have school-based mental health services (1)
- Teachers/school staff send students to the school-based mental health providers' office (2)
- Designated staff person (e.g., Wellness Coordinator) receives all referrals (3)
- Students in need of services are discussed at school meetings, such as Student Services Team (SST) meetings or Restorative Practices meetings, and referred to appropriate services (4)
- Parents refer students to school-based mental health providers (5)
- Students self-refer/drop into the school-based mental health providers' office (6)
- Positive Behavioral Interventions and Supports (PBIS) system for referral to Tier 2 interventions (7)

Q24 Approximately how many students were referred to school-based mental health services (services on your campus) provided by community-based mental health providers?

- ☐ None (1)
- ☐ 1–10 (2)
- ☐ 11–20 (3)
- ☐ 21 or more (4)
- ☐ Do not know (5)

Q25 Approximately how many students were referred to community-based mental health services (services in the community)?

- ☐ None (1)
- ☐ 1–10 (2)
- ☐ 11–20 (3)
- ☐ 21 or more (4)
- ☐ Do not know (5)

Q26 Approximately how many students received school-based mental health services (services on your campus) provided by school mental health staff, such as school social workers and school psychologists (excluding school/guidance counselors and school nurses)?

- ☐ None (1)
- ☐ 1–10 (2)
- ☐ 11–20 (3)
- ☐ 21 or more (4)
- ☐ Do not know (5)

Q27 Approximately how many students received school-based mental health services (services on your campus) provided by guidance counselors and school nurses?

- ☐ None (1)
- ☐ 1–10 (2)
- ☐ 11–20 (3)
- ☐ 21 or more (4)
- ☐ Do not know (5)

Q28 Approximately how many students received school-based mental health services (services on your campus) provided by community-based mental health providers?

- ☐ None (1)
- ☐ 1–10 (2)
- ☐ 11–20 (3)
- ☐ 21 or more (4)
- ☐ Do not know (5)

Q29 Approximately how many students received community-based mental health services (services in the community)?

- None (1)
- 1–10 (2)
- 11–20 (3)
- 21 or more (4)
- Do not know (5)

Q30 Did your school have a waitlist for students who needed school-based mental health services?

- Does not apply—we do not have school-based mental health services (1)
- No, we did not have a wait list (2)
- Yes, we had a wait list (3)

Q31 If your school had a waitlist for students who needed school-based mental health services, approximately how many students were on the waitlist, on average?

- Does not apply—we do not have school-based mental health services (1)
- 1–10 (2)
- 11–20 (3)
- 21 or more (4)
- Do not know (5)

Q32 If your school had a wait list, approximately how long did students have to wait to receive school-based mental health services on average?

- Does not apply—we do not have school-based mental health services (1)
- 1–2 days (2)
- 3–6 days (3)
- 1–2 weeks (4)
- 3 or more weeks (5)
- Do not know (6)

Q33 Barriers to Service Provision: To what extent are the following factors barriers to the delivery of mental health services at your school?

Q34 Lack of school-based mental health providers

- No barrier (1)
- Minor barrier (2)
- Moderate barrier (3)
- Serious barrier (4)

Q35 Lack of community-based mental health providers who can provide services at our school.

- No barrier (1)
- Minor barrier (2)
- Moderate barrier (3)
- Serious barrier (4)

Q36 Lack of funding for school-based mental health services

- No barrier (1)
- Minor barrier (2)
- Moderate barrier (3)
- Serious barrier (4)

Q37 Limited school space/facilities for mental health professionals to work

- No barrier (1)
- Minor barrier (2)
- Moderate barrier (3)
- Serious barrier (4)

Q38 Stigma associated with mental health services

- No barrier (1)
- Minor barrier (2)
- Moderate barrier (3)
- Serious barrier (4)

Q39 Parental cooperation and consent

- No barrier (1)
- Minor barrier (2)
- Moderate barrier (3)
- Serious barrier (4)

Q40 Language and cultural barriers

- No barrier (1)
- Minor barrier (2)
- Moderate barrier (3)
- Serious barrier (4)

Q41 Concern about students missing classroom time to receive services

- No barrier (1)
- Minor barrier (2)
- Moderate barrier (3)
- Serious barrier (4)

Q42 Staff Professional Development: To what extent does your school staff need more professional development, training, mentorship, or support in the following areas?

Q43 Ways to identify students with social, emotional, and/or mental health needs

- No need (1)
- Minor need (2)
- Moderate need (3)
- High need (4)

Q44 Ways to support students with social, emotional, and/or mental health needs

- No need (1)
- Minor need (2)
- Moderate need (3)
- High need (4)

Q45 Ways to refer students with social, emotional, and/or mental health needs to support services

- No need (1)
- Minor need (2)
- Moderate need (3)
- High need (4)

Q46 Ways to support staff/teachers' own social, emotional, and/or mental health needs

- No need (1)
- Minor need (2)
- Moderate need (3)
- High need (4)

Q47 Training, Programs, and Policies

Q48 Have you ever attended a Youth Mental Health First Aid Training? These trainings introduce common mental health challenges for youth, review typical adolescent development, and teach how to help young people in both crisis and non-crisis situations text.

- Yes (1)
- No (2)
- Do not know (3)

Q49 Have any of your school staff ever attended a Youth Mental Health First Aid Training? These trainings introduce common mental health challenges for youth, review typical adolescent development, and teach how to help young people in both crisis and non-crisis situations.

- Yes (1)
- No (2)
- Do not know (3)

Q50 Does your school implement any of the following curricula/programs to improve student mental health and wellness? Please mark all that apply.

- None (1)
- Character Counts (2)
- Directing Change (3)
- National Alliance on Mental Illness (NAMI) on Campus High School (4)
- Positive Behavioral Interventions and Supports (PBIS) (5)
- Restorative Justice/Practices (6)
- Second Step (7)
- Other (8)

Q51 Does your school's Comprehensive School Safety Plan specifically outline how to address any of the following topics? Please mark all that apply.

- ☐ Student mental health policies and services (1)
- ☐ Suicide prevention and post-suicide (i.e., support after a suicide attempt has occurred) (2)
- ☐ Wellness policy (3)
- ☐ Restorative practices (4)
- ☐ Do not know (5)
- ☐ Do not address student mental health (6)

Appendix C

Research Participant Consent

Research Participant Consent

Dear Charter School Principal:

You are receiving this email because your name is listed as the principal in EDDIE. The purpose of this research is to gather charter school principals' perceptions of school-based mental health services in their buildings. As a charter school principal in North Carolina your views are essential for this research to be conducted.

This research project is being conducted as partial fulfillment of the requirements of the Educational Administration EdD program at Gardner-Webb University. The survey will require approximately 15–20 minutes of your time to complete.

There is no compensation for responding and nor is there any known risk. This survey is anonymous and if you choose to participate in this study, please answer all questions as honestly as possible. Participation is strictly voluntary, and you may refuse to participate at any time during the survey. By sharing your perspectives as a charter school principal, you will provide knowledge to help to improve school mental health support in North Carolina's charter schools.

This research has been approved by the Gardner-Webb University Institute Review Board (IRB). There is an active link to the survey at the bottom of this e-mail. The data collected will provide useful information regarding the impact of mental health care service in North Carolina's charter schools. Completion of the survey will indicate your willingness to participate in this study. Thank you for taking the time to read this email. I hope you will complete the survey and share your perspectives.

Sincerely,

Barry Ross



Survey Monkey Link: