IMPLEMENTING SCHOOL-BASED MENTAL HEALTH CENTERS TO INCREASE ACADEMIC OUTCOMES FOR STUDENTS

A Record of Study

by

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ABSTRACT

Although there have been many attempts to close the achievement gap through academic interventions, achievement gaps among African-American, Hispanic, and Economically Disadvantaged students continues to be prevalent in public schools in the United States. As a part of a school turnaround strategy, school-based mental health centers were installed in high schools throughout an urban school district to address severe mental health challenges of some of its students. Students from three of the high schools that utilized a school-based mental health center at least five times were compared with students in a computer-generated comparison group to determine whether the school-based mental health counseling affected student academic performance.

Attendance, discipline records, grade point averages, and standardized examination scores of students during the year prior and during the treatment year were analyzed. A descriptive analysis found that students treated in a school-based mental health center had improved attendance, reduced disciplinary infractions, improved grade point averages, and better standardized examination scores than the comparison group.

This Record of Study recommends practices to implement and monitor a school-based mental health center successfully. School administrators need to consider strategies to identify students who need mental health services, provide professional development for staff on mental health issues, the plan to promote the services provided in the mental health center to the school community, and support systems required to fully realize the potential of providing counseling on a school campus.

Recommendations for further study include measuring the effectiveness of the school-based mental health center based on cohorts of students, using students who refuse treatment as a

control group, determining the effects of the school-based mental health center on the culture and climate of a school community, and using questionnaires to document feedback from students, parents and staff.

DEDICATION

"Personality must be educated, and personality cannot be educated by confining its operations to technical and specialized things, or to the less important relationships of life. Full education comes only when there is a responsible share on the part of each person, in proportion to capacity, in shaping the aims and policies of the social groups to which he belongs."

– John Dewey

For Claudia

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CHAPTER I

INTRODUCTION AND PURPOSE OF THE ACTION

Although many attempts have been made to improve student performance outcomes, achievement gaps in standardized testing data still exist across the United States. Educators have tried to close the achievement gap primarily through academic interventions; however, many school administrators have struggled for decades with the academic performance of African American, Hispanic and economically disadvantaged students. “Despite more than three decades of urban school research and reform aimed at improving disadvantaged student achievement performance, current data on urban achievement reveal that these programs have not met the task" (Becker & Luthar, 2002, p. 198). The accountability systems contained within the No Child Left Behind and All Students Succeed Act laws have accentuated the need to improve student outcomes. Over three decades ago school and district leaders began to provide resources and personnel to deliver interventions to improve academic performance. However, the achievement gap remains today.

Some school and district administrators began to see the connection between mental health and academic performance. School leaders hypothesized that providing additional mental health counseling through the opening of school-based mental health centers, academic achievement would then improve. Consequently, some district leaders have turned to providing mental health services for their students and families because “mental health disorders negatively impact social and academic functioning with decreased opportunities for educational employment and social mobility advancement” (Larson, 2017a, p. 675). Research has found that “a strong association exists between poor mental health and other health and development concerns for young people, including educational achievement” (Amaral, Geierstanger, Soleimanpour & Brindis, 2011, p.

138). Therefore, instead of solely investing resources in academic interventions, the opening of school-based mental health centers has the potential to improve student health, and thereby, improving academic performance of treated students.

Students with untreated mental health concerns during childhood may face bleak futures as adults because “poor academic achievement can lead to decreased employment opportunities, with less social mobility advancement, as well as severe disability and early death" (Larson, Spetz, Brindis, & Chapman, 2017b, p. 485). Other research indicates children with poor academic records “were overwhelmingly represented among the unemployed, incarcerated, and those dependent on a welfare system” Bains & Franzen, 2014, p. 411). If mental health is not addressed during childhood, the untreated face limited options in adulthood. Treating mental health issues in childhood rather than addressing their effects in adulthood may improve the lives of people because “mental health disorders are the most common cause of disability in terms of years of life lost and premature death in the United States” (Bains, Cusson, White-Frese, & Walsh, 2017, p. 584). Therefore, increasing access to mental health care professionals can improve the lives of some of our most vulnerable students.

Current State of Counseling in Schools

Most secondary schools in the United States do not have the guidance staff to handle students with severe mental health problems. School budgets include guidance counselors that are available to assist students with all types of academic, social, and emotional issues. However, the ratio between the number of students in a school and trained guidance staff is high. Students with the most severe mental health needs require so much time and attention that school counselors have trouble addressing the needs of all of the students in their caseloads. However, schools with school-based mental health centers can develop a tiered approach to counseling services. Those

students who need the most care can be treated by highly trained professionals who have the time to devote to specialized treatments. School guidance counselors can then attend to students with less severe problems. Implementing a tiered counseling approach can allow school leaders to address mental health issues proactively and prevent minor problems from developing into major crises.

One of the school-based mental health center's advantages is the ability to serve students where they are most of the day because school-based centers eliminate the need for transportation to appointments and dependence on caregivers to take them to doctors. "Over 52 million youth attend 114,000 schools, and over 6 million adults work in schools. Combining students and staff, 1/5 of the US population can be reached in schools" (Paternite, 2005, p. 657). Enhancing counseling services by providing access on school campuses can improve both students' academic performance outcomes and their psychological health. **"**School-based health centers represent a partnership between schools and community health and mental health centers to increase health care access for ethnically, socioeconomically, and clinically diverse students through providing onsite clinics in schools" (Kerns et al., 2011, p. 617). By providing convenient access to mental health services in schools more children can access mental health care.

Defining the Problem

Mental health issues permeate society today. The problem is made worse because people do not get treatment. According to a United States Surgeon General report "two-thirds of Americans who have mental illness do not receive care, and many that receive medical treatment do so in the primary care setting" (Dinwiddle et al., 2012, p. 67). Children with mental health issues struggle with accessing mental health services. "Recent estimates indicate that mental health issues affect 20–25% of children and adolescents in the United States, and of these, only 36%

receive mental health services" (Banes & Diallo, 2015, p. 8). There are many students entering schools that exhibit the need for care.

Providing access to mental health providers is critical to the health of the students who have mental health challenges. Students who do not have access to quality care can exhibit behavioral and academic difficulties in schools. Researchers found "along with variables such as educational and instructional quality, social/environmental factors, resiliency, and school climate; student health status is hypothesized to be an important predictor of school dropout" (Kerns et al., 2011, p. 617). Untreated mental health issues may explain why students have high rates of absenteeism, are suspended more frequently, have low grade point averages, and perform poorly on standardized examinations. Since many school-aged children do not have access to appropriate mental health care, they may not reach their academic potential in part due to the untreated mental health concerns.

School-Based Mental Health Centers as a Solution

To combat the effect of poverty and access to care, district leaders across the United States have installed school-based mental health centers; researchers believe that providing students mental health care on school campuses removes a significant barrier to access to mental health care. "Schools are thus in a unique position to fulfill the role as an effective mental health delivery system to reach children in need of psychological services" (Fedewa et al., 2014, p. 60). Providing services on a school campus has many advantages, including the improvement of student academic performance. Bear, Finer, Guo, & Lau (2014) found that on-campus mental health centers provided several benefits:

> There may be some credence to the notion that SBMH [School-Based Mental Health] represents an innovation in care delivery that reduces disparities in care by eliminating or

> reducing logistic barriers to access (e.g., clinic hours, transportation, insurance), decreasing stigma associated with mental health care, improving the chances of detecting mental health problems, and providing education and outreach. (p. 389)

Therefore, by providing mental health care in schools, mental health centers can be an essential strategy to provide much-needed services to students at schools. By addressing the mental health needs of untreated students' performance outcomes can improve.

Development of a Mental Health Program

Schools across the country have struggled with student performance. In one urban high school in this study, many students had poor attendance, failing grades, and a high number of discipline referrals. Previous school administrators attempted to improve students' performance outcomes by providing additional academic tutoring, incentivizing attendance, and offering school wide behavioral supports. All three strategies had little effect on students' academic progress as the school was deemed academically unacceptable under the Texas accountability system in 2006 and 2008. None of the strategies implemented to improve student performance addressed student mental health. The lack of focus on mental health in reform planning is not surprising. "An important and often-neglected precursor to early adolescent achievement performance and motivation in urban school reform efforts is the state of children's mental health" (Becker & Luthar, 2002, p. 203). Leaders in the district analyzed in this study decided that a mental health program that provided mental health services on the school campus before, after, and, during the school day would be a part of the overall turnaround plan for the school.

The school and district administration consulted literature to review successful programs that would (1) identify students in need of mental health services, and, (2) create a process to open an on-campus mental health clinic. Although there were school systems elsewhere in the United

States that offered mental health services for students, there were very few mental health clinics in Texas public schools. Therefore, there was no Texas Education Agency guidance on how to implement a school-based mental health center. Health care providers, attorneys, school and district administrators, developed an identification, referral, and monitoring system. Also, the district and school leaders had to find a mental health provider to serve students, locate space on the school campus to house the clinic, and develop policies on the school campus to schedule mental health services.

Research Question

The research question that guided the quantitative design for this study is this: Is providing access to mental health services on a school campus effective in improving student performance outcomes? The data that was used to judge whether the implementation of the mental health program had an impact on academic performance included attendance rates, discipline rates, grades, and standardized test scores. Table 1 summarizes the outline of the study.

Table 1. Questions and Data Collected in the Study

Area	Question(s)
Research Question	Is providing access to mental health services on a school campus effective in improving student performance outcomes?
Sub Questions	Comparing the treated group with a computer-generated control group: 1. Did the change in the treated group attendance rates differ from the attendance rates of the control group? a. How do the groups compare by marking period? b. How do the groups compare by year of intervention? 2. Did the number of disciplinary referrals in the treated group differ from pre-intervention year to intervention year in the treatment group? The control group? 3. Did the change in Grade Point Average (G.P.A.) in the treated group differ from the control group? 4. Did the change in passing rate for the treated group for the Algebra I STAAR examination differ from the control group?

Table 1 Continued

Area	Question(s)
Sub Questions	5. Did the change in passing rate for the treated group for the English Language Arts I STAAR examination differ from the control group? 6. Did the change in passing rate for the treated group for the English Language Arts II STAAR examination differ from the control group? 7. Did the change in passing rate for the treated group for the Biology STAAR examination differ from the control group? 8. Did the change in the passing rate for the treated group for the United States History STAAR examination differ from the control group?
Data Collected	Average Daily Attendance, Count of number of referrals, Grade Point Average of students, the approaches standard rates for Algebra I, ELA I, ELA II, Biology, and US History STAAR End of Course Examinations

Personal Context Researcher's Roles and Personal Histories

I have been an educator for over 25 years. During this time, I have developed a passion for implementing programs that help students and their families while improving student performance outcomes. I completed a Master's Degree in Education from Fordham University in the area of Teaching English as a Second Language in 1996 and became a fully certified English as a Second Language teacher. I spent the next 11 years of my career working to improve the educat1ional outcomes of immigrant students. My mentor, Dr. Norman Wechsler, encouraged me to begin my studies to become a school administrator. I returned to school and earned a Professional Diploma in School Administration and Supervision from Mercy College in 2000. Soon after, I served as an Assistant Principal in two schools in the Bronx, New York. I was appointed to my first principalship in October 2004, and I held the position for four years.

I moved to Austin, Texas in 2008 to become a high school principal in an urban school district in Central Texas. The school was labeled academically unacceptable during the 2005-2006 and 2007-2008 school years. After employing some strategies, including strengthening the social and emotional health of students, the large urban high school met academic standards in

2009 and had since met and exceeded State and Federal standards. One of the key turnaround strategies was to install a school-based mental health center. Over the eight years, the graduation rate for the school rose from 72% to 94%, the yearly dropout rate decreased from 4.3% to 1%, and annual student home suspensions dropped from 768 home suspensions to 168. Although there were many changes in the academic plan, the foundation for the increase in student performance outcomes at the school was the attention paid to the mental health of the students.

After eight years as the Principal of the school that installed a school-based mental health center, I was appointed as an Associate Superintendent of High Schools for a large, urban Central Texas school district. I am responsible for 17 high schools and sit on the Superintendent's senior cabinet. As Associate Superintendent, I work with all of the high school principals to improve educational outcomes for all students in the district. One of the key initiatives the Superintendent has focused on has been developing the social and emotional well-being of students. After the successful implementation of the on-campus mental health center at the high school I led, district administration decided to expand the mental health initiative to all its comprehensive high schools and some middle schools as a vital part of the Whole Child Initiative. Recently, additional grant funding has allowed the district to expand the school-based mental health program to 22 elementary schools.

I believe that providing outstanding instruction and academic supports for struggling students is not enough. Students who have mental health challenges and no access to adequate treatment will not reach their full potential, even when taught by expert teachers. By designing systems to identify students who may need professional mental health services, and then making such services accessible and convenient, student academic achievement should improve for the treated students.

Definitions

Externalizing Disorders. People with mental health issues that can be identified by others (i.e., oppositional defiant disorder, conduct disorder).

Internalizing Disorders. People with mental health issues that may not be readily identified by others (i.e., depression and anxiety).

Mental Health Model. Comprehensive mental health programming offered by a school entity that provides mental health education, promotion, assessment and treatment to all students and their families.

On-Campus Mental Health Center. Mental health provider who is housed on a school campus. Students and their families can access services before, during and after school.

Project Coordinator. Liaison between the mental health provider, school administration, and the community. The coordinator promotes available services, assists with identification and intake, and reviews systems of support.

Service Accessibility. Difficulties when students may not know how to access mental health services, the services are not provided in the language of the students, the services are not culturally aligned to students' needs, and mental health services are not coordinated with other social services provided to students.

Social Emotional Learning. Programming that teaches students how to become aware of their behaviors, build relationship skills and how to make healthy decisions.

State of Texas Assessments of Academic Readiness (STAAR). The battery of standardized examinations the State of Texas requires all public school students to take to determine if they are learning the standards. According to the Texas graduation requirements in 2016, all high

school students are required to pass English I, English II, Algebra I, Biology and United States History to graduate from high school.

Student and Aggregate Reports for Student Service Providers. A computer program, used by school districts that supplies service providers academic, social and emotional data for a group of treated students.

Closing Thoughts on Chapter 1

Different academic programs have been implemented in schools across the country that purport to address performance gaps between demographic groups. As one report suggests, “children with socio-emotional and behavioral problems are at increased risk of academic underachievement, as children who exhibit behavior difficulties may have a harder time developing adaptive learning skills that positively influence their later academic achievement" (Powers, Swick, Wegmann & Watkins, 2016, p. 23). However, student’s mental health has been largely ignored as a cause of performance gaps. Research shows that “school-wide, multicomponent intervention strategies can reduce child discipline problems and promote student achievement” (Rones & Hoagwood, 2000, p. 229). The implementation of school-based mental health centers in schools may help struggling students.

The trajectory of students with mental health needs can be changed by implementing a mental health program in schools. A one study found “malleable health risk factors associated with academic achievement that may be addressed within a school-based clinic include unmanaged chronic health conditions (e.g., asthma), substance use, attention problems or depression, risky sexual behavior, and adjustment problems" (Kerns et al., 2011, p. 617). Without addressing mental health, schools will continue to expend enormous sums of resources with limited impact

on academic outcomes. Providing mental health centers on school campuses is a promising strategy to increase student performance outcomes.

CHAPTER II

REVIEW OF SUPPORTING SCHOLARSHIP

Several recent studies have shown the impact of providing mental health care programs in schools. “School-based health centers represent a partnership between schools and community health and mental health centers to increase health care access for ethnically, socioeconomically, and clinically diverse students through providing onsite clinics in schools” (Kerns et al., 2011, p. 617). The research reviewed the implementation of school-based mental health programming and the importance of integration of the program into the culture of the school. Studies also highlighted the importance of including families and caregivers in the communication plan and specific effects of the program on vulnerable populations, including African American, Hispanic and economically disadvantaged students.

