SOCIAL WORKER PERCEIVED BARRIERS TO WORKING WITH AT-RISK YOUTH AND RECEIVING INFORMED CONSENT

A Project

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MASTER OF SOCIAL WORK

by

Gregory Fisher

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Gregory Fisher

Approved by:

____________________________, Committee Chair
Dale Russell, Ed.D., LCSW

____________________________
Date

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Division of Social Work
Abstract

of

SOCIAL WORKER PERCEIVED BARRIERS TO WORKING WITH AT-RISK YOUTH AND RECEIVING INFORMED CONSENT

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In the United States over 3 million students drop out over the course of a year from public schools. Many of these dropout students are considered at-risk due to poverty and issues surrounding mental health status. The purpose of this study is to investigate potential barriers school social workers face in trying to reach this at-risk population to provide interventions and receive informed consent. The study surveyed 12 school mental health professionals who work in the Natomas Unified School District to gain a better understanding of commonly present barriers that impede the provision of services to at-risk youth. Results from the study indicated that receiving informed consent to work with at-risk youth can be problematic due to issues involving mental health stigma and symptom identification, lack of understanding of confidentiality laws, and insufficient screening tools to identify students in need. Finally, the study highlights the need for social workers to do outreach in educating students on the topic of mental health.

_______________________, Committee Chair
Dale Russell, Ed.D., LCSW

_______________________
Date
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Chapter 1

STATEMENT OF THE PROBLEM

In America’s public school system, it is hard to deny that our education system continues to let students slip through the cracks and go unnoticed. Nearly 8,000 public school students drop out each day, and over 3 million students drop out over the course of the year (Franklin, Harris, & Allen-Meares, 2013). Even with national dropout rates continuously decreasing over the past ten years, many at-risk youth do not receive support services needed to promote academic, emotional and behavioral well-being. The school social worker is a valuable asset that can help students attempt to meet emotional and behavioral needs so they can focus on academic success.

A majority of students who are considered at-risk live in poverty, have a dysfunctional family life, and experience a lack of access to resources and counseling, which, in turn, affects their mental health status. Potentially, without early identification and interventions, and with at-risk youth experiencing mental health problems, consequences can be more severe and permanent. Currently, 20% of children and adolescents experience signs and symptoms of DSM-V disorders during the course of a year (Adelman & Taylor, 2010). Students experiencing issues with mental health created by social, emotional, and behavioral influences tend to have lower academic performance, higher rates of suspensions and expulsions, greater likelihood to become truant and dropout, disengagement from school environment and personnel, problematic
peer relationships, and increased risks of suicide (Geierstanger, Amaral, Mansour, & Walters, 2004; Franklin, Harris, & Allen-Meares, 2013).

In an effort to help students who are at-risk and improve resources and services needed to promote socioemotional well-being, this study examined school social workers’ perceptions of barriers that prevent receiving informed consent and ultimately immobilizing any intervention effort. This descriptive study investigates the perceptions of school social workers within the Natomas Unified School District (NUSD) and barriers from working with at-risk youth. The Natomas Unified School District was selected for this study based primarily on the ethnic and cultural diversity of the students and families who live in this school district. According to the Natomas Chamber of Commerce, the northwest part of Sacramento has approximately a population of 99,000 people with 10,300 students attending schools within the NUSD. A 2012 report by Business Insider identified Natomas as the 9th most diverse region in the U.S.A. based on area code (Natomas Buzz, 2014). Also, one of the main high schools in the district, Natomas High, was identified as the second most ethnically diverse schools in the country (Natomas Buzz, 2013). The information documented in this study was obtained through questionnaires completed by school social workers in the NUSD. The sample consisted of credentialed school social workers, social work interns, and school mental health professionals. The client population with which the school social worker serves is students ages 5-19, ranging from kindergarten to seniors in high school, and attending a school within the Natomas Unified School District.
A major contributing factor to the specific topic of study was the researcher’s prior experience as a school social work intern. Being a key facilitator of strengthening home-school collaborations, deficits that may prevent receiving informed consent to work with at-risk youth were recognized and further exploration was warranted. It was observed that some parents refused to provide informed consent to work with their child, a couple of teachers would not refer students for his services or would only when the problem became a manifested behavior, and administration would only select certain at-risk students for the researcher to work with instead of identifying all students who were at-risk and in need of help.

**Background of the Problem**

According to the National Association of Social Workers (NASW) Code of Ethics, social workers’ primary goal is to help people in need and to address social problems (Brill, 2001). In the public school setting, school social workers are in a unique position to support the success of all students in schools. School social worker awareness of social environmental risk and protective factors promotes the use of preventative strategies and awareness of causes of poor performance that go beyond the child and instructional methods (Bowen, Lee & Weller, 2007). School social workers are also key mental health professionals who are in a position to help child, parents, and community develop social competence, and, at the same time, to help increase the school’s responsiveness to the needs and aspirations of children, parents, and community (Lee &
Ely, 655). However, to provide school-wide or individual interventions, informed consent is necessary, yet, in many cases, is not obtained.

A home-school collaboration is a partnership between schools and families and is considered an integral relationship needed for an at-risk youth to succeed (Cox, 2005). However, there are multiple risk factors that can create a weak home-school collaboration involving students, teachers, parents, and administrators. The potential risk factors created by stakeholders can provide a substantial barrier to a school social worker receiving informed consent to work with at-risk youth.

For many teenagers, privacy is a key concern and may be a risk factor if they perceive that their information will not remain confidential. Multiple studies have found that between 31-78 percent of adolescents will not seek mental health services due to issues regarding confidentiality and stigmatization (Block, Gjesfjeld, Greeno & Best, 2013). A lack of confidentiality in mental health and physical health settings can deter some adolescents from seeking services (Hollander, 1993). Public stigma, peer stigma, and self-stigmatization can potentially influence whether a student provides informed consent in regard to receiving mental health services. Gulliver, Griffiths, & Christenson (2010) found from reviewing 22 studies that young people perceive stigma and embarrassment as important barriers to seeking mental health services at school. Student perceptions of confidentiality and being stigmatized for seeking help may be significant risk factors in why a school social worker may not receive informed consent from particular students.
Parents play a critical role in how their child experiences school. However, many parents themselves may have had negative experiences in school, decreasing the likelihood of seeking out additional services (like the services of a school social worker) when their child requires additional supports. Additionally, although the vast majority want what is in the best interest of their children, many parents lack information about school social workers or have negative perceptions of the social work profession based on false stereotypes, possibly creating barriers from getting their child socioemotional help when it is needed. A national random sample of 797 parents found over 40 percent of parents had no idea whether or not their school had a school social worker on campus (Kirchofer, Telljohan, Price, Dake & Ritchie, 2007). In other cases, parents have false perceptions of the social work profession based on the media’s portrayal of child protective service workers and a false stereotype that social workers cheat the government (LeCroy & Stinson, 2004). Lack of knowledge of resources available and false perceptions can cause parents to fail to provide informed consent for their child, ultimately putting them at a higher risk of behavioral, academic, and emotional problems.

While the vast majority of teachers have a positive influence and serve as role-models to students, a minority of teachers can intentionally or unintentionally prevent at-risk students from receiving interventions from school social workers. Unintentionally, teachers are not trained in identifying students exhibiting mental health problems and many teachers admit to feeling inadequate in screening and determining if a student has a mental health concern (Graham, Phelps, Maddison & Fitzgerald, 2011). If teachers cannot identify students in need of a referral to a school social worker, some students
may advance multiple grades, allowing the problem to become more extreme. However, many teachers can intentionally create problems for students through psychological bullying. In most schools, there are 2-3 teachers who are considered bullies to their students and these individuals are less inclined to seek additional support services for their students who need additional emotional or behavioral support (McEvoy, 2005). Teachers who were unwilling to collaborate with school social workers and lacked knowledge of the social work profession also present barriers to practicing school social work (Teasley, Canfield, Archuleta, Crutchfield, & Chavis, 2012).

Finally, administrators, such as principals, can potentially be contributing to the problem school social workers face in attempting to receiving informed consent. School leadership has a direct correlation with school climate. However, principals who are not good leaders can inadvertently foster a negative school climate, which increases violence on campus, bullying, and student disengagement from anything associated with school. Students who hold aggressive attitudes and perceive the school climate to be tolerant of bullying were less likely to report a willingness to seek help (Williams & Cornell, 2006). Also, some principals use inefficient screening methods when trying to identify at-risk youth, missing a large segment of students who need help. The response to intervention model (RtI) is a three-tiered early intervention approach that incorporates evidence-based practices and screens all students reducing the number of at-risk youth not identified (Franklin, Harris, & Allen-Meares, 2013). A segment of public school administrators refuse to use this model in fear of parental disapproval and increased costs due to more students being identified as needing mental health intervention. School-based screening
can identify suicidal and emotionally troubled students not recognized by school professionals (Scott, Wilcox, Schonfeld, Davies, Hicks, Turner, & Shaffer, 2009). Scott et al. (2009) found the RtI model, on average, identified 27 percent more students at risk when compared to alternative screening methods implemented by principals. Many school districts have implemented policies and procedures that are inadequate at identifying students with mental health concerns and may pose a barrier to receiving informed consent.

Understanding which barriers to receiving informed consent are more prevalent and persistent will not only help the profession of school social work further evolve by addressing these issues head-on, but it will also help in creating innovative techniques and policy for reducing the number of students who fall between the cracks. Identifying common barriers school social workers have to cope with is crucial in developing solutions to prevent and reduce specific barriers. Every child and teenager has a right to succeed in our public schools, both academically and socially. Breaking down barriers blocking students from access to needed services and resources from school social workers is crucial in serving those who are marginalized within the public school system.

**Statement of the Research Problem**

The study was conducted to explore school social worker perspectives of what barriers within the home-school collaboration may significantly hinder their ability to receive informed consent to intervene with at-risk youth. The study was an evaluation of which barriers, manifested by teachers, students, parents, administrators, issues of
confidentiality, or other means, school social workers perceived to have impacted their ability to work with at-risk youth. In analyzing the data collected, it is anticipated that commonly faced barriers directly impacting school social workers and the frequency of these barriers occurring will be found within the Natomas Unified School District. This can lead to a better understanding whether or not barriers created within the home-school collaboration are indicative factors to school social workers failing to receive informed consent is crucial to the social, emotional, and behavioral well-being of all students in the NUSD.

**Purpose of the study**

The primary goal of this study is to explore the perspectives of school social workers on the topic of informed consent and what barriers could potentially be contributing to not receiving informed consent to work with at-risk youth. The mixed method study will examine school mental health professionals’ observations and opinions as to why students in need of mental health interventions in public schools go unnoticed and untreated. The researcher administered (12) surveys to school mental health professionals to explore potential barriers to receiving informed consent and to identify specific issues related to mental health workers’ experiences. In the field of school mental health, issues regarding stigma, lack of information, confidentiality, staff training, and parental involvement can play a crucial role in a student’s ability to be successful in public. Figuring out which barriers are more prevalent than others may facilitate changes needed to meet the needs of at-risk students in public school.
The secondary goal is to contribute advanced knowledge to school social workers and other school mental health professionals about barriers presented in the school setting than could prevent mental health workers from working with at-risk youth. By understanding which barriers are consistently presented when attempting to provide interventions to at-risk youth, mental health workers can work to address these issues and develop policy to meet every student’s social and emotional needs. The objective of this study is to figure out what barriers are frequently presented when mental health workers attempt to provide services to at-risk youth in order to increase the likelihood of helping students who struggle with mental illness that would otherwise not receive services needed.

*Theoretical Framework.*

School social workers are in a unique position to help others, as they can work within the school, family, social and community environments to facilitate change. These environments have a profound impact in a youth’s development and maturation. When a child or an adolescent has negative interactions in one environment, it can lead to negative influence in other environments. School social workers cannot just intervene in the school environment and have to look at the bigger picture, understanding the role the home, community and social environment play in how an at-risk youth interacts at school. The Ecological Systems Theory (EST) provides a theoretical framework necessary to identify specific systems that can be creating problems for an at-risk youth.
Ecological Systems Theory developed by Uri Brofenbrenner, cofounder of the Head Start program, a school readiness program for disadvantaged children under the age of five, proposed individuals exist within a variety of settings, starting at the individual level and extending outward into the family, friends, school, workplace, etc. (Duerden & Witt, 2010). We encounter different environments throughout life that can potentially influence behavior to a certain extent. The theory recognizes that development is a process involving interactions within and across various systems with which the individual interacts. For example, youth’s interactions within the family environment influence peer-selection and ability to resist peer pressure in school (Duerden & Witt, 2010). Influences within environmental systems can have positive and negative consequences in a child’s development.

Four systems make up the ecological systems model: the micro, meso, exo, and macrosystems (Brofenbrenner, 1994). The micro system is the direct environment we live in. It includes many systems such as friends, family, school, neighborhood, etc. (Brofenbrenner, 1994). The microsystem has a direct effect on a child’s behavior and beliefs, especially the home system. The mesosystem is the linkage between two or more environments containing the developing individual. The mesosystem is a system of microsystems and examines how the influence of one system on an individual influences their behavior in another system. For example, an individual’s family experience may be related to their school experience, such as negative experiences with peers may cause a child to withdrawal interacting in class. The third system is the exosystem, which contains two or more settings that indirectly influence a developing youth (the
relationship between home and a parent’s workplace). The final system is the macrosystem, which refers to institutional patterns of culture, such as the economy, customs, and body of knowledge (Brofenbrenner, 1994). When we are in an economic recession, it can have a detrimental effect on the family system and school system.

If an individual is experiencing problems or stress in one microsystem, it can create problems within other microsystems, such as a child who is having problems with their parents also having trouble with other authority figures. The theory recognizes that a child's or adolescent’s behavior represents the interactions between all four systems (Brofenbrenner, 1994). If a child does not have proper interactions in its microsystems, they may fail to explore the rest of their environment leading to anti-social behavior and a lack of self-direction (Brofenbrenner, 1994). Understanding the influence multiple systems has on a developing child or adolescent can help us understand complex interactive processes that contribute to maladaptive behavior.

School social workers aim, then, is to identify problematic transactional patterns between microsystems in a youth’s life. There are many potential risk factors created in a child’s direct environment (family, peers, neighborhood, etc.) that are expressed in the school setting, inhibiting and preventing a child from reaching their full potential in academia. Many children and adolescents cannot experience school positively unless other problems in microsystems are addressed. The school social worker, through assessment and intervention, can potentially influence the individual’s experiences in other systems positively. Making a Child Protective Services report, counseling,
preventing violence and gang activity, making resource referrals, creating enrichment programs, and collaborating with parents are just a few ways the school social worker can positively influence other systems. Also, understanding how macrosystems, such as culture, media, and socioeconomic status, influence a student is a necessity in practicing cultural competence.

When it comes to failure to receive informed consent to work with at-risk youth, the Ecological Systems Theory recognizes barriers created within the mesosystem, particularly within the home-school collaboration. There are numerous reasons why at-risk youth may deny informed consent. For example, a student may have been abandoned by a mother or father, and, because of this, may not want to work with a school social worker that is of the same gender of the parent that left them. On the other hand, a student may be bullied by peers at school, which may cause the student to avoid taking part in community sports. Parents may not provide informed consent to work with their child in fear of stigmatization in the social environment. When a problem occurs within a more significant microsystem, like the family, the problem is likely to manifest in another significant microsystems, like school, especially when those two systems have direct communication. Receiving informed consent to work with an at-risk student is crucial because the Ecological Systems Theory allows the student and school social worker to conceptualize the four domains of systems in a way that shifts viewing the student as a problem toward viewing the client as one part of a complex system.
**Definition of Terms.**

The following list of terms is used throughout the study and are significant terms used within the school setting, social work, and mental health. These terms will help describe specific areas of school social work and provide a specific framework for viewing school mental health and informed consent.

