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Solano Community College Student Health Center: A Case Study to Evaluate How the Mental Health Service Should Evolve

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Submitted by

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Abstract

The top ten impediments to learning, reported by students, include seven mental health concerns (Westheimer et al, 2008). When students are connected early to support and treatment, most mental health problems can be successfully managed, with symptoms reduced or eliminated (Campus Mental Health Action Planning [CampusMHAP] www.jedfoundation.org). Coupling this understanding, with the fact that improving mental health services has been a longstanding goal for the Solano Community College Student Health Center, a public-nonprofit partnership between the college and a local nonprofit agency commenced in January of 2012, the spring semester. The purpose of this study is threefold as it seeks to: determine if students are satisfied that a therapist is available, on campus in the Student Health Center; ascertain the students' opinion of whether these services help students to remain in school; and obtain qualitative information regarding students' vision of "excellent" mental health service.

Student satisfaction data and recommendations for improvement were obtained via survey. Key informant interviews were also conducted. Results of this study may inform the partnership regarding students' perception of quality service. It may also inform policy pertaining to campus-based mental health services.

Author Note

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Acknowledgement and thanks are extended to Noel Robinson and to Regina Huerls-Washington for their mentorship and support in the Student Health Center. Nurse Robinson's astute community acumen and persistence brought the realization of professional mental health service within the Student Health Center to fruition. It is an honor to support this achievement with this study. Acknowledgement and thanks are also extended to Solano Community College District's Student Services Dean Erin Vines and to Student Development Director Mostafa Ghous both of whom supported the idea of mental health service in the Student Health Center from the beginning.

Chapter 1 - Introduction

The purpose of this study is threefold as it seeks to: determine if students/non-student stakeholders are satisfied that a therapist is available, on campus in the Student Health Center; ascertain the students'/non-student stakeholders' opinion of whether these services help students to remain in school; and obtain qualitative information regarding students'/non-student stakeholders' visions of "excellent" mental health service. Obtaining student input for the mental health service within the Student Health Center on the Fairfield campus of Solano Community College in Fairfield California, is the prime objective of this research. It also seeks input from non-student stakeholders.

The key research question asks: Are students/non-student stakeholders satisfied that a therapist is available in the Student Health Center providing mental health service, on campus, to eligible students 4-5 hours per week? The secondary question asks: Do students/non-student stakeholders feel that, a therapist providing mental health service, on campus, in the Student Health Center helps students to remain in school? The tertiary question asks: What is included in students'/non-student stakeholders' visions of "excellent" mental health service?

There are also two sub-questions within this research. The first asks: May the Four-Branch Model of Emotional Intelligence be utilized to design a tool for screening, referral, and monitoring, based upon how respondents express themselves in the qualitative data collected? The second sub-question asks: Do New Public Service-Management/Governance principles (Public Administration) and the Four-Branch Model of Emotional Intelligence (Psychology) demonstrate congruence with Self-Care deficit Nursing Theory (Nursing)? Subsequently, may

they inform the design of a nursing system of care focusing on mental health within the public administration context of the Solano Community College Student Health Center?

The Solano Community College (SCC) Student Health Center (SHC) is a Public Health Nurse (PHN) managed center in Solano County California. The PHNs and Health Assistant (HA) are assigned to the college via a public-public collaborative partnership between the Solano Community College District and the Solano County Health and Social Services (H&SS) Public Health Division (PHD).

The Public Health Division's vision statement is "Healthy People-Healthy Community" (H&SS PHD 2011-2015 Strategic Plan DRAFT as of Jul, p. 2). Its mission statement reads: "To optimize the community through individual and population-based services which promote health and safety through prevention and treatment of disease and injury" (H&SS PHD 2011-2015 Strategic Plan DRAFT as of Jul, p. 2). Mental health is one such service.

Integrating mental health into primary care is a global public health initiative supported in the Affordable Care Act of 2010. Closer to home, Californians passed the Mental Health Services Act of 2004 which is essentially a tax supporting improvements in mental health services. Therefore, mental health and its integration into primary care are also of great import for the Public Health Division. The Student Health Center may be considered primary care in that; it is for many students the initial and often the only point of contact with the health care system.

Westheimer et al (2008) indicate that the top ten impediments to learning, reported by students, include seven mental health concerns. In the spring of 2010, fourteen of California's Community Colleges (CCC) participated in the American College Health Association National

College Health Assessment II (ACHANCHA II) (Health Service Association California Community Colleges [HSACCC] Perelli, 2011). A total of 11,386 Community College students were represented; 52.7% were female, 41.6% male, and 0.3% transgender. The average age of respondents was 24.2 years with a little over one fourth (26%) older than 24 years old. 30.5% were enrolled part-time, 64.4% lived with a parent or guardian, and 61.7 worked hours for pay (Perelli, 2011). The top ten factors impacting academic performance reported by California Community College students included: stress; work; sleep difficulties; cold/flu/sore throat; anxiety; depression; internet/computer games; relationship difficulties; finances; and concern for friends and/or family members (Perelli, 2011).

The ACHANCHA II also queries students regarding their mental health experience within the last twelve months. Percentage-wise, the spring 2010 findings for California Community College students fell into two categories when compared to national findings. The first category consists of mental health experiences falling below the national percentage and were as follows: 72.8% of CCC students reported feeling overwhelmed by all they had to do; 69% reported feeling exhausted (not from physical activity); 57.3% reported feeling very sad; 50.7% were very lonely; and 43.7% felt overwhelming anxiety. Mental health experiences standing above the national percentage include: 48.4% felt things were hopeless; 43.3% felt overwhelming anger; 33.9% felt so depressed that it was difficult to function; 8.2% seriously considered suicide; 7.2% intentionally cut, burned, bruised, or otherwise injured themselves; and 2.6% attempted suicide (Perelli, 2011; ACHANCHA II Spring, 2010).

When students are connected early to support and treatment, most mental health problems can be successfully managed, with symptoms reduced or eliminated (CampusMHAP www.jedfoundation.org). Coupling this understanding, with the fact that improving mental

health services has been a longstanding goal for the center a public-nonprofit partnership between the college and a local nonprofit agency commenced in January of 2012, the spring semester.

The Student Health Center, via this partnership, is furnished with a Marriage Family Therapist intern (MFTI) two days per week for three hours on one day and two hours on another. Eligible students may access mental health services either on-campus in the Student Health Center or at an off campus site operated by the nonprofit agency. The nonprofit provides up to ten counseling sessions for each eligible student at no cost. It also provides referrals for ineligible students. The non-profit agency has access to a psychiatrist for refilling/generating psychotropic medication prescriptions. Finally, the MFTI/nonprofit offers mental health first aid training to students, staff, and faculty. This service had operated for about three months, at the time of this study.

The MFTI/nonprofit is co-located within the Student Health Center. The center supplies the space, campus advertising, and referrals direct and/or via fax to the nonprofit. However, patient records and what transpires between the MFTI and the student is not shared with the Student Health Center hence maintaining confidentiality. Given this arrangement, PHNs are unable to monitor/gauge the therapeutic benefits of the service to students directly by reviewing the patient record.

Protecting the citizens' right to a confidential medical record is in keeping with "the policy intention of creating individualized, responsive, and citizen-centered public services" (Ferlie, 2007, p. 160). But, the PHNs running/managing the center retain a professional/managerial responsibility to establish a mechanism for evaluating both students'

need for MFTI/therapy services and the effectiveness of said services. Therefore, moving forward with the mental health service must entail developing or otherwise securing a measurement mechanism/tool for screening, referral, and monitoring service effectiveness.

Hence, the discussion of the conceptual frameworks guiding this research and the evolution of a mental health service within the Student Health Center will address their focus on community/citizen involvement, strategic planning, and accountability. This discussion occurs in the Chapter 2 Literature Review.

Chapter 2 - Literature Review

Conceptual and Theoretical Frameworks/Models

This literature review commences with an overview of the conceptual and theoretical frameworks/models utilized in this study. Leedy and Ormrod (2013) indicate that, "a theory is an organized body of concepts and principles intended to explain a particular phenomenon" (p. 20). Three broad conceptual/theoretical frameworks are employed in this enquiry. The first is public administration and some of its theoretical underpinnings. Next, there is a brief presentation of emotional intelligence comprised of a selected model and two theories. Finally, the nursing theory of choice for this research is depicted. The review continues with an examination of topics relevant to the investigation at hand.

Public Administration and Selected Theoretical Underpinnings

Public administration is the management of human capital and other resources in the attainment of state purposes (Shafritz & Hyde, 2008, p. 50). Public administration's objective is largely the efficient utilization of public resources (p. 51). In short, executing the public business with the goal of achieving expeditious, economical, and comprehensive programs/services is public administration (p. 51). Synonyms for public administration include public management and public service.

Historically, public professionals have demonstrated allegiance to an ethos of public service and its associated administrative values. This allegiance has proven to be a critical factor when delivering public services and programs (Rayner, Williams, Lawton, & Allinson, 2010).

Hood & Jackson (1991) divides these administrative values into three clusters/categories/families (in Shafritz & Hyde, 2008). The first, the "sigma" cluster of values correlates to economy and parsimony (p. 500). The second category is termed "theta". The theta category addresses honesty and fairness (p. 500). Finally, the "lambda" family is concerned with security and resilience.

These value clusters are reflected in the Warner and Hefetz (2008) discussion of mixed public-private service delivery. However, the values are mirrored via the public administration paradigms of New Public Management, transaction cost economics, and New Public Service. New Public Management stresses the significance of competition and efficiency (p. 155); consistent with sigma values. New Public Service allots foremost attention to citizen engagement; corresponding with theta values. Lastly, transaction cost economics focusing on contract management, is compatible with the lambda value set.

Transactional cost economics forms the theoretical framework for privatization and contracting out as related to public sourcing determinations (Hefetz & Warner, 2011, p. 291). Administrative costs and the costs of contracting are usually the transactions under consideration (p. 291). Public, mixed, and private comprise the sourcing options continuum (p. 291). It is advised that sourcing decisions emanate from a service-quality perspective contemplating service characteristics. One service characteristic to consider is the level of specific physical infrastructure and technical expertise required (p. 292). Another is the difficulty in contract specification and monitoring (p. 292).

Complete privatization/outsourcing of public services has fallen out of favor for a number of reasons. However, public-public/intergovernmental and mixed/public-private service contracts are public sector staples. Both are evident in the Student Health Center.

The Student Health Center is a public-public/intergovernmental collaborative effort between the Solano Community College District and the Solano County Health and Social Services Public Health Division. Consequently, it resides at the intersection of two traditional Weberian bureaucratic organizational structures. Although, the Student Health Center derives from two large bureaucratic, well-integrated vertical multi-divisional or M-form public organization governance models (Ferlie, 2007), as an operating unit, its internal governance model is more consistent with the network or N form of governance (p. 158).

Decentralization to operating units, flattened organizational hierarchies, restricted head office roles, and more elaborate lateral communication networks are core features of the N governance form (p. 158). Within the public sector this network governance form is deployed to cope with concerns/service delivery which crosses functional boundaries (p. 158). For example, given the concern of providing campus-based health-related services to students, the Community College District possesses the facilities and a sustainable income source via fees but did not possess the health care staff or the health care infrastructure to support such a staff. However, the Public Health Division possesses both the staff and the infrastructure.

Network or N governance brings with it a focus upon the “experience of users of public services, as seen from their own eyes” (p. 159). Hence, the public organization’s interaction with clients stands front and center with a normative commitment to helping the weak or weakened (p. 159).

Public-public/intergovernmental contracting stimulates cooperative competition in the markets for public goods (Hefetz & Warner, 2011, p. 292). The absence of competition leads to the vanquishing of cost savings. Hefetz and Warner (2011) continue saying, "intergovernmental contracting ensures the benefits of scale economies while still allowing local governments to retain public control and local identity in service delivery" (Anas 1999; Morgan & England, 1988; Parks & Oakerson, 1993 [in Hefetz & Warner, 2011, p. 292])

Mixed/ public-private delivery otherwise known as joint contracting is also evident within the Student Health Center with respect to the arrangement for the Mental Health Service. Warner and Hefetz (2008) favor the term "mixed delivery" indicating that it acknowledges the public sector's abiding presence in the delivery process. Originally, the inherent redundancy of mixed delivery resulting in cost effectiveness was its primary virtue (p. 155). However, the lived experience of local governments has highlighted the confines of quasi-markets (Lowery, 1998), the significance of transaction costs (Brown & Potoski, 2003; Sclar, 2000), and the core need for citizen engagement in the service delivery process (Hefetz & Warner, 2007; deLeon & Denhardt, 2000; Frug, 1999 [in Warner & Hefetz, 2008, p. 155]).

The Four-Branch Model of Emotional Intelligence (EI) and EI Theory

Mental health expressed in terms of the emotional intelligence construct/concept is the focus of this study. Edwardson (2007) indicates that using conceptual frameworks/models specific to their clinical milieu reflects the unshakeable clinical focus of nurse researchers to understand the context and correlates of care for patients with specific health problems (p.4).

Mental health may be defined as "a state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in

society, and meet ordinary demands of everyday life" (http://www.thefreedictionary.com/mental+health). The terms mental health and emotional health are viewed as synonyms in this study. The Student Health Center mission statement commits to facilitating "emotional" health in ways that promote achievement of academic goals. Therefore the mission may be construed as positing emotional health/mental health, in terms of emotional intelligence (EI).

Mayer and Salovey (1997) advance the Four-Branch Model of Emotional Intelligence (in Mayer, Salovey, & Caruso, 2008). A model serves as a simple explanation of the relationship between selected elements within the model (O'Sullivan, Rassel, & Berner, 2008). The model is described as follows:

> Emotional abilities can be thought of as falling along a continuum from those that are relatively lower level, in the sense of carrying out fundamental, discrete psychological functions, to those that are more developmentally complex and operate in the service of personal self-management and goals. Crucial among lower level, fundamental skills is the capacity to perceive emotions accurately. Higher level skills include, for example, the capacity to manage emotions properly. These skills can be arranged in a rough hierarchy of four branches (these branches refer to a treelike diagram; Mayer & Salovey, 1997). These include the abilities to (a) perceive emotions in one-self and others accurately, (b) use emotions to facilitate thinking, (c) understand emotions, emotional language, and the signals conveyed by emotions, and (d) manage emotions so as to attain specific goals (Mayer, Salovey, & Caruso, 2008).

There are presently two major theoretical perspectives on the nature of EI. One is referred to as ability-based and the other as trait-based (Parker, Keefer, & Wood, 2011). The ability-based line of thought conceives EI as an array of "emotion-related" cognitive skills lodged with positive aspects of cognitive intelligence (Mayer, Caruso, & Salovey, 1999; Mayer, Salovey, & Caruso, 2008). Maximum-performance tests are undertaken in the measurement of ability-based EI as with other mental abilities. Individuals are asked to solve problems involving reasoning about emotions and using emotional information to facilitate reasoning (Parker, Keefer, & Wood, 2011).

The trait-based visage casts EI as an assortment of emotion-related temperaments, attitudes, and self-perceptions situated in the subordinate echelons of the hierarchical personality taxonomy (Petrides & Furnham, 2001; Petrides, Pita, & Kakkinaki, 2007). Self-report questionnaires are the tool of choice for measuring trait-based EI. Respondents are asked to report on their typical beliefs, feelings, and behaviors (Parker, Keefer, & Wood, 2011). The same is true for other personality variables.