Frameworks for Implementation of Mental Health Centers

There are many approaches to implementing mental health services in schools. A school-based mental health center is “an intervention intentionally designed to reduce the future incidence of adjustment problems in currently normal populations as well as efforts directed at the promotion of mental health functioning” (Durlak & Wells, 1997, p. 117). The New Freedom Commission on Mental Health, the Surgeon General, and American Academy of Pediatrics agreed on the elements of a school-based mental health model (SBMH): "(a) school–family–community agency partnerships, (b) commitment to a full continuum of mental health education, mental health promotion, assessment, problem prevention, early intervention, and treatment, and (c) services for all youth, including those in general and special education” (Paternite, 2005, p. 658). Another framework stresses the importance of including the entire school community in the development of a comprehensive mental health plan:

> The general framework (of SDP) is based on three structures: (a) the school planning and management team, which involves parents and school staff in making decisions that influence school policy, climate, and programs; (b) the student and staff support team, which comprises mental health and child development professionals who work to identify and address developmentally and socially appropriate responses to issues affecting students and staff; and (c) the parent team, which enables parents to participate in the school's social and academic programs. (Becker & Luthar, 2002, p. 200)

District leaders should use these frameworks to design a comprehensive mental health model in schools to ensure they are implemented successfully.

Historical Background

The number of schools that contain a school-based mental health center have increased since the program first was attempted during the 1950s. In 2017, "nationally, there are over 2000 school-based health centers, 69% are located in schools identified as economically disadvantaged, and over 70% of them have a mental health care provider" (Bains, Cusson, White-Frese & Walsh, 2017, p. 585). Although there is evidence that addressing student mental health (and physical health) within a school can improve student academic performance, "fewer than 2% of US schools have one [a school-based health center] and one third of school-based health centers do not have a mental health provider as part of their staff" (Larson et al., 2017b, p. 485). Based on the research, school-based mental health centers are just beginning to become a regular practice in schools today.

The school-based mental health centers are designed to "provide a mechanism for delivering diagnostic, preventative, and treatment services to youth whose healthcare needs are underserved by other providers" (Bersamin, Fisher, Gaidus & Gruenewald, 2016, p. 926). A school-based

mental health center can have additional benefits. Strolin-Goltzman, Sisselman, Melekis & Auerbach (2014) stated the opening of a mental health center has the potential to improve both school connectedness and bridging student health, services and academics. The importance of installing a school-based mental health center is critical because "there is typically no other setting for children in which problem behaviors, social/emotional behaviors, prosocial functioning, and academic performance can be observed together (Fedewa et al., 2014, p. 60). By providing mental health services on school campuses, schools can potentially realize improvements in both student academic outcomes and emotional health.

Alignment with Action Research Traditions

Action research is a process whereby practitioners research to solve local issues. The development of the school-based mental health center considered in this study would most align with de Schutter and Yopo's characteristics of participatory action research. The development of the school-based mental health center was enacted because of a series of tragedies that affected a high school campus. The school and district staff were faced with some students who needed assistance and did not have a process or resources to provide mental health counseling. School and mental health leadership decided to take action and simultaneously developed, executed and monitored a plan to implement a school-based mental health center.

Theoretical Framework

Bronfenbrenner's Social Ecological Model aligns with the model used in this study. Bronfenbrenner (1977) surmised that the relationships between human being are influenced by the environments in which they live and work. He defined the ecology of human development as:

> the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives, as this process is affected by relations obtaining within and between these immediate settings, as well as the larger social contexts, both formal and informal, in which the settings are embedded. (p. 514)

The Social Ecological Model aligns with the implementation of a school-based mental health center as each of the elements has to be examined both individually and collectively. Based on the model, only implementing a counseling center will not be effective in improving student health because changes to a school culture and climate are also necessary for the success of a mental health program. The Social Ecological Model provides the blueprint for educators and mental health providers to follow to insure both students and their environments improve.

There are four interdependent factors that the model investigates: individual, relationship, community, and societal. The following areas need to be investigated to determine the effectiveness of the school-based mental health center.

Individual factor. How individual students were affected by analyzing academic data before and after treatment.

Relationship factor. How the rapport between peers, families, and school personnel affects the implementation of a mental health center.

Community factor. How the implementation of the school-based mental health center affected the entire school community.

Societal factor. How cultural norms affected the implementation of school-based mental health centers.

The question posed in the project ask if students benefited academically from the counseling services in a school-based mental health center. This Record of Study concentrated on analyzing the individual factors that need to be addressed when implementing a successful school-based mental health center. Other factors were not reviewed because permission forms to use academic and treatment data in research projects was not provided to caregivers during the intake process. In future years, the district will request permission to collect data from parents and caregivers for research purposes. Future study models could measure how providing counseling in a school-based mental health center can affect the relationship, community, and societal model elements within Social Ecological Model.

Current Research on Effectiveness of School-Based Mental Health Centers

Although the number of school-based mental health centers have increased since 1985, the body of research that measured the success of the program remains inadequate. “It is surprising that so little attention has been given to the effectiveness of school programs targeted toward prevention, reduction, or treatment of mental health problems” (Rones & Hoagwood, 2000, p. 223). Two meta-analyses have reviewed the research in the area of mental health and schools and found that there is a need to for more research to determine whether school-based mental health centers are effective in improving student mental health and academic performance.

Rones and Hoagwood (2000) completed an analysis of over 5000 research papers and found only 47 included a pre- and post-study model that included a control group. Of the 47 research reports, 19 school-based mental health center services were effective, 19 had mixed results, and 9 found the program was not effective. The review found that implementation variation is linked to success of a mental health program. The implementation factors that led to better results included school culture, climate, school leadership, funding, and fidelity to the program

implementation. The review also found that programs that address specific behaviors and skills are more effective that those that have wide-ranging outcomes. Finally, the review found programs that infuse mental health programming within daily classroom lessons are more effective than those that have separate modules.

Banes and Diallo (2016) completed an analysis of over 982 articles that identified studies that addressed mental health. Only 23 studies met the criteria that the study included outcomes using quantitative or qualitative methods and evaluated the effectiveness of mental health services in schools. The review of literature included areas such as access and utilization of mental health services and the content of mental health visits. The review found that students who had psychological issues were 3-10 times more likely to use school-based mental health centers, especially those with suicidal ideation than those students with no access to mental health care in their schools. Also, students served in both a school-based mental health center and a community health center were 21 times more likely to use the school-based center. Finally, several studies found students who attended mental health centers had lower grades.

Need to Develop Systems to Implement School-Based Mental Health Centers

The review of the literature highlights the need to measure whether school-based mental health centers can improve students' mental health and academic performance. There are signs that providing mental health services can improve the mental health of students. Different studies separately measure aspects of a comprehensive program. However, the current research is imperfect to determine how to measure the success of a comprehensive, school wide mental health program. Without research that reviews the effectiveness of mental health programming, the implementation blueprint needed to ensure mental health services are effective will continue to be inadequate.

Implementing a School-Based Mental Health Center

The research on school-based mental health centers reviewed many factors that could have effects on the success of its implementation. There are many considerations administrators must take into account before opening a school-based mental health center. Paternite (2005) suggested the following systemic issues need addressing when designing a comprehensive mental health program:

> Strategies (a) ensuring strong coordination and collaboration among families, school leaders and mental health program leaders as programs are being planned, (b) ensuring that school mental health providers are well trained, closely supervised, and socially skilled, and that they understand the culture of schools and to work as collaborative partners in them, (c) emphasizing and ensuring the high quality and empirical support of school mental health services, (d) framing school based mental health (SBMH) services as effective means for reducing barriers to learning and creating positive conditions that promote school success, and (e) documenting that services, in fact, lead to outcomes valued by youth, families, and schools. (p. 660)

The school and mental health providers must work together to educate the entire school community because the campus-based center strategy will only work to improve performance outcomes if there is a school-wide focus on social and emotional learning and teachers are provided training in identification and intervention of mental health issues.

When the implementation of mental health services is school wide, the results can be positive. Durlak & Wells (1997) found one high school program that installed a school-based mental health center also implemented procedures that improved teacher-student relationships, increased parent involvement, changed the curriculum, combined student ability groups, and improved

evaluation procedures. The results from the changes produced significant improvement for at-risk high school students' absenteeism, disciplinary referrals, grades, and dropout rates. Therefore, installing a mental health center should be combined with other schoolwide initiatives which improve the relationships between students and staff to improve student performance outcomes.

Monitoring Implementation Using Academic Targets

Opening a mental health center requires coordination between the school and mental health providers to monitor student progress. The school must develop procedures that identify and address students' mental health needs before opening the program to students and their families.

> Education data (e.g., attendance, homework completion, grades) have been identified as critical drivers of effective multilevel data-driven decision-making. This type of information can function as a possible cornerstone for the integration of mental health services into schools, enhancing collaboration among the diverse professionals working in schools around a shared objective of improving educational functioning. (Lyon et al., 2013, p. 57)

The goals of the mental health program need to include the improvement of the mental health and academic success for students. Lyon et al. (2013) found that most implementation plans do not include monitoring academic outcomes. They suggested school administrators need to consider examining grades and other academic statistics as an essential part of the overall mental health plan to ensure the counseling in the school-based mental health center is having a positive effect on student academic outcomes.

Teachers and the Mental Health Center Effectiveness

Teachers play a critical role in the success of the school-based mental health. Wegmann, Powers & Blackman (2013) recognized that teachers could identify students who may need

mental health care and assist in implementing schoolwide mental health education efforts. Anyon et al. (2013) found that in one school district, 49% of the student referrals the mental health center was initiated by teachers. Fazel, Garcia & Stein (2016) found teachers can influence decisions because they are trusted and can mediate contact with mental health providers. Teachers, therefore, can play a critical role in the implementation of a school-based mental health center by cultivating trusting relationship with their students.

Teachers not only play a significant role in identifying students that need mental health services, but they also "increase the probability of service sustainability and maintenance" in school-based mental health initiatives" (Wegmann, Powers, & Blackman, 2013, p. 298). Since teachers see their students on a regular basis, they can monitor and share their observations with mental health staff. Furthermore, faculties of schools can help support the mental health center through recommending student use, educating pupils on the importance of mental health, and building relationships of trust so students feel they can share private information. Soleimanpour et al. (2010) outlined the importance of school staff in the identification process: "When the school health center staff members were integrated into the school and were familiar, a student might be more comfortable seeking care from the school health center than from another health facility" (p. 1601). Without addressing the fear, anxiety or unfavorable view of mental health counseling, families may not elect to use the center's services.

Although teachers are essential to the identification and implementation of a schoolwide mental health strategy, they are not typically provided the training required to identify or assist students in using the school-based mental health center. Huggins et al. (2016) found teachers lacked comprehensive knowledge of their school's services. Therefore, school-based mental health implementation plans must include constant professional development in both the

identification of students who may need the services and how to support students while they are the treated in the mental health center.

Removing Barriers to Care

One of the reasons why so many children do not receive mental health services are the barriers to care. Some of the reasons why students do not access mental health care include "stigma, lack of information, inaccessible location of services, or difficulty with transportation" (Farahmand, Grant, Polo, Duffy, & Dubois, 2011, p. 373). Barriers to care "disproportionately affect ethnic minority and immigrant youth include pragmatic barriers to access (e.g., insurance, transportation, language access, clinic hours)" (Bear et al., 2014, p. 388). One study found that the most vulnerable students to mental health challenges are also more likely to site barriers as the reason they do not seek mental health professionals. "Parents of students most at need are most likely to report barriers to care, further cautioning us that students with the highest risk may be most unlikely to get care" (Bear et al., 2014, p. 394). Therefore, providing mental health services on school campuses can eliminate the barriers to care.

Challenges to Engagement

Providing services in a school-based mental health center alone does not eliminate all of the barriers to care. "Despite policy changes to implement more mental health services in schools, these services remain widely underutilized by adolescents experiencing mental health problems" (Huggins et al., 2016, p. 21). Lai, Guo, Ijadi-Maghsoodi, Puffer & Kataoka (2016) have identified three challenges to engagement that must be addressed to increase mental health enrollment: trust, confidentiality, and stigma related to mental illness. If these issues are not addressed, students will not avail themselves of mental health services. "Despite policy changes to implement more mental health services in schools, these services remain widely underutilized

by adolescents experiencing mental health problems" (Huggins et al., 2016, p. 21). Although students show signs of needing mental health services, Garmy, Berg & Clausson (2015) found:

> many depressed adolescents are reluctant to seek professional help for mental illness and are therefore not diagnosed, or they do not reach the diagnostic threshold for major depressive disorder but still have symptoms that may have long-term clinical and social implications, such as school failure, loss of confidence, and isolation. (p. 1)

When the challenges of engagement are not addressed in the mental health implementation plan, “there was less acceptance of counseling services; this may reflect denial and societal reluctance to deal with mental and psychological issues” (Santelli, Kouzis, & Newcomer, 1996, p. 354). Therefore, a mental health education campaign for students should be a part of any plan when installing a school-based mental health center.

Once students begin to avail themselves of the services and discuss with peers the benefits of the program, the stigma towards mental health professionals will be reduced, and more students will seek assistance. Huggins et al. (2016) found that students will use school-based mental health centers if they trust their counseling sessions remain confidential, align with individual student beliefs and peer groups have positive experiences. Santelli, Kouzis & Newcomer (1996) found that peer and social factors were especially strong predictors of enrollment. The key to reducing the fear, anxiety, and uneasiness towards mental health centers is to establish a school culture that promotes student wellness and communication with the families about the services rendered in a mental health center.

Family and Caregiver Education

The school-based mental health center implementation plan must include how the school will work with families and caregivers. "School-based mental health programs that can successfully

involve families enjoy increased rates of service utilization, greater effectiveness of treatment, and better academic outcomes" (Wegmann, Powers, & Blackman, 2013, p. 298). The more the families of students are included in the process, the more likely they will permit to begin treatment. "Caregivers with limited knowledge of mental health services are less likely to accept, enter, and complete treatment when it is offered" (Bear et al., 2014, p. 394). without the support of the families in the community, students will not be permitted to start treatment. Building trust between the mental health center staff and student caretakers is crucial to increasing enrollment of students.

The Importance of a Project Coordinator

The coordinator's job is to act a liaison between the families and the mental health center. The dissemination of information about the services provided in the mental health center is critical to its successful implementation. Wegmann, Powers & Blackman (2013) found the project coordinator needed many skillsets to successfully act as an intermediary between the mental health center and the community. They also highlighted that the project coordinator needs to possess an advanced level of mental health education, training, and experience, as well as familiarity with the pilot school's neighborhood and community resources. The mental health program material must be delivered by a person that is thoroughly knowledgeable and can be trusted by the community. When project coordinators are successful, parents and caregivers will report "their concerns were treated confidentially and that they could trust the advice and referrals given by the project staff" (Wegmann, Powers, & Blackman, 2013, p. 302). Therefore, the project coordinator position is key to the successful implementation of a school-based mental health center.

As the relationship between families and the project coordinator blossom, other issues concerning the well-being of the treated students can be addressed because the project coordinator was, "able to devote the necessary time to making repeated calls and home visits to difficult-to-reach families, strengthen relationships between the school and such families" (Wegmann, Powers & Blackman, 2013, p. 304). Parents and caregivers can rely on one person in within a school organization to help navigate services and discuss issues. The project coordinator is therefore critical to educating parents and caregivers.

Promoting the Program to the Community

While providing a project coordinator is an essential part of the program, school administrators must also play a significant role in communicating the services in the mental health center. Lai et al., (2016) found that any communication plan should:

> Emphasize the importance of partnering with and providing education to parents about potentially serious mental health issues. They reported including parent representatives in wellness center planning meetings, holding workshops on parent chosen topics, and providing information about wellness centers at back-to-school nights. (p. 3)

The communication plan should go beyond providing information about the program. (Wegmann, Powers, & Blackman (2013) found some successful programs also visit the homes of identified students in addition to the general announcements delivered during parent-teacher conferences and PTA meetings. They also stressed that school mental health professionals learn about the social norms of the community they serve. Therefore, the success of the mental health center depends on the execution of a well-developed communication plan that invites parents and caregivers to be a part of the process.

