2022

Supporting The Mental Health of Black Students: A Framework for Comprehensive School-Based Mental Health Systems

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A Framework for Comprehensive School-Based Mental Health Systems

A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy in Educational Leadership, Policy and Justice at Virginia Commonwealth University

by

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Richmond, Virginia
May 2022

Dedication

To Phaedra Princess Aniya—to the moon, around the sun a billion times and as far as the last unknown planet that exists—my love for you knows no bounds.

You are loved, you are worthy, and you matter.

Acknowledgements

I had a goal and He created the way. I know that I am in this space, at this moment in time, because of **God**. There just isn't any other explanation. Three words kept me focused over the past two years: Stay. The. Course. I didn't break. For this opportunity, for this journey, I am thankful, grateful, and appreciative.

Two kids from north and south Philly—**Stephanie and Willie**—better known as my Momma and Daddy. I love you. God already knew the struggles you would encounter individually, as a couple, and as a family . . . and as Mom says, "The will of God will not take you where the grace of God cannot sustain you." Look, Mom and Dad—you were the vessels for something amazing. I made it!

To my brother, **Willie**—I love you more than you will ever know.

To—Cheryl—the best **Aunt Nana** in the world. I love you.

To my brother from another mother, my cousin—**Dia**—thank you for your friendship. We live and learn . . . and we make each new day count. I love you.

Line sister we can make it! **Zen**—thank you for encouraging me, laughing with me, telling me how strong I am, telling me to sit down, listening to me say the same things over and over—and letting me be me. Buckle up . . . and enjoy the ride.

To my other, other brother from another mother—**Tremayne**—my pseudo everything. You are amazing and I am thankful for you.

A heart of gold—**Ebony**—honest, trustworthy, and kind. I picked the right Godmother. Thank you for loving us.

My DLP—**Marion**—for every time I want to play Worse Case Scenario, for every random text of I love you, for reminding me of how good enough I am . . . I thank you.

To my Day 2--**Dr. Portia Newman**—You are amazing . . . hands down. There is no other . . . I thought I was a beast and then I met you. He knew I needed a person and he also knew that I am funny acting . . . so, he tapped you. In a world of "no new friends"—I have found a friend for life.

We walked in together and now we get to walk out into the world together—**Portia, Marquita, Kendra**—I appreciate y'all. #Blackwomendocs

My unofficial cohort: **Beth**—thank you for matching my nerdiness, letting me bounce ideas off you, and Saturday morning Starbucks . . . #teamJasmine. **Allison**—I knew you were golden when you leaned over in class after I took that phone call and you asked me if everything was okay. You are a keeper and I dig your energy.

For letting me share tidbits of wisdom and my experiences with you—**Shima, Yaa, Tasha**— to my group of highly skilled, amazing, dope Black social workers . . . thank you for allowing me to learn from you. I'll rock with y'all to the end.

For being professionally supportive and personally interested in my success—**Dr. Jan Parrish**—I thank you for encouraging me along the way.

The Invisible Knapsack—to **Mark**—our paths crossed for a reason. Thank you for the four plus years of conversations about race, culture, class, education, and politics. Our relationship is truly a testament to the possibilities of positive change in the world when we engage in open and honest dialogue.

To my study participants—I am thankful for your dedicated time to this important body of work and forever grateful for how you show up for our Black youth. Keep pressing. They need you.

The opportunity to work with two amazing research teams has definitely been one of the highlights of this journey. Thank you for letting me learn from and with you: **Dr. Andrene Castro, Dr. Melissa Yeung, Dr. Genevieve Siegel-Hawley, Dr. Jenna Furman, Dr. Kimberly Bridges, and Dr. David Naff**.

To my committee: Relationships are important to me and this dissertation process is as much about relationships as it is academic achievement. I had no questions about your intellect, skill, or experience to be a part of my team, that was obvious. For a process as intimate as this—I knew I had to genuinely like the people I would be working with . . . so, know that I would choose each of you every time.

Our practitioner selves always seemed aligned and asking the same questions—**Dr. Kimberly Bridges**—thank you for giving me my first research opportunity . . . and for being outspoken when it counts.

The plane has landed—**Dr. David Naff**—I am so fortunate to have been able to work alongside of you on two well-written and much needed publications. Thank you for believing in my abilities and valuing my contributions to our research team.

Home visits and winter coats--**Dr. Thelma Bryner**—thank you for being genuinely interested in the lives of all children. I had no idea that the person (you) who was so open to learning from their school social worker (me) would play a pivotal role in my own learning…it makes sense though because you and I clicked from the very beginning.

Thank you for seeing more than just my vision—**Dr. Charol Shakeshaft**—thank you for seeing me. I have an enormous amount of respect and appreciation for more than just your work, but for you. I am sure being a good dissertation chair comes with experience. However, being a <u>great</u> dissertation chair comes from within—it comes from a genuine and authentic place of wanting to see the success of someone else just as much as they want to see it for themselves.

CS: I hope you are internalizing how smart, strong, intellectual, and competent you are.

Me: I just said to someone the night before that even though people were saying good job . . . I was saying to myself, but was it really good?? Self-doubt will really get you.

CS:
Every day, say . . .

I am Shenita
I am really smart
I am really analytical
I am really thoughtful
I am an intellectual
I am a scholar
I am real
I am many more things in addition
REALLY!

This is what great dissertation chairs are made of . . . Dr. Shakeshaft, you are great chair and advisor.

Finally, to my Black girls and Black women—the world needs you and I got you. **Black women are dope**. Period.

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Abstract

SUPPORTING THE MENTAL HEALTH OF BLACK STUDENTS: A FRAMEWORK FOR COMPREHENSIVE SCHOOL-BASED MENTAL HEALTH SYSTEMS

By Shenita E. Williams, Ph.D.

A dissertation submitted in partial satisfaction of the requirements for the degree of Doctor of Philosophy in Education Leadership, Policy and Justice at Virginia Commonwealth University.

Virginia Commonwealth University, 2022.

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School-based mental health is plagued with two primary challenges: (a) design and (b) service delivery. The design of school-based mental health is often comprised of fragmented, individual programs and services, and the delivery of mental-health services and support are culturally insensitive. The purpose of this Delphi study, grounded in African-centered thought (Afrocentricity), was to identify essential components of a comprehensive school-based mental-health system necessary to adequately address and support the mental health of Black students in K–12 public school settings. Through the cultural lens of Black experts, the needs of Black students along a continuum of mental health was highlighted. Further, the panel of Black experts identified culturally relevant factors necessary for school-based mental health practitioners to include in their delivery of mental-health services and support to Black students. Findings from this study resulted in the development of a framework for a comprehensive school-based mental-health system intentionally centering the mental health of Black students.

Keywords: Black student(s), school-based mental health, comprehensive school-based mental health system, Delphi method, mental health, African-centered thought, Afrocentricity, Black culture

CHAPTER 1: THE MENTAL HEALTH OF YOUTH

An estimated 13–20% of all children and adolescents (i.e., approximately one of five) experience a mental disorder in a given year (Hoover et al., 2019; Mental Health America, 2017). Depression, attention deficit hyperactivity disorder (ADHD), and substance abuse are the top mental health challenges one in 10 adolescents will experience (Bloxsom-Carter, 2019). Gudino et al. (2009) reported 21% of children and adolescents aged 9–17 are diagnosed with a mental health disorder, and 14–40% who demonstrate a mental health need will go without any mental health services or support. Hoover et al. (2019) reported the number of children and adolescents who will go without any mental health services or support to be as high as 88%. Underrepresented youth and families (i.e., African-American, Hispanic, and Asian-American) are more likely to have their mental health needs unmet or experience a delay in receiving mental health services and support (Gudino et al., 2009).

According to World Health Organization (WHO; 2014), *mental health* is the "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (p. 12). Mentally healthy children and adolescents have a positive quality of life and function well at home, school, and in the community (Centers for Disease Control and Prevention [CDC], 2021). Additionally, mentally healthy children and adolescents are able to effectively self-regulate their emotions and behaviors when faced with challenges because they have healthy social and emotional skills; however, the opposite of being mentally healthy is not a state of being mentally ill nor having a mental disorder (CDC, 2021). Students can experience poor mental health and not have a diagnosed mental disorder (WHO, 2014).

As such, it is important to also define mental health need. For Pfeiffer and Reddy (1998), *mental-health need* referred to a level of distress or discomfort experienced by a person who does not meet established psychiatric criteria for a specific mental disorder. Pfeiffer and Reddy (1998) cited examples of mental health needs experienced by children as low self-esteem; grief following the death of a family member or close friend; stress accompanying parental conflict, separation, or divorce; social skills deficits; and a range of subclinical threshold emotional and behavior problems.

Approximately 50% of students with mental health needs may demonstrate heightened behaviors, such as aggression, withdrawal, agitation, or impulsivity compared to students identified as experiencing positive mental health (EAB Global, 2020). Students who experience mental health needs may be more likely to drop out of school, encounter future problems with employment and relationships, and or have a mental health disorder diagnosis in adulthood (Wolpert et al., 2015).

Statement of the Problem

The mental health of Black students within the context of school-based mental health is largely absent from existing literature. School districts routinely report providing school-based mental health when what is actually provided are fragmented programs, interventions, and services (Anderson, 2007). Consequently, challenges exist regarding how school-based mental health is defined, designed, implemented, and evaluated. Additionally, more culturally appropriate ways of addressing and supporting the mental health of Black students in the school setting often go unused. There has been little-to-no attention given to the influence that race, culture, and class have on the mental health of Black students and the school-based mental-health services and support they receive.

School-based mental health needs to reflect cultural sensitivity (Stempel et al., 2019) and schools should examine the impact of oppressive conditions on student mental health (O'Toole, 2017). However, many schools do not provide culturally responsive nor inclusive mental health services or support. As a result, creating a framework, model, or system of school-based mental health recognizing the contextual experiences and needs of students of color who experience mental-health challenges could prove instrumental for school systems in adequately supporting the mental health of Black students (Johnson, 2010).

Conceptual Framework: Afrocentricity (African-Centered Thought)

Continuing to assess and analyze Black students using theories normed on non-Black students is ineffective, inappropriate, and dismissive of cultural differences (Hatcher et al., 2017). Illustrated through existing research, there are benefits to using Afrocultural theories (Hatcher et al., 2017) and an Afrocentric worldview when working with Black youth (Wang et al., 2013). Therefore, because this research is specific to Black students, an African-centered approach (i.e., Afrocentricity) foregrounded this study. Although purposefully designed school-based mental health systems may have the well-being of its students anchored at the core, the centering of students' contextual experiences and unique cultural factors are often missing. A way to successfully meet the mental health needs of Black students is to use an African-centered worldview in mental-health service delivery and design.

Asante (1987) defined *Afrocentricity* as "placing African ideals at the center of any analysis that involves African culture and behavior" (p. 2). The center, or location, where Blackness exists is equal to any other worldview (Asante, 1987; Monteiro-Ferreira, 2009). Afrocentricity is a way of thinking, acting, and living to advance social justice and human rights honoring cultural uniqueness, personal strengths, and community development (Bent-Goodley et

al., 2007; Borum, 2017; Hatcher et al., 2017). As a practice framework, individual and collective functioning; the family and the community (Bent-Goodley et al., 2017; Borum, 2007; Graham, 1999; Hatcher et al., 2017; Schiele, 1990; Stewart, 2004); the oneness of mind, body, and spirit (Graham, 1999); and the fundamental goodness of people (Bent-Goodley et al., 2017; Schiele, 1990) are key tenets identified as foundational in direct practice work in the fields of social work, psychology, and sociology (Bent-Goodley, 2017; Carroll, 2014; Schiele,1990).

Purpose of the Study

The purpose of this Delphi study was to identify essential components for comprehensive school-based mental-health systems to adequately address and support the mental health of Black students in K–12 public school settings. This study included a panel of experts with research, practice, and personal experience in the field of mental health and knowledge and experience of Black culture and student needs. Following the Delphi data collection, individual interviews were conducted to enrich the collected data from the four rounds of the study.

Research Questions

The following two research questions targeted the information necessary to develop a framework for a school-based mental health system that addresses the needs of Black students:

- Thinking along a continuum of mental well-being, what are the needs of Black students?
- What culturally relevant factors are necessary for school-based mental health practitioners to include in their delivery of mental-health services and support to Black students?

Overview of Research Design

Focusing on the three key components of a Delphi method, a selected panel of 14 Black experts participated in a series of four rounds. In Round 1, experts responded to three open-ended questions around the topic of the needs of Black students, the role of school-based mental-health practitioners, and the expectations of a school-based mental-health system. Data collection and analysis in a Delphi study are interconnected processes because of the feedback received between each round (Masser & Foley, 1987). With the goal of consensus, data were collected and analyzed after each round, and presented in the following round.

Experts were unknown to one another and their responses were confidential. Through consensus, experts identified key elements necessary for adequately supporting the mental health of Black students. Panel experts also identified key needs and culturally relevant factors school-based mental-health practitioners must understand, acknowledge, and do to provide adequate mental health services and support.

Ten experts participated in individual, semistructured interviews after the four Delphi rounds were completed as an opportunity to expand on their responses. Data collected from interviews enhanced and enriched data collected during the Delphi rounds. A thematic analysis of interview data added context, voice, and depth to the collected data from the final Delphi round.

Definitions of Terms

The following defined terms offer a clear understanding of the meaning of mental health within the context of school-based mental health as addressed in this study.

- *Mental health* is the state of well-being where one realizes their own potential, can cope with the "normal" stresses of life, and productively contribute to the larger society (WHO, 2014).
- *Mental illness (mental disorder)* is often viewed as the opposite of mental health; a state of being unwell or unhealthy (WHO, 2014).
- *Mental health need* refers to distress or discomfort that does not meet psychiatric criteria for a specific mental disorder (Pfeiffer & Reddy, 1998). The use of the phrases *mental health* and *mental illness* give the impression there is no space between the two—that a person is either one or the other. However, this is not always the case.
- *Continuum of mental health* refers to mental-health experiences that occur along a continuum ranging from healthy to disordered. The continuum includes the traditionally understood concepts of mental health and mental illness (disorder), but also encompasses mental health needs.
- *School-based mental health* refers to individual programs, interventions, or strategies applied in a school setting specifically designed to influence students' emotional, behavioral, or social functioning (Rones & Hoagwood, 2000). These resources are intended to identify, diagnose, prevent, and/or treat behavioral, emotional, or psychological problems independently of sector, provider type, or source of payment (Pfeiffer & Reddy, 1998).
- *School-based mental-health system* is the comprehensive system providing support and services specifically addressing school climate, social–emotional learning, mental

health, and well-being, with the goal of reducing the prevalence and severity of mental illness and mental health needs (Hoover et al., 2019).

Significance of the Study

First and foremost, there is limited information in extant literature surrounding the mental health support and services provided to Black students in the school environment; therefore, the significance of this research was twofold. One, this research addressed the identified gap in literature by clearly defining and describing components necessary for effective and adequate school-based mental health systems. Second, this research pinpointed culturally responsive practices for school-based mental health design and implementation. Considering insufficient information exists on what makes school-based mental health practices great—or at best, adequate—this research delivered a response for such an unknown variable.

These two points are significantly important; however, they truly are second to the most critical factor in this research: centering Black students. There was no comparative group, as one was not needed. This research began from the premise that Black students alone are worthy to be centered in any analysis and their reality does not need to be measured nor compared to that of any other racial or ethnic student groups.

Additionally, this study created a blueprint for how culturally responsive and inclusive school-based mental health systems can be designed and implemented. In that regard, findings from this literature are groundbreaking in that these key identified elements can be broadly used to ensure culture is respected, appreciated, and supported when providing mental health services and support, regardless of students' cultures.

This research stresses the importance of mental health across a continuum and challenges practitioners to think about mental health as more than a binary concept of mentally healthy or

mentally ill. This research recognizes mental health in schools spans from prevention services to more individualized services and support. Another highlight of this research was how the mental health of Black students, with clinical needs and subclinical needs, is gravely impacted by racism, discrimination, stereotypes, and bias, and what schools can do to subvert this impact.

Putting It All Together

This research focused on identifying essential elements for school-based mental health systems that adequately support the mental health of Black students at the center—culturally responsive and inclusive systems. African-centered thought provided the framework and support for this research. The Delphi method provided the structure for the study design. This study is immensely important in helping to fill a gap in existing literature surrounding the mental health of Black students within the context of school-based mental health.

This dissertation is comprised of four additional chapters. Chapter 2 is a two-part comprehensive review of the literature surrounding school-based mental health and the mental health of Black students. In this chapter, gaps in the literature are addressed and provide support for why this research is important. Chapter 3, details the research method and design and how the research was conducted. Chapter 4 presents the findings and Chapter 5 describes a model for addressing the mental health of Black students.

CHAPTER 2: LITERATURE REVIEW

This chapter focuses on the extant literature surrounding school-based mental health and the mental health of Black students. The literature review is presented in two phases. The first phase reviews the history of school-based mental health, schools as providers of mental health, the traditional types of school-based mental health, and valuable components of school-based mental health as identified in the literature. The second phase reviews school-based mental health as it relates to the mental health of Black students. This phase, based on the literature, highlights challenges for Black students. More specifically, barriers to mental health, educator perception and bias, and the influences of class, race, and culture are presented and discussed. This chapter concludes with an introduction and discussion of the conceptual framework, Afrocentricity, and the use of the guiding principles of African-centered thought in mental health service delivery.

Literature Review: School-Based Mental Health

A comprehensive search of published literature between 2000–2021 was conducted to explore the history of school-based mental health, schools as providers of mental health, and approaches to school-based mental health. The following keywords were searched in ERIC via ProQuest, EBSCOhost, Social Work Abstracts, Social Services Abstracts, *Journal of School Health, Children and Schools, School Social Journal,* and *School Mental Health:* school-based mental health, PK–12, elementary, secondary, programs, providers, services, program effective(ness), program evaluation, analysis, review, student mental health, and framework.

The search yielded 147 viable data sources. Articles written before 2015 (for the purpose of using the most recent literature); articles that did not specifically focus on effectiveness, evaluation, or analysis of school-based mental health; or those that did not offer significant

contributions to the broader conversation surrounding school-based mental health were excluded. Literature pertaining to the history of school-based mental health, theory, framework, and models provided useful information and warranted an exploration into earlier works. Hence, scholarly articles from earlier years (i.e., 2000–2014) in those areas were included. After applying these exclusionary and inclusionary criteria, 33 data sources were reviewed in depth.

History of School-Based Mental Health

During the Progressive Era (1890s–1930s), which Flaherty and Osher (2002) identified as the "mental hygiene movement" (p. 12), school-based mental health support was focused on compulsory education and child labor laws, immigration and social order, urbanization and public health, and professional and scientific development. During this time, there was (a) an increase in the number of students who were unprepared to learn; (b) an increase in discipline problems; (c) cultural disconnect between schools, staff, and students; and (d) concern about the impact uneducated students would have on the larger society. There was great debate over the role of the school in addressing problems outside of reading, writing, and arithmetic. During this period of reform, some educators, social workers, and Progressive reformers wanted to "fix" schools by creating community schools that would address barriers to student achievement, such as mental health. Others believed poor mental health was the reason for poor student achievement and behavior problems, and fixing the student was the answer. Unresolved disagreements about the role of the school in providing support meant students with mental health and behavior needs were referred to agencies outside the school (Flaherty & Osher, 2002).

Despite disagreement between who and what needed fixing, a shared agenda focused on vocational counseling, special education classes, the introduction of school-based clinics, and the

emergence of the first visiting teachers (i.e., school social workers). Focus on these areas continued to frame education policy beyond the Progressive Era; however, between WWI and WWII (1914–1917 and 1940–1945, respectively) four distinct societal factors limited the progressive ideology of education policy (Flaherty & Osher, 2002). First, Black students were restricted in the services they could receive due to racial segregation. Second, the economic depression of the 1930s negatively impacted the financial resources of less wealthy schools. Third, many people, including educators, still did not believe schools had a role in providing ancillary services to students. Lastly, teachers rarely changed the way they taught students. In response to these factors, progressive ideology of education policy began to fade in the 1930s and 1940s, along with the discourse of collaboration between schools and community-based agencies. As a result, community mental health clinics addressed student mental health with little-to-no collaboration with schools. The consequences of this arrangement have had long-term implications for school-based mental health, due in large part to the separatist approach and differing perspectives of the school community and the mental health community (Kutash et al., 2006).

Schools as Providers of Mental Health Services

Rones and Hoagwood (2000) defined the term *school-based mental health* as any program, intervention, or strategy applied in a school setting specifically designed to influence students' emotional, behavioral, or social functioning. This definition was similar to that of Pfeiffer and Reddy (1998) who defined school-based mental health as any service or set of coordinated services intended to identify, diagnose, prevent, and/or treat behavioral, emotional, or psychological problems independently of sector, provider type, or source of payment. As Anderson (2007) noted, the term *school-based mental health* encompasses substance abuse

prevention and treatment and prevention of other risky behaviors common to youth. Hoover et al. (2019) defined school-based mental health as a comprehensive system that provides support and services that specifically address school climate, social–emotional learning, mental health, and well-being with the goal of reducing the prevalence and severity of mental illness. The system involves collaboration and partnership with school staff, students and families, and communities.

Students are 21 times more likely to seek mental health services from school than a community clinic (EAB Global, 2020), rendering schools the primary mental health providers for school-aged youth (EAB Global, 2020; Walter et al., 2006). Schools provide 70–80% of the mental health services and support children and adolescents need (EAB Global, 2020; Hoover et al., 2019). They are able to address the disconnect between the number of adolescents who experience a mental health condition each year and those who receive services from a trained mental health professional, which is only about 7% of students (Mental Health America, 2017).

The Federal Commission on Safety's (2018) final report identified schools as natural settings for students to receive mental health support because of the amount of time they spend at school. School-based mental health professionals, by virtue of their proximity to students and their consistent interaction and engagement with students, are readily able to meet the needs of students experiencing mental health challenges (Naff et al., 2020). They are able to identify and connect children and adolescents to treatment and any other services they may need (McCance-Katz & Lynch, 2019).

Emotional and behavioral health challenges can create significant barriers to learning (Paternite, 2005). By way of illustration, a first grader who demonstrates aggressive or withdrawn behaviors may show decreased academic achievement in math and English in the third grade (Frauenholtz et al., 2017). Students who experience positive mental health are more

likely to experience a greater sense of overall health and well-being as well as academic success (Quirk, 2020). Positive mental health and academic success impact and influence one another (Zeng et al., 2013); therefore, the connection between school-based mental health services and school outcomes cannot be ignored nor underemphasized (Rones & Hoagwood, 2000). In sum, successful student achievement means tending to the whole student, including student mental health.

Approaches to School-Based Mental Health

There are four historical ways schools have attempted to address the mental health of students: school-based health centers, expanded school mental health, community schools, and full-service schools.

School-Based Health Centers (Clinics)

Born from the concept of public health centers, *school-based health centers* surfaced in the 1980s to provide public primary health care to adolescents. School-based health centers are in or near communities and provide comprehensive primary care to students, school staff, and community members. School-based health centers, originally found mainly in urban school settings, increased in number from 200 clinics in 1992 to over 1,300 clinics reported in 2000 (Flaherty & Osher, 2002). Between 2007–2009, the numbers held steady with 2,000 school-based clinics, 70% of which had mental health providers on site (Bains & Diallo, 2016). In 2016–2017, there were over 2,500 school-based health centers in 48 states (School-Based Health Alliance, n.d.).

A student can visit a school-based health center for any reason, making it less stigmatizing for students in need of mental health support (Anderson, 2007). Bains and Diallo (2016) conducted a systematic literature review of 23 studies focused on school-based health

centers. One finding from their review was students were more likely to access school-based health centers for mental health issues than for medical issues. Students identified familiarity with the school setting, established trust, ease of access, helpful staff, and confidentiality as reasons for visiting the school-based health center. Students experiencing more significant mental health issues were more likely to seek and receive services from school-based health clinics than from community clinics. As such, the number and frequency of these student visits at school-based health clinics were greater than visits to community clinics. Students were also more likely to revisit a school-based health center when a mental health need arose rather than seek support at a community-based agency (Stempel et al., 2019).

Expanded School Mental Health

The emergence of *expanded school mental health* programs began in the 1980s as a supplement and expansion of traditional school services focused on special education and crisis management (Flaherty & Osher, 2002). In 2003, the President's New Freedom Commission described expanded school mental health as programs added to the core services typically provided by schools (Anderson, 2007). Expanded school mental health is a framework for programs and services, usually supported and provided by community agencies to fill identified gaps in school services. In addition to what is provided at the school, community agencies provide a full continuum of services, such as mental health assessment, education, promotion, prevention, early intervention, and treatment to all students (Kutash et al., 2006).

Community Schools

Community schools, as defined by Varlas (2008), have two goals: "helping students learn and succeed and strengthening families and communities" (p. 2), According to Olubiyi et al. (2019), community school models focus on the integration of academic achievement, youth

development, family support, health and social services, and community development. Although there is an intentionality in the utility of community school models to support mental health delivery and outcomes (e.g., health and social services), they do not always include mental health services in practice.

Full-Service Schools

Varlas (2008) defined *full-service schools* as an extension of community schools, whereby the school is the center of the community. These full-service schools encompass after-school opportunities, early childhood education, real-world learning approaches, and physical and mental health services for adults and young people in the neighborhood. Full-service schools are promoted as "one stop shopping" (Flaherty & Osher, 2002, p. 18) for students, families, and communities, with the primary goal of providing health care. Schools and communities work together as not to overburden the system or fragment services. Full-service schools are intentionally integrated into the school, taking advantage of school resources and community resources to meet the needs of students and families. Full-service schools are typically, but not necessarily, located on school sites.

Valuable Components of School-Based Mental Health

Partnership, collaboration, and implementation are identified in the literature as essential components of school-based mental health regardless of the approach, program, or intervention. Partnership and collaboration focus on how schools actively engage community partners, agencies, and licensed professionals. Implementation focuses on how services within school-based mental health systems are effectively implemented.

Partnership and Collaboration

Partnership and collaboration can effectively sustain and support school-based mental health while ensuring student needs are met (Kern et al., 2017). Perrault (2013) identified formal connections with community mental health services as one of the primary models of school-based mental health programming. As Perrault's *School Mental Health Services in the United States, 2002–2003* report noted at that time, over 50% of schools had partnered with a community agency, center, or individual private provider. The report, with respondents from over 83,000 public elementary, middle, and high school staff and district offices across the United States, described schools as having a role in the delivery of mental health services. The President's New Freedom Commission on Mental Health also stressed the importance of partnerships with schools (Paternite, 2005).

Effective collaboration helps ensure flexible, easily accessible, culturally sensitive, and cost-efficient programs (Pfieffer & Reddy, 1998). An illustration of collaboration and partnership between multiple state agencies, local school districts, and local community mental health agencies can be seen through the School-Based Mental Health Project (SBMHP; Motes et al.,1999). Over a 3-year period, the SBMHP, supported by the Center for the School Mental Health Assistance at the University of Maryland at Baltimore, was implemented in 20 rural and underserved South Carolina schools. The schools were identified with having low graduation rates, low standardized test scores, and high child poverty levels. The project used a full community school approach emphasizing intentional integration of services to meet academic, behavioral, and emotional needs of students and families. Though the researchers involved in the study decided their attempt to evaluate project effectiveness was premature, they noted several accomplishments. The perceived success of these efforts resulted in the implementation of the

model at additional schools and increased financial and in-kind support. The greatest achievement was the response of the schools to the needs of the community for resources and services, such as mental health counseling (Motes et al., 1999).

The Significance of Implementation

Unsuccessful implementation of school-based mental health (e.g., programs, services, and support) tends to be the norm (Lyon & Bruns, 2019). Chiodo and Kolpin (2018) identified several issues negatively impacting successful implementation: (a) the difficulty of activities and interventions, (b) limited instruction for teachers to implement the program, (c) evidence-based programs presented as one-size-fits-all, and (d) teachers being required to implement programs not aligned with their beliefs nor their readiness to implement such programs. Therefore, assessing the implementation of school-based mental health is key when discussing service delivery (Kern et al., 2017). One effective way to support successful implementation of school-based mental health is to use diffusion of innovation theory and key opinion leaders (KOL), (Atkins et al., 2008; Cappella et al., 2008). Diffusion of innovation theory underscores the importance of partnership and collaboration necessary for program implementation. In essence, diffusion of innovation theory means giving consideration to how new ideas are accepted, and then identifying persons most influential in garnering support of others to get new ideas implemented. Atkins et al. (2008) investigated the influence of KOL teachers on teacher use of recommended strategies for students with attention deficit hyperactivity disorder (ADHD). The researchers found a positive association between schools with high KOL support and high teacher-reported use of recommended strategies for addressing ADHD behaviors in the classroom.

Because evidence-based programming is not one-size-fits-all, some schools will not be able to simply use the program as is—nor should they be expected to do so. Lyon and Bruns (2019) questioned whether an evidence-based program can be successfully implemented without adapting the program to fit the specific needs of the school and the students it serves. They asserted program adaptation must be considered when discussing program implementation.

In summary, the literature review on school-based mental health yielded important information necessary for understanding the historical context for school-based mental health, the role of schools as providers of mental health, and various approaches to the delivery of school-based mental health. Additionally, key elements—partnership, collaboration and implementation—emerged as critical components to providing successful school-based mental health services and support. Still, the most important finding was there remains minimal mention in the literature about school-based mental health as it relates to students of color, namely Black students. Even with the recent publication, *Advancing Comprehensive School Mental Health: Guidance from the Field* by Hoover et al. (2019), which offers core features of a comprehensive school mental health system, the specific mental health needs of Black students are not addressed. This identified gap in the literature was the impetus for further analysis leading to the literature review in the following section.

Literature Review: Black Students and School-Based Mental Health

This literature search was conducted to explore the literature concerning Black students and school-based mental health. The following keywords were searched in ERIC, APA/PsycInfo, and EBSCO databases: African American, African American students, Black students, African American children, African American child, Black children, Black child, African American adolescent, Black adolescent, African American youth, Black youth, mental health, mental

illness, mental disorder, socio-emotional, emotional health, school-based, school based, secondary, elementary, K–12, middle school, junior high, elementary school, and high school. With over 2,100 pieces of data, a title and abstract review of each publication resulted in 65 research articles. The keywords African American, Black, Black American, and school-based mental health were used in an additional search in the journals of *School Mental Health, Child Adolescent Mental Health, Psychology in Schools, School Psychology,* and *School Social Work* and the Web of Science database, which resulted in 31 publications.

First, a thorough reread of the abstracts of 96 collected publications led to a final pared list of 40 publications. Then, each publication was read in depth, paying close attention to introductions, findings, and conclusions; this in-depth review resulted in the inclusion of only eight articles. However, those eight articles referenced 12 additional articles included in this literature review. Though there were over 2,100 articles initially identified through searches, most were excluded because the articles did not discuss the mental health of Black school-aged youth within the context of school-based mental health or they only focused on individual assessments or evaluations of individual programs and interventions instead of comprehensive school-based mental health systems. The sections below discuss barriers to mental health services and support and educator perceptions of and biases toward Black students before addressing influences of class, race, and culture on the mental well-being of Black students.

Reasons for Underutilization and Early Termination

Underrepresented youth receive mental health services at lesser rates than White youth (Gamble & Lambros, 2014; Office of the Surgeon General, 2001). More explicitly, Black youth, in comparison to White youth, receive school-based services at lesser rates, rendering the underutilization of mental health services and support by racial and ethnic youth a public health

problem (Hatcher et al., 2017; Herring, 2015). Challenges with transportation, a lack of insurance, stigma associated with mental health, and issues with accessibility to community mental health tend to be among the well-known barriers to seeking and receiving services (Gamble & Lambros, 2014; Gudino et al., 2009). Less discussed barriers to seeking and receiving mental health services include lack of racially and ethnically diverse mental health professionals and lack of bilingual professionals (Gudino et al., 2009). Gamble and Lambros (2014) conducted a qualitative study of school-based mental health providers' efforts to support families in accessing mental health services. Culturally related factors, such as stigma, culture-specific training and professional development, language translation services, and ethnic specific clubs were the primary reasons provided for limited access to mental health services for underserved populations.

Not receiving mental health services when needed is a concern for Black and other racial and ethnic youth and youth with low socioeconomic status (Cokley et al., 2014). Huff (2011) reported the results of a cross-sectional analysis of three national surveys focused on access to mental health services, which found 80% of Black children and adolescents aged 3–17 who were eligible to receive services based on a documented mental health need did not receive any mental health treatment in the preceding 12 months. Similarly, Farahmand et al. (2011) reported the same high percentage (80%) for low-income youth. A lack of understanding of the lived experiences of Black families (Herring, 2015) and mental health professionals' lack of awareness in working with diverse groups (Bloxsom-Carter, 2019) are additional barriers contributing to the underutilization of mental health services.

Early termination of mental health treatment is high for Black students (Bloxsom-Carter, 2019; Gamble & Lambros, 2014). Although mental health stigma, lack of information, location

of services, and transportation are barriers to seeking and receiving services, they also contribute to the early termination of services, which Farahmand et al. (2011) found trended upward at a rate of 50%. Likewise, Hoover et al. (2019) found early termination rates for populations of color to be as high as 60%. Having available school-based mental health services can address issues of unmet need and possible premature termination of services (Bloxsom-Carter, 2019; Cokley et al., 2014; Herring, 2015).

Hatcher et al. (2017) reported mental health services are often underused by Black students because selected programs and services are not designed nor implemented with Black students in mind. A systematic analysis by Metzger et al. (2013) found risk prevention-based programs more effective when interventions were grounded in Afrocultural theories (Hatcher et al., 2017). In another study of Black American college students, Wang et al. (2013) found Black American students were better able to manage life stressors and reported lower incidents of depressive symptoms when an Afrocentric worldview was used.

Black caregivers and adolescents have acknowledged the importance of mental health services and support; yet, due to a history of distrust in the system, racism, discrimination, and stigma, they may not seek nor receive needed support (Hatcher et al., 2017; Herring, 2015). The mistreatment of Black caregivers is a significant, often less frequently acknowledged and admitted barrier to seeking help. Black caregivers often feel alienated, powerless, and uniformed about specific processes for school-based mental health services (Huff, 2011). In fact, most mental health services offered in the school setting do not include nor engage the family (Gamble & Lambros, 2014). In a study conducted by Herring (2015), the lived experiences of Black parents of elementary students participating in school-based mental health services revealed several parents were concerned about the process used to diagnose their child. When

Black families do seek mental health services and support, their experiences are not always positive (Borum, 2007). According to Borum (2007), there are three interrelated reasons why Black people who seek mental health services do not perceive their experiences as positive. First, many social service agencies and their staff are seen as part of a system of oppression. Second, when Black people receive support from such agencies, they are scrutinized for the way they parent or the way their families function. This scrutiny results in many Black people terminating services and further feeling at odds with a system perceived as not caring about them. Lastly, the cultural beliefs and strengths of Black people are often ignored. Discourse around race and culture as influential barriers to seeking and receiving mental health warranted an examination of what this finding means for Black students at school.

Educator Perception and Bias

Teacher perceptions and responses affect the mental health of Black students (Cokley et al., 2014). The inclination of teachers to rate Black students low across various measures, including behavior, have lower expectations of academic performance, and treat Black students "less favorably" (p. 235) than White classmates has been documented in research as early as 1961 in Dr. Kenneth Clark's study of urban classrooms (Chang & Sue, 2003). This type of teacher behavior is consequential for Black students, even those as young as preschool aged. Cokley et al. (2014) reported Black preschoolers are 3–5 times more likely to be expelled from school, 3 times more likely to be labeled with a mental disorder, and almost 2 times as likely to be labeled with an emotional or behavioral disorder than their Asian-American, Latinx, or White peers.

Stein et al. (2010) conducted a study examining racial and ethnic differences among youth diagnosed with having depression. Contrary to expectations, there were no ethnic

differences in self-reporting of depression among youth participants; however, there was a difference in how Black adolescents were observed and rated by the interviewers (Stein et al., 2010). In comparison to White adolescents, the interviewers rated Black and Latinx adolescents as displaying more severely depressed behaviors; yet, neither Black nor Latinx adolescents self-endorsed higher symptoms of depression in comparison to White adolescents. Stein et al. suggested three possible influencers of these results.: (a) implicit bias of the mostly White evaluators and their interpretation of the behaviors of non-White adolescents, (b) cultural misinterpretation of Black adolescents' behavior (e.g., misinterpreting the flat affect and listlessness of participants as depression as opposed to attributing those behaviors to adolescents being cautious or guarded), and (c) Black adolescents in the treatment study presented with more severe behavioral symptoms. They further noted, despite the challenge with being able to determine the exact reason, of greater concern was the cultural competence of the evaluators.

There is a stark difference between how the behaviors of Black students are labeled and judged in comparison to their White counterparts. Gudino et al. (2009) conducted a study of disparities in the use of mental health services between racial and ethnic youth groups according to internalizing and externalizing behaviors. The authors discovered that in comparison to White students, Black students were more likely to be inaccurately identified as having anger issues or behavior issues when displaying externalizing behaviors (e.g., irritability, frustration, annoyance, anger) that are often associated with depression in adolescents (Gudino et al., 2009). Black students displaying externalizing behaviors were more readily identified and referred for mental health services than when they experienced internalizing issues (e.g., anxiety, depression). Non-Hispanic White students were more likely than any other student group to receive mental health services for internalizing issues. The needs of Black students with internalizing issues tended to

be overlooked and go untreated. According to Gudino et al. (2009), pathways for Black students into special education and the juvenile justice system were created due in part to bias in treatment and evaluation and the misinterpretation of externalizing behaviors of Black students. When educators focus solely on behavior without considering possible underlying factors—including their own biases—they are likely to overidentify Black students for services, such as special education. This behavior perpetuates disparities in school discipline where Black students are more harshly penalized for similar and subjective infractions (e.g., disrespect, excessive noise, threat, and loitering) in comparison to White students (Cokley et al., 2014; Gudino et al., 2009).

The teacher–student relationship is critical to student success; yet, researchers have suggested teachers are less competent in working with Black students than with White students (Serpell et al., 2009). In many cases, the behaviors of Black students are viewed poorly in comparison to other race peers due to deficit thinking, often couched in the use of microaggressions (Baker, 2019). Cokley et al. (2014) suggested teachers' perceptions and reactions to the behaviors of Black students are moderated by race. Many studies identified Black students are more harshly assessed by White teachers than non-White teachers, which may indicate "racial bias in teacher expectations" (Trent et al., 2019, p. 4). Murray et al. (2008) examined the association between teacher–student interactions and school adjustment of Black, Latinx, and White students attending low-income urban schools. The study revealed race moderated the teacher–student relationship and Black students were more likely to dislike school settings when conflict with the teacher was high and closeness with the teacher was low. Race and ethnicity were also regarded as potential moderators of intervention outcomes (Serpell et al., 2009).

The Influence of Class on the Mental Well-Being of Black Students

In their policy brief, *Child Poverty in America 2019: National Analysis*, the Children's Defense Fund (2022) defined poverty as "an annual income below $25,926 for a family of four with two children—about $2,161 a month, $499 a week or $71 a day" (p. 1) The brief reported that of the 30 million people living in poverty, approximately one third (30.8%) were children. Moreover, 71% of those children were children of color. Comparatively speaking, more than one in four (26.5%) Black children were impoverished in 2019 compared with one in 12 (8.3%) White children. The gap widened when extreme poverty rates were assessed in 2019. The Children's Defense Fund (2022) defined extreme poverty as "an annual income of less than half the poverty level" (p. 2) More than one in nine Black children compared to one in 25 White children experienced extreme poverty in 2019.

People who live in poverty are more vulnerable and susceptible to experiencing mental health challenges than those who do not live in poverty (Cokley et al., 2014; Office of the Surgeon General, 2001; Hatcher et al., 2017; Herring, 2015). Poverty was identified by the Office of the Surgeon General (2001) as a community/social risk factor of mental health problems and mental health disorders. Persons who live in poverty are more likely to encounter risk factors that create psychological stressors, such as child abuse, family conflict, lack of money, and exposure to crime and violence (Farahmand et al., 2011). Consequently, Black youth are disproportionately impacted by factors—such as living in segregated communities with limited access to resources, high rates of unemployment, homelessness, and crime—directly impacting their psychosocial development (Serpell et al., 2009). Additionally, persons identified as being in the lowest socioeconomic status are 2–3 times more likely to have a mental health disorder than persons in the highest socioeconomic status. However, it is important to understand

persons of similar socioeconomic status do not behave, speak, and live the same way, nor do they value the same things simply because they are in the same socioeconomic bracket. Therefore, continuing to associate socially constructed levels of class with predetermined lifestyles and values impacts practitioners' ability to accurately assess students' needs and provide appropriate services (Borum, 2007).

The Influence of Race and Culture on the Mental Well-Being of Black Students

The rate of mental illness among Black adolescents is no higher than the national average or the average of any other racial/ethnic adolescent group (Bloxsom-Carter, 2019; Herring, 2015). However, race and culture exacerbate issues for Black students (Cokley et al., 2014) experiencing mental health challenges and influences how their problems are perceived and addressed (Stewart, 2004). Although all adolescents, regardless of race, experience many of the same stressors, Black adolescents experience additional stressors, such as race-related stress (Cokley et al., 2014; Serpell et al., 2009). Masko (2005) argued the prevalence of racism is a mental health issue for children. Children experiencing racial issues are often humiliated by the racist actions of others, and considered a behavior problem when responding in anger to those feelings. The American Academy of Pediatrics also declared in their 2019 policy brief that racism is a social determinant of health linked to mental health problems in children and adolescents (Trent et al., 2019). Additionally, children are impacted by the effects of structural racism throughout every aspect of their lives, including educational institutions where they learn (Trent et al., 2019). An example of the effects of structural racism on children is illustrated in Masko's (2005) ethnographic study, "'I Think About It All the Time': A 12-Year-Old Girl's Internal Crisis With Racism and the Effects on Her Mental Health." In the study, Keandra, a 12-year-old Black girl, reported that she thinks about racial issues all the time.

Weeks and Sullivan (2019) published a paper investigating the relationship of discrimination to mental health outcomes. Analyzing data from the 2011–2012 National Survey of Children's Health, data revealed children who experienced discrimination were 3–4 times more likely to have problems with internalizing and externalizing behaviors than children who did not have any experiences with discrimination. To illustrate this point, Black children who experienced discrimination were almost 3 times as likely to have problems with anxiety in comparison to children of other races/ethnicities. Race was found to be a moderating variable between discrimination and anxiety, but not depression and behavior problems.

Black students are confronted with racialized and culture specific issues judged against the norm of White culture (Cokley et al., 2014). In a 2007 study regarding racial climate and achievement, Black students reported their schooling experiences were less racially fair than their White counterparts (Serpell et al., 2009). As such, Black students are vulnerable to biases and stereotypes of their behaviors, often determining if and how their mental health needs are addressed (Cokley et al., 2014). Additionally, perceived discriminatory experiences also negatively impact the mental health of Black children (Weeks & Sullivan, 2019) and have been linked to conduct problems and depressive symptoms (Serpell et al., 2009).

Culturally responsive practices demonstrate an acknowledgement and understanding of the unique values and beliefs of Black students (Serpell et al., 2009); therefore, school-based mental health practitioners should employ culturally responsive practices supporting mental health needs of Black students (Bloxsom-Carter, 2019; Huff, 2011; Serpell et al., 2009). The same holds true for teachers as well. They should also employ culturally responsive practices. Unfortunately, with a limited number of school-based mental health professionals, teachers and other school staff often find themselves left to address the mental health needs of Black students

(Cokley et al., 2014). However, given the limited training many graduate curriculums provide, teachers and other staff may be ill-equipped to address the mental health needs of Black students. Harper et al.'s (2016) research on perceptions of school mental health practitioners in relation to Black girls in low-income households found all participants received limited culturally responsive training in their graduate programs. In the same study—and in spite of reported limitations in culturally responsive training—participants reported using culturally sensitive practices in their work with Black girls. School-based interventions, programs, and services must be culturally appropriate to be effective (Cokley et al., 2014). Program models that do not explicitly account for nor consider race, ethnicity, or culture need to be adapted. Simply put, a disregard for the contextual, cultural experiences of Black students maintains the existing system that mislabels, misdiagnoses, and misinterprets the behaviors of Black students with mental health needs (Bloxsom-Carter, 2019; Cokley et al., 2014; Herring, 2015; Huff, 2011; Serpell et al., 2009).

In summary, issues of race, culture, and class impact and compound existing mental health needs of Black students. The underutilization and early termination of services are not due solely to issues of transportation, insurance, or even the stigma of mental health. A lack of diverse mental health professionals, mental health programs and services not designed with Black students in mind, mistreatment of Black caregivers, and their distrust in the system are prominent, less frequently discussed reasons why Black caregivers do not seek and Black adolescents do not receive or participate fully (e.g., early termination) in mental health services and support. However, Black adolescents also contend with negative perceptions and biases of educators. A demonstrated need for mental health support and services often goes unaddressed, minimized, or dismissed as behavior issues as a result. Class, race, and culture influence the

mental well-being of Black students experiencing needs along a continuum of mental health. In the following pages, I discuss why the use of an African-centered worldview in school-based mental health service delivery and system design is one way to effectively support and meet the mental health needs of Black students.

Conceptual Framework

> By regaining our own platforms, standing in our own cultural spaces, and believing that our way of viewing the universe is just as valid as any, we will achieve the kind of transformation that we need to participate fully in a multicultural society. However, without this kind of centeredness, we bring almost nothing to the multicultural table but a darker version of whiteness. (Asante, 1987, p. 8)

Asante (1987) defined Afrocentricity as "placing African ideals at the center of any analysis that involves African culture and behavior" (p. 2). The center is where one thinks and moves about within the context of the African Diaspora (Asante, 1987). This center—or, as Monteiro-Ferreira (2009) referred to it as African "location"—is a methodological approach that rejects and decenters the Eurocentric confinement imposed by scholars upon Black expression. An African worldview contrasts with the Eurocentric worldview, which has assumed a dominant position and claimed itself as the center against which all things are defined and ultimately judged (Oyebade, 1990). In essence, the heritage and culture of the Black Diaspora are intentionally centered in any analyses or discourse regarding persons of African descent (Borum, 2007; Fairfax, 2016; Graham, 1999; Monteiro-Ferreira, 2009; Oyebade, 1990; Schiele, 2016; Stewart, 2004). Afrocentricity recognizes Black families and communities are not a monolithic group (Borum, 2007; Hatcher et al. 2017; Schiele, 1990; Stewart, 2004), and there are differences within and across Black culture (Hatcher et al., 2017). Yet, these differences do not

invalidate shared commonalities in history, culture, identity, and experience (Borum, 2007; Graham, 1999; Oyebade, 1990; Stewart, 2004). From this perspective, culture is neither stagnant nor unchanging (Borum, 2007). Culture is dynamic and fluid (Borum, 2007) and the cultural agency of all people is respected (Monteiro-Ferreira, 2009).

Multiple African researchers (e.g., Molefi Asante, Mualana Karenga, Ruth Reviere, Ana Mazama, Linda James Myers, Cheikh Anta Diop) are credited with the conceptualization of Afrocentricity (Monteiro-Ferreira, 2009; Oyebade, 1990). Although the African-centered worldview may seem novel, it is not. The history and culture of the Black Diaspora (including the history and culture of African-Americans) began long before the existence of Western knowledge and civilization (Bent-Goodley et al., 2017; Oyebade, 1990). Based on African cultural beliefs, practices, and values (Thabede, 2008), Afrocentricity proffers and recognizes there are multiple perspectives or worldviews (Graham, 1999; Monteiro-Ferreira, 2009; Oyebade, 1990; Stewart, 2004). In essence, claiming an African identity and an Afrocentric place to stand is similar to the practices of others who challenge the oppression of groups based on sexual orientation, gender, or culture (Asante, 1987). Afrocentricity is a way of thinking, acting, and living to advance social justice and human rights that honors cultural uniqueness, personal strengths, and community development (Bent-Goodley et al., 2017; Borum, 2007; Hatcher et al., 2017). Afrocentricity is a "non-hegemonic alternative" to "understanding human expression" (Monteiro-Ferreira, 2009, p. 335). It is a "human centered model that should be used by all to eradicate worldview conditions that produce and replicate systems of oppression" (Schiele, 2016, p. 8).

Philosophically, African-centered thought (a) views reality as an interdependent, interrelated, and interconnectedness of all things; (b) believes all elements (e.g., people, animals,

inanimate objects) are spiritual in nature; (c) affirms an emotionally affective and expressive way of knowing and obtaining information is just as valid as intuition or scientific knowledge; and (d) highly values interpersonal relationships, which are prioritized over material possessions (Borum, 2007; Carroll, 2014; Graham 1999; Monteiro-Ferreira, 2009; Schiele, 1990; Stewart, 2004; Thabede, 2008). Given the positive link between the use of an Afrocentric worldview and psychological well-being (Wang et al., 2013), it is necessary to talk about the utility of Afrocentricity in guiding mental health practice (Asante, 1987; Bent-Goodley et al., 2017), which can be used in school-based mental health.

African-Centered Thought as a Practice Framework

As a practice framework, (a) individual and collective functioning; (b) the family and the community (Bent-Goodley et al., 2017; Borum, 2007; Graham, 1999; Hatcher et al., 2017; Schiele, 1990; Stewart, 2004); (c) the oneness of mind, body, and spirit (Graham, 1999); and (d) the fundamental goodness of people (Bent-Goodley et al., 2017; Schiele, 1990) are some key tenets identified as foundational in direct practice work in the fields of social work, psychology, and sociology (Bent-Goodley, 2017; Carroll, 2014; Schiele, 1990). The practitioner, regardless of race or ethnicity, uses an African-centered approach in working with persons who are of the Black Diaspora (Bent-Goodley et al., 2017; Steward, 2004). The use of an African-centered approach is important given the fact the community is a great influencer of an individual's mental health (Hatcher et al., 2017).

In 2017, Hatcher et al. published a paper focused on the use of African-centered thought in mental health practices with youth. The authors declared the continued use of Eurocentric theories as the dominant explanation and understanding of behaviors of persons of African descent was ineffective, inappropriate, and dismissive of cultural differences. Wang et al. (2013)

supported this position as they identified a disconnect between the use of Western-based theories with Black individuals and the use of an Afrocentric worldview centering the family and community. Similarly, Thabede (2008) wrote knowledge and understanding of African culture was essential when treating the psychological, intellectual, spiritual, and emotional needs of African people.

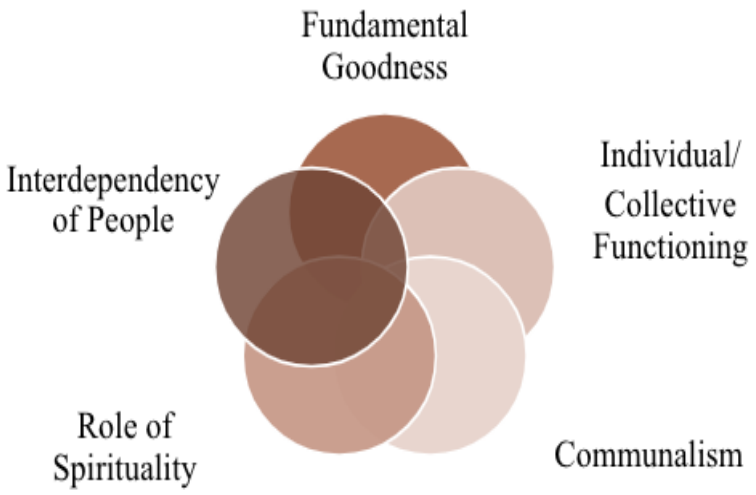
Transformational mental health practice is possible when using the cultural perspective of the person served (Thabede, 2008); therefore, the practitioner develops strategies and interventions grounded in an Afrocentric paradigm. They build and design systems from an Afrocentric worldview instead of merely adapting Eurocentric strategies, interventions, and programs. This approach is important because, as the literature previously indicated, there are several environmental and societal factors that influence the mental health of Black students and compounds issues for Black students with existing mental health needs.

Guiding Principles of an African-Centered Approach

African-centered thought as a framework or model for practice includes uplifting the fundamental goodness of people, acknowledging the critical ways people are interdependent, encouraging individual and collective functioning, highlighting the importance of family and community, and understanding the role and significance of spirituality (Bent-Goodley et al., 2017; Graham, 1999; Schiele, 1990). These guiding principles become the cornerstones of comprehensive school-based mental health systems committed to being culturally responsive to mental health needs of Black students (see Figure 1). The following paragraphs highlight these guiding principles in action for the school-based mental health practitioner based on the work of Bent-Goodley et al. (2017).

Figure 1

Guiding Principles of Afrocentricity



The first guiding principle is the *fundamental goodness of people.* An Afrocentric framework for practice reminds us of the humanity in people, all people (Bent-Goodley et al., 2017; Oyebade, 1990). Practitioners upholding this principle believe in the goodness of Black students and, without hesitation, advocate for equitable access to educational opportunities, including necessary mental health services and support.

Interdependency or interconnectedness of people means understanding the connection of people to systems. The success of Black students connects to the success of the systems within their environment. Instability in one system creates instability in other systems. Practitioners must work with students, teachers, families, and community members to address barriers to overall mental health and well-being of Black students and examine positive, effective support across systems.

The African proverb, “I am because we are and because we are, therefore I am,” signifies in the spirit of *individual and collective functioning* that one is not separate from the community and is always seen within the community and vice versa (Graham, 1999; Schiele, 1990). Individuals are most often seen as a reflection of their community; thus, problems and successes experienced by the individual and the community are one in the same. Practitioners must understand that when they work with an individual student, they are supporting that student, that student’s family, and that student’s community. A rippling effect occurs and transcends beyond the school building, impacting the student’s overall system. Collective functioning is not to be confused with sameness, as there is an inherent understanding of uniqueness within Black culture (Hatcher et al., 2017).

An important African principle is *communalism*. Communalism underscores the equal importance of family and community as essential and necessary stakeholders in the development and well-being of Black students. Practitioners recognize and acknowledge the Black student’s family and community as great sources of knowledge. They are resolute in engaging and partnering with key people in the student’s life for the purpose of relieving student stress by connecting them with programs promoting positive mental health outcomes.

Spirituality connects all things within and to the universe (Schiele, 2016). A common definition is “that invisible universal substance that connects all human beings to each other and to a Creator or a Supreme Being” (Graham, 1999, p. 113). Graham explained this belief requires placing a higher value on human life than on social and/or economic status. For many in the Black community, the church is the primary place for support with mental health concerns due to distrust in the system and the stigma of mental health (Hatcher et al., 2017). Spirituality is the way many Black people cope with life stressors (Borum, 2007). Therefore, when conducting

assessments and developing interventions, practitioners should attempt to understand the influence spirituality may have on Black students' sense of self, meaning, and purpose.

Putting it All Together: School-Based Mental Health and the Mental Health of Black Students

At its inception, the design and development of school-based mental health historically excluded Black students. During the Progressive Era and periods of reform, the role of schools and the focus of school-based mental health was in a state of influx. The discourse around whether it was the child or the school that needed fixing fueled referrals to community mental health agencies. This period would have been a prime opportunity for schools and community agencies to join efforts to address student mental health. However, with several societal issues—among them, the impact of the economic depression of the 1930s, ongoing disagreement about the role of schools in providing mental health services and support, and teachers' resistance to alternative ways of teaching—collaboration and partnership did not occur. The literature very briefly mentioned racial segregation as a fourth societal issue during this period (Flaherty & Osher, 2002). I assert the issue of racial segregation is one issue most critical to the conversation of mental health services and support for Black students, then and now. Black students who were being educated separately—if at all—were excluded from the conversation. So, even if collaborative efforts between schools and communities had been successful, Black students would not have been the recipients of such services. The exclusion of Black students has had grave implications for how schools have attempted to support the mental health needs of all its students.

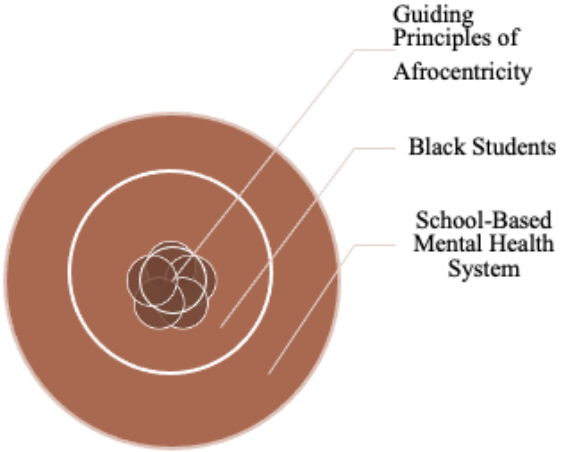
Black youth and families face barriers to mental health services based on class, race, and culture. These factors not only impact help seeking and receipt of mental health services, but

influence how Black students in need of emotional and behavioral support are perceived and judged. Further, class, race, and culture often determine if and how mental health services are provided to Black students. For students who experience a mental health crisis, who have a mental health diagnosis, or who have a subclinical mental health need the experience is doubly impactful.

Whereas race, racism, racial discrimination, racial stress, issues of class, and culture negatively impact the mental well-being of Black students, an African-centered approach to the mental health of Black youth has been documented as beneficial to Black youth seeking and actively using mental health services (Hatcher et al., 2017). By foregrounding tenets of an Afrocentric worldview in school-based mental health, schools actively demonstrate a commitment to culturally sensitive and responsive practices in the mental health support of Black students. The figure below illustrates the centrality of these tenets within a school-based mental health system (see Figure 2).

Figure 2

Centering Blackness in School-Based Mental Health



In summary, a comprehensive, school-based mental health system that recognizes the inherent goodness of Black students sends the message Black students are valued. That same system understands the interconnectedness of systems; respects the spirit of individual and collective functioning for Black students, their families, and their communities; and is grateful for the knowledge of the family and community. Spirituality, not religion, is tapped into as an identified supportive modality for Black students and families.

CHAPTER 3: RESEARCH DESIGN AND METHODS

This chapter describes the research design and methods used in this Delphi study focused on the mental health of Black students. In exploratory research, including mental health research, the Delphi method is recommended for use where there is limited literature or where topics are not well defined (Avella, 2016; Fletcher & Marchildon, 2014; Habibi et al., 2014; Jorm, 2015). With little-to-no extant literature specifically addressing how school-based mental health systems can effectively address the mental health needs of Black students, the use of the Delphi method was well suited. As knowledge about the mental health needs of Black students increases, so does the ability to create and design competent mental health services that capture, understand, and have embedded in the blueprint appropriate ways to address and meet their unique cultural needs.

Researcher Positionality

I am Black. I bet on Black. I root for everybody and everything that is Black. I see the world through a cultural lens of Blackness. So, when conducting this study, it was important for me to explore, examine, and acknowledge what that might mean for me as a researcher.

I have been a social worker for over 25 years and a licensed clinical social worker for over 20 years. I have worked with diverse groups of people (e.g., race, ethnicity, gender, age, religion) in various settings (e.g., private practice, nonprofit community-based agencies, for-profit community-based agencies, and public schools) who have at least one issue in common: mental-health distress. Despite this commonality, race, culture, and class or rather discrimination based on race, culture, and class, add an additional layer of complexity and concern for Black people, and Black students are not exempt. As a school social worker having worked in two very different localities (one predominantly white and rural, the other racially and ethnically diverse

and suburban), I witnessed both divisions struggle to meet the mental health needs of their students, particularly Black students. My concerns regarding how school-based mental-health services address the mental-health needs of Black students increased as I experienced schools struggling to meet the mental health needs of my own academically gifted Black daughter.

As a Black momma, a Black professional, and a Black social worker, I knew there was a better, more appropriate way to provide mental health services to all students by centering the cultural uniqueness of Black students, but I couldn't see a pathway, until now. The development of a framework that could improve the quality of mental-health services and support in school settings for Black students became a professional and personal goal. Also, because racism and discrimination heighten existing struggles with mental health, there must be a two-fold approach. One, I believe society must continue to talk about and positively support student mental health, but in a more comprehensive manner. Two, society must actively commit to confronting and challenging practices that exacerbate and negatively impact the mental health of Black students. It is my hope that educators, community members, researchers, and policy makers will openly embrace and accept the notion that centering the mental health needs of Black students is a benefit to all students.

Statement of Purpose

The purpose of this study was to identify essential components of a comprehensive school-based mental health system that adequately addresses the mental health needs of Black students. The findings from this study can aid a school division in developing a school-based mental health system—guided by principles and core values (Anderson, 2007; Pfeiffer & Reddy, 1998) —that is culturally sensitive (Stempel et al., 2019) and recognizes and supports the

contextual, cultural experiences and needs of Black students who experience mental health challenges (Johnson, 2010).

Research Questions

To ensure the mental health needs of Black students are appropriately identified and adequately addressed, there must be an intentional focus on centering Black students within school-based mental health systems. Additionally, challenges, such as racial stressors must be acknowledged. The following two research questions targeted the information necessary to develop a framework for a school-based mental health system that addresses the needs of Black students:

- Thinking along a continuum of mental well-being, what are the needs of Black students?
- What culturally relevant factors are necessary for school-based practitioners to include in their delivery of mental health services and support to Black students?

The Delphi Method

The Delphi method, developed in the late 1940s by the Rand Corporation, is a "systematic method for eliciting expert opinion in a variety of topics" (Sackman, 1974, p. iii). The Delphi method allows forecasting, a look into the future (Davidson, 2013; Sackman, 1974), that provides suggestions for what should be done about an issue or problem or what it looks like in practice. Dalkey, in his 1967 presentation to the Second Symposium on Long-Range Forecasting and Planning, defined the *Delphi method* as a research practice used to obtain consensus opinion from a group of persons considered knowledgeable in the specific area of study. He further offered although some of the information provided by experts was based on

generalizations from observations—empirical or otherwise—most of what was offered was simply opinion based upon their knowledge of the topic.

The basic design of the Delphi method is the use of a panel of participants providing their expert opinions on a specific topic. The process is iterative, time intensive, and exploratory. The goal is consensus from the group (Hasson et al., 2000). The use of expert opinion, convenience for participants (because they can complete the questionnaire online), and minimal costs for the researcher are but a few of the strengths of using the Delphi method in research (Masser & Foley, 1987; Stevenson, 2010). The following sections explain important features of the Delphi method, the study participants, data collection, data analysis, and trustworthiness of the study.

Research Design: A Conventional Delphi Approach

A conventional Delphi method has three basic features: use of a panel of experts, series of questionnaires delivered in rounds, and feedback of findings to participants in between rounds (Masser & Foley, 1987). Pertinent to this type of study is a clear focus and understanding of experts for the panel, the questionnaire as a tool to collect data, and feedback provided to experts from round to round (Masser & Foley, 1987). The key elements of the Delphi method (i.e., experts, questionnaires, and feedback) supported my choice for this research design for a variety of reasons, but mainly because of its alignment with guiding principles of an African-centered practice approach to mental health. The design stands firm in agreement and affirmation with African-centered thought—that knowing what is best for Black students *can* originate from Black people. Leading the study with voices of experts through open-ended questions gave authentic space and opportunity for their expert opinions to be heard. This decision sought to validate their lived experiences—as Black people, Black professionals, Black caregivers—as real and true ways to examine and provide expertise about the mental health needs of Black students.

The Experts

There is no standard definition of what constitutes an expert (Masser & Foley, 1987; Stevenson, 2010) using a Delphi approach; therefore, Masser and Foley (1987) suggested the selected experts have a range of experiences and are collectively able to offer varied perspectives on the topic. Skulmoski et al. (2007) suggested selected experts have knowledge and experience with the topic. They added the researcher should consider the identified experts' capacity and willingness to participate, availability with respect to time, and ability to effectively communicate. Several authors (e.g., Masser & Foley, 1987; Stevenson, 2010) also called into question if an expert in the field was more of an expert than anyone else in providing an opinion on a given topic, or whether the opinion of the group was better than that of an individual's opinion. Despite such criticism, the absence of a standard definition of what constitutes an expert supported Jorm's (2015) position that consumers and caregivers are also experts of topics, particularly in mental health.

Not having a standard definition opened the door for participation in this study by persons who might otherwise not be considered in the scholarly realm as experts; for example, the intentional selection of Black participants created an opportunity for participation in research where the opinions became the dominant voice regarding school-based mental health systems' obligation to support mental health of Black students. The exclusive participation of Black experts illustrated Asante's (1987) point about placing African ideals at the center of the analysis of Black students. Additionally, Black expert participation highlighted the guiding principle of communalism where Black students' families and communities were acknowledged as great sources of knowledge.

Anonymity among participants was used to suppress the influence of group members who might dominate and/or influence the opinions of other group members (Dalkey, 1967) and helped to curtail *group think* where everyone in the group has the same thoughts and ideas. There is little to no room for individual ideas. However, some researchers have argued anonymity gives experts the freedom to say whatever they choose without any accountability for what they say (Davidson, 2013; Stephenson, 2010). In this study, participants were unknown to one another and their responses were confidential. Experts in this study worked interdependently to identify necessary components for school-based mental health services and support, although they did not know the other participants. Further, participants were safeguarded against the potential for group think and dominance by individual participants. Due to noted challenges with attrition in Delphi studies because of the extensive time commitment, there was no opportunity for experts to be in community with one another.

There is no standard for the number of experts serving on a panel. Skulmoski et al. (2007) advised a range of 10–15 participants, which differed from Jorm's (2015) advised panel size. Jorm reviewed several mental health studies using the Delphi method with professionals, consumers, and caregivers as experts and found there was stability in results of panels with as few as 16 participants and as many as 41 participants. Avella (2016) declared the typical panel size was between 10 and 100. Avella added that with panels of fewer participants, the researcher may encounter issues with attrition and stability in the findings. The panel size for this current study was 14 participants. Although an increase in sample size may have decreased any group error, other factors were considered when increasing the number of experts, such as more extensive coding, results only yielding minimum benefits (Skulmoski et al., 2007), and recruiting participants during the COVID-19 global pandemic.

Participation in a study using the Delphi method can be time intensive because participants must willingly commit to several rounds of input and feedback (Davidson, 2013). Therefore, the researcher must anticipate working quickly in between rounds and adjust for possible participant attrition (Davidson, 2013; Jorm, 2015). To address concerns with attrition, study participants were informed of exactly what they would have to do, the time involved, and how the information gathered would be used prior to their participation in this study (Hasson et al., 2000).

The Questionnaire

The panel of experts completed a survey or questionnaire given to them in a series of rounds. Although the panel could have been presented with specific questions based only on literature (Davidson, 2013), the questions in the first round were broad, open ended (Davidson, 2013; Masser & Foley, 1987), and based on a combination of the literature and my professional experiences in the field. Fletcher and Marchildon (2014) described Round 1 as an "explorative phase" (p. 13) and the subsequent rounds as "evaluative phases" (p. 13). Either way, the first round is the most crucial as it becomes the foundation for subsequent rounds, which are more restricted and narrowly focused. Davidson (2013) reported the key to the final round is experts having an opportunity to explain, using open-ended questions, how they put the top ranked items into practice. Masser and Foley (1987) also supported making full use of the expertise of panels by giving experts an opportunity to fully expand on and explain their responses. Dalkey (1967) suggested having experts rank order questions as it related to their specific level of expertise for the purpose of being able to make comparisons between subgroups.

Based on existing literature, the standard for the number of rounds appears to be three (Dalkey, 1967; Davidson, 2013; Masser & Foley, 1987). Initially, the number of rounds was

dictated by consensus of the experts (Stevenson, 2010). Having a predetermined number of rounds can equate to forced consensus, which Fletcher and Marchildon (2014) presented as a criticism of this method. One way to address forcing consensus is to clearly define the meaning of consensus at the onset of the study (Jorm, 2015). There are differing opinions on the topic of consensus with the Delphi method. Diamond et al. (2014) conducted a systematic review of 100 Delphi studies and learned the most common definition of consensus was based on percentage of agreement, with 75% as the mean threshold. Any study where participants feel their opinions are lost (i.e., not captured in the collected data) and undervalued can result in their withdrawal from the study (Stevenson, 2010). Therefore, more recent approaches have emphasized stability in responses. The study ends when there are no longer any significant changes in the responses of the experts. Stevenson (2010) remarked instead of forcing consensus, capturing information from persons with differing responses could also be just as valuable. Hasson et al. (2000) shared examples of various methods (e.g., using percentages) to establish consensus. They remarked 51% agreement by participants could be consensus, but so can 70% or 80%.

Feedback to Participants

Controlled feedback reduces noise (Dalkey, 1967). When the group is tasked with topics requiring numerical answers, feedback of findings between rounds given to the panel of experts can be provided using simple measures, such as mean, standard deviation, or median (Dalkey, 1967; Masser & Foley, 1987; Stevenson, 2010). However, with difficult subject matter, such as mental health, results after each round can be provided in summary form (Dalkey, 1967). The findings—analysis of results—from each round are typically used in one of two ways (Stevenson, 2010). First, with the aim of moving closer to consensus, participants are given the opportunity to revise their initial responses based on findings from the previous round and to

provide feedback on responses not aligning with the group's responses. In the second way, the researcher devises a new set of questions based on responses and gives the new questionnaire to the original group or a new group.

To determine how much convergence (i.e., group consensus) is due to social pressure, rethinking the problem, and a transfer of information during feedback, Dalkey (1967) conducted a study that sought to identify factors influencing participants' responses in structured face-to-face discussion groups and anonymous questionnaires. This study identified two things. First, the questionnaire responses were more accurate than structured discussion group responses. Second, the structure imposed on the face-to-face discussion groups did not adequately eliminate influence of the dominant member, noise, or pressure for consensus. Another development was that responses in the second round were more accurate than responses in the final round, suggesting possible participant fatigue or saturation effect.

The feedback between rounds of this study unearthed the convergence (i.e., consensus) of opinions, ideas, beliefs, and thoughts. The opinions of individual experts were effectively captured and shared with other experts in this study as they thought about their own opinions and thoughts in relation to the responses of others.

Study Participants: The Experts

For this study, the lack of a standard definition of expert and what determines expertise proved supportive of one basic concept of an African-centered worldview—more than one worldview (perspective) can exist *and* be true. Self-identifying as Black, although by itself not automatically rendering the prospective participants as experts, was a necessary factor. Identification with the Black Diaspora connected participants to the community at the center of analysis: Black students. Here, community was regarded as shared commonalities in history,

culture, identity, and experience (Borum, 2007; Graham, 1999; Oyebade, 1990; Stewart, 2004) and not a boundary of geographical location. For the purpose of this study, participants met this study's definition of expert if they reported having, at minimum, knowledge and understanding of the mental health needs of Black children/adolescents (i.e., school-aged) and an understanding of the implications of mental health challenges within a public school context. Bearing in mind that consumers and caregivers are experts of mental health (Jorm, 2015), caregivers and young adults were identified as desired expert subgroups for the panel.

To have experts with a variety of experiences and perspectives as noted by Masser and Foley (1987), the selected panel of experts represented 4 subgroups: research scholars, school-based mental health practitioners, caregivers, and young adults. They had knowledge of and/or direct experience with Black school-aged youth with mental health needs. The inclusion of caregivers and consumers in this study as experts was important (Jorm, 2015). Their involvement aligned with the guiding principle of communalism, which views caregivers and consumers as equally important, essential, and necessary stakeholders. Further, when assessing the needs of a particular group, the information should be collected from a diverse group of stakeholders, which includes students, parents, and community leaders (Walter et al., 2006).

The all Black expert panel was composed of 14 participants: six research scholars, seven school-based mental health practitioners, and one caregiver (see Table 1). Despite recruiting efforts, the expert opinions of young Black adults were not represented in this study. A total of 10 participants completed all five rounds.

Table 1

Study Participants

Participant	Gender	Professional position	Education	Years' experience
Participant 1	Female	Researcher at a children's hospital	PhD in human development and family science	15
Participant 2	Female	Associate professor, program director	PhD in school psychology	17
Participant 3	Female	Behavior health Clinician	Master's in social work, Licensed clinical social worker	8
Participant 4	Female	School social worker	Master's in social work	20
Participant 5	Female	School social worker	Master's in Social Work	14
Participant 6	Female	Hospital executive	PhD in clinical psychology	13
Participant 7	Male	School social worker	Master's in social work, K–12 admin endorsement	27
Participant 8	Female	School social worker	Master's in social work	21
Participant 9	Female	Researcher, PhD candidate	Master's in developmental psychology	5
Participant 10	Female	School social worker	Master's in social work	8
Participant 11	Female	Identified as SBMH practitioner	unknown	unknown
Participant 12	Male	Identified as SBMH practitioner	unknown	unknown
Participant 13	Female	Identified as research scholar	unknown	unknown
Participant 14	unknown	Identified as caregiver	unknown	unknown

Research scholars were defined as persons who had conducted any level of scholarly research regarding the mental health of Black youth and who had experience and knowledge regarding mental health needs of Black children and adolescents. School-based mental health (SBMH) practitioners were defined as persons who had direct, practical experience providing mental health services in public K–12 schools located in the metro-Richmond, Virginia area, regardless of job title (e.g., school social worker, school counselor, school psychologist, behavior support specialist). SBMH practitioners had to have at least 3 years' practical experience in the past 5 years. To participate in the study, caregivers had to have a child who experienced a mental health need as an adolescent and who was (or had been) a student attending public school in the metro-Richmond, Virginia area. Young adults (i.e., those aged 18–23) had to have experienced at least one self-identified mental health need during their years of attendance in a metro-Richmond, Virginia, K–12 school. They did not need to be presently experiencing a mental health need. This research confined the experiences of its participants to the metro-Richmond, Virginia area. The school divisions in this area typically use school-based mental health practitioners to address the mental health of its students, either as school employees or persons working in partnership with school divisions.

Recruitment

Overall, recruitment of participants consisted of exploration of websites of practitioner-based organizations (e.g., VA School Social Work Association and School Counseling Association) and educational institutions, departments, or student organizations (e.g., higher education schools of social work, psychology departments). Identified organizations were asked to share and post the study information on their websites, social media sites, and listservs. The recruitment email sent to individuals served as both an invitation to participate in the study and a

request the information be shared and posted with their professional organizations, professional social media sites, professional newsletters, professional listservs, and professional websites.

Potential research scholars for the study were identified either through their written work (regardless of publication type) or through presentations or conferences and personally invited via email (see Appendix A) to participate in the study. SBMH practitioners were recruited by two methods: (a) scouring the websites of school divisions in the metro-Richmond, Virginia area and sending an email to those identified as SBMH practitioners, and (b) identifying organizations or agencies employing practitioners who provide SBMH services and sending an email directly (see Appendix B) to the organization or agency. Recruitment of SBMH practitioners meant there could be persons with whom I had a personal and or professional relationship with because of my professional role as a SBMH practitioner. I attempted to mitigate the influence this role had on persons receiving the recruitment information—and subsequently meeting the criteria to participate—by reassuring SBMH practitioners their opinions, knowledge, and experiences were respected, necessary, and would have no bearing on the future of our relationships, personal or professional. For the recruitment of caregivers and young adults (i.e., those ages 18–23), community mental health agency personnel were notified via email (see Appendix B) and asked to share information regarding the study with their staff, out in the community, and their professional organizations. Additionally, college-level student organization listservs were reviewed and sent information about the study asking they share the information with their professional and educational organizations.

A recruitment flier (see Appendix C) was included in each recruitment email for posting to websites, information boards, newsletters, listservs, and social media sites. No more than two email follow-up requests were sent to participate in the study or post the information about the

study. Approximately 1–2 weeks occurred between recruitment efforts. Recruitment was ongoing until 1 week after the study began. This timeline was possible because Round 2 was an opportunity for experts to review their submitted responses from Round 1 and make any necessary changes or include additional responses. Therefore, experts could join the study at Round 2, but no later. The participant screening form was hyperlinked in each email.

Participant Screening Form

All persons interested in participating in the research study were instructed to complete the participant screening form (see Appendix D). The screening form was used as a mechanism to determine prospective experts' suitability for the study. The recruitment flier included a hyperlink and QR code directing people straight to the participant screening form. The participant screening form contained information about the purpose of the study. It also informed prospective participants their identity and responses would be kept confidential and they would be compensated for participating and completing each round of the study. Prospective participants were advised their participation would require approximately 4–6 weeks of their time, consisting of weekly questionnaires for the first 4 weeks of the study and concluding with an individual semistructured interview.

Because I was most interested in developing an expert panel representative of the racial identity of Black students explored in the study, the first question of the participant screening form asked prospective participants if they identified as Black or African American. If participants did not identify as either, they were not asked any additional questions. They were screened out because of that question. Participants were also asked to identify themselves as a research scholar, school-based mental health practitioner, caregiver, or young adult. Additional questions were asked about access to a computer or smartphone device, access to Wi-Fi,

willingness and availability to participate in short (i.e., 10–20 minute) online questionnaires, and participation in an individual semistructured interview. If all criteria for the screening were met, the potential participant was asked to participate in the study. If they answered yes, they were asked to provide their contact information. If potential participants answered no, they were thanked and the survey ended; additionally, their email address and responses were immediately deleted and they were not further contacted. If they responded that they wanted additional information, I invited potential participants to arrange a meeting with me. Two potential participants made such a request; they were provided additional information regarding the study. If a person did not meet eligibility other than the email address they used to complete the form, no other information was gathered or requested from them. Their screening form was deleted after it was reviewed to determine the reason for their exclusion from the study.

Ethical Considerations

Prior to data collection, Institutional Review Board (IRB) approval was obtained from Virginia Commonwealth University. Participation in the study was voluntary and experts were able to withdraw at any point. All participants received a copy of the research participant information and consent form (see Appendix E) that outlined the purpose of the study, benefits and risks, and how their information would be protected. Participants were informed any potentially identifiable information would be kept separate from collected responses to questions, interview notes, and recordings, with pseudonyms used as the identifier.

A personal benefit for experts was using their expertise to positively influence the development of a framework for school-based mental health services, supporting the mental health of Black students. Although it was unlikely experts would experience any significant risks or discomforts from participation in this study, it was possible. A risk of the study for experts

could have been loss of privacy or emotional discomfort due to the subject matter and questions asked. Sometimes talking about personal experiences, beliefs, and thoughts can be difficult. Participants were not required to answer any questions that made them uncomfortable.

Data Collection and Analysis Across Five Rounds

Collecting data and analyzing the data using the Delphi method was an interwoven, interdependent process. Therefore, details of data collection and analysis are discussed together for the benefit of clarity in data collection methods, immediately analyzed, and simultaneously prepared for presentation to the participants for the next round.

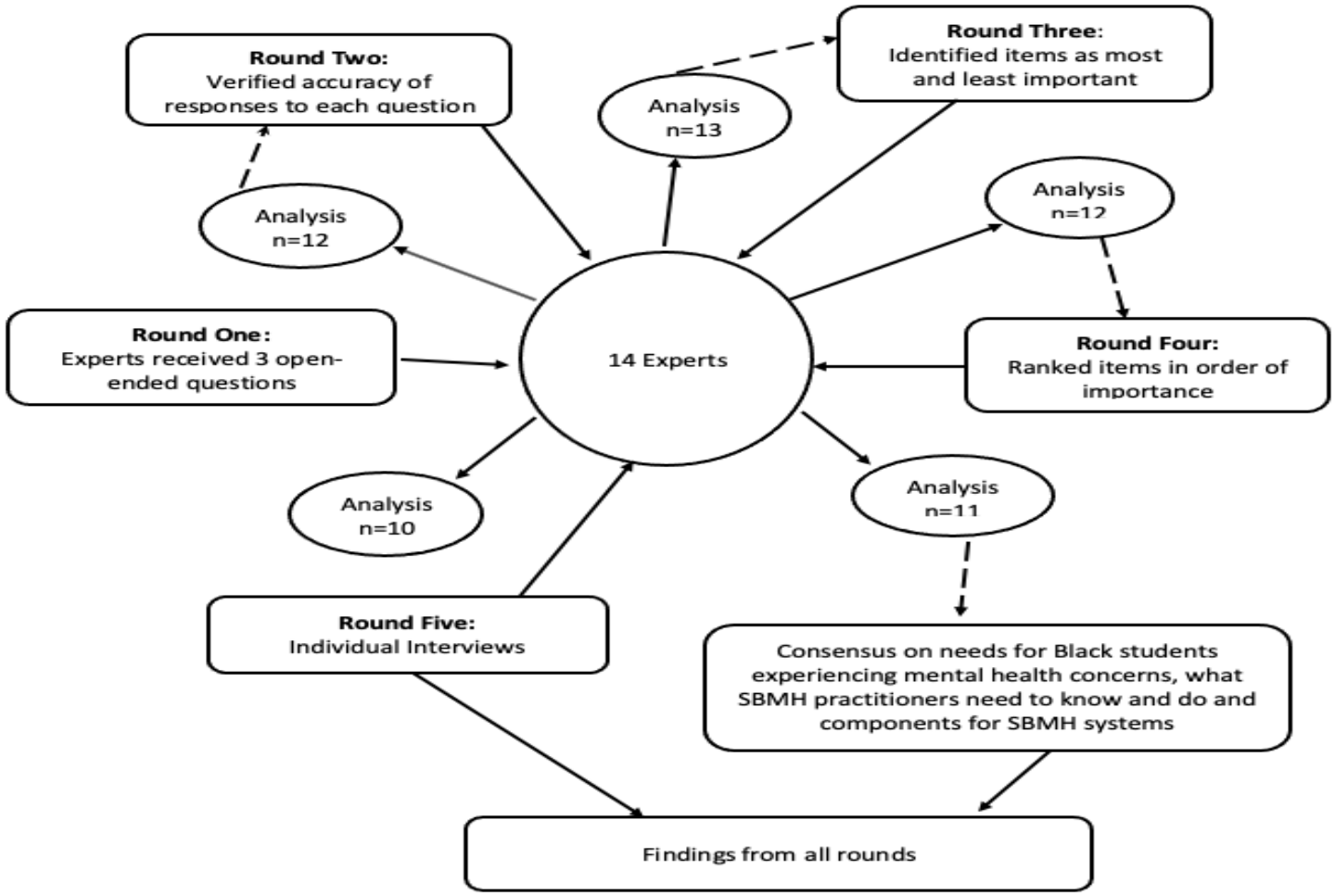
Design Structure

Prior to the start of the study, experts received a welcome email (see Appendix F) explaining the study, the start date of the study, and information about weekly questionnaires that included a visual sample of the Google form. Most people are familiar with and have previously used a Google Form. As such, Google Forms was the platform for this study (for Rounds 1–4) as it was suitable for collecting data for the rounds in a Delphi study (Sekayi & Kennedy, 2017). Google Forms are relatively easy to use and can be accessed from a smartphone. Google Forms allow an unlimited number of generated questionnaires and an unlimited number of questions on each questionnaire. Data for Round 5 were collected through virtually conducted semistructured interviews. The email included the research participant information and consent form (see Appendix G) and an outline of each round (see Appendix H) for participants' reference. This research study was conducted over the course of four rounds and the inclusion of individual interviews. Data were collected and analyzed between each round and at the conclusion of the study. The decision to have four rounds versus three was made to fully capture participants'

voices (Stevenson, 2010) through questionnaires and the inclusion of an individual semistructured interview. A visual map (see Figure 3) identified the process for this study.

Figure 3

Visual Map



A predetermined number of rounds introduced the issue of consensus. Initially, consensus of the experts dictated the total number of rounds (Stevenson, 2010). Jorm (2015) recommended clearly defining the meaning of consensus at the onset of the study. However, reality is that consensus could be 51%, 70%, or even 80% (Hasson et al., 2000). As previously noted, participants could end up feeling their opinions were lost and undervalued if they did not see them reflected in the responses that achieved consensus. This perception could result in withdrawal from the study (Stevenson, 2010.) One way to address this challenge was to conclude the study when stability occurred in the responses. After considering all things and attempting to balance participants' time and the highest rate for a consensus threshold that made sense according to the sample size, the initial determination for this study was a threshold of 70% agreement.

Experts received a questionnaire at the start of the week (Day 1) for 4 consecutive weeks (Rounds 1–4). The questionnaire for the individual interviews was sent to the experts within 2 days of their submission of Round 4. Experts were given 5 days to complete each weekly questionnaire. Any expert who had not completed the questionnaire by Day 3 received a Google forms reminder. This process was repeated on Day 4 and Day 5 for experts who still had not completed the questionnaire for the week. Each expert's weekly participation (or nonparticipation) was logged. Experts were not withdrawn from the study for noncompletion of a week's questionnaire. They were allowed to participate in subsequent rounds.

Though there were multiple rounds, there was only one set of questions. The questions were open ended and remained the same throughout subsequent rounds. The questions were:

1. Thinking along a continuum of mental well-being, what do you perceive as the needs of Black students?

2. What culturally relevant factors, specific to Black students, would you identify as necessary for school-based mental health practitioners to acknowledge and incorporate/address in their delivery of mental health services and support to Black students?
3. What components would you identify as necessary and essential for comprehensive school-based mental health systems to adequately address and support the mental well-being of Black students?

Round 1

At the start of Round 1, there were 13 participants. A total of 12 experts completed the questionnaire for Round 1 (see Appendix I). Participants provided responses to each question and each question yielded its own list of unique responses. The total number of responses varied based on participant. Question 1 received 31 individual responses, Question 2 received 47 individual responses, and Question 3 received 36 individual responses.

The compiled lists were transferred to a Google Doc and then downloaded as a PDF. A PDF file was shared in lieu of Google Sheets or Google Docs as a safeguard to maintain confidentiality of participants' identity and responses. No responses were omitted, edited, or censored; participants' responses were presented in Round 2 exactly as participants wrote them.

Round 2

An additional participant joined the research study in Round 2, bringing the total number of participants to 14. Experts were provided a copy of the randomized lists of responses to each question from Round 1. Experts were instructed to review each list to verify their responses were included. They were also given an opportunity to add additional responses, if they chose to do so, and review the responses of other participants. Eleven participants replied their answers were

correct and did not have any further responses to add. The newest participant completed the Round 2 survey, but did not contribute any responses to Round 1. The one participant who did not complete Round 1 selected the option to add responses, which they did. One respondent missed the deadline for completing the questionnaire and sent the researcher an email stating their answers were correctly presented and they had no further responses to add. A total of 13 participants completed Round 2.

Collected data from Round 2 were analyzed to develop Round 3. First, the compiled lists of responses from Round 2 were reviewed. Then, responses were exported into a separate Google Sheet and each response was reviewed line by line with significant words and phrases highlighted. Next, every identified, highlighted word and phrase was categorized according to similarity. After categorization, duplicate items were deleted. Even if the meaning of a participant's response was unclear, the response was not removed from the list. Leaving unclear responses was done to maintain integrity of the process by not ascribing my own thoughts or interpretations of meaning to a participant's response. This decision also gave autonomy to the participants in making meaning of the responses on their own. Further, whomever provided the response would have an opportunity to add clarity to their response in Round 5. This process was completed for every response to each question.

Round 3

The focus for Round 3 was to have participants identify items most important to them. The initial thought was to have participants only identify those items from the lists most important to them by having them to select a certain number of responses based on the overall total of responses for each individual question; however, there was not a clear justification for deciding how many items should be selected. The second thought was to list all items and have

participants rank them in order of importance (from most important to least important). Using this idea, though appropriate, was a challenge with respect to the design of Round 3 because displaying all items in one section and on one page using Google Form was overwhelming. It was even more of an issue with Questions 2 and 3 because of the high volume of responses. This became an ongoing challenge with use of Google Forms for the remainder of the study. After careful consideration, I decided Round 3 would list all items for each question and have participants only identify items they found most important and least important for each question. Each list was divided in three equal parts with the idea that items falling into the top third of the list would be representative of 70% agreement for consensus set for this study. Participants were not asked to rank items in order, but simply to identify items. By default, any item not marked was categorized as the middle—neither most nor least important. This solution seemed to be as close as possible to having participants rank the full list without overwhelming them visually.

At the start of Round 3, there were 14 participants. In an effort to increase the number of participant responses, the closing date for the questionnaire was extended by 2 days. A total of 12 people completed the questionnaire for Round 3. The total number of responses received for Question 1 was 32. After evaluating the collected data using the process described above, 17 unique items remained. Participants were asked to select six items (representing approximately one third of the list) most important and six items least important to them as it related to the needs of Black students along a continuum of mental well-being.

Question 2 yielded 43 responses. After examining the data, I realized Question 2 had to be separated out into two different questions based on responses from Round 2. The wording of Question 2 asked participants what school-based mental health practitioners needed to do to *acknowledge and incorporate/address* in their delivery of mental health services and support to

Black students. This phrasing led to responses that spoke to knowledge or action (incorporate/address) with unique responses of 23 and 24, respectively. Therefore, in preparation for Round 3, Question 2 (Part 1) participants were asked to identify eight items (representing approximately one third of the list) they found most important and eight items least important with respect to information practitioners need to *acknowledge/understand.* Part 2 of Question 2 asked participants to identify eight items (representing approximately one third of the list) most important and eight items least important with respect to the things that practitioners need to *do (action).*

For Question 3, 37 responses were received. After reviewing the responses using the process as described above, 30 unique responses remained. Participants were asked to select 10 items most important and least important to them with respect to school-based mental health systems efforts to adequately address and support the mental well-being of Black students.

The collected data from Round 3 were reviewed. The following describes the process for reviewing and analyzing the data in preparation for presentation in Round 4. First, all responses were read completely through. Then, any response where at least 70% of the participants agreed was identified as having met consensus based on the research design. For Question 1—regarding the needs of Black students along a continuum of mental well-being—only one item met the 70% threshold for most important. For Question 2 (Part 1) —regarding what school-based mental health practitioners need to acknowledge (and/or understand)—one item met the threshold of 70% for most important. For the second part of this question regarding school-based mental health practitioners efforts, one item met the 70% threshold for most important. For Question 3—regarding comprehensive school-based mental health systems' efforts to adequately

address and support the mental health of Black students—one item met the 70% threshold for most important.

Having a 70% threshold for consensus revealed some clear responses; however, because so few items met the 70% threshold for consensus, I reexamined the data. I was concerned some key elements might be overlooked because of the small sample size and not all participants completed this round. Therefore, I decided an item receiving at least 50% or greater agreement from participants would be identified as having met consensus and included in lists for Round 4. Again, in Round 3, participants only rank ordered responses identified as most important.