Emotional intelligence concerns the ability to understand, to reason about, and use emotions and emotional knowledge to enhance thought and action (Mayer, Roberts, & Barsade, 2008). The four branch model (Salovey & Grewal, 2005) advances that EI encompasses four subcomponents constituting two primary domains (Ford & Tamir, 2012). The components within the experiential domain are the perception of emotion and the integration of emotion into thought. EI's strategic domain also contains two components, understanding emotion and managing emotion (Ford & Tamir, 2012). EI is associated with greater mental health and well-being (Austin, Saklofske, & Egan, 2005) and more pleasant emotional experiences over time (Schutte, Malouff, Simunek, McKenley, & Hollander, 2002).

Emotional intelligence is a construct rooted in the discipline of Psychology. Network or N governance, contract management, and mixed service delivery are concepts deriving from the discipline of Public Administration. Each concept is relevant with respect to developing the mental health service within the Public Health Nurse run/managed Student Health Center. As such, the intent is to deploy them within a nursing context despite the fact that they originate outside of the Nursing discipline. They are therefore borrowed constructs co-opted for nursing purposes.

Villarruel et al (2001) posit that, regarding borrowed theories, concepts/constructs, and models, questions arise as to their adequacy as empirical descriptors, explainers, or predictors of nursing phenomena (p. 158). Nurses effect positive changes in clients'/persons' health via interventions identified by nursing conceptual models (p. 160). Subsequently, the litmus test for a borrowed theory, model, or concept is a pre-existing nursing theory/framework.

The Self-Care Deficit Nursing Theory (SCDNT)

Dorothea Orem's Self-Care Deficit Nursing Theory (SCDNT) serves as the conceptual/theoretical framework for this study. Villarruel et al (2001) indicate that, "the linkage of a nursing conceptual model and a borrowed theory must first take into consideration the logical congruence of worldviews that undergird the conceptual model and the theory" (p. 160). Before exploring these linkages a description of Self-Care Deficit Nursing Theory is in order.

Orem (2001) postulates that persons in society requiring nursing, persons producing nursing, the relationship between them, and the process structures utilized to produce nursing comprise nursing practice and nursing science (Banfield, 2011). Self-Care Deficit Nursing

Theory is a general theory providing a descriptive explanation of the human requirements for nursing and the processes entailed in constructing the requisite care (p. 42).

Self-care, self-care agency, therapeutic self-care demand, self-care deficit, nursing agency, and nursing system are the principle concepts associated with Self-Care Deficit Nursing Theory (p. 42). The concept of nursing agency affords the link between nursing science and nursing practice within this paradigm (p. 42).

Self-care denotes deliberate actions a person executes to promote life, health, and well-being (p. 42). The objectives met via self-care are deemed self-care requisites (p. 42). There are three types of self-care requisites: universal, developmental, and health deviation (p. 42). Therapeutic self-care demand symbolizes "a calculation of all of the self-care requisites that a person is experiencing at a particular time and the means through which these requisites can be met" (p. 42). Self-care agency is the ability or power of a person to engage in self-care (p. 42).

A self-care deficit exists when self-care demand exceeds a person's self-care agency (p. 43). The presence of a health-related self-care deficit is an indication for nursing (p.43). "A nursing system refers to the system designed and produced to meet the person's therapeutic self-care demand and regulate the development and exercise of the person's self-care agency" (p. 43). "The design and production of the nursing system is the result of the exercise by nurses of their nursing agency" (p. 43).

Therapeutic self-care demand and self-care agency are viewed as patient variables, while nursing agency is considered a nurse variable (p. 43). These three quantitatively and qualitatively variable concepts embody powers and properties of either the patient or nurse at any given point in time (p. 43; Orem, 1997 [in Banfield, 2011]). Age, gender, health state, and resource

availability are termed basic conditioning factors (p. 43). These basic conditioning factors stipulate or influence the values of the patient variables and the nurse variable at any given point in time (p. 43).

The Theoretical and Conceptual Linkages/Triangulations

This triangulation seeks to demonstrate congruence between Self-Care Deficit Nursing Theory, an existent conceptual framework from the Nursing discipline, and selected constructs/models from the disciplines of Public Administration and Psychology. Establishing congruence relies upon the use of direct quotes from Orem's work in an effort to retain her purity of thought/meaning. It is hoped that the current researcher's train of thought/line of reasoning regarding a given matter are conveyed via the arrangement/ordering/discussion of the selected quotes from Orem's work within the context of this study/review.

The impetus of this triangulation originates from a course of study in Public Administration. It is only fitting that overarching principles of Public Administration serve as its starting block. Seven principles may be associated with New Public Management-Service/Governance (Denhardt & Denhardt, 2000, 2003; Ingraham & Rosenbloom, 1989 [in Vandenbeele & Hondeghem, 2011]). The principles are delineated as follows: serve, rather than steer; seek the public interest; think strategically, act democratically; serve citizens not customers; value citizenship and public service above entrepreneurship; value people, not just productivity; and, accountability is not simple (p. 3).

The spirit of these seven principles may be summed up as community focus/involvement, strategic planning, and accountability. Subsequently, the congruencies between the theoretical/conceptual frameworks/models of public administration, the Four-Branch Model of

Emotional Intelligence, and Dorothea Orem's Self-Care Deficit Nursing Theory are discussed in terms of these three foci.

Community Focus/Involvement. Self-Care Deficit Nursing Theory/Orem (2001) defines the term community as "a group sharing common characteristics or interests based in the inter-subjective spontaneity of group members and an intelligently devised social order and perceived or perceiving itself as distinct in some respect from the larger society in which it exists" (p. 515). The evolution of the mental health service on a Community College Campus is the focus of this study.

Orem (2001) indicates that, "service connotes action and implies that the results of action or work are beneficial to individuals or groups or whole communities" (p. 70). After giving a nod to the importance of the quality of services, New Public Service targets citizens not customers as service beneficiaries. Community building and support, via its multifaceted roles, is the collective occupation of a democratic citizenry. Government's role is to exert an enabling influence upon this endeavor (Vandenbeele & Hondeghem, 2011, p. 43). Orem (2001) explicitly cites community development, group processes, political processes, and communication as strategies for meeting the self-care demands/facilitating the self-care agency of community members (p. 418).

A community focus is also visible in the Four-Branch Model of Emotional intelligence. The branch described as the ability to "perceive emotions in one-self and others accurately" (Mayer, Salovey, & Caruso, 2008) conveys a community focus by requiring one to consider "others". Orem (2001) states, "care and concern for others is an element of human love, mature love…" and that, "mature love with its element of care and concern for others develops and is

expressed when individuals live in or seek communion with one another in fundamental unity as persons in community" (p. 30).

Self-Care Deficit Nursing Theory (Orem, 2001) explains that a conditioning factor is "a circumstance or a qualitative or quantitative feature of a factor(s) in a situation of action that affects the values or the operability of other situational factors" (p. 515). In a discussion of community as a conditioning factor Orem states that,

> When the goal of nursing is to alter the conditioning effect of community variables on the person variables of self-care agency and therapeutic self-care demand, the community becomes a multi-person unit of service. The self-care systems of single persons and of individuals as members of the multi-person units making up the community and community variables become interacting components. The nurse in such situations must be able to think about populations, conceptualizing the components of therapeutic self-care demand pertinent to members of the population, evaluating the development and effectiveness of self-care agency of community members, and relating the conditioning effects of community variables to significant components of the therapeutic self-care demand and the production of self-care (p. 417).

The introduction of mental health service within the Student Health center may be considered a conditioning factor/community variable. It is anticipated that this mental health service undertaking will exert an influence on the campus community's therapeutic self-care demand and its production of self-care. Orem advises an inter-disciplinary/multi-disciplinary approach (p. 417), for instance, one involving public administration, psychology, and nursing with respect to

this type of endeavor. Thus evidence suggests that, these borrowed paradigms demonstrate congruence with Self-Care Deficit Nursing Theory regarding its focus on community.

The expectation of dynamic discourse inherent in each of these theories is reflective of self-care agency. According to Self-Care Deficit Nursing Theory, self-care agency is the "complex acquired ability of mature and maturing persons to know and meet their continuing requirements for deliberate, purposive action to regulate their functioning and development" (Orem, 2001, p. 522). Within the community context these actions may take the form of citizens' ongoing participation in opportunities to provide input regarding the development and/or evaluation of services, as well as, the government's ongoing actions to obtain such input. This discourse or give-and-take between government and community/citizens is unlikely to occur in the absence of a predetermined, structured plan/strategy.

Strategic Planning. Public policy has played a key role in introducing mental health service into the Student Health Center. Vandenbeele and Hondeghem (2011) indicate that, the public administration policy implementation process, "should be a collective effort (for example, a network) with the community" (p. 3). It should be an interaction to create a lasting responsiveness of the government towards the community (p. 3).

Contracts form the fulcra of community network construction within the Public Service paradigm. Orem (2001) defines a contract as "a promissory agreement about specific matters between two or more competent parties creating a mutuality of agreements and obligations expressed in ascertainable terms" (p. 515).

Redundancy via mixed delivery/contracting is a governmental/public administrative means of creating a "lasting responsiveness" or a fail-safe mechanism in terms of community

services. This approach is invaluable in the event of contract failure. Through the strategy of mixed delivery, government retains its capacity to deliver a service, hence fulfilling its goal of responding to community needs (Warner & Hefetz, 2008).

The Self-Care Deficit Nursing Theory advances that, "the nurse-patient relationship is contractual in nature" (Orem, 2001, p. 88),

> This means that the functions and responsibilities of nurses are necessarily limited to matters within the domain of nursing, that the help sought is for a limited time, and that nurses are remunerated (directly or indirectly) for the help provided (p. 88). There should be an initial agreement between the nurse and the nurse's patient or between the nurse and those responsible for the patient's affairs about the general characteristics of the nursing required and the nursing to be provided (p. 88).
>
> When nurses are employees of health care institutions, such as public health organizations, hospitals, or nursing homes with which patients have contracted for care directly or through their insurance company, there should be a second, preferably explicit, verbal agreement between the nurse and each patient or individuals acting for the patient about the nurse's willingness to provide nursing and the patient's willingness to receive nursing from the assigned nurse (p. 89). Agreements to provide nursing to individuals, families, or groups bind nurses to the provision of nursing in accord with objective nursing requirements (p. 89).

The use of mixed/joint contracts for network construction represents public administration's commitment to providing citizens with uninterrupted service. Self-Care Deficit Nursing Theory expresses a similar sentiment in terms of the nurse-patient relationship. Orem

(2001) describes the nurse-patient relationship as “complementary” (p. 99). She continues saying,

> Complementary is used in the sense that the production of nursing care by nurses’ and patients’ participation in care produces a ‘whole system of action’ to achieve the human regulatory purposes expressed by patients’ calculated therapeutic self-care demands. The emphasis here is on the interpersonal cooperative action of nurses and patients to produce organized systems of action in time and over time to know and meet the self-care requisites of patients including selection of ways and means for meeting them. When nurses’ patients are unable to cooperate or participate because of their physical or psychic conditions, nurses must produce whole systems of required care, making up for patients’ total to near total incapacities for voluntary action (p. 99).

Hence, the nurse-patient relationship is both contractual and redundant. It also requires a strategy.

A strategy is a plan of action or policy designed to achieve an overall or major goal (www.google.com). In short, strategizing involves thinking, planning, or managing for goal achievement. The Four-Branch Model of Emotional Intelligence acknowledges the role of emotions in facilitating thought and goal attainment (Mayer, Salovey, & Caruso, 2008). Not infrequently, policy is the consequence of an emotional response arising from the government and/or from the community. Thus, the emotional response may function as a “trigger” upon the policy agenda generating the policy underpinning the nursing service and/or nursing care needed during the implementation process. Strategic plans incorporated into contracts

operationalize/benchmark public policy goals and objectives throughout the policy implementation process.

Strategic planning within Self-Care Deficit Nursing Theory, for the purposes of this study, is best exemplified via the concepts of nursing design and nursing systems. Orem (2001) describes nursing design as follows,

> A professional function performed both before and after nursing diagnosis and prescription through which nurses, on the basis of reflective practical judgments about existent conditions, synthesize concrete situational elements into orderly relations to structure operational units. The purpose of nursing design is to provide guides for achieving needed and foreseen results in the production of nursing toward the achievement of nursing goals; the units taken together constitute the pattern to guide the production of nursing (p. 518).

She defines nursing system as, "series and sequences of deliberate practical actions of nurses performed at times in coordination with actions of their patients' to know and meet components of their patients' therapeutic self-care demands and to protect and regulate the exercise or development of patients' self-care agency" (p. 519). Taylor (1988) summarizes the dynamics of nursing design and nursing system as follows,

> Design is a creative process and is reflective of the state of development of the nursing art. Through a deliberate planning process, the nurse can develop a projected design. The actual design of the nursing system emerges as nurses and patients interact and engage in action to achieve results over time (p. 113).

Subsequently, the co-opted frameworks demonstrate congruence with Self-Care Deficit Nursing Theory regarding the use of contracts and strategic planning. Congruence is also evident as each deploys redundancy as a fail-safe mechanism ensuring continuous service delivery. Utilizing fail-safe devices hearken to the Public Administration value of accountability.

Accountability. Public administrators' knowing that their work is "consistent with the public's wishes" (Denhardt & Denhardt, 2001, p. 393) is the crux of accountability. New Public service, in addition to compelling adherence to the law, requires that public servants embrace "community values, political norms, professional standards, and citizen interests" (p. 393) within the purview of accountability. The government must espouse standards of accountability when monitoring network dynamics to safeguard that "principles of democracy and social equity" (p. 292) are upheld among, between, and within networks (p. 292).

Accountability is akin to prudence. Self-Care Deficit Nursing Theory defines prudence as, "the habit that disposes persons to make right choices and decisions about what to do in concrete life situations in which relevant conditions may be extensive and complex" (Orem, 2001, p. 512).

"Acting prudently may require acting in accord with what is just. It involves acting with courage and with moderation, in control of one's instincts and desires (p. 11). The proper interest of prudence is morality; the goodness of individual human actions in concrete situations of daily living" (p. 293).

"Nursing prudence is the quality of nurses that enables them (1) to seek and take counsel in new or difficult nursing situations, (2) to make correct judgments about what to do and what to avoid when particular conditions prevail or suddenly develop in nursing situations, (3) to decide

to act in a particular way, (4) to take action" (p. 293). "Nursing prudence is concerned with doing this or that act at particular moments in light of one's knowledge of the situation" (p. 294).

One is now inclined to inquire as to the relationship between accountability, prudence, and emotional intelligence. This relationship may manifest via the connection between emotional intelligence, mental health, and well-being. Emotional intelligence is associated with greater mental health and well-being (Austin, Saklofske, & Eagan, 2005). Orem and Vardiman (1995) indicate that, "All things being equal, [personal maturity] positive mental health of individuals affects what persons seek to know, what they will question, the roles they are willing or unwilling to take, and what they seek to learn and do for themselves and others" (p. 166 [in Orem, 2001, p. 383]). Orem (2001) defines well-being as, "a perceived condition of personal existence including persons' experiences of contentment, pleasure, and kinds of happiness, as well as spiritual experiences, movement to fulfill one's self-ideal, and continuing personal development" (p. 524).

