GRANT PROPOSAL TO CONDUCT A NEEDS ASSESSMENT FOR COMMUNITY-

BASED PARTNERSHIP OPPORTUNITIES IN THREE OREGON HIGH SCHOOLS

TO ADAPT THE MOBILE MENTAL HEALTH COMMUNITY RESOURCES

by

BRENDA L. KLEINFELDER

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Student: Brenda L. Kleinfelder

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This dissertation has been accepted and approved in partial fulfillment of the requirements for the Doctor of Education degree in the Department of Educational Methodology, Policy, and Leadership by:

Jo Smith, Ph.D.	Chairperson
Jean Kjellstrand, Ph.D.	Core Member
P. Shawn Irvin, Ph.D.	Core Member
Kent McIntosh, Ph.D.	Institutional Representative

and

Janet Woodruff-Borden	Vice Provost and Dean of the Graduate School

Original approval signatures are on file with the University of Oregon Graduate School.

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DISSERTATION ABSTRACT

Brenda L. Kleinfelder

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Title: Grant Proposal to Conduct a Needs Assessment for Community-Based Partnership Opportunities in Three Oregon High Schools to Adapt the Mobile Mental Health Community Resources

This dissertation presents a grant application for the Spencer Foundation Small Research Grants Program to secure funding for the development of a needs assessment for the comprehensive mapping and analysis of state, school, and community-owned resource partnership opportunities needed to adapt the Mobile Mental Health Community Resources (MMHCR), a school-based mental health service. The proposed needs assessment will be conducted in three high needs high schools located in three geographically and demographically diverse locations in Oregon. School-based mental health services are an important point of contact for adolescents facing symptoms of untreated trauma including emotional and behavioral difficulties, sexually risky behavior, substance use, and academic problems. The needs assessment will provide policymakers and practitioners recommendations for determining how best to implement school-based mental health services for educational equity and school improvement purposes. In addition, adapting MMHCR services to match the culture and context of schools can function on the "cutting edge" by providing creative partnership solutions beyond basic mental health concerns and understanding. Embedded in this proposal are the following research questions: What community resources and barriers to mental health services

exist in three Oregon *high needs* high schools? And, what are the key factors for the

MMHCR to leverage school and community resources to develop comprehensive,

multifaceted, and integrated mental health service approaches to address identified

barriers in three Oregon *high needs* high schools?

CURRICULUM VITAE

NAME OF AUTHOR: Brenda L. Kleinfelder

GRADUATE AND UNDERGRADUATE SCHOOLS ATTENDED:

> University of Oregon, Eugene
> California State University, Chico
> Modesto Junior College, Modesto

DEGREES AWARDED:

> Doctor of Education, Educational Methodology, Policy, and Leadership, 2019, University of Oregon
> Master of Education, Middle/Secondary Special Education, 2011, University of Oregon
> Bachelor of Arts, Geography and Telecommunications, 1988, California State University, Chico
> Associate of Arts, Photography, 1985, Modesto Junior College

AREAS OF SPECIAL INTEREST:

> Adolescent School-Based Mental Health

PROFESSIONAL EXPERIENCE:

> Research Assistant, New York University, New York, NY, 2018-Present
>
> Research Consultant, Teachers College, Columbia University, New York, NY, 2018-1019
>
> Special Education & Media Arts Instructor, Academy of Arts & Academics, Springfield, OR, 2011-2016

PUBLICATIONS:

Scalise, K., Irvin, P. S., Alresheed, F., Zvoch, K., Yim, H., Park, S., Landis, B., Meng, P., Kleinfelder, B., Halladay, L., & Partsafas, A. (2018). Accommodations in digital interactive STEM assessment tasks: Current accommodations and promising practices for enhancing accessibility for students with disabilities, *Journal of Special Education Technology, 33*(4), 219-236. doi:10.1177/016263418759340

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER I

INTRODUCTION

This grant proposal is directed to the Spencer Foundation Small Research Grants Program (see Appendix A). I will serve as the Principal Investigator and conduct the proposed project including data collection and analysis. Table 1 shows an overview of the project timeline, which will take 12 months complete and cost $50,000.

Table 1

Project Timeline

Study Phase	Months 1-3	Months 3-6	Months 6-9	Months 9-12
Phase I – Create and Pilot Instruments	X			
Phase II – Recruit Schools		X		
Phase III – Conduct Site Visits		X		
Phase IV – Analyze Data			X	X
Phase V – Disseminate Findings			X	X

The grant competition uses field-initiated research and allows me to draw upon the Mobile Mental Health Community Resources (MMHCR) pilot data collected in two charter high schools over the 2017-2018 academic year. The Spencer Foundation Small Research Grant Program RFP requirements include: (a) proposal summary, (b) proposal narrative, and (c) budget and timeline. The proposal narrative includes four parts: (a) a description of the project, the central research questions and their significance; (b) a brief summary of the relevant literature, the relationship of the proposed research to the literature, and the new knowledge expected to result from the proposed research; (c) a

summary of the conceptual framework, research methods, data collection instruments, and modes of analysis that the project will employ; and (d) identification of the principal investigator and definition of the role of the researcher and any supporting researchers will play.

Project Significance

The project aims to create a grant application for the Spencer Foundation Small Research Grant Program to secure funding for the development of a needs assessment for the comprehensive mapping and analysis of state, school, and community-based resource partnership opportunities needed to adapt the Mobile Mental Health Community Resources (MMHCR), a school-based mental health service. The proposed needs assessment will be conducted in three *high needs* (i.e. high rates of chronic absenteeism per Oregon ESSA Plan) secondary schools located in three geographically and demographically diverse regions in Oregon as determined by the Oregon Department of Education Student Resources [Coos (west-coastal), Jackson (southwest), and Wheeler (north-central) counties]. The needs assessment will provide policymakers and practitioners evidence of important factors (i.e. community-based resources and contextual barriers) for determining how best to implement school-based mental health (SBMH) services to meet student needs, including adapting the MMHCR services to match culture and context of schools. Evidence may help such programs to function on the "cutting edge" by providing creative partnership solutions beyond basic mental health concerns and understanding, thus providing an understanding of if/how the MMHCR model can be used across diverse school settings.

The grant uses field-initiated research and draws upon MMHCR pilot data collected in two charter high schools in 2018 for school improvement purposes. Pilot results indicated the need for a study in select Oregon schools to examine school and community resource capacities and assets for potential partnerships for SBMH services. In the proposed grant, I will use a qualitative research approach to build on pilot data, which is mostly quantitative. Additionally, the Spencer Foundation grant competition favors a multi-disciplinary research approach, which is a good match for my study given that the work spans areas in secondary education, special education, mental health, adolescent psychology, social geography, and community development. The grant competition notes that the award is suitable for early career scholars; if successful, this grant would meet my post-doctorate goals.

Study Background

More than half of all children in the United States are exposed to trauma through victimization or eye-witnessing traumatic events, with approximately one in five children developing a mental health disorder that can cause severe lifetime impairment if left untreated (Larson, Chapman, Spetz, & Brindis, 2017). Children and adolescents facing symptoms of untreated trauma are more likely to experience emotional and behavioral difficulties, sexually risky behavior, substance use, and academic problems, but up to 70% do not receive needed mental health services (Chandra & Minkovitz, 2006; Larson et al., 2017). Schools can be an important point of contact for providing access to prevention services (Adelman & Taylor, 2014), and thus, expanding SBMH services has the potential to increase health equity for underserved at-risk youth and reduce barriers

for children and adolescents seeking care (Larson et al., 2017; Richardson, Morrissette, Zucker, 2016).

SBMH services. SBMH services are those delivered by state-owned Community Care Organizations (CCOs) and school and community-based providers in school buildings (Doll, Nastasi, Cornell, & Song, 2017). The World Health Organization defines *mental health* as a state of well-being in which the individual realizes their own abilities, can cope with the normal stress of life, can work productively, and is able to contribute to their community. On the contrary, *mental disorders* comprise a broad range of problems with different symptoms including schizophrenia, depression, intellectual disabilities, anxiety, and substance use disorders that inhibit well-being (World Health Organization, 2018). Importantly, most mental disorders are treatable, however, only 10% to 30% of adolescents and youth seek effective mental health treatments (Larson et al., 2017; Richardson et al., 2016).

Often, the first signs of mental disorders or emotional distress for adolescents emerges in the school environment (Doll, et al., 2017; Dryfoos, 1993; Lyon, Borntrager, Nakamura, & Higa-McMillan, 2013; Richardson et al., 2012). Often, the first signs of mental disorders or emotional distress for adolescents emerges in the school environment (Adelman & Taylor, 2014; McLeod, Uemura, & Rohrman, 2012). Nationally and in Oregon, public schools are reporting an increase of adolescents with mental health disorders (Pates, 2018; Paschall & Bersamin, 2017). SBMH services provide considerable advantages for students and school staff (Biolcati, Palareti, & Mameli, 2017; Doll et al., 2017; Dryfoos, 1993; Fazel, Garcia, & Stein, 2016; Lyon et al., 2013; McKeague, Morant, Blackshaw, & Brown, 2017; McLeod et al., 2012), and yet, most

schools do not have the capacity or adequate staff on site to respond to (or anticipate) situations that require skills in crisis intervention or evaluation (Richardson, et al, 2012). Schools provide a natural cost-effective opportunity to reach an entire school population, especially students receiving special education services, who are often underserved regarding mental health needs (Biolcati et al., 2017; Nabors, Proescher, & DeSilva, 2001). Schools can also connect students and their families to community resource supports (Adelman & Taylor, 2014; Fazel et al., 2016).