Shifting from a 70% threshold for consensus to a 50% threshold for consensus, the following changes were made. For Question 1—regarding the needs of Black students along a continuum of mental well-being—seven items met the 50% threshold for most important. For Question 2 (Part 1)—regarding school-based mental health practitioners efforts to acknowledge (and/or understand)—six items met the threshold of 50% for most important. For the second part of this question regarding school-based mental health practitioners efforts, four items met the 50% threshold for most important. For Question 3—regarding what comprehensive school-based mental health systems need to do to adequately address and support the mental health of Black students—eight items met the 50% threshold for most important. The goal for Round 4 was for participants to rank order each list of responses for each question; therefore, the items that met the 50% threshold for most important were presented in Round 4 for participants to rank them in in order of importance.

Round 4

In Round 4, participants were given results from Round 3 and asked to rank items identified as most important in order of importance. In an effort to increase the number of

participant responses, the closing date for completing the questionnaire was extended by 2 days. Unbeknownst to me, there was an error in the messaging with the closing date for the questionnaire. I was contacted by a participant who informed me they attempted to complete the survey, but it was closed. After realizing the error with the date, participants were sent an email informing them I would honor the date of extension. Round 4 was completed by 11 of the 14 study participants.

Data collected from Round 4 were reviewed and analyzed to create the final lists (a) identifying needs of Black students with mental health concerns, (b) targeting points of consideration for school-based mental health practitioners to acknowledge/understand and do when working with Black students with mental health needs, and (c) determining essential components necessary for school-based mental health systems to adequately address the mental health concerns of Black students. Reverse scoring was used to determine the ranked order of importance for each list.

When participants submitted their responses to Round 4, within 48 hours they received instructions for scheduling their individual interview. Participants were not given the final rank-ordered list at this point, as it was not necessary for them to have the information prior to the interviews.

Individual Interviews

Experts need an opportunity to explain, expand, and discuss their submitted responses (Davidson, 2013). Because relationships are important (Borum, 2007; Carroll, 2014; Graham 1999; Monteiro-Ferreira, 2009; Schiele, 1990; Stewart, 2004; Thabede, 2008), the individual semistructured interview offered an opportunity for personal connection. In addition, speaking directly with experts was a way to leverage access of their full expertise (Masser and Foley,

1987). Once participants received the questionnaire for scheduling interviews, they were directed to a scheduling calendar. Blocks of dates and times were made available to participants over a 2-week period of time. Additionally, I shared with participants their schedule would be accommodated if what was offered was not conducive to their schedule. I also shared with participants the interview would allow them an opportunity to share their specific opinions regarding the mental health of Black students, factors essential to the delivery of mental health services in the school setting, and expectations of school-based mental health systems. Participants were informed the semistructured individual interviews would be audio recorded and last approximately 45–60 minutes. Participants' responses were confidential and their identity was protected. A total of 10 individual interviews were conducted.

A qualitative data-analysis software, was used to code data collected from individual semistructured interviews. An inductive approach to developing the codebook was selected because inductive coding "ensures a closeness, gives voice to the data" (Linenberg & Korsgaard, 2019, p. 14) by allowing development of codes directly from the data (Bhattacharya, 2017; Linenberg & Korsgaard, 2019). Additionally, an inductive approach fits well with coding of an exploratory study such as this (Linenberg and Korsgaard, 2019). More importantly, this approach resonated with me because the voice of the Black experts became the dominant narrative for this research, which kept this study closely linked to its conceptual framework, Afrocentricity. Instead of having experts respond to questions regarding existing literature, Black experts' opinions became the foundation for a framework centering the mental health of Black students.

My process for coding followed Braun and Clarke's (2006) six-step framework for conducting thematic analysis. An advantage to using a thematic approach or analysis is the approach can be used regardless of epistemological or theoretical perspective (Maguire &

Delahunt, 2017). After audio recordings were transcribed using and reviewed for accuracy, I read the transcripts of each expert all the way through without coding to help familiarize myself with the data, the first step in Braun and Clarke's framework. Next, I reread each transcript, coding while I read. I then went back and coded line by line using open coding. Afterward, I categorized the codes. This step was where the categorization of codes (clusters) began to present themselves as patterns and I could start to make sense of the data based on connections between patterns (Linenberg & Korsgaard, 2019). Once themes were established, I reviewed and defined each theme.

Trustworthiness

Maxwell (2013) identified validity as the "correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account" (p. 132). Leung (2015) explained validity as the appropriateness of instruments, process, and data. He further identified dependability as having to do with consistency or reliability. Frankly, varying views regarding the use of validity and reliability in qualitative research exist. Hasson et al. (2000) suggested exploring credibility, transferability, dependability, and confirmability—to ensure findings are believable and trustworthy. These widely known and accepted criteria can be used to address researcher concerns with potential issues of acceptance and usefulness in their research (Nowell et al., 2017). In the following sections below, I explain the four criteria related to this study as outlined by Hassen et al. (2000).

Credibility

Seemingly, the most important criterion of trustworthiness is credibility. In essence, credibility is the inquiry into how true research findings are in a study. Credibility in this study was established through accurate representation of the expressed opinions of experts using

interview transcripts, prolonged engagement, and member checks (Nowell et al., 2017). Each round was a point of contact with participants and feedback in between rounds kept experts engaged.

Dependability

In qualitative studies, dependability relates to consistency in findings, or rather, the stability of the data over time. With consensus as the goal in this Delphi study, stability of the data over time (in the study) was inherent. Also, reading and rereading the data helped with ensuring stability of the study's data. These strategies sought to ensure the research process was "logical, traceable, and clearly documented" (Nowell et al., 2017, p. 3).

Confirmability

This criterion addresses researcher bias, motivation, and interest as it relates to ensuring the interpretation of the findings were directly tied to the experts responses and not my own thoughts and beliefs (Nowell et al., (2017). Bias, motivation, and interest can be addressed through reactivity or reflexivity, which is the impact a researcher has on the setting and the experts due to existing relationships and nature of the study. Because I conducted the participant interviews, I could not eliminate the influence I might have had on experts or their feeling compelled to provide answers they thought I was looking for. To mitigate this influence, I asked open-ended questions and allowed experts to respond to questions as they saw fit. I was cognizant of how I asked follow-up questions as not to make experts feel they, themselves, or their responses were being judged.

Transferability

This research was specific to Black students and does not espouse transferability to other populations. Black people are not a monolithic group; yet, they do have shared commonalities.

Contextual factors, societal factors, and lived experiences must be considered. This research design and the underlying conceptual framework supported the centering of various races, ethnicities, and cultures in providing group specific analysis based on that group's true center and not the dominant narrative just because that is what it has been. Therefore, this research provided rich data allowing persons interested in the exploration of transferability as it relates to a different racial or ethnic youth group (Nowell et al., (2017).

Threats to Validity

A validity threat is the way one could be wrong about the hypothesis or revealed findings (Maxwell, 2013); however, it is impossible to identify and/or address every possible threat to validity. Acknowledging and attempting to address possible threats in this study may have helped make the threats as insignificant as possible.

As an intimate part of this research study, I was aware my values and expectations might influence the conduct of experts or the conclusion of the study. Remembering my own beliefs and thoughts, including my researcher positionality, was important due to the potential influence on every aspect of this study. Transcriptions of each participant interview were created as a strategy to ensure the capturing of rich details of participants' responses. Also, transcribing interviews supported the goal of minimizing my implicit inclinations to include information only of interest to me and exclude information not necessarily adding to the overall study. Differences of opinions, thoughts, and beliefs added to the richness of this study. I clearly understood study participants may not share my values and beliefs regarding the mental health of Black students nor school-based mental health systems actions to support Black students in need of mental health services and support.

Assumptions and Limitations

I made a few assumptions based on existing literature and my personal and professional experiences. I assumed the panel would demonstrate a convergence of opinion based on their direct or indirect understanding of the cultural context of being Black within the existing complexity of mental health. In essence, I assumed the expert panel would in fact identify race, culture, and class as having significant impacts on the mental health of Black students. I also assumed the results of this research would affirm the needs (mental health and otherwise) of Black students as necessary and critical given the current state of urgency surrounding mental health and issues of racial and social justice and the implications when the two intersect. Another assumption was the findings from this research would support the necessary development of a framework for a comprehensive school-based mental health system, which school systems should have an interest in for the sake of holistically supporting Black students. Although the findings are not meant to be transferable, it was assumed that the identified key elements for a comprehensive school-based mental health system by the Black expert panel for Black students would be foundational in design for other racial or ethnic student populations. This assumption was due in large part to the conceptual framework, Afrocentricity (African-centered thought), which recognizes, accepts, and appreciates the space in the "center" for multiple worldviews (Graham, 1999; Monteiro-Ferreira, 2009; Oyebade, 1990; Stewart, 2004).

A clear limitation of this research was a lack of participation of young adults in the study. Further, currently enrolled K–12 Black students would be ideal. As persons who have directly experienced some level of emotional distress, children, adolescents, and young adults are valuable experts. Therefore, hearing directly from them could have provided either confirmation or contradiction of the results and subsequent findings. Another limitation was the sample size

because there was too much variability in attrition in the study from round to round. So, an increase to no more than 20 participants may have addressed the issue of inconsistent participation and decreased overall attrition from the study. A final limitation was the lack of opportunity for participants to provide immediate written, open-ended feedback in each round. This meant that without the individual interviews the findings would lack specific context and may require a great deal of researcher interpretation.

Putting it All Together: A Research Design for Tapping Into Black Expertise

This study was designed to harness the knowledge and experience of Black community members as experts of Black students' mental health needs. Using the Delphi method achieved that objective by supporting the analysis of Black students by Black experts. Conventional use of the Delphi method has three key features: experts, questionnaires, and feedback to participants in between rounds (Dalkey, 1967). Black experts in this study participated in five rounds of data collection aimed at determining the needs of Black students with mental health concerns, pinpointing what school-based mental health practitioners need to acknowledge, know, and do, and identifying essential elements for effectively supporting Black students' mental health in a school-based setting. The data collection and analysis for a Delphi study simultaneously occurred, as subsequent rounds were dependent on the analysis of data collected in the preceding round. In the next chapter, I present the findings of my research.

CHAPTER 4: FINDINGS

Chapter 4 discusses the findings of this Delphi study and subsequent interviews that provide context and increased detail to the research questions targeted at collecting data necessary to develop a framework for a school-based mental health system that addresses the needs of Black students:

- Thinking along a continuum of mental well-being, what are the needs of Black students?
- What culturally relevant factors are necessary for school-based practitioners to include in their delivery of mental health services and support to Black students?

The following sections include findings from the Delphi process of gathering expert responses and additional descriptions from interviews that provide necessary knowledge to develop a framework for a comprehensive school-based mental health system for Black students. I begin with the needs of Black students, followed by expert identification of what school-based mental health (SBMH) practitioners should know, understand, and do. Lastly, I discuss essential elements, as identified by the expert panel, necessary for comprehensive school-based mental health systems to adequately support the mental health of Black students. The findings represent components the experts agreed were most important.

The Mental Health of Black Students

According to the expert panel, Black students present behaviors often associated with anxiety and depression, attention deficit hyperactivity disorder (ADHD), grief and loss from the death of loved ones and absent caregivers, violence, substance abuse, and trauma. As noted by Expert 8, essentially 85% of her students of African American descent have dealt with or are dealing with a “variety of different [mental health] issues” diagnosed by community

practitioners, such as psychologists and psychiatrists. Furthermore, the concern regarding deaths of Black youth by suicide are alarming. Six of 10 experts identified pressing concerns about the increased rate of deaths by suicide in Black communities. Expert 2 expressed a state of urgency surrounding the need to address and support the mental health of Black youth:

> I really think that schools need to be educated about the urgency of supporting the mental health of Black youth, particularly given the new data that we see from the Youth Risk Behavior Survey. And the increase in suicide attempts and suicides in Black youth, I think when people hear those kinds of things, that it makes it a little bit more urgent. We need [mental health] support. Did you know that these numbers have not historically been this high for our youth than they are? This is the urgency. . . . Data [were] collected pre COVID-19 from the last round of the Youth Risk Behavior Survey. I think that was up until 2017. So, I think folks need to be educated and aware of how important it is that we come up with frameworks and ways to support our youth specifically.

Needs of Black Students

When asked to consider the needs of Black students across a continuum of mental health, experts came to consensus on seven areas of need. Table 2 indicates the amount of consensus among experts. Experts gave each option a unique rating between 1–7. The consensus score is the sum of the scores of all raters who answered the question (n = 11).

Table 2

Expert Consensus on Black Students' Needs

Black students need _____	Consensus score
Resources that are developmentally and culturally appropriate, comprised of quality mental-health support and services such as individual counseling, group counseling, peer mentoring, outside agency referrals, etc., delivered by qualified providers, and adequately funded	70
Coping skills to manage mental health (e.g., anxiety, depression), build resilience, and deal with experiences of trauma, community crime, family instability, etc.	53
Support dealing with race-based stress, racial trauma, stereotypes, social injustice, and trauma caused by systemic oppression	46
Education regarding mental health and mental illness for youth and parents and how to and who to contact for available support and services	44
A trusted adult to talk to (free of judgment)	40
Providers who look like them	31
Access to resources	24

Note. Highest possible rating = 77; lowest possible rating = 11

First and foremost, experts stated there was a need for adequately funded developmentally and culturally appropriate resources. Experts wanted Black students to receive quality mental health support and services, such as individual counseling, group counseling, peer mentoring, and outside agency referrals delivered by qualified providers. Second, experts identified coping skills as a needed skill of Black students to build resilience in dealing with negative experiences, such as community crime, family instability, and trauma. Coping skills were seen as ways to mitigate crises and avoid hospitalization in more severe cases. Expert 4 explained:

> I'm also big on preventative care, some things we need to put in place, so all students already have access to groups and coping skills and coping mechanisms before it gets to the point of crisis. Because once we get to crisis, I don't want to say too late, but it's more of an issue. So, if we could address some of it at the beginning, maybe then it wouldn't be such an issue that will require hospitalization later on.

Third, experts identified the need for support to deal with the effects of race-based stress, racial trauma, stereotypes, social injustice, and trauma caused by systemic oppression. Expert 2 explained:

> The lack of understanding and training that professionals had, or educators and others may have had, about the potential impact of . . . racial trauma and things like that in the school setting, or the impact of not creating a nurturing environment for Black students, and of not knowing that these things exist . . . not having an understanding. So, a need for more training I think was a systemic issue, creating that in the district and creating a culture around these issues of diversity are important.

Experts expressed a need for mental health education. For instance, knowing who to contact and how to obtain mental health services was a need for Black students and their families. Seven of 10 experts expanded on the need for increased mental health literacy. Expert 4 shared a discussion held with the parent of a depressed child regarding the importance of getting mental health help:

> I had a parent say, "I think the child was depressed or something. My child didn't need any medication." And I said, "Ma'am, if your child had diabetes, would you give that child insulin?" "Yes, yes, I would." Okay, then. It's the same thing. You have to address the mental health just like you would address that insulin. This is the same thing for their

> life, for their well-being. It needs to be done. And you know what? She said, "I never thought about that."

Expert 4's experience highlighted some of the challenges with providing education for and to Black students, families, and communities. Expert 10 elaborated on this difficulty of connecting with and providing much needed education surrounding mental health:

> I don't think that some of us Black people understand that mental health is an issue in our community. So, if you say, we're doing a symposium on mental health, I can see family members saying, well we don't have any mental health issues in our family. So, I don't need to be a part of that. But if we can show this is targeted to Black families, because we're noticing the suicide rate in Black families is increasing in our county, the rates of depression and anxiety [are increasing].

Having resources does not always equate to access even for populations for which they are created, particularly in resource-deficient communities. Expert 3 explained:

> I'm trying to gather the history of the people in [city], and I've heard all this is what happened to them, a lot of people have failed in the community, a lot of services have left. So now we're dealing with families who don't even think we're [the agency] going to be around for that long, so they don't know even who to contact because they might not be here. Or it might be good for a little while, but [parents say] they ain't gonna be there for that long.

Black students need to be able to access supportive resources and services and trust that these services will remain. This was a strong argument expressed by experts in the study: the reach and access that schools have make them the primary provider of mental health services to

many historically marginalized communities, such as the Black community (Global EAB, 2020). However, families cannot access resources of which they are unaware, as Expert 9 detailed:

> The thing that came to mind . . . advertising that resources are available in a way that students know. So that would be incorporating that somehow in the school systems and the places where they are, which would be school—where they are most of the day. Another thing I think about, particularly for students, is somehow getting their parents involved to know that there are resources available. So maybe something geared towards the parents or their guardians or whoever is responsible for the student.

Black students having access to a trusted adult and providers who look like them rounded out the list. The experts in the study agreed Black students need to have access to trusting adults with whom to talk freely. Expert 9's opinion illustrated these beliefs:

> Not just someone but you know, someone who is culturally relevant, someone who can relate to these experiences, someone who has training or you know, can be specifically for, like students so that part and then also, I mean, it's kind of hard to get around the discussion on making sure you know, people who are serving Black students are aware of racism, aware of stereotypes, aware of, you know, the systemic, all of that. But I do feel like, it's something in my work that I always have to talk about and always have to, you know, convince, or say like, yes, Black students do have different experiences, therefore, they need different things.

Expert 4 desired for practitioners to be culturally competent, but did not believe they needed to be Black. Expert 4 explained:

> I didn't necessarily believe in that. Simply, because I work with White students, and make a difference, you know what I mean? So, to me, if I can work with a White student,

> and make a difference, then a White practitioner should be able to work with a Black student . . . but you do have to have cultural competency. Right? Like we talked about, you have to have that base to understand what's going on, because the Black student is dealing with so many other layers that the White student may not be dealing with. Right?

Further, the experts found it necessary for the adult to be someone who could relate to the experiences of being Black. Expert 8 expressed the importance of practitioners of different ethnic, cultural, and racial backgrounds recognizing their limitations when working with Black students because of the harm that can occur. Expert 8 stated:

> I don't think that it is impossible for someone of a different ethnicity and culture to work with a child, but the knowledge of knowing your limitations, recognize that you do have limitations, and then actively try to bridge those gaps. When, you just want to put your stuff on us [using one's own culture as the center instead of the student's culture]. Because I mean, you think about . . . even if you're, if you were White upper class, grew up with both of your parents. Your parents have degrees and most everybody in your family has advanced degrees and . . . you did this, you did, you know, vacations, you did that. And then you're trying to relate to a child, who has never been on a vacation, who, if they graduate, they're the first person to graduate, . . . live in neighborhoods, you know, this neighborhood is against that neighborhood. They've seen people, they know people that have died of gun violence. . . . You can't just sit there . . . and help these children and these families without trying to understand what they're doing as a form of survival because of their life. So, it's a lot and it's unfortunate when they don't, when they don't recognize it . . . because you're doing harm to these children. But you can't tell them that they are. You can't convince them that they're not this savior.

Context Matters

Family is an integral part of Black students' lives. To further enhance the understanding of the needs of Black students, it is important I share the experts' contextualization of these identified needs. I cannot talk about the needs of Black students without discussing the needs of the Black family, because they are interdependent, influencing and impacting one another. To add depth and understanding to these identified needs, I briefly discuss additional topics regarding the Black family based on the expert panel's presented thoughts, beliefs, and opinions on family dynamics and relationships, basic needs, trust, and vulnerability.

Family Dynamics and Relationships. Half the experts spoke to family dynamics and relationships that may be different than the traditional definition of family. The students these experts work with may not be raised by their biological parents, but by grandparents, great grandparents, aunties, and family friends. According to Expert 10, these relationships—some of which are not biological in nature—are just as meaningful. Similarly Expert 3 shared the mental health of a student's parent affects the student's own mental health. In essence, the experiences of parents become the experiences of the students. Expert 3 added they work with students who "come in with stuff from their parents" and these issues add weight on top of existing societal stressors for students.

Another prominent factor discussed by experts was the role of the church in the Black family. According to Expert 3, the church may be the first place a family turns to for help with their child, if they seek services at all. Expert 4 considered spirituality as a possible protective factor and a way to provide support to Black students by leveraging their relationship with God. In the same vein, Expert 6 mentioned the dual role of the church in the Black family, identifying

church as a place for comfort, but also a place where mental health may be minimized or families are discouraged from seeking outside help.

Black Families and Basic Needs. Families experiencing difficulty meeting their basic needs repeatedly came up as a part of the discussion with the experts. Half the panel indicated unmet basic needs impacted the mental health of Black students or at least the ability to process their feelings about it. For example, Expert 6 reflected on Maslow's hierarchy of needs as critical to their work with Black students. Moreover, Expert 6 found it counterintuitive to attempt to provide mental health services when students were hungry and had no clear way to process the emotional impact of not having their basic needs and the needs of their family adequately met. The experts in the study observed many students faced familial and community issues, such as housing instability, food insecurity, and overall safety. Experts 8 and 4 shared the same opinion in wanting to ensure Black students seeking mental health services were fed, safe, and had access to resources. These experts prioritized the basic needs of Black students over other competing priorities, such as standardized testing (Standards of Learning-SOLs) because of their understanding of the impact that being without basic necessities has on the mental health of Black students.

Trust and Vulnerability. Several experts spoke about the distrust Black families and communities have with "the system" because of the horrific things that they've done to our [Black] people" (Expert 1). This legitimate distrust in the healthcare system, as Expert 3 described, has often kept Black families from disclosing vital mental health information out of fear of how the information will be used once it is shared. Practitioners need relevant information for the purpose of accurately assessing need and providing the appropriate interventions and strategies. Therefore, it is important to establish or in some instances reestablish trust with

families. Additionally, establishing trust was vital when attempting to educate caregivers on mental health. Expert 8 explained her experience building trust with a caregiver of a student in need of mental health services and support:

> But the times that it has worked, it's just time, it took a lot of time, and a lot of conversations with the parents, and I had to almost befriend them. I mean, of course, still trying to keep that professionalism. But I had to befriend them, they had to really truly believe that I was there for their child, and their child alone. And I kept explaining it and I had to repeat and do and explain and explaining to them, I had to walk them through a lot. Like these are parents that I've had to actually, you know, let's find you somebody, where's your insurance card.

SBMH Practitioners: Know, Acknowledge, and Act

SBMH practitioners are charged with providing quality, effective mental health services and support. When experts were asked to identify culturally relevant factors necessary for school-based practitioners to include in their delivery of mental health services and support to Black students, the experts brought forth guidance for what SBMH practitioners need to know, acknowledge, and do as it relates to mental health service delivery for Black students. Their responses fell along two broad categories: (a) knowledge and understanding, and (b) action. Experts identified six factors necessary for SBMH practitioners to know and understand and four factors they wanted to see SBMH practitioners put into action.