**At-risk youth:**

Children and adolescents under the age of eighteen who may be exhibiting problems such as: having trouble coping with the stresses of life, coming from single or dysfunctional families, being abused sexually, physically or emotionally, lacking social and emotional supports, experiencing violent behavior involved with delinquent peers, and/or failing academically.

**Informed consent:**

Is a legal process for obtaining permission before providing an intervention for an at-risk student that informs the student about the nature of the intervention, risks and benefits and student/parent rights. Children under the age of twelve must have parents provide informed consent to receive intervention, while minors ages 12-17 may provide informed consent due to mature minor status.

**School social worker:**
The link between home, school, and the community, which promotes student academic and socioemotional success through specialized interventions and assessments and helps remove barriers to student academic success.

Home-school collaboration:

A reciprocal relationship between the home (parents and families) and school (teachers, administrators, and school social workers) who share in decision making towards mutually common goals related to a student. The home system and the school system pool their resources to create a cooperative alliance to establish and achieve academic, emotional and behavioral goals for an at-risk student.

School-based mental health:

Mental health professionals who support positive student connections with peers, family, school and community to promote student development. Also, they help students deal with problems, crisis, and traumatic events while fostering resiliency, problem-solving skills, and healthy relationships to enhance school success.

School-based intervention:

A specific process aimed at alleviating or reducing problems impeding the well-being of the individual students ranging to the entire student body and, in some cases, the family and community. Interventions are specifically chosen based
upon ongoing assessments and are highly effective when the school social worker implements preventative and evidence-based practices.

Socio-emotional functioning:

An individual’s capacity to interact within the social environment and the individual’s ability to attach proper meaning to those situations.

Risk factors:

Variables that increase the potential for an at-risk youth to not reach their full potential. Conditions created within the home-school collaboration that increases the likelihood of a school social worker failure to receive informed consent to work with an at-risk youth.

Assumptions.

1. A portion of students who are at-risk due to academic, behavioral, and emotional issues do not receive the support and services needed and go unnoticed or unassisted.

2. Parents, teachers, students, and administrators can potentially consciously and/or unconsciously increase mental health problems within an at-risk student by creating unnecessary barriers to working with a school social worker.

3. School social workers are indispensable helping professionals on a school campus that, through training and education, are in the best position to intervene with at-risk youth.
4. The issue of confidentiality can either promote or reduce help-seeking behavior in at-risk youth and parents, depending on their perceptions.

5. There is insufficient knowledge about what mental health is and the school social work profession from the general public creating macro level implications to school social work practice.

**Social Work Research Justification.**

Understanding which barriers within the home-school collaboration consistently affect the process of obtaining informed consent to provide intervention with at-risk youth is crucial to furthering the school social work profession. The identification of specific barriers, confirmed by the study, can potentially lead to redesigning school policies, student screening processes, and changes within the home-school collaboration making at-risk students more accessible to school social workers. According to the NASW, the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty (Brill, 2001). Realizing, collectively, common barriers participants in the study face to receiving informed consent will promote awareness that specific problems are denying vulnerable populations of students the help needed to enhance their well-being. This study can potentially lead to larger scale studies, further research on the time, and collective problem-solving for lifting barriers.
Depending on the results of the research, social workers in schools may have to intervene and pay more attention to specific areas within the home-school collaboration. Social work practitioners may need to increase training sessions and consultations with administrators and teachers, increase communications and services provided to parents, and address specific issues affecting students, such as the school climate. If the findings indicate that the actions or inactions of teachers, students, administrators, or parents do not pose significant barriers to receiving informed consent, Natomas Unified School District can rule out each entity as an independent variable. Since this study may be the first to examine barriers to receiving informed consent for social workers, future studies should further examine other independent variables that influence working with at-risk children.

**Study Limitations.**

The primary focus of this study is to identify significant barriers to informed consent created by parents, teachers, administrators, confidentiality, and students. This study does not examine other areas, such as the school social worker, peer groups, etc. that can potentially create barriers to working with at-risk youth. Additionally, this study is focused on furthering the school social work practice, and is not applicable to mental health professionals in outside agencies who are contracted by school districts to provide mental health services to students. Finally, the researcher does not look at the impact funding sources (Individuals with Disabilities Education Act, McKinney-Vento, etc.) at the federal, state, and municipal level have on the capability to work with at-risk youth.
The limitations encountered during this study may restrict the generalizability of the findings.
Chapter 2

REVIEW OF THE LITERATURE

The purpose of this research study is to explore the existing barriers to receiving informed consent to work with at-risk youth for social workers. Herein, relevant research on many key issues regarding barriers to receiving informed consent for home-school collaboration will be presented. The literature review is organized into the following themes: confidentiality, the relationship between families and schools, and barriers created by teachers, parents, students and administrators preventing at-risk youth from receiving services from school social workers. The themes were selected based on their consistent presence in literature related to the research topic. The primary focus of each section will outline key research and studies related to that particular issue within the home-school collaboration.

Confidentiality

Confidentiality within a school setting is considered by many to be arguably one of the most complex elements of a school social worker’s job. School social workers, as do social workers in other practice settings, have a professional obligation to respect the privacy of their clients (La Voyce, 2012). However, furthering the intricacy of the school social workers role in maintaining confidence of student information are federal, state, and school district laws regarding minor confidentiality. La Voyce (2012) stated that
confidentiality is a critical element in developing and maintaining trusting relationships with students.

Many professionals in the field of school social work in California argue that the federal law regarding confidentiality of minors, Family Educational Rights Act of 1974 (FERPA), conflicts with California’s Mature Minor Doctrine. Typically, federal law trumps state law, unless state law elaborates into further details giving additional rights. This federal law afforded many privacy rights and FERPA guidelines apply to elementary, secondary, and adult students in public and private institutions that receive federal funds. They provide explicit regulations regarding the privacy and release of students’ educational records (Hall & Marsh, 2003). F.E.R.P.A came about due to misuse and abuse of students’ files from primary and secondary schools, as well as to protect students’ confidential information from being revealed to third parties that have no legitimate interest in the information (Weeks, 2001). Violations of FERPA can potentially lead to sanctions and a loss of federal funding from the Department of Education. The federal law, FERPA, has major social work implications, as it not only requires parents to provide informed consent to work with their child if they are under the age of eighteen, but also establishes that parents control the privacy rights of their students and can request information such as documents and conversations from counseling sessions. Overall, although minor clients have an ethical right to privacy and confidentiality in a counseling relationship, the privacy of minors legally belong to their parents or guardians (Remley & Herlihy, 2001).
Further confusing the issue of student confidentiality and informed consent in the state of California is the Mature Minors Doctrine. In regard to counseling and mental health services, the law states that a minor who is twelve years of age or older may consent to mental health treatment or counseling if they are mature enough to participate intelligently, and if the minor presents a physical or mental threat to themselves or others (National Center for Youth Law, 2006). This law also extends to medical care and counseling of minors twelve years and older who can consent to abortion services, drug and alcohol-related problems, and family planning (National Center for Youth Law, 2006). While the rights to providing informed consent heavily differ between FERPA and the Mature Minor Doctrine and without a clear focus on confidentiality and informed consent in California’s Education Code, rules regarding which laws to follow may be implemented at the district level.

When professionals trained in confidentiality, whether through social work or counseling, cannot agree on when to share or not to share private information, this can be potentially problematic for not only the student, but parents and families as well, creating a potentially strong barrier to receiving informed consent. In a recent survey of 204 middle and high school counselors across the United States, counselors were asked to determine whether specific adolescent risk-taking behaviors of varying intensity, frequency, and duration warranted parental and administrative notification (Moyer & Sullivan, 2008). Moyer and Sullivan (2008) found all behaviors of the counselors showed a statistically significant variance or disagreement among respondents with regard to their willingness to break confidentiality. Moyer and Sullivan (2008) noted that
confidentiality in a school setting could, in itself, be enough to prevent school social workers from receiving informed consent from parents and students, as both parents and children do not know what information will be shared, and with whom.

Due to differences in opinion regarding disclosure of information and complications between federal and California state law, students may be less willing to share private information because of a lack of transparency regarding disclosure policy. A landmark study during the 1990s involving student perceptions of confidentiality surveyed 1,295 Massachusetts high school students and found that a large majority (69 percent) had concerns with their physical and mental health, and that confidentiality was the most critical aspect determining whether or not they would provide informed consent (Hollander, 1993). Hollander (1993) also discovered that 25% of all students said they would forgo providing informed consent if there were a chance that their parents might find out, and 15% reported that they would forgo care if there was the possibility that their peers or teachers might find out. Finally, the study revealed students felt school-based health services were not adequate in protecting their private information and, because of this, made them less inclined to seek counseling and health services on their school campus.

The Massachusetts high school students’ perception that confidentiality is consistently breached in a public school setting has been proven to be true in many cases. There are few certified staff on a campus that have a strong working knowledge of laws and ethics regarding student confidentiality, and those individuals sometimes are
compelled, in the interest of a students’ education, to share this information with teachers and administrators. In many cases, it is in the student's and family’s best interest to disclose confidential information to develop a strong collaborative intervention (Feinstein, Fielding, Udvari-Solner & Joshi, 2009). Feinstein et al., (2009), a review of research regarding school-staff collaboration, indicated that students typically have one to two teachers with whom they have a therapeutic connection, making it necessary to inform teachers, to a certain extent, about the student's extracurricular considerations, so teachers can provide support in meeting the student’s educational needs. However, due to the need of collaborative interventions and lack of staff training in confidentiality, private student and family information is often needlessly shared with other staff (Hallet, Harger, & Eder, 2008). Many students and parents are well aware of teacher negative gossip about students and families that takes place in staff lounges and other informal settings. Research conducted during a two year qualitative study in the Midwest at an elementary school about workplace gossip found that teachers in informal settings, such as the teacher lounge, would routinely gossip about a student's poor academics, antagonizing behavior, and disclose confidential information about students to other staff who did not need to know (Hallet, Harger, & Eder, 2008). During the two year study, Hallet, Harger, and Eder (2008) also found that, unless a teacher intervened in these negative banters or conversations, the talk would become more demeaning about the student.

La Voyce (2012) contended that knowing information will be shared in confidence is crucial to providing interventions and receiving informed consent but also
noted that school social workers must accept their inability to offer their students absolute confidentiality. The literature has consistently voiced that the message must be conveyed to students and their families and that it should state that information about the family and child may be shared in situations requiring mandated reporting, or where there is a legitimate educational interest. Weeks (2001) specifically advised that school social workers must address reasons for breaching confidentiality when working with a student age twelve or older when the guardians of the child request to know what is going on with their child

**Home-school collaboration.**

The relationship between the school and the families that have students enrolled at the school is a key facilitator for promoting student achievement. A more trusting and positive relationship within the home-school collaboration leads to better communication, student engagement, and parental participation in school activities. A strengthened relationship between the home and school is also thought to be extremely beneficial when a student needs support for their mental health, making informed consent easier to obtain. However, when communication between the school and the home is problematic or non-existent barriers are presented to receiving informed consent due to a mutual lack of trust and respect by both the family and the school. Potentially, a negative or positive home-school collaboration can have a strong influence on a school social worker’s ability to receive informed consent to work with at-risk youth.
Home-school collaboration refers to the relationship between families and schools where parents and educators work together to promote the academic and social development of children (Cox, 2005). The recognition in the recent years that a home-school collaboration needs to happen for some students to succeed has sparked interest in researching the impact collaboration has on families and schools. Home-school collaboration does not simply mean parental involvement. The term focuses on the exchange of two-way communication working towards a common goal (Cox, 2005). Since the year 2000, there have been two major studies on the topic of home-school collaboration. Shepard and Carlson (2003) examined 20 school-based prevention programs that involved parents and examined characteristics to the best practices in home-school collaboration. The examinations of twenty studies in the 1990s of the home-school collaboration was conducted and results from the study showed that 15 of the 20 prevention programs showed positive treatment outcomes (Shepard and Carlson, 2003). The research from the 1990s collectively showed a shift from viewing home and school as two separate entities to seeing them as highly interrelated to a student’s success. Another study conducted by Cox (2005) reviewed eighteen home-school collaboration studies looking for common evidence-based practices within the home-school collaboration. The study in general found that home-school collaboration interventions involving a single at-risk student were highly effective in helping achieve desired school outcomes, including changes in academic performance, and school-related behavior (Cox, 2005). Home-school collaborations also create effective outcomes for behavior at home as well.
However, when there is not a strong relationship between parents, students, and the school, unnecessary barriers are created making it harder for a student to succeed and/or to get mental health services provided by the school. Lareau (2000) described social class as the key component to poor home-school collaborations. While parental involvement in school is positively linked to student success, working and lower-class parents fail to go to parent-teacher conferences at a rate of 60 percent (Lareau, 2000). Social class is considered a predictor on values of education. Upper and Middle-class parents have been shown to view family life and school life as interconnected while relations between the lower class and school have been shown to be based on separation (Lareau, 2000). Since teaching in public school is considered a “middle-class” profession, many teachers and administrators perceptions of students and parents are also based on social class.

**Teacher created barriers.**

In our society, public school teachers are in a unique position to impact how a child’s experience in the classroom and serve as a buffer for when a student struggles socially and emotionally. While the vast majority of teachers have a positive influence on at-risk youth and promote the process of informed consent by identifying students in need and working with parents, some teachers actually pose a burden to receiving informed consent reducing the likelihood of a child succeeding. Issues teachers may present directly relating to obtaining informed consent are teacher burnout, teachers bullying students, and teacher training related to mental health. Many teachers who are
emotionally exhausted by their job, belittle students and psychologically bully students and these types of individuals typically do not seek out mental health services for students in need causing teachers to be a direct barrier to receiving informed consent. Indirectly, many teachers do not have the knowledge and training needed to identify students with mental health concerns. Without the teacher’s ability to identify specific mental health symptoms or recognize a particular student is in need, students will go untreated without help from a social worker because the student has not been identified for help which is first needed for the informed consent process to take place.

Teachers play a significant role in how an at-risk child experiences school and are the educators who implement interventions in the classroom. Many teachers are seen as role-models and leaders, while other teachers, unfortunately, are seen as burnt-out or, possibly, as obstacles to student success. A positive student-teacher relationship predicts school adjustment and may serve as a protective factor for children at high risk of poor school and developmental outcomes (Lander, 2009). However, teachers may often engage in the psychological maltreatment of at-risk students, including making sarcastic comments, ridiculing, and name calling, contributing to the intensification of maladaptive behavior (Lander, 2009). How teachers manage a student’s behavior problems is critical to the overall functioning of a pupil.

Peer on peer bullying by students has become a major issue, as it can cause physical and psychological pain and is some cases suicide in students. There has been a large shift in education research to develop evidence-based bully prevention programs,
and with accompanying new laws and Supreme Court rulings, there has been a lot of effort to alleviate the consequences bullying creates. However, the teacher who bullies students usually receives no retribution or other negative consequences (McEvoy, 2005). Like stalked victims, students who are the targets of teachers who bully feel trapped in a situation where the abuser is all-powerful (McEvoy, 2005). Sometimes they may be literally trapped in an environment (e.g., classroom or office) where offensive conduct is imposed upon them, and there is no escape (McEvoy, 2005). When teachers bully students, especially those students considered at-risk, students are less likely to seek out help when they are in need.