Review of the Effectiveness of Existing Programs

Since many school systems are turning to providing mental health services for students, it is critical to measure whether offering mental health services on school campuses is effective in both improving student performance outcomes and the overall mental health of students. Students who avail themselves of mental health services show "significant improvements in social and classroom performance as reported by their teachers. They also demonstrated improvements in academic outcomes such as attendance and standardized test scores" (Montañez, Burger-Jenkins, Rodriguez, McCord & Meyer, 2015, p. 104). In addition to academic performance, teens report they find such services beneficial for their personal growth. One study discovered that counseling supports "was perceived as beneficial for both intrapersonal strategies and interpersonal awareness" (Garmy, Berg & Clausson, 2015, p. 7). In another research study "analyses of citywide survey data and achievement test scores of middle school students in Chicago showed that student learning was significantly increased when both achievement standards and social support were emphasized" (Becker & Luthar, 2002, p. 209). Therefore, it is possible that addressing the mental health of students can improve academic performance.

Effects of Mental Health Centers on Academics and Attendance

More study is necessary to measure the impact of school-based mental health centers on attendance rates. Geierstanger, Amaral, Mansour, & Walters (2004) found that about half of the studies they reviewed showed student use of a school-based mental health center had a positive impact on attendance. A study completed by Warren and Fancsali "found that participating in a high school-based program included typical school-based health center services … produced a non-statistically significant, but positive, impact on absences over the first two years of high

school" (Geierstanger et al., 2004, p. 348-349). Although more research is required to determine whether there is a definite relationship between attendance and the implementation of mental health centers, it appears that providing mental health counseling to students has a positive impact on academic success and attendance.

Some studies also measured the impact of mental health centers on both grades and attendance. "Although insufficient research exists to support a direct link between school-based health centers and academic performance, the literature has demonstrated the influence of several intermediate outcomes which, in combination with social or educational factors, can influence academic performance indirectly" (Geierstanger et al., 2004, p. 351). Students who avail themselves of mental health services show "significant improvements in social and classroom performance as reported by their teachers. They also demonstrated improvements in academic outcomes such as attendance and standardized test scores" (Montañez et al., p. 104). More research is needed to measure whether school-based mental health centers have a significant impact on grades and attendance.

Increased Student Connectedness to School

Students who feel connected to the school through positive relationships with peers and adults will more likely have higher grades and better attendance. **"**School connectedness, the perception of closeness to school and school personnel, also has been associated with improved academic performance" (Geierstanger et al., 2004, p. 351). The mental health center provides "an increased sense of school connectedness and engagement due to a relationship that has developed with a member of the school-based health center staff. School-based health center-led ancillary student groups focused on health, and youth development may also provide an additional outlet for students to become engaged in school" (Strolin-Goltzman, 2010, p. 157). Mental health centers

have shown to provide a welcoming and caring location on a school campus. For these reasons, it is critical that students who need mental health programming connect with the school community.

Improving the Overall School Culture and Climate

There are research reports that show a school's culture and climate improves after installing a school-based mental health center. For instance, a study of the Baltimore City Schools, a system that implemented school-based support centers, "have found improvements in school climate, reductions in reliance on special education for students with emotional and behavioral problems, and other positive outcomes" (Wegmann, Powers, & Blackman, 2013, p. 306). Strolin-Goltzman (2010) surmised that by assisting the students who consistently disrupt the classroom environment, the number of disruptions to the educational process would decrease. Fewer behavioral incidents can stabilize the school atmosphere and increase a sense of connectedness and engagement among treated students.

Not only can academic performance improve for those students receiving mental health services, but all students in the school community can also benefit. Instruction and climate are compromised when untreated students continuously interrupt the teaching and learning process. "Children with socio-emotional and behavioral challenges may disrupt the learning environment in the classroom, thus negatively influencing the performance and behavior of their peers" (Powers et al., 2016, p. 23). However, when students are receiving needed treatment, there are fewer interruptions which can positively affect the overall culture and climate of classrooms and schools.

Reducing Suspensions

There is a national call to decrease the number of suspensions, especially for minority students. Many times, students are suspended from school for behaviors that could be treated if there was a school-based mental health center. Bruns, Moore, Stephan, Pruitt, & Weist (2005) concluded that there need to be changes in discipline policies to improve student mental health:

> Rather than linking students in need with services that may promote behavior change, OSS (Out of School Suspension) policies often place students in unproductive or unsafe environments, or in highly restrictive settings that fail to address mental health problems that may be giving rise to problem behaviors. As a result, there have been increasing calls to reduce the incidence of suspension in schools." (p. 23)

Providing mental health care has the potential to "reduce behaviors that often result in suspension, through the teaching of communication, conflict resolution, and social skills; reinforcement of positive behavior; and engagement of parents and students in school-based family therapy" (Bruns et al., 2005, p. 24). One report states that school-based mental health centers are "associated with reductions in disciplinary actions, office referrals, and suspensions as well as improvements in attendance and symptoms of conduct disorder, ADHD, and depression" (Powers et al., 2016, p. 24). By addressing mental health conditions instead of solely punishing their negative behavior, students may improve both their conduct and academic performance.

Although implementing mental health centers in schools could reduce home suspensions, there is little evidence that decreasing school disciplinary actions was considered by administrators during the implementation of some school-based mental health centers. In one study, there was no intentional link between the mental health center and reduction in

suspensions: “schools with ESMH components were not systematically employing an explicit strategy for addressing OSS (Out of School Suspensions)” (Bruns, Moore, Stephan, Pruitt, & Weist, 2005, p. 28). Implementing mental health centers may not reduce suspensions without updating home suspension policies.

School administrators need to be purposeful in aligning school discipline procedures and the mental health center referral processes to realize a reduction in student suspensions. Schools need to review their discipline policies as “studies have shown that OSS [out of school suspensions] may actually exacerbate behavior problems among students because students prefer suspension to attending school and/or because suspension is rarely accompanied by additional interventions focused on developing pro-social responses” (Bruns, Moore, Stephan, Pruitt, & Weist, 2005, p. 24). Another study found “a positive, but statistically non-significant, improvement in suspensions and other disciplinary actions among youth services program participants” (Geierstanger et al., 2004, p. 349). In conclusion, Discipline and mental health procedures must be aligned to realize a reduction in suspensions.

Improved Student Social and Emotional Health

In addition to academic performance, teens report they find mental health services beneficial for their personal growth. One school-based mental health program “was perceived as beneficial for both intrapersonal strategies and interpersonal awareness” (Garmy, Berg & Clausson, 2015, p. 7). Soleimanpour et al., (2010) reviewed additional studies that showed a significant decline in depression and suicide ideation among students who received mental health services. Students also reported that they appreciated the services provided by a school-based mental health center. According to Fazel, Garcia & Stein (2016) a study of recent refugees who participated in a mental health program, participants reported that "they felt less worried about things." and "they

felt more relaxed as a result, and this had an effect on many other aspects of their lives." By improving the health of at-risk students, the more likely they will be successful academically.

The Effects of Race and Ethnicity on Enrollment in Mental Health Centers

Research shows that one out of five students regardless of income, race, and ethnicity could benefit from mental health services. The treatment of mental health maladies helps all ethnicities equally:

> Ethnicity moderator tests found no significant difference in treatment benefit between majority Caucasian samples and majority non-Caucasian samples indicating that psychological therapy is efficacious for ethnic minority youths and adults across multiple problem areas, and about equally efficacious for minorities and Caucasians. (Weisz et al., 2017, p. 95)

However, non-Hispanic White students seem to have more access the mental health care system, while other student groups lag behind:

> Rates of need among ethnic minority youth are no lower than among Whites, but there are pronounced disparities in receipt of care, with ethnic minority children being less likely than Whites to receive services even when controlling for symptom severity, impairment, insurance, and socioeconomic status. (Bear, Finer, Gou & Lau, 2014, p. 388)

Although their children may need mental health services, “ethnic minority parents have been found to be less likely to identify their children's mental health needs, less likely to view services as potentially effective, and less likely to enter treatment to address problems that have been identified” (Bear, et al., 2014, p. 394). Therefore, it is vital that parents underserved students receive information about the benefits of using school-based mental health centers.

Another barrier to mental health care is the “limited availability and quality of health services in low-income communities of color, along with inadequate insurance coverage, creating obstacles to accessing appropriate care” (Anyon et al., 2013, pp. 457-458). The research also identifies that some groups do not either seek or receive quality mental health care. “Clear racial disparities disfavoring African American, Asian American Pacific Islander, and Latino adolescents in treatment receipt for depression, suicidal ideation, and delinquency in specialty mental health settings” (Bear et al., 2014, p. 389). There is a need to address mental health needs of all students, especially those who are more likely not to have access to services.

All students should have access to quality mental health professionals. However, African American and Latino children are less likely to have access to care. According to one report, "communities with high proportions of African-American and Latino residents are four times more likely than non-Latino whites to have a shortage of specialists, regardless of community income" (Dinwiddie, Gaskin, Chan, Norrington & McCleary, 2013, p. 68). Research also revealed that non-Hispanic White students are more likely to receive preventative care than Hispanic students. “It is possible that non-Hispanic White youth may be more likely to be referred to prevention-oriented services in the public sectors of care under study, whereas minority youth may be more likely to use the system when tertiary intervention is needed for severe problems” (Gudino, Lau, Yeh, McCabe & Hough, 2009, p. 12-13). Waiting until a mental health problem becomes severe not only hurts the child but requires more resources to correct.

School-based mental health centers “hold the promise of reducing unmet mental health need among youth, in general, and that can also reduce racial disparities in care" (Bear et al., 2014, p. 389). One study demonstrated the potential of the mental health center to close service gaps among student minority groups as “low-income Latino and African American youth were 20

times more likely to seek mental health services at a school-based clinic than in community mental health centers over a 5-year period" (Bear et al., 2014, p. 389). School-based mental health centers have the potential to remove barriers to health care for all students.

Need to Educate Parents About Mental Health Services

One of the reasons for the disparities in performance among student groups is the stigma or misunderstandings parents have about mental health services. Gudino et al. (2009) posed a reason for the disparity among student groups and mental health treatment services:

> Each ethnic or racial group has different reasons why they do not access mental health services as much as other student groups. Because problems of an internalizing nature may be difficult to recognize and cultural beliefs may render them less concerning, minority parents may be especially unlikely to seek treatment for these problems. (p. 14)

Although their children may need mental health services, "ethnic minority parents have been found to be less likely to identify their children's mental health needs, less likely to view services as potentially effective, and less likely to enter treatment to address problems that have been identified" (Bear, et al., 2014, p. 394). Therefore, it is imperative that parents of underserved students receive information about the benefits of using school-based mental health centers.

Barriers to Care for African American and Hispanic Students

Many reasons cause disparities among minority students and enrollment in mental health centers. "Barriers to care appear that disproportionately affect ethnic minority and immigrant youth include pragmatic barriers to access (e.g., insurance, transportation, language access, clinic hours), cultural barriers in problem recognition, beliefs about appropriate care, and stigma" (Bear et al., 2014, p. 388). The effects of these barriers can affect usage of mental health centers. "Among African American and Latino adolescents, fewer than 10% make use of outpatient

mental health services, and when they do access services they are less likely to receive the needed care than their White peers" (Bains, Franzen, & White-Frese 2014, p. 411). The research also identified issues that pertain to specific minority groups.

African-American Students. African-American students are more inclined to be identified to enroll in school-based health centers. According to one study, African American youth were 20 times more likely to seek mental health services at a school-based clinic than in community mental health centers over a 5-year period" (Bear et al., 2014, p. 389). Therefore, it is less likely that African American children will use community clinics. For example, "African American children with ADHD were 58% less likely than non-Hispanic White children with ADHD to use out-of-school behavioral health services" (Locke et al., p. 51). As a result, installing a school-based mental health center can assist African American children.

Although African American students have higher mental health identification rates, the reason is not always positive. "Social and institutional factors result in African American youth being more closely scrutinized for disruptive behavior, resulting in disproportionate rates of referral for services in various sectors of care" (Gudino et al., 2009, p. 14). Although more African American students will be identified for externalizing disorders (i.e., oppositional defiant disorder, conduct disorder), they will less likely be diagnosed with internalized disorders (i.e., anxiety and depression). "Stereotypic beliefs about minority child behavioral patterns may make the recognition of internalizing symptoms by other adult gatekeepers [educators] less likely" (Gudino et al., 2009, p. 14). Therefore, African American students may not be receiving the proper medical treatment.

The misdiagnosis of African American students can have devastating outcomes. Lindsay, Brown & Cunningham (2017) found African American students were 87% less likely to have

ever received mental health services. For example, “Many African American adolescent boys have serious problems connecting to mental health treatment to address their depression and other precursor issues leading to suicidal behavior” (Lindsey, Brown & Cunningham, 2017, p. 377). There must be an effort by school administrators to not only treat externalized symptoms but must also screen for internalized maladies as well.

Suicide Among Black Students (1998) reported the rate of suicides was the highest for African American students between the ages of 10-14 years old and the percentage of suicides increased by 233% between 1980 to 1995. The same report poses that “the exposure of black youths to poverty, poor educational opportunities, and discrimination may have negatively influenced their expectations about the future and, consequently, enhanced their resiliency to suicide” (Suicide Among Black Youths, 1998, para. 8). Also, African American students “in upwardly mobile families may experience stress associated with their new social environments. Alternatively, these youths may adopt the coping behaviors of the larger society in which suicide is more commonly used in response to depression and hopelessness” (Suicide Among Black Youths, 1998, para. 7). Therefore, financial security does not reduce the risk of suicide for African American students.

Another factor that can affect the identification and treatment of African American students is the teacher and parent impressions of African American student behavior. The relationship between school personnel and African American families “tend to diverge markedly, with teachers perceiving significantly more externalizing problems and more need for special education services than parents” (Gudino et al., 2009, p. 5). The only way to address the situation is for teachers to receive training on how to reduce externalizing behaviors. “Bias in treatment and evaluation of African American youth has been implicated as one explanation for the

overrepresentation of African American youth in the most restrictive care settings such as special education services for emotional disturbance and juvenile justice" (Gudino et al., 2009, p. 14). Therefore, school leaders must have a culture of high expectations for all students to reduce the likelihood that bias is affecting discipline and health determinations.

Hispanic students. Language and economic barriers are the primary reasons why some Hispanic students do not access mental health care. Sometimes, like doctors who treat African American students, primary care physicians do not adequately diagnose mental health issues "despite reports that Latino youths have the highest rate of suicide, they are less likely than others to be identified at risk for suicide." (Montañez, et al., 2015, p. 100).

Latino students who do not access mental health services are more likely to struggle in school. Montañez et al., (2015) found that Latino students have the lowest level of academic achievement and the highest dropout rates among all student groups in the United States. Because of the lack of success in school, many Latino students live in poverty which increases the risk for continued mental health problems. Increasing access to mental health services can be a strategy that helps break the cycle of poverty by improving student performance outcomes.

Economically Disadvantaged Students. Children in poverty are especially vulnerable to the effects of untreated mental health issues. "Examining 6-to 18-year-old children, the Midtown Manhattan Survey of Psychiatric Impairment in Urban Children in New York City found strong evidence that children from families on welfare were almost twice as likely to manifest impaired health and behavior" (Guo, Wade & Keller, 2008, p. 769). Another study found that "growing up in neighborhoods with concentrated poverty and exposure to racial discrimination is associated with a host of negative health and psychosocial outcomes in adolescence" (Anyon et al., 2013, p. 457). Becker & Luthar (2002) surmise that economically disadvantaged teenagers need a safe

and supportive school climate because many come from family backgrounds and environments where emotional support is not provided. (p. 198). School leaders and mental health providers should consider economic disadvantage as critical criteria when reviewing potential students for the center.

Farahmand et al. (2011) found that low-income, urban youth are less likely to receive mental health counseling even though they are at a higher risk of developing psychological problems. (p. 372). One study found that poor children with attention deficit hyperactivity disorder "were twice as likely to receive the diagnoses as wealthy children, but less likely to receive treatment" (Montañez et al., 2015, p. 100). Therefore, mental health center implementation plans must include the identification and treatment of economically disadvantaged students.