Knowledge and Understanding

Experts identified the most important items for SBMH practitioners to know and understand. Table 3 indicates the amount of consensus among experts. Experts gave each option

a unique rating between 1–6. The consensus score is sum of the scores of all raters who answered this question (n = 11).

Table 3

Expert Consensus on Practitioner Requirements

It is necessary for school-based mental health practitioners to acknowledge (and/or understand) _____	Consensus score
The role of trauma and intergenerational trauma	45
The differences in the availability of and access to resources for Black students in comparison to non-Black students	43
The daily experiences of racism and discrimination for Black people as a whole	42
That risk factors are going to be different for Black students than for other students they may encounter (e.g., homelessness, food insecurity, parental unemployment, foster care, trauma, violence)	41
The stigma (and shame) of mental health in Black communities	31
The family dynamic in some Black families (some students being raised from persons other than birth parents)	29

Note. Highest possible rating = 66; lowest possible rating = 11

Experts indicated the primary "need to know" for SBMH practitioners was an understanding of the role of trauma and intergenerational trauma in the lives of Black students. Six of the 10 experts talked about the trauma that Black adolescents experience, including racial trauma; however, as Expert 2 explained, there was a realization that the current societal climate may not be conducive to talking about race-related issues, including racial trauma:

> I'm training my [college] students on issues related to race and mental health, and we're talking about racial trauma in my classes, but then they go out and work in a … public school where it's questionable if they can even bring up these issues, because we have a

> governor, who has said, who doesn't understand critical race theory, and that we're not teaching or addressing critical race theory, there are those types of things or you go out, and you have all this great knowledge, but you go work in a school in rural [state], where they've never heard some of these concepts.

Racism and discrimination were issues each expert mentioned, described, or detailed. One expert shared her students' experiences with racism in their school district and the implicit bias that many practitioners bring to their work. Expert 10 stated:

> I am in a district that has some racial history that has been embedded into the school, transferred over into the school setting. So, when teachers have grown up in this area, they already have these preconceived notions about Black students because that's what my grandma, grandpa, whoever, told me Black students don't excel or Black students are this, Black students are that or Black people in general are X, Y and Z. So, when I get in the classroom, although I may have taken every diversity class in college, I took that one class that lets me know that I'm diverse, you're really not because you still have some of that thought in your head. Or the education classes that tell you that Black students don't succeed the way they're supposed to or at a higher rate or at the same rate as a White student. When you're in those classes then you say, oh, yeah, well, that does make sense because I remember when I was in school, and XYZ was happening and . . . my family member told me about Black students, so now all of this makes since when that's really not the case. But that's what people have put in their heads.

Experts indicated Black students dealt with racism, discrimination, and stereotypes within schools and verbalized how they do not feel comfortable—and neither did their parents—when it came to talking to SBMH practitioners, particularly White practitioners. However,

acknowledging the existence of racism and discrimination students experience is not enough, as there exists this pervasive notion that situations will not change. Expert 2 questioned whether there would be visible change at some of the schools where she previously practiced. Expert 2 spoke of the "great White awakening and the murder of George Floyd" as markers in time that shook "communities to the core". Yet, Expert 2 also questioned whether there would be long lasting change in school buildings as a result of this tragedy. The conclusion for Expert 2 was "probably a little bit, but not too much, just depends on administration."

It is important to acknowledge and understand there are differences in the availability of and access to mental health resources for Black students. Additionally, the risk factors for Black students are also different from risk factors other students may encounter (e.g., homelessness, food insecurity, parental unemployment, foster care, trauma, violence). For several experts in the study, community violence was a concern because of the impact on the mental health of Black students, but also due to the loss of Black lives. Expert 7 shared the grave reality regarding violence in his students' communities:

> I serve five housing projects. One of the things that sticks out is the community violence. The drug boys and the neighborhood beefs, all that stuff is hopping off 24/7. And as you can see, that goes through peaks and valleys . . . you have a shooting, and then you see there's another one that may happen a week or two later, or a few days later, but a lot of times stuff is interrelated.

In a different district, amid similar concerns with community violence and its impact on the lives of the Black students with whom she works, Expert 3 shared:

> I'm in a new district, but from what I've been told, there is a lot of community violence, or a lot of community factors. . . . I could say poverty, meaning that students prioritize

> their financial gains over their academic gains, which impacts them being in the building. And then the community violence that happens outside of the school happens inside of the school or carries over inside of the school. Which, if it's not addressed, or if kids are not forced to come to me, the light bulb might not come off that, hey, there's another way or, hey, I might need some other interventions to address how I'm feeling, or how I'm acting, or how I'm interacting with other kids, other teachers, my parents.

Consensus was reached among the experts in the study regarding the stigma of mental health within the Black family and the Black community. The experts deemed it important for SBMH practitioners to understand the influence of the family on student mental health and whether or not mental health help would be sought. Expert 10 commented:

> [For] a lot of our students . . . going to therapy is a stigma where I'm not crazy. I'm not, you know, and getting parents to buy into that and making it a family thing and not just working with the student, but also helping the mom and dad and grandma, whoever else understand the need for counseling services and things like that, I think school-based mental health has to go beyond the student. It has to reach the family.

Understanding the influence of the family on help seeking behaviors requires an understanding of family dynamics, which I addressed earlier in the chapter. SBMH practitioners have to acknowledge familial systems may not look like society's definition of a traditional family and in turn how that impacts the lives of Black students. Expert 10 commented:

> Understanding the family dynamic, and how that plays into that child, that student's life. Because that can come with trauma. Different things that, if you don't have a full understanding of how grandma plays a role in the student's life, or how mom does not, and you use how you grew up . . . [in a] two-parent household, then you're not going to

be able to reach that student or understand that student. Also understanding some of the background in our district, and knowing our town in general, and knowing the racial tensions that lie within that, and knowing that some of our teachers still have those beliefs.

Knowledge and Understanding Into Action

Experts provided their opinion on four action-oriented factors they want to see SBMH practitioners perform when delivering mental health services. The foremost response from the experts on what SBMH practitioners need to do in their work with Black students was providing mental health services that enhance well-being instead of pathologizing Black students. Additionally, experts considered it necessary for SBMH practitioners to listen to Black students, involve the family and community in service delivery, and provide therapy specific (i.e., culturally relevant) to Black students and Black culture. Table 4 indicates the amount of consensus among experts. Experts gave each option a unique rating between 1 and 4. The consensus score is the sum of the scores by all raters who answered this question (n = 11).

Table 4

Expert Consensus on Practitioner Roles

It is necessary for school-based mental health practitioners to _____.	Consensus score
Provide mental-health services as a means of enhancing the overall well-being of students instead of as a means to pathologize the individual student	38
Listen	36
Include the family and community throughout service delivery to inform treatment goals	19
Provide therapy specific to the student and the population	18

Note. Highest possible rating = 44; lowest possible rating = 11

As described by Expert 9, the second directive for SBMH practitioners was to "listen to your Black students, listen to them." This idea of SBMH practitioners listening seemed to be associated with experts' opinions on students needing and wanting to be seen and heard. Expert 1 explained:

> But also acknowledging that you may not be in the position to actually help, but you can be a listening ear and allow that child to just speak and get it off their chest. And not always feel like you have to solve the problem. And not always feel like you have to have the resources available right then and there. But acknowledging that you are present, you are listening, you are hearing what they're saying. And just repeating back what they're saying. So, make sure that you are clearly getting it and that they know you're listening. So, I think that's really important to give them that space to feel seen and wanted and to feel heard.

However, for Black students being seen often means being seen through a lens of bias, racism, and discrimination, which impacts if and how Black students in need of mental health services will be treated. Expert 1 shared:

> I think what it really boils down to, for me anyway, is that they're not being seen. And if they are being seen, they're being seen as something that's violent, something that isn't a person that doesn't deserve . . . a person that's like struggling, low income. . . . There's this persona that is surrounding this child. And that's not the case. And I think that's really the stigma and the biases and the discrimination and the racism and all of that, that, unfortunately, encompasses this child's life on a regular daily basis. And they have to fight every single day against that, to just survive. That's nonsense. Who else does that in this beautiful United States of America, right?

These mischaracterizations of behavior have sobering consequences on the lives of Black students who, according to Expert 4, are often labeled by White educators as bad and in need of an Individualized Education Program (IEP) to fix the Black student. The mislabeling and misinterpretation of the behaviors of Black students, particularly when Black students externally express internal distress become barriers to the support they need as illustrated by Expert 5:

> I think when Black students display an outward reaction to something that is internal, it feels sometimes automatically assumed it's just a behavior concern or the student is being defiant. I feel like sometimes for Black students, it's so much easier for school staff to jump to the defiance or whatever the negative behavioral piece is instead of looking at, okay, well, what's going on. Whereas for White students, if they know something's going on in the home, they're quick to say, well, this is happening at home. For Black students they may know that [something is going on] and it's a—but still [it doesn't matter]. So, I think, that piece is automatic because it feels like it's just a behavior, instead of the mental health piece or, just like you said, temporary distress or something. It's just behavior. I feel like that is pretty prevalent.

Listening to Black students also means listening to Black caregivers and Black community members. Based on their professional experience and expert opinion, Expert 9 asserted the key to actively listening to the Black community means asking community partners what they need. Attentively listening to the needs of students and parents is a way to build rapport and establish relationships as discussed earlier. It is important that caregivers feel that their interaction with school staff is genuine and expressed student concerns emanate from a place of care and respect. Expert 5 commented:

> Approach is very important, especially for parents, I think you can burn that relationship pretty quickly. And so, be mindful of what you say to parents and how you say it, especially if you want to recommend some type of assistance. . . . Sometimes I think people just don't stop to think about what they're going say. How they're going to say it. How the parents are going to perceive it. And just showing the parent that respect. Don't have a conversation in the hallway. . . . Pull them into the office. So just basic courtesy. It's important. I think really listening to what the parent is saying, listening to what the student is saying. I think sometimes, school staff get into the habit of just wanting to say what they think is wrong and don't take the time to listen. So, I think listening to what the parent and student is communicating is key.

Experts talked further about building relationships with Black families and communities as a way to broker active partnerships and collaboration. The experts maintained involving the family and community in the delivery of mental health services was critical to collaboratively partnering with one another. Expert 4 elaborated:

> I think we have to build rapport. We have to sit down and speak with the parent and say, Listen, I understand you feel like oh, there's nothing wrong with my child, my child does not need this. But I'm here to tell you, as another African American, this is what your child needs. This is what I've gone to school to study. Please know that I would never do anything to harm your child. I only want the best for your child. So, I try to meet the family where they are. I try to talk to them at their level and not make them feel inferior and just let them know this is what's really needed to help your child and given the high suicide rates, [which is] another issue. So, we definitely have to do something with the mental health to keep our students safe and healthy for their own well-being.

The experts described the intentionality of involving caregivers, particularly for Black students, as an opportunity to support the family system. This intentionality may mean providing mental health services or providing referrals for community support to caregivers who are important to the student. As Expert 3 described:

> So, whatever they [Black students] come in with, you have to have a deeper understanding of where it manifests from to help them. I shake my head, and I'm like, I need to be working with your mama. I need to be working with your daddy because it's them that's affecting your mental health. So now, I have shifted my thinking to, how can I help this student survive in their environment, so that the environment does not take over their mental [health]. . . . But they're able to thrive in the environment themselves without taking on what the environment might put on them.

Finally, experts deemed it necessary for any analyses, assessments, services, treatments or support to be culturally appropriate. Experts discussed how questionable it was to continue using educational tools, such as cognitive and achievement tests, with Black students when they were normed on non-Black students. Expert 6 stated:

> And so, I remember being in class all these years ago, saying this is not right . . . we're giving these scores. And there's no way for me to discuss [this scoring]. Let's be honest, I have to write the report [psychological assessment], right? And it's my job to write the report. But let's be clear that some people never read the report. They look at the numbers. And the numbers are still skewed. And so, I would go off . . . this isn't right. You are giving scores that do not take into account the cultural competency lack that this test has. . . . So, we're giving tests that were normed on all-White populations. We're giving tests that were normed on wealthy White people. And we're putting them in urban

> schools with poor Black kids. And we're not able to adjust for that in the scoring, which some people only look at the score. So, I can talk about it in my report, but if it's never read, who talks about that? How is that addressed?

Some experts declared the continued use of culturally biased assessments with Black students adds to misdiagnoses and inappropriate labels. Yet, there seemed to be a lack of clarity surrounding alternatives. Expert 1 further explained:

> The amount of research that has been done on Black people in general is so limited. And it's, it's kind of disgusting when you start thinking about it because we're using these interventions or using these treatments and we have no idea, no idea if they're really universal as what they say they are. So, we're using, you know, Signs of Suicide [suicide awareness program] in the school setting. Does that really work for Black youth? Not according to the literature, it doesn't. So why are we using it? . . . It drives me a little bit crazy. As it probably does you as well, to think about all these things that have been tested and tried on one or two Black people, that now they're universal? No, that's not the case.

School-based mental health services and support occur within a system; thus, SBMH practitioners alone do not bear the sole responsibility for ensuring effective, quality, and culturally appropriate mental health services and support be provided for Black students. The next section answers the central research question by discussing essential components of comprehensive school-based mental health systems.

Essential Components of a School-Based Mental Health System

When experts were asked, "What components would you identify as necessary and essential for comprehensive school-based mental-health systems to adequately address and

support the mental well-being of Black students?" they responded with 30 unique responses. Through consensus, experts identified eight critical elements (see Table 5). Table 5 indicates the amount of consensus among experts. Experts gave each option a unique rating between 1 and 8. The consensus score is the sum of the scores by all raters who answered this question (n = 11).

Table 5

Expert Consensus on Addressing Mental Well-Being of Black Students

In order to adequately address and support the mental well-being of Black students, comprehensive school-based mental health systems need to _____.	Consensus score
Address the environment, making sure it is conducive to the healthy mental health for Black students; correcting systemic racism that directly works against Black students	70
Acknowledge racism and discrimination and the associated long-term implications	54
Provide culturally competent educational materials about mental health to school-based mental-health providers, school staff, and schools in general	51
Provide culturally competent services to students	51
Provide appropriate school-based intervention and treatment components (e.g., small group counseling, individual counseling, after school programs, social skills group)	50
Provide school wide training on trauma and the use of trauma informed care	49
Listen to Black students	41
Include prevention services for students, such as suicide training, social emotional learning, restorative circles	37

Note. Highest possible rating = 88; lowest possible rating = 11

Above all, the environment in which school-based mental health services take place was most important to experts. The experts wanted environments conducive to supporting the mental health of Black students and addressing systemic issues of racism that work directly against

Black students. As Expert 5 pointed out positive school culture fosters students' willingness to speak up and know their voices will be heard. Expert 10 shared an illustration of how a lack of attention to school culture and climate can sustain practices that cause harm to Black students. In Expert 10's district, challenges surrounding racism weighed heavily on Black students who felt they were treated unfairly and who felt unsafe at school because they were Black. Expert 10 explained:

> They were distraught. They were, as far as mentally, they couldn't function. They were not going to class because they felt that they weren't being supported in the classrooms. They weren't being supported by the administration and the only place they could go was, which was their safe place, the counselor's office. They didn't feel safe in the school setting. So, they were coming to school every day because they had to, but they were saying, I don't feel safe in my classroom. I don't feel safe in the school. I feel like at any point, someone can get upset and harm me, or I get upset enough that I will harm someone else. So, I don't think mentally they were in a good space. And it probably took about 2 or 3 weeks for us to really . . . to be honest . . . I don't know if the students ever really got back into a really safe place.

Experts expressed concern when the school environment did not protect the mental health of Black students in such a way that the unfair treatment they experienced in the school building impacted their mental health. Expert 2 described:

> The girls would talk about things like, I feel like I'm being treated unfairly, they don't ever listen to my side, they suspend us for I feel like for no reason. . . . And so, they would say those things that you read about . . . school push out and so forth. And it did have an impact on their self-concept, and I think it did not have a positive impact on

> mental health. Of course, I didn't do a study to link specifically those outcomes to their mental health. But you could tell that it affects them. It affects their anxiety about being in a school setting, when you feel like you can't, you know, go to your teacher, and those types of things, and they talk very openly about that.

The concern regarding the school environment was coupled with the importance of acknowledging the long-term implications of racism and discrimination. Several experts recounted the experiences of Black folk with respect to racism and discrimination, historically and at present. Expert 1 indicated:

> People of color struggle so much because of the way, unfortunately, that this country was built, right? And all of these ingrained stereotypes and racism and discrimination that continues to be present even now. And I hate to say it, probably will be here for the next 10, 20, 30, 50 years, unfortunately. And we're having these conversations with these youth about how to literally survive in circumstances that are "normal" by the majority. Driving down the street in a car, you see a police car that's behind you, what do you do, or walking in a park . . . nonsense . . . going for a run. Just these normal things that we can't do because of the color of our skin.

Sharing a personal family experience about the implications of racism and discrimination, Expert 1 spoke about the difficulty her family had discussing with her son how some people were not going to "like him or think of him as being just who he is because of the color of his skin." Another example of the long-term implications of racism and discrimination was illustrated by Expert 7. Expert 7 spoke of organizations, such as the American Psychological Association (APA), issuing apologies after the killing of George Floyd regarding their "misleading role in stigmatizing, blaming, and negatively quantifying Black behavior" with little

regard for the damage their historical influence and continued control of the narrative regarding Black people and mental health has done. Expert 6, too, shared a personal experience highlighting the implications of systemic racism and discrimination and the sacrifices that she makes to have a proverbial seat at the table to advocate for resources and access to services. Sharing a story about a conversation with a friend about how Black hair in its natural state is often viewed as unprofessional, Expert 6 indicated:

> She said, I'm tired of people telling you, you can't wear your hair natural. . . . And I said, let me tell you what I do every day . . . and you need me in the room. Because if I'm not in the room, then things don't happen. And I would much rather straighten my hair for them [White folk] to feel comfortable with me being in the room. And I've been in a room where people's appearance was discussed. . . . And so, I said, you know what, I'm not fighting to wear my hair natural. Because I want to be in the room. And guess what, people are not getting access to the room. . . . I'm in the room and I'm not giving up my seat because this man over here who owns the room is mad. . . . Let me work this room. . . . There is a certain expectation about how I'm going to present, how I'm going to be present. . . . And the unfortunate reality is, me and my natural self is uncomfortable to the White people who own the room. And so, I'm not willing to not be in the room to fight for natural hair. And that's just the reality.

Culture is important. However, differences within cultures exist and these differences must be understood by persons working with students in the Black Diaspora. Expert 1 noted:

> When you think about Black people, that's not one type of people. And I don't think people really realize that . . . there's African American people, there's Caribbean people,

> there's West Indian people, there's, you know, African people, there's, there's all of these beautiful, wonderful cultures under that umbrella. And they're so different.

Experts indicated these differences did not take away from shared cultural experiences; yet, as Expert 6 experienced at a training regarding community resources and access for Black communities, one Black person does not speak for all Black people. Expert 6 described:

> So, someone asked me in one of our trainings, well, what do the Black people—I can't make this up—What do the Black people think? How should we do this for Black people? And I said, I'm different from this Black woman sitting next to me. I don't know. I know how I think about it.

Experts wanted culturally competent educational mental health information provided to all school staff and culturally appropriate mental health services provided to Black students. Every expert addressed some form of training and/or professional development focused on cultural responsiveness or cultural competency. Expert 4 thought training was necessary, particularly when persons did not understand nor believe racism existed and that the impact on the mental health of Black students was consequential. Expert 4 shared:

> There would have to be some training. I believe in cultural competency. That's the only way they could do it so they can understand how to, you know, empathize with students of another race, if you don't have that, you're not going to be able to do it. I mean, and how can you help someone if you don't really understand where they're at?

Expert 9 commented on the need for authentic culturally relevant training that would provide practitioners with the necessary skills to work with Black students. Expert 1 suggested offering webinars about cultural responsivity and having open and honest small group conversations amongst teachers with experts in the field of cultural competency and unconscious biases. The

experts also wanted appropriate services matching the needs of the student (e.g., small group counseling, social skills support). Included in services and support, experts wanted schoolwide trauma-informed education, trauma-informed practices, and preventative services, such as restorative practices, suicide training, and social–emotional lessons.

Lastly, when discussing the concept of listening, the expert panel wanted not just the SBMH practitioner to listen, but also the system "to listen." Experts encouraged parents to speak up and presented a reminder that sometimes the system must make and give space to parent voice. Expert 8 stated:

> No one knows your child better than you. You are the expert on your child. You've had that child from Day 1 on up to whatever year we are in. You have them all the time. And your voice is valuable. And I think that gets lost sometimes. . . . I'm saying they come to us and they want to be quiet because all the professionals are there. No, you need to speak up because they don't know your particular child to the degree that you do. So yes, you are the expert on your child.

Listening was viewed as instrumental in active collaboration across home, school, and community. Expert 2 commented:

> How many untapped strengths there are within our communities, and how if we really work with and listen to families, and listen to students tell us what they need, a lot of times, they have a good handle on what they need, or what they want. And we have to make it where we're not just saying, okay, they're just kids, they don't know. . . . They do know and we need to listen to them to see what it is that they think that they need, and work with them to create any school mental health support. Don't leave them out of that

process. Include them in that process and listen to what they say they need and reflect critically on that and try to come up with ways for them to be involved and to feel valued.

Putting It All Together: The Experts Have Spoken

The use of the Delphi method for my study allowed me to harness the knowledge of experts who had research, practice, and personal experience with the mental health of Black students. Experts clearly identified the needs of Black students, including their thoughts and opinions of the Black family and community as a connected and interdependent system influenced by Black students and influencing Black students. The expert panel clearly defined what SBMH practitioners need to know and understand about Black students (culturally), and equally important, what they must do to provide culturally responsive services and support.

The identification of these factors undergirded the experts' establishment of components supporting the mental health of Black students. The experts deemed it essential that the school environment inherently support the mental health of Black students and call out systemically racist actions. This support entails acknowledging that Black students are impacted by racism and discrimination and often mischaracterized behaviors of Black students by school personnel have long-term consequences for Black students. The experts presented several ways for comprehensive school-based mental health systems to support the mental health of Black students; however, mental health support must be culturally appropriate and provided by SBMH practitioners who are culturally competent. Mental health support and services should span the continuum and include schoolwide preventative services and support. The art of listening was woven throughout each of these identified elements as critical to the development and implementation of comprehensive school-based mental health systems that intentionally center Black students in service delivery.

CHAPTER 5: THE EXPERTS HAVE SPOKEN. NOW WHAT?