Sylvester (2010) identified the four most common ways teachers bully their students. The first was sarcasm and making insensitive remarks in front of a classroom directed towards one student. This can have major consequences on a student’s academics as well as socioemotional functioning. The second form is "secret names," in which a teacher will not bluntly state a student is stupid, dumb, or a failure, but will use words and statements that have the same type of connotation. The third and fourth forms cited were trashing late papers and standing behind their reputation. Standing behind their reputation allows teachers to take on a fearful persona that allows them to threaten and humiliate students while at the same time making them fearful of the teacher (Sylvester, 2010). This form of bullying is often directed at students who they know have behavioral or academic issues prior to deviant behaviors occurring to create a strong authoritative classroom environment.
A study examining 236 college and high school aged participants examined perceptions of teacher-to-student bullying. The results from McEvoy (2005) found that 93 percent agreed that certain teachers in their schools bullied students or had been the victims themselves of teacher bullying. The study found that bullying is typically done by 2-3 teachers at a school site depending on school size. In addition, 77 percent of the participants felt that teachers could bully students without getting any type of reprimand. Teachers who bully students not only are less likely to refer at-risk youth to a school-social worker, but also may be a contributing factor to a student developing issues with mental health. Many of the students who are bullied were found to be disadvantaged or different than the teacher based on characteristics such as race, gender, sexual orientation, and social class. The bullying was found to be done typically by teachers who have tenure or an established position. Respondents identified 89 percent of the bullies as having taught at their school for at least five years (McEvoy, 2005). This gives indications that some of these teachers bullying may be experiencing burn out, chose the wrong profession to enter, or, potentially, enjoy belittling students.

Teachers are also central in identifying mental health concerns of their students. Teachers’ roles in promoting social development and reducing challenging behaviors gave Taylor and Adelman (2000) onus to suggest that teachers are proxy mental health service providers regardless of their training or professional domain. Teachers are now expected to be responsive to a wide range of student mental health needs and circumstances. They receive little in their pre-service and subsequent teacher education to adequately prepare them for such realities (Graham, Phelps,
Maddison & Fitzgerald, 2011). Ultimately, teachers may have the most profound impact on a student’s well-being at school, and that is why it is important that teachers have sufficient capabilities to identify and refer students expressing mental health issues. If teachers do not have adequate skills to recognize student mental health concerns, many at-risk youth may go unnoticed and undetected to school social workers. With twenty percent of children under the age of eighteen displaying mental health problems it is necessary to examine teacher capabilities to address this increasing segment of students (Reinke, Stormont, Herman, Puri, & Goel, 2011).

In a 2011 study on teachers’ perceptions of their capabilities to identify and address mental health issues, Reinke, et al. (2011) surveyed 292 teachers and their attitudes towards mental health. Results of the study showed that only 34 percent of the teachers felt that they had the skills necessary to identify and address students with mental health issues (Reinke, et al., 2011). The study also described teacher feelings that students needing mental health services slip through the cracks due to a lack of teacher training in that specific area. Although teachers in public schools are trained in classroom management techniques, some feel that the training is not adequate and they are not fully prepared to identify, intervene, and assess potential students who have mental health concerns. Evidence-based practices need to be implemented and introduced to teachers along with sufficient training and support from school psychologists and school social workers (Renke, et. al., 2011).
In the school setting, parent contact with teachers can be a determining factor in receiving consent from a child's guardian to let a school social worker work with their child. However, many teachers are not aware of the resources readily available to them to help with at-risk youth such as the school social worker. A 2010 study focusing on the perceived barriers of 284 school social workers indicated that lack of teacher knowledge and awareness of school social work tasks, and lack of resources, were identified as the biggest barrier to culturally competent school social work practice (Teasley et. al., 2012). While the study utilized a small sample size and knowledge of school social work can vary by rural, suburban, and urban setting, the study demonstrated a need for school social workers to actively convey the wide array of areas they are trained in to teachers and administrators (Teasley et. al., 2012).

At the same time, research also indicates in the practice of school social work that individual counseling dominates the profession, and work with teachers is less common. A national survey of school social workers found social worker-teacher sessions were an inconsistent part of practice, and many did not consider in-service training to teachers as part of their job (Berzin, O’Brien, Frey, Kelly, Alvarez & Shaffer, 2011). While research indicates collaborations between teachers and school social workers, as well as in-service trainings, promote social, emotional, and behavioral health of students.(Berzin, et. al., 2012) In many cases there is a lack of collaboration creating distance in understanding what school social workers are capable of on campus and the role teachers can play in mental health interventions.
In another similar study of 2,956 school social workers, it was found that the majority of school social workers collaborate, consult, provide resources and create behavior support plans with and for teachers (Berzin, et. al., 2011). Berzin et. al. (2011) also found during the courses of their study that 10 percent of school social workers were considered “non-collaborators” with teachers and had little, if any, collaborations with teachers. A study this large, showing that one in ten school social workers do not collaborate with teachers who are the source of over 50 percent of the referrals for school social work services, implies that there is a lack of staff knowledge of the school social worker’s role on campus, and that these social workers lack engagement, training and skills necessary (Berzin, et. al., 2011). As a consequence, non-collaborating school social workers may create a situation where at-risk youth are not referred to them due to lack of contact with other school personnel.

Kindergarten through twelve grade teaching is a profession characterized by high levels of emotional exhaustion and burnout. Due to the isolated environment, teachers may become frustrated, bored, and depleted as they privately struggle with their anxieties (Chang, 2009). Another cause of teacher burnout is that teachers often feel drained intellectually and emotionally when they deal with student misbehaviors (Chang, 2009). This, in turn, decreases the likelihood of teachers seeking out academic and mental health resources for their students. Teacher burnout is creating a teacher shortage. Almost forty percent of teachers leave the field of education within five years (Milner and Woolfolk, 2004). A high turnover rate, especially in elementary schools, can reaffirm attachment issues and promote social distance between teachers and
students. Internally, for some teachers who remain in the profession, fatigue and burnout harms the classroom, school, and prevents adequate services and referrals for at-risk youth (Olivier and Venter, 2003). Also, schools that had a lower socioeconomic status tended to have higher reports of teachers feeling burnt out and teacher turnover (Chang, 2009). Basically, the schools where there is a large demographic of low-income students, an increased need for resources and role models there is a higher teacher burn out rate.

In another study that compared two groups of teachers, one with National Board for Professional Teaching Standards (NBPTS) certification, and the other without NBPTS certification, found that those with the NBPTS certification experienced significantly lower levels of burnout than teachers without the certification (Pucella, 2011). In the study, Pucella (2011) found that 80 percent of the teachers who had NBPTS certifications reported low levels of burnout while 34 percent of teachers who did not have a NBPTS certification experienced low levels of burnout. This study and other studies expressed similar results showing that teacher training is a strong necessity for the success of school social workers to work with at-risk youth, and ultimately receive informed consent via teacher referral.

**Parent created barriers.**

For children under the age of twelve, informed consent is only possible when a parent signs a permission form. A signature on this document can make the difference between intervening with a student in need or letting them go untreated. Most parents
will go above and beyond to get their child the services they need. However, some parents directly present a barrier to receiving informed consent. Some parents have negative perceptions of the school system and the social work profession based on personal experiences in school and how the media portrays social workers. This mistrust creates a situation where informed consent is highly unlikely because trust is a crucial component for a positive school-parent relationship. Many students with mental health needs have parents with mental health problems making the process of seeking help for their child and providing informed consent harder due to their specific mental illness. Lack of understanding of symptoms of mental illness is another problem in receiving informed consent. A barrier to receiving informed consent is created when parents cannot identify mental health symptoms in their child or try to convince themselves that nothing is wrong.

Parents play a vital role in accessing mental health care for children and adolescents. In a year, around 20 percent of children and adolescents will experience a mental health problem (Boulter & Rickwood, 2013). Teenagers and children alike both turn to their family and friends when they are experiencing mental health problems. However, many parents do not recognize a mental health problem in their child and seek out services. The rates at which parents perceive or recognize a problem in their child’s mental health varies across studies, but Teagle (2002) found it to be as low as 16 percent. In other similar studies, the percentage of parents recognizing a mental health problem in their child never goes above 20 percent (Teagle, 2002). Even if behavioral problems are quite severe, the majority of parents feel they do not need to seek
professional help. 66 percent of parents of children who met the diagnostic criteria for Attention Deficit Hyperactivity Disorder did not perceive they needed services or there were mental health concerns (Bussing, Zima, Gary & Garvin, 2003). However, Boulter & Rickwood (2013) discovered that when a child’s mental health issues are externalized and it impacts their family and parent’s well-being, services are more actively sought out by parents.

In many cases, the parents themselves of at-risk youth are in poor mental health. In a 2011 study, that examined data from the 2007 National Survey of Children’s Health on 80,982 children ages 2-17, the researchers found an association between children and parent’s mental health status (Bennet, Brewer & Rankin, 2012). The study found that roughly 32 percent of children experience poor mental health if their parents’ mental health is in bad condition (Bennet, Brewer, & Rankin, 2012). The findings also suggested that a non-white racial/ethnic background, lower social class, male gender, parental unemployment, single-parent households, and living in a dangerous area were strong contributing factors to mental health status of children and parents. Some parents with mental health issues are less inclined to seek mental health services for their children due to barriers created by their own mental health.

Many parents have had negative personal experiences with the education system making them more hesitant to get involved or to provide consent to work with their child. When attempts to involve parents stall, or fail altogether, negative side effects tend to follow (Alameda-Lawson, Lawson & Lawson, 2010). Chief among these are educator's
perceptions that parents are not committed to their children's education (Alameda-Lawson, Lawson & Lawson, 2010). In a recent study, an analysis of 12,426 parents who completed the National Household Education Surveys-Parent and Family Involvement Survey revealed that parent's participation in school is linked to better grades and behavior, and is associated with supportive schools and positive parenting practices (Toldson & Lemmons, 2013). The study also revealed that parents who were Black or Hispanic, non-native English speakers, lived in unsafe neighborhoods, and had less than a high school education were less likely to visit their child’s school (Toldson & Lemmons, 2013).

There are many reasons why parents are not involved in their child’s education. One major issue is the demeaning treatment of some low-income parents by schools. These parents have often had negative experiences as students at schools. One ambitious study that interviewed 350 low-income parents found that all low-income parents interviewed carried bad memories of schools and talked about being intimidated by teachers and administrators (Lott, 2001). Many low-income parents develop a sense of learned helplessness when it comes to their children’s education because, while they were in school, they were taught to recognize that intelligence and value were only traits of the economically advantaged (Lott, 2011). The feeling of perceived powerlessness by low-income parents creates a sense of having little control over their child’s educational fate and fosters a lack of confidence when attempting to intervene at school.
Yet, despite the considerable barriers schools create for low-income parents, recent research indicates these parents are resilient when it comes to their child’s education and future. Stereotypes of low-income parents not caring about their child’s education, behavior, and mental health are just not applicable to all low-income parents (based on them missing parent-teacher conferences, lack of communication, parenting-style or student continuous behavioral problems). The Hart Research Center conducted a survey of 1,006 parents who had children in high school or recently graduated, and the finding showed a major divide based on socioeconomic status of parents and the schools their students attend. While 92 percent of African-American and 90 percent of Hispanic parents consider college as very important, collectively, both parent groups strongly felt (85 percent) that the low-income school their children attended did not challenge them (Bridgeland, Dilulio, Streeter & Mason, 2008). Parents of students in low-income schools are less likely to communicate with teachers, as the study found that slightly over half (51 percent) of low-income parents have conversations with their student’s teachers (Bridgeland et. al., 2008). The study also found that low-income schools are significantly less likely to notify and engage parents if their child is having academic or disciplinary issues. High-performing schools are more likely than low-performing schools to inform parents right away if their child is having academic or disciplinary issues (53 percent versus 25 percent), and more likely to encourage parents to be actively involved and to make them feel welcome in the schools (82 percent versus 51 percent), showing a significant divide based on parental wealth (Bridgeland et al., 2008).
School social workers aim to promote achievement among students who are experiencing academic problems due to social, emotional, and behavioral problems. Social workers also collaborate with parents by helping address student and parent needs and connecting them with resources. However, in many cases parents are unaware of the presence of school social workers on their child’s campus, and the services that social workers provide. In a recent study of parents’ perceptions of school health personnel, 41 percent of parents did not even know if there was a school social worker on their child’s campus (Kirchofer, Telljohan, Price, Dake & Ritchie, 2007). The study of 797 elementary school parents also found that only 22.6 percent of the schools had a social worker and they worked an average of 18.8 hours a week making availability of school social workers to parents and their students highly insufficient (Kirchofer, et. al., 2007). The findings indicated a strong lack of awareness of the presence of school social workers on elementary school campuses by parents due to part-time status of these social workers, a school having no social worker, and a lack of interaction between students and the social worker. While data supports the need for well-trained mental health professionals, such as school social workers, to be a part of the educational team to help students address social, emotional, and behavioral needs; a lack of awareness of school social workers by parents creates potential barriers to receiving informed consent and implementing interventions.

Some parents’ lack of knowledge of school social work may be influenced by how the public views the helping profession of social work and is another potential barrier to receiving informed consent. Understanding the public’s perception of social
work can contribute to the continuing growth and value of the profession (LeCroy & Stinson, 2004). Also, the general public’s opinion of social work can potentially help in identifying false stereotypes and barriers in school social work practice. LeCroy and Stinson (2004) conducted a random, national, telephone survey of 386 participants to understand their views on the social work profession. Respondents were asked to answer “yes” or “no” to multiple questions about negative and positive stereotypes of social workers. Almost one in five (18.8 percent) believed social workers take advantage of the government, and 35 percent viewed the social work profession as having the power to take children away from their families (LeCroy & Stinson, 2004). Although the results of the study were significantly positive showing the public views social work as very important (84.8 percent) and social workers were perceived as more valuable than other helping professions (social work, 60.8 percent; psychologists, 44.8 percent; counselors, 58.3 percent) by respondents, data from the survey showed there is still ongoing confusion about the social work profession. Media portrayal of child services workers and other false, negative stereotypes can potentially blind parents from actively seeking services from social workers, thus presenting a barrier to receiving informed consent due to poor public perception of the profession.

**Student created barriers.**

Informed consent with students, particularly adolescents can be harder to receive than with younger children. This age group may not seek out services because of the fear of being stigmatized by others, common myths our society holds about people who have
a mental illness, and the inability to recognize symptoms of mental health disorders.

Lack of information may be the biggest contributor to student created barriers for a social worker to receive informed consent to intervene with a student. Also, the perception that others will view you differently and a misguided understanding of confidentiality can greatly reduce students seeking help for mental health services. Another potential barrier to receiving informed consent.

For many students with mental health problems, failure to obtain mental health treatment will increase their likelihood of intensifying short-term and long-term symptoms. Many adolescents with mental disorders experience peer group problems and poor school performance (Block, Gjesfjeld, Greeno & Best, 2013). However, multiple studies have found that 31-78 percent of adolescents will not seek out mental health services, creating a major barrier to working with at-risk youth. Block, et. al, (2013) conducted a mixed-method study with twenty-five adolescents referred to mental health care through a school-based referral service in Western Pennsylvania. The study found that 40 percent of the students did not follow through with mental health services, citing autonomy, stigmatization, and need for privacy as reasons why they did not try to get help (Block, et al., 2013). All participants believed that mental health treatment was an issue that would cause their peers, teachers, and, in some cases, parents to stigmatize them. The results of the study also found that those who did not seek mental health services were less likely to experience fear of being stigmatized as compared to those who utilized mental health services (9 of 13 students utilized mental health services)
showing that anxiety over being labeled and stigmatized was the greatest barrier preventing youth from seeking mental health services in the study (Block, et al., 2013).

In a similar study on adolescent mental health, Moses (2010) sought to understand self-stigma experiences of teenagers who were the recipients of mental health treatment. The findings were based on data from separate interviews of 60 adolescent-parent dyads. Focusing on the individual teenager and their parent(s), the study showed that 20 percent of parents and students reported significant concerns about self-stigmatization (Moses, 2010). Moses (2010) also found that one third of the teenagers from the study felt that people will not like them anymore due to their behavioral and emotional issues, and some parents in the study (30 percent) felt shame about their child having mental health problems and would try to conceal it. Self-stigmatization can put these young youth at greater risk of developing a chronic mental illness and identifying themselves based on that mental health disorder.