All-in-all accountability and prudence share a kinship. However given the definitions of mental health and well-being, one must question if it is possible to exercise either accountability or prudence in the absence of emotional intelligence. So, for the purpose of the research at hand public administration, the Four-Branch Model of Emotional Intelligence, and the Self-Care Deficit Nursing Theory are presumed to exhibit congruence regarding the concept of accountability.

The preceding discussion establishes the "logical congruence of worldviews" (Villarruel et al (2001, p. 160) foundational to Public Administration, the Four-Branch Model of Emotional Intelligence, and Self-Care Deficit Nursing Theory. Given this congruence, it is acceptable that

the theory of New Public Management-Service/Governance and the Four-Branch Model of Emotional Intelligence inform the design of a nursing system of care as defined within Self-Care Deficit Nursing Theory.

This study seeks to design a nursing system of care for delivering mental/emotional health services on a community college campus. The remainder of this literature review explores selected topics relevant to that design.

A Review of Literature Regarding Relevant Topics

Emotional Intelligence

Ford and Tamir (2012) tested the link between EI and preferences for emotions in contexts where they may or may not be useful. The instrumental approach to emotion regulation (Tamir, 2009) speculates that a variety of reasons inspire people to indulge in emotions. Instrumental emotion regulation is manifest in persons preferring useful emotions within a given context irrespective of their degree of pleasantness (Ford & Tamir, 2012).

Goal achievement exacts a hedonistic bounty in terms of EI when unpleasant emotions are useful or pleasant emotions are not useful (Ford & Tamir, 2012). Ford and Tamir (2012) found that preferring useful emotions such as anger when pursuing confrontational goals or happiness when pursuing collaborative goals was associated with higher EI. On the other hand, preferring emotions that are not useful, such as anger when pursuing a collaborative goal or happiness when pursuing a confrontational goal, was associated with lower EI. These findings also held true when controlling for trait emotions (trait-anger & trait-happiness) and cognitive intelligence (Ford & Tamir, 2012).

Subsequently, being higher in EI predisposes an individual to use emotions in a manner facilitating personal goal achievement. Thereby, instrumental emotion regulation promotes goal attainment and improves task performance (Tamir & Ford, in press; Tamir et al, 2008).

Côte, Gyurak, and Levenson (2010), in the laboratory setting, measured how the ability to regulate emotional expressive behavior via emotion regulation strategies is associated with real-world criteria. The associations revealed that persons who can best modify their emotional expressive behavior have the highest well-being, disposable income, and socioeconomic status (Côte et al., 2010).

Firstly, these findings support the view that the association between the ability to regulate emotions and the criteria, is positive not negative. Second, this study demonstrates that objective measurement of an individual's ability to implement a strategy is critical for fully assessing that person's general ability to regulate emotions (Côte et al, 2010). Finally, these findings provide direct evidence that an important emotional ability, the ability to implement regulation of the behavioral signs of emotion, is associated with socioeconomic criteria (Côte et al, 2010).

Emotional intelligence (EI), recognition and management of emotions (Goleman, 2001) is essential in a nursing context, in terms of "breaking bad news, building rapport, and leadership" (Taylor-Moss, 2005) [in Davies et al, 2009]. Nurses enter homes as guests, routinely challenged by emotionally charged situations (Taylor-Moss, 2005 [in Davies et al, 2009]).

"Critical reflection promotes improving practice rationally, yet practice involves the non-rational emotional dimension" (Davies et al, 2009). EI differentiates exceptional and average practitioner abilities (Freshwater & Stickley, 2004 [in Davies et al, 2009]). A requisite for home nursing is a self-aware, empathetic practitioner equipped to manage her own and others'

emotions (Davies et al, 2009). Cognizance of emotional dimensions is important for quality care provision (McQueen, 2004) necessitating more than addressing technical skills (Davies, 2005) [in Davies et al, 2009]. The presence of EI in the nursing literature brings with it the promise of enhancing care, teamwork, and well-being (Davies et al, 2009).

Public Health nursing is riveted with complex and emotional issues however little research has explored the value of EI in Public Health nursing in particular (Davies et al, 2009). With respect to nursing, Davies et al (2009) highlights the following points stating that EI: 1) is a prerequisite for enabling technical and caring aspects of practice to be delivered comprehensively; 2) supplements assessment processes, providing more comprehensive appreciations that best inform care interventions; is of particular relevance to palliative care contexts; and 4) requires, and is sustained via supportive, educative formal dialogue and supervision.

In summary, the ever-increasing and multifaceted demands of public health/community nursing practice require technical proficiency and up-to-date awareness in Public Health Nurses (PHN) (Davies et al, 2009). However, these same ever-increasing and multifaceted demands also require a concomitant consciousness of and capacity for candid engagement with patients, caregivers, and colleagues (Davies et al, 2009).

Chapman and Hayslip (2006) broached the question of mid-life differentiation of EI dimensions raised by Schaie (2001). On the basis of the basic continuity of emotional systems, they hypothesized that the empirically derived factor structure of a self-report measure of EI in young adults would be replicable in mid-life adults. They also set out to investigate mean differences emerging along EI domains expecting that mid-life adults would report better mood

regulation, particularly to the extent that a dimension taps optimism (Chapman & Hayslip, 2006). Findings demonstrated that, both age groups were characterized by the same set of comparably related dimensions. However, mid-life adults reported significantly greater use of optimism as a mood-regulation strategy than was reported by young adults (Chapman & Hayslip, 2006).

The conceptual coverage of brief instruments for the emotional intelligence construct is limited (Parker, Keefer, & Wood, 2011). The Brief Emotional Intelligence Scale is promising.

Brief History of Mental Health in the College Setting

Kraft (2009) outlines the history of college mental health. He indicates that, "Mens sana en corpore sano" translated as "a healthy mind in a healthy body", a Roman ideal served as the paradigm for the first college service established at Amherst College in 1861 (p. 267). However, the first dedicated mental health service for students hails from Princeton University in 1910. Other schools launched similar services between 1914 and 1925. Nonetheless, a resource shortage of psychiatrists, psychologists, and psychiatric social workers committed to the emotional development of college students postponed institution of mental health services on many campuses; despite the fact that most then extant campus-based mental health services were founded by psychiatrists.

The importance of "mental hygiene" was recognized by the American College Health Association (ACHA) in 1920 and its Mental Health Section commenced in 1957. A strategy/definition for campus-based mental health and counseling services was devised between 1920 and 1960. A combination of psychologists, psychiatric social workers, and psychiatrists formed the most common staffing matrix.

A rapid expansion of campus-based mental health services occurred from the 1960s through the 1970s. Kraft (2009) reports that towards the close of the twentieth century "the use of brief psychotherapies, prevention and treatment of drug and alcohol abuse, prevention of suicide and homicide, the use of psychotropic medications, and effective campus interventions" (p. 267) were under consideration.

Kraft (2011) takes another look at the history of college mental health. He begins by tracing the evolution of psychotherapeutic therapies. He then reviews the chronology of college mental health in two fifty year time segments. The first covers 1910 to 1960. The second deals with the years of 1960 to 2010. A discussion of mental health organizations is presented. The article concludes with a review of the recent history and current status of college mental health.

Students' Knowledge of and Use of Mental Health Service on Campus

Yorgason, Linville, & Zitzman (2008) explore four questions: 1) What factors are related to students' knowledge of university mental health services? 2) What factors are related to students' use of university mental health services? 3) How do knowledge and use of university mental health services vary for students of different ethnic groups and for international students? And, 4) What relationship exists between mental health, knowledge of mental health services, and use of those services? Their findings indicate that, overall mentally distressed students were more likely to be aware of and utilize services. Yet, a sub-group although mentally distressed and knowledgeable regarding the availability of mental health services did not access them. Less knowledge of campus mental health services was associated with living off campus, male gender, and fewer years in college. Predictors of higher service use included female gender and higher number of years in college. Yorgason, Linville, & Zitzman (2008) concluded that, "With

the high prevalence rates and severity of mental health problems, university mental health providers must continue to make strategic efforts to disseminate knowledge about mental health services to all students" (p. 173).

Help-Seeking Behavior of College Students

Hunt and Eisenberg (2010) reviewed the research literature regarding college student mental health comparing it to "parallel literature on the broader adolescent and young adult populations" (p. 3). Their areas of interest consisted of: 1) the current state of mental health in the college student population; 2) risk factors among college students; 3) the apparent worsening in recent years of mental health in this population, and potential explanations for this trend; and 4) the extent to which students with mental health problems are receiving treatment (p. 3). Finally, practices and policies directed towards mental health and help-seeking on college campuses is discussed. The authors also put forth potential opportunities for improvement.

Downs and Eisenberg (2012) investigate how attitudes, beliefs, and social network factors relate to help-seeking among suicidal students. They begin by tendering two questions. The first asks, "What are the help-seeking attitudes, social network factors, and treatment use among suicidal college students?" The second queries, "How are these factors associated with treatment use among suicidal students?" (p. 105).

Regarding barriers to help-seeking behaviors, findings show that nearly three-fourths of suicidal students report preferring to handle their concerns independently. A denial of need is a second barrier. Perceptions such as "Stress is normal in college", "I question how serious my needs are", and "The problem will get better by itself" pose additional barriers.

Findings also reveal the multidimensionality of the help-seeking process. Factors involved are both interpersonal and contextual. Positive correlates of treatment use are need, beliefs about treatment effectiveness, contact with service users, and unexpectedly "perceived stigma". Negative correlates of treatment use are personal stigma and access to warm and trusting relationships.

Recommendations include a public health approach to suicide prevention; employment of a range of strategies aimed at various domains of the campus "social ecology" to encourage help-seeking by a diversity of students and to heighten the helping capacities of persons comprising students' social networks (p. 112).

Eisenberg, Hunt, Speer, and Zivin (2011) set out to depict a contemporary, exhaustive picture of service utilization and help-seeking behavior for mental health problems among United States college students. Their picture arises from a nationwide, twenty-six campus survey conducted in 2007 and 2009 seeking to answer four research questions. The questions addressed are as follows: 1) To what extent do students utilize various types of mental health services? 2) How does service utilization vary by sex, race/ethnicity, and other student characteristics? 3) How does service utilization vary across campuses and across types of campuses (defined by size, public/private status, and academic rank)? And, 4) What factors seem to explain why many students with mental health problems do not receive treatment?

Findings denoted that, just over one-third of the randomized sample had received "any treatment" in the preceding year. Psychotherapy and medication use demonstrated a virtually equivalent prevalence. However, treatment prevalence varied widely across campuses, with some campuses having prevalence rates double to triple that of others. Identified barriers to

help-seeking activities were skepticism revolving around treatment effectiveness and an absence of perceived urgency. Summarily, the findings reveal that help-seeking for mental health fluctuates significantly amidst student characteristics and amongst campuses. The study advises that, strategies addressing the low treatment prevalence must be responsive to this diversity.

Vader, Walters, Roudsari, and Nguyen (2011) endeavored to identify predictors of use of health information sources in U.S. college students. Their findings indicated that health center medical staff, health educators, faculty or coursework, and parents comprise the four most believable sources of health information for students. Considering their perceived believability, health center staff, health educators, and faculty were underutilized by students. However, parents were both believed and utilized frequently.

Older students, females, full-time students, and African-American and Hispanic students were more likely to access information from one of these four sources although, there was substantial subgroup variability, particularly in the use of parents as a source of health information. Vader et al (2011) advise that their results can assist colleges with designing more effective health education campaigns.

Resilience, Mental Health, and Academic Persistence

Hartley (2011) looked at undergraduate college students to examine relationships between resilience, mental health, and academic persistence. One research hypothesis is that, the interpersonal and intrapersonal resilience variables would positively contribute to explaining variance in the response variables. In other words, the resilience variables would accompany higher grade point averages (GPA) and a greater sense of belonging. The other hypothesis proposes that, some of these variables would serve as useful moderators for interpreting variance

in the response variables, "including the hypothesis that mental health and credits completed would moderate the relationship between resilience and response variables". For example, the resilience variables would be more important for students with lower mental health scores and fewer completed credits (p. 597).

Hartley (2011) distinguishes tenacity, tolerance of stress and negative emotions, positive acceptance of change, control, and spirituality as indicators of intrapersonal resilience; while categorizing social support as an indicator of interpersonal resilience. The intrapersonal resilience factors played a part in variance in cumulative GPA. Both types of resilience factors were inter-related and deemed important to academic persistence and health promotion at the college level. There was no significant interaction between mental health and resilience (p. 602).

Hartley (2011) admonishes, "rather than waiting for students to learn to cope with stress on their own, research needs to examine the impact of resilience interventions" (p. 602). He continues recommending that, "as part of the first-year experience, holistic transition curriculum can be used to help students develop coping resources" (p. 602).

Miller and MacIntosh (1999) investigated racial socialization, collective self-esteem, and ethnic identity as resiliency factors in adolescents in terms of academic achievement (in Greig, 2003, p. 328). Ethnic identity was positively associated with grade point average and demonstrated and inverse relationship with absenteeism in African-American students at risk of academic failure (p. 328). The cushioning or safeguarding effect of ethnic identity on academic achievement was also evident in the presence of a "high amount of daily hassles" (p. 328) reported by this population.

Student Ethno-Racial Diversity

Depression is associated with poor academic performance and factors into students' decision to drop out of college. Herman, Archambeau, Deliramich, Kim, Chiu, and Frueh (2011) survey an ethno-racially diverse sample of students largely comprised of Asian Americans, European Americans, Native Hawaiians, and Pacific Islanders to examine the prevalence of depressive symptoms and the utilization of mental health treatment.

Findings present no significant intergroup difference in levels of depressive symptoms. Nearly three-fourths of students with high levels of depressive symptoms denied obtaining/receiving mental health treatment within a twelve month period. European Americans were almost four times more likely to report having obtained/received mental health treatment within a twelve month period than other students. In concluding, Herman et al suggest increasing outreach efforts with the goal of improving utilization of mental health services by depressed college students, particularly by members of ethno-racial minority groups.

Masuda, Anderson, and Sheehan (2009) examine mindfulness, psychological flexibility, and self-concealment as relating to mental health in African American college students. The mindfulness construct is viewed in a number of ways including as a technological method, a psychological process, as being dispositional, and/or as being trait-like to name a few. Mindfulness as a process, is the developing of an "awareness that is inherently present focused, ongoing, nonjudgmental, and flexible as opposed to being excessively entangled with verbal evaluations and conceptualizations" (Brown, Ryan, & Creswell, 2007 [in Masuda et al, 2009]).

Hayes, Luoma, Bond, Masuda, and Lillis (2006) define psychological flexibility as "the ability to contact the present moment fully as a conscious human being, and to change or persist

in behavior when doing so serves valued ends" (p. 7 [in Masuda et al., 2009, p. 115-116]). Psychological flexibility is inversely associated with a broad range of psychological and behavioral concerns such as depressive symptoms, anxiety, non-specific psychological distress, and emotional distress in stressful interpersonal situations to name a few (Masuda et al, 2009, p. 116). Mindfulness is also inversely affiliated with a variety of negative psychological outcomes encompassing responses to specific situations such as emotional distress in stressful interpersonal and emergency situations, to stable traits, like rumination, and from specific symptoms of depression and anxiety to nonspecific psychological symptoms (p. 116).

Mindfulness and/or psychological flexibility in general, within acceptance-based treatment approaches, are viewed as principle means for realizing psychological health (Hayes et al., 2006 [in Masuda et al., 2009, p. 116]). Examining theoretical constructs and their relation to psychological health in ethno-racially diverse populations is important. It is particularly important in the African American population due to persistent bias leading to "misdiagnosis and misunderstanding" (A Report of the Surgeon General, 2001 [in Masuda et al., 2009, p. 116]).