SBHC services in Oregon. In 1986, Oregon began piloting school-based health centers (SBHC) through partnerships between the Oregon Public Health Division, county public health departments, school districts, public and private groups, students, parents, and community members (OSBHA-SBHC Report, 2015). Today, Oregon operates a statewide network of 78 certified SBHC in 25 (of 36) counties across the state (Oregon Health Authority, 2018). According to the Oregon Health Authority (2018), SBHC services provide both primary health care and mental health. More specifically, SBHC services may include: well-child exams, diagnosis and treatment of chronic illnesses, treatment for minor injuries/illnesses, vision/dental/blood pressure screenings, vaccinations, alcohol/drug treatment and prevention, reproductive health, medication prescription, social support referrals, counseling and referral for mental health concerns, preventive health, and wellness messaging (Oregon Health Authority, 2018). Not all SBHC provide mental health services, but those that do have shown evidence of reducing, though not eradicating, mental health care disparities (Larson, Spetz, Brindis, & Chapman, 2017). The SBHC that do offer mental health services face a high demand compounded by a shortage of licensed child and adolescent therapists (Turban, 2017). In

addition, SBHC are reliant on their patients having health insurance coverage, which can be problematic for adolescents seeking confidential care (Ford, English, & Sigmar, 2004). The necessity for a parent to sign the insurance claim or furnish a Medicaid card significantly limits the confidentiality of services and might inhibit adolescents from seeking care (Ford et al., 2004). Mental health care costs and confidentiality can also serve as a health equity barrier for low-income, non-English speaking adolescents and families facing resident status insecurity (Amaral, Geierstanger, Soleimanpour, & Brindis, 2011; Cappella, Frazier, Atkins, Schoenwald, & Gilisson, 2008; Fazel et al., 2016). These mental health accessibility barriers can be particularly problematic for newly arrived refugee and asylum-seeking adolescents struggling to ease the effects of trauma that disrupt social functioning and academic focus needed for acculturation (Fazel et al. 2016).

The seriousness of student emotional distress is evidenced by the pervasiveness of child mental health disorders and suicide in Oregon (Paschall & Bersamin, 2017; Pates, 2018), which ranks 41 out of 50 states nationally in the prevalence of youth mental illness and low rate of access to care (Mental Health America, 2018). Students with untreated conditions often become chronically absent, perform low academically, exhibit disruptive behavior, and drop out of school (McLeod et al., 2012). In 2017, the Oregon State Legislature signed House Bill (HB) 2648 to address the growing epidemic of student mental health and trauma and lack of accessible care in Oregon. The bill distributes funding to school districts and education service districts providing school-based systems of trauma care for the purpose of decreasing school absenteeism (OR HB2648, 2017). Students with disabilities, including students with mental disorders, are most commonly

chronically absent with only 73 percent attending school regularly (Pates, 2018). HB 2648 limits districts to fund only traditional school-employed services and professional healthcare providers, including SBHC, social workers, and clinical psychologists (OR HB2648, 2017).

While passing HB 2648 was a positive step toward better serving students' mental health care support needs, shortcomings are evident. Notably, funding under HB 2648 does not include non-traditional community-based partnership options to provide culturally and contextually relevant SBMH services (Bell, Summerville, Nastasi, Patterson, & Earnshaw, 2015; Doll et al., 2017; Dryfoos, 1993). Non-traditional SBMH services (e.g., indigenous practices, the arts, recreation) have the potential to develop limited rural community mental health capacity through partnerships that adhere to cultural assets unique to a given community. Non-traditional approaches can creatively integrate mental health into the curriculum and reach students experiencing severe to mild disorders using innovative multitiered systems of prevention and intervention (Bell et al., 2015). For example, a filmmaking class can potentially integrate Language Arts Common Core State Standards (CCSS), Career Technology Education (CTE), and College and Career Readiness Skills (CCRS) with mental health through personal creative expression that builds social and academic connections. Embedding non-traditional community-based partnerships into SBMH and curriculum can increase the cultural relevancy of mental health for students, reduce stigma, and contextualize programs to support school personnel experiencing secondary traumatic stress (Bell et al., 2015).

With clear understanding the need for SBMH services in Oregon and the potential

for non-traditional, culturally-specific approaches to serve student mental health needs, I designed the Mobile Mental Health Community Resources (MMHCR), also driven, in part, by my "on-the-ground" experiences as a high school special education teacher (see Figure 1, below).
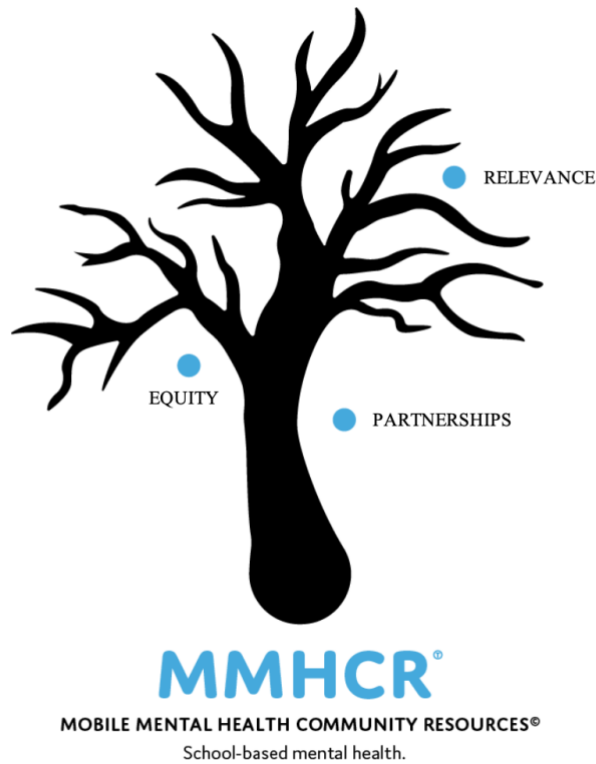
Figure 1. Three Cornerstones of the Mobile Mental Health Community Resources.

The MMHCR is a SBMH model designed to implement services for adolescents using culturally-specific, community-based partnerships contextualized to schools (Appendix B). I strategically designed the MMHCR to offer free services on a voluntary, drop-in basis, allowing students to get the help they need in *real-time*. Under Oregon law, minors 14 years of age or older can initiate healthcare services without parental consent (ORS 109.675). Confidential, free, and easy access to mental health care encourages students to view schools as a safe place to seek and find help and learn skills for self-care

(Adelmen & Taylor, 2014). Thus, the MMHCR was intended to provide opportunities for schools and school districts to encourage innovative community engagement through culturally-relevant partnerships and equitable solutions to school-based mental health. In this way, the MMHCR aimed to circumvent the shortage and availability of licensed child and adolescent therapists in Oregon (Pates, 2018; Turban, 2017), and increase health equity by removing cost and confidentiality barriers associated with SBHC and healthcare providers (Amaral, et al., 2011). Health equity barriers can lead to academic issues; students with untreated mental health conditions often become chronically absent, perform low academically, exhibit disruptive behavior, and drop out of school. The MMHCR aims to bridge the gap between health and academic equity.

MMHCR Preliminary Pilot & Results

In the fall of 2016, I facilitated a partnership between the charter high school where I was employed (School A), and a community-based health crisis non-profit to pilot the MMHCR. The health crisis response community partner was selected based on the similarities between the School A student population and the youth population the non-profit serves. In spring 2017, School A and the community partner preliminarily piloted the MMHCR every other Wednesday for two-hours after-school over a two-month period, or four days in total. The purpose of this preliminary pilot study was to examine level of participation and service request of students who self-sought services, and time of day they would be most likely to attend.

Free drop-in services were provided by a crisis counselor and medic every other week for two hours. Over the two-month pilot, survey data were collected by clinicians who used a 1 to 4 ordinal scale to rank the nature/level of service need requested by

students seeking help with: 1 = No request/information offered, 2 = Request for literature, 3 = Request for referral, and 4 = Request for on-site counseling (see Figure 2, below). Students were also asked what time of day they would be most likely to access the MMHCR (i.e. before, during, or after school).

Findings from the preliminary test pilot showed all student responses ($n = 4$) were at the high level, that is, the students reported needing on-site counseling support. Additional findings showed sustained contact time (60 minutes on average), with students listing their primary concerns as suicidal ideation, depression, and anxiety. Participants indicated they would be more likely to access the MMHCR services during school hours. In addition, in late spring 2017, the MMHCR was implemented at a second charter high school (School B) in a nearby district, using the same community partner. The preliminary pilot from School A was replicated in School B over four sessions with results showing a high level of requests from students ($n = 4$), with a preference for access to the MMHCR services during school hours. The findings prompted stakeholders from School A and School B to fund and increase the number of MMHCR services to weekly throughout the duration of the 2016-2017 academic year.

Direction of increased level of service request

Students and community members	Service Request

HIGH
1. Students needing on-site counseling support (under 18).
2. Community needing on-site counseling support.

Request for on-site counseling.

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MID-RANGE
1. Students needing referral for crisis support.
2. Community needing referral for crisis support.

Request for referral specific to crisis need: homelessness, domestic abuse, substance abuse, mental health.

LOWER LEVEL
1. Students wanting crisis support literature information.
2. Community wanting crisis support literature information.

Request for crisis literature information: homelessness, domestic abuse, substance abuse, mental health.

LOW
1. Students on-site to browse.
2. Community on-site to browse.

No request. General information offered.

Direction of decreased level of service request

Figure 2. Mobile Mental Health Community Resource Preliminary Pilot Assessment Construct Map.

Field-Initiated Research: MMHCR 2017-2018 Pilot Study & Results

Over the 2017-2018 academic year, School A continued the weekly two-hour

MMHCR services during the last hour of school and one hour after school. School B

implemented the MMHCR every Tuesday for two-hours (during school hours). Both

schools chose to continue with the same community partner used in the preliminary pilot.

The purpose of the 2017-2018 pilot study was to examine and evaluate the

implementation of the MMHCR in two high-needs charter secondary schools in Western

Oregon. The pilot study utilized a culturally relevant conceptual framework, called the

Participatory Culture-Specific Intervention Model (PCSIM), to evaluate implemented

SBMH programs using community-based partnerships (Doll, et al., 2017; Nastasi &

Hitchcock, 2016). Embedded in PCSIM is the Comprehensive Mixed-Methods

Participatory Evaluation (CMMPE), a conceptual model that uses stakeholders to

evaluate cultural relevancy and program success (Appendix C). Nastasi & Hitchcock

(2016) explain that the CMMPE is based on multiple assumptions: (a) program success is

dynamic and multidimensional; (b) the definitions and perspectives of program success

are likely to vary among stakeholders; (c) program evaluation has multiple purposes;

(d) comprehensive program evaluation requires mixed qualitative-quantitative methods;

(e) comprehensive program evaluation requires participation of stakeholders; and (f)

comprehensive program evaluation requires advanced planning and is integral to program

implementation (p. 83-84). As illustrated in Appendix C, within these assumptions, the

multiple dimensions of program success include eight stakeholder groups, including

agency staff, program recipients, program developers, administrators/policy makers,

researchers/evaluators, community members, funders, and program implementers. The

seven evaluation criteria of success listed in Appendix C are designed for formative

and/or summative assessments as part of the implementation process and guide

researchers in formulating relevant evaluation questions. The CMMPE was used to

construct a summative student self-report assessment of the MMHCR using three criteria

from the full conceptual model to understand cultural relevancy and program success: (a)

social validity – the cultural relevance of program goals and outcomes to the target group;

(b) *institutionalization* – the capacity of the organization to continue program efforts over

time and the extent to which the program has become integral to the system; and (c)

program acceptability – the extent of student support for the program which facilitates its

implementation and sustainability (Nastasi & Hitchcock, 2016). Student and staff self-

report surveys were designed to align with the CMMPE (Nastasi & Hitchcock, 2016), to

evaluate cultural relevancy and program success of the MMHCR using a community-

based partner. The student self-report survey from the field-initiated pilot conducted in

both schools is shown in Appendix D, with the results informing the research design for

the current proposal.