Trauma, Victimization and Economic Disadvantage

Students who are economically disadvantaged are more likely to be exposed to trauma and victimization. Some of the types of victimization experienced by poor youth include, "peer-sibling, physical abuse or assault, sexual victimization or assault, exposure to community violence, bullying, maltreatment, and witnessing family violence" (Larson et al., 2017b, p. 485). Exposure to these maladies can have devastating effects on children, especially those children who live in poor neighborhoods:

> Youth, especially those of low income and/or racial/ethnic minorities, who are exposed to trauma or victimization or the greater risk for developing anxiety, depression, conduct disorder, post-traumatic stress disorder, suicidal ideation, attention deficit hyperactivity disorder, and have lower GPAs than their peers who have not experienced trauma or victimization. (Larson, 2017a, p. 677)

Students “living in communities where they are consistently exposed to chronic poverty, residential instability, violence, crime, lack of adequate green space, and noise puts these children and adolescents edit greater risk to develop chronic stress” (Bains & Diallo, 2015, p. 8). Therefore, students who are “exposed to chronic trauma had a higher risk for dropout as mediated by mental health disorders. Mental health symptoms and disorders that predicted poor academic achievement were PTSD, anxiety, aggressive behavior, and depression” (Larson, 2017a, p. 677). School administrators must plan to address poverty’s effects on health and academics when implementing a school-based mental health center on a school campus.

Closing Thoughts on Chapter 2

Students who are not mentally healthy will not meet their academic potential. Unless student mental health is addressed, school administrators may continue to struggle with academic, behavioral and climate issues. Although school-based mental health centers show promise in improving educational outcomes for students, only 2% of all schools in the United States house a mental health center. “There is much room for improvement — ample opportunity for clinical scientists and practitioners, working together, to strengthen clinical care for young people and their families, who deserve the best interventions our collaborative efforts can produce” (Weisz et al., 2017, p. 96). Establishing a school-based mental health center can have a positive effect on student academic performance outcomes and provide much-needed services to the community at large.

CHAPTER III

SOLUTION AND METHOD

The development of a school-based mental health center at an urban high school in central Texas was in response to some tragic events during the 2010-2011 school year. Ten school community members, including students and staff, passed away. In one week, the school community suffered the loss of three of its students. Some teachers had as many as five students pass away during the school year. In response to the overwhelming need to assist the entire school community, the Superintendent provided funding to develop the district's first school-based mental health center. The district identified a Federally Qualified Community Health Center (CHC) to help implement a school-based mental health program on a high school campus.

The Student Referral Process

The school administration decided to meet weekly with counselors, assistant principals, social workers and the school nurse to discuss the students who showed signs that they could benefit from the new clinic. The group developed a protocol to identify students who might qualify for services. A form was created to collect information regarding the student's behavioral/physical/social-emotional health and school-related performance. School administrators, counselors, social workers, and the school nurse reviewed the information entered on the form to determine if counseling services were recommended. If the team determined the student met the criteria to receive services, a school referral team member contacted the student's parent or caregiver to offer mental health services. A Referral Consent Form was completed and signed by the parent or caregiver. Once the parental consent form was signed, the referral paperwork is brought to the school-based mental health center.

The School-Based Mental Health Center Intake Process

A counselor that works with in the school-based mental health center contacted the parent or caregiver via telephone and schedules a face-to-face meeting with the guardian to begin services for the student. Additional Release of Information forms and consent forms are then completed, as needed, to initiate clinical treatment for the student. A Referral Tracking Sheet is utilized to track students referred to the program and their referral outcome.

Services Provided by the Privately Administered Mental Health Clinic

The school-based mental health provides a range of services that include "diagnostic assessment, individual, family, and group counseling, teacher training and consultation groups, school-wide workshops, and trauma-informed culture building" (Privately Administered School-Based Mental Health Clinic, 2018, para. 1). The counseling service team included a Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Supervised Doctoral Candidates, and Doctor of Philosophy in Clinical Psychology. During the beginning of the counseling process students were administered up to two mental health evaluation tools: Strengths and Difficulties Questionnaire (SDQ) and Behavioral Assessment System for Children – 3 (BASC-3). Based on the assessment outcomes, students are provided the appropriate counseling services.

School-Site Additional Requirements and Agreements

In addition to reviewing student referral forms, the school administration and the clinic staff agreed that student records and any information shared during treatment would remain confidential in accordance to the state and federal laws. Training for both the school and school-based mental health center staffs on FERPA and HIPPA rules was provided to ensure that treated students' rights are protected.

School teachers were involved in the implementation of the new school-based mental health program. An agreement between the school staff and the CHC was that students could attend sessions before, during and after school. The school staff attended professional development opportunities that reviewed the services provided by the school-based mental health center. Most teachers were willing to allow students to participate in sessions during the school day, even if they missed classes. Also, teachers communicated with mental health center staff regularly when they saw issues arise in their classrooms. The CHC and district personnel met regularly to address issues that occurred, including communication, acquiring parent permissions, and providing data that supported the program.

Additionally, school administrators provided an office for the clinic to provide students' counseling. The office selected was accessible to students and their families before, during and after school. There was no signage outside the clinic to protect the confidentially of the students who attended sessions on the campus.

Justification of Proposed Solution

As the school implemented the program, home suspensions fell while attendance, course passing rates, and standardized exam scores all increased. There were fewer behavioral incidents on campus and teachers reported they faced fewer classroom disruptions during their lessons. After three years of the implementation of the pilot, the district decided to expand the program to 17 additional high and middle schools. Because of the high number of students served throughout the district, it was determined that one mental health provider could not provide all of the services required to meet the needs of additional student caseloads. Austin Travis County Integral Care (ATCIC) was added to provide mental health services to 14 campuses and began to serve students in 2014 and a private school-based mental health clinic (SBMHC) currently serves

three high schools, including the school that implemented the pilot program. The district assigned a coordinator to provide the structures similar to the one developed in the pilot school.

Study Context

Although there is evidence that the school-based mental health center provided needed supports for struggling students, a comprehensive review of the program has not been completed. The study attempts to link the implementation of the school-based mental health center and the increasing student performance outcomes. The study will review students who attended school-based mental health centers on three high school campuses during the 2016-2017 school year. A descriptive analysis will summarize student characteristics of the sample. An inferential analysis will examine differences between the treatment and control group.

Study Participants

Three high schools within a large urban school system in Central Texas, who were served by a privately administered school-based mental health clinic (SBMHC) in 2016-2017, are the focus of the study. The three comprehensive high schools studied house grades 9-12 and can have students from age 14-21. All three schools implemented a school-based mental health center administered by a privately administered clinic.

Selection Process

The students who used the school-based mental health clinic were identified by school staff as possibly needing mental health counseling. A team of counselors, administrators, and social workers review students' academic and behavioral records to determine if they meet the criteria for a referral. All students whose caregiver consented to counseling and attended at least five counseling sessions in one of the three SBMHCs were selected for the study. There were two middle school students included in the study because family therapy sessions are provided. The

lead administrator of the SBMHC entered the names of the students who met the counseling threshold in the Standard Aggregate Reports for Student Service Providers (SAR-SSP) system software program. The SAR-SSP created a control group comprised of a group of students with similar demographic, academic, and behavioral records that were not treated in a school-based mental health center.

The Characteristics of the Three High Schools in the Study

The high schools in this record of study are located in a major urban school district in Texas. The schools have differing demographic, economic and gender student bodies.

Demographic data. The demographic data for the three schools varied because they are located in different parts of a large urban city. Table 2 describes the demographic groups that attended the three high schools during the school year 2015-2016:

Table 2. Demographic Data for Three High Schools in the Study in School Year 2015-2016

School	# African American	% African American	# Hispanic	% Hispanic	# Non-Hispanic White	% Non-Hispanic White
School 1	94	3.2%	1069	36.9%	1455	50.2%
School 2	132	5.8%	728	32.1%	1154	50.9%
School 3	96	6.6%	1092	74.9%	277	15.6%
Total	322	4.9%	2889	43.6%	2886	43.6%

The majority of the student demographic groups were either Hispanic (43.6%) and non-Hispanic White (43.6%). African American students made up (4.9%) of the schools' total population.

Student economic status. School administrators determine the economic status of students based on the Federal Food and Nutrition Guidelines. The Food and Nutrition Service (2015) determines the eligibility for free and reduced priced meals in schools. During the 2015-2016 school year, a family of four would have to earn below $44,863 to be eligible for free or reduced

priced meals. Any student who qualifies for free and reduced lunch is considered economically disadvantaged. Table 3 summarized the economic status for the three high schools in the study.

Table 3. Economic Status Data for Three High Schools in the Study in School Year 2015-2016

School	# Economically Disadvantaged	% Economically Disadvantaged	# Not Economically Disadvantaged	% Not Economically Disadvantaged	Total
School 1	344	11.9%	2552	88.1%	2896
School 2	518	22.9%	1748	77.1%	2266
School 3	868	59.5%	590	40.5%	1458
Total	1730	26.13%	4890	73.87%	6620

During the 2015-2016 school year, 26.13% of the students qualified for free and reduced lunch, thereby were identified as economically disadvantaged. There may be other students who attend one of the three high schools who might have met the definition of economically disadvantaged, but did not complete the Free and Reduced Eligibility Lunch Forms.

Student gender in the high schools. The number and percentage of male and female student populations in the three schools are summarized in Table 4.

Table 4. Gender Classification for the Three High Schools in the Study in School Year 2015-2016

School	# Female	% Female	# Male	% Male	Total
School 1	1475	49.4%	1509	50.6%	2984
School 2	1181	50.3%	1166	49.7%	2347
School 3	750	47.9%	816	52.1%	1566
Total	3406	49.4%	3491	50.6%	6897

The population of female students (3406) is slightly less than the population of male students (3491) in the three high schools. The schools do not collect data on transgender students.

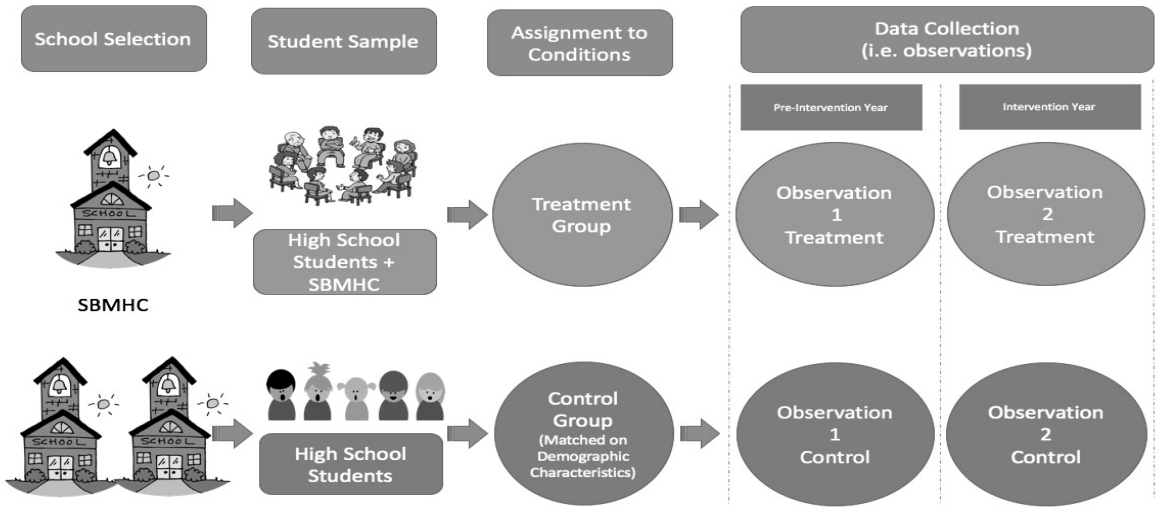
Research Questions

This study explored whether providing access to mental health services on a school campus effective in improving student performance outcomes. Eight research questions were explored: Comparing the treated group with a computer-generated control group:

1. Did the change in the treated group attendance rates differ from the attendance rates of the control group?
    a. How do the groups compare by marking period?
    b. How do the groups compare by year of intervention?
2. Did the number of disciplinary referrals in the treated group differ from pre-intervention year to intervention year in the treatment group? The control group?
3. Did the change in Grade Point Average (G.P.A.) in the treated group differ from the control group?
4. Did the change in passing rate for the treated group for the Algebra I STAAR examination differ from the control group?
5. Did the change in passing rate for the treated group for the English Language Arts I STAAR examination differ from the control group?
6. Did the change in passing rate for the treated group for the English Language Arts II STAAR examination differ from the control group?
7. Did the change in passing rate for the treated group for the Biology STAAR examination differ from the control group?
8. Did the change in the passing rate for the treated group for the United States History STAAR examination differ from the control group?

Research design. The quasi-experimental matched control ex post facto study involved students from three urban Central Texas high schools who attended at least five sessions in a school-based mental health center (Figure 1). The independent variable was treatment at the SBMHC's high school on-campus mental health center (two levels, treatment group and matched control group). Eight interval dependent variables were examined: attendance rates, the number of infractions that were entered in the Disciplinary Electronic Educational Documentation System (DEEDS) discipline, grade point average, and passing rates on five STAAR End of Course exams. Each dependent variable was measured at two points in time: the pre-intervention year and during the intervention year. The study compared the attendance, discipline, grade point averages, and standardized test scores of treated students with a computer-generated, matched comparison group in each of the time periods.

Figure 1. Research Diagram



Descriptive statistics were used to summarize demographic characteristics, attendance rates, discipline infractions, grade point averages, and passing rates for the independent variable's two groups. Inferential statistics were used to determine if the treatment group, attending at least five

counseling sessions in a school-based mental health center, differed from the control group on each of the dependent variables (i.e., attendance rate, discipline rates, grade point averages, and standardized test scores).

Sampling design. Three high schools within a large urban school system in Central Texas, who were served by a privately administered SBMHC in 2016-2017, are the focus of the study. The study sampled high school students from these three high schools. All of the high school students who attended at least five counseling sessions in one of the three privately administered on-campus mental health centers were selected for inclusion in the treatment group (n = 155). The Standard Aggregate Reports for Student Service Providers (SAR-SSP) system software program selected a matched control group based upon the treated group's characteristics including race/ethnicity, economic disadvantage and academic performance (n = 150). District staff masked the student identifiers in the data delivered.

Data Collection Methods

Based on the masked set of student ids in both the treatment and control groups, the district downloaded student attendance, discipline, GPA, and standardized examination data from the intervention year in 2016-2017 and the pre-intervention year in 2015-2016. Student attendance data included the number of days the students were registered and present in school. Discipline data contained all student infractions reported by administrators during the first semester in the pre-treatment, treatment, and post-treatment years. Student Grade Point Averages included the average grades earned by the students in both the treated and control group during the first semester for the year prior to treatment, the treatment year, and the year after treatment commenced. The STAAR standardized examination data contained all tests taken by the students in both treated and control group during the treated year. For each of the STAAR

examinations, an indicator of a '1' was provided when a student met the minimum standard threshold set by the Texas Education Agency.

Data Analysis Strategy

Raw student data had to be transformed in the dependent variables used in analyses: (1) the attendance rate of students, (2) the number of disciplinary actions taken against students, (3) the grade point average (GPA) of students, and (4) the results of STAAR examination for students who took them during the 2015-2016 and 2016-2017 school years.

Preparing the data. School district staff will provide masked data for both the treated and the computer-generated comparison group. Attendance, discipline, grade point averages, and standardized test scores were reviewed separately. A codebook that lists the variables, their definitions and numbers associated with the collected data were developed and kept by the district.

Preparing the attendance data. The attendance rate was computed for each student by dividing the number of days present by the number of days enrolled.

Preparing the discipline rate data. The discipline rate data was computed by counting each referral entered for every student in both the treated and comparison group. The total number of referrals were counted within the treatment and control group. The total number of referrals included students with multiple offences. Unique number of students with at least one referral were counted within the treatment and control groups.

Preparing the Grade Point Average data. The GPA was computed for each student by adding all of the class grades earned during the school year divided by the number of classes taken during the school year,

Preparing the STAAR End of Course data. The STAAR End of Course (EOC) passing rate for each test was computed for each student by determining if the student met the 'approaches standard' threshold on a given examination. If a student score is above the 'approaches standard' measure, then the student meets the minimum graduation requirement for that examination.

Exploring the data. Descriptive analysis was used to summarize the sample of students based on the demographic characteristics used when generating the matched control group. The data included grade level, gender, race/ethnicity, and economic status.