A penchant for withholding "distressing and potentially embarrassing information from others" is termed self-concealment (Larson & Chastain, 1990 [in Masuda et al., 2009, p. 117]). On one hand, self-concealment is positively linked to depression, anxiety, psychological distress, and global psychological symptoms (p. 117). On the other hand, self-concealment as a coping mechanism, may be a "deliberate attempt at down-regulating, fixing, avoiding, controlling, or suppressing unwanted private experiences" such as "negative feelings, judgmental thoughts, and personal secrets" but may ultimately, enigmatically result in greater emotional distress after a brief period of apparent effectiveness (p. 117).

The primary hypothesis for Masuda et al (2009) is that, “mindfulness and psychological flexibility will be positively related to each other and negatively related to psychological outcomes associated with poor mental health, including stress in interpersonal and emergency situations, and general psychological ill health” (p. 117). Secondarily, Masuda et al (2009) examine “whether mindfulness and psychological flexibility mediate the relationship between self-concealment and psychological distress” (p. 118).

The findings confirm mindfulness as “a significant predictor of mental health-related variables” and it also “mediated the relation between self-concealment and emotional distress in stressful interpersonal situations (full mediation) and general psychological ill health (partial mediation)” (p. 115). The researchers advise that mindfulness may prove instrumental in understanding mental health within African American college students (p. 115).

Greig (2003) examined mental health and ethnic identity development in adolescents and young adults via a review of the literature. She cautions that “choices adolescents make concerning their developing identities can have an impact on long-range mental health outcomes” (p. 319). The construct of ethnic identity is correlated with “positive aspects of mental and psychological functioning” (Phinney, 1992; Phinney & Chavira, 1992 [in Greig, 2003, p. 322]).

In terms of college students and high school students in the minority, ethnic identity and self-esteem exhibit a positive relationship (p. 322). This also held true for white students when they were the minority in a school setting (p. 322).

African-American and Hispanic young adults tracked longitudinally beginning in high school showed that “achieved” ethnic identity was positively linked to higher self-esteem both at

baseline and follow-up; and that self-esteem remained relatively constant as ethnic identity evolved developmentally (Phinney & Chavira, 1992 [in Greig, 2003]). In a large sample of adolescent students of Mexican-American, African-American, and European-American decent elevated levels of coping, "general mastery, self-esteem, and optimism" were correlated with ethnic identity (Roberts et al, 1999 [in Greig, 2003]).

Lower levels of self-destructive behavior in parallel with higher levels of inattentiveness and nervousness speak to the possible presence of vulnerable periods throughout ethnic identity development (Rotheram-Borus, 1989 [in Greig, 2003]). There is evidence suggesting that for African-American students ethnic identity is inversely related to depression and loneliness. However this relationship was not evident in Mexican-American adolescents (Roberts et al, 1999 [in Greig, 2003]).

"Racelessness" defined as "identification with mainstream European-American culture at the expense of racial identification" resulted in in increased levels of anxiety and depressive symptoms in African-American students (Arroyo & Zigler, 1995, p. 904 [in Greig, 2003, p. 325]). These findings allude to a potentially protective role for achieved ethnic identity relating to internalizing symptoms of mental health.

Drug use was lower, in the presence of known risk factors, in persons with higher ethnic identity levels. Ethnic identity was also protective against marijuana use in the presence of "social influence risk" and "social skills risk" (Scheier et al, 1997 [in Greig, 2003, p. 327]). However, in the presence of cognitive risk factors, high ethnic identity was associated with high alcohol use in African-American and Hispanic adolescents (p. 327). Ethnic identity measured via Spanish language preference, immigrant status, familism, and Hispanic awareness were found to

improve several known risk factors for substance abuse, enhance resiliency, and enhance other protective factors (Brook, Balka et al, 1998; Brook, Whiteman et al, 1998 [in Greig, 2003]). Overall, the literature communicated an "inverse relationship between ethnic identity and adverse mental health outcomes" (p. 328).

Anger, Suicidal Ideation, and Gender

Lee, Choi, Kim, Park, and Shin (2009) assessed gender differences in: 1) the level of suicidal ideations and anger; 2) predictors for suicidal ideation; and 3) the varying association between suicidal ideation and anger in adolescents living in South Korea aged 13 to 15 years old. They found that anger was a significant predictor of suicidal ideation in males, while school life satisfaction and anger were both significant predictors of suicidal ideation in females. Lee et al (2009) conclude that the gender-specific patterns of the relationship between suicidal ideation and anger and the existence of threshold points confirmed the need for targeted programs for suicide prevention focused on controlling for anger.

Alcohol Use, Brief Motivational Intervention, and Clinician Continuity

Short, Fernandez, Borsari, Hustad, and Wood (2011) investigated clinician continuity or in other words having the same versus a different clinician for Brief Motivational Interventions. Brief Motivational Intervention has been identified as an effective approach for reducing college student alcohol use and its associated negative consequences. Their results found no significant differences in alcohol use and associated consequences at follow-up between participants who had the same versus a different clinician. Therefore, Short et al (2011) conclude that clinician continuity across Brief Motivational Interventions for college students has no bearing on

participant satisfaction or intervention effectiveness, particularly if the clinicians abide by empirically supported techniques.

Intimate Partner Violence

Su, Hao, Huang, Xiao, and Tao (2011) investigated the incidence of "love affairs" and intimate partner violence in college students endeavoring to explore the relationship between intimate partner violence and other mental health risk behavior. Specifically, in terms of mental health they looked at intimate partner violence, depression, satisfaction with school life, self-esteem, suicidal psychology and behavior. They found that college students demonstrated high rates of sexual behavior with their intimate partners, but their self-protection awareness was low. Su et al (2011) concluded that the high prevalence of intimate partner violence among college students is an indication that attention must also be given to other mental health and risk behavior in adolescents pertaining to intimate partner violence.

Coker, Sanderson, Cantu, Huerta, and Fadden (2008) studied the prevalence of partner violence, by type, among Mexican-American college women. Their findings showed that partner violence was ubiquitous in this population, and that participants experienced numerous forms of violence. However, because few women experiencing physical violence report that violence is a problem in their relationship, interventions must address perceptions of violence and how it impacts women's mental and physical health in the college population.

Deliberate Self-Harm (DSH)

Mikolajczak, Petrides, and Hurry (2009) hypothesized that, "higher trait emotional intelligence (trait EI) would be associated with a lower likelihood to harm oneself, and that this relationship would be mediated by the choice of coping strategies" (p. 181). These authors set

out to explore the etiology of deliberate self-harm in terms of the role of dispositional factors in an adolescent population.

Choice of coping strategies was proven to partially mediate the relationship between trait emotional intelligence and self-harm. Emotional coping was an especially powerful mediator, leading the researchers to question if self-harm is utilized as a mechanism for decreasing "the negative emotions that are exacerbated by maladaptive coping strategies, such as rumination, self-blame, and helplessness" (p. 181). Adaptive coping actions correlated positively with trait emotional intelligence, while maladaptive coping behaviors and depression negatively correlated with trait emotional intelligence (p. 181). Resultant recommendations support the idea of "incorporating coping coaching programs" into the therapeutic options kit for treating patients with a history of and/or engaging in self-harm.

Ecological Influences on College Student Mental Health

Byrd and McKinney (2012) advanced that numerous factors working at the individual, interpersonal, and institutional levels are related to the mental health of college students, in general (p. 185). They explicate factors influencing student development and mental health, on the whole, utilizing an ecological approach.

Students' "physical, cognitive, and emotional health as well as intrapersonal functioning, including internal influences and internal capacities" (p. 186) define the individual level. Individual level factors also encompass skills, competencies, and academic adjustment to college. Students' ability to "function in the social environment, including their involvement in social activities and their satisfaction with various social and academic aspects of their college experience" (p. 186) comprise the interpersonal level. Institutional level factors consist of "the

educational setting, including the academic requirements and curricula, teaching practices, and the social and institutional climate" (p. 186).

Depression and perceived stress are influenced by individual level factors; with perceived stress correlating negatively with self-esteem (p. 186). This relationship translates into higher risk for depression, suicide, and poor health habits. Poor health habits, say binge drinking for example, are associated with poor academic performance as evidenced by lower grade point averages, missing classes, and falling behind in classwork (p. 186).

Interpersonal adjustment and social adjustment are requisite for psychological development and for the rigors of higher education (186). They are intrinsic necessities for students struggling with making the transition to college in the midst of feelings of "isolation, loneliness, and low levels of social support" (p. 186). An adequate support system is associated with facilitating or easing the transition to college for students who often find college more stressful than they had anticipated.

On an institutional level, Byrd and McKinney (2012), indicate that "these factors can become chronic stressors that negatively impact psychological (and physical) health (p. 186). The results of their study found that student mental health was related to individual and institutional factors in tandem. They specifically cite "limited coping abilities and a perceived racially tense campus climate" (p. 185) as key elements of psychological distress for college students (p. 185). Byrd and McKinney (2012) advise that, "Simultaneously addressing the individual and institutional level influences on mental health offers the most promising help for students" (p. 185).

Kury and Kury (2006) examined the interactions between collaborative partners who may have opposing aims when providing mental health services within the school setting (p. 164). They indicate that coordinating appropriate interventions may be hindered by established organizational norms involved in the collaboration.

Multidisciplinary professional involvement in the collaboration may also influence providing school-based mental health services. Kury and Kury (2006) acknowledge that the disciplinary norms, standards, expertise, definitions, and responsibilities guiding each profession may coalesce forming barriers to effectiveness and generating conflict within the collaboration (p. 164). They advise using a negotiation process to reconcile differing professional views and to identify/implement best practices.

Therapist-Client Interactions

Coppock, Owen, Zargarskas, and Schmidt (2010) examined therapy outcomes by looking at the relationship between clients' perceptions of hope and therapists' hope in their clients (p. 619). In terms of psychotherapeutic change, Wampold (2001) attributed 70% of the therapeutic effects to common factors such as alliance, hope, and empathy; 8% to "specific ingredients" including therapeutic techniques; and 22% had no identifiable justification (p. 619 [in Coppock et al, 2010]).

Seven client-specific change characteristics or precursors to change were identified by Hanna (2002) thy are as follows: 1) a sense of necessity or urgency for change to occur; 2) a willingness or readiness to experience anxiety or difficulty; 3) awareness of the existence of the problem and its symptoms; 4) confronting and addressing the problem; 5) effort or will towards change; 6) hope for change, identified as the client's ability to see the possibility for change and

the pathway to change; and 7) social support for change (p. 619 [in Coppock et a, 2010]). Hanna (2002) viewed hope as a catalyst for the aforementioned seven due to its ability to "attenuate anxiety, decrease apathy, and increase confidence to confront the problem" (p. 619).

Menninger (1959) viewed therapists' hope in their clients as "positive expectancy of goal attainment" (p. 620 [in Coppock et al, 2010]). Cheavens, Feldman, Woodward, and Snyder (2006) conceptualize it as "motivation and planning…necessary to attain goals" (p. 620). Additionally, therapists' hope in their clients is changeable, may be related to positive outcomes, and may impact clients both directly and indirectly (p. 620).

Coppock et al (2010) found that client-rated hope significantly increased after one therapy session; there was no significant relationship between therapy outcomes and client-rated hope; and no significant relationship between pre-therapy client-rated hope and first-session symptom change (p. 619). However, therapists' hope in their clients after the first and last sessions was significantly related to client outcomes (p. 619). Subsequently, Coppock et al, recommend that "therapists should be mindful about how their perceived hope in their clients may impact their clients' therapy outcomes" (p. 625).

Saunders (1999) investigated "clients' in-session experience of affective environment conceptualized as the clients' report of their own feelings combined with their perception of their therapists' feelings" (p. 603). "Generally speaking, clients rated session quality greater when they felt relatively less distressed and inhibited, when they perceived the therapist to be confidently involved and not distracted, and when they perceived mutual affection with the therapist" (p. 603). "Consistent with the generic model of psychotherapy (Orlinsky & Howard, 1987 [in Saunders, 1999, p. 603]), clients feeling remoralized (e.g., hopeful, relieved, confident)

rated session quality higher" (p. 603) "the model further predicts that the accumulation of such micro-outcomes predicts ultimate treatment success" (p. 603).

"The results suggest that therapy success depends on the client willingly implementing his or her respective role; that is, a successful client will not feel inhibited but will instead be open to the therapeutic process and that effective therapy is occurring when the therapist is perceived as confident and interested" (p. 603).

The findings also "suggested that early session affective experiences of the client are unrelated to treatment success when treatment is of fairly long duration. Explained outcome variance accounted for by the affect factor scores dropped from about 24% (for clients attending less than 9 sessions) to less than 1% (for clients attending more than 52 sessions)" (p. 603). The association between clients' affective experience during the session and treatment effectiveness was fairly strong for relatively brief therapy but insignificant for lengthy therapy.

Caskey, Barker, and Elliott (1984) compared clients' and therapists' perceptions of individual therapist responses. Their findings indicated that clients' and therapists' response-by-response reports of therapist intention were positively correlated, although average ratings of the session were not. They also found that their response-by-response ratings of impact were not concomitant, but their average ratings of helpfulness and affective impact were. Additional findings revealed that length of therapeutic relationship was not linked with client-therapist agreement; a surprising finding was that there was a trend toward lower agreement between client and therapist as the length of their association increased. Finally, client-therapist agreement was not predicted by therapist experience either.

Owen, Leach, Wampold, and Rodolfa (2011) studied therapist variations in clients' rating of their therapists' multicultural competencies and if therapists who were rated as demonstrating greater multicultural competencies also had better therapeutic outcomes (p. 1). Their findings indicated that therapists' level of multicultural competency did not explain the capriciousness of therapeutic outcomes that were attributed to them. Furthermore, their results posit that clients' race/ethnicity, therapists' race/ethnicity, or the interaction of clients'-therapists' race/ethnicity were not significantly associated with clients' perceptions of their therapists' multicultural competencies.

Ridley and Shaw-Ridley (2011) critiqued three major components of the research by Owen, Leach, Wampold, and Rodolfa (2011). The critiqued components included: the conceptual and methodological underpinnings; the interpretation of research findings; and the implications for future research. Despite the fact that, Ridley and Shaw-Ridley (2011) "believe that some of the researchers' underlying assumptions are worthy of examination" (p. 16). They also assert that, "alternate interpretations of the findings are possible, and several recommendations for future research are imperative" (p. 16).

Owen, Tao, Leach, and Rodolfa (2011) conducted a retrospective investigation regarding if clients' perceptions of their therapists' multicultural orientation were affiliated with psychological functioning, working alliance and real relationship scores. Their findings revealed that clients' perceptions of their therapists' multicultural orientation exhibited a positive relationship to working alliance, real relationship, and psychological functioning. Only clients' ratings of working alliance mediated the relationship between clients' perceptions of their therapists' multicultural orientation and psychological functioning. Therefore, if clients' perceive their therapists' as being more oriented toward cultural issues, they quite possibly may imbue the

therapist with a greater degree of credibility and this fact may facilitate the clients' sense of comfort during the therapeutic process. Subsequently, clients' strong alliance promotes improvement in psychological well-being.