In 2002, Flaherty and Osher concluded school-based mental health was not designed for Black students. Two decades later, the experts in my study agreed, in many respects, school-based mental health still is not designed for Black students, due in part to a lack of cultural awareness and understanding. The purpose of this Delphi study was to identify essential components of comprehensive school-based mental health systems in an effort to adequately address and support the mental health of Black students in K–12 public school settings.

Using the Delphi method over a series of four rounds of questionnaires, the assembled expert panel came to consensus and successfully identified key elements necessary and essential for culturally sensitive, comprehensive school-based mental health systems capable of effectively supporting the mental health of Black students. These elements highlighted and detailed the needs of Black students and the culturally relevant factors school-based mental health practitioners must acknowledge and act upon.

As such, outlined in this chapter is a framework for school-based mental health designed to address the mental health needs of Black students. The framework is anchored in cultural awareness, competency, responsivity, and inclusivity. The framework design is comprehensive and specifically developed for use by school divisions to address and support the mental health of Black students.

Review of Findings

The experts asserted Black students need access to adequately funded and culturally appropriate resources comprised of quality mental health support and services delivered by qualified providers. The culturally relevant services and support must include educational information about mental health and coping skills for Black students to be better equipped to

manage their mental health, build resilience, and deal with trauma-related experiences. Black students must have access to qualified staff who they can trust and who are representative of Black culture. The staff must be adept at supporting Black students in dealing with race-based stressors, social injustice, and trauma caused by systemic oppression.

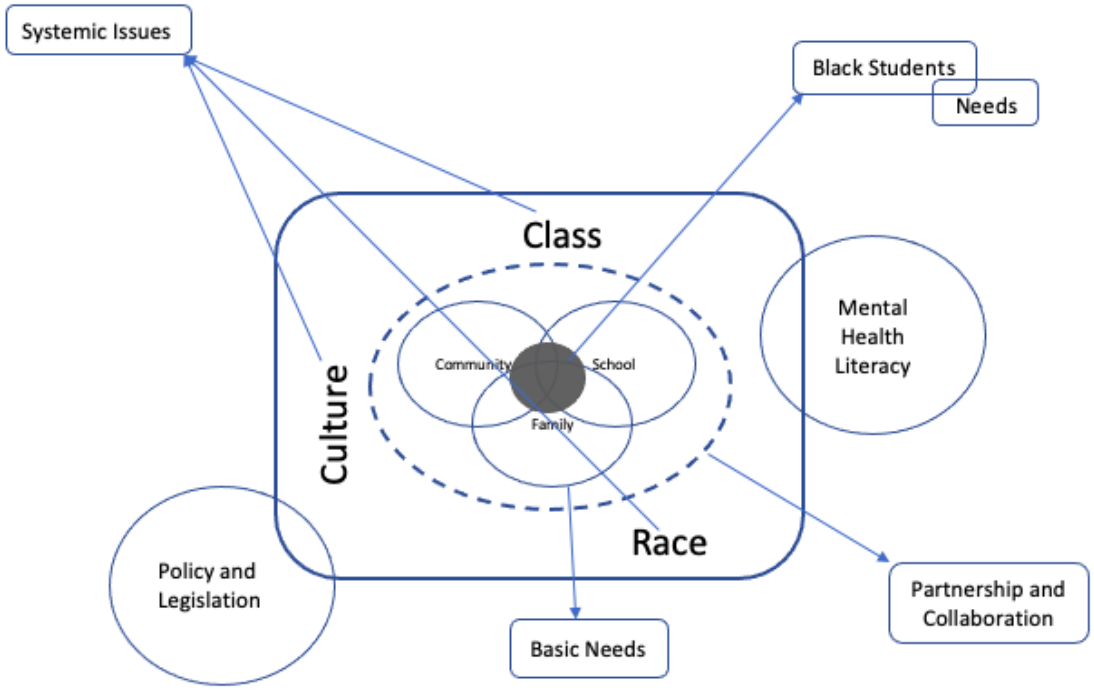
With respect to culture, the expert panel identified several relevant factors necessary for school-based mental health practitioners to know and act upon when working with Black students. Practitioners must be aware of risk factors and that availability of and access to resources are different for Black students in comparison to other racial and ethnic student youth groups. Additionally, practitioners must understand the impact of various key persons in Black students' lives, the stigma within the Black community, and the role of trauma and intergenerational trauma. The expert panel affirmed practitioners must listen to Black students, include the Black family and community as support for and throughout service delivery, and provide culturally appropriate services to Black students.

The expert panel's opinions aligned with existing literature regarding challenges faced by Black students. The Map of Expert Opinions (see Figure 4), visually explained how the experts viewed the interconnectedness of the Black student's family, school, and community and the necessity for collaborative partnerships between the three. The experts in the study highlighted the problematization of systemic issues related to race, culture, and class in the lives of Black families, Black communities and schools in most of the responses they provided. The experts in the study were clear that each identified system was in need of increased mental health education, including Black students themselves. The experts' opinions supported the development of a framework for a comprehensive school-based mental health system supporting the mental health of Black students. The framework incorporates key elements, such as listening

to Black students, access to and the provision of culturally competent resources, services and support, and positive school environments.

Figure 4

Map of Expert Opinions



The Framework for Culturally Responsive School-Based Mental Health Systems

This section of the chapter is divided into four parts. The first part outlines three fundamental components of the framework related to the significance of racism and discrimination in Black students' lives, the importance of partnership and collaboration, and the inclusion of culturally competent services and support. Part 2 provides key elements specific to Black students, Part 3 outlines facets for addressing Black families and communities, and Part 4 details necessary components for schools to address.

Part 1: Fundamental Factors

The framework must first address three major components: (a) the impact of racism and discrimination, (b) partnerships and collaboration, and (c) the inclusion of culturally competent resources and services. These elements are fundamental to the model and necessary for ensuring success of establishing and sustaining a comprehensive system.

Disavowing Racism and Discrimination

The experiences of racism and discrimination gravely influence and impact the mental health of Black students as they are confronted, in some instances, with daily experiences of racism and discrimination. Therefore, schools must take the following actions:

1. Increase awareness and challenge of racist and discriminatory practices by educating school staff on discrimination based on race, color, and class.
2. Recognize that racism and discrimination exist and have long-term implications on the lives of Black students.
3. Address biased beliefs that impact if and how Black students' mental health will be supported.
4. Monitor and assess interactions between school staff and Black students, where the behaviors of Black students are culturally mislabeled and misinterpreted.
5. Accurately identify and assess behaviors of Black students, paying close attention to internalizing symptoms often overlooked and externalizing symptoms often misjudged.

The experts in this study were steadfast in their opinions that being Black (race) often resulted in negative outcomes for Black students for various reasons (e.g., being inaccurately assessed for mental health services or misdiagnosed for treatment interventions). The assertion of

the experts that Black students experience life-long effects as a result of racism and discrimination is supported by existing literature (Bloxsom-Carter, 2019; Cokley et al., 2014; Herring, 2015; Huff, 2011; Serpell et al., 2009). Racism is a social determinant of health linked to the mental health of youth (Masko, 2005; Trent et al., 2019; Weeks & Sullivan, 2019). This means Black students negotiate inextricably linked systems—home, school, and community—while navigating experiences of racism and discrimination.

Creating Collaborative Partnerships

Partnership and collaboration are directly associated with the guiding principle of communalism, as it recognizes Black families and Black communities are key stakeholders in the overall well-being of Black students. As such, schools must include these key stakeholders by taking the following measures:

1. Collectively make decisions with Black families (and Black communities when appropriate) regarding Black student support by openly sharing information and including any supportive persons connected to and influential in the Black student's life.
2. Foster a community of shared responsibility for and accountability to Black families and communities.
3. Establish and build authentic relationships by expressing genuine interest in the Black student's family and community.
4. Identify and actively support Black communities by making referrals to agencies providing services in the immediate community and assisting with coordination of wraparound services for continuity of care.

5. Create a reciprocal relationship with Black communities by encouraging a sharing of resources.
6. Provide staff professional development and training for Black families by leveraging the mental health expertise of community agencies.

The systems Black students navigate (e.g., family, schools, communities) are interconnected, interdependent, and interrelated (Bent-Goodley et al., 2017). However, too often these systems function independently of one another and without consideration for the other. This disconnect between systems makes it extremely difficult to know if and when a system experiences discord or is in a state of disarray, which in turn makes it challenging to effectively support Black students across each system. Each system has a role and each must be cognizant of the impact it has on the other. Successful partnering requires shared power, responsibility, and accountability. Therefore, building relationships with Black families and communities is critical.

Culturally Competent Services and Support

Culturally inclusive mental health practices must be provided by practitioners who have some level of understanding of Black culture to accurately assess, provide direct services, and make any necessary referrals for mental health support. Therefore, schools must implement the following strategies:

1. Use a cultural perspective that recognizes, accepts, and appreciates cultural agency, (e.g., using African-centered thought; perspective).
2. Employ school-based mental health practitioners (practitioners) who understand the significance of culturally responsive practices in mental health.

3. Adopt a practice of open discussion and dialogue that supports staff who lack awareness and insight into their own biases, are not prepared to address the topic of cultural responsivity and inclusivity, or who simply do not see the value in doing so.
4. Assess for practitioner knowledge and unbiased understanding of Black culture when working with Black students.
5. Provide school staff with access to culturally competent resources, (e.g., interventions, strategies, programs, literature, and educational materials) for Black students by offering support on appropriate implementation and use of such resources.
6. Require practitioners to provide culturally relevant mental health assessments, direct services and support, and community referrals.
7. Recognize that being Black is not a monolith by appreciating the uniqueness in individual Black students.

As the primary providers of mental health for school-aged youth (EAB Global, 2020), schools have a responsibility to be culturally responsive and inclusive in their mental health practices (Bloxsom-Carter, 2019; Huff, 2011; Serpell et al., 2009). In the expert panel's opinion, school-based mental health practitioners must have an appreciation for and understanding of Black culture when working with Black students. In essence, for mental health services and support to be helpful, they must be culturally relevant (Cokley et al., 2014). Furthermore, the experts insisted school staff must be provided with culturally relevant resources for Black students to provide adequate culturally responsive and inclusive mental health services and support.

Part 2: Black Students

This section of the framework outlines suggestions for strategies and interventions supportive of the mental health of Black students.

The Environment

Black students need school environments that positively support their mental health. Therefore, the following positive changes must be established:

1. Create a school culture that is emotionally and physically safe by challenging all practices, policies, and procedures that discriminate against Black students based on race, culture, and class.
2. Provide physical spaces promoting trust by being warm, friendly, and inclusive.
3. Encourage and support Black students to seek help when experiencing any level of emotional distress by normalizing feelings and offering support.

The expert panel agreed schools must have environments conducive to supporting the mental health of Black students. This support includes ensuring racist practices, policies, and procedures are directly addressed and challenged. As long as Black students experience racism and discrimination on a daily basis, the mental health model needs to address the impact of racism on students. These racist and discriminatory acts can leave Black students feeling unsafe, untrusting, and vulnerable, which may affect whether they seek mental health support when they need it.

The experts in this study stated Black students were less likely to receive mental health support in comparison to other racial and ethnic youth groups due in large part to misinterpretation of their actions and conduct as behavior problems and not potential mental health challenges. Some experts added not all school-based mental health practitioners providing

direct mental health services need to be Black, but they must all have a clear understanding of Black culture. These expert opinions regarding the likelihood of receiving mental health services and the need for practitioners to be culturally aware are supported by literature (Cokley et al., 2014; Farahmand et al., 2011; Herring, 2015; Huff, 2011).

The expert panel also discussed the vulnerability of Black students based on a lack of trust in and distrust of the system, which impacts if Black students will seek services and if they follow recommendations for treatment. Several authors (Bloxsom-Carter, 2019; Hatcher et al., 2017; Herring, 2015) supported the experts' shared opinions that Black students, Black families, and Black communities are hesitant to participate in services due to historical and modern experiences with racism and discrimination.

Listening As A Demonstration Of Support

Active listening to Black students conveys an understanding of care and concern for their mental health. To effectively demonstrate active listening the following practices must be enacted:

1. Engage, intentionally and positively, Black students by calling them by their name, asking how they are doing, and noticing when they are absent from school or class.
2. Advocate on behalf of Black students to ensure access to quality mental health services and support.
3. Listen for ways Black students need emotional and physical support, (e.g., experiencing housing instability, food insecurity or job loss) and facilitate connections to appropriate support.

4. Avoid comparing or judging Black students against other racial or ethnic youth groups by acknowledging the uniqueness of Black students because of the multitude of stressors they face simply associated with being Black.

Listening to Black students is a demonstration of support, a sign of understanding, and a declaration that one can see the fundamental goodness they possess (Bent-Goodley et al., 2017; Oyebade, 1990). It also means advocating and ensuring Black students have access to and receive mental health services and support they may need. Therefore, centering Black culture is critical when working with Black students, particularly when attempting to assess need and provide mental health support (Borum, 2007; Fairfax, 2017; Graham, 1999; Monteiro-Ferreira, 2009; Oyebade, 1990; Schiele, 2016; Stewart, 2004). Active listening centers the voices of Black students, and by extension, voices of their families and communities, which is an example of individual and collective functioning in action (Bent-Goodley et al., 2017; Graham, 1999; Schiele, 1990). Therefore, practitioners must understand the full weight of what this means because their work goes beyond the Black student. Their work also impacts the Black student's family and community.

Part 3: Black Families and Communities

The inclusion of Black families and communities as key stakeholders is vital to the mental health support of Black students. A clear assertion of valuing Black families and communities as stakeholders can be demonstrated in the following ways:

1. Understand and acknowledge the importance of extended family and friends in the lives of Black students by identifying and establishing relationships with key persons in their lives.

2. Assess the needs of the Black student's family and community, with specific attention to their emotional, physical, and mental health needs by asking questions and not making assumptions based on preconceived notions of what Black families and communities need.
3. Assess the role of the church body, with respect to mental health, in the Black family and Black community by asking about spiritual beliefs and values and incorporating that information in services if it positively supports mental health of Black students.
4. Support the destigmatization of mental health in Black families and Black communities by providing mental health education.
5. Become familiar with the Black student's community to develop a greater understanding and appreciation of their experiences by physically going into the community where they reside.

Very similar to the experiences with racism and discrimination Black students face, so too do Black families and Black communities. According to the expert panel, Black families and communities are generally not consulted about the course of action considered in supporting the mental health of their child. A lack of respect for Black caregivers as key stakeholders who are the experts on their child(ren) is unfortunately the typical course of actions for school systems (Borum, 2007; Gamble & Lambros, 2014).

Part 4: School Systems

Schools are the largest providers of student mental health services and support. They have a responsibility to ensure quality mental health services and support skilled practitioners by implementing the following:

1. Recruit, hire, and retain Black school-based mental health practitioners to diversify school-based mental health teams (e.g., departments, units) and clearly identify to the entire student body who they are, the services they provide, and how students can connect with them.
2. Assess and evaluate qualified, trained mental health professionals providing culturally relevant mental health services and using a cultural lens to assess the behavioral, emotional, and mental well-being of Black students.
3. Make practitioner caseloads manageable by creating appropriate student-to-staff ratios.
4. Identify and leverage the influence of key opinion leaders in the school district and school buildings to increase support and buy in of culturally responsive and inclusive mental health practices.
5. Provide a continuum of services aligning with mental health needs occurring across the continuum of mental health.
    a. Include prevention services in delivery of mental health support by presenting schoolwide mental health education, awareness, and information, (e.g., social–emotional learning, suicide awareness, and trauma informed care) to the entire student body on an ongoing basis.
    b. Provide small-group services for Black students needing more individualized and specialized services.
    c. Provide individual counseling to Black students exhibiting more intense (i.e., frequency and intensity) mental health needs.

6. Provide engaging and interactive staff trainings throughout the school year by incorporating and embedding them in division-wide planning.
7. Invite and include Black families to culturally relevant training on topics specific to Black families by having speakers directly from the community present.
8. Develop a metric evaluating the school district, individual schools within the district, and school-based mental-health practitioners in the area of culturally responsive and inclusive mental health practices by using the components of the comprehensive, culturally responsive and inclusive framework outlined in this chapter.

Mental health is not a binary concept. It occurs across a continuum from persons not experiencing any levels of distress to persons experiencing significant mental health concerns, with persons experiencing varying levels of distress in between. Because mental health spans a continuum, so should appropriate levels of mental health services and support. Programs, such as social–emotional learning and suicide awareness, are preventative in nature and may not require the facilitation of trained practitioners. However, based on expert opinion, highly skilled and trained practitioners are the most appropriate providers of interventions, such as small-group counseling and individual counseling. The experts added, regardless of service type, mental health services provided must be culturally appropriate or at best adapted to be culturally appropriate. In essence, culturally responsive mental health services center Blackness, and judge and assess behaviors and action through a cultural lens of Blackness.

Recommendations for School-Based Mental Health Practitioners

Based on the findings from this study, the following recommendations are offered to school-based mental health practitioners. As unfortunate as it may be, it is important for practitioners to assume responsibility for their own professional development and training.

Considering the sense of urgency and need to address and support the mental health of Black students, practitioners cannot wait on the school division to provide funding for training and professional development.

Practitioners should adopt a culturally appropriate practice framework (e.g., Afrocentricity) to provide mental health services and support to Black students. Doing so is a clear statement of cultural respect and appreciation, and a commitment to conduct assessments, develop service plans, and evaluate progress from a cultural (i.e., Black) perspective.

No racial or ethnic group is the same, and within-group differences also exist. Practitioners must accept what they do not know, seek to learn in areas they lack, and ask for support for cultural grounding from colleagues when necessary. It is imperative practitioners process their own beliefs, thoughts, and biases about Black students and Black culture. A lack of self-examination and self-awareness may do more harm or at the very least be of no support to the Black student experiencing distress.

Finally, practitioners must understand and fully lean into the weight of their work with Black students because their work spans beyond the student to the generation of family members before them. As such, school administrators should include Black families in service regarding their children by offering nontraditional ways to participate, such as after hours, text messaging, or virtual calls. These actions actively demonstrate to parents their participation is expected and wanted, but more importantly, a school staff person sees value in their contribution with the services and support their child(ren) receive.

Recommendations for School Divisions

The research findings also provided a basis for recommendations offered to school divisions. Schools must make a commitment to adequately fund culturally appropriate mental

health services and support at all levels of need regardless of competing priorities, because treatment and intervention are far more costly than prevention services. Adequate funding includes realistic caseload ratios. School administrators must review current school division policies and practices for alignment with written and verbal commitments to racial and social justice, which includes students with mental health concerns. The framework presented in this research, based on literature and expert opinion, can be used to evaluate existing school mental health practices and create a new school-based mental health system. Using a division-wide comprehensive framework provides the structure and guidance necessary for consistency across the system while still allowing for autonomy and agency at the building level.

Recommendations for Future Research

In closing, I have identified four recommendations for future research:

1. Poverty is a risk factor of mental health problems and mental health disorders (Department of Health and Human Services, 2001) and persons living in poverty are more vulnerable and susceptible to experiencing mental health challenges than those who do not live in poverty (Cokley et al., 2014; Department of Health and Human Services, 2001; Hatcher et al., 2017; Herring, 2015). Black children experience poverty at greater rates (1 to 4) in comparison to their White counterparts (1 to 12). This research acknowledges compounding effects of race, culture, and class; however, findings of this research with respect to class were not as prominent as findings emerging for race and culture. Therefore, future researchers should focus on

the impact(s) of classism on the mental health of Black students within the context of school settings.

2. Future researchers should consider using this study's research design (i.e., Delphi method) with a different racial or ethnic student group. Findings of this research, although specific to Black students, have provided the groundwork for developing a school-based mental health system that recognizes and respects cultural agency (Monteiro-Ferreira, 2009). It may be possible to use findings from this current study to design and develop a culturally responsive and inclusive comprehensive school-based mental health system that centers the cultural perspective of other marginalized student groups.
3. In this study, the voices of Black youth and families are shared through the lens of Black experts. Future research should actively seek and include the participation of Black youth enrolled in K–12 settings, as the findings of this research are specific to this demographic.
4. Lastly, this research did not specifically discuss implications of findings as related to policy and legislation. As such, additional research in this area is needed. The suggested focus is on aligning school board policy with school-based practices, specifically in the area of mental health and cultural responsivity. School districts will have to assess and determine where their commitment to mental health and culturally relevant practice lies. Adequate funding is needed to create safe school spaces conducive for supporting mental health and to address staffing ratios allowing students with mental health needs to receive culturally relevant mental health services and support from qualified mental health practitioners. Although the list of needs is

quite longer than discussed here, ultimately the recommendation is for research that would support pathways for adequate funding of culturally responsive and inclusive mental health services and support.

Future research will help to address the identified gap in literature surrounding the services and support of mental health of Black youth in school settings. Additionally, the aforementioned research will strengthen the existing framework presented in this study.

Putting It All Together: For the Sake of the Mental Health of Black Students

It takes a village to raise a child.

—African Proverb

This proverb is fitting for the final chapter of this dissertation. The village—home, school, and community—is responsible for addressing and supporting Black students, particularly when mental health concerns are present. Therefore, as an intricate part of the Black students' village, schools have a responsibility to Black students, their families, and their communities to provide culturally responsive and inclusive mental health services and support. Addressing and supporting the mental health of Black students requires an understanding of the needs of Black students, which must be explored and examined through a cultural context. For this reason, providers of school-based mental health need not be Black to provide effective mental health services, but they must have a clear, simple, and plain unbiased understanding of Black culture. Without such a cultural understanding, practitioners perpetuate the practice of inaccurate assessments, misdiagnoses, and insufficient interventions and strategies to the detriment of Black students.

Schools are a microcosm of the world in which Black students live, where they are often discriminated against simply for being Black. This discrimination has significant implications for

Black students because issues of racism and discrimination affect their mental health. Practitioners must actively use and seek culturally relevant resources to provide, remain aware of their own biases, recognize the influence of their lived experiences on the services and support they provide, and ultimately assume responsibility for their own professional growth and development. The practitioner should adopt an African-centered approach to mental health practices. In plain terms, this approach simply means Black students they work with are not judged against non-Black cultural norms, because there is an appreciation for and acceptance of Black culture where its value is not determined based on any other racial or cultural groups. Black students are worth the time, effort, and energy to ensure they are cared for and properly supported. Centering Black students at the core of a comprehensive school-based mental health system ensures the mental health of all student groups is addressed and supported regardless of their race, culture, or class.

Using the Delphi method through a series of four rounds, experts reached consensus on the needs of Black students, expectations of school-based mental health practitioners, and the school system. Findings from this research provided the impetus for the presented framework and incorporated key factors: (a) centering Black culture for the benefit of any analyses and assessment of Black students; (b) establishing and maintaining relationships with Black families and Black communities for the purpose of fully supporting the mental health of Black students; (c) disrupting school policies, procedures, and practices discriminatory toward Black students; and (d) offering suggestions for providing ongoing mental health and culturally responsive training and professional development for staff. The framework for a comprehensive school-based mental health system is presented as an outcome of this study, which provides schools

with necessary components for ensuring the mental health of Black students is supported—and protected.