Table 2 shows the self-reported mean approval rating of the MMHCR service for

students in School A (A) and School B (B) based on the three CMMPE criteria described

above. Based on the dichotomous no/yes response options (transformed quantitatively as

proportions ranging from 0 = no, to 1 = yes), students in both schools reported a low rate

of personal relevance to MMHCR services (*social validity - personal*): $M = 0.32$ (A); $M

= 0.47$ (B). In comparison, students reported a high rate of school-wide relevance to

MMHCR services in both schools (*social validity - school*): $M = 0.95$ (A); $M = 1.00$ (B).

Students at the two schools reported preference differences for time of service

(*institutionalization*) for the MMHCR: $M = 0.54$ (A) after school; $M = 0.73$ (B) during school. Students reported high rates of *program acceptability* in both schools: $M = 0.74$ (A); $M = 0.85$ (B).

Table 2

Mean Approval Rating of the MMHCR Service for Students in Two Schools

Success Criteria	School A (*n* = 149)	School B (*n* = 42)
Social validity		
Personal relevancy	0.32	0.47
School relevancy	0.95	1.00
Institutionalization		
Before school	0.07	0.07
During school	0.49	0.73
After school	0.54	0.41
Program acceptability	0.74	0.85

Note. Adapted from Nastasi and Hitchcock (2016).

Table 3 shows the self-reported mean approval rate of the MMHCR service for staff in School A and School B. The staff self-report survey from the field-initiated pilot conducted over the 2017-2018 academic year in School A and School B is shown in Appendix E, with the results informing the study design for the current proposal. The staff self-report summative assessment of the MMHCR used three CMMPE criteria for evaluating the program's success: (a) *program acceptability* – the extent the staff support the program (specific to meeting student need and trauma reduction) to facilitate its implementation and sustainability; (b) *sustainability* – the extent to which implementers can continue the program and have the needed skills and motivation to sustain the

14

program (specific to infrastructure capacity and program commitment); and (c)

implementer competence – the critical knowledge, attitudes, and skills of the implementer

to implement the program with integrity and adapt the program to meet the cultural and

contextual needs of the recipients (Nastasi & Hitchcock, 2016).

Staff in both schools reported a high rate of MMHCR *program acceptability*

related to meeting student need: $M = 0.95$ (A); $M = 0.89$ (B). In addition, staff reported a

reduction in student trauma (*program acceptability*): $M = 0.94$ (A); $M = 1.00$ (B). Staff in

School A reported slightly lower infrastructure capacity required to sustain the MMHCR

(*sustainability*; $M = 0.88$) compared to staff in School B ($M = 1.00$). Staff commitment

for sustaining the MMHCR rated high in both schools (*sustainability*): $M = 0.96$ (A); $M =$

1.00 (B). *Implementer competency* in School A rated slightly lower ($M = 0.92$) than in

School B ($M = 1.00$).

Table 3

Mean Approval Rating of the MMHCR Service for Staff in Two Schools

Success Criteria	School A (*n* = 25)	School B (*n* = 9)
Program acceptability		
Meets need	0.95	0.89
Trauma reduction	0.94	1.00
Sustainability		
Infrastructure capacity	0.88	1.00
Program commitment	0.96	1.00
Implementer Competence	0.92	1.00

Note. Adapted from Nastasi and Hitchcock (2016).

Field-initiated research pilot key findings. Key findings from the self-report surveys for students and staff in the two pilot schools inform the study design in the current grant proposal. First, the inconsistency of lower percentages of students reporting *personal relevancy* versus higher percentages of *school-wide relevancy* of the MMHCR may be consistent with Zeifman et al.'s (2015) study of self-stigma among high school students seeking mental health services that examined whether adolescents with high perfectionism are prone to experiencing self-stigma as a barrier to seeking psychological help. Zeifman and colleagues' findings indicated that students with no prior exposure to persons with mental illness significantly associated self-oriented perfectionism with self-stigma. Thus, it appears important that the proposed study examine student perception of barriers and stigma influencing individual self-help seeking behaviors, or student prior experience with mental health.

Second, the staff's high approval rating of *program acceptability* and *competence of implementer* in both schools may have positively influenced student perception and acceptance of the MMHCR services in *school-wide relevancy*, but not *personal relevancy*. Biolcati et al.'s (2017) study of school-based counseling services on adolescent help-seeking behavior explored the strategies used by school prevention programs to overcome barriers to individual counseling. Biolcati et al.'s findings suggest that an "open-minded culture" in schools concerning help-seeking behavior will de-stigmatize mental health programs if consistently implemented over multiple years. Even still, Jaycox et al.'s (2006) study of challenges in implementing and evaluating school-based prevention and intervention programs on sensitive topics for adolescents found implementation problems were associated with: (a) implementer lack of knowledge about

16

the cultures within the schools, (b) implementer lack of knowledge about school systems, and (c) programmatic competition with existing school priorities. Thus, it appears important that the proposed study consider student and staff perceptions of community partners to hold critical knowledge and skills needed to implement the MMHCR , student perceptions of culture-specific and contextualized intervention on positive attitudes, and administrator perceptions of school priorities and the MMHCR capacity for school improvement, including the reduction of secondary traumatic stress on staff. It may also be important that the proposed study explore perceptions of community resource partner knowledge of school systems and cultures.

Last, the staff reported high *program acceptability* for the MMHCR in meeting student need and reducing trauma in both schools, but this finding is not consistent with students' report of its low *personal relevance*. McKeague et al. (2017) looked at black minority and ethnic adolescents in London, U.K. public schools and found hard-to-reach students may not understand their problems in the same way as SBMH providers. McKeague et al. (2017) found students may struggle to engage in interventions even after overcoming barriers associated with accessing them. Their research further suggests the importance of stakeholders (e.g. students and school staff) fully understanding the nature of the intervention and the value of participation to increase acceptability and sustainability. Thus, it appears important that the proposed study needs to accurately gauge both student and staff perceptions of SBMH services prior to implementing a community partnership like the MMHCR. These inconsistent perceptions might indicate a cultural disconnect between the community service provider and students, or indicate barriers and stigma related to student gender and cultural perception, or limited

17

experience with and knowledge of mental health. The inconsistency may also mean a lack of professional development surrounding culturally-specific trauma-informed care, or low staff buy-in to the MMHCR and/or community partner. The next section reviews the current literature base that informs understanding of current SBMH services, practices, and gaps in the research.

CHAPTER II

LITERATURE REVIEW

I began my process by searching for peer-reviewed articles focused on: (a) the association between school improvement and school-based mental health, (b) an examination of SBMH systems, and (c) evaluation of SBMH intervention and prevention. To access more articles targeting key words related to my research questions, I expanded the themes to encompass (a) chronic absenteeism associated with mental and behavioral health, (b) SBHC/SBMH for adolescents related to stigmas, barriers, frameworks, school culture, school staff secondary trauma/stress, and (c) evidence-based assessments used to evaluate SBMH community partnership prevention and intervention services for adolescents. I defined *adolescents* as students between the ages of 14 to 18. I then narrowed the inclusion criteria of my literature review to include, *adolescent help-seeking behavior, school improvement outcomes, teacher secondary trauma,* and *cultural barriers and stigma,* and *evidence-based assessment for school-based mental health.* I summarize the results of the literature review based on three themes and accompanying main effects measured: (a) Theme 1: the association between school improvement to SBMH, including help-seeking behavior and academic outcomes; (b) Theme 2: SBMH systems in particular conditions specific to staff secondary stress, barriers and stigmas,

and culture-specific intervention; and (c) Theme 3: SBMH intervention and prevention programs, specifically procedures related to implementation and evaluation. A total of 12 peer-reviewed articles are included in the literature review for this grant proposal dissertation.

Theme 1

      Help-seeking behavior. Five of the 12 studies selected for review provided insights into the impact of SBMH on school improvement through help-seeking behaviors. Biolcati et al. (2017) found student help-seeking behavior was related to confidence in a counselor's ability to build a relationship, be accessible, and possess good listening skills. In addition, counselors' positive attitudes at school and years of continuity increased their credibility with students. McKeague et al.'s (2017) study of black, minority, and ethnic adolescents in London, U.K. urban public schools found hard-to-reach students may not understand their problems in the same way as SBMH providers, and, as a result, students may struggle to engage in interventions even after overcoming barriers associated with accessing them. McKeague and colleagues found the importance of stakeholders (e.g., students and school staff) fully understanding the nature of the intervention and the value of participation increased SBMH program acceptability and sustainability (McKeague et al., 2017). Paschall and Bersamin's (2017) study of SBMH services on suicide risk and substance use among at-risk adolescents in Oregon found that an increase in availability of SBMH services was associated with a significantly lower likelihood of suicidal ideation and suicide attempts, and decreased frequency of cigarette, marijuana and prescription drug use over 30-days relative to other public schools without such services.

Four of the 12 studies found girls report a wider use of SBMH services than boys (Biolcati et al., 2017; Chandra et al., 2006; McKeague et al., 2017; Paschall & Bersamin, 2017). The 2015 Oregon Health Teen Survey (OHT) indicate that 35% of girls reported using the SBHC at least once in the past year compared to 28% of boys (Paschall & Bersamin, 2017). Chandra et al.'s (2006) study of gender differences and parental influences on adolescent mental health help-seeking attitudes found that among eighth graders who turned to a parent for help versus their peers, boys were less willing to use mental health services compared to girls. Boys also scored lower than girls in mental health knowledge and had limited experience relative to girls in helping someone with an emotional concern.