Analyzing the data. The data for treatment and control group were analyzed separately for each of the eight dependent measures. Attendance data was explored by marking period for the treatment and control group in the year of treatment. The data was also analyzed across two years; pre-intervention and the year of intervention. Within each of the two school years an independent samples t-test was used to explore differences in average daily attendance between treatment and control group. Discipline data was studied by counting the number of unique students with at least one referral with infractions for the treated and control groups during the pre-treatment and treatment years. Grade point average data was explored by taking the mean of all course grades for the treated and control groups during the pre-intervention and the year of intervention time periods. The STAAR data was studied by counting the number of the treated and control group students who took and passed Algebra I, Biology, English Language Arts I, English Language Arts II, and United States History examinations during the treatment year. Each of the examinations was analyzed separately.

Timeline

Table 5 lists the timeline for this study:

Table 5. Timeline for Study

Topic	Approximate Date of Completion
Completion of Proposal for The Study	Summer, 2017
Submit the IRB Application	Summer, 2017
Completion of Chapter One	Summer, 2017
Begin Review of the Research for Chapter Two	September 2017
Request Data from District	September 2017
Develop a Memorandum of Understanding for Data Use	October 2017
Receive the Descriptive Data from the district	October 2017
Begin Writing Draft of Chapter Two	October 2017
Receive the Individual Data Sets for Inferential Analysis	November 2017
Begin Writing Draft of Chapter Three	November 2017
Submit Draft Chapters 1-3 for Review by Chair	November 2017
Begin Inferential Analysis of Data	December 2017
Submit Updated Chapters 1-3 based on Chair Review	December 2017
Oral Defense of Proposal to Committee	December-January, 2017-2018
Submit Draft of Chapters 4 & 5 for review by Chair	January 2018
Submit Final Copy of ROS to Committee	February 2018
Oral Defense of ROS to Committee	February 2018
Graduation from Program	May 2018

Reliability and Validity Concerns or Equivalents

Establishing validity is an essential step in the process of research, regardless of the type of research conducted. There were internal validity, external validity, and reliability concerns with the study research design.

Internal validity. There is a threat to internal validity because the design the record of study's design is quasi-experimental. There was no assignment of participants to treatment and control groups as in laboratory experiments. However, the internal validity was increased by using a matched control group. There is threat to fidelity because there is no mechanism to control for the quality of counseling services, the educational and experience level of counselors that work in the SBMHC, and student willingness to participate in the counseling experience. However, the protocols used by the SBMHC minimized the threat to fidelity of implementation of the counseling services. Also, in a therapeutic setting, there is a lack of controls which makes

it difficult to assess the impact of counseling. Therefore, to reduce the threat of this study's limitations to measure the effectiveness of the counseling services, five counseling sessions was identified as the minimum number of counseling sessions a student had to attend to be included in the study. Research defines five sessions as the minimum number of sessions required to impact behavior.

External validity. There is an issue of generalizability of the findings. One potential threat to the external validity is the self-selection of students in the treatment group. There is no way to guarantee the students in the study represent the population of the schools. The study was conducted in schools as opposed to a laboratory setting. The research is not settled in whether male or female students attend counseling at a higher rate. In this sample, 60% of the students in the treatment group are female and 40% are male. The participation rate of females is higher than the total population of the three high schools in the study. Therefore, the findings about the clinics should not be generalized beyond similar students at similar high schools.

As the self-selection of female and male students is a threat to external validity, the race/ethnicity of students in the treated group also is a threat to validity. Although the total population of students who are Hispanic (43.6%), non-Hispanic White (43.6%), and African American (4.9%), the students in the treated group differ. The treated group participants based on race/ethnicity were Hispanic (49%), non-Hispanic White (43.9%), and African American (2.6%). The difference between the treated group and the student populations of the three schools may be due to the self-selection of students who enter into the mental health center program. The data also may reflect the inability of the school-based mental health program to reach more African American families. Therefore, the results from the study may not be replicated in other situations.

Reliability. All attendance, grade point average, and standardized examination score data were produced through larger systematic processes to ensure reliability. However, school discipline referrals depend on a number of factors that may be different in and among campuses. For example, gender differences, differences in assistant principal interpretation or enforcement of school rules, possible race and ethnicity bias, and the stigma attached to disciplining students may be factors that affect whether student behavior might result in a referral.

CHAPTER IV

ANALYSIS AND RESULTS/FINDINGS

The Office of Research and Evaluation met with the mental health provider to review the dataset needed to complete the research inquiry. The Director of the privately administered SBMHC provided the names of all students who received mental health counseling at least five times in the three schools served by a school-based mental health center. The student identification numbers were entered into the Standard Aggregate Reports for Student Service Providers (SAR-SSP) system. The Office of Research and Evaluation personnel masked the names of the students and prepared reports that included demographic, attendance, discipline, grade point averages, and standardized test scores for each student. The Research and Evaluation team used the SAR-SSP program to develop a comparison group. The demographic and comparison data were delivered via electronic mail. Further analysis of the summary and comparison data was completed using the Statistical Package for the Social Science (SPSS) program.

Description of the Treated and the Comparison Group

Out of the total population of the three high schools, 155 students met the threshold for inclusion in the treatment group. Once the treated group was identified, the SAR-SSP program identified a similar comparison group. Table 6 breaks down the grade levels of the students in both groups.

Table 6. Grades of Students in the Treated and Comparison Group

Grade	# Treated Group	% Treated Group	# Comparison Group	% Comparison Group	Total
6th	1	1.0%	1	1.0%	2
7th	1	1.0%	1	1.0%	2
8th	0	0%	0	0%	0
9th	28	18.1%	28	18.7%	56
10th	33	21.3%	32	21.3%	55
11th	41	26.5%	38	25.3%	79
12th	51	32.9%	50	33.3%	101
Total	155	100.8%	150	100.6%	295

The data shows that more 12th graders (33.33% of the sample) attended one of the three mental health centers. The high school grade with the least number of students who used a mental health center was the 9th grade (18.67%). As the grade level increases so do the number of students, who attended counseling sessions in the campus-based mental health center. Two middle school students who were not high school students were in the sample and comparison groups because they received counseling on the high school campus.

Gender of Students

The breakdown of the percentage of males and females in the treated and control groups are enumerated in Table 7.

Table 7. Gender of Treated and Comparison Group

Gender	# Treated Group	% Treated Group	# Comparison Group	% Comparison Group	Total
Male	61	39.35%	84	56%	145
Female	94	60.65%	66	44%	160
Total	155	100%	150	100%	305

According to the data, 21.3% more females used the on-campus mental health center than the male students. The comparison group, however, contains a higher percentage of male students

because the SAR-SSP computer program can only match a limited number of variables when generating a control group.

Race/Ethnicity of Students in the Treated and Comparison Group

The percentage of African American, Hispanic, and Non-Hispanic students that attend one of the three target schools are 4.86%, 43.64%, and 43.60% respectively, and the treated group has a higher percentage of non-Hispanic students. The race/ethnicity of the treated and comparison group is summarized in Table 8.

Table 8. Race/Ethnicity of Students in the Treated and Comparison Group

Race/Ethnicity	# Treated Group	% Treated Group	# Comparison Group	% Comparison Group	Total
Asian	3	1.94%	3	2.00%	6
American Indian	1	.65%	4	2.67%	5
Black	4	2.58%	4	2.67%	8
Hispanic	76	49.03%	74	49.33%	150
Pacific Islander	0	.0%	0	0%	0
2 or More Races	3	1.94%	3	2.0%	6
White (non-Hispanic)	68	43.87%	65	43.33%	133
Total	155	100.00%	150	100.00%	305

The percentage of African American students who used the center is low relative to the overall African American population in all of the schools. The Hispanic and non-Hispanic White populations in the treatment and comparison groups are similar to the total population of the three schools in the studies.

Economically Disadvantaged Population Characteristics

Based on the research, students who are deemed economically disadvantaged are more likely to need mental health services. Table 9 shows the treated and comparison group economic status.

Table 9. Economically Disadvantaged Population Characteristics

Characteristics	# Treated Group	% Treated Group	# Comparison Group	% Comparison Group	Total
Economically Disadvantaged	65	44.92%	62	41.64 %	127
Not Economically Disadvantaged	85	55.08%	88	58.36%	173
Total	155	100.00%	150	100.00%	305

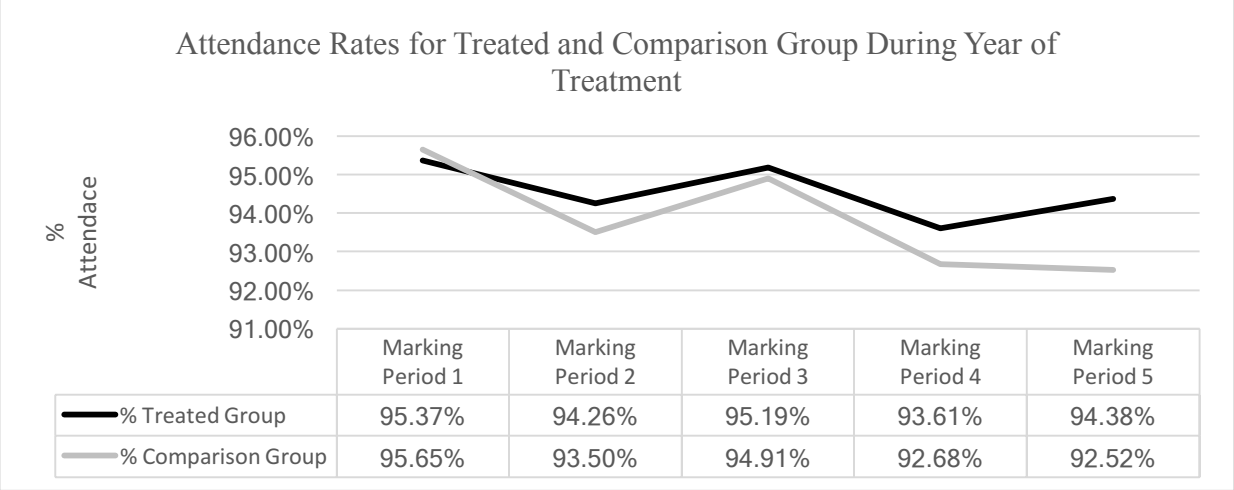
The percentage of the economically disadvantaged students in the three schools is 26.13%. However, 44.92% of the students who are in the sample have used the on-campus mental health center more than five times. Therefore, more economically disadvantaged students did use the school-based mental health center than the total population percentage.

Presentation of Data

The results of the study showed that the sample of students who attended the school-based mental health centers improved in the areas of attendance, grades, and standardized test scores.

Attendance. Student attendance in schools is critical to the teaching and learning process. Students with low attendance rates can struggle academically. Untreated mental health issues tend to lead to attendance issues. Introducing a mental health center on a school campus was hypothesized to increase attendance. Figure 2 shows how treated students' attendance rates in 2016-2017 related to the comparison group.

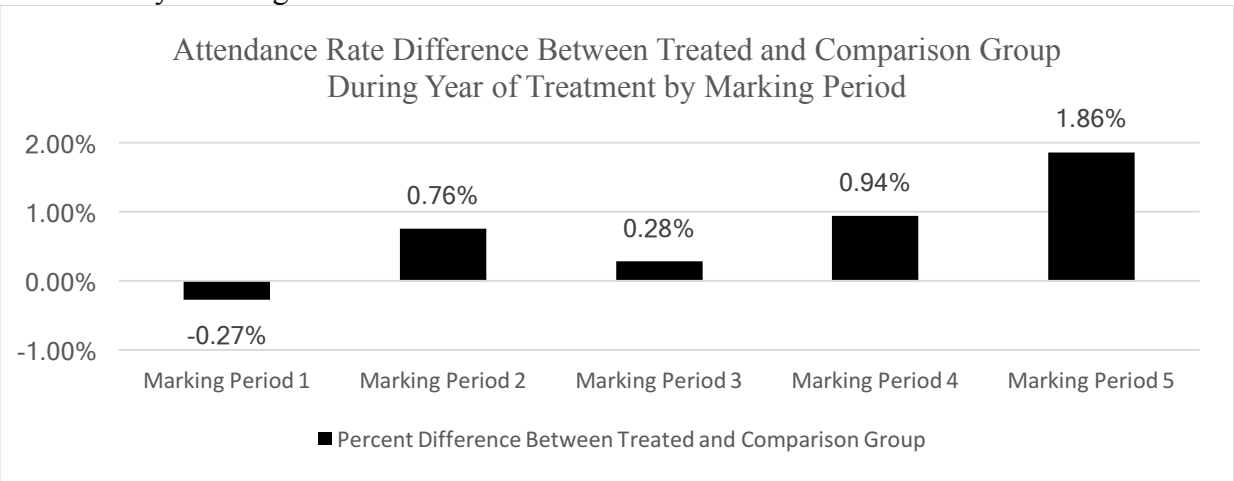
Figure 2. Attendance Rates for Treated and Comparison Group During Year of Treatment



Note: Scale is truncated to better see details in the data and not to inflate perceived magnitude of differences.

During the first marking period in 2016-2017 (i.e., the intervention year), the comparison group (95.65%) had better attendance than the treated group (95.37%). The treatment group demonstrated better attendance starting in the second marking period. Figure 3 illustrates how the difference between treated and comparison groups increased through the second half of the 2016-2017 school year.

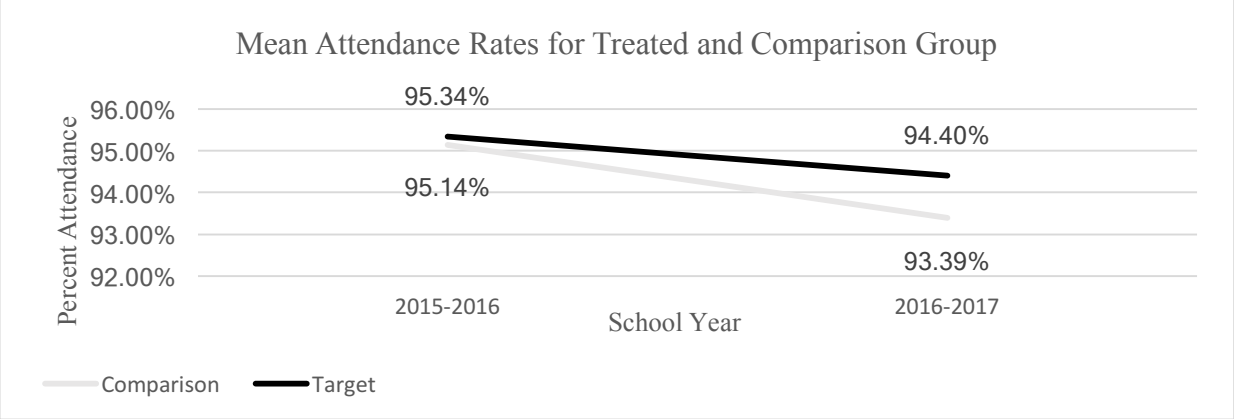
Figure 3. Attendance Rate Difference Between Treated and Comparison Group During Year of Treatment by Marking Period



As the 2016-2017 school year progressed, students treated in an on-campus mental health center had better attendance rates than the comparison group. The largest group difference in the data occurred in the 5th marking period.

Mean attendance rates for treated and comparison group. Attendance of treated students in the on-campus mental health center averaged about the same the year before and during treatment. Figure 4 summarizes the changes in the mean attendance rates.

Figure 4. Mean Attendance Rates for Treated and Comparison Group



Note: Scale is truncated to better see details in the data and not to inflate perceived magnitude of differences

Although the attendance for both groups of students fell over the tested years, the treated group dropped at a lesser rate. Student attendance in the comparison group fell by (1.75%) while the treated group declined by (.95%). Table 10 describes the independent samples t-tests conducted using SPSS for the attendance data for both the target and comparison groups.

Table 10. Comparison of Attendance Rates for Treated and Control Group

Variable	*M*	*SD*	t	df	P
Attendance					.
2015-2016			-.366	291	.715
Treated	.9534	.3886			
Control	.9514	.0533			
2016-2017			-1.271	259.6	.205
Treated	.9439	.7971			
Control	.9340	.0535			

Inspection of the data shows the attendance rates were not significantly different between the treated and control group in either year. The P values were above .05 for both groups.