Nasar and Devlin (2011) explored the notion that, in terms of counseling settings, softness, personalization, and order impact the perceived expertness, trustworthiness, and social attractiveness of the therapist with a sample of college students. Their findings exhibited strong correlations in respondents based upon if they had a prior history of therapy, their level in school, gender, major, and the location and size of the school. Additionally, the odds that one would select a given therapist based on his/her office improved with increases in the office's softness, personalization, and order as did students' perception s of quality of care, therapist boldness, and therapist qualifications. Finally, students' perceptions of friendliness also improved with increases in softness and personalization.

Chapter 3 - Research Methodology

A mixed-method design, also known as triangulation and/or synthesis, was utilized in this study in that both quantitative and qualitative data were collected simultaneously via survey and/or key informant interviews. Quantitative and qualitative data were weighed equally. Triangulation serves two functions (Silverman, 2000, 2001[in Williamson, 2005]). Triangulation's convergent function asserts that extracting data from a variety of contexts "allows a 'true' state of affairs to emerge, increasing the study's validity" (a quantitative focus) (p. 10). Triangulation's completeness function advances the notion of holism in terms of gaining a holistic view of the phenomenon under investigation thereby enhancing the depth and breadth of understanding (a qualitative focus) (Fielding & Fielding, 1986; Begley, 1996 [in Adami & Kiger, 2005, p. 21]).

One goal of this study based upon the completeness function, was that through triangulation of results a complete picture of students' and/or non-student stakeholders' attitudes and perceptions regarding mental health service within the Student Health Center as related to the study's research assumptions would emerge. Another goal based upon the convergent function, was that this current study would also lend credence for the future development of an instrument for screening, referral, and monitoring service effectiveness incorporating the four branch model of emotional intelligence.

The key assumption is: Students are satisfied that a therapist is available in the Student Health Center providing mental health service, on campus, to eligible students 4-5 hours per week. The dependent variable is: Students are satisfied that. The independent variable is: a

therapist is available in the Student Health Center providing mental health service, on campus, to eligible students 4-5 hours per week.

The secondary assumption is: Students feel that, a therapist providing mental health service, on campus, in the Student Health Center helps students to remain in school. The dependent variable is: Students feel that. The independent variable is: a therapist providing mental health service, on campus, in the Student Health Center helps students to remain in school.

The tertiary assumption is: Students have a vision of what "excellent" mental health services must include. The dependent variable is: Students have a vision of. The independent variable is: what "excellent" mental health service must include.

There are also two sub-assumptions in this study. The first sub-assumption states that: the Four-Branch Model of Emotional Intelligence may be utilized to design a tool for screening, referral, and monitoring, based upon how respondents express themselves in the qualitative data collected.

The second sub-assumption is as follows: New Public Service-Management/Governance principles (Public Administration) and the Four-Branch Model of Emotional Intelligence (Psychology) demonstrate congruence with Self-Care Deficit Nursing Theory (Nursing). Subsequently, they may inform the design of a Nursing System of care focusing on mental health within the Public Administration context of a community college campus?

Data Collection Plan Overview

The Survey

A five-item survey was developed by the researcher for data collection (Appendix A). The first three items addressed the research assumptions. Quantitative data were collected by the first two survey items pertinent to the primary and secondary assumptions using a Likert scale ranging from "Strongly Disagree" to "Strongly Agree." Qualitative data were also collected by these two items via providing an opportunity for respondents to explain their responses. The third item reflective of the tertiary assumption elicited qualitative data. The fourth item afforded an opportunity for the respondent to share information important to him/herself with the Student Health Center staff, this is also qualitative data. Finally, the fifth item requested respondent gender, age, and enrollment status; quantitative data. A key informant interview guide was also developed using these survey items sans the Likert scale and item number five. The survey was submitted to the college Director of Research and Planning for feedback and approval before distribution.

The survey was designed as a self-report instrument. Leedy and Ormrod (2013) indicate that self-report data may represent what respondents think they believe at a specific point in time (p. 190). It may also reflect the respondent's perception regarding what he/she believes the researcher wants to hear (p. 190), or it may constitute an intentional misrepresentation of the facts (p. 190). However, the fact that self-report data provides a current snapshot of the respondent's self-portrayal of his/her "typical beliefs, feelings, and behaviors" (Parker, Wood, &

Keefer, 2011, p. 763)at a particular point-in-time may prove highly valuable with college students given the ever changing nature of the college environment.

In some instances, the survey/key informant interview guide was emailed a week or more before the interview. Leedy and Ormrod (2013) admonish that outlining interview items in advance may result in limited or distorted information. They continue, advising that, survey research captures a fleeting moment in time. As such, it affords one an opportunity to extract conclusions from an ephemeral aggregate of data thereby allowing one to generalize about the state of affairs over an extended time frame (p. 190). Acknowledging this characteristic of survey research it is the researcher's intention to re-distribute this survey in the future at pre-determined intervals.

Population Sampling

The sampling design of this study utilized a combination of convenience sampling and purposeful sampling. This blended purposeful sampling approach enables triangulation and flexibility in accommodating the needs of various stakeholders (Suri, 2011).

Convenience sampling was based upon respondents being present in campus common-areas when the researcher or research designee was present soliciting survey participation. This decision was made based on the fact that the Guide to Campus Mental Health Action Planning (2011) indicates that students do not ask for help even when needing it; treatment eludes many depressed students; and most completed student suicide attempts were not connected to campus mental health service. This suggests that students who are not connected to mental health service may be in grave danger of negative consequences therefore convenience

sampling is appropriate in an effort to include and inform as many students as possible. Ethical considerations were also overtly explicit given these circumstances.

Although, convenience sampling may threaten external validity in terms of generalizability this is an exploratory study regarding a specific entity. Convenience sampling is appropriate in such instances to provide illustrative case material. Survey design and timeline are intended to protect internal validity. Data are analyzed using descriptive statistics.

Purposive sampling entails that participants are selected deliberately because their views are relevant to the issue under investigation (Ntui, 2012). The views of the students and non-student key informants represent vital input for developing a consumer-centered/responsive mental health service within the Student Health Center.

Discourse analysis and narrative analysis were the mechanisms for qualitative data analysis in this study. Ntui (2012) indicates that, discourse analysis "involves looking at language in its context, the idea being that particular communities, be they social, disciplinary, cultural or organizational, give language a distinct meaning to describe their experiences" (p. 49).

Ntui (2012) goes on stating that, narrative analysis examines texts, conversations and interviews as narratives describing participants' experiences presuming that these narratives are influenced and modified by social processes (p. 49).

The unit of analysis, in the context of this study, was thematic. Qualitative data discourses and narratives were analyzed for the emergence of key ideas, patterns, and themes. In terms of population sampling, the data derived by using these mechanisms of analyses inform the researcher regarding adequacy of the sample size via evidence of data saturation. Data saturation

may be associated with the stage when further collection of evidence provides little in terms of further themes, insights, perspectives or information (Suri, 2011). Purposeful data collection facilitates the odds of reaching data saturation for instance, "the more precise a question, the quicker it tends to reach data saturation" (p. 72). For the purpose of this study, survey item numbers 1 and 2 were constructed using thick description, a precision procedure.

Data sufficiency is another concept which may influence a researcher's perception regarding the adequacy of sample size. Two principles of data sufficiency in triangulation are that, the data should be sufficient affording comparisons among selected dimensions and constructs and there should be ample enough data to answer the research question (Patterson et al, 2001 [in Suri, 2011, p. 73]). Data sufficiency is a determination made by the researcher based upon his or her perception of what constitutes sufficient evidence for accomplishing the intended purpose of triangulation. Said evidence must also support any claims made by the researcher (Suri, 2011, p. 73).

A pilot study was conducted over a three day period to test the survey's appropriateness. During the pilot study students entering the Student Health Center between the hours of 8:00AM to 7:00PM Monday through Thursday and 8:00AM to 3:00PM on Fridays were informed of the purpose of the survey. Students professing a willingness to participate were given surveys to complete. Once the survey was finalized, this process was repeated to survey students inside of the Student Health Center.

Students who were on-campus, outside of the Student Health Center were surveyed by the researcher in-person in common areas of the Fairfield campus after obtaining their consent following an explanation of purpose. The common areas included were the cafeteria and the

lobby of Building 1400; the library, lobby, and hallway areas of Building 100; the computer lab hallway of Building 500; the bus stop/patio area between Buildings 500 and 600; the lobby areas of Building 400; and the day-care center in building 200.

Finally, opportunity to participate was extended to the entire population of enrolled students via Survey Monkey. The survey was input into Survey Monkey with a cover letter and emailed several times to all actively enrolled students during the spring semester of 2012. The survey was available for completion from May 10, 2012 to May 28, 2012. The results were downloaded by staff from Research and Planning.

The key and secondary assumptions, for the purposes of this study, were deemed supported if fifty-one percent or more respondents either “Strongly Agreed” or “Agreed” with survey items number one and/or two respectively. The tertiary assumption was considered supported in the presence of any and all responses to survey item number three.

Interviews with key informants were scheduled and conducted over a five week period. A key informant interview guide based upon the survey designed by the researcher was employed. Key informants were afforded the options of completing the interview guide by hand, on the computer, telephone interview, via face-to-face interviews, or through a combination of any of the above. Key informants and/or their designees were contacted via email and/or telephone. Some face-to-face interviews were tape recorded post obtaining interviewee consent.

Issues Regarding Validity

The Validity and Reliability of the Survey Instrument

A measurement instrument must possess both validity and reliability for its purpose (Leedy & Ormrod, 2013, p. 89). The validity of a measurement instrument is the extent to which the instrument measures what it is intended to measure (p. 89). The validity of a measurement instrument manifests in a variety of configurations, each of which is important in different situations. In other words, instrument validity is situation-specific. The survey designed for this study demonstrates face validity, criterion validity, and construct validity.

Face Validity. Survey item numbers 1, 2, and 3 each contain the phrase "mental health service." Therefore, on the surface this instrument appears focused upon measuring elements/characteristics relevant to mental health service. So, it demonstrates face validity.

Criterion Validity. Criterion validity is the extent to which the results of an assessment instrument correlate with another, ostensibly related measure (the latter measure is, in this case, the criterion) (p. 90). Survey instrument item number 1, correlates "providing mental health service" with the criterion of satisfaction. Survey item number 2 correlates "providing mental health service" with the criterion of "helps students to remain in school" also termed retention. There is evidence in the literature supporting positive correlations between campus-based mental health service and the criteria of satisfaction and retention. Subsequently, the survey exhibits criterion validity.

Construct Validity. Construct validity is the extent to which an instrument measures a characteristic that cannot be directly observed. However, the existence of said characteristic is presumptive based upon patterns in people's behavior (such a characteristic is a construct) (p. 90). "Satisfied"/satisfaction, "feel"/feeling and "vision" are constructs contained within the first three survey items. The fact that respondents replied to statements assessing these

underlying constructs as they relate to mental health is evidence that these items, do in fact, measure the aforementioned constructs. Subsequently, the survey also demonstrates construct validity.

Finally this survey instrument was submitted to the college Director of Research and Planning for approval prior to utilization. The survey was approved for implementation post minor modifications. Consequently, the survey was deemed to possess validity for its stated purpose via expert judgment. Now, let us examine the survey in terms of reliability.

Leedy and Ormrod (2013) define reliability as the consistency with which a measuring instrument generates a certain, consistent result when the entity under measurement remains unchanged (p. 91). The survey instrument developed for this study demonstrated four types of reliability.

Interrater Reliability. The degree to which two or more parties evaluating the identical product provide equivalent judgments is termed interrater reliability (p. 91). The survey was judged acceptable for its stated purpose by two faculty advisors and by the Director of Research and Planning of a local community college. This represents interrater reliability.

Test-retest Reliability. When a single instrument produces the same results for the same people on two different occasions it has demonstrated test-retest reliability (p. 91). The survey instrument demonstrated test-retest reliability in that it yielded the same results from persons from the same population on two or more different occasions. It also yielded the same results for individual persons on two different occasions.

Equivalent Forms Reliability. Equivalent forms reliability is the magnitude to which two different versions of the same instrument produce similar results. A key informant interview

guide was designed using item numbers 1, 2, 3, and 4 from the survey. The key informant interview guide delivered results analogous to those received from the survey, thereby demonstrating equivalent forms reliability.

Internal Consistency Reliability. When similar items within a single instrument produce similar results, internal consistency reliability has been established. The survey instrument also demonstrates internal consistency reliability.

The Validity of the Research Methodology

This aspect of validity refers to the validity of the research project in its entirety. It addresses "accuracy, meaningfulness, and credibility" (Leedy & Ormrod, 2013, p. 101). Issues of internal and external validity are grappled with by answering the following two questions: 1) Does the study have sufficient controls to ensure that the conclusions drawn are truly warranted by the data (p. 101)? This is a question of internal validity. And, 2) Can the results obtained reasonably be used to make generalizations about the world beyond hat specific research context (p. 101)? This is a question of external validity.

Internal Validity. Triangulation is one strategy employed by researchers to increase the probability that their explanations are the most likely ones for the observations they have made (p. 102). Triangulation requires that multiple sources of data are assembled with the hope that they will all converge to support a particular hypothesis or theory (p. 102). This approach is common in qualitative research where in-depth data is amassed then scrutinized for shared themes (p. 102).

The utilization of triangulation in mixed-methods designs it is not unconventional. The current study employs a mixed-methods design, in that, both quantitative and qualitative data are

accumulated in an effort to answer research questions and to support or refute research assumptions and/or proposed theories/theoretical approaches. Subsequently, triangulation is the mechanism-of-choice for safeguarding the internal validity of this research project.

External Validity. The external validity of a research study is the magnitude to which its results apply to situations beyond the study itself. Said another way, external validity is the degree to which the conclusions drawn from a study are generalizable to other contexts (Leedy & Ormrod, 2013, p. 103). Two strategies utilized to enhance the external validity of this research study are: a real-life setting and a representative sample (p. 103). Sample adequacy/representativeness was discussed previously. So, a discussion regarding the relevance of real-life setting in this study, in terms of nursing, follows here.

The current study seeks input for designing a mental health service within a nurse managed environment in the Student Health Center of a community college campus. Nursing is a practical and an applied science. Banfield (2011) indicates that, "Practical sciences are those sciences in which knowledge is developed for the sake of the work to be done" (p. 43). Nursing care seeks to generate currently non-existent conditions and/or events. Banfield (2011) goes on saying that, "Nursing practice situations are concrete, each takes place in a particular time and place. Each individual nursing situation is unique" (p. 43) subsequently, nursing science derives from applied research. Applied research conducted in real-life settings/environments enhances the external validity of the research. Enhanced external validity increases the probability that the study's findings are generalizable to other real-life situations and problems (Leedy & Ormrod, 2013, p. 104). This study was conducted in the community college setting.

Thick description and feedback from others are options in the qualitative researcher's toolkit for supporting the validity of their findings. Thick description necessitates describing the situation in such rich, "thick" detail that readers are able to draw their own conclusions from the data (p. 104). Specificity may serve as an acronym for thick description. In this study the researcher imbued survey item numbers 1 and 2 with a high degree of specificity to elicit credibly valid responses.