Academic outcomes. Two studies looked at the relationship of SBMH to academic outcomes. Fazel et al.'s (2016) study of adolescent student refugees found schools offered a trusted location for mental health services and provided access to community support services. Additionally, the role of teachers was important to support students' social and academic integration. McLeod et al.'s (2012) study found that externalized problems such as attention disorders, delinquency, and substance use were associated with earning a lower GPA, but that depression was not. Youth who experienced co-occurring problems had lower GPAs than youth who experienced only one problem. However, low GPA associated with substance use was not significantly diminished when adding depression, attention problems, or delinquency.

Theme 2

Staff secondary traumatic stress. Two of the 12 studies examined the impact of secondary stress on adult school staff. Borntrager et al.'s (2012) study of secondary

traumatic stress (STS) among school staff members from six schools found high levels of reported STS. Despite this, the Borntrager and colleagues found comparable job satisfaction and job burnout rates relative to national averages. Caringi et al.'s (2015) follow-up qualitative study to Borntrager et al.'s (2012) study conducted 256 school staff interviews and found that 75% of participants had thoughts of changing careers, or were actively planning to retire, or move to a new placement. The findings illustrated the need for systematic policy reform to respond to high attrition rate and organizational structures that serve as contributing factors to STS. Caringi and colleagues also found that interventions targeting STS in school personnel would benefit from team-based collaborative program development, which is consistent with the positive impact of peer support in Borntrager et al.'s (2012) study. Additional findings from Caringi et al.'s (2017) study included individual treatment by community-employed professional healthcare services and traditional cultural practices or spirituality to be appropriate interventions for mitigating STS and building positive coping skills.

Barriers and stigmas. Six of the 12 studies examined barriers and stigmas associated with access to mental health services for adolescents who may need support (Biolcati et al., 2017; Chandra et al., 2006; Doll et al., 2017; Fazel et al., 2016; McKeague et al., 2017; Zeifman et al., 2015). Zeifman et al.'s (2015) study of self-stigma among high school students seeking mental health services examined whether adolescents with high perfectionism were prone to experiencing self-stigma as a barrier to seeking psychological help. The study found that students who associated with self-oriented perfectionism were more likely to self-stigmatize if they had no prior exposure to persons with mental health conditions (Zeifman et al., 2015). Biolcati et al. (2017)

study of school-based counseling services on adolescent help-seeking behavior explored the strategies used by school prevention programs to overcome barriers to individual counseling and ascertain if services reached the most vulnerable or problematic adolescents. The scores related to stigma and embarrassment were low across the sample, with very few differences between subgroups (i.e., gender, type of school, nationality, help-seeking behavior). Biolcati and colleagues argued that schools' "open-minded culture" concerning help-seeking behavior would de-stigmatize mental health programs if consistently implemented over multiple years.

Culture-specific intervention. Bell et al.'s (2007) study using the PCSIM to promote psychological well-being in an urban school found implementing multitiered systems of support in school settings resulted in program abandonment due to an inattention to local priorities and culture. Doll et al.'s (2017) study of models of effective SBMH services and practices found that school psychologists could foster school-agency partnerships to coordinate and implement SBMH services that are comprehensive, child centered, family focused, and culturally competent. Fazel et al.'s (2016) study of SBMH service locations for refugee adolescents found that teachers play a valuable role in bridging cultures and mediating contact with SBMH services for students with no immediate family to assist them through the mental health services process (Fazel et al., 2016). Jaycox et al.'s (2006) study of the challenges in evaluating and implementing school-based prevention and intervention programs on sensitive topics for adolescents found that a program implementer's lack of knowledge about the school culture and school systems is associated with problems in SBMH implementation.

Theme 3

  Program implementation and evaluation. The Jaycox et al.'s (2006) study looked at challenges in evaluating and implementing school-based prevention and intervention programs on sensitive topics for adolescents and found the critical element underlying the success of the projects was flexibility. For example, the stressful work environment required researchers to have the ability to adapt project requirements to unanticipated organizational obstacles to achieve the best possible study within contextual constraints (Jaycox et al., 2006). McKeague et al. (2017) looked at the feasibility and acceptability of school-based self-referral intervention for adolescents with emotional difficulties. The researchers found that students preferred programs that were interactive, engaging, personalized, and short in duration, while teachers preferred to take a more active role in developing or delivering workshops and having a role in the evaluation process. Doll et al.'s (2017) study found school psychologists can play a pivotal role in promoting, implementing, and evaluating school-based mental health services to maximize benefits to children. In addition, Bell et al. (2007) found that schools who institutionalized a universal screening procedure were successful at generating data that could be used to provide staff with on-going reminders of student mental health needs and evaluate multitiered SBMH programs.

  Gaps in the research base. My review of prior research included 12 studies that examined adolescent school-based mental health based on three over-arching themes: school improvement, SBMH systems, and evaluation of SBMH prevention and intervention programs. In reviewing the literature, I found gaps in the research base regarding the research design and measures used. For example, of the 12 studies, only

23

one examined SBMH for adolescents in Oregon (Paschall & Bersamin, 2017), thus confirming a context gap in the research. Finally, the literature review uncovered additional research gaps including a lack of SBMH studies looking at barriers and stigmas, cultural affects, academic achievement, program implementation and evaluation, and STS on school staff. In the next section I summarize how the proposed study will contribute to the research base by using a qualitative design to enhance understanding around the gaps in SBMH research and providing a needs assessment to help describe and explain the complexity of implementing culturally contextualized SBMH services in ways that can lead to school improvement in Oregon.

Summary

If funded, the proposed study would advance the understanding of culture and context in the adaptation of the MMHCR leading to school improvement. This proposed study will utilize a culturally relevant conceptual framework for evaluating school-based mental health programs implemented through community partnerships (Doll, et al., 2017; Nastasi & Hitchcock, 2016). As shown in Appendix F, I will examine the *context-specific program adaptation* for the MMHCR in three *high needs* public high schools located in Oregon using the Participatory Culture-Specific Intervention Model (PCSIM; Nastasi & Hitchcock, 2016). Using this framework, I will address barriers specific to culture and context and assess community-based resources for the adaption of the MMHCR.

Research Questions

The purpose of the proposed grant study is to conduct a comprehensive needs assessment of relevant state, school and community-based resources for the adaptation of the MMHCR in three *high needs* high schools located in three demographically diverse

24

regions in Oregon. Under the guidance of the Oregon ESSA Plan, the proposed study will address two components: (a) an examination of schools with high rates of chronic absenteeism (an ESSA accountability measure for school quality and success), and (b) a school improvement needs assessment for advancing student social and emotional mental health supports through partnerships and community-based organizations. For this proposed study, I will answer the following two research questions:

RQ1: What community resources and barriers to mental health services exist in three Oregon *high needs* high schools?

RQ2: What are the key factors for the MMHCR to leverage school and community resources to develop comprehensive, multifaceted, and integrated mental health service approaches to address identified barriers in three Oregon *high needs* high schools?

Theoretical Framework

This study will utilize the culturally relevant conceptual framework used in the MMHCR 2017-2018 pilot study to evaluate SBMH programs implemented through community partnerships (Doll, et al., 2017; Nastasi & Hitchcock, 2016). Using the Participatory Culture-Specific Intervention Model (PCSIM; Nastasi & Hitchcock, 2016), I will examine the *context-specific program adaptation* for the MMHCR in three public *high needs* high schools located in Oregon. The PCSIM theoretical framework draws from the work of Bronfenbrenner's (1989, 1999) Ecological Systems Theory (EST) to develop an ecological perspective used to understand the context of an individual child (Nastasi & Hitchcock, 2016, p. 29). Appendix F depicts the recursive PCSIM phases of program development. The 10-phase process involves continual reflective application of

research to inform partnerships and intervention. The goal of PCSIM is to develop acceptable, sustainable, and culturally grounded interventions in partnership with stakeholders to ensure cultural sensitivity in programming (Nastasi & Hitchcock, 2016). According to Nastasi and Hitchcock (2016), the process can be transferred across groups and locations to help advance a cultural and contextual fit for interventions. Nastasi & Hitchcock (2016) defined *culture specific* as "an individual's real-life experiences within a given cultural context (e.g., neighborhood) and his or her understanding of those experiences" (p. 18). Within the realm of PCSIM, Nastasi and Hitchcock referred to *context* as a specific setting or set of circumstances in which "an intervention is designed, delivered, and evaluated" (p. 17). Because I am using a qualitative design seeking stakeholder perspectives, the PCSIM is an appropriate choice for adapting the MMHCR.

Adaptation of the PCSIM to Needs Assessment and MMHCR

Of the ten phases of program development per PCSIM, I will focus on one for this proposed study, *context-specific program adaptation*. Specifically, I will conduct a needs assessment in three public *high needs* high schools in Oregon looking at community-based partnership opportunities that can be adapted to fit the MMHCR intervention. I will rely on qualitative interviews and focus groups with CCO administrators, school administrators, teachers, and students, and community business leaders. The needs assessment will comprehensively map and analyze CCOs and school and community-based resource partnership opportunities that are needed to adapt MMHCR services in the three Oregon high schools. The *context-specific program adaptation* phase of the PCSIM will provide evidence-based cultural grounding to facilitate better understanding of target groups and stakeholders during program adaptation.

CHAPTER III

PROJECT DESIGN AND MANAGEMENT PLAN

This one-year project fits within the Spencer Foundation Small Research Grants

Program by employing a field-initiated qualitative needs assessment of community-based

partnership opportunities to adapt the MMHCR into three *high needs* high schools in

Oregon (Appendix G). The proposed study will be conducted by Dr. Brenda Kleinfelder,

who will serve as Principal Investigator. The following sections first describe the

research approach, and then unpack the approach by describing the units of analysis,

timeframe, participants and setting, sampling logic, data collection instruments and

procedures, data analysis and interpretation, and anticipated threats to validity.

Research Approach

To address my research questions, I will use a qualitative approach to examine

and describe the context-specific program needs to adapt the MMHCR in three high

needs public high schools in Oregon. The intent of using a qualitative study design is to

richly describe and explain the complexity of the study context and key findings of the

field-initiated research (Creswell & Creswell, 2018). For example, by conducting

interviews and focus groups with key stakeholders, I hope to better understand barriers to

SBMH and available resource partnerships for the adaptation of the MMHCR in the three

schools. Appendix H diagrams the qualitative procedures in the proposed study.