When it comes to receiving school-based mental health services, student attitudes about providing informed consent to mental health treatment can be largely based on their personal experience with mental health professionals. Chandra & Mikovitz, (2007) interviewed 57 suburban, mid-Atlantic, eighth graders and found that 90 percent of the participants who had a prior beneficial experience with a counselor or social worker non-related to mental health were more likely to change their views on mental health and receive services. However, the majority of respondents described having negative views of mental health based on family conversations, peer
conversations, and conversations with school staff. Four-fifths of respondents described their family as avoiding conversations about mental health, and over half of the teenagers felt their parents would be upset with them, or deny that they have a mental health issue altogether (Chandra & Mikovitz, 2007). Students, especially male students that were in the study, also strongly felt that peers would react negatively to other peers seeking mental health services. The respondents described peers viewing those who seek mental health services as weak, necessary to avoid, and an easy target to bully or tease, and would associate mental health problems with mental retardation or being psychotic (Chandra & Mikovitz, 2007). Finally, results of the study found that students perceived teachers and other school staff as not caring about a student’s mental health concerns, unless the students involved were the ones with behavioral problems and bad grades.

One of the most devastating results of undiagnosed and untreated mental illness is suicide. Up to 90 percent of adolescents and young adults who die from suicide suffer from mental illness (Moskos, Olson, Halbern, & Gray, 2007). Yet, the perceived stigma attached to mental illness can prevent even those with the most severe cases (such as suicide) of mental health problems from seeking help. While there is a substantial amount of research regarding barriers to mental health treatment among teenagers who attempt to commit suicide, Moskos, et al. did a study in Utah, interviewing 49 parents of the adolescents who committed suicide (2007). The study found six significant themes as a result of interviewing parents about perceived barriers to their deceased child not receiving mental health treatment. 73 percent reported the deceased believed nothing could help, 71 percent believed the deceased perceived seeking help as a sign of
weakness, 58 percent of parents felt that the teen who committed suicide was reluctant to admit that he or she had a problem, and 52 percent felt the decedent felt too embarrassed to seek help (Moskos et al., 2007). Another significant finding from the study was that the majority of parents (31) sought mental health services for their child but were put on a waiting list and had a negative experience with mental health providers (Moskos et al, 2007).

In a 2010 meta-analysis of 22 published studies focused on adolescent perceived barriers to receiving mental health services, Gulliver, Griffiths and Christenson (2010) found five key recurring barriers. Public stigma, peer stigma, and self-stigmatization was rated the highest by the researchers as it was found to be the key barrier in ten of the studies analyzed. Confidentiality was rated second highest (main concern in 6 studies), followed by difficulty identifying the symptoms of mental illness (5 studies), self-reliance and not wanting to seek help (5 studies), and lack of knowledge of mental health services (4 studies) (Gulliver, Griffiths & Christenson, 2010). This study and the other studies previously mentioned show critical misconceptions and fears surrounding mental health to a point where the perceived reaction of others can prevent students from giving informed consent to receive mental health services from a school social worker.

Another potential risk factor for a student not seeking help for their socio-emotional needs is student engagement. Student engagement is considered by many to be the most critical variable in student dropout rates. Student engagement is a concept that requires psychological connections within the academic environment in addition to active
student behavior (Christenson, Reschly, Appleton, Bernam-Young, Spanjers, & Varo, 2008). Positive relationships with adults and peers, and attendance, effort, participation and pro-social behavior are critical elements that determine whether a student is engaged in school or not. Christenson et al, (2008) recognized four major subtypes of student engagement: academic, behavioral, cognitive, and psychological. When students are psychologically disengaged they have feelings of not identifying with the school or that they do not belong, and a lack of connection to the school and to support services (Reschly & Christenson, 2006). This lack of psychological engagement creates a situation where students are at increased risk of dropping out and not seeking help.

While many causes of student disengagement are created from within the school, such as a hostile school climate, poor teaching styles, and a disconnect between adults and students, many reasons for disengaging and not seeking help when needed can be internal traits of a student. According to Balfanz, Herzog, & Mac Iver (2007), poverty was the highest predictor of disengagement, followed by the onset of adolescence, living in dangerous neighborhoods, and attending chaotic, disorganized, and underfunded schools with high teacher turnover. The longitudinal study examined 13,000 students from 1996 to 2004 who lived in high-poverty areas and found that a significant amount of the students are recruited from an early age by their families to be caregivers, by drug gangs to be cheap labor, or by peers to be colleagues on out-of-school adventures (Balfanz, Herzog, & Mac Iver, 2007). The researchers also found that ten day or more absenteeism increased from 15 percent in elementary school to 55 percent in middle-school for these students (Balfanz, Herzog, & Mac Iver, 2007). Low-income students are
more at-risk of becoming disengaged from school and dropping-out, and this provides a major barrier to helping professionals attempting to provide intervention due to an inconsistency in attendance and availability to receive informed consent from the disengaged youth.

*Administrative barriers.*

School leadership is a crucial element in the process of receiving informed consent to work with at-risk youth. Not only do school administrators refer students in need, they also implement school-wide policies and procedures that dictate what kind of school climate will be present. If students do not feel safe at school do to violence, bullying, and drugs, many students will not feel safe enough to seek help and provide informed consent for services needed. Also, student identification for mental health services greatly depends on how the school principal wants to identify students. Many principles use evidence-based screening processes while other principles do not. Those who do not use evidence-based screening processes identify less students in need of help from a school social worker and without identifying those students informed consent is impossible because some students in need were not recognized.

Educational leadership can quite possibly be the single most important factor in creating and maintaining a positive and constructive school climate. It can serve as a buffer for at-risk youth. School climate, school principle leadership, and quality instruction are frequently associated with effective schools (Kelley, 2005). As
instructional leaders, principles can foster an understanding of the school mission, facilitate implementation of the mission, and establish what type of climate the school will have (Kelley, 2005). The school climate is a major aspect of the school environment that everyone at the school experiences and which affects the participant’s behavior based on their perception of the school. When there is not a strong and positive school environment, it causes students to disengage, academic achievement to go down, and students to be less likely to seek help for social or emotional needs (Kelley, 2005). The principal’s behavior is directly related to school climate. Kelley (2005) measured the perceptions of principle leadership and how it relates to school climate by interviewing teachers at 31 different elementary schools. The researcher found three common themes teachers associated with negative school climates that involved principal leadership. The first was poor communication skills, such as not listening and not adequately sharing information. The second perceived barrier to a successful school climate was the principal's inappropriate response in certain situations (Kelley, 2005). Unnecessary and excessive suspensions and expulsions of students and disregarding staff input were examples of improper responses by principals. The final leadership style that teachers found to have a negative impact on the school climate was principals being too flexible. For example, not having consistent student discipline can correlate with a negative school climate that in some cases allows bullying to happen, and increases violence on campus, and student disengagement from needed academic and mental health services (Kelley, 2005).
Characteristics of a positive school climate are associated with lower risk behavior in students. Higher levels of school sense of community were also associated with significantly less student drug use and delinquent behavior (Klein, Cornell, & Konold, 2012). Bullying on a school campus is considered a major indicator of a negative school climate. A bullying school climate is associated with key student risk behaviors of fighting, substance abuse, depression, weapon-carrying, students not seeking help for socio-emotional needs and poor principle leadership (Klein, Cornell, & Konold, 2012). In a 2012 study by Klein, Cornell, & Konold of 3,687 high school students who completed the School Climate Bullying Survey, the results showed that a positive school climate may be the biggest prevention measure a school can take in reducing risky behavior of students. They found from their study that students’ willingness to seek help was not statistically significant (p=.22) in a school environment that had a significant level of aggressive attitudes and a prevalent rate of bullying and teasing. The study also found that students who felt their school climate was not positive reported higher levels of substance abuse, aggressive behavior, avoiding school, sadness, and suicide (Klein, et. al., 2012).

Bullying often thrives in negative school climates because teachers and principals are unaware that it is taking place, or do not take necessary measures in addressing or preventing bullying. Williams and Cornell (2006) found that help seeking declined from grades 6-8 and was lower among males than female students. Students who are at-risk are less willing to seek help for bullying, mental health issues, and other dangerous behaviors (Williams and Cornell, 2006). Understanding why students refrain from
seeking help is crucial in helping, but we must also consider barriers in the screening methods used in identifying at-risk youth in need of support. A response to intervention (RTI) model is widely considered one of the best practices of early intervention with at-risk youth, because RTI uses many evidence-based practices, and is data-driven (Franklin, Harris, & Allen-Meares, 2013). RTI involves screening all students for academic/behavioral problems and then systematically applying data-driven curricular modifications and adaptations to students who don’t meet established benchmarks to bring them up to academic and behavioral levels of success in relation to their age-peers (Franklin, Harris, & Allen-Meares, 2013). This method not only involves a high degree of collaboration between the home and the school, but is also recognized in federal and state legislation as a priority within public schools. RTI operates in a three-tier framework. In Tier 1 the entire school receives intervention (peer mediation, anti-bullying curriculum, suicide questionnaires, etc.); Tier 2 involves focusing on a clusters of students (group counseling, pregnant teens, classroom intervention, etc.); and tier 3 focuses on one-on-one intervention (counseling, etc.) (Franklin, Harris, & Allen-Meares, 2013). However, despite strong support and the evidence-base for RTI, many school principals do not use the three tier approach causing many at-risk students to slip through the cracks without being identified for intervention.

Many principals often opt out of school-wide screening, based on perceptions that implementation faces more barriers such as parental disapproval, fear of costs and potential of identifying a large number of students needing mental health services, and issues regarding legality. However, just relying on informants such as counselors, social
workers, psychologists and teachers has been proven through numerous studies and data to be less efficient than a school-wide screening process for identifying at-risk youth. In a 2009 study to determine the degree of overlap between students identified through school-based suicide screening and those thought to be at-risk by school administrative and clinical professionals, the results showed a significant difference in students identified as at-risk (Scott, Wilcox, Schonfeld, Davies, Hicks, Turner, & Shaffer, 2009). The study administered the Columbia Suicide Screen to 1,729 students in the New York area and found that 23 percent screened positive for being at-risk (Scott et. al, 2009). Scott et al. (2009) found that only 13 percent of those who screened positive were identified by school professionals. School-based screening can identify emotional troubled and suicidal students not recognized by school professionals, increasing the likelihood of receiving informed consent to work with at-risk youth due to more efficient student screening.

**Summary**

After a comprehensive analysis of literature related to issues involving the home-school collaboration, a gap in research was found directly involving school social workers’ perceived barriers to receiving informed consent. The absence of information shows a further need for research to take place in determining which barriers are potentially significant factors in not receiving informed consent. The literature identified potential risk factors that had school social work implications, but the research and studies reviewed did not identify the risk factors as having a correlation with not
receiving informed consent. Potential risk factors identified by the literature that prevented student success are listed in the following paragraph.

Many students will not share private information or seek counseling due to a fear that their parents or peers may find out what they are saying. Risk factors preventing students from receiving services created by teachers included: bullying students, lack of training in identifying at-risk youth, awareness of the school social work profession, perceptions of low-income parents and teacher burnout. Parents who deny their child has mental health problems, and experience mental health problems themselves, had a negative experience in school. Low-income parents have negative perceptions of social work, and their lack of knowledge of school social workers at their child’s school increases the risk of their student not receiving services needed. The fear of stigmatization and unrealistic perceptions of mental illness contribute significantly to students not seeking out mental health services as well as student disengagement. Poor principal leadership leads to a poor school climate and inept methods of identifying at-risk youth, leading to student disengagement and students with mental health concerns going undetected by school social workers.
Chapter 3

METHODOLOGY

The purpose of this study is to help identify if there are common barriers created within the home-school collaboration that can potentially prevent school social workers from receiving informed consent to provide services to at-risk youth within the school setting. If there is no informed consent given, then no needed services can be provided to students. The identification of specific barriers, confirmed by the study, can potentially lead to redesigning school policies, student screening processes, and changes within the home-school collaboration; making at-risk students more accessible to school social workers. The purpose of this chapter is to explain the methodology used by the researcher during the process of developing and analyzing data. The sections within this chapter will examine the study design, sampling and data collection procedures, instruments, data analysis, and provide a discussion of the Institutional Review Board process.

Study Design

The study will have a mixed method descriptive design using both qualitative and quantitative forms of data analysis. The qualitative aspect of the study will attempt to discover and describe the feelings, knowledge, and attitudes of school social workers about barriers to receiving informed consent to work with at-risk children. The quantitative aspect of the study will provide standardized measurements and numerical
values to the school social worker responses. Quantitative methods are an approach to data collection that measures the quantity of something (Dudley, 2011). A questionnaire was developed comprising twenty-four questions. The survey contains a combination of twenty quantitative questions and four open-ended qualitative questions asking participants within the Natomas Unified School District to describe their feelings and experiences in school mental health services. The results of the study are primarily focused on gaining a better understanding of potential barriers within the home-school collaboration that can ultimately prevent school social workers from receiving informed consent to provide services to the students within the school district.

Natomas Unified School District was primarily selected for this study based on the ethnic and cultural diversity of this northwest area of Sacramento. Based on area code, Natomas is the 9th most diverse area in the United States with Natomas High School being identified as the second most ethnically diverse high school in the nation (Natomas Buzz, 2014). With this much diversity in an area with a population of approximately 99,000 and 10,300 individuals attending NUSD schools, social workers and other mental health professionals play a key role in providing culturally competent mental health services. Also, unique to their position to help students in such a diverse school district, is that these mental health professionals can identify barriers to receiving informed consent based within a specific cultural context as well as recognizing issues that prevent informed consent that cross cultural boundaries.
Sampling Procedures

The sample type will be a non-probability criterion sample. The criterion sampling approach is often used because a study is interested in the views of people with a certain experience or set of circumstances (Dudley, 2011). Social workers and other helping professionals that help at-risk students and families within the Natomas Unified School District will be the sample frame. The researcher met with the Natomas Unified School District’s social work liaison to identify other social workers and helping professionals within the district. During the meeting, the social work liaison for the school district identified thirteen participants with backgrounds in social work, marriage and family therapy, psychology, and counseling. Prior to collecting data, the researcher will contact all potential participants by email, or phone to set up a time to meet at their specific school site. The meeting will only last about 5-10 minutes, and the purpose of the study, along with voluntary consent and confidentiality, will be discussed.

Data Collection

Upon this initial meeting, a questionnaire will be distributed, along with an informed consent form, stating the purpose of this study and insuring confidentiality and anonymity throughout the process. During the time period from 12/02/2013 to 12/04/2013 the researcher met with the thirteen potential participants to explain the study and why it is being conducted. The researcher visited eight school sites ranging from elementary schools to high schools within the Natomas Unified School District. During
the first meeting, the researcher also explained that he will pick up the survey a week from the day it was presented to the participants, and also explained that a Starbucks gift card will be rewarded to them upon completing the survey. Also, two manila envelopes will be presented to each participant, one for the informed consent form and the other for the questionnaire. Once the researcher has received all surveys and informed consent forms, they will be combined into two larger manila envelopes so the researcher does not know which surveys belonged to what participants.