Discipline. Students who are referred to an administrator are missing classroom instruction. Reducing the frequency of students that need behavioral conferences can impact their academic progress. Table 11 describes the reduction of the number of referrals in both the treated and comparison group.

Table 11. Total Number and Difference in Referrals for Treated and Comparison Group

Year	# Treated Group	# Comparison Group	Total
2015-2016	143	114	257
2016-2017	109	112	221
Difference	34	2	36

Upon inspection of the data, treated student referrals dropped by 34, while referrals in the comparison group dropped by two. The percentage of referrals for students in the treated group was reduced by 7.8% while the comparison group percentage fell .5% over the two years. Table 12 counts the unique number of students who have discipline records.

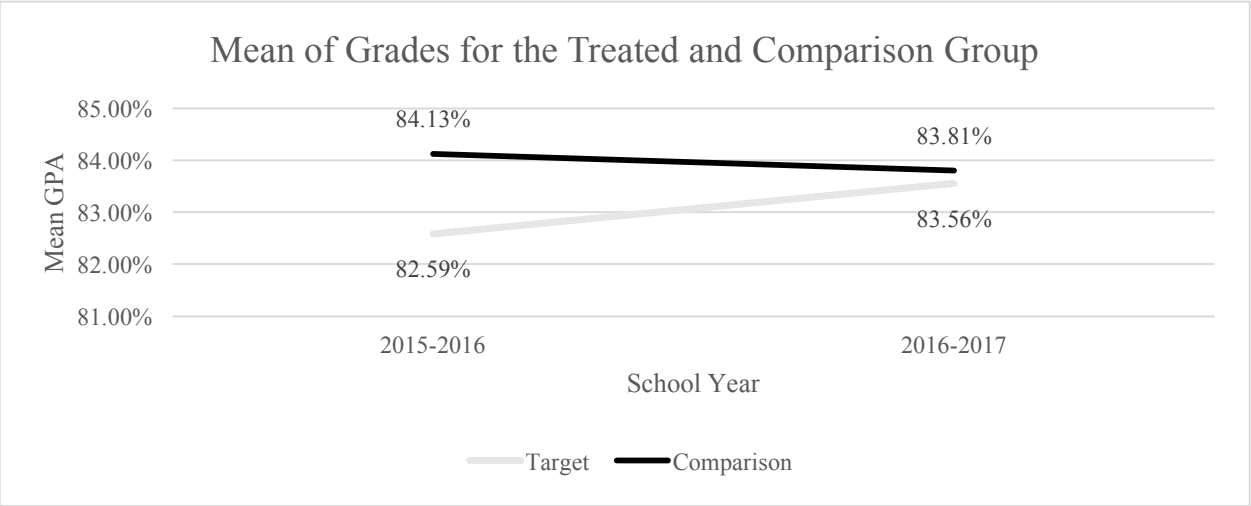
Table 12. Number of Students With At Least One Referral for Treated and Comparison Group

Year	# Unique Students Treated Group	% Unique Students Treated Group	# Unique Students Comparison Group	% Unique Students Comparison Group	Total
2015-2016	37	23.87%	28	18.67%	55
2016-2017	32	20.65%	33	22.00%	65
Total	69		61		120

Inspection of the data in Table 12 shows that the number of unique students who had at least one discipline record fell by (5) students in the treated group while the number of unique students in the comparison group increased by (5) students. The percentage of unique students in the treated group with at least one discipline referral dropped by (3.22%) while the percentage of unique students in the comparison group with at least one discipline referral increased by (3.33%). In the pre-treatment year, the percentage of unique students in the treated group was (5.2%) higher than the control group. During the treatment year, the percentage of unique students in the treated group was (1.35%) lower than the comparison group.

Grades. Poor course grades can be an indicator of academic need. However, lower student report card grades can also indicate a possible mental health issue. Therefore, tracking grades can be one method of identifying students who may need mental health services. Figure 5 provides the data for the mean grades of both the treated and comparison groups for the school years 2015-2016 and 2016-2017.

Figure 5. Mean of Grades for the Treated and Comparison Group



Note: Scale is truncated to better see details in the data and not to inflate perceived magnitude of differences

The data shows the mean grades for the comparison group are always higher than the target group. However, during the treatment year, the difference between the treated and comparison groups closed from 1.54 to .25. Table 13 enumerates the comparison of the mean and standard deviation for the two groups.

Table 13. Comparison of Mean and Standard Deviation GPAs for Treated and Control Group

Variable	*M*	*SD*	t	df	P
Grades					
2015-2016			1.353	284	.177
Treated	82.59	10.57			
Control	84.13	8.62			
2016-2017			.238	289	.812
Treated	83.56	7.66			
Control	83.81	9.51			

The inspection of the data shows that the grade point average of the treated student group increased by .97 while the grade point average for the control group fell by .32. The standard

deviation for the treated group fell from 10.57 to 7.66 while the standard deviation for the control group increased from 8.62 to 9.51.

Standardized examinations. Students are required to pass five STAAR examinations as a part of the graduation requirements. Students take Algebra I, Biology, and English Language Arts 1 in their freshman year, English Language Arts 2 in the sophomore year, and United States History test in the junior year. Table 14 summarizes the results of the STAAR examination during the 2016-2017 school year.

Table 14. STAAR Passing Exams for Treated & Comparison Group by Exam Type During 2016-2017 School Year

Test	# Pass Treated Group	# Took Treated Group	% Pass Treated Group	# Pass Comparison Group	# Took Comparison Group	% Pass Comparison Group	% Treated Increase
Alg. 1	22	25	88.00%	17	20	85.00%	3.00%
Biology	23	27	85.19%	22	26	84.62%	0.57%
ELA 1	22	32	68.75%	20	28	71.43%	-2.68%
ELA 2	28	35	80.00%	28	37	75.68%	4.32%
History	37	40	92.50%	30	35	85.71%	6.79%
Total	132	159	83.02%	117	146	80.14%	2.88%

The students in the treated group performed better on the Algebra I (3%), Biology (.57%), English Language Arts 2 (4.32%), and the United States History (6.79%) examinations while the comparison group achieved better results on the English Language Arts I (2.68%) test. The data showed the treated group had a higher percentage of students passing in examinations that are administered during the 10^{th} and 11^{th} grade.

The comparison between the performance of the treated and control groups by school year provides additional insight into the possible effect of school-based mental health centers. Table

15 encapsulates the number of STAAR EOC examinations taken by the treated and control group in 2015-2016 and 2016-2017.

Table 15. Comparison of STAAR EOC Results for Treated and Control Group by Year

Variable	# No Test	% No Test	# Failed	% Failed	# Passed	% Passed	Total
Test Period							
2015-2016							
Treated	30	10.99%	68	24.91%	175	64.10%	273
Control	29	11.60%	45	18.00%	176	70.40%	250
Total	59	11.28%	113	21.60%	351	67.11%	523
2016-2017							
Treated	54	24.77%	32	14.68%	132	60.55%	218
Control	61	28.24%	38	17.59%	117	54.17%	216
Total	115	26.50%	70	16.13%	249	57.37%	434

Inspection of the data finds that the failure rate for the treated group fell from (24.91%) in the 2015-2016 school year to (14.68%) in 2016-2017 while the control group failure rate dropped from (18%) in 2015-2016 to (17.59%) in 2016-2017. The (10.23%) decrease in failure rate for the treated group is higher than the decline of (.41%) for the control group.

The passing examination percentage for both the treated and control groups decreased from 2015-2016 to 2016-2017 school years. The treated group's passing rates fell from (64.10%) in 2015-2016 to (60.55%) in 2016-2017 while the control group passing percentage dropped from (70.40%) during the 2015-2016 school year to (54.17%) in the 2016-2017 school year. The difference in the percentage of the treated students' passing rate was (-3.55%) while the control groups percentage was (-16.23%).

Results of Research

The treated student group, who were treated at least five times in the school-based health center during the 2016-2017 school year, had better attendance rates, lower discipline rates, and

standardized examination scores when compared to the students in the computer-generated comparison group in the same academic year. Although the grade point averages of students in the treated group continued to lag behind the control group, the gap between the pre-treatment year and year of treatment was reduced. The data differences between the control and treatment groups were not statistically significant, but the observed improvement descriptively in attendance, discipline, grade point average, and standardized examination scores would be considered an improvement by campus and district leaders. The effects of interest are minimal in context. Since the measurements deal with fractions of a percentage point, study designs may need much larger sample sizes to show statistical significant results. Therefore, the data trends illustrate the need to conduct further studies with a larger group of treated students.

The statistical analysis determined that the difference between the comparison and treated groups were not statistically significant. However, using a descriptive analysis demonstrated that students in the treatment group in the study had improved student attendance, discipline rates, grade point average, and the STAAR standardized examination scores when compared to the control group. Since a small change in attendance, discipline, grade point average, and standardized examinations data can be significant to school and district leaders, there is a need to increase the number of students in future studies to accurately measure whether the implementation of school-based mental health centers has statistically significant effects on academic performance.

Impact of School-Based Mental Health Center on Attendance Rates

Attendance rates were improved for the treated group when compared to the comparison group during the year of treatment. Although not statistically significant, the increases in attendance can have a positive effect on both the student and the school as a whole.

Attendance rates are critical to academic success because students who miss school regularly are less likely to pass courses, have good grades, and pass required standardized State examinations.

Attendance by marking period. The difference of the attendance rates between the treatment group and the comparison group during the treatment year increased from .28% in the third six weeks grading period to 1.86% in the fifth six weeks grading period. Therefore, students who used the school-based mental health center at least five times attended school at a higher rate than the comparison group. The attendance improvement shows that students in the treated group attended school more often as the school year progressed.

Attendance by year of intervention. Although the comparison group posted higher attendance rates in both years, the difference between the control and treated groups declined from 1.54% to .25%. Students in both groups had lower attendance rates in 2016-2017. However, the treated group's decline (.95%) was less than the comparison group rate (1.75%). The data indicates that students in the treated group attended school more often.

Impact of School-Based Mental Health Center on Discipline Rates

Students who are removed from classes due to disciplinary issues miss classroom instruction. Students who are frequently removed from class may begin to struggle academically, possibly leading to more behavioral problems in school. Providing students mental health services on school campuses can improve behavior by treating the underlining reasons for poor behavior.

Disciplinary referral differences. The number of disciplinary referrals in the treated group declined when compared to the control group. Both the number of discipline referrals and the percentage with at least one referral decreased for the treated group. The number of unique students with at least one discipline record fell by (5) students between the 2015-2016 and 2016-2017 school years while the control group increased by (7) students in the same period. The

percentage of unique students disciplined in the treatment group fell below the control group in the treatment year. The number of discipline referrals for students in the treated group dropped from (143) to (109) while the comparison group's referral counts decreased slightly from (114) to (112). The trend demonstrates that the mental health center counseling might affect whether students face disciplinary actions less frequently.

Impact of School-Based Mental Health Center on Grade Point Average

Grades are one primary way of measuring academic success. Higher grade point averages indicate students are successful in learning. Poor or failing grades can greatly reduce both the grade point average and the likelihood of graduation from high school. Low grade point averages might also indicate that students have mental health difficulties in addition to academic deficits.

Grade Point Average differences. The mean grades for the treated group improved by (.97) while the comparison group saw a decline in the mean grade point average (-.32). The overall mean grade point average difference was reduced from (1.54) during the 2015-2016 school year to (.25) during the 2016-2017 school year. The statistical analysis demonstrated that these changes were statistically insignificant. However, although it seems minor, an increase of one point in a grade point average can impact class ranking, scholarship opportunities, and college choices. Although not significant, the upward trend in the mean grade point average for the treated group warrants further study that includes more students.

Impact of School-Based Mental Health Center on STAAR Examinations

Students who attend school more often, are disciplined less, and have improved course grades are more likely to pass standardized examinations at a higher rate. Failing to pass all five required STAAR examinations will prevent students from graduating from high school with a diploma.

STAAR result differences. Overall, when comparing the data from the school years 2015-2016 and 2016-2017, the STAAR failure rate fell for the treated group by (10.23%) while the control group was reduced by (.41%). The passing rates declined for both groups, but the treated group fell by (3.55%) while the control group declined by (16.23%). The difference in passing and failure rates may show the potential impact the school-based mental health center can have on STAAR examinations.

STAAR Algebra I, Biology, and English Language Arts I differences. The review of the STAAR examination data shows that the school-based mental health center affects passing rates depending on the grade the tests are administered to students. Passing rates for STAAR examination results for the target group improved slightly for the Algebra I (3.0%) and Biology examinations (.57%). The English Language Arts I data showed the comparative group passed the test at a higher rate (2.68%). All three of these examinations are administered to students in the ninth grade. Based on the analysis of the data, the impact of the school-based mental health center counseling on STAAR examinations taken during the freshman year of high school was negligible.

STAAR English Language Arts II and United States History differences. Although there was a slight difference of STAAR passing rates for exams taken in the freshman year, treated students in the sophomore and junior years were more successful on the STAAR examinations than those in the comparison group. Results indicated that the treated group passed more English Language Arts II (4.32%) and United States History (6.79%) exams than the comparison group. Older students may have had more academic interventions that would affect test scores overall. However, the data suggests treating students in a school-based mental health center could improve performance on standardized examinations, especially for older students.

Interaction between the Research and the Context

A large urban school district in central Texas has been implementing social and emotional programming for the past five years. District and school officials believe that teaching skills that promote healthy relationships are critical to improving student academic performance. The district was the first in central Texas to open a school-based mental health center as a part of a comprehensive school turnaround plan. The results from this study will be used to inform future research about the implementation and execution of school-based mental health centers within the district.

Many community members are interested in supporting mental health in schools. This study was welcomed by the district administration and the Board of Trustees because the district has invested resources into improving the mental health of students. Also, many health providers, mental health professionals, private funders, and legislators have expressed interest in the outcomes of this study. Since the district implemented social and emotional instruction in all of the schools, attendance, graduation rates, and dropout rates have all improved. Studies are now needed to accurately measure the impact the school-based mental health centers have on performance to justify the expansion of the counseling program to more schools. Therefore, this Record of Study will be used to show the effects of the school-based mental health program on student performance and to provide the basis for future school-based mental health center study designs.

How did the Research Impact the Context

There are plans for many constituencies to review the findings. The Board of Trustees and the Superintendent have supported the improvement of mental health as a strategy to improve the school system. Mental health providers will review the identification, intake, and monitoring

aspects of the study to improve the service to the students. Legislators are interested in funding mental health programs and need the data to support legislation to expand these programs throughout Texas.

Based on the conversations that have taken place when presenting the findings, the research process used in this study will be replicated to review all of the schools in the district with some additional components. The community has asked that student and parent surveys be a part of future studies to support the academic data collected. Some community members are interested in following a cohort of students for their entire high school careers to measure the short and long-term impacts of providing school-based mental health counseling. As the results of the program have been presented, some school districts are interested in replicating the program and will conduct more extensive studies to provide proof that the investment in mental health counseling will impact student performance.

Summary

Although the results from this study show that school-based mental health centers have a positive effect on attendance, grades, and standardized test scores, more research is needed to prove that school-based mental health centers can improve academic performance. The next study should include a larger number of treated students. Therefore, all of the district's mental health programs need to be in the upcoming series of studies. Finally, the study design should measure student results over the four years of high school. With the suggested changes, future studies may support the hypothesis that school-based mental health centers can significantly improve both academic performance and the culture and climate of a school campus.

CHAPTER V

SUMMARY AND DISCUSSION

Educators across the United States are struggling to close the academic achievement gap. Although many academic interventions have been implemented by school leaders, many students still struggle academically, especially those with untreated mental health needs. If students had access to quality care, then they may be better prepared emotionally to improve academically in schools. This study aimed to measure whether providing counseling services in schools by installing school-based mental health centers was effective in improving student academic performance.

Eight questions were posed for this record of study to determine if installing mental health centers on school campuses affected critical indicators; attendance rates, disciplinary rates, grade point averages, and standardized test scores. The study compared a treated group with a computer-generated control group. The questions posed include:

Comparing the treated group with a computer-generated control group:

1. Did the change in the treated group attendance rates differ from the attendance rates of the control group?
    a. How do the groups compare by marking period?
    b. How do the groups compare by year of intervention?
2. Did the number of disciplinary referrals in the treated group differ from pre-intervention year to intervention year in the treatment group? The control group?
3. Did the change in Grade Point Average (G.P.A.) in the treated group differ from the control group?