Units of analysis. The units of analysis for this study are the three communities in

which the high schools are located in Oregon. The participants are situated in three public

high schools in three counties that reported high percentages of chronic absenteeism in

2018. Chronic absenteeism is the accountability measure the Oregon ESSA Plan

identifies as an indicator of school quality and success (Oregon Department of Education, 2017).

Participants and setting. The study includes three public high schools in three locations across Oregon. The participants consist of key stakeholders as potential partners in the adaptation and implementation of the MMHCR, including CCO administrators, school administrators, teachers, students, and community business leaders. As Table 4 shows, although the three schools are in the bottom 10 percent statewide in Oregon school performance rating for 2018 under the Oregon ESSA Plan, they differ from each other in several ways including (a) grade-levels offered, (b) size of student populations, (c) number of teachers and school counselors, (e) percentage of students of different race and ethnicity, (f) percentage of English learners, (g) percentage of students with disabilities, (h) percentage of economically disadvantaged students, and (i) percentage of students regularly attending school.

Appendix I maps the location of the three high schools in Oregon. The geographic locations were strategically selected by an administrator from the Office of Student Resources with the Oregon Department of Education as having schools with high needs. The geographic locations are (a) the urban Interstate 5 corridor, (b) rural coast, and (c) frontier (most rural). The school settings are selected based on the Oregon ESSA Plan accountability component that measures school quality and success based on chronic absenteeism. Based on the ESSA criteria, I selected schools with chronic absenteeism at the bottom 10 percent statewide and matched the schools to counties within each geographic location.

Table 4

Comparison of Student Population Demographics in Three High Schools in Oregon Counties

County / Demographic	Coos	Jackson	Wheeler
Grade levels	7-12	9-12	7-12
Student enrollment	212	233	463
Number of teachers	17	16	12
Number of counselors	1	1	1
Race/ethnicity			
American Indian	5%	1%	3%
Asian	<1%	<1%	<1%
African American	1%	3%	3%
Hispanic/Latino	10%	32%	21%
Multiracial	17%	8%	9%
Pacific Islander	0	0	<1%
White	65%	55%	64%
Ever English Learners	5%	18%	<5%
Students with disability	17%	23%	14%
Free reduced lunch	>95%	>95%	50%
Regular attenders	67%	14%	41%

Note. Source is Oregon Department of Education, Oregon At-A-Glance School Profile 2017-2018.

Sampling logic. The criteria for selecting the three schools and associated communities was determined by high rate of chronic absenteeism in each school. The Oregon ESSA Plan looks at school absenteeism as an indicator of school success as schools with high absenteeism rates are less academically successful. The three schools were identified by an administrator at the Oregon Department of Education Office for

Student Resources as areas known to have significant student needs that are comparatively diverse based on geography and demographic make-up.

Instrumentation. The proposed study utilizes researcher-created, semi-structured interview protocols and focus groups with five key stakeholder participant groups: Community Business Leaders, CCOs, School Administrators, Teachers, and Students. To ensure that interview and focus group instruments acquire data that will adequately address each research question, I matched each of the five key stakeholder groups to the research topics and research questions in the proposed study (see Table 5, below).

Table 5

Interview and Focus Group Stakeholders by Topic and Research Question

Topic / Research Question	School Improvement Practices (ESSA)	Student Needs	School Wide Needs	Barriers and Stigmas	Culturally-Specific SBMH	Potential Community Partnerships
RQ1: What community resources and barriers to mental health services exist in three Oregon *high needs* high schools?	3	3, 4, 5	3, 4, 5	1, 2, 3, 4, 5	1, 4, 5	1, 2, 3›
RQ2: What are the key factors for the MMHCR to leverage school and community resources to develop comprehensive, multifaceted, and integrated mental health service approaches to address identified barriers in three Oregon *high needs* high schools?	2, 3	4, 5	3, 4, 5	1, 2, 3, 4, 5	4, 5	1, 2, 3

Note. Community Business Leaders = 1; Community Care Organizations (CCOs) = 2; School Administrators = 3; Teachers = 4; and Students = 5.

Interviews. I will conduct semi-structured interviews with community business leaders, state-owned CCO administrators, and school administrators to learn about school-based mental health needs and partnership opportunities to adapt the MMHCR services to match the culture and context to each school. Semi-structured interview protocols include a guided list of questions addressing the key findings of the literature review and pilot study including: (a) school improvement practices under ESSA, (b) perception of student and school-wide mental health needs, (c) associated barriers and stigmas, (d) culturally-specific SBMH contextualized to each school, and (e) potential community-based partnerships. Interview questions will be both structured and unstructured allowing for flexibility with no predetermined wording or order (Merriam & Tisdell, 2016). The purpose of the interviews is to learn about and explore particular issues or questions from individual members of the local culture (Nastasi & Hitchcock, 2016). For example, business leaders, CCOs, and school administrators will be asked, "What community partnership options exist for developing comprehensive SBMH services to adolescents?" All stakeholder groups will be asked, "What barriers and stigmas exist in providing SBMH services in your local high schools?".

Focus groups. I will conduct semi-structured focus groups with teachers and students in each of the three school communities. The focus groups will include a list of guided questions or issues identified in the individual interviews along with key findings from the pilot study and literature review. The purpose of the focus groups is to understand specific topics, beliefs, values, or experiences from the cultural perspectives of teachers and students in each community (Nastasi & Hitchcock, 2016). A benefit to holding focus groups is that the teachers and students can share their views, hear from

31

others, and possibly think of new insights based on what they hear (Merriam & Tisdell, 2016). I intend to learn the perceptions surrounding the need for mental health in schools and what community-based resources and barriers to mental health exist in the schools. Finally, I aim to learn what community-based resources are available to meet students' mental health needs, and how those resources could be woven together to implement culture-specific SBMH services contextualized to schools. For example, to understand potential community partnerships based on the culture and context in each school, teachers and students will be asked, "What community-based resources might best provide culturally relevant SBMH services to high school students?"

Data collection procedures. Here, I discuss data collection procedures, including initial email/phone follow-up recruitment procedures, interviews, and focus groups.

Initial email and phone follow-up. Before the proposed study begins, I will send out an initial email to CCO administrators, school leaders, and community groups and organizations in each school community explaining the scope and purpose of the study and the ways in which they can be involved: (a) an individual interview in-person or over the phone and/or (b) a focus group. A follow-up phone call will be made if no reply to the initial email is received. The follow-up call will provide a personal contact and allow the administrator to ask questions and gather more information before agreeing to participate.

Interviews. I will conduct interviews with members from each of the five stakeholder groups to better understand barriers they face in providing SBMH services for high school students in their respective communities. All interviews will be conducted at sites convenient to the interviewees and last between 40 to 60-minutes in length. Interview questions will inquire about potential partnership opportunities to develop

comprehensive, multifaceted, and integrated approaches to address identified SBMH barriers. I will record the interviews by taking notes *in situ* and audio recording to ensure that the interview is preserved for later analysis, including checks for note-taking accuracy (Merriam & Tisdell, 2016). I will use a snowball sampling technique of asking respondents at the end of an interview to refer and help contact others who might have helpful insights on the topic (Nastasi & Hitchcock, 2016).

Focus groups. First, I will introduce the group and explain the purpose of the focus groups. After the participants introduce themselves, I will begin by asking questions about perceptions of students' mental health needs in their community and potential partnership opportunities available to implement SBMH. The focus groups will be conducted at local sites pre-determined by participants, not to exceed 90-minutes in length, and consisting of no more than ten participants per group. Merriam and Tisdell (2016) recommend a range between "six to ten participants, preferably people who are strangers to each other" (p. 114). For each focus group, I will have a script, and a list of questions that address my research questions. In addition to recording responses, I will also document how participants are reacting to each other, the overall tone of the group, and the non-verbal communications that are happening within the group.

Data analysis and interpretation. Below, I discuss my approach to data analysis and interpretation of study findings.

Data analysis. This study involves two sources of qualitative data, interviews and focus groups. I will follow Creswell's (2014) steps for analyzing qualitative data: (a) transcribing participant responses into spreadsheets; (b) organizing and preparing the data for analysis by categorizing it into the different themes that emerge; (c) reading through

all of the data to obtain an overall sense of information; (d) coding the data and beginning to develop general topics for eventual categorization; (e) generating a description of the settings, people, and themes; (f) interpreting the findings; and (g) writing a narrative to report on what has been learned. The participants' responses will be coded and categorized with consistency checks completed by an experienced faculty member at the University of Oregon. After the interviews are transcribed and entered into Dedoose, an online program for analyzing qualitative research, I will identify items and create codes that reveal similar patterns and themes. Example codes for school leaders may include: stigmas and barriers (e.g. cost, infrastructure), professional development (e.g. trauma informed training, staff secondary traumatic stress), district/school improvement plan under ESSA (e.g. chronic absenteeism reduction), and the cultural needs of students and staff within the context of the school and community. After all of the data have been coded and categorized into themes, I will begin to look for similarities and differences between the themes and schools and communities.

   Data interpretation. All data will be reported descriptively and interpreted in ways that connect them to the findings from the literature review and research questions (Alonzo & Tindal, 2011; Creswell & Plano Clark, 2018) as well as the field-initiated pilot study results. For example, school leaders might express community-based partnership concerns related to cost, safety, and liability that indicate barriers to adapting the MMHCR in their school. Descriptive information about the needs assessment in each school community will be presented in tables with interconnected story narrative and quotations from participants (Creswell & Creswell, 2018). Appendix J shows the process I will use for data analysis and interpretation using a qualitative research design.

Study implications. The proposed needs assessment will provide comprehensive mapping and analysis of the resources available to adapt the MMHCR using community-based partnerships to provide relevant mental health services in three high needs secondary schools in Oregon. The comprehensive mapping will include an analysis of state, school, and community-based resource partnership opportunities. The overall analysis will examine potential community resources relevant to SBMH and how they may be implemented. In addition, the needs assessment will provide policymakers and practitioners evidence of important factors (i.e. community-based resources and contextual barriers) for determining how best to implement SBMH services to match culture and context of schools. For example, the study may find the importance of blending state, school, and community-owned resources together to develop comprehensive, multifaceted, and culturally integrated approaches to address barriers to SBMH. Evidence may help SBMH programs to function on the "cutting edge" by providing creative partnership solutions beyond basic mental health concerns and understanding, thus providing an understanding about if/how the MMHCR model can be used across diverse school settings. Last, the needs assessment will offer insight into complications stemming from the scale of Oregon's high rate of chronic absenteeism in public schools related to community-based resource capacity. Understanding community-based resource capacity will help determine if the MMHCR model and procedures is effective for replication and "scale up" in Oregon public high schools.