Utilizing "feedback from others" involves the researcher seeking the opinion of colleagues in the field to determine whether they agree or disagree that the researcher has made appropriate interpretations and drawn valid conclusions from the data (p. 104). For the purposes of this study, the primary results from key informant interviews and the secondary data results from the American College Health Association/National College Health Assessment Fall 2011 Reference Group Data Report and its Fall 2011 Reference Group Executive Summary; the California Community Colleges Chancellor's Office "Supporting Students with Mental Health Needs" from April 16, 2010; the Health Services Association California Community Colleges (HSACCC) website; and any other sources deemed credible will serve as "colleagues in the field"/feedback from others. Hopefully, these feedback sources will provide "confirmability" for the findings and interpretations from this study.

Operational Definitions

Student Health Center means Room 1409 in Building 1400 at 4000 Suisun Valley Road in Fairfield California. The Student Health Center provides health-related services to students, staff, and faculty who are currently enrolled or employed while they are on campus. The Health Services fee must have been paid if not waived.

Mental Health Service means services provided within the Student Health Center, by the Marriage Family Therapist Intern (MFTI) from the local nonprofit agency. Students are persons enrolled during the current semester. Eligible students are uninsured persons enrolled during the current semester whose condition/diagnosis does not meet the criteria for referral outside of the Student Health Center.

For the purpose of this study satisfaction/satisfied means aligns with student/non-student stakeholder expectations. A Marriage Family Therapist Intern (MFTI) is a licensed mental health professional. Therapist refers to the MFTI from the local nonprofit agency. Vision refers to a person-specific perception/preference of correctness regarding what something should look like. Excellent means closely aligned with one's vision.

Helps means provides the support a student needs. Remains in school means a student is attending classes and is up-to-date with assignments and readings. Finally, available means the therapist is present and ready to engage in providing mental health service to students.

Ethical Issues

This study involves the participation of human beings. Therefore, they must be protected from harm. The survey and interview methodologies used in this study under normal circumstances posed an imposition on the participants' time. This is a potentially significant consideration because the survey and some of the key informant interviews were conducted during finals week. Some potential participants declined to participate siting unusually high finals-related stress levels. All persons were treated in a courteous and respectful manner whether they participated or not. Participation was voluntary and anonymous following informed consent.

Chapter 4 – Results and Findings

This research project was undertaken to obtain student and non-student key informant stakeholder input regarding how the three month old mental health service within the Student Health Center should evolve into the future. To this end, three assumptions were advanced and input was secured via survey and key informant interviews. The results and findings are presented in this chapter.

The Survey

The survey served in five iterations. It was employed during a pilot study and a non-pilot study within the Student Health Center. The third iteration was on-campus outside of the center. Next, it was deployed as an online survey via Survey Monkey.

The Key/Primary Assumption

The key assumption in this study states that, "Students and non-student stakeholders are satisfied that a therapist is available in the Student Health Center providing mental health service, on campus, to eligible students 4-5 hours per week." Survey item number one and key informant interview guide item number two addressed this primary assumption.

The Pilot Study. Nine students completed surveys during the pilot study; eight females and one male. Seven of nine agreed (N=1) or strongly agree (N=6) with the key assumption. The remaining two respondents strongly disagreed with the key assumption. However, after indexing the Likert Scale from five (strongly agree) to 1 (strongly disagree), the overall average response was 4 (agree).

Gender-wise, the sole male was age 26 to 35, enrolled as a part-time student, and he strongly agreed with the key assumption. Five of the female respondents were age 18 to 25, two 26 to 35, and one 46 to 55; one half (N=4) was enrolled part-time and the other full-time. The average response rate for females in this group was also 4 (agree) with six of eight strongly agreeing or agreeing and two strongly disagreeing thereby supporting the primary assumption as well.

The primary assumption was supported by each female age group. The median responses were 4, 3, and 5 for those 18 to 25, 26 to 35, and 46 to 55 respectively. Female full-time enrollees demonstrated an average response of 3.75, while part-timers were a 4. Percentage-wise, 77% (N=7) agreed or strongly agreed while 22% (N=2) strongly disagreed.

No opportunity for explanatory/qualitative commentary was provided in the pilot study for survey items one and two. However, the pilot study revealed the potential benefits of furnishing such opportunity. Therefore, subsequent survey iterations encouraged commentary regarding these items.

The Non-Pilot Study Conducted Inside of the Student Health Center. Ten students participated in the non-pilot study which was conducted inside of the Student Health Center. Six females and four males returned questionnaires. One female participant was a part-time student age 26 to 35. The remaining (N=5) female participants were 18 to 25 years old attending college on a full-time basis. One male respondent was between 26 to 35 years of age attending college full-time; three were aged 18 to 25 one was a full-time student, one part-time, and one did not identify an enrollment status. Given an overall average response of 4.00 this group supports the key assumption. This 4.00 response held for both genders irrespective of age or enrollment

status. In this group 90% (N=9) of respondents either agreed or strongly agreed with the first statement and 10% (N=1) strongly disagreed with it.

Survey item number one received qualitative commentary from two (20%) of ten respondents. Both respondents were female between the ages of 18 to 25. One strongly agreed with the statement and commented, “I didn’t [know] we had a therapist here but I still find it very helpful to those who might need it”. The other strongly disagreed with the statement and her comment was “Fast, friendly, very knowledgeable staff”.

The On-Campus Study Outside of the Student Health Center. On-campus outside of the Student Health Center 103 students consented and completed the survey. Respondents self-identifying as male comprised 48.5% (N=50) of the sample. 49.5% (N=51) identified as female while 1.9% (N=2) did not provide a gender identity. The vast majority (78.6%, N=81) of respondents were 18 to 25 years old. Nearly 11% (10.6%, N=11) were aged 26 to 35. 5.8% (N=6) and 2.9% (N=3) were in the age ranges of 36 to 45 and 46 to 55, respectively. Approximately 1% (0.9%) each was either under 18 years old or did not provide an age range.

The average response for 18 to 25 year olds was 3.99; 4.17 for males and 3.82 for females. The mean response for persons aged 26 to 35 was 4.05; 3.80 for males and 4.33 for females. Individuals in the age range of 36 to 45 demonstrated a median response of 4.50; 4.00 for males and 5.00 for females. The overall response for persons aged 46 to 55 was 4.75; males 5.00 and females 4.50. The average response for the one individual under 18 years old (female) and the one person who did not provide either an age or gender was 4.00 each.

Relating to enrollment status, 72.8% (N=75) were full-time students, 25.2% (N=26) were part-time, and 1.9% (N=2) did not identify an enrollment status. The full-time students consisted

of 36 (48%) males, 38 (50.6%) females, and 1 (1.3%) who did not identify a gender. The part-time students were comprised of 12 (46.1%) males, 13 (50%) females, and 1 (3.8%) provided no gender identification. The overall average response for full-time students was 4.13. The male average was 4.11, the female average was 4.13, and 5.00 for the respondent of unidentified gender. The overall average for part-time students was 4.23. It was 4.25 for males, 4.20 for females, and 4.00 for the person of unidentified gender.

Most (80.4%, N=29) full-time males and females (86.7%, N=33) agreed or strongly agreed with the first statement. In general, 82.6% (N=62) of full-time students supported the key assumption. Full-time male students "neither agreed nor disagreed" with this statement at a ratio of 5:1 compared to females. Full-time female students strongly disagreed with the initial statement at a ratio of 4:1 with males. Part-time students (88.4%, N=23) on the whole, also supported the first assumption. Subsequently, 87.3% (N=90) of respondents agreed or strongly agreed with statement number one thereby, supporting the primary assumption. The overall average response was 4.19. Males (84%, N=42) and females (86%, N=44) supported the key assumption in almost equal numbers. The average response for males was 4.06; it was 4.15 for females.

Twenty-one (20.3%) of 103 student respondents provided insightful commentary supplementing their Likert scale selections. The remaining either did not respond (75.7%; N=78), wrote "N/A" meaning "not applicable" (2.9%; N=3), or responded with the word "None" (0.9%; N=1). There were recurrent themes in the narrative. Frequently narratives/commentary fit into more than one thematic category. 66.6% (N=14) of the discourse focused on the Therapist either by directly (38.0%; N=8) including the word "therapist" or indirectly (28.5%; N=6) via phrases such as "someone to talk to", "the resource", "their/those services" and "this option".

Knowing (47.9%; N=10) constituted another theme. Knowing in the sense of a knowledge deficit via the expressions “I didn’t know”, I’m not familiar”, and “I have not heard” (N=6; 28.5%). The other form of knowing was evident in the gist of advertising by phrases/words such as “more information that…”, “make…more known”, “no one will know”, and “advertise”.

A third theme involves access expressed as “I have not used”, “I have not accessed”, and “to better accommodate students’ schedules”. Availability was another theme perceived in words for instance including “having”, “offered”, “available”, and “accommodate”. The fifth theme is the recognition that service entails a cost component. Students communicated this awareness through sayings such as “a lot of people don’t have medical insurance” and “not everyone can afford going to other places”.

The willingness and/or the ability of students to make potentially emotion laden decisions are conveyed indirectly through the fact that they are able to determine what is “good”, “help/helping”, and “nice”. The direct capacity to discern emotions in self and others is imparted via the phrases “a lot of hurting people”, “actually really care”, and “dealing with stress”.

The On-Line Survey. The on-line survey was implemented via SurveyMonkey. Ten students completed the survey; two (20%) males and 8 (80%) females. Four (40%) were aged 18 to 25; three were aged 26 to 35; and the age ranges of under 18, 36 to 45, and 46 to 55 were each represented by one student a piece. Six students were enrolled full-time and four were part-time. Ten (100%) out of ten respondents either agreed or strongly agreed with statement one. Six (60%) strongly agreed and four (40%) agreed with the statement. Subsequently, the key

assumption was supported with an average response of 4.60. The respondents provided no narrative discourse.

The Secondary Assumption

"Students and non-student stakeholders feel that, a therapist providing mental health service, on campus, in the Student Health Center helps students to remain in school" is the secondary assumption in this study. It is addressed by survey item number two and key informant interview guide item number three.

The Pilot Study. The overall average response for the second survey item was 3.88. Seven individuals strongly agree or agree with the statement and two strongly disagree. Female respondents overall (3.75) support the secondary assumption to lesser degree than the singular male respondent (5.00). These eight female respondents exhibit a slightly lower level of confidence in the secondary assumption than for the primary assumption.

The mean response of 2.50 shown by females age 26 to 35 (N=2) fails to support the secondary assumption. Females 18 to 25 (N=5) with a mean response of 4 display equivalent levels of support for both the primary and secondary assumptions. The one female age 46 to 55 viewed both assumptions as equally (5.00) important. Full-time (N=4) and part-time (N=4) female students attached the same level (3.75) of significance to the secondary assumption. The lone male viewed it with higher (5.00) regard than did the female respondents.

The Non-Pilot Study Conducted Inside of the Student Health Center. The overall response to survey item number two is 3.60 subsequently supporting the secondary assumption. However, as a group the secondary assumption was supported at a 4.00 mean response level by everyone except females aged 18 to twenty-five. Females 18 to 25 supported the secondary

assumption with an average response of 3.20; suggesting that this group may hold reservations regarding the effectiveness of therapy in terms of keeping students in school. Again, two (20%) of ten respondents took advantage of the space for commentary. One male aged 26 to 35 simply wrote "N/A". One female aged 18 to 25 commented, "Any help to the students is greatly appreciated".

The On-Campus Study Outside of the Student Health Center. 68.9% of respondents agreed or strongly agreed with statement number two and a little over 21% (21.3%) had no opinion either way. Almost ten percent (9.6%) neither agreed nor disagreed. Therefore, support is also conveyed for the secondary assumption but, to a lesser degree than for the primary assumption. Since those having no opinion approaches about one quarter of the sample this may represent ambivalence regarding therapy effectiveness in terms of helping students to remain in school.

The overall average response for the secondary assumption was 3.87. Male respondents averaged 3.86; female respondents 3.98; and 3.00 for the respondents declining to supply a gender identity. The median response for students 18 to 25 was 3.53; males were 3.17 and females 3.9. Students between the ages of 26 to 35 had a modal response of 4.00 for males, females, and their composite. The normative response for students 36 to 45 was 4.50; males 4.00 and females 5.00. Persons aged 46 to 55 demonstrated a mean response of 4.75; males 5.00 and females 4.50. Regarding the person of unidentified gender and age, as well as, the sole individual under the age of 18; both had an overall average response of 3.00 to the second statement.

The overall average response for full-time students was 3.50; males 3.72, females 3.80, and the person with no identified gender had an average of 3.00. The overall mean for part-time

students was 3.69; males 4.00 and 4.07 females, and 3.00 for the individual with no gender identification. The median response for those not identifying an enrollment status is 4.00.

Over three-fourths (77.6%, N=80) of students declined the opportunity to comment regarding their choice from the Likert scale; almost 4% (3.8%; N=4) wrote "N/A" meaning "not applicable"; and nearly 1% (0.9%; N=1) commented by writing the word "none". Overall, 82% (N=85) of respondents essentially did not shed any light on factors contributing to the sample's low level of confidence regarding the mental health service/therapist helping students to remain in school.

An examination of those not supporting the second assumption took a closer look at the respondents who "Do not agree nor disagree", "Disagree", and "Strongly Disagree". Students responding "Do not agree nor disagree" totaled 21.3% (N=22); ten (45.4%) were male, ten (45.4%) were female, and 2 (9.0%) did not provide a gender.

Two (20%) of ten females in this category provided comment. One commented "It gives them another option when going to a doctor's office is not an option" and the other commented "I have never used or spoken with students who have used the service". Only one (10%) of ten males in this category responded. His comment was "I didn't even know we have one nor do I know a person who uses it, so I can't really agree or disagree".

Those disagreeing with statement two totaled four persons and consisted of one female and three males. The female did not provide comment. All three males provided commentary. The first responded "They only help if people visit them". The next response was "Students with problems staying in school don't necessarily have mental problems". The final comment was, "Unless more people know about it, it won't really help anyone".

Five individuals strongly disagreed with the second statement; three females and two males. The three females and one male provided no commentary. The one male commenting said, “School can be very stressful so a therapist is necessary”.

Recurrent themes were evident in the discursive responses to this item as well. However, eighty-five (82.5%) of 103 persons essentially eschewed the opportunity to provide a narrative response to this item. 76.6% (N=80) did not offer any response; almost 4% (3.8%; N=4) responded “N/A”; and nearly 1% (0.9%; N=1) simply commented by writing the word “none”.

The most frequently recurring theme centered directly (N=3) and indirectly (N=8) upon the therapist (N=11). The construct of “help/helping” (N=5) demonstrated the second highest frequency followed by non-mental health reasons for dropping out (N=4). The emotions/emotion-laden constructs of “stress”, “good”, and “need” dominated the fourth highest frequency (N=3 each) in equal numbers. Academic strategies for drop-out prevention (N=2) and the Student Health Center mental health service as an “option” for care (N=2) rounded out the recurring thematic units associated with statement number two.

The On-Line Survey. Seven (70%) of ten students strongly agreed with the second statement, two (20%) students did not agree or disagree with it, and one (10%) proffered no response. The median response was 4.56. So, the secondary assumption was supported to a lesser degree than the primary assumption in keeping with the results from the paper and pencil survey. No one provided commentary.

The Tertiary Assumption

The tertiary assumption posits that, "Students and non-student stakeholders have a vision of what 'excellent' mental health service must include." This assumption is the topic of survey item number three and key informant interview guide item number four.