4. Did the change in passing rate for the treated group for the Algebra I STAAR examination differ from the control group?
5. Did the change in passing rate for the treated group for the English Language Arts I STAAR examination differ from the control group?
6. Did the change in passing rate for the treated group for the English Language Arts II STAAR examination differ from the control group?
7. Did the change in passing rate for the treated group for the Biology STAAR examination differ from the control group?
8. Did the change in the passing rate for the treated group for the United States History STAAR examination differ from the control group?

If improvement in attendance, discipline referrals, grade point average, and standardized examination scores are observed after students begin mental health counseling, it would suggest that on-campus mental health centers could help improve academic performance overall.

Discussion of Results about the Extant Literature or Theories

The Social Ecological Model examines four areas that health services can impact; Individual, Relationship, Community, and Societal. The Record of Study concentrated on the effects of mental health counseling on individual students. The data analysis showed the gains measured between the treated and comparison group data to be statistically insignificant. However, attendance, discipline rates, grade point averages, and standardized examination scores did improve for the treated group when compared to the control group.

Attendance. The study found that when compared to the control group, the treated students' attendance improved, but was not statistically significant. However, the treated group's attendance rates did improve when compared to the control group. Although the increase in

attendance for the treated group seems insignificant, a small increase in the rate can have positive effects for both the treated student and the student body.

Since school budgets are established based on the daily attendance rate, increases in attendance impacts the resources available in a school. The higher the attendance rates, the more money school administrators have to provide more robust course offerings and provide additional supports. A one percent increase in attendance can have an impact on a budget of a school. For example, 6,620 students attend the three high schools in this study. If the daily attendance rate of the three student bodies increases by one percent (66 students) in one school year, the three schools combined will receive $531,630 in additional funding. Schools could use the increased funding to pay for the school-based mental health center costs as well as other interventions. Therefore, increases in attendance percentages can lead to increased intervention supports for struggling students.

Discipline rates. The analysis of the data showed that percentage students who used the services in the school-based mental health center that were referred to administration for disciplinary actions dropped in the treatment year. The reduction of behaviors that interrupt the teaching and learning process can positively impact all students. By improving the classroom climate, all learners benefit. Also, students who are assigned home suspension are counted as absent from school reducing the budget of the school. Not only is the disciplined student affected by the removal from class, but the entire student body also loses funding for teachers and programs. Therefore, it may be advantageous for school leaders to implement school-based mental health centers as a strategy to reduce student discipline rates.

Grade Point Average. The data analysis revealed that treated group's mean grade point averages improved during the treatment year while the control group's GPA fell. Students with

low grade point averages are assumed to have solely academic challenges. School administrators will usually respond to low or failing grades by providing additional academic supports like tutoring, Saturday school, or limiting or eliminating elective courses from a student's schedule in favor of additional content area support classes. However, students with mental health difficulties may be struggling academically because they are not 'head ready' for school. Therefore, the data suggests students that are emotionally prepared to engage in class activities can earn higher grades by receiving mental health counseling.

STAAR examination rates. The data analysis showed that there was an improvement in STAAR scores for the treated group, especially for the examinations taken in the second and third years of high school. One reason for the passing rates for students in the transition year might have less to do with academic difficulties and more to do with transitioning to high school culture and demands. Another reason for the lack of improvement could be the number of exams students are required to take in one testing period.

Students with poor academic, attendance, or discipline records will also have difficulties on the STAAR tests. Instead of only considering academic and test preparation interventions, school leaders could implement programs that address student mental health struggles. Providing mental health services in schools may improve student self-esteem, self-confidence, and reduce anxiety. The result of the counseling in a school-based mental health center can improve both academic performance during the school year and their performance on STAAR examinations.

Discussion of Personal Lessons Learned

There are many lessons learned from engaging in the Record of Study process. The first lesson is how important the design of the research project is in the collection and analysis of data. There were many adjustments made at the beginning of the process due to IRB

considerations and the availability of the data sets needed to conduct the study. Also, narrowing the focus of the study was also challenging. Overall, the variables that had to be considered throughout the process made the development of the Record of Study more complex than anticipated during the beginning stages of designing the project.

Another lesson learned was the Record of Study process is time-consuming. There were many times during the process that progress was hindered due to unforeseen issues such as delays in collecting data, issues with IRB considerations, and defining the scope of the record of study with the committee. Also, many writing components go beyond the actual Record of Study. There were some proposals, discussions, and clarifications that throughout that added months to the schedule. Therefore, the amount of time it took to complete a research study was more than predicted.

Finally, many people are involved in developing and producing research. The Record of Study committee, the IRB committee, district personnel, and mental health professionals all played a part in developing the research proposal and paper. Communicating a clear message about the plan and needs to different constituencies is key to completing the Record of Study. Therefore, the researcher must be prepared, focused, and an excellent communicator to be successful.

Implications for Practice

The outcomes from the Record of Study suggests that school-based mental health centers have positive effects on attendance, grades, and standardized examination scores. Students who have untreated mental health issues will have difficulty meeting graduation requirements and face an uncertain future. Providing only academic interventions for students who are struggling with mental health problems may not be sufficient in improving student performance outcomes.

Therefore, school systems should look to address students' mental health concerns as a part of a comprehensive school improvement plan.

The research provides some considerations school and district leaders must take into account for the school-based mental health center to thrive and positively affect student performance outcomes. First, the process to identify students who need mental health counseling must be developed. The plan should consider the demographic population of the student body, the role of different faculty members in the identification process, and the documentation required during the intake process. A second consideration when implementing a school-based mental health center must include a plan to educate the entire school community about the services provided in a school-based mental health center. Incorporating staff development and community workshops in a communication plan are critical to student enrollment. Finally, collecting and monitoring data to ensure the services are effective. All of these steps are all elements of a comprehensive plan that are needed to address student mental health successfully.

The resources devoted to school-based mental health centers can improve more than an individual student's mental health. All of the members of a school community can benefit from hosting counseling services, even if they do not personally use the mental health center. By addressing students with mental health needs, teachers may have fewer classroom disruptions and be more effective in presenting their lessons. Reducing school discipline-related incidents also allows school leaders to shift resources from disciplinary processes to spending more time in classrooms coaching teachers. Although this study did not review the schoolwide impact of mental health, the research suggests that providing services in schools can play a role in improving the culture and climate in a school and affect student performance outcomes.

Recommendations

After completing the analysis of the academic data, some adjustments to the Record of Study model are recommended. First, the comparison group should be comprised of students who were identified as needing mental health services but did not agree to meet counselors. Also, the data for this study were collected for students who availed themselves of mental health services at least five times in one particular year. Further studies should follow a cohort of students from the ninth to twelfth grades to measure the short and long-term impact of the counseling services. Finally, data could be analyzed to measure the effect of the treated students on schoolwide data.

Another modification to the current research design should include increasing the sample size of the treatment group to help demonstrate statistical significance. A greater sample size will allow for more robust statistical analysis in the future such as evaluating predictor models and conducting moderation (see if model fits differently for White compared to Hispanic, male vs. female, etc.). Although the descriptive analysis using the quantitative data collected in this study showed improvement in attendance, discipline, grade point average, and standardized examination scores, the results proved to be statistically insignificant.

Since the measured changes in attendance, discipline, grade point average, and standardized examination scores data are small, a larger number of students in the treated group is required to measure whether the differences are statistically significant. The sample size is particularly important in studies that measure academic data because minor changes in scholastic data can prove to be significant to both the practitioner and the student. Therefore, future studies should include a larger number of students to demonstrate statistical significance when comparing data before and during counseling treatment.

The effectiveness of the mental health counseling may impact academic performance outcomes. The results of the statistical analysis showed the changes in data were not significant. In addition to the sample size, there may be aspects of the counseling intervention that need to be modified. The type of treatment or treatment efficacy wasn't measured in this study. Further studies should measure the effectiveness of the counseling services on improving the mental health of students.

In addition to improving this Record of Study, further study models are needed to measure how the school-based mental health center can affect the relationship, community, and societal model elements. A mixed methods study that includes student interviews could complement the academic data. Interviewing the students that were treated in a school-based mental health center would allow researchers to understand why the counseling improved academic performance. Also, parent, teacher, and community member interviews should also be considered to measure the impact of mental health counseling on relationships, the school community, and society.

Academic data does not give a complete picture of the impact of mental health services. Survey and interview data of students, teachers, and administrators in the schools with school-based mental health centers could also provide additional perspectives that would increase the knowledge of the field. The qualitative data could support the quantitative outcomes and provide a context for how counseling services are affecting the overall disposition of members of the community. Providing a venue to document and share the voices of those students, teachers, and administrators would assist in providing school and district administrators the feedback necessary to improve mental health care. Therefore, mental health providers should consider including permission to interview students and their families as a part of the intake process.

Other research designs could be conducted to measure how the mental health program effects on non-treated students in a school that contains a mental health center. A quantitative study may collect and analyze schoolwide data to measure the effects of the school-based center on students who may not have used the services in a mental health center, but benefited from the improved culture and climate within the school. Finally, a longitudinal study could be conducted to see if neighborhood crime rates or drug arrests are reduced by providing students mental health counseling.

Closing Thoughts

With the changing job market and economy, the educational level ultimately obtained by students will continue to play a prominent role in whether they can have a good standard of living. However, many students, especially African American, Hispanic, and economically disadvantaged children, continue to struggle academically. There have been many academic interventions developed by education experts that have attempted to address performance gaps that have not been successful. Academic supports may not be adequate without addressing the mental health of students. For some students, the lack of success in school may not be solely due to learning deficits but untreated mental health disorders.

Providing students mental health facilities can improve the culture, climate, and academic performance of a student body. School-based mental health centers provide students with convenient counseling services that can treat children and their families. The center can serve to erode the stigma that is still attached to mental health counseling by providing information to the school community about the benefits of therapy. The easy access to mental health counseling can ensure students receive regular treatments. Once students receive care, academic, social and emotional health may improve.

Some schools that have implemented mental health centers have realized improved attendance, grades, discipline rates and standardized test scores. Although the practice of opening a school-based mental health center is a promising program, only 2% of the schools in the United States provide mental health counseling in schools. As mental health programming is expanded throughout school districts across the United States, implementation guidelines will be needed to assist schools. More research is required to develop the identification, treatment, and monitoring of mental health services to guide schools who implement a school-based mental health center. The school-based mental health center holds the promise of improving the lives of students by treating mental health symptoms and improving student performance outcomes.

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APPENDIX A

CLINIC INTAKE FORM

HIPAA / FERPA Consent
Authorization for [redacted] Clinic and [redacted] ISD to share information.

CONFIDENTIALITY NOTICE: THIS DOCUMENT AND ALL THE INFORMATION CONTAINED HEREIN IS THE SOLE PROPERTY OF VIDA CLINIC, PLLC. SHARING AND USE OF THIS DOCUMENT IS PROHIBITED WITHOUT WRITTEN APPROVAL FROM VIDA CLINIC.

Part 1: HIPAA Disclosure to [redacted]. Complete Part 1 of this form to allow [redacted] Clinic to share the named student's identifiable protected health information (PHI) with school officials at [redacted], as set forth below and in accordance with federal healthcare privacy laws (45 CFR 164.508). This authorization does not authorize the sharing of the student's full medical record.

Individual / Student: _____
First Name Last Name MI First Name Date of Birth

Authorization. I authorize [redacted] CLINIC and its affiliated clinics to disclose the named student's PHI to [redacted], including administrative officials and licensed care professionals of the school. I permit and request my child's information to be shared with such persons when, *in the professional judgment of an* [redacted] *CLINIC provider*, it is necessary to protect and provide for the student's best interest or to provide for appropriate care coordination between [redacted] CLINIC and school officials. Common examples of situations in which information might be shared include:

- Alerting school officials if emergency care for the student is needed
- Coordinating appointments with the student's classroom schedule
- Coordinating prescription drug administration or managing allergies
- Communicating appropriate information to athletic trainers and coaches
- Alerting school officials if the student poses a danger to him- or herself, or others

Duration and Revocation. I understand this authorization is effective immediately and will expire one year from the date of my signature. I may revoke this authorization at any time by giving written notice to [redacted] CLINIC. I understand that revocation will not affect any action that [redacted] CLINIC took in reliance on this authorization before receiving my written notice of revocation.

Re-disclosure and FERPA Protection. I understand that any information disclosed by [redacted] CLINIC will no longer be protected under HIPAA, but that [redacted] and school officials must protect the information as required by the Family Educational Rights and Privacy Act (FERPA) and that this information may become part of the student's educational record. The information may be shared with individuals working at or with [redacted] for the purposes of providing safe, appropriate, and least restrictive educational settings, school health services, or other academic or extracurricular programs. Sharing this information outside of [redacted] will generally require my consent.

Authorization not required to receive care or treatment. I understand that refusing to sign this form will not affect the named student's ability to receive care from [redacted] CLINIC. However, if I refuse, some school services may be delayed or involve additional inconvenience. Finally, I understand that even if I do not sign this authorization, [redacted] CLINIC may share information with a licensed health care professional employed by [redacted] to the extent the professional is involved in the student's health care.

Approval: _____
Printed Name Signature Date

_____ _____
Date Relationship to Student Area Code and Phone Number

Part 2: FERPA Disclosure to [redacted] Clinic. For the student named above, complete Part 2 of this form to allow [redacted] to share the student's educational records with Vida Clinic. You are not required to sign either Part 1 or Part 2 of this form to receive services at [redacted] Clinic. You may sign only Part 1 *or* Part 2, or you may sign *both* Part 1 and 2.

Authorization. I authorize [redacted] to share the named student's FERPA-protected educational records, including school health records and the student's class schedule, with [redacted] CLINIC personnel. I understand this authorization will help ensure care is properly coordinated between [redacted] CLINIC and school officials, counselors, and nurses. I understand [redacted] CLINIC will not re-disclose the information to any party without further consent. I also understand refusing to sign this consent will not prevent my child from receiving care at [redacted] CLINIC, but it could make care coordination and scheduling appointments more difficult.

Approval: _____
Printed Name Signature Date

_____ _____
Date Relationship to Student Area Code and Phone Number

ROI AISD [redacted] 02.23.2018

APPENDIX B

CONSENT TO RECEIVE SERVICES

STATEMENT OF GENERAL CONSENT TO RECEIVE SERVICES

[redacted] CLINIC

Patient Name: _____
Birth date: _____ **SSN:** _____

The behavioral health-related services at [redacted] Clinic are provided by licensed and certified mental health professionals including; licensed psychologists, licensed clinical social workers and licensed professional counselors. [redacted] Clinic serves as a training site for students in clinical training, such as graduate students in psychology and social work, and trainees' work is directly supervised by a licensed clinician such as a licensed psychologist. Trainees will identify themselves as trainees and will clearly communicate who is their supervisor. You have the right to inquire fully about the credentials, education, and experience of your therapist and to have your questions answered to your satisfaction. [redacted] Clinic also conducts research on school mental health programs.

Description of Services

At [redacted] Clinic we provide individual, group and family therapy services for children and adolescents referred for behavioral, emotional and social concerns. Consultation with individuals from a young person's school is likely in order to assist in implementing effective support strategies. The therapist will work to provide the most effect treatment possible. The treatment approach and goals will be individually based and developed in collaboration with you and your child. Response to therapy is different for each person and should be discussed on an ongoing basis with the therapist.

Confidentiality

Currently, both law and professional ethics require therapists to maintain complete confidentiality in the vast majority of cases. In these cases, the therapist cannot release any information about your family without your expressed permission. There are some exceptional circumstances in which therapists are required to communicate information about therapy to persons outside the family. These exceptions include the following situations:

- The client presents a clear and present danger to himself or herself and refuses to accept appropriate treatment.
- The client communicates to the therapist a threat of physical violence against a clearly identified or reasonably identifiable victim, or the therapist has a reasonable basis to believe there is a clear and present danger of physical violence against such a victim.
- The client introduces his or her mental condition as a defense in a legal proceeding.
- The client initiates legal action against the therapist.
- The therapist has grounds to believe a child under the age of 18 or an elderly person (over age 60), or a handicapped adult, has been, or is at risk of being abused or neglected.