Future dissemination activities. This needs assessment will provide policymakers and practitioners data for determining how best to implement SBMH for educational equity and school improvement purposes under Oregon's ESSA Plan. In addition, the

study will address some of the complications stemming from the scale of student mental health concerns in Oregon's public schools and determine if the MMHCR model and procedures are effective for replication and "scale up" in Oregon high schools.

Descriptive information about the needs assessment in each school community will be presented in tables with interconnected story narrative and quotations from participants for school-based mental health conferences including 'The 2019 Annual Conference on Advancing School Mental Health', and The 2019 Confederation of Oregon School Administrators Conference. In addition, I will write a three-page study brief written in the language of my five stakeholders to share my key findings. Also, to reach a wider audience, I will write an opinion editorial in common language for magazines and newspapers to relate my findings and discussion.

Validity threats. In order for researchers to understand internal validity threats, they must look specifically at the type of design they are using (Creswell and Plano Clark, 2018). In this next section I discuss two main threats to validity to the proposed qualitative research study researcher bias and response bias.

Researcher bias. Because I am the designer and facilitator of the MMHCR pilot, researcher bias poses a threat to the study's reliability (Babbie, 2012). To minimize this threat, Creswell & Creswell (2018) suggest researchers recognize that their own backgrounds shape their interpretation and position themselves in the research to acknowledge how their interpretation flows from their personal, cultural, and historical experiences. Transparency of my role is important to avoid the perception that the data have been collected and/or interpreted with a subjective, positivist lens aligned to my personal interests (Galdas, 2017). Other strategies I plan to use include: (a) *respondent*

validation member checking of my findings from the people in the study to solicit

feedback about the data and conclusions (Maxwell, 1992); (b) *triangulation* of data

drawn from multiple sources to build the evidence for coding during analysis; (c)

searching discrepant evidence to assess and confirm the data as it is in real life while

"being aware of all the pressures to ignore data that do not fit" my conclusions (Maxwell,

p. 127); and, (d) *external auditors* using faculty members familiar with qualitative

research , and my content, to examine the data (Creswell & Creswell, 2018).

   Response bias. Response bias is the effect of responses and nonresponses from

the participants and non-participants (Creswell & Creswell, 2018). For example, people

who chose to participate in the interviews and focus groups might represent a different

point of view from those who chose not to participate or were not available. This will

have important implications for suggesting actions for cultural adaptation of the

MMHCR services in each school. To address the potential for lack of variability in

responses *triangulation* of data will be drawn from multiple sources using protocols to

support the expression of varying opinions to build evidence for coding and analysis

(Maxwell, 1992).

CHAPTER IV

BUDGET AND TIMELINE

This section provides a timeline (Appendix H) and a budget narrative for the proposed project. First, the project personnel costs are described, followed by costs for travel, project materials, participant support, and facilities and administrative costs. The total budget is $50,000 (Table 8), the maximum amount allowed under the RFP.

Personnel

Brenda Kleinfelder will serve as Principal Investigator and be allocated 0.5 FTE for the duration of the study. Dr. Kleinfelder will be responsible for project oversight and coordination, including recruiting schools and participants, and piloting instruments.

Travel

Oregon per diem rates include nightly lodging of $93, per diem of $51, and $0.56 per mile based on average site distance from Eugene, OR. Travel-related expenses include travel/overnight stays to conduct interviews/focus groups, develop rapport with stakeholders, and accommodate participant schedules (i.e., meeting after work/evenings). Tables 6 and 7, respectively, display estimated travel costs and daily itineraries.

Table 6

Averaged Costs of Hotels and Roundtrip Mileage from Eugene

Travel expenses	Coos Bay	Medford	Mitchell	Total
Hotel average cost per night	$107/night	$120/night	$162/night	$389
Mileage roundtrip from Eugene at $0.56/mi.	$133.28 (234 mi.)	$190.40 (340 mi.)	$214.48 (383 mi.)	$538 (961 mi.)
Total	$240	$310	$376	$927

Table 7

Itinerary for Three Site Visits

County	Interviews	Focus Groups
Coos	• 8:00am-9:00am: Meet with CCO - Advanced Health, Coos County Advisory Council Chairperson. • 9:30am-10:30am: Meet with Coos County City Manager • 11:00am-11:30am: Meet with H.S. Principal	• Noon-1:00pm: Meet with students (provide lunch) • 2:30pm-3:30pm: Meet with teachers (provide snacks) • 5:30pm-6:30pm Meet with community members (provide dinner)
Jackson	• 8:00am-9:00am: Meet with CCO – Jackson Care Connect, County Advisory Council Chairperson. • 9:30am-10:30am: Meet with Jackson County City Manager • 11:00am-11:30am: Meet with H.S. Principal	• Noon-12:30pm: Meet with students (provide lunch) • 2:30pm – 3:00pm: Meet with teachers (provide snacks) • 5:30pm-6:30pm Meet with community members (provide dinner)
Wheeler	• 8:00am-9:00am: Meet with CCO – Eastern Oregon Coordinated Care Organization, County Advisory Council Chairperson. • 9:30am-10:30am: Meet with Wheeler County City Manager • 11:00am-11:30am: Meet with H.S. Principal	• Noon-12:30pm: Meet with students (provided lunch) • 2:30pm-3:00pm: Meet with teachers (provide snacks) • 5:30pm-6:30pm Meet with community members (provide dinner)

Note. CCO = Community Care Organization.

Project Materials, Facilities, and Administrative Costs

Project materials are budgeted at $500. These include (a) project supplies (e.g., paper, binders), (b) food and beverages for focus groups, (c) presentation materials for dissemination (e.g., posters, printed abstracts, reports), and (d) a monthly access to Dedoose. Because I am not offering a stipend to focus group participants, materials such as food and beverages are budgeted to help build rapport and show consideration of the

range of groups and time availability. In addition, a projected cost of $200 is included to cover basic technological infrastructure such as internet, printing services, phones, data storage, and technology support.

Table 8

Project Budget

Budget Area	Budget Indicator			
Research Team Wages and Salaries	Salary Base	12-Month Period	Estimated Hours	1-Yr Total
Brenda Kleinfelder (Principal Investigator)	$47,913	50.00%	2190	$47,913
Total Salaries and Wages				**$47,913**
Supplies				
Project Supplies (paper, copies, binders)				$500
Hosting Focus Groups/Interviews				$200
Dedoose Subscription				$300
Total Supplies				**$1,000**
Travel (three school locations)		Rate	Aggregate	1-Yr Total
Vehicle Mileage (round trip)		$.56/mile	961 mi.	$538
Meals		$51/day	3 days	$153
Lodging		$132/night	3 nights	$396
Total Travel				**$1,087**
Total Costs				**$50,000**

Action Plan

This dissertation grant application allowed me to gain experience in developing a budget and timeline for the proposed project and assemble an appropriate research plan to conduct the project. As I continue in the field of educational research, the skills acquired to write a grant application will be directly applicable to my future work. The Spencer Foundation Small Research Grant Program submission format differs from the graduate school dissertation format, which would require me to make several adjustments if I submit this grant application. The RFP differs from the graduate school chapter base format which will require I make several format adjustments. If I were to submit this grant application, I would need to submit a web-based Notice of Intent to Apply by (date) of the year in which I apply. The full application would then need to be submitted through the online submission portal by summer 2019 through the Spencer Foundation website.

APPENDIX A

SPENCER FOUNDATION SMALL RESEARCH GRANT PROGRAM (RFP)

SMALL GRANT APPLICATION SAMPLE

Type: Small Grant

Principal Investigator:

Administering Organization:

The deadline for this application is
Detailed application guidelines for this program can be found by clicking here.

Proposal Personnel

Principal Investigator (PI): As the PI, you are required to update your My Profile page (link in the upper right corner) and upload a PDF version of your current CV. By clicking My Profile, you will be leaving this page; we recommend clicking Save Draft in order to retain any information you may have input into the application before updating your profile.

Co-Principal Investigator (Co-PI): If there will be a Co-PI(s) on the project, they must be a registered user of the Spencer Foundation online system. The Co-PI is also required to update their My Profile page and upload a PDF version of their current CV.

Adding Co-PI(s) to your proposal: Once the Co-PI is a registered user, they will need to provide you with their Researcher PIN Number. They can find this number by logging in and clicking their My Profile link. Click the button below to enter the Co-PI's PIN number and last name; this will add them as a Co-PI and give them access to view and edit the proposal prior to submission.

Add Co-PI

Note: Below is a sample of the Assign Co-PI dialog box that will appear once you click the Add Co-PI *button.*

Add Co-Applicant - Google Chrome

https://spencer.smartsimple.us/s_viewpagefield.jsp?fieldid=1348180&codedid=VE9cI1Ne8QEFO

Assign CO - Principal Investigator

Researcher PIN Number

Researcher Last Name

Retrieve Researcher

Proposal Summary

* Proposal Title:		*** Project Start Date:**	mm/dd/yyyy
Requested Amount:	*This will be pulled from the budget worksheet*	*** Project End Date:**	mm/dd/yyyy
Research Area:	--Select One--	**Number of months for project:**	*This will be calculated based on the project start and end dates.*

* Proposal Summary (200 word limit)

200 words left

Proposal Budget — Budget Status Total Budget Created Date

You must set your Project Start Date and Project End Date values and click Save Draft before proceeding to complete your proposal budget.

Note: After clicking Save Draft, the Click Here to Edit Budget *button will appear which will allow you to access your Proposal Budget. See Appendix A for a sample of the budget forms.*

Proposal Budget	Budget Status	Total Budget	Created Date
Click Here to Edit Budget	Draft		

Taken from the *Small Research Grants Program* (Spencer Foundation, 2018).

APPENDIX B

MMHCR (SBMH) MODEL

Mobile Mental Health Community-Based Resources Model Flowchart.