**Instruments**

A questionnaire was utilized to collect data containing twenty-four questions. According to Dudley (2011), questionnaires present no interviewer bias and privacy and anonymity are more likely to be assured. The survey was comprised of twenty quantitative questions and four open-ended questions that required at least a one to two sentence response. The instrument included nominal, prenominal, ordinal, and interval/ratio levels of measurement. The nominal level questions were focused on demographics and other questions that required the participant to answer with a “yes or “no” or decide between two distinct categories. Ordinal level questions utilized Likert-scales and questions on attitudes ranging from four to nine point scales. An example of a Likert-scale is used in the survey when participants were asked if “informed consent is preventing you from working with at-risk youth?” The participant would have to choose “never,” “hardly ever,” “sometimes,” “a majority of the time,” or “all the time.” The prenominal questions would list characteristics of a nominal response category and ask
the respondents to check all that apply. The interval/ratio level questions were designed to have respondents select a specific percentage range where each value was of equal distance. Question 23 asks “what percentage of at-risk youth at your school location do you feel you are aware of?” The participants have to choose either 0-20%, 20-40%, 40-60%, 60-80% and 80-100%. The other instrument used was a participant consent form that outlined the purpose of the study and how the participant’s information and identity would remain anonymous and confidential.

Data Analysis

After all questionnaires were obtained, the researcher used two different techniques to analyze the data collected. For the quantitative questions, SPSS (Statistical Package for the Social Sciences) was used to enter the information contained and run a data analysis. The researcher was primarily concerned with descriptive statistics as a way to describe the responses to all of the quantitative questions. Primarily, the focus during statistical analysis was toward examining the variation of responses to different questions using percentages. However, a mean score was utilized for both the 4-point and 9-point Likert Scale which were questions seven and eighteen in the survey. Four of the questions from the survey required quantitative analysis. All qualitative responses were transcribed into Microsoft Word.
Protection of Human Subjects

In order to ensure the safety and confidentiality of potential participants in the study, the researcher submitted a Request for Review for the protection of Human Subjects before the research questionnaire was administered. The researcher submitted a Human Subjects Review application to the Sacramento State Committee Division of Social Work for approval to move forward with the study. The Human Subjects review application requires the researcher to explain the purpose of the study, design of the study, procedures, how data will be analyzed and protected, who the participants will be, and how will the subjects’ right to privacy and safety be protected. The committee approved the researcher’s Human Subjects Protocol # 13-14-019 on October 31, 2013 as exempt under 45 CFR 46.101(b) because the study will be asking professionals in the field of school mental health questions that do not cause any level of harm and provides participants with 100 percent confidentiality and anonymity. The informed consent form notified participants that this study was 100 percent voluntary and they had the right not to answer questions if it made them uncomfortable. Also, the informed consent form notified potential participants that data would be destroyed after being analyzed and transcribed and that nobody except the researcher would have access to their anonymous and confidential responses to survey questions. They were also informed that personal identifying information was not necessary for this study.
Chapter 4

STUDY FINDINGS AND DISCUSSION

The purpose of this study was to identify if there are any barriers to receiving informed consent from the perspective of school professionals that provide mental health services to at-risk youth. To gain a better understanding of barriers within the home-school collaboration, twelve school professionals were asked to fill out a twenty-five question survey to help the researcher gain a better understanding of specific barriers preventing interventions with at-risk youth. Issues related to confidentiality, parents, students, teachers, and administrators were explored in the survey as potentially common barriers mental health workers may face in the Natomas Unified District to receiving informed consent. Also, the range of services provided by the helping professionals will be presented.

The results of the study will be organized into multiple sections. The first section will present the overall findings. In this section, demographic data will be presented on the school population the helping professionals serve and services provided. The following section will present specific findings related to the research purpose. The specific findings section was organized as follows: (a) perceptions of reaching out to at-risk youth and general feelings. (b) The process of receiving informed consent and potential barriers presented by informed consent. (c) Potential barriers to receiving informed consent presented by teachers. (d) Potential barriers presented by parents to
receiving informed consent. (e) Potential barriers students present to receiving informed consent. (f) Potential barriers administration presents in receiving informed consent. (g) Specific factors contributing to not receiving informed consent, other potential barriers outside the home-school collaboration that may contribute to not receiving informed consent, and additional comments. The final two sections of the chapter will provide an interpretation of the findings and a general summary of the chapter.

Overall Findings

Demographic Information

Respondents from the study all worked at different school sites in the Natomas Unified School District, practicing at elementary schools, middle schools, and high schools. Helping professionals identified students with a working-class background as a population whom they predominately serve (83.3%). Low-income students were identified as the second population served based on socioeconomic status (75%). The population helping professionals worked with the third most was students coming from middle-class families (25%). Finally, participants did not identify upper-class as a population to whom they provide services (0%). This data suggests that the majority of students within the Natomas Unified School District come from predominately low-income and/or working class families (86.4%).

Based on the data obtained from participants, Natomas Unified School District predominately has students coming from Hispanic and African-American communities.
The Hispanic population was identified as having a significant presence at 80% of the schools participants work at. African-American students also make up a majority of the student population served at schools (80%). Half of the participants identified white students (50%) present at their school site and 30% of the participants identified students as mixed. 0% of respondents selected other showing that the majority of the students within the district are either Hispanic, African-American, and/or white.

**Services provided by mental health workers.**

Due to the diversity of issues with which participants deal, there is a wide variety of services provided. Since there is a lot of diversity not only in professional titles, but also in services provided the results of respondents varied considerably. Participant responses indicated that they are primarily focused on dropout prevention, homeless and foster youth services, or individual and group counseling. However, all respondents (N=12, 100%) said they provided social skills training to students. Anger management was identified as the second most common service provided (n=9, 75%). The third most common services provided were both mental health (n=6, 50%) and homeless and foster youth services (n=6, 50%). The fourth most common service provided concerned attendance (n=5, 41.7%) which could range from home visits and truancy checks to working with individual students on increasing their school attendance. Three participants (25%) identified they provided services around bullying. Finally, “other” was selected as the least common service provided (n=2, 16.7%).
With the selection of “other,” respondents were asked to elaborate on why they selected “other.” One respondent stated they dealt with “students with home issues.” The other participant who selected “other” elaborated by identifying, “suicidal ideation, depression, and family systems,” as other relevant issues. There may have been a misunderstanding in the response of the second respondent because suicidal ideation and depression would fall under the category of mental health. Overall, the data suggests that participants provide a wide array of services with many specializing in particular areas.

**Specific Findings**

This section of the chapter will present specific findings related to the research topic. Respondents were asked to identify specific areas within the home-school collaboration that may be impacting the ability to receive informed consent and to provide services to at-risk youth. The use of open-ended questions and quantitative questions were used to examine the roles parents, students, teachers, administrators, and confidentiality can have in preventing informed consent from the participant’s perspective.
Reaching Out to At-risk Youth and General Feelings

Table 1

*Students Who Slip Through the Cracks*

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>

When respondents were asked if they thought at-risk youth slip through the cracks and go unnoticed at their school site, a large majority (n=10, 83.3%) responded “Yes.” Only two respondents (16.7%) felt that there were not a significant number of at-risk students slipping through the cracks or failing to utilize mental health services. This finding suggests that within the Natomas Unified School District, school mental health workers may be having problems reaching a significant amount of at-risk students. Potentially, without a mental health intervention or providing services to students in need, many of these students may continue to experience difficulties with their socioemotional functioning.

When participants were asked to use their expert opinion and estimate the range of at-risk youth of which they were aware in 20% increments, the majority of the sample (n=7, 58.3%) felt that they were only aware of 0-20% of at-risk students. 25% of respondents (n=3) felt they were aware of 20-40% of at-risk students. Only one participant (8.3%) felt they were aware of 40-60% of at-risk students and one participant (8.3%) felt they were aware of 60-80% of at-risk youth. The option 80-100% was not
selected by any of the participants. With 83.3% of respondents feeling that 0-40% of at-risk students have been identified at their school suggests that students may be slipping through the cracks and going unnoticed on a large scale.

When asked if participants felt they were effectively reaching at-risk youth, the question used a 5 point Likert-scale which ranged from: 1 “Never,” 2 “Almost Never,” 3 “Sometimes,” 4 “A majority of the time,” and 5 “All the Time.” An important finding was that 75% (n=9) selected “sometimes.” When it comes to reaching at-risk youth, many of the participants acknowledge that they are doing what they can to help this population of students, however, there is also an understanding that resources are not in place to effectively reach at-risk youth all the time. Two participants (16.7%) felt that a majority of the time they are effectively reaching at-risk youth. One participant left this question blank. 0% of those participating in the survey picked “never,” “almost never,” and “all of the time” showing that there is a major consensus (92.7%) who feel that they are effectively reaching at-risk youth but not at the type of level where they are making contact with all at-risk youth at their school location.

Table 2

*Feelings of not Being Able to Work with At-risk Youth*

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upset</td>
<td>4</td>
<td>33.3</td>
</tr>
<tr>
<td>Somewhat Upset</td>
<td>6</td>
<td>50.0</td>
</tr>
<tr>
<td>Indifferent</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>does not affect you</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Not applicable</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Participants were asked to select either 1 “upset,” 2 “somewhat upset,” 3 “indifferent,” and 4 “does not affect you” based on how they feel when they are prevented from working with at-risk youth. Half of the sample (n=6, 50%) selected “somewhat upset” 4 participants (33.3%) selected “upset.” 88.3% were either upset or somewhat upset, insinuating that there is a certain level of frustration and stress when they are unable to provide services to students in need of help. One respondent (8.3%) selected “indifferent” and another respondent (8.3%) left the question blank. The participants’ responses highlighted a collective feeling of frustration related to not having the ability to prevent an at-risk youth from slipping through the cracks in public school.

Social workers, psychologists, marriage and family therapists, and academic counselors were asked to give a qualitative response to the question listed above ranging from 1-3 sentences. The primary focus was to understand some of the consequences if these helping professionals are unable to receive informed consent. Two common themes emerged from the respondents answers. 10 of 12 participants responded to the question

One participant felt that, “behaviors intensify which can cause disciplinary action and/or impede the student’s learning.” Also, the participant stated that, “if the emotional disturbance is great enough, the student could receive a change in placement (SpEd).” Five other respondents identified the negative consequences a student in need will have if mental health services are not provided. “The student will continue to struggle, grades will go down, and the negative behavior will increase,” said one school mental health
worker. Academically, respondents recognized students who need mental health services but do not receive them will suffer and be unable to learn. “Students will not be able to complete work on time and will not be able to participate in classroom interactions,” according to one participant. Another respondent felt that, “the student can be a distraction or not advance with the rest of the class and teachers may become too focused on that student.” Because the individual student is not receiving services, attendance and disciplinary issues were identified as common results of not receiving informed consent to work with an individual student. “Behavior becomes more defiant, issues with attendance start to occur and truancy may become a problem, one participant stated. The same participant went on to say, “self-injury can happen in more extreme cases and a crisis may occur.” “Discipline issues and attendance are the most common and academic problems will occur as well,” another respondent noted.

On the other hand, teachers are left to deal with a problematic child and that child’s behavior can influence the learning of other classmates in a negative way, “maladaptive behaviors progress and the class environment deteriorates,” according to one respondent. This respondent continued by stating, “this causes a learning barrier not just to a particular student but to the class as a whole and unneeded stress for the teacher.” Another participant noted that peer relationships with other students in the classroom will be hard to create or maintain when a student is not receiving mental health services. “Disruptive behavior and student’s level of learning could be negative influences on others and weak peer relationships can occur,” said a participant.
According to another respondent, teachers may become extremely frustrated with a student who has had mental health services withheld.

Participant:

The student does not learn effective coping strategies. The teacher becomes more frustrated due to lack of progress on the student’s part. The student becomes discouraged and shuts down or acts out. This prevents learning from happening.

The Process of Receiving Informed Consent and Barriers

Table 3

<table>
<thead>
<tr>
<th>How Informed Consent is Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
</tr>
<tr>
<td>1 Parent Permission Form</td>
</tr>
<tr>
<td>2 Implied Consent (verbal approval from student, parent, and/or teacher)</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

The majority of participants (58.3%, n=7) received informed consent by sending a parent permission form home for parents to sign in order for the mental health workers to provide intervention to students. 41.7% selected the form of consent they receive is implied. They can receive implied consent through verbal approval from students, parents, and/or teachers. This data shows that it was almost an even split (seven
participants send home permission slips and five participants receive implied consent). More than likely, the even split may have to do with the grade level of the school site they work at. Typically, in elementary schools, parent permission forms are sent home because the student is not of age (12 and under) to make decisions regarding mental health interventions. At the high school level, implied consent is more frequent because the students are over the age of 12. Under California’s Mature Minor Doctrine and having the ability to make their own decisions for voluntary mental health services, students can make an informed decision as to whether or not they would like to receive support services not involving academics.

Participants were allowed to select all options that apply to how students are identified to receive mental health services. If they selected “other” they were asked to explain why they chose that option. 100% (n=12) of participants identified teacher referral as a primary way to identify at-risk students for services. Teachers are often in the position to be mental health workers by proxy, and when students are exhibiting maladaptive behavior, some teachers will make referrals for additional support. Also, 100% of respondents (n=12) identified parent referral for mental health services. Since parents are situated in the home environment and students spend a majority of their time with their parents, parents are in a position to identify behavior that could be problematic within their family system. 10 of the 12 respondents (83.3%) identified administration referrals as having an influence concerning which students are identified to receive services. Administrators often have to deal with students having disciplinary issues at school and make decisions to do what is in the student’s best interest, which could be a
referral for support services. Student referral (50%, n=6) was the second least common form of referral.

Finally, 41.7% (n=5) of those surveyed selected “other” and school psychologist referrals were the most common. One respondent cited they get “school psychologist referrals” as well. Another mental health professional said “school psychologist and special education team” are other means of receiving a referral. Other respondents identified academic counselors and student peers as other means of receiving informed consent. A participant state, “sometimes a client will refer their peers for help and services.” Another individual that took the survey said they also get referrals from the “district office.” “Students can be identified through conversations with the academic counselor and explanations for poor attendance/grades can reveal a need for services,” said another participant.

Table 4

_Difficulty in Receiving Informed Consent._

<table>
<thead>
<tr>
<th>Difficulty in receiving informed consent.</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Easy</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>2 I get informed consent a majority of the time</td>
<td>8</td>
<td>66.7</td>
</tr>
<tr>
<td>3 I get informed consent about half the time</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>4 I hardly ever received informed consent</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>
This question asked participants on a 4 point Likert-scale the level of difficulty in receiving informed consent. The choices were: 1 “Easy,” 2 “I get informed consent a majority of the time,” 3 “I get informed consent about half the time,” and 4 “I hardly ever receive informed consent.” Participants selected 2 a majority of the time (66.7%, n=8). The second most common choice selected was “I get informed consent about half the time” (16.7%, n=2). One participant (8.3%) described getting informed consent as “easy.” Another respondent selected the option “I hardly ever get informed consent,” (8.3%). This was a significant finding in the study. 91.7% of mental health workers taking the survey have some level of difficulty receiving informed consent. This shows that there are some barriers to receiving informed consent in the Natomas Unified School District.

Table 5

Informed Consent May Prevent Services to At-risk Youth

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Never</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>2 Hardly Never</td>
<td>4</td>
<td>33.3</td>
</tr>
<tr>
<td>3 Sometimes</td>
<td>5</td>
<td>41.7</td>
</tr>
<tr>
<td>4 A majority of the time</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>5 All the time</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>6 Not applicable</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Respondents were asked to answer this question using a 5 point Likert-scale. The options to select were: “never,” “hardly never,” “sometimes,” “a majority of the time” and “all of the time.” No one who took the survey felt that informed consent never
prevents them from working with at-risk youth. 33.3% (n=4) selected “hardly never.” Informed consent “sometimes” prevents mental health workers from working with at-risk youth was the most common selection (41.7%, n=5). One respondent selected informed consent prevents them from working with at-risk youth “a majority of the time” (8.3%). One participant (8.3%) felt that informed consent was a barrier “all of the time,” and one respondent did not answer the question (8.3%). With 58.3% of all mental health workers describing some level of difficulty of working with at-risk youth because of informed consent, there is evidence that informed consent may pose a barrier in providing services to at-risk youth. These findings indicate that informed consent may play a role in why many at-risk youth slip through the cracks and go unnoticed in our public schools.