- The therapist has reason to believe that a child was prenatally exposed to a potentially addictive or harmful drug or controlled substance.
- The therapist has reason to believe a health care professional has engaged in professional misconduct.
- A judge orders the therapist to release client information.

In an effort to maintain best practice approaches at [redacted] Clinic, we consult with each other on treatment plans and progress. Consultation and supervision discussions may include your child's treatment. Anyone involved in such discussions is legally required to keep your child's information confidential.

Fees and Payment

Your fee will be discussed with you prior to the first session. We request that you pay your fee according to the arrangements that have been decided with your therapist. We accept cash, personal checks, cashier checks, major credit cards. Returned checks will incur a $25 fee. We reserve the right to charge a no-show fee for missed appointments without previous cancellation notice. Please keep in mind that if your therapy is court-ordered, you may incur additional fees due to report writing, phone consultations, etc.

Electronic Communication and Social Media Use

[redacted] Clinic cannot ensure the confidentiality of any of communication through electronic media, including text messages. Please also be advised that any email sent to your therapist via computer in a work-place environment is legally accessible by an employer. [redacted] Clinic requests that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. Please note, there may be a delay in response to messages sent outside of regular business hours. In these instances, please contact community mental health resources, or in an emergency call 911.

Additionally, our therapists do not accept friend or contact requests from current or former clients or their family members on any social networking site (Facebook, Snapchat, LinkedIn, etc.) as this can compromise confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this policy, please bring them up with your therapist.

Emergencies

Although we frequently check our messages, we may not be available if you urgently need to speak with someone. If an emergency arises, you can dial 911 or go to the nearest emergency room. In addition, Psychiatric Emergency Services (PES) offers 24-hour confidential crisis counseling over the telephone as well as in person: 512-472-4357.

Complaints

If you have a concern or a problem with your treatment, we hope that you would feel comfortable addressing it directly with your therapist or [redacted]. However, if that is not the case, it is

important for you to know that you can file a complaint with the Texas State Board of Examiners of Psychologists. They can be reached at (512) 305-7700.

Program Evaluation and Research

[redacted] **Student ID #**_____

Our agency conducts research and evaluation to better understand how we can improve our services. Vida Clinic will use your student's ID # in order to evaluate and research our programs and/or interventions as related to student school functioning. We will use student ID numbers to access [redacted] ISD information about our participants' attendance, discipline and academic achievement. We also ask that parents, teachers and youth complete periodic surveys that help us to better understand student behavior and emotional functioning. At times, we partner with other agencies to conduct research and evaluation, and no personally identifying information is ever associated with the data shared.

I understand the information in this form, and I voluntarily request and consent to the services of this clinic for myself or the minor I am accompanying. I understand that I will have the opportunity to discuss with my Vida Clinic provider the nature and purpose of recommended treatment or procedure(s), as well as alternative methods.

I understand that the information I provide to the [redacted] Clinic is confidential and will generally be released to others only by my written consent. I have been informed, however, that the therapist is required to disclose confidential information without my consent in certain circumstances that include those situations described above.

I understand that [redacted] Clinic conducts research on their program, that data associated with my treatment may be shared with a third party agency to evaluate programming , and that personally identifying information will always be kept confidential.

I understand this consent is valid until revoked in writing, which I may do at any time.

_____

Signature of Consenting Adult (Patient is a minor) Today's Date

_____

Signature of Patient

_____

Printed Name of Patient

APPENDIX C

REFERRAL FOR STUDENT SERVICES

[redacted] SCHOOL MENTAL HEALTH CENTER
REFERRAL FOR STUDENT SERVICES

NOTE: SMHC Referral Form is to be completed by [redacted] Staff, not parent/ guardian. Parent/Guardian signatures are required to submit SMHC Referral to Referral Coordinator to then be submitted to SMHC Therapist.

Date of Referral: _____ **Date staffed by Campus CST:** _____

Referral by: _____ **Campus:** _____ **Referral**

Contact (phone /e-mail): _____

NOTE: [redacted] Staff - Prior to submitting completed referral form to ***Referral Coordinator*** *(please attach* ***current student schedule****,* ***signed Consent to Refer****, and* ***signed Authorization of Health Information****.*

Referral Coordinator Signature: _____ _____ **Date:** _____

Student's First Name: _____ **Last Name:** _____
Student ID #:_____ **Current Grade:** _____

Administrator: _____ **Counselor:** _____

Does student receive Special Education Services? ☐ Yes ☐ No ☐ 504 Accommodations

Date of birth: _____ / _____ / _____ **Age** _____ **Gender:** Female ☐ Male ☐ Other ☐

Ethnicity: ☐ Hispanic/ Latino ☐ Non-Hispanic/ Latino

Race: ☐ American Indian ☐ Asian ☐ Black/ African American ☐ Pacific Islander ☐ White

Parent/ Legal Guardian Name: _____ **Preferred Language:** _____

Address: _____ **City:** _____ **Zip code:** _____

Phone #s **Home** _____ **Work** _____ **Cell**_____

Does family/ student have health insurance? ☐ **Yes** _____ ☐ **No** ☐ **Unknown**
Regardless of insurance status, SMHC will work with family prior to intake to determine payment options.

Does the student have any other medical conditions/concerns/ diagnoses? ☐ **Yes** (Explain) ☐ **No**
_____
_____

Is the student currently taking any medication? ☐ **Yes:** _____ ☐ **No** ☐ **Unknown**

Other agency involvement: ☐ **Yes** ☐ **No** **If yes, please explain:**
_____
_____
_____

Questions? Contact the [redacted] Department of Comprehensive Health Services at [redacted].
Revised Sept 1 2017

[redacted] SCHOOL MENTAL HEALTH CENTER
REFERRAL FOR STUDENT SERVICES

Behavioral/ Physical/ Social-Emotional Health Information

Please indicate which of the following relate to the student's current overall health and/ or history.

- ☐ Self-injurious behavior (cutting, burning, etc.)
- ☐ Grief/ Loss (recent loss/ death OR terminally-ill family member/ friend/ caregiver)
- ☐ History of trauma (crime victim, witness of violence, child abuse, abusive relationship, refugee, etc.)
- ☐ Current or history of suicidal ideation (or past suicide attempt)
- ☐ Symptoms of depression (fatigue, loss of interest, isolation, or changes in appetite, mood, behavior)
- ☐ Symptoms of anxiety (excessive worry, avoidance, somatic complaints, panic attacks)
- ☐ Explosive behavior interfering with home and/ or school functioning (fighting, aggression, disregard of rules)
- ☐ Bullying, either target or perpetrator
- ☐ Sexual identity/ gender issues
- ☐ Irregular/ extreme eating behaviors (binging/ purging/ restricting, etc.)
- ☐ Substance use/ abuse/ experimentation, either illegal or prescription (consider age/ substance)
- ☐ Chronic health issues (fatigue, somatic complaints, pre-/diabetic, overweight, cancer, heart, etc.)
- ☐ Family disruptions (conflict, separation/divorce/remarriage, incarceration, CPS, homelessness, etc.)
- ☐ Issues related to life transitions (transition to new campus/ home, upcoming graduation)
- ☐ Pregnancy/ teen parent
- ☐ School-related issues (stress due to poor grades/ scores, lack of interest/ motivation, poor peer relationships)
- ☐ Attention problems affecting home and/ or school functioning
- ☐ Sudden / Increased high-risk behaviors

School-Related Information

Please indicate which of the following relate to the student's current academic performance and/ or history.

- ☐ Failing 2 or more core classes
- ☐ At least one discipline referral
- ☐ At least one disciplinary removal
- ☐ At least one teacher report of behavior concerns
- ☐ Attendance issues (5 or more within a grading period)
- ☐ At least one Stay Away Agreement

NOTE: Appropriate referrals must meet at least one criterion in each category. Referrals will be prioritized by date received, number of criteria met, and severity of issues.

Please indicate which of the following interventions have been tried/ implemented prior to this referral.

- ☐ Grade level counselor involvement
- ☐ Parent conference – *Date/ Staff:* _____
- ☐ Home visit – *Date/ Staff:* _____
- ☐ Referral to CIS – *Is student CIS Case Managed? Yes / No*
- ☐ Referral to other school-based program: (CARY, Safeplace, FRC, etc.)
- ☐ Referral to Dropout Prevention Specialist
- ☐ Contact with Juvenile Probation Officer (if court involved)
- ☐ Referral(s) to other community agency(ies): _____
- ☐ Other: _____

Additional Information, which may be helpful for School-Based Therapist:

_____
_____
_____
_____

Questions? Contact the [redacted] Department of Comprehensive Health Services at [redacted]
Revised Sept 1 2017

[redacted] SCHOOL MENTAL HEALTH CENTER
REFERRAL FOR STUDENT SERVICES

CONSENT TO REFER STUDENT FOR SERVICES

The agreement below is to be signed by the youth's parent/legal guardian. The signature indicates the parent/legal guardian's consent to be contacted by a School Mental Health Center provider and allows for communication between the referring entity and the provider.

I _____, agree to allow _____ [redacted] _____ to provide information to and receive information from the School Mental Health Center provider regarding my child, _____, and family. I am further consenting to be contacted by the School Mental Health Center provider so I can be provided additional information regarding how this program can serve my child and family.

_____ _____
Parent/ Legal Guardian Signature Date

_____ _____
Preferred telephone number E-mail (Optional – Only for office use)

El padre de familia o custodio legal tiene que firmar el acuerdo a continuación. Al firmar, el padre o custodio indica que está de acuerdo en que el proveedor del Centro de la Salud Mental Escolar se comunique con él y permite la comunicación entre la entidad remitente y el proveedor.

Yo, _____, estoy de acuerdo en permitir que _____ [redacted] _____ dé información sobre mi familia y mi hijo, _____, al proveedor del Centro de la Salud Mental Escolar y la reciba de este. Además, doy mi consentimiento para que el proveedor del Centro de la Salud Mental Escolar se comunique conmigo para darme información adicional sobre la forma en que este programa puede ayudar a mi hijo y a mi familia.

_____ _____
Firma del padre de familia o custodio legal Fecha

_____ _____
Número de teléfono preferido Correo electrónico (opcional)

Questions? Contact the [redacted] Department of Comprehensive Health Services at [redacted].
Revised Sept 1 2017

[redacted] SCHOOL MENTAL HEALTH CENTER
REFERRAL FOR STUDENT SERVICES

Austin ISD Partner/Provider Organization Name: [redacted]
Student ID: (**Note:** If unknown, [redacted] can obtain student ID from [redacted] ISD's central office)
Student Name: **DOB:**
Campus Name:
Grade Level:

- [redacted] Clinic requests your permission for ongoing access to data about your student from [redacted] ISD. [redacted] Clinic will collect the data for the duration of your student's participation in the [redacted] Clinic program.
- [redacted] Clinic will be granted permission to view your student's data in [redacted] ISD's electronic data system. The following specific data will be viewed by the authorized [redacted] Clinic staff:

  - **Demographics** – 11-digit TEA identification number, date of birth, age, gender, ethnicity, grade level, AISD enrollment dates, and types of services received, English Language Learner (ELL) flag and retained flag.
  - **Attendance** (current and previous school year) – days enrolled, date absent, absence reason and dates tardy.
  - **Grades** (current and previous school year) – teacher's names, courses, grades, teacher comments, personal development scores, missing assignments, HS graduation date, HS endorsement track, credits attempted (HS only), credits earned (HS only), class rank (HS only) and cumulative GPA (HS only).
  - **Discipline** (for all the years enrolled in [redacted] ISD) – dates, reasons, actions and incident location.
  - **Standardized Test Scores** – District, State and National standardized tests (For example – STAAR, American College Testing (ACT) etc.)
  - **Interventions and Services** as documented by [redacted] ISD staff.

- In addition, [redacted] Clinic will be able to generate group reports of all participants' average attendance, discipline and academic achievement.
- [redacted] ISD and [redacted] Clinic will share information about your student's attendance in the program.

- I understand that the data access will be granted to the authorized [redacted] Clinic staff. Each authorized staff is responsible to maintain the confidentiality of his or her login and password and may not share access with any other individual.
- I understand that this data will be used to provide individualized services to my student. Data may also be used, as approved, for the purpose of service tracking, grant reporting and/or program evaluation. No identifying data about my student will be published or distributed to third parties. Any reporting will be done in aggregate.
- I understand my consent is optional and I may choose to withdraw permission at any time.
- I understand sharing my student's data with [redacted] Clinic is not a requirement to participate in [redacted] Clinic's programs.

Parent's/Guardian's Signature _____ Date _____

_____
Parent's/Guardian's Printed Name

Questions? Contact the [redacted] Department of Comprehensive Health Services at [redacted]
Revised Sept 1 2017

[redacted] SCHOOL MENTAL HEALTH CENTER
REFERRAL FOR STUDENT SERVICES

[redacted] ISD Partner/Provider Organization Name: [redacted]

Identificación del estudiante:

(Nota: Si no lo sabe, [redacted] Clinic puede obtenerlo en las oficinas centrales del [redacted] ISD)

Nombre del estudiante:

Nombre de la escuela:

Grado:

- [redacted] Clinic solicita su consentimiento para tener acceso continuo a la información del [redacted] ISD de su hijo. [redacted] Clinic recopilará la información durante el tiempo que su hijo esté participando en el [redacted] Clinic programa.
- [redacted] Clinic tendrá autorización para ver la información de su hijo en el sistema electrónico de datos del [redacted] ISD. Personal autorizado de [redacted] Clinic podrá ver la siguiente información específica:

- **Datos demográficos** – número de identificación de 11 dígitos de la TEA, fecha de nacimiento, edad, género, origen étnico, grado escolar, fechas de matrícula en el [redacted], tipos de servicios recibidos, clasificación como aprendiz del idioma inglés (ELL) y clasificación como retenido.
- **Asistencia** (actual y del año escolar anterior) – días en que el estudiante ha estado matriculado en la escuela, fecha de las ausencias, motivo de las ausencias y fecha de los retrasos.
- **Calificaciones** (actuales y del año escolar anterior) - nombres de los maestros, cursos, grados, comentarios de los maestros, puntaje relacionado con el desarrollo personal, tareas no entregadas, fecha de graduación de la preparatoria, trayectoria de especialización en la preparatoria, materias/créditos cursados y no obtenidos (solo preparatoria), créditos obtenidos (solo preparatoria), rango
- **Disciplina** (durante todos los años que el estudiante haya estado matriculado en el [redacted] ISD) – fechas, motivos, medidas adoptadas y lugar del incidente.
- **Puntaje en las pruebas estandarizadas** – pruebas estandarizadas a nivel de distrito, estatal y nacional (por ejemplo – *STAAR, American College Testing (ACT)* etc.)
- **Intervenciones y servicios**-tal como esta documentado por el personal del [redacted] ISD.

- Además, [redacted] Clinic podrá generar informes grupales de la asistencia promedio, disciplina y logro académico de todos los participantes.
- El [redacted] ISD y [redacted] Clinic compartirán información de la asistencia de su hijo al programa.

- Entiendo que se permitirá el acceso a la información al personal autorizado de [redacted] Clinic . El personal autorizado es responsable de mantener la confidencialidad de su clave de acceso y contraseña y no puede compartirla con ninguna otra persona.
- Entiendo que esta información será utilizada para proporcionar servicios individualizados a mi hijo. La información también será utilizada, conforme sea aprobado, con la finalidad de dar seguimiento de los servicios que recibe, informe sobre subvenciones y/o evaluación del programa. No se publicará o distribuirá a terceras personas información que identifique a su hijo. Todos los informes se harán en conjunto.
- Entiendo que mi consentimiento es opcional y que lo puedo retirar en cualquier momento.
- Entiendo que compartir la información de mi hijo con [redacted] Clinic no es un requisito para participar en los programas de [redacted] Clinic.

Firma del padre/madre o tutor legal

Fecha

Nombre escrito en letra de molde del padre/madre o tutor legal

Questions? Contact the [redacted] Department of Comprehensive Health Services at [redacted]

Revised Sept 1 2017