Adaption of the Mobile Mental Health Community Resources (MMHCR)
across groups and schools.

Assess community-based parternship opportunities (e.g. state-owned CCOs,
and school and community-based resources).

Conduct fall term student needs pre-assessment using the universal
screening tool - Strenghts & Difficulties Questionnaire (SDQ; Goodman,
2006).

Selection and implementation of culturally-specific community-based
partnerships contextualized to groups and schools.

Conduct spring term assessments : (a) post-universal screening using SDQ;
(b) program success using Comprehensive Mixed-Methods Participatory
Evaluation (CMMPE-PCSIM; Nastasi & Hitchcock, 2016).

Note. CCOs = Coordinated Care Organizations.

APPENDIX C

COMPREHENSIVE MIXED-METHODS PARTICIPATORY EVALUATION MODEL
USED IN THE INTITIAL PILOT STUDY
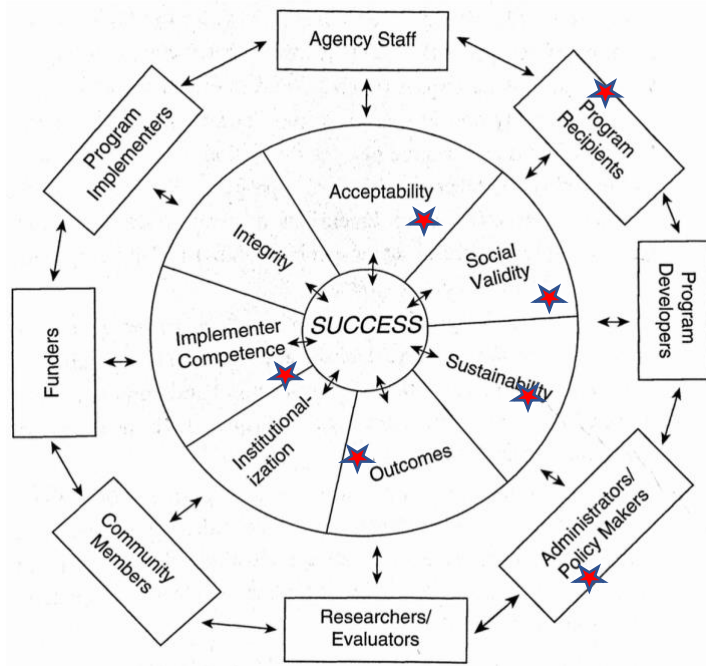
Source. Comprehensive Mixed-Methods Participatory Evaluation (CMMPE; adapted from Nastasi & Hitchcock, 2016).

Nastasi & Hitchcock's (2016) dimensions of success are defined as:

• *Program acceptability*: The extent of stakeholder support for the program, which facilitates its implementation and sustainability.

• *Social validity*: The cultural relevance of program goals and outcomes to the target group.

• *Sustainability*: The extent to which implementers can continue the program and have the needed skills and motivation to sustain the program.

• *Outcomes*: The effects of the intervention, both intended and unintended.

• *Institutionalization*: The capacity of the organization to continue program efforts over time and the extent to which the program has become integral to the system.

• *Implementer competence*: The critical knowledge, attitudes, and skills of the implementer to implement the program with integrity and adapt the program to meet the cultural and contextual needs of the recipients.

• *Integrity*: The extent to which the program is implemented as designed.

SPRING 2018 PILOT STUDENT SELF-REPORT SURVEY FOR
SCHOOL A AND SCHOOL B

Spring 2018 - Student self-report survey for School A and School B.

███████/Mobile Mental Health Resource Clinic (MMHRC)
STUDENT SELF-REPORT SURVEY
May 2018

Thank you for sharing your thoughts. All information is confidential and will be used to help improve mental health services in schools.

1. Have you used ██████? *(circle)* YES NO
   • If YES, what did you seek help for? *(circle all that apply)*
      a. Mental health counseling.
      b. Mediation with family or friends.
      c. Food, clothing, sexual health, and hygienic items.
      d. Help accessing other social services.
      e. Basic medical support.
      f. Someone to talk to confidentially.
      g. Other (tell us):

2. Have you referred a friend? *(circle)* YES NO

3. Where are you on this pyramid? *(circle all that apply)*

I feel I can reach my goals.

I have something in my life I'm proud of.

I have some close friends or family members I love.

I feel safe in the world most of the time.

I have enough food and I get enough sleep.

4. Do you feel the ██████ services are relevant to your life? *(circle)* YES NO

5. Many students say they know about ██████, but very few say they use it. Do you think the free, confidential mental health services is a good idea at your school? *(circle)* YES NO

6. Would you feel comfortable seeking support at ██████? *(circle)* YES NO

7. What time of day would you be more likely to attend ██████ at school? *(circle)*

   BEFORE SCHOOL   DURING SCHOOL   AFTER SCHOOL

APPENDIX E

SPRING 2018 PILOT STAFF SELF-REPORT SURVEY FOR
SCHOOL A AND SCHOOL B

Spring 2018 - Staff self-report survey for School A and School B.

██████████/Mobile Mental Health Resource Clinic (MMHRC)
SCHOOL STAFF SELF-REPORT SURVEY
May 2018

Thank you for sharing your thoughts. All information is confidential and will be used to help improve mental health services in schools.

1. Have you previously participated in a ██████████/MMHRC survey? *(circle)*   YES   NO

2. Do you feel ██████ meets the needs of students at your school? *(circle)*   YES   NO

3. Do you feel ██████ reduced student crisis and trauma at your school? *(circle)*   YES   NO

4. Does your school have the needed infrastructure and capacity (e.g. money, space, time) to continue with the MMHRC? *(circle)*   YES   NO

5. Do you feel committed to the MMHRC continuing? *(circle)*   YES   NO

6. Do you feel the ██████ staff have the skills, attitude, and knowledge to provide the mental health services for your students' needs? *(circle)*   YES   NO

7. Have you referred students?
    (circle)   YES   NO
    (if no, why not?)

8. Have you used ██████/MMHRC services for yourself?
    (circle)   YES   NO

9. Have you personally felt a reduction in mental and physical stress associated with undertaking student crisis and trauma?
    (circle)   YES   NO

10. Do you feel having ██████ in your school has had a positive effect on staff morale?
    (circle)   YES   NO
    (if yes, how)
    (if no, why?)

11. What would reduce your stress at school?

If you would like to participate in a follow-up interview, please contact Bren Kleinfelder:
brenk@uoregon.edu
(541) 743-3583

Thank you.

PARTICIPATORY CULTURE-SPECIFIC INTERVENTION MODEL:
CONTEXT-SPECIFIC PROGRAM ADAPTATION
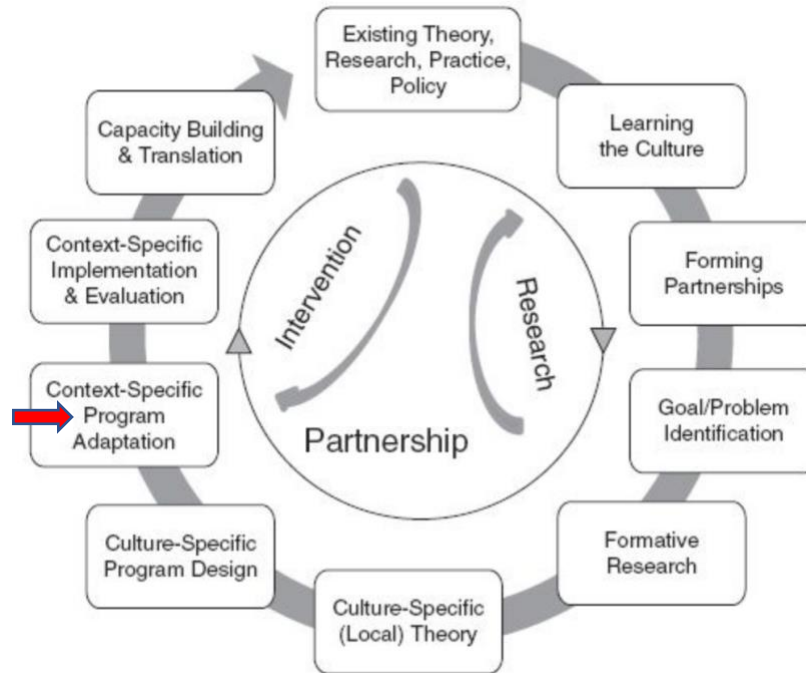
Context-Specific Program Adaption refers to 'context' as a 'specific' setting or set of circumstances in which the intervention is designed, delivered, and evaluated (Nastasi, Moore, and Varjas, 2004; Nastasi & Hitchcock, 2016).

APPENDIX G

MODEL FOR THE MOBILE MENTAL HEALTH COMMUNITY RESOURCES
IMPLEMENTATION ACROSS DIVERSE CONTEXTS

*STEP 1
Identify high need regions and schools Oregon (ESSA, ODE)