The Pilot Study. The parameters indicating support of the third assumption were any and all responses to the statement. Nine (100%) of 9 students responded to this statement. The two themes centered directly and indirectly on the therapist and on "helping". The comment (N=1; 11%) focusing directly upon the therapist, written by an 18 to 25 year old female read, "Caring, patient therapist who understands each individual". The statements (N=6; 66%) indirectly focusing upon the therapist were: "Diagnosis, advice, medicine"; "Closely watch patient-follow-ups"; "Open minded & non-judgmental"; "Effective communication, empathy, and considerate"; "Pays attention to student's needs, is understanding, and informs procedures adequately"; and "It must have someone who can set aside time to listen to the students, that is important to me". The two (22%) comments regarding were, "Helping other[s] with disability problem[s]" and "Actively helping student[s] with their problems".

The Non-Pilot Study Conducted Inside of the Student Health Center. Nine (90%) of 10 students gave comment regarding their vision. Evident themes included availability, the therapist (indirectly), and uncertainty. In addition to the one (10%) non-respondent; one (10%) student's response was "N/A". Another (10%) individual student expressed uncertainty stating, "Not yet sure". The remaining seven (70%) indirectly reference the therapist via the following comments: "Understanding able to provide proper resources", "Complete evaluation, regular

visits, information", "Quick, professional, private service", "Someone who is always available to help with whatever mental health issues may occur on a daily basis", "Just be there for students", "Always available", and "Good available hours". Finally, the last four (40%) statements also pertain to availability.

The On-Campus Study Outside of the Student Health Center. The group of 103 students surveyed on campus outside of the Student Health Center exhibited an 87.3% response rate to this statement, in that only thirteen individuals declined to provide any response at all. Therefore, the tertiary assumption was upheld. Students not only have visions of what is included in 'excellent mental health service, they are excited and willing to share their visions.

Response data regarding the tertiary assumption is entirely qualitative. Discourse analysis and narrative analysis protocol routinely dictates that revealed thematic units are sorted into predetermined categories. For the purposes of this research the four branches of the Four-Branch Model of Emotional Intelligence serve as the predetermined categories. The analysis commences with identification of thematic units.

The principle thematic units of students' visions of 'excellent' mental health service included service availability, access, and eligibility; as well as, student expectations regarding a therapist. Other themes touched upon were cost and forms or types of availability.

One may easily view availability, access, and eligibility as the two sides and edge of the same coin. After eliminating the seventeen persons who responded with "N/A", "none", or declined to provide a response there remained 86 respondents. Twenty-nine (33.7%) of these remaining respondents included requests or specifications concerning availability in their visions

of excellent mental health service. Another twelve (13.9%) outlined access stipulations and five (5.8%) included eligibility requirements.

Types and forms of availability were varied and numerous. Some visions of availability included counseling in groups, one-on-one, and by telephone. Others envisioned a "24/7" availability, five days per week availability, open office hours, advanced appointments and walk-in appointments. Yet others want faculty to provide reminders and explanations regarding the availability of the service. Still others want positive follow-up/check-up on students, ease of access when needed, and uncomplicated access.

Cost recommendations ranged from a small fee to free to everyone. The most requested eligibility requirement was that the service be open to everyone. However, there was evidence of special concern for those without insurance.

Twenty-one (24.4%) of the eighty-six respondents referenced their expectations of a therapist, either directly (47.6%; N=10) or indirectly (52.3%; N=11). The most desirable quality in a therapist is the ability to help. Twenty (23.2%) of eighty-six respondents included help as a requirement in their vision in terms of the therapist, one or more times. The second most sought after quality was availability. The third most coveted ability in a therapist was the skill of listening (5.8%; N=5).

Additional requirements for a therapist were many and diverse. They include: empathy, caring, positivity, encouraging; the ability to provide moral support, advice, protection, and testing. Other necessities are dedication, compassion, trustworthiness, and "being present". More requisites are the ability to provide explanations, help resolve/cope with issues, provide counseling, maintain confidentiality, provide life coaching, and help with coping with stress.

Finally, a therapist must be "well educated both in methodologies and conditions that effectively identify and resolve problems with students". They must also be "proactive and approachable in getting students the help they need".

The On-Line Survey. Five (50%) persons provided responses to the third statement. Therefore, the tertiary assumption was also supported by the on-line survey. The therapist was the theme common to each response indirectly. One of the five responses mentioned "availability".

The aforementioned comprise what is included in students' visions of excellent mental health service. Next is a discussion of how the qualitative data sorts into the branches of the **Four-Branch Model of Emotional Intelligence.**

The first branch concerns perceiving emotions accurately in oneself and others. It may involve reading facial expressions and noting voice inflections. Students' visions for a therapist include empathy, compassion, trustworthiness, caring, and positivity. Requiring these characteristics in a therapist indicates that students are evaluating the therapist for their presence or absence and this constitutes perceiving emotions accurately in others. Phrases such as "…a student's well-being", "one's self-interests", "feeling important to community, family, and friends", and "students should be able to walk in during a crisis" are suggestive of students' ability to accurately perceive emotions/feelings within themselves. The search for evidence of perceiving emotions accurately in oneself began with a quest for the personal pronouns "I" and/or "me".

The pursuit of the personal pronoun "I" and/or "me" revealed that only two of 103 persons had utilized it in responding to the third statement in the paper and pencil surveys. A

perusal of responses to statements one and two was executed. It was noted that only five persons had made "I" statements responding to the second statement. In response to the first statement the personal pronoun "I" was used by nine respondents. This was deemed interesting since survey items 1, 2, and 3 each employed the use of a first person pronoun as the first word in the statement.

Noteworthy, it appears that instead of turning inward focusing on him or herself as an individual, on the whole students looked outward into the campus community. One might venture to speculate that with each successive response students immersed themselves more deeply into the community. Ultimately, they exchange their individuality for oneness with their community evidenced via the near absence of "I" and "me" statements in the narrative discourse of the third statement. However, this trend appears to reverse itself in the on-line responses to item number three.

The tone of the on-line responses to survey item number three is more personal or proximal. A tonal quality which holds true in four of the five responses. Two respondents utilize the personal pronouns "my" and "me" as in: "_who isn't judgemental_willing to listen_comes with strategies to solve my problem" and "A caring person who listens and helps me to get through the difficult times". The students' employ of these personal pronouns naturally direct one to conclude that each student is speaking of "self" from the standpoint of subjective experience with mental/emotional health challenges.

"The" a definite article; the word "this"; and the pronoun "it" convey specificity and proximity. These words were applied in on-line responses to the third survey item. For instance,

"this" in the following quote may be construed as connoting a very intimate almost personal proximity.

> Being able to assist a person suffering from psychotic schizophrenia/bipolar when medication has not started to accommodate[d] its effects in that person. A mental health person must have the skills to be able to relate to that person until his/her medication start[s] to take effect. A mental health coordinator must be able to educate faculty members on how to deal with a situation when a person with this disorder gets out of control. This illness is undetected because it does not show on the outside like a person with a physical or mental disability that can be seen. Staff members need to be educated on what to do when a problem arise[s] and how not to set themselves; by putting others in danger from saying the wrong wor[ł]ds which could trigger an attack.

The respondent in the following quote applies the definite article in a manner implicating intimate/personal knowledge. The student wrote, "Someone will talk to the student in a needed time someone who knows what the person is going through". These usages of words and parts of speech were not evident in the paper and pencil survey results.

It seems that as the paper and pencil surveys in the presence of fellow students and on-campus accoutrements engenders immersion into the community. The solitude and privacy of the on-line experience facilitates reflection upon self and one's first-hand experiences. This line of thinking bares fruition in on-line respondents' commentary to survey item number four.

The fourth survey item was included to afford students the opportunity to comment regarding the Student Health Center in general. The vast majority of students completing the paper and pencil survey did not provide comment. Those who did comment for the most part

expressed contentment with services and/or extended thanks to the center staff. However, all five of the on-line respondents to item number three also responded to item number four. Three of the five continued their line of thought/reasoning from item number three. One comment as follows reiterates the line of thought broached in survey item number three saying,

> A Mental Health and Student Health coordinator must be able to educate faculty members on how to deal with a person suffering from psychotic schizophrenia/bipolar. This illness is undetected because it does not show on the outside like a person with physical or mental disability that can be seen. Staff members need to be educated on what to do when a problem arise[s] and how not to set themselves; by putting others in danger from saying the wrong wor[ł]ds which could trigger an attack.

Another comments, “Please picture yourself in the student’s shoes with the downfall in the economy and budget cuts; added onto the extra stress”. Yet another unabashedly shares, “I have a mental illness and it is comforting to know there is help on campus if things get really bad”. Therefore, it appears that narrative/discourse analysis with the goal of discerning the ability to accurately identify emotions in oneself and others is a complex task even though this first branch of the model is deemed its simplest level.

The second branch is termed “using emotions to facilitate thinking”. This branch is evident in phrases such as “help students resolve/cope with their issues”, “helping with classes”, “help coping with stress”, and “not complicated and readily available”. Making the determinations that an issue is resolved, that one is coping, and that something is or is not complicated require thinking/cognition.

The third branch deals with “understanding emotions, emotional language, and the signals conveyed by emotions”. Phrases and words including “great individuals who really do care to listen with their hearts not just their ears”, “welcoming”, “an understanding, neutral, nonjudgmental person” and “a person in whom, trust can be placed” each convey and require the skill set outlined in this branch to discern whether or not one has encountered the desired entity/state.

Finally, “managing emotions so as to attain specific goals” is the fourth branch. “Comfortable surroundings”, “help with classes”, “prevent shoot-ups”, “stress relievers”, “proper care for mental problems”, “good assistance, fast and reliable”, and “someone who doesn’t go postal” are examples of specific goals requiring one to manage emotions to facilitate their attainment.

These excerpts taken from student responses to survey item number three demonstrate that students express themselves in a manner congruent with the Four-Branch Model of Emotional Intelligence. Therefore, this model may serve a foundational role in developing a tool/measurement device for screening, referral and monitoring the effectiveness and quality of the mental health service within the Student Health Center.

The Key Informant Interviews

The key informants were comprised of three health care professionals, four academic professionals, and an elected official with a multi-decade history as a public school academician. Key informant interview results supported the three main assumptions one hundred percent of the time. The beauty of the results of the key informant interviews is that the ecological perspective unfolds in terms of the institution, the community, the globe, and history. While each

interviewee supports and recognizes the value of mental health service for students each interviewee enhances the ecological picture with a unique contribution (Appendix C).

Chapter 5 - Conclusions and Recommendations

Five conclusions flow from the research questions, sub-questions, assumptions, and sub-assumptions in this study. The first conclusion drawn from this research is that, students and non-student stakeholders are satisfied regarding the existence of mental health service within the Student Health Center. This conclusion is supported by the fact that greater than 51% survey participants and key informants agreed or strongly agreed with survey item number one.

The second conclusion is that, overall students and non-student stakeholders believe that offering mental health service within the Student Health Center is an effective way to help students to remain in school. More than 51% of student and non-student stakeholders supported survey item number two.

The third conclusion is that students and non-student stakeholders share very similar visions of what constitutes “excellent” mental health service. Survey item number three had the highest response rate on the survey and 100% of key informants responded to this item. Students and non-student stakeholders used virtually the same terms and phrases when discussing/describing their visions.

The fourth conclusion is that narrative/discourse analysis results support the sub-assumption that based upon the way that students express themselves in the qualitative data the Four-Branch Model of Emotional Intelligence may be utilized as a foundational element for developing a tool for screening, referral, and monitoring in terms of the mental health service within the Student Health Center.

Finally, the fifth conclusion is that the non-nursing theories/models of New Public Service-Management/Governance (Public Administration) and the Four-Branch Model of Emotional Intelligence (Psychology) are congruent with Self-Care Deficit Nursing Theory (Nursing) in terms of a focus on community involvement, strategic planning, and accountability and therefore they may inform the design of a nursing system of care for mental health service within the Student Health Center.

Recommendations

The first recommendation from this study is to repeat the survey both on-campus and on-line during a time period devoid of finals, mid-terms, and end-of-semester pressures. The purpose for this re-survey is that redistribution under such conditions will increase participation. This recommendation includes both on-campus and on-line distribution because each method provides a unique view of the populace under study.

Availability of the mental health service/therapist was an overarching concern for students. Regarding availability respecting hours and days, it is recommended that the possibility of expanding the service to five days per week and to four hours per day initially be explored with the non-profit agency. It is also recommended that availability expressed as eligibility be explored.

Given the PHNs' responsibility to establish a mechanism for evaluating both students' need for MFTI/therapy services and the effectiveness of those services, as well as, the need to maintain and respect student confidentiality via a non-shared medical record it is recommended that a measurement mechanism/tool for screening, referral, and monitoring for the service be developed or otherwise secured. Study results show that service confidentiality is of great import

to students. Additionally, even though overall, students confirmed a belief in the effectiveness of therapeutic intervention on retention there were pockets of doubt/questioning evidenced in the results. Subsequently, it is imperative to monitor, document, and communicate effectiveness to the campus community at large as needed.

It is recommended that New Public Service-Management/Governance theory's mixed delivery/redundancy and Self-Care Deficit Nursing Theory's concept of complimentary service design be recognized via the co-development of clinical path-like protocols for the mental health service within the Student Health Center. The goal of this recommendation is to keep students on track with what they are experiencing during sessions with the MFTI, and to maintain service availability when the MFTI is not on site.

The vision of a couple of students were "Comfortable surroundings" and "Better atmosphere". Coupling these findings with the research findings of Nasar and Devlin (2011), it is recommended that the PHNs and MFTI explore ways of increasing the softness, personalization, and order of rooms utilized for counseling purposes.

In terms of the second research question/assumption, there is a gradual upward trend in the mean rating for each age group represented in the on-campus paper and pencil sample. For example for the age groups of under 18, 18 to 25, 26 to 35, 36 to 45, and 46 to 55 the overall group averages were 4.00, 4.01, 4.02, 4.50, and 4.87 respectively. These increasing group averages are interpreted as increasing levels of confidence regarding the effectiveness of therapy in dropout prevention with increasing age. Increasing age is usually associated with increasing years in college. One predictor of higher service use by college students is higher number of years in college (Yorgason et al, 2008). Hartley (2011) and Mikolajczak et al (2009) advise

incorporating a holistic transition curriculum /coping coaching programs to help students develop coping resources rather than waiting for them to learn how to cope with stress on their own. It is the recommendation of this study that this approach be adopted.

Given students' emphasis on therapist qualities and characteristics; another recommendation is that this study and its results be shared with the non-profit organization. Students' also demonstrated a deep concern regarding the mental health of the campus community in general. It is recommended that the "helping capacities of persons comprising students' social network be heightened "(Downs & Eisenberg, 2012).

One goal of these recommendations is the development of a nursing system of care for mental health within the Student Health Center which contributes to students' academic, intrapersonal/interpersonal well-being and self-care agency. A second goal of these recommendations is to enhance the composite well-being and self-care agency of the campus and the community at large.

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Appendices

APPENDIX A

Solano Community College Student Health Center Survey

The purpose of this survey is to obtain student input for the mental health service provided on the Fairfield Campus in the Student Health Campus.

Thank you,
Deborah Summers-Collins, PHN
Student Health Center Nurse

1) **I am satisfied that, a therapist is available, on campus, in the Student Health Center providing mental health service to eligible students for 4-5 hours per week. (Check one)**

☐Strongly Disagree ☐Disagree ☐Do not agree nor disagree ☐Agree ☐Strongly Agree

(1) (2) (3) (4) (5)

If you have any further comments or wish to add anything to explain your answers please use this space.