**Potential Barriers Presented by Teachers**

Participants were asked to whether teachers have awareness of the services these mental health workers provide. Respondents were asked to select an option using a 4 point Likert-scale by selecting either: 1 “not aware,” 2 “somewhat aware,” 3 “usually aware,” and 4 “very aware.” 50% (n=6) described teachers of being usually aware. 41.7% (n=5) described teachers as somewhat aware of their job description and services they provide. One respondent (8.3%) selected “not aware” and no respondent selected “aware.” The results indicate that, for the most part, teachers have a general understanding (91.7%) of what mental health workers do and the services they provide. However, there is not a complete understanding of what helping professionals do at their
school site which may be linked to a lack of communication and knowledge of the mental health worker’s job.

Table 6

*Teacher Referrals to Mental Health Services*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>1</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Disagree</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Somewhat Agree</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Agree</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>System</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

Participants were asked to respond to the above question by selecting a choice from a 5 point Likert-scale. The choices were: 1 “strongly disagree,” 2 “disagree,” 3 “somewhat agree,” 4 “agree,” and five “strongly agree.” 7 participants (63.6%) somewhat agreed that if a teacher does not refer a student to receive services, it influences the mental health worker’s ability to work with at-risk youth. 18.2% (n=2) participants agreed that not receiving a teacher referral influences their ability to work with at-risk youth. One respondent (8.3%) strongly agreed and one respondent (8.3%) did not answer the question. This data shows that teacher referral may be an integral part for mental health workers working with at-risk youth. 90.9% of those surveyed that answered the question believed that not receiving teacher referrals can prevent a barrier on some level to receiving informed consent to work with at-risk students.
Do teachers have the knowledge and skills needed to identify students with a wide array of mental health concerns? For this question, participants were asked to either select “yes,” “no,” “somewhat,” or “n/a” in relation to teachers having the knowledge and skills to identify students with a wide array of mental health concerns. A large majority (75%, n=9) believed teachers “somewhat” have the knowledge and skills to identify students with mental health concerns. 25% (n=3) of participants felt teachers did not have this skill. No participants selected “yes” or “n/a.” The data suggests that those who answered this item feel that teachers do not possess the knowledge and skills needed to identify students with a wide array of mental health concerns. This can, potentially, lead to many students slipping through the cracks and going unnoticed due to teachers being unable to identify students with different mental health needs. This may also indirectly influence mental health workers’ ability to receive informed consent. If teachers cannot accurately identify at-risk students’ mental health issues that vary from one student to the next, many students may not receive services needed. Data may suggest that teachers are knowledgeable of some mental health concerns students have but do not possess the skills needed to identify a diverse range of mental health symptoms.

The level of influence teachers have in preventing mental health workers from receiving informed consent. Based on respondent expertise, they were asked to rank the role teachers play in preventing mental health workers from receiving informed consent on a scale from 1 to 9. The choices were” 1 “never prevent,” 2 or 3 “below average,” 4 or 5 “average,” 6 or 7 “above average,” and 8 or 9 “prevent all the time.” 58.3% of respondents (n=7) felt that teachers never prevent them from receiving informed consent.
25% (n=3) believed that teachers have a below average impact in preventing participants from receiving informed consent. 16.7% (n=2) believed that there was also a below average level of prevention in receiving informed consent presented by teachers. No respondents selected options 4 through 9. The results suggested that teachers are not a significant barrier to receiving informed consent for mental health workers. In some cases, there is a below level barrier to receiving informed consent presented by teachers, but data indicates that teachers do not pose a major influence in not receiving informed consent.

**Potential Barriers Presented by Parents**

Those who took the questionnaire were asked if parents were aware of the services they provide. Participants were asked to select options based on a 4 point Likert-scale. The choices were: 1 “not aware,” 2 “somewhat aware,” 3 “usually aware,” and 4 “very aware.” 9 participants (75%) felt parents were somewhat aware of the services they provided. 16.7% (n=2) believed parents were not aware of their job description and services provided. One respondent (8.3%) felt parents were usually aware of the services they provided. No respondent felt parents were “very aware” of the services that mental health workers provide. The data shows that parents may have a lack of awareness and knowledge regarding the services mental health workers provide at their student’s school location. Many parents may have an understanding of the services provided by the mental health worker at their child’s school, but, the data suggests there is not a complete understanding of the wide array of services mental health workers provide.
Based on the expertise of those who took the survey, mental health workers were asked to rank the role parents play in preventing mental health workers from receiving informed consent on a scale from 1 to 9. The choices were 1 “never prevent,” 2 or 3 “below average,” 4 or 5 “average,” 6 or 7 “above average,” and 8 or 9 “prevent all the time.” 33.3% of those surveyed felt parents have an average level of preventing informed consent. 25% of respondents felt parents presented an above average level in preventing mental health workers from receiving informed consent. Two participants (16.7%) felt parents prevent receiving informed consent all of the time. Finally, 25% of those who took the survey felt the level parents have in preventing informed consent was below average. Considering 41.7% of participants viewed parents as preventing informed consent all the time or a majority of the time, mental health workers may feel parents prevent receiving informed consent at a higher rate than teachers. These feelings may be representative of the mental health workers who work in elementary schools. Without a signed parental consent form, mental health workers cannot provide services to at-risk students. Parents may pose a barrier to receiving informed consent for reasons such as: the informed consent form never makes it to the parent, feelings that there is nothing wrong with their child, stigma of having a child with mental health needs, and family problems in the home that parents want to keep private.
Potential Barriers Presented by Students

Table 7

Level of Awareness Students Have

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not aware</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Somewhat aware</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Usually aware</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Always aware</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>

Mental health workers who took the survey were asked to select options based on a 4 point Likert-scale. The choices were: 1 “not aware,” 2 “somewhat aware,” 3 “usually aware,” and 4 “very aware.” Respondents were split between three options. 33.3% (n=4) felt students were not aware of the services those surveyed provided. Another 33.3% felt students were somewhat aware of the services staff who deal with student mental health concerns provide. 33.3% (n=4) believed students were usually aware of the services the respondents provided. No respondent selected “not aware.” The data shows that a segment of the student population in the Natomas Unified School District is not aware of support services for mental health concerns. Without knowledge of helping professionals on campus students may not know who to turn to when they are experiencing problems in socioemotional functioning leaving students to figure out how to handle their mental health concerns.
Table 8

*Issues with Confidentiality*

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
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<td>50.0</td>
</tr>
<tr>
<td>2 No</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>3 Maybe</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>4 Not applicable</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>

When it comes to issues with confidentiality presenting a barrier to receiving informed consent, half of the respondents (50%, n=6) believed issues regarding confidentiality could be preventing at-risk youth from seeking help. 25% (n=3) felt confidentiality does not play a role in students seeking out mental health services. 16.7% of those surveyed (n=2) selected “maybe” and one respondent did not answer the question. This was a significant finding because half of the respondents felt issues with confidentiality play a role in not receiving informed consent with at-risk youth. Many students may refrain from seeking help in fear that private and confidential information may be shared with parents, friends, and other staff. Also, in our society there is a stigma attached to mental health which may pose another reason why students will not seek out help for their mental health concerns.
Table 9

*Fear of Being Stigmatized*

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Yes</td>
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<td>50.0</td>
</tr>
<tr>
<td>2 No</td>
<td>1</td>
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<td>41.7</td>
</tr>
<tr>
<td>Total</td>
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<td>100.0</td>
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</table>

The results from this question confirmed that stigma can potentially lead to at-risk students not seeking out mental health services. 50% (n=6) believed stigma surrounding mental health does cause students to not seek out mental health services. Another 41.7% (n=5) of participants felt stigma maybe prevents students and families from seeking help from school professionals. One participant did not believe stigma prevented students and families from seeking help related to their socioemotional needs. The fear of being stigmatized may ultimately prevent receiving informed consent to work with at-risk youth. Unfortunately, those students and families deterred from seeking mental health services are left to find solutions for the mental health concerns or seek services outside of the school setting instead of utilizing support services at their school sites.
Table 10

*Student Prevention in Receiving Informed Consent*

<table>
<thead>
<tr>
<th>Valid</th>
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<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
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</tr>
<tr>
<td>2 Below Average</td>
<td>5</td>
<td>41.7</td>
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<td>3 Average</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>4 Above Average</td>
<td>2</td>
<td>16.7</td>
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<tr>
<td>5 All the Time Prevent</td>
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</tr>
<tr>
<td>Total</td>
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<td>100.0</td>
</tr>
</tbody>
</table>

Respondents were asked to select their response on a 5 point Likert-scale. The options were: 1 “never prevent,” 2 “below average prevent,” 3 “average,” 4 “above average,” and 5 “all the time prevent.” Five participants (41.7%) believed that there is a below average barrier to receiving informed consent presented by students. 25% (n=3) felt that students posed an average level barrier to receiving informed consent. Two of those surveyed (16.7%) selected that students present an above average level to receiving informed consent. One respondent said students never prevent and another respondent believed students prevent receiving informed consent all of the time. The results from this question show a divide in feelings related to students presenting barriers to receiving informed consent. The divide in opinion shows that students do not significantly impact receiving informed consent to work with at-risk youth but do pose a certain level of resistance to receiving mental health services in the opinion of those surveyed.

Respondents were asked to provide a 2-3 sentence response to gain a better understanding if services are provided to at-risk youth without parental consent. Three common themes emerged from the participants responses. The qualitative responses
show a philosophical difference in when a mental health professional should and should not provide services when informed consent is not present. 10 of 12 respondents answered the question and their responses are listed below.

The first theme identified was that services cannot be provided without receiving informed consent from the parent. “We cannot provide services without the signed parent consent form,” said one participant. Three other participants felt that without parental consent students who are in need of mental health services cannot receive that at their school. “I am unable to work with a child without parental consent and I am not really sure how they receive services when this happens,” according to a participant. Another participant simply stated, “they will not receive services.” For one of the participants who would not provide services without informed they felt handcuffed by school policy and federal law and cannot contact a student without parental consent. “Services cannot be provided if parents do not provide consent federal law requires parental approval to provide services,” described another participant. It is possible that the four respondents who would withhold services work in elementary school settings where students are not of age to make conscious choices in regards to mental health. However, the contradiction between state and federal law regarding informed consent and confidentiality could play a key role in deciding whether to provide services based on which law is followed.

Another theme emerged from participants who most likely work in the high school setting. Due to the Mature Minor Doctrine, parental consent is not needed; thus,
the issue of receiving parental consent is not much of concern to them. Older students have the option to voluntarily accept or decline mental health services on a middle or high school campus. However, only two respondents felt they did not need informed consent. “High school students can meet with me without consent if in need,” said one participant. Another respondent stated,

through the Parody Act students have the right to seek treatment without a parental consent and high school students can meet with me without consent if in need.

The final theme that emerged was if the student is in crisis, a danger to self or others, or there is some type of imminent threat, services can be provided. “As needed, usually in a crisis or a check-in basis I can forgo informed consent,” stated one participant. When the health and safety of a student may be in jeopardy some school mental health workers will bypass parental consent to make sure the student is safe. “In particular, situations, such as serious, imminent threat to health and safety a student may receive support,” a social worker stated. This respondent also said “as a social worker, we need to review the NASW code of ethics to guide services provided.” Two respondents described forgoing informed consent if the student is legally a threat to themselves or others (51/50). The first respondent felt that, “51/50 if urgent and real I will not obtain informed consent.” The other participant who felt 51/50 was needed to not obtain informed consent stated:
51/50 and in the case of student crisis I will not seek parental consent. Student violence is an area I feel I will need to act immediately. Also, high school age students can seek services on their own by law.

Overall, the data suggests that there is some level of confusion within NUSD as to when to receive informed consent and in what situations they can provide services when a parent or child has not gave permission to receive help. Participants who worked primarily in high school or primarily in elementary schools did not have a unanimous and uniform response showing there may not be a standard policy or procedure set in place.

**Potential Barriers Presented by Administrators**

Do the school mental health workers use a response to intervention framework (RtI) when intervening with at-risk youth? 75% (n=9) selected “yes” that their school site does use RtI. 16.7% (n=2) selected “no” and one respondent did not answer the question. This question may have posed a problem in many of the participants’ responses. All schools within the district have RtI setup for academic intervention and intervening in Special Education. However, at many school sites, there is no RtI setup for the general student population. Replacing the original question by asking if there is a Response to Intervention regarding mental health services for the general student population may have influenced the responses of those who completed the survey question.
Table 11

School Climate and Informed Consent

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
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<td>9</td>
<td>75.0</td>
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<tr>
<td>2 No</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>3 Uncertain</td>
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<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Respondents were asked to answer the question listed above by either choosing “yes,” “no,” and uncertain. 9 Respondents (75%) felt the school climate can contribute to not receiving informed consent. 16.7% of those surveyed (n=2) identified the school climate as not playing a significant role in preventing informed consent. One respondent was uncertain of the role school climate plays in not receiving informed consent. Negative school climates have the potential to deter students and families from providing informed consent for their student to work with a mental health professional. Typically, school violence, sexual harassment, bullying, and school administration not enforcing school discipline or over zealously punishing students contribute to a negative school climate. When the school climate is negative students may fear seeking services and providing informed consent in fear of how other students may react or a belief that staff at the school will not care.
Table 12

Administrator Knowledge of Mental Health Services

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
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<tbody>
<tr>
<td>1</td>
<td>Not aware</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Somewhat aware</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Usually aware</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Very aware</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>

Participants were asked to answer the question listed above based on their perception of how aware administrators are of their job and services provided. The options were: 1 “not aware,” 2 “somewhat aware,” 3 “usually aware,” and 4 “very aware.” The most frequent option respondents selected was “usually aware” (41.7%, n=5). Three participants (25%) felt administrators were very aware of their job and services provided. “Somewhat aware” was selected by 25% of respondents (n=3), and one respondent answered “not aware.” The results from this section show that the majority of administrators have a strong level of awareness.

Level of influence administrators have in preventing mental health workers from receiving informed consent. Respondents were asked to answer the question listed above using a 5 point Likert-scale. The choices were: 1 “never prevent,” 2 “below average,” 3 “average,” 4 “above average,” and 5 “all the time prevent.” Most administrators at the respondents school were perceived as never posing a barrier to receiving informed consent (66.7%, n=8). 16.7% of those surveyed felt that the level administrators prevent receiving informed consent was below average. One participant (8.3%) felt the level administrators prevent receiving informed consent was average and 8.3% of participants...
felt that administrators prevent receiving informed consent to work with at-risk youth all the time. The majority of participants (83.4%) felt that administrators do not play a significant role in preventing mental health workers from receiving informed consent. The data shows that administrators do not pose a significant barrier to receiving informed consent to work with students.

**Specific Factors and Additional Comments**

The examination of specific barriers within the home-school collaboration that may be influencing social workers and other mental health workers’ ability in receiving informed consent were identified based on the perception of those surveyed. The results from this particular section are extremely important, as it will help identify specific areas of which mental health workers should be aware regarding parents, students, teachers, administrators, confidentiality, and the increased barrier to receiving informed consent under specific circumstances.

The most common barrier identified by social workers and other helping professionals was parent lack of knowledge about mental health symptoms in a child (91.7%, n=11). The second most common barrier to receiving informed consent was lack of parental involvement in child’s school (83.3%, n=10). Negative parental feelings towards counseling and therapy was the third specific barrier mental health workers identified as a barrier to working with at-risk youth (75%, n=9). 50% of the respondents (n=6) identified perceived stigma of having a child with mental health issues, negative
relationships between parents and school personnel, inability of students to recognize symptoms contributing to mental health problems, and stigma for students seeking mental health services as contributing to the problem of not receiving informed consent. 33.3% (n=4) believed teachers lack of mental health training contributes to not receiving informed consent. Student’s lack of information about confidentiality was seen as a barrier to receiving informed consent by 25% (n=3) of participants. Teachers who lack motivation to seek helping services for students and administration screening processes for identifying at-risk youth were perceived as the least common barrier to receiving informed consent by those surveyed (16.7%, n=2).