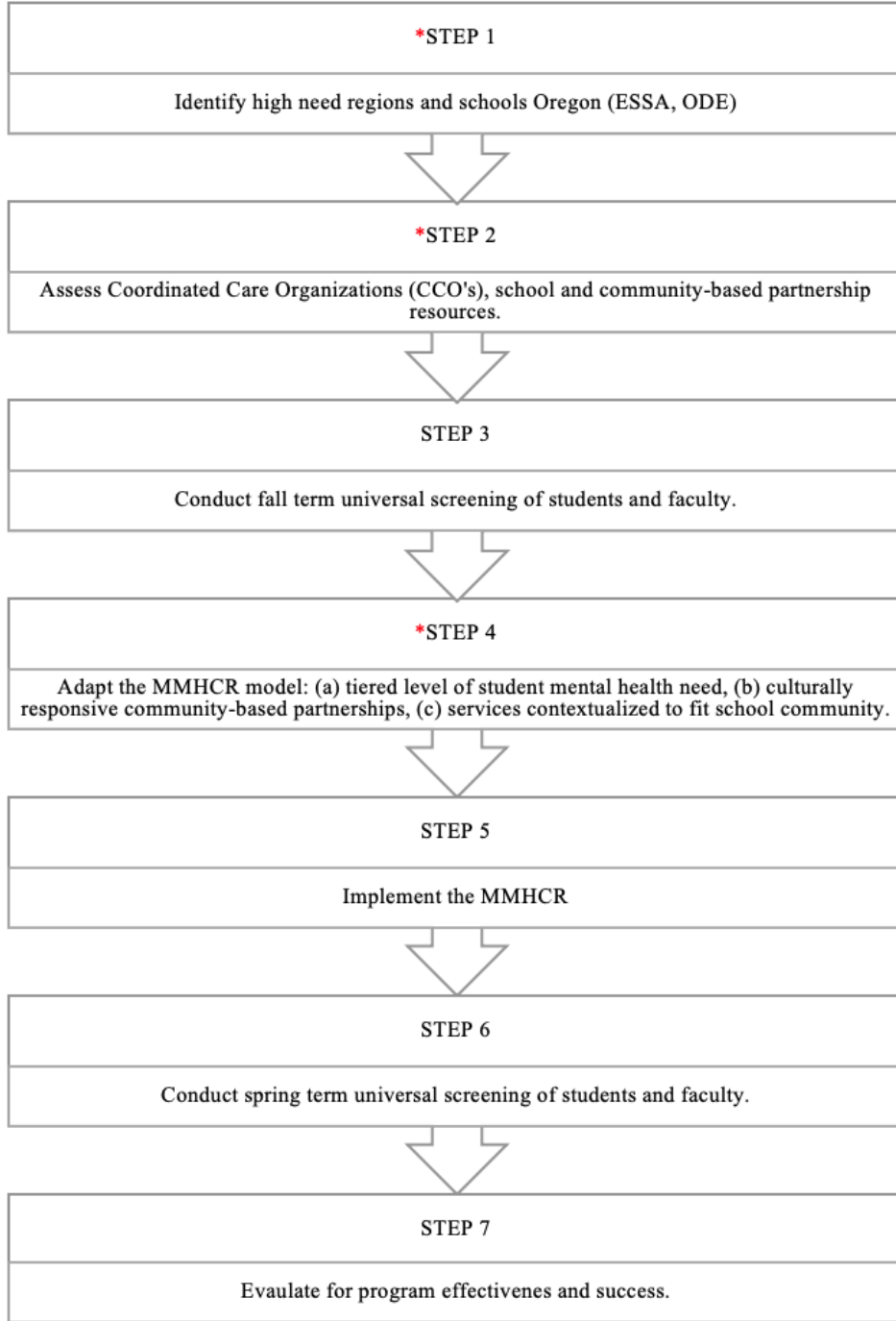| *STEP 2 |
| --- |
| Assess Coordinated Care Organizations (CCO's), school and community-based partnership resources. |

STEP 3
Conduct fall term universal screening of students and faculty.

*STEP 4
Adapt the MMHCR model: (a) tiered level of student mental health need, (b) culturally responsive community-based partnerships, (c) services contextualized to fit school community.

STEP 5
Implement the MMHCR

STEP 6
Conduct spring term universal screening of students and faculty.

STEP 7
Evaulate for program effectivenes and success.

*Denotes the steps (1, 2 and 4) proposed in the one-year Spencer Foundation Small Research Grant.

APPENDIX H

FLOWCHART OF A QUALITATIVE STUDY RESEARCH APPROACH

| STEP 1	• Design qualitative research interviews and focus group questions. • Collect open-ended qualitative data with instruments.

STEP 2	•Analyze the qualitative data using procedures of theme development and qualitative coding.

STEP 3	• Converge data findings and make comparisons: - Provide descriptive summary of qualitative findings. - Discuss how resource compare for three schools based on selected criteria and results.

STEP 4	• Interpret the converged results of resources: - Interpret individual schools and resource capacity. - Interpret similarities and differences of resource capacity between each school. - Interpret how the understanding of resources for each school is enhanced by the integrated conclusions.

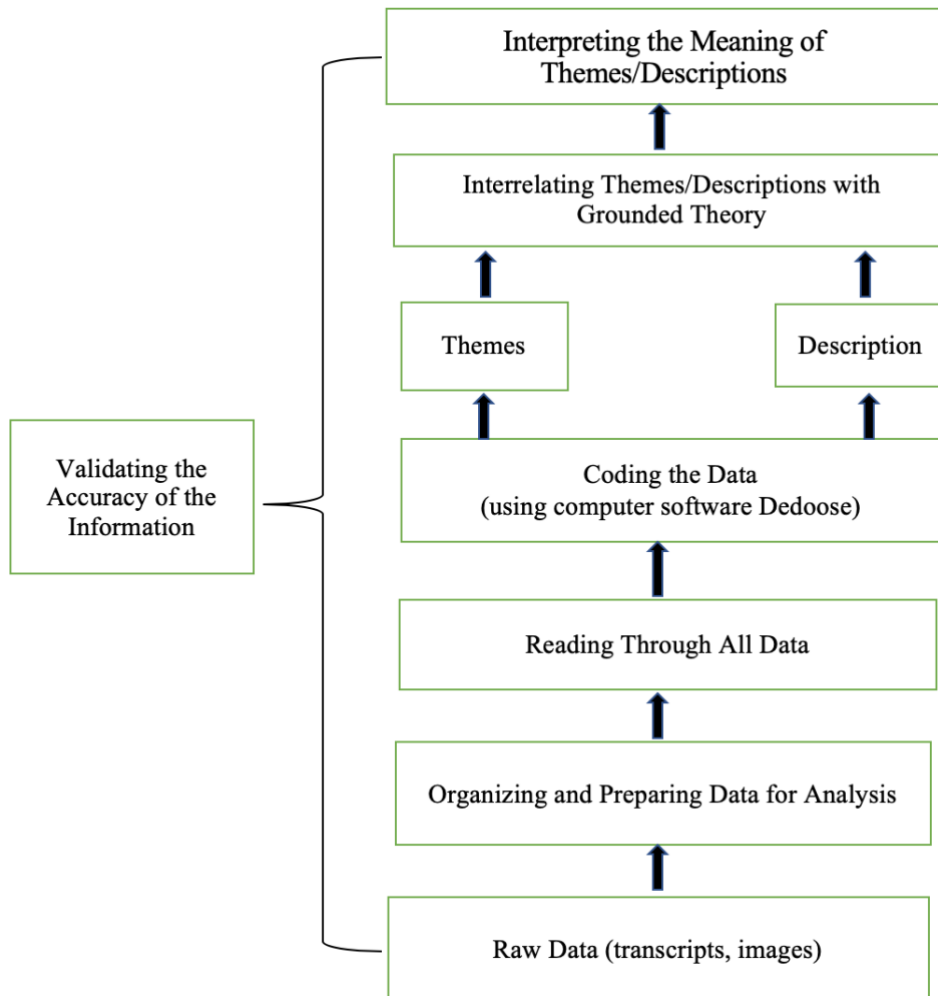Adapted from Creswell & Creswell (2018). Steps 1-4 will be conducted over one year for the proposed grant.

APPENDIX I

GEOGRAPHIC AND COUNTY LOCATIONS OF THREE
HIGH SCHOOL STUDY AREAS
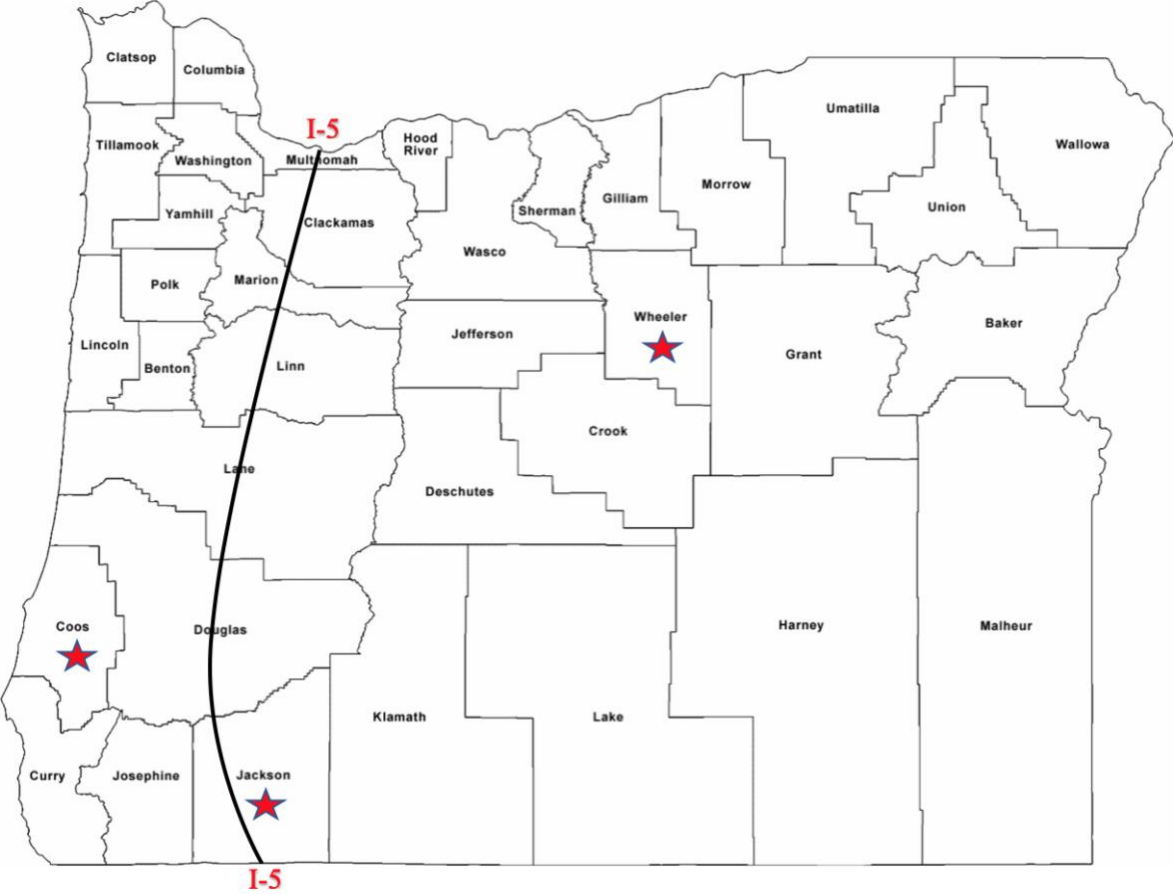
DATA ANALYSIS IN QUALITATIVE RESEARCH FOR NEEDS ASSESSMENT

Adapted from Creswell & Creswell (2018).

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