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Appendix A: Email Recruitment Letter

Dear [insert name],

My name is Shenita E. Williams. I am a doctoral student in the School of Education at Virginia Commonwealth University. I am writing to invite you to participate in a study exploring essential components of school-based mental health systems necessary for supporting the mental health needs of Black students.

The study is a part of my doctoral dissertation entitled *How School-Based Mental Health Systems Can Address and Meet the Unique Cultural Needs of Black Students Experiencing Mental Health Challenges.* The study focuses on identifying challenges faced by Black students with mental health needs, identifying relevant cultural factors that school-based mental health practitioners should be aware of when providing mental health services in school to Black students, and the overall expectations of school-based mental health systems that support the mental health needs of Black students.

Because of your role as a [insert role] you are invited to participate in the study. I am using the Delphi Method, which collects data using a series of rounds, to gather data from study participants. Your participation in the study will consist of:

- Four rounds of web-based Google surveys, each of which take approximately 10-20 minutes to complete, and
- One audio recorded individual interview conducted via Zoom (which will take approximately 45-60 minutes to complete)

Your participation in this study will last approximately 4-6 weeks. **Your participation is confidential and voluntary.**

If you are interested, please complete this short Participant Criteria Screening Form. If you meet the criteria to participate in the study, I will contact you directly to provide further information about the study, time commitment, and how the findings will be used. Additionally, I am asking you to share information about this study (including the Participant Criteria Screening Form) within your professional organizations for posting on their social media sites and website, in their newsletter, and through their listservs. The attached informational flyer provides some details regarding participant criteria. Participants will be compensated for participation in the study.

If you have any questions regarding this research and/or concerns about the study, you may contact the Virginia Commonwealth Institutional Review Board at XXX-XXX-XXXX or xxxx@vcu.edu. The IRB number for this study is HM20022809. Questions specific to the study may be directed to Shenita E. Williams at xxx@vcu.edu or Dr. Charol Shakeshaft (my dissertation advisor) at xxx@vcu.edu.Thank you! Please keep this letter for your records.

Respectfully,

Shenita E. Williams, LCSW

Appendix B: Email Recruitment Letter

Dear [insert name],

My name is Shenita E. Williams and I am a doctoral student in the School of Education at Virginia Commonwealth University. I am studying how school-based mental health systems can address the mental health needs of Black students.

The study is a part of my doctoral dissertation entitled *How School-Based Mental Health Systems Can Address and Meet the Unique Cultural Needs of Black Students Experiencing Mental Health Challenges.* More specifically, the study focuses on identifying challenges faced by Black students with mental health needs, identifying relevant cultural factors that school-based mental health practitioners should be aware of when providing mental health services in school to Black students, and the overall expectations of school-based mental health systems that support the mental health needs of Black students.

I am writing to ask if you would share/post information about my study (along with the Participant Criteria Screening Form) to your organizations social media sites and website, your newsletter, and through your listservs.

Participation in the study will last approximately 4-6 weeks and consists of:

- Four rounds of web-based Google surveys, each of which take approximately 10-20 minutes to complete, and
- One audio recorded individual interview conducted via Zoom (which will take approximately 45-60 minutes to complete)

Participation is confidential and voluntary.

The attached informational flyer provides some details regarding participant criteria. Participants will be compensated for participation in the study.

If you have any questions regarding this research and/or concerns about the study, you may contact the Virginia Commonwealth Institutional Review Board at XXX-XXX-XXXX orxxxx@vcu.edu. The IRB number for this study is HM20022809. Questions specific to the study may be directed to Shenita E. Williams at xxx@vcu.edu or Dr. Charol Shakeshaft (my dissertation advisor) at xxxx@vcu.edu.

Thank you! Please keep this letter for your records.

Respectfully,

Shenita E. Williams, LCSW

Appendix C: Recruitment Flier

How School-Based Mental Health Systems Can Address and Meet the Unique Cultural Needs of Black Students Experiencing Mental Health Challenges

Purpose of Study: To identify essential components of school-based mental health systems necessary for supporting the mental health needs of Black students. This study explores and seeks to identify and highlight compounding issues of race and culture faced by Black students experiencing mental health challenges.

Participants:

- young adults (18-23)
- caregivers
- school-based mental health practitioners (SBMH)
- research scholars

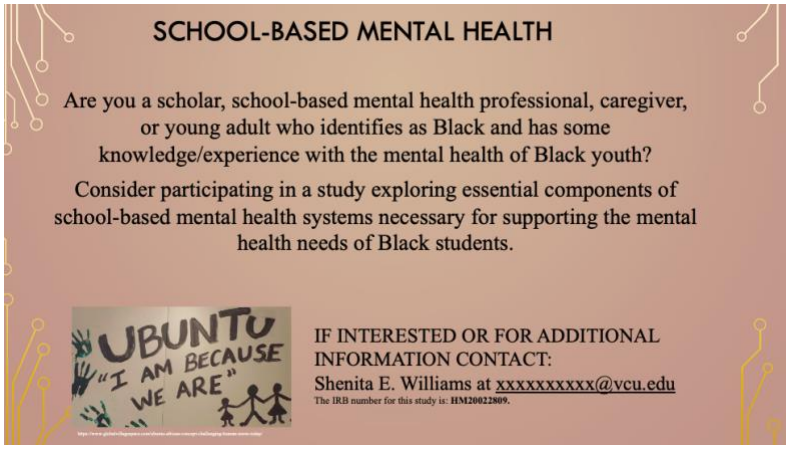
Participant Criteria:

- identifies as Black or African-American
- experience/knowledge of the mental health needs of Black adolescents
- attends (or attended) a public school the metro-Richmond area
- SBMH practitioners who work (or worked) in a public school metro-Richmond area
- Participant Criteria Screening Form

Participation is confidential and voluntary. You may withdraw from the study at any time.

If you have any questions regarding this research and/or concerns about the study, you may contact the Virginia Commonwealth Institutional Review Board at XXX-XXX-XXXX or xxxx@vcu.edu. The IRB number for this study is: HM20022809.

Questions specific to the study may be directed to Shenita E. Williams at xxx@vcu.edu or Dr. Charol Shakeshaft (my dissertation advisor) at xxx@vcu.edu.



Appendix D: Participant Screening Form

Hello and thank you for taking the time to complete this screening form. The purpose of this study is to identify key elements of school-based mental health systems that support the mental health needs of Black students.

This study is interested in the opinions of Black caregivers, young adults, school-based mental health professionals, and research scholars who have some experience and understanding of the mental health needs of Black students. Your identity and responses are confidential. No one other than the researcher for the study will know who you are or how you responded to questions. Participants will be compensated for participation in the study.

In this study, you will be asked to do the following things:

Participate in four (4) weekly surveys using Google forms and one (1) individual interview. Each survey takes about 10-20 minutes to complete. The individual interview will take approximately 45-60 minutes. The total time for the study is approximately 4-6 weeks.

*metro-Richmond includes Richmond, Henrico, Goochland, Hanover, Chesterfield, New Kent, Petersburg, Colonial Heights, Caroline County.

Please complete each of the questions below.

* Required

1. Email *

2. I identify as Black or African-American. * *Mark only one oval.*

Yes *Skip to question 3*
No *Skip to section 8 (Thank you for completing the form.)*

Which statement below describes you best.

3. * *Mark only one oval.*

-I am a caregiver of a child (under the age of 24) who is/was enrolled in public school in metro-Richmond and who currently (or previously) presented with a mental health need.

- I am between the ages of 18 and 23 and I attended a public school in the metro-Richmond area. I experienced some mental health challenges during that time.

- I am a school-based mental health practitioner. (school social worker, school psychologist, school counselor, behavior interventionist) with three years of experience in a public school setting. My work as a SBMH practitioner involves direct mental health supports and services to

Black students. I am currently employed or have been employed by a public school division in the metro-Richmond region within the last five years.

-I am a research scholar with published literature (within the past 10 years) focused on the mental health needs of Black children and adolescents, challenges with compounding issues of race and culture on mental health, and an understanding of the implications of these challenges within a public school setting. *Skip to question 4*

None of these statements describe me.

Skip to section 8 (Thank you for completing the form.)

4. I have access to a computer or smartphone device and Wi-Fi access. * *Mark only one oval.*

Yes
No *Skip to section 8 (Thank you for completing the form.)*

Maybe

5. I am willing and available to participate in four weekly online surveys. Each survey takes approximately 10-20 minutes. * *Mark only one oval.*

Yes
No *Skip to section 8 (Thank you for completing the form.)*

Maybe

6. I am willing and available to participate in one individual interview. Interviews are held virtually and will take approximately 60 minutes. * *Mark only one oval.*

Yes
No *Skip to section 8 (Thank you for completing the form.)*

Maybe

7. If I meet the screening criteria, I would like to be contacted to participate in this study. * *Mark only one oval.*

Yes
No *Skip to section 8 (Thank you for completing the form.)*

Maybe

8. *(Thank you for completing the form.)* Based on your responses you do not meet the criteria necessary to participate in this study. If you have any questions please contact Shenita E. Williams at xxx@vcu.edu.

(Thank you for completing the form.) Based on our responses you meet the criteria necessary to participate in the study. Please provide your contact information below and someone will be in touch with you within 72 hours.

Contact Information

Provide your first name and last name. *

Provide your contact information--telephone and email address. *

Appendix E: Research Participant Information and Consent Form

STUDY TITLE: How School-Based Mental Health Systems Can Address and Meet the Unique Cultural Needs of Black Students Experiencing Mental Health Challenges

VCU INVESTIGATOR:
Charol Shakeshaft, PhD
xxx@vcu.edu
XXX-XXX-XXXX

AN OVERVIEW OF THE STUDY AND KEY INFORMATION

Why is this study being done?
The purpose of this research study is to identify essential elements of school-based mental health systems for Black students who have mental health challenges. The findings from this study will help schools establish and employ culturally sensitive practices that recognize and support the unique challenges that impact Black students experiencing mental health issues.

In this study, you will be asked to complete 4 web-based surveys and participate in 1 individual interview, for a total of 5 rounds. Each survey will take approximately 10-20 minutes to complete. Individual interviews will take approximately 60 minutes. In the first round you will be asked to give your opinion on student mental health, the mental health needs of Black students, and relevant cultural factors important to supporting the mental health needs of Black students. In the second round, you will verify that your responses to each question. In the third round, you will choose responses that you believe to be most important. In the fourth round, you will rank each list in order of importance. In the fifth round, you will participate in an individual interview. Interviews will be audio recorded for accuracy in capturing all responses. Names will not be recorded. All individual responses are confidential to other participants. The researcher will be the only one to know how you responded.

Your participation in this study will last up to 4-6 weeks. Approximately 12-16 individuals will participate in this study. Your participation is voluntary and you can stop participation in this research study at any time.

What are the benefits of being in the study?
There is no guarantee that you will receive any benefits from being in this study. However, possible benefits include increased awareness of school-based mental health practices and increasing your awareness of the needs of Black students who experience mental health. We hope the information learned from this study will provide more information about the mental health needs of Black students and effective and adequate ways to support these students within school-based mental health systems.

What are the risks of participating?
It is highly unlikely that you will experience risks from participating in the study though participants may become uncomfortable sharing their perspectives or opinions on mental health and the mental health needs of Black students. There are minimal data risks, such as loss of

confidentiality and privacy. You do not have to disclose any information that makes you uncomfortable. The goal of this research is to build consensus among participants. Therefore, answering all questions for the web-based portion (the first four rounds conducted via Google forms, does not allow for skipped questions. However, in this phase of data collection participants are not asked personal information regarding their own mental health. They are providing their opinions on features of school mental health systems. In phase II of data collection (individual interviews) participants will be allowed to skip questions of the semi-structured interview or stop the interview at any time.

WILL I BE PAID TO PARTICIPATE IN THE STUDY?
You will be paid $25 by gift card if you complete all surveys and interview. If you withdraw before the end of the study or do not complete each web-based survey and interview, you will not receive any compensation. You will not receive a gift card for partially completed participation.

HOW WILL INFORMATION ABOUT ME BE PROTECTED?
Potentially identifiable information about you will consist of interview notes and recordings. Data is being collected only for research purposes. Your data will be identified by pseudonyms and your email address will be connected with the data, not names, and stored separately from interview transcriptions in a locked research area. All personal identifying information will be kept in password protected files and these files will be deleted within five years. Recordings will be destroyed once the data is analyzed and the dissertation is successfully written. Access to all data will be limited to study personnel.

In general, we will not give you any individual results from the study. Once the study has been completed, we will send you a summary of all the results of the study and what they mean. We will not tell anyone the answers you give us; however, information from the study may be looked at or copied for research or legal purposes by Virginia Commonwealth University. Again, unless you tell us otherwise, what we find from this study may be presented at meetings or published in papers, but your name will not ever be used in these presentations or papers.

The interview will be audio taped, but no names will be recorded. At the beginning of the interview, you will be asked pseudonyms so that no names are recorded. All data will be destroyed as soon as the researcher has finished analyzing the data and successfully published materials from it. In the future, identifiers might be removed from the information and samples you provide in this study, and after that removal, the information/samples could be used for other research studies by this study team or another researcher without asking you for additional consent.

WHOM SHOULD I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY?
The investigator and study staff named below are the best person(s) to contact if you have any questions, complaints, or concerns about your participation in this research:

Dr. Charol Shakeshaft at xxx@vcu.edu or XXX-XXX-XXXX and/or
Shenita E. Williams at xxx@vcu.edu or XXX-XXX-XXXX

If you have general questions about your rights as a participant in this or any other research, or if you wish to discuss problems, concerns, or questions, to obtain information, or to offer input about research, you may contact:

Virginia Commonwealth University Office of Research
800 East Leigh Street, Suite 3000, Box 980568, Richmond, VA 23298 (804) 827-2157;
https://research.vcu.edu/human-research/

Please retain a copy of this Participant Information Sheet for your records.

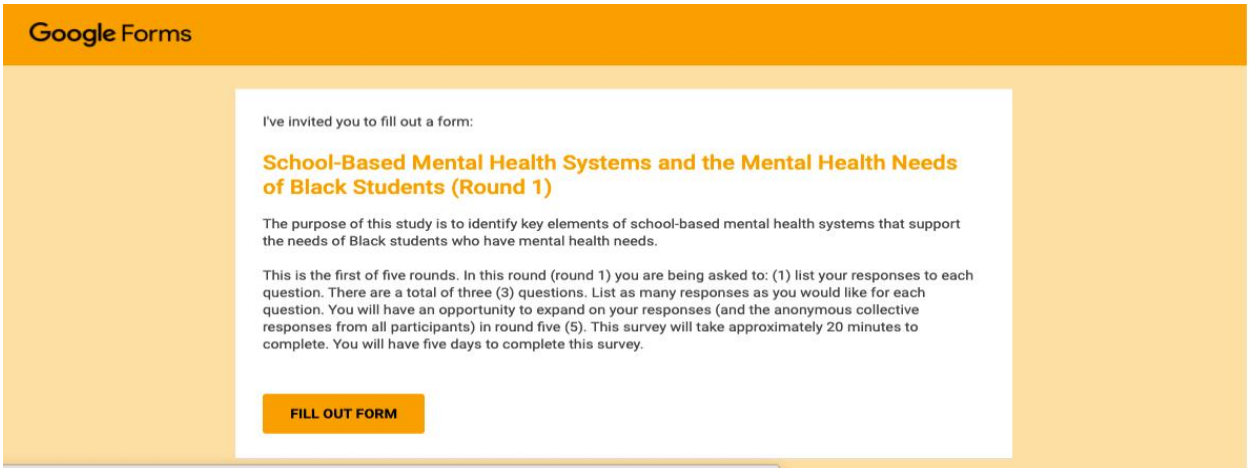
Appendix F: Welcome Email

Dear [Prospective Participant],

Thank you for your interest and willingness to participate in this study! The purpose of this study is to identify essential components of school-based mental health systems that are necessary for supporting the mental health needs of Black students. Because of your knowledge and experience with mental health, specifically with Black students, your opinions in this study are highly regarded. You will be asked to:

1. Give your opinions to questions about the mental health needs of Black students, culturally relevant factors that school-based mental health practitioners should know or be aware of, and what should be expected from school-based mental health systems, and
2. Participate in an individual interview.

This study has five rounds. The first four rounds are web-based. This means that you will receive an email invitation to complete the rounds using Google forms. Below is an example of what you will receive for each round:



The Google form will be used to record and submit your responses. You will have approximately five days to complete each survey. The individual interview will be scheduled at a time convenient for you and will take approximately 45-60 minutes. Your participation in this study will last approximately 4-6 weeks. Participants will be compensated for participation in the study. The consent form is attached for you to review.

If you have any questions regarding your rights as a participant in this research and/or concerns about the study, or if you feel under any pressure to enroll or to continue to participate in this study, you may contact the Virginia Commonwealth Institutional Review Board (which is a group of people who review the research studies to protect participants' rights) at 804-827-2157 or ORSP@vcu.edu. The IRB number for this study is: HM20022809.

Questions specific to the study may be directed to Shenita E. Williams at xxxxxxxxxxx@vcu.edu or Dr. Charol Shakeshaft (my dissertation advisor) at xxxxxxxxxxx@vcu.edu.

Thank you again for participating. Please keep this letter for your records.

Shenita E. Williams, LCSW

Appendix G: Explanation of Participation

The purpose of this study is to identify key elements of school-based mental health systems that support the needs of Black students who have mental health needs. This study uses a process that collects the expert opinions of its study participants (approximately 12-16 participants) to address school mental health and Black students. Each participants responses are anonymous to other participants.

In this study, you will be asked to do the following things:

1. Give your opinion to questions about the mental health needs of Black students, culturally relevant factors that school-based mental health practitioners should know or be aware of, and what should be expected from school-based mental health systems.
2. Participate in an individual interview.

There are five total rounds. The first four rounds are web-based. Google forms are used to submit and record responses. Participants have five days to complete each survey, which takes approximately 10-20 minutes to complete. The fifth round is an individual interview conducted via Zoom. Your participation in this study will last approximately 4-6 weeks.

Round One: There are a total of three (3) questions. Please list as many responses as you would like to each question. You will have an opportunity to expand on your responses in round five.

Round Two: Verify that your initial responses to each prompt are included in the comprehensive list of generated responses.

Round Three: Choose which responses you believe are most important.

Round Four: Rank items in order of importance, from most important to least important.

Round Five: Schedule an individual interview with the researcher.

Contact Shenita E. Williams for questions: xxx@vcu.edu

Appendix H: School-Based Mental Health Systems and the Mental Health Needs of Black Students (Round 1)

Thank you again for agreeing to participate in this research study. As you know, the purpose of this study is to identify key elements of school-based mental health systems that support the mental health needs of Black students.

This study has five total rounds. Here is a brief outline of each round: Explanation of participation (hyperlink will be inserted).

This is the first of five rounds. In this round (round 1) you are being asked to: (1) list your responses to each question. There are a total of three (3) questions. List as many responses as you would like for each question. You will have an opportunity to expand on your responses (and the anonymous collective responses from all participants) in round five (5). This survey will take approximately 20 minutes to complete. You will have five days to complete this survey.

* Required

1. Email *

2. Question 1: Please list the challenges faced by Black students with mental health needs. *

3. Question 2: Please list factors specific to Black culture that school-based mental health practitioners should be aware of and consider when working with Black students who have mental health needs. *

4. Question 3: Please list your expectations of school-based mental health systems as it relates to Black students. *

Appendix I: Interview Questions

Hello, my name is Shenita Williams. Thank you again for participation in this study thus far.

This fifth and final round will allow you an opportunity to share your reflections on the final compiled lists: the mental health needs of Black students, the cultural factors essential to the delivery of mental health services within the school setting, and your overall opinion on the expectations of school-based mental health systems. This interview will last approximately 60 minutes. Your responses are confidential and your identity is protected. With your permission, I will audio record (through Zoom) our conversation and have the interview transcribed to ensure all the details you share will be accurate. What questions do you have before we begin?

1. How would you describe your experience as a (researcher, caregiver, adolescent, SBMH professional) as it relates to the mental health of Black students?

a. What is your role? (for professionals)
2. As an important part of this research, how would you rate your level of expertise in the

following areas (scale 1-10): the experiences of Blacks students with mental health needs, school-based mental health.

a. Can you elaborate on how you decided on those ratings?
3. What has been your direct/indirect experience with school mental health systems?

Needs and Challenges

4. In your opinion, what are the emotional, mental, and physical needs of Black students with MH challenges?

5. In your opinion, what do Black students with mental health challenges need to feel supported?

a. On what do you base that opinion?
6. In your opinion, what challenges do Black students with mental health needs encounter?

a. What are some external/internal factors that contribute to these challenges [that you have identified]?

Race and Cultural factors

1. What is your experience of race and/or culture as it relates to (impacts) the mental health needs of Black students in school settings?
    0. What might be the best way to educate staff about experiences such as these?
    1. How can (these experiences) be addressed effectively?
2. In your opinion, what do you think school-based (SB) professionals need to include in

their work with Black students who have mental health challenges?

a. What professional supports do SB professionals need in order to be able to

effectively meet the mental health needs of Black students?

Expectations of SBMH systems

9. What are your expectations of school-based mental health systems as it relates to Black students? What do you hope for?

Elements of a school-based mental health system that recognizes the cultural uniqueness of Black students.

10. In your opinion, what are some necessary functions (responsibilities) of a school MH system?

1. What would you like to see school mental health systems include in their design? implementation? evaluation?
2. As we moved from round 2 to round 3 what were your thoughts about the responses that were collectively decided as "important?" (Participants will be provided a list of responses)

a. Were there items that you identified as important that did not make the final list? 13. As we moved from round 3 to round 4 what were your thoughts about how the responses

were ranked in order of importance? (Participants will be provided a list of responses) a. How did this list compare to your list? Thoughts?

Closing

14. What additional feedback would you like to give regarding school-based mental health and the mental health needs of Black students that I may not have asked?

Vita

Shenita E. Williams is a social worker with over 25 years of experience. She is a three-time alum of Virginia Commonwealth University. As a licensed clinical social worker, she has worked with diverse groups of people (e.g., race, ethnicity, gender, age, religion) in various settings (e.g., private practice, nonprofit community-based agencies, for-profit community-based agencies, and public schools). Shenita has coauthored the following publications: *Supporting Student Mental Health During and After Covid-19*, *The Mental Health Impacts of COVID-19 on PK–12 Students: A Systematic Review of Emerging Literature*, *and School Segregation by Boundary Line in Virginia: Scope, Significance and State Policy Solutions*.