The data indicates that mental health workers feel that parents pose the most frequent barrier to receiving informed consent (8.4 respondents on average selected barriers created by parents. Those who responded to the question identified “barriers students present” as the second most significant barrier preventing informed consent within the home-school collaboration (5 respondents on average selected barriers created by students). Results also show that teachers are seen as the third leading cause in preventing informed consent to provide services to at-risk youth (3 respondents selected barriers created by teachers). Finally, findings suggest that administrators pose the smallest barrier within the home-school collaboration to receiving informed consent (2 respondents selected barriers created by administration). The results in this section help identify specific areas within the home-school collaboration that may be preventing mental health workers from obtaining informed consent to intervene with at-risk youth.
Due to the instrument requiring participants to select specific options, other barriers to receiving informed consent may be present but were not explored.

How strong are barriers not involving parents, teachers, students, and administration influence receiving informed consent? Participants were asked to select an answer using a 4 point Likert-scale on other barriers to receiving informed consent. 41.7% (n=5) believe other barriers are somewhat strong. 25% (n=3) of participants felt other barriers are strong to not receiving informed consent. Other barriers to receiving informed consent were seen as not strong at all by 25% of respondents (n=3) and one participant thought other barriers to receiving informed consent was very strong. These results show that future studies need to explore other possible barriers to receiving informed consent.

Participants were asked to further explain their reasons for why teachers, parents, at-risk youth, and administrators may be preventing them from receiving informed consent. Understanding respondent’s perceptions as to how members of the home-school collaboration may prevent informed consent is important in understanding and developing policies to reach more at-risk youth. Two respondents did not answer this section of the survey. Three themes emerged based on the qualitative responses of participants.

Four respondents felt that stigma played a major role in why mental health workers cannot receive informed consent. “If parents or students feel a stigma is attached
to receiving support services at school, they may deny consent,” described one participant. The stigma attached to receiving treatment for mental health may cause parents and students to try to ignore ongoing symptoms according to one participant. “Parent/student may not admit a problem exists because of how society views mental health.” Combined with stigma, lack of knowledge surrounding mental health symptoms can both contribute to not receiving informed consent according to two participants. One participant believed “administration wants students to utilize services but at-risk youth’s lack of mental health knowledge and stigma contribute to not receiving informed consent.” The other participant felt that “teachers and administrators want to help the student perform better in class but youth may not want to go to counseling and parents do not want to seek mental health services for their child.”

In the elementary school setting primarily, parents hold the power to decide whether or not their child needs help. According to one of the four respondents who identified parents as the biggest barrier to receiving informed consent, “I haven’t had any issues with getting consent from teachers, youth or administration. I only have had an issue with parents giving consent.” Having a child with mental health problems may make a parent perceive that they will be stigmatized for having a child in need of help. “The level of influence depends, however, in my experience parents based consent on at-risk youth’s approval,” stated one participant. They then went on to say, “also, I feel parents’ level of understanding may prevent receiving informed consent.” Other parents may not comprehend services and other resources available to help their child at the school they attend. According to another participant, “staff always are seeking ways to
help their students but parents can be a little leery when not receiving adequate information when needed.” One participant felt that parents just may not want to get involved in their child’s school or services that can be utilized. “I think teachers usually make referrals to get help and sometimes parents don’t want to have their child participate and sometimes the child doesn’t want to either.” Whether it was stigma, lack of information, or lack of interest in a child’s school or the services available for mental health parents can create barriers to receiving informed consent.

Three participants felt that administration can potentially create a barrier to providing adequate services to at-risk youth in need of help. One respondent felt that the inability to collaborate with other school personnel was a barrier. “Administration misunderstands laws which prevent teachers from getting necessary information so they can help triage kids for help,” stated one participant. A lack of communication between school staff created by confusion surrounding laws of confidentiality could potentially be a major issue to mental health workers. Also, an administrative lack of understanding of support services available may create a barrier to receiving informed consent by not referring students to necessary services. “If teachers and administrators do not fully understand the services available and/or do not value the services, they may hinder the communication with parents regarding consent,” according to a respondent. Finally, some mental health workers may potentially feel that negative relationships between administrators and students can impact services provided. Administrators are often in position where they must discipline students creating negative relationships. “I can
usually talk students into getting the help they need and what I say is viewed with more weight than admin comments due to the positive relationship I have with students.”

Participants were asked to list other potential barriers to receiving informed consent. Four participants did not fill out this section. One respondent stated “schools level of connectedness and access to information,” as other potential barriers. Another participant believes “there is no district process for working with at-risk youth and there is a lack of organization and communication. A lot of this is due to the constant rotation of administrators with differing points of view.” Another mental health worker who took the survey identified 3 other barriers to receiving informed consent. “Students and families are unaware of services available, negative experiences with mental health services in the past, and income/financing.” “Some parents don’t feel their children/child have any problems,” was cited by one respondent as another barrier.

Four respondents felt that “cultural and language” barriers are other barriers to receiving informed consent. Cultural and language barriers seem to be the most common barrier listed as “other” which is a significant finding. Cultural competence and access to interpreters may be an area the Natomas Unified School District needs to improve on due to the fact that a segment of the student population has English as a second language. Also, trainings in culture and how different cultures view mental health concerns will further improve cultural competence and how services are provided to this population.
Five of those surveyed completed the last question of the questionnaire asking if there were any additional comments they would like to add. No specific themes emerged, but, many respondents took the opportunity to voice their opinion in this session.

One of the respondents felt that parent training was a necessity and that all staff need to be trained in cultural sensitivity. “There is a significant need for parent training (elementary level), mental health workers and teachers being trained in cultural sensitivity,” the respondent stated. Lack of cultural awareness may be facilitating factor in not receiving informed consent from students and parents who belong to different cultures.

One of the participants felt that they are not aware of a majority of those students who may be in danger of slipping through the cracks of public school and going unnoticed and without the support they need. “The percentage of at-risk youth at my agency is higher than my 20%-40% that I am aware of. However, without increased/awareness for at-risk youth there will continue to be a deficit.” Potentially, schools in the NUSD do not have adequate procedures and practices in place to identify and refer at-risk youth for services. Also, there could be an insufficient amount of support staff at a school site to meet the socioemotional needs of students.

Another individual who answered the final question was confused by what the researcher meant by “at-risk youth.” “Not sure of your definition of at-risk but informed
consent issues become more complicated at high school. I think challenges in receiving informed consent at elementary, middle, and high school might be different.” The participant is correct about issues surrounding informed consent have the potential to be different depending on working at a primary or secondary school.

One of the interns who completed the survey may have confused mental health issues and concerns with mental health disorders. Because of this misunderstanding, questions may have been left blank when a response could have been made.

Intern participant:

Some of my answers didn’t have the option of not applicable. In my personal situation as an intern in a school, I don’t work with foster children and I have had very few experiences of children with Mental Health issues. Most of the children I work with have anger and social skills issues. Only one child that I worked with had an attachment disorder and emotional disturbance, he was also referred to out of site counseling.

According to the final participant who completed the final question on the survey, the biggest barrier is not being able to collaborate with other employees to provide comprehensive support both academically and socioemotionally.
Participant:

The biggest barrier to helping the top tier (5%) that need services is our administrations misunderstanding the laws. We are all confidential employees, we all have ownership of all kids, and with the proper access, kids would get served more readily and completely if we worked as a community. It’s a shame.

**Interpretations of the Findings**

This section presents primary findings of the research question and examines specific factors that may be contributing to social workers not receiving informed consent. The results indicated that informed consent does contribute to not receiving informed consent on some level by 66.9% of those surveyed. Barriers to receiving informed consent prevent social workers from having the ability to work with at-risk youth explaining why 83.3% of respondents feel they are only aware of less than 40% of at-risk youth at their school and why 83.3% of participants believe a significant number of at-risk youth slip through the cracks and go unnoticed in public schools.

One potential barrier to receiving informed consent could be student awareness of social workers at their school site and services they provide. 33.3% of those who took the survey felt students are not aware of the services they provide creating a situation where students do not know who to turn to for their socioemotional needs. For the most part, parents, administrators, and teachers are aware of school social workers and other helping professionals and the services they provide.
The study unfortunately found multiple barriers presented within the home-school collaboration that may prevent mental health workers from receiving informed consent to work with at-risk youth. Issues regarding confidentiality and fear that a student’s private information may be shared with their parents, staff, and friends were seen as a barrier by 50% of respondents. When it comes to seeking mental health services, the stigma attached to mental health was seen by 50% of respondents as contributing to not receiving informed consent. Students’ inability to recognize mental health symptoms were also believed to be a barrier to not receiving informed consent by 50% of respondents.

Teachers and administrators seemed to have the lowest effect on receiving informed consent to work with at-risk youth. The only barrier presented to teachers was their lack of training in identifying mental health concerns by 33.3% of respondents, but those who took the survey felt teachers are proactive in making referrals and genuinely care about their students’ mental health. Administrators presented no specific barriers to receiving informed consent and were seen as very beneficial to a large majority of respondents. Administrators are active in making referrals and ensuring school safety. Also, many administrators understand that for a student to succeed in the classroom and focus on school work, problems students present not related to academics must be addressed in order for them to succeed.

The results from this study show that parents provide the biggest barrier to receiving informed consent to work with their child. The most common barrier presented
was parental lack of knowledge about mental health services (91.7%) and lack of parent involvement in their child’s school (83.3%). 41.7% of those surveyed felt parents present an above average and consistent barrier to receiving informed consent. For many parents, they may truly feel that there is nothing wrong with their child and mistrust the agenda of the school due to negative relationships with school personnel. The lack of knowledge surrounding mental health also appears to be a key contributor in not providing services to their child.

**Summary**

The study’s main purpose was to identify barriers created by students, teachers, administrators, and parents to receiving informed consent for social workers to provide interventions for at-risk youth. A significant number of those surveyed identified parents as being the most frequent barrier to receiving informed consent. Also, student lack of understanding around confidentiality, mental health symptoms, and stigma attached to mental health significantly contribute to not providing informed consent and seeking student services. Besides lack of training in mental health, teachers primarily do not pose a barrier to receiving informed consent. Administrators were seen as having minimal effects in receiving informed consent. Both teachers and administrators were seen by the majority of participants as instrumental in helping at-risk youth.

Overall, issues regarding the prevention of informed consent seem to be more present in the home system, not the school system. This shows that there are some
aspects of the home-school collaboration absent, preventing a positive relationship between the home and the school. The lack of knowledge and awareness surrounding mental health may be the piece missing in order to strengthen the home-school collaboration and ensure a higher success rate of receiving informed consent. There is also a lack of knowledge on the parents and students part regarding school social workers and other helping professionals and the services they provide that can potentially enhance an at-risk youth’s school experience.
Chapter 5

CONCLUSION, SUMMARY, AND RECOMMENDATIONS

The purpose of this study was to examine potential barriers to receiving informed consent that prevent school social workers from providing interventions with at-risk youth. Within the home-school collaboration, potential barriers to receiving informed consent created by parents, teachers, administrators, and students were explored in order to gain a better understanding of why at-risk youth are not receiving services needed and continue to slip through the cracks and go unnoticed. Contributions to not receiving informed consent ranged from minimal to highly significant. This study shows that administrators and teachers pose a minimal barrier for social workers trying to receive informed consent to work with at-risk youth. Students were found to have a moderate level of informed consent prevention for mental health workers in the Natomas Unified School District. Participants from the study revealed that parents present a highly significant barrier to receiving informed consent.

Results from the study indicate that teachers may not have the training, knowledge, and skills needed to identify students with a wide array of mental health concerns. If teachers do not have knowledge of presenting symptoms ranging from hyperactivity to anhedonia, informed consent cannot be obtained if teachers do not know the behaviors or emotions to look for. This can potentially lead to at-risk youth failing to receive much needed services and slipping through the cracks of public school. Without
teacher training in mental health, many students will continue to suffer with mental illness and less students will be identified for mental health services.

This small-scale study also found students can contribute to not receiving informed consent for multiple reasons. A significant amount of mental health workers in the Natoms Unified School District believe a lack of understanding surrounding confidentiality is a barrier to receiving informed consent. The belief that private information can be shared with parents, staff and friends can cause students not to seek out mental health services. Also, stigma surrounding mental health and inability to recognize mental health symptoms can further impede students from not seeking out services. Inadequate student help seeking behavior can be detrimental in creating a barrier for students in need to be provided with informed consent. Students may not be entirely to blame for not seeking out mental health services. Many students do not know what support services are available showing a lack of communication surrounding mental health and services provided created by the NUSD.

This study’s findings on the perceptions of school social workers regarding barriers to receiving informed consent showed parents as presenting the most significant barriers to receiving informed consent. In the elementary school setting, parents need to provide written consent for their students to receive services from school social workers. If a parent does not provide consent, the student is off limits and cannot receive services, creating ramifications, not only for the student, but for his or her classroom as well. Again, like barriers presented by students and teachers, lack of knowledge surrounding
mental health symptoms plays a significant role in not receiving informed consent from a parent. The perceived stigma surrounding mental health appears to be problematic for both parents and students to a point where mental health services are not actively sought out. Finally, negative relationships between parents and the home school collaboration create distrust within the home-school collaboration, making it even harder to receive informed consent from a parent. If a parent does not believe staff at the school are acting in the best interest of the parent and the student, parents will not be involved with their children’s schools, making it even harder to receive informed consent.

The belief that nothing is wrong with my child or fear that the student and parent will be stigmatized shows that some parents are not looking out for their student’s best interests. Without services, these students will not grow socially or emotionally causing many negative behaviors to manifest. Also, if many more parents were proactive about seeking help for their child, the amount of support services and staff could increase to meet the needs of multiple families struggle with a child with mental health concerns.

The study confirmed previous findings from relevant literature reviewed in chapter two of this study. Previous studies indicated students and families do not seek out mental health services due to the inability to identify mental health symptoms. Stigma was also found by multiple studies to be a key reason in why students and families do not seek out services. The fear of being ostracized by peers, losing friends, and being seen as different can prevent students from seeking help. The literature reviewed also suggested mass confusion among school personnel on the topic of confidentiality and what can be
shared with whom. The confusion school professionals have surrounding confidentiality is also shared by students. Literature reviewed confirmed students do not seek professional help due to the fear that parents and other individuals will have access to their private, confidential information. Also, on the topic of mental health, previous research on teacher training in mental health showed teachers are not adequately prepared to deal with their students' socioemotional needs, which vary from one student to another. Finally, after an extensive review of literature, all studies which focused on the home-school collaboration showed that a strong, positive home-school collaboration is a key component of student academic success and student socioemotional well-being. When parents do not have strong ties with their students' schools mistrust can develop from negative contacts with the school, further creating a situation that makes parents less likely to seek help for their students at the schools.

Three common themes emerged from the qualitative questions in the study that showed there is confusion among mental health workers regarding three key issues. The first identified was that there is a lack of understanding in regards to confidentiality. Each social worker at different levels of education had different perspectives surrounding confidentiality. Some believed in FERPA where parents must be always informed. Others who took the survey felt that services should be provided no matter what the situation following state law. Other felt they could forgo informed consent if a student is in crisis. The lack of a common structure and policy regarding confidentiality may be creating confusion for students and parents about what information is shared with whom.
Not knowing whether or not private information is truly private can greatly reduce help seeking behaviors.