2) **I feel that, a therapist providing mental health service, on campus, in the Student Health Center helps students to remain in school. (Check one)**

☐Strongly Disagree ☐Disagree ☐Do not agree nor disagree ☐Agree ☐Strongly Agree

(1) (2) (3) (4) (5)

If you have any further comments or wish to add anything to explain your answers please use this space.

3) **My vision of what an "excellent" mental health service must include, is as follows:**

4) **I also want the Student Health Center staff to know the following:**

5) **Please respond to the following:**

Gender: ☐Male ☐Female

Age Group: ☐Under 18 ☐18-25 ☐26-35 ☐36-45 ☐46-55 ☐56-65 ☐Over 65

Enrollment Status: ☐Full-time ☐Part-time ☐Not currently enrolled

APPENDIX B

Key Informant Interview Questions

1) From a historical perspective, what factors contributed to the decision to enter into the current collaborative arrangement for providing mental health service, on campus, in the Student Health Center? Where did the idea originate? What makes it unique?

2) Why is it important to have a therapist available, on campus, in the Student Health Center providing mental health service to eligible students 4-5 hours per week?

3) Do you feel that, a therapist providing mental health service, on campus, in the Student Health Center helps students to remain in school? If yes, why? If no, why not?

4) Describe what your vision of an "excellent" mental health service includes.

5) Would you like to share anything else?

APPENDIX C

Deborah Summers-Collins: From a historical perspective, what factors contributed to the decision to enter into the current collaborative arrangement for providing mental health service, on campus, in the Student Health Center? Where did the idea originate? What makes it unique?

President/Superintendent Dr. Laguerre: I think more and more colleges especially community colleges are receiving students who have issues with mental health. Not only because of the economy, but because we are pushing more and more students who in the past, would not feel for whatever reason, that they belong in college, whether it is illness, mental illness or disabilities. That they are coming into college has, over the past twenty years, really pushed colleges to look at more health services as something that is important to the student body. Also as you know there have been several acts of violence throughout higher education. I think those acts of violence have made us be more aware of the fact that sometimes we ignore the mental health of our students, while if they were sick with other things we would have taken care of them. But I think those subsequent acts really have awakened the higher education community and taught us that it is best for us to prevent certain things, to really attend to the mental health of our students. I think those are some contributing factors that made that possible.

Mayor Price: I think part of that answer from a global perspective deals with the fact that so many students come from such varying backgrounds in both cultural as well as linguistic and in our society today even though we have come a long way in bringing people together there are many students who come with mental health needs that have not been addressed either in the home adequately, at church adequately, or certainly at school. And on the college campus we see evidence of that deficiency in so many cases that result in violence and I really think that it is important no matter what educational level it is, whether it is a preschool, elementary school, middle school, high school or college it is important for those professionals, and I am speaking specifically now as a retired teacher, for those professional teachers to be sensitive to and aware of those needs, so that they can be properly addressed by skilled mental health care professionals.

VP Reyes: I am a fairly new arrival to the college to the system, so I am not very sure what the details were about the historical arrangement. I do know that the County seems to lack providers of mental health services for the general community and population. And I probably could assume that that decision was made because there is a definite need in the community, in the county and on the campus for different services so the students can function, so that they can succeed in their classes.

Dean Vines: Typically we have different groups, non-profits, come to us and ask us to enter into agreements like the one we are in currently. They came to our campus and asked if we were interested. And their request was brought to me by one of our employees. We had a meeting. They talked about the services they could offer our students who do not have health care in a moment of crisis. So it ends up being a win/win situation, because we have students that are in crisis, as you well know, and we do not always have services for them. So it ended up being a win/win situation. I do not know if there is anything that makes it unique because this happens in many places. So I do not know if there is any uniqueness, even here at Solano there may have been similar agreements in the past. I am aware that we were working on one with the County. The process was moving along and we were getting pretty far, then it fell through, right when the budget started getting bad nationally is when they said they were not going to be able to complete the project.

Director Ghous: Students' needs, looking to see what it costs in terms of our resources. Providing a service we don't normally offer has the potential to take up a lot of resources.

MFTI Kirkland: As part of the [non-profit's] grant, we provide free mental health services to all eligible adults in Solano County. It is a free service, as opposed to $20-$100/hr. It is a community based service.

PHN Robinson: FACTORS: 20% of student visits to the Student Health Center were for emotional/mental health issues.

UNIQUE: Only sees students who are uninsured or underinsured.

HA Huerls-Washington: Many students make requests for mental health services to the Health Center, Counseling, DSP Program and other offices on campus. Students need a place on campus to seek the services of a mental health counselor.

Deborah Summers-Collins: Where did the idea originate?.

Dr. Laguerre: I do not quite know where it did. As you know sometimes before something like this comes into being it takes a long time for the idea to germ and also for people to warm up to it. I know that there have been a number of faculty members over the past many years that have identified in their classes, especially those who teach social work and psychology, that there are mental health issues on the college campus. I think the idea might have originated through those discussions because the college has had multiple conversations around this particular issue, where the faculty and counseling were most concerned about what we were not providing for better health of our students.

Mayor Price: We certainly saw it with the Civil War. Where we had people in the same family opposing one another over philosophical reason, not necessarily religious reasons, so you had brother fighting brother, father fighting son, and somehow or other it was the wife the mother that attempted to bring them together. I think that had a very profound effect on President Lincoln. I say that because if you take a look at his Gettysburg address very simple words but profound words that focused attention. That speech is one of the most admired messages in any language and the notion or brother loving brother and of course that applies to sister loving sister too but I think that comes sharply under focus we're seeing it anew now as a result of the hostilities in the Middle East specifically in Iraq and Afghanistan with the IED's the Improvised Explosive Devices causing very severe injuries that in another era would have probably would have resulted in death but now medicine has improved so much that when they return home they are not physically intact as they were when they left, emotionally mentally they tend to be fractured too. So that we create acronyms Post Traumatic Stress Syndrome is a very real thing and at the Solano Community College there are more than 1,200 students who are attending college on the GI bill some of them experienced extraordinarily horrific things and they are trying to fit in again in the classroom and with proper mental health counseling and therapy they'll be able to do both, they will be able succeed. In the city of Fairfield, earlier this spring we were asked to host a domestic violence seminar. It was an attempt by a tragedy at Penn State University to have that lead investigator come and give us the real life story of what happened with someone who ended up murdering his wife. And all the folks who chose to participate in that time in Fairfield all of them some of them were relatives of victims but all of them learned that you don't just tolerate but you have to provide health and again the victim in the Penn State story and her husband was a war veteran who was fighting the demons, a very poignant story but absolutely essential and domestic violence often times perpetuates itself as a result of very small children seeing it in their own homes with their own parents and they become abusers and it isn't just man against woman domestic violence is also woman against man as well so the therapy is absolutely, absolutely essential and it's got to be.

VP Reyes: Beyond tutoring or beyond academic counseling I think in our county there are a significant number of individuals who need more attention and more guidance and perhaps some intervention to be successful in classes. I am assuming that is where this originated. I do know that at some point there was a group of students who seemed to have more needs than other students and I think there was some kind of an issue off campus where they needed more support. So I do not know if that is where this originated or not, but definitely there is a need in the county and we are glad that there is a collaboration and that the services are offered.

Dean Vines: We know that we have a need and they have a need to work with people who do not have insurance to meet the parameters of their agreement or grant. So the idea is not a new idea, we have had many non-profits come to us with proposals but they did not materialize.

Director Ghous: A phone call led to a meeting and multiple conversations with [non-profit agency]. Eventually. A contract was established.

MFTI Kirkland: As part of the [non-profit's] grant, we provide free mental health services to all eligible adults in Solano County.

PHN Robinson: IDEA ORIGINATION: New Horizons Program at Solano Community College had an academic counselor who addressed mental health concerns which led to student success at Solano Community College. Other Community College Student Health centers in the State were addressing mental health issues with therapists.

HA Huerls-Washington: Many students make requests for mental health services to the Health Center, Counseling, DSP Program and other offices on campus. Students need a place on campus to seek the services of a mental health counselor.

Deborah Summers-Collins: What makes it unique?

Dr. Laguerre: A lot of times we do not have money to do things and because we do not have money we wind up doing nothing. In this case being able to partner with another agency to provide these services I think is quite unique. Actually the whole Student Health Center is a unique opportunity with partnerships that we have with different people. So I think that being able to pull that partnership together makes it very unique, because alone we would not have been able to afford to do it.

Mayor Price: I think academicians have realized that from theory to practice often times there is a hole and it's the very wise Dr. Laguerre, the president of the Solano Community College, the superintendent he is a very wise educator. An individual like him is able to translate what is with what can be or what should be; and there are more and more who are learning that lesson from him. The violence on college campuses continues, whether it is a hazing that results in a death of a band member or whether it is someone who had a mental health problem before taking the

lives of others as you saw as in Columbine and we have seen too many cases and the urgency is now the solution can't wait there are precious lives at stake.

VP Reyes: I do not know enough about the program to know what makes it unique. I think one the features that has to be a positive is that it is right here on campus, so that if a student has an issue or is having concerns that they need help addressing they can take care of it right here on campus. Kind of a one stop idea, if you need financial assistance you come here, if you need academic counseling you come here, if you need mental health services or counseling you have that on campus so I think that makes it unique. Whereas at other community colleges they do not have the services so agencies in the community, agencies that are distant would provide the services. I think having it accessible, having our staff and faculty know that it exists so that they can refer students I think that is important as well. And I think another thing that makes it unique is when it is on a campus it combines with education, which together I think empowers students more than one without the other. So if students coming in for classes and they recognize there are some needs that they have they can go and get those resolved. At the same time if persons coming here for services they may be directed to other classes that they think will facilitate their ability to succeed in those classes.

Dean Vines: I do not know if there is anything that makes it unique because this happens in many places. So I do not know if there is any uniqueness, even here at Solano there may have been similar agreements in the past. I am aware that we were working on one with the County. The process was moving along with the grant and we were getting pretty far, then it fell through, right when the budget started getting bad nationally is when they said they were not going to be able to complete the project.

Director Ghous: It is unique because it is a service which is needed very much. It is available to students with unique needs who cannot afford healthcare.

MFTI Kirkland: It is a free service, as opposed to $20-$100/hr. It is a community based service.

PHN Robinson: UNIQUE: Only sees students who are uninsured or underinsured.

Deborah Summers-Collins: Why is it important to have a therapist available on campus in the Student Health Center providing mental health services to eligible students four to five hours a week?

Dr. Laguerre: A lot of times if we identify mental health problems with students we refer them to an agency able to provide that kind of service. Many times because of life situations the students will end up not going where they need to go and sometimes it leads to bigger problems for the students because they will go untreated. While this is not the maximum we can do, to at

least have some initial work done with the student, to be able to see someone who can encourage them to provide at least the minimum services possible, I think it beats the referral that we may give them that may lead to nothing, so we feel it really is an important part. The immediacy of the service to the students can be a matter of life and death for some of them, so I think that having someone available at the college to be able to do that is quite advantageous.

Mayor Price: The demands on the college student are emotional, financial, physical, and mental and often times it is common for some students to pull "all-nighters" they have an exam and they may have been studying all along but they'll stay up all night because they want to do well. They want to succeed. So they'll use any stimulant they can to keep themselves mentally and physically alert but they are stressed out. Those stressors if they are identified need to be handled as quickly as possible and if you have a therapist on campus, the response is there. Whether the student admits himself or a friend who says "Let me take you to meet someone who can help you", or the wise observant professor, or the secretary, it doesn't matter who it is. If the service is readily available chances are people will use it. It makes the campus much safer. It makes the quality of education one receives so much better and it certainly indicates to all students whether they need the service or accepts the service or not they know that it is available and if it is available and if it is convenient and if it is skilled that it will be used.

VP Reyes: Definitely there is a need for the services on campus, in the county, in the region. So it is important to have the services on campus because one of the biggest problems with having people get services is accessibility. If the students are on campus, if they recognize or the instructor recognizes that there is either some kind of plan or expectation that they receive services; having them on campus makes it a lot more convenient, makes it easier for them to access, and so it becomes part of their normal routine, part of their life to say I am going to school and I am going to see somebody about the issues I am having or that has been suggested that I see someone about. It is not a separate activity it is part of what they do, it is part of their life and it is very convenient for them. So I think that is an important part of having it on campus.

Dean Vines: It is important because we have limited services and limited skill sets as a campus and as counselors. And to have a therapist available who is trained in every crisis imagined is very beneficial. There are many times when we have crisis and the organization is not available or the student has insurance and cannot be seen (due to grant restrictions) and we have to cancel the appointments. So, for example if someone has a crisis right now either I am going to counsel the student or someone in here is going to counsel the student. Having another avenue open to students is very beneficial because there is one more person available to them, someone who is trained to work with them. Also they can get tied into agencies that serve students like themselves, students without insurance.

Director Ghous: Many Students go into counseling. Counselors are limited regarding services. Most counselors on a campus are trained for academic counseling. The mental health clinicians

free up space for the campus counselors to do regular academic counseling: They also provide the mental health services needed, whereas academic counselors may not.

MFTI Kirkland: Availability and convenience, students have unique emotional needs. Students are more apt to take advantage of services if they are already on campus.

PHN Robinson: To alleviate suffering, students can concentrate on school and be successful at their goals when their mental wellness is supported.

HA Huerls-Washington: Students are on campus part of the day and having mental health services at a time and place that is convenient to them is an important factor in getting and keeping appointments.

Deborah Summers-Collins: Do you feel that a therapist providing mental health service on campus in the Student Health Center helps students to remain in school?

Dr. Laguerre: I believe that it does for some of the reasons I've shared before. Because if a student is to make an appointment somewhere else that is not on the campus chances are life would interfere with that and also the potential for them to forget while they are trying to make an appointment. Here there is the convenience because we know what is convenient to us a lot of times allows us to make more progress than otherwise. But because this is on their way to doing something else, it is not a big disturbance to their lives. I feel that it is really a good way to not only provide the services but to help them remain because a lot of times not having the services would allow them to drop out. So, I really feel it is important.

Mayor Price: Oh very, very definitely whether it is a residential college campus or whether it is a day student just knowing that the service is available works. It's always nice if you know that as part of freshmen orientation, or if you're a transfer student if it is part of your information package that you know help is available here. It is why historically, college instructors and professors held office hours for students but they tend to be academic focused; they tend not to be the health care services. So the student health service that is available will be used. If it is not then referrals can be made and it is friend helping friend. So, you have the peer influence that is more positive.

VP Reyes: Definitely, I think that students today live in a much more complex world than they did twenty, thirty, forty, fifty years ago. And all of the issues that the students have and the obstacles they are over coming and all of the mental health issues they may be addressing cannot be separated from who they are and what they are doing. So definitely it keeps students here. Very few students simply need a little bit of direction or only need to be guided to the right classes. There are a host of different factors that contribute to a student succeeding and many of those are based in mental health issues. So having services on campus definitely contributes to

their success or retention and ultimately their ability to transfer and move on. I think part of the mental health for a lot of our students is them having to deal with the changes they are going through from, in terms of their diversity, in terms of their ability to cope with everything they are dealing with in their lives and the support services we provide at the college without the mental health services would not be sufficient for the students to be able to succeed in college. Again, I think when compared to previous years, when the expectation was that students had everything taken care of and the hardest thing they had to worry about was their grade; this is not true anymore. I think being in school is one of twenty, thirty, or forty things that