The second theme that emerged surrounded informed consent. Mental health workers were divided on when they should intervene with a student. This again may reflect a lack of structure and policy surrounding specific behaviors a student must exhibit before forgoing informed consent. Some mental health workers feel that a student must be in crisis or a threat to themselves or others before providing services regardless. Other mental health workers believe they should not provide interventions without informed consent even if a child is in crisis, suicidal, or may cause harm to another person. Finally, the rest of those who took the survey felt informed consent was not necessary because they were providing a service to the school that required voluntary student participation. The split by mental health workers on the topic of informed consent shows that there is a need for a district wide policy to guide mental health workers in future interventions and situations where informed consent is not easily obtained.

Finally, the most alarming finding from the study found that the majority of mental health workers are only aware of less than 40% of students in need of their services. This can be contributed to multiple reasons. There is no universal screening tool administered to the student population even though evidence shows a strong correlation between screening the entire school population and identifying more at-risk youth. A lack of information surrounding mental health and services for mental health at
school also may reflect the small percentage of students social workers are aware of. Many of these schools only have a mental health intern on location and lack support services to meet the demand of students in need. Students and parents also lack awareness of the mental health professionals at their school site showing that presentations are needed and outreach is necessary to communicate services available.

Given the findings of the study, steps must be taken to inform parents, students, and teachers about issues and symptoms surrounding mental health. Increasing awareness surrounding mental health may increase the likelihood of receiving informed consent. In regards to the research question, all respondents to the 25 question survey feel that informed consent is a barrier to receiving informed consent ranging from a minimal to a very significant barrier. Potentially, federal, state, and district policies regarding informed consent and confidentiality should be further explored and potentially amended to make sure the students within Natomas Unified School District have access to mental health workers and services so they do not slop through the cracks while in public school.

**Summary of the Study**

The goal of this study was to identify barriers school social workers face in receiving informed consent to provide services to at-risk youth. Data confirmed previous research surrounding confidentiality, lack of knowledge surrounding mental health, and how negative home-school collaborations influence seeking services for students at school. Previous data and results from the study provide implications for the Natomas
Unified School District. An alarming amount of respondents have indicated that their school site needs to improve home-school collaborations. This may be the missing piece of the puzzle needed to identify more at-risk students and promote help seeking behaviors by parents and students. Surprisingly, teachers and administrators were seen as increasing the likelihood of receiving informed consent instead of posing a barrier. Previous research indicated that administrator screening processes for students in need of mental health services is an integral part of identifying at-risk youth. Yet, comprehensive, school-wide preventative screening is not yet implemented in Natomas Unified School District. Key screening tools, such as the Colombia Suicide Screening and other evidence-based screening tools, are not used within the district. Teacher burnout, bullying students, and lack of motivation were not identified as barriers to receiving informed consent presented by teachers while previous literature reviewed showed these factors to be significant in preventing informed consent.

Respondents in this study were asked to answer a 24-question survey to help gain a better understanding of barriers within the home-school collaboration that prevent informed consent. The most common findings found mental health stigma, lack of knowledge around mental health symptoms, confidentiality, and negative relations between parents and the school to pose significant barriers to receiving informed consent. Teacher training around mental health and mental health awareness were seen by respondents as actions needing to take place to increase the likelihood of receiving informed consent to work with at-risk youth.
Implications for Social Work

At-risk youth slipping through the cracks and going unnoticed can possibly be one of the greatest fears for school social workers - especially due to the belief that many of these at-risk youth will have an increased chance of entering the California correctional system and be stratified to low-paying jobs because of their inability to graduate high school. Informed consent may be an unnecessary barrier to helping these at-risk youth receive services from a school social worker. Issues surrounding mental health services, such as stigma, insufficient screening tools, and lack of information are key areas social workers need to address in order to increase their effectiveness in helping students succeed in public school.

Social workers represent over half of the mental health workers in the United States (Corcoran & Walsh, 2010). Specific to the school setting, school social workers are in a position to facilitate changes needed at the macro, micro, and mezzo level in order to obtain informed consent through directly addressing barriers surrounding school mental health. Given their unique position to provide mental health services, school social workers may want to concern themselves with mental health outreach. Mental health workers in the NUSD felt parents (91.7%) and students (50%) do not have a significant understanding about mental health, stigma, and potential symptoms. Holding some type of gathering or conference for parents could be very resourceful for families and provide information and education related to mental health, and what support services are available at school and in the community. To ensure a preventative approach
to mental health, social workers could provide parents who have students just entering the school district with educational materials and provide a presentation on mental health during new parent orientation.

To promote mental health awareness within the student population, it may be necessary to adopt new policy aimed at providing the student body adequate knowledge regarding mental health while dispelling misinformation surrounding mental health. This could be done at the secondary school level through the required health and safety class all freshmen are required to take. During a one week period, school social workers could provide mental health first aid, other education, and hold discussions related to mental health disorders that may surface during primary school and adolescents. Due to training and knowledge surrounding mental health, school social workers are in a position to advocate for policy and practice that benefits all students. Another potential activity that might assist social workers is creating a school-wide survey that helps screen students who are experiencing socioemotional problems. This survey could be administered once a year and help identify students with mental health needs who would otherwise go unnoticed and may provide valuable information about mental health supports on the school site. In-service training to teachers and other staff surrounding mental health is also another valuable skill school social workers can use to, not only identify more at-risk youth, but provide support to the teachers and their classrooms. Additionally, there needs to be continuous professional training for school social workers to provide effective mental health services as well as promote evidence-based practices to improve interventions, prevention, and reduce barriers to receiving informed consent.
Recommendations

This study primarily focused on the perspectives of school social workers, psychologists, academic counselors, and marriage and family therapists regarding what they believed posed barriers to receiving informed consent to work with at-risk youth. The main findings of the study indicated that there are barriers to receiving informed consent ranging from mild to moderate. Specifically, parental and student lack of knowledge surrounding mental health, mental health stigma, confidentiality, and a lack of awareness parents and students have towards school support staff, especially school social workers and the services provided. Due to these findings, the researcher recommends, for future studies, that a more comprehensive approach takes place when identifying barriers to receiving informed consent. The home-school collaboration is comprised of parents, students, and school personnel. In this study, only mental health professionals were surveyed. A comprehensive study that surveys teachers, parents, social workers and students surrounding mental health and perceived barriers could provide a more concrete explanation by identifying mutual perceived barriers by all members of the home-school collaboration.

A further recommendation would be to expand on the research conducted in this study to include an equal representation of school mental health workers whose student and family population served have a homogenous socioeconomic status. This study primarily surveyed social workers who work at school sites where the population is working-class and low-income. However, surveying social workers who primarily serve
schools in lower-middle class, middle-class, and upper-middle class neighborhoods could potentially provide great insight into barriers that affect all students and specific barriers to receiving informed consent based on social class. Finally, the researcher’s last recommendation would be to analyze perceived barriers to receiving informed consent based on professional student support position. In this study, psychologists, academic counselors, marriage and family therapists, social work interns, and social workers were all considered mental health workers. Understanding barriers specific to social workers or specific to academic counselors or psychologists could potentially show barriers to receiving informed consent that a specific profession faces in the school setting.

**Limitations**

This study produced many significant findings; however, there are some limitations that should be recognized. The study only surveyed mental health workers from one of the smaller school districts in the city of Sacramento. This limits the ability to generalize the findings from this study to all other school districts in California and nationally. Another limitation was the sampling method. Criterion sampling was utilized to identify mental health workers within the Natomas Unified School District as well as the district social work liaison identifying mental health workers. However, due to time constraints the researcher was only able to survey 50% of those identified as mental health workers in the school district. The last limitation identified is school district policy in regards to how mental health services are administered and informed consent. School support positions and mental health services vary from school district to school district.
One school district may have a social worker at every school site but another school district may not even hire social workers showing the results of this study may not represent all school locations. Also, informed consent forms and procedures are not the same in every school district.

Conclusion

While there are significant limitations in this study, the researcher firmly believes that findings from the research show that there are significant barriers to receiving informed consent. The goal of this study was to identify what these barriers are that can contribute to at-risk youth slipping through the cracks and going unnoticed and to encourage further research in order to develop comprehensive mental health services in public schools to ensure school success. Results of the study indicated that barriers to receiving informed consent to work with at-risk youth range from moderate to severe. Stigma and lack of education surrounding mental health seems to be the most significant contributor to school social workers not receiving informed consent. Students and parents may not seek out social worker services and may not provide informed consent in fear that peers, teachers, and others will stigmatize them for having problems, fear that confidentiality will not be maintained, and fear of being different than other students. Awareness of what mental health means, education on the topic, and dispelling false beliefs may potentially reduce barriers to social workers receiving informed consent and help in identifying more students in need. With informed consent school social workers
have the ability to help a student succeed in life, but without it, the cracks that a lot of students slip through in public school widen.
Appendix A

Human Subjects Approval Page
Appendix A

Human Subjects Approval Page

To: Gregory Fisher
Date: October 31, 2013

From: Research Review Committee

RE: HUMAN SUBJECTS APPLICATION

Your Human Subjects application for your proposed study, “Social Worker Perceived Barriers to Working with At-risk Youth and Receiving Informed Consent, is Approved as Exempt. Discuss your next steps with your thesis/project Advisor.

Your human subjects Protocol # is: 13-14-019. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Research Review Committee members Professors Maria Dinis, Jude Antonyappan, Serge Lee, Francis Yuen, Kisun Nam, Dale Russell,
Appendix B

Consent Form
Appendix B

Consent Form

**Practical Implications to Receiving Informed Consent for School Social Workers and Trying to Work with At-Risk Youth**

Dear social workers of the Natomas Unified School District:

You are invited to participate in a study that will be exploring the reasons why informed consent is creating a barrier to student services. This study will be examining the roles and functions teachers, students, administrators, and parents may potentially have in preventing interventions by school social workers, and what potentially could be the causes of not receiving permission to work with an at-risk child. My name is Greg Fisher and I am a student in the Social Work graduate program at CSU Sacramento specializing in school social work. For this study, your cooperation would be crucial in exploring potential barriers to working with at-risk youth. Your knowledge, along with your other colleague’s knowledge on the subject is highly valuable and could potentially create new avenues to providing services to students who would otherwise slip through the cracks unnoticed.

Participation is completely voluntary, and if you chose to participate, you are not required to fill out questions that may feel uncomfortable. This study will survey social workers like yourself through a questionnaire containing 25 questions. These questions will be multiple choice, as well as short essay. The questionnaire should not take more than 25 minutes to complete. The questions will be focused primarily on barriers to the process of receiving informed consent. Your opinion on certain issues regarding informed consent is extremely valuable in this study.

Again, your participation is completely voluntary and confidential. Two manila folders will be distributed to you. There will be one folder for the informed consent page, and the other folder for the questionnaire. Note: Only the researcher will be reviewing the documents and your identity will be anonymous. However, if you complete this questionnaire, you will be eligible for a summary of the results.

If you would like to participate in this study, please sign below and fill out the contact information. This study will be conducted at your school site and you may complete the questionnaire at your own convenience. If you chose to decline, please indicate so below. Thank you for your time and consideration. Your input will be valuable in this study aimed at helping school social workers understand barriers to receiving informed consent. If you have any questions you may contact Greg Fisher at (xxx) xxx-xxxx. For further questions please feel free to contact Dr. Dale Russell at (xxx) xxx-xxxx who is the social work intern’s thesis advisor.

____________________________________________________________________

Name of participant

Signature and date

____________________________________________________________________

Contact Information: Email and/or phone number: ______________________________________

[111]
Appendix C

Questionnaire
Appendix C

Questionnaire

Thank you for your time and effort in completing this survey. The questionnaire should not take more than 25 minutes to complete. The questions will be focused primarily on barriers to the process of receiving informed consent. Your opinion on certain issues regarding informed consent is extremely valuable for this study.

1. **How would you describe the demographics of students and families you help?**
   Please describe below.

2. Do you feel a significant number of students who could benefit from school social work services slip through the cracks and go unnoticed?
   Yes__ No__ N/A__

3. Does your school use a response to intervention framework (RtI) when intervening with at-risk youth?
   Yes__ No__ N/A__

4. In your opinion, what issues do you most frequently deal with most? Please select all that apply.
   ___ Mental Health ___ Social Skills ___ Bullying ___ Homeless/Foster
   ___ Anger Management ___ Attendance

   Other (please specify): ______________________________________________________

5. Do you feel that you effectively reach at-risk youth?
   ___ Never
   ___ Almost Never
   ___ Sometimes
   ___ A majority of the time
   ___ All the time

6. How do you receive informed consent? (please check one below)
7. Please rank below the level of awareness teachers, students, administrators, and parents are of your job description and the services you provide.

<table>
<thead>
<tr>
<th></th>
<th>Not aware</th>
<th>Somewhat aware</th>
<th>Usually aware</th>
<th>Very aware</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Parents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Administrators</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Students</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

8. How does a student receive services needed if a parent will not provide informed consent? Please explain below.

9. Do you feel that issues with confidentiality prevent at-risk students from seeking help and the services you provide? Please Explain.

10. What are the ramifications for the student and their classroom if services are withheld?

11. How are students in need of services identified to utilize your services? Please check all that apply.

__ Teacher Referral  __ Administration Referral  __ Student Personal Referral  __ Parent Referral
__ Other, please specify:

______________________________________________________________________________

12. If teachers do not refer students to you, do you feel that influences your ability to work with an at-risk student? Please check below

__ Strongly Agree __ Agree __ Somewhat Agree __ Disagree __ Strongly Disagree

13. Do you feel teachers have the knowledge and skills needed to identify students with a wide array of mental health concerns? Please check below.

__ Yes __ Somewhat __ No

14. Does the fear of being stigmatized for seeking mental health services significantly contribute to students and families not seeking help from school professionals?

__ No __ Yes __ Maybe

15. How would you describe the level of difficulty in receiving informed consent?

__ Easy
__ I get informed consent a majority of the time
__ I get informed consent about half the time
__ I hardly ever received informed consent

16. Below, please check the boxes that you feel contribute to not receiving informed consent.

__ Student’s lack of information about confidentiality
__ Stigma for students seeking mental health services
__ Inability of students to recognize symptoms contributing to mental health problems
__ Teacher lack of training around mental health
__ Teachers who lack motivation to seek helping services for students
__ Negative relationships between parents and school personnel
__ Administration screening processes for identifying at-risk youth
__ Negative parental feelings toward counseling and therapy
__ Lack of parent involvement in their child’s school
__ Perceived stigma for having a child with mental health issues
__ Parental lack of knowledge about mental health symptoms in a child

17. Please list any other potential barriers to receiving informed consent below.
18. Do you feel that school climate/environment can contribute to not receiving informed consent? 

__ Yes __ No __ Uncertain

Please rank the following groups on how they may prevent receiving informed consent on a scale of one through nine.

<table>
<thead>
<tr>
<th>Group</th>
<th>Never</th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
<th>All the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Parent</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>At-Risk Youth</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Administrators</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

19. Please explain your reasoning in the box below.

20. How does it make you feel when you are prevented from working with at-risk youth?

Upset _____ Somewhat Upset _____ Indifferent _____ Does Not Affect You _____

21. How strong do you feel barriers not involving parents, teachers, students, and administrators influences receiving informed consent. Check below

__ Not strong at all
__ Somewhat strong
__ Strong
__ Very Strong
22. Do you feel that informed consent is preventing you from working with at-risk youth?

___ Never
___ Hardly Never
___ Sometimes
___ A majority of the time
___ All the time

23. What percentage of at-risk youth at your school location do you feel you are aware of? Please circle a response below

0% - 20%  20% - 40%  40% - 60%  60% - 80%  80% - 100%

24. Please write additional comments below.

Thank you for your time and consideration in filling out this survey. Have a great day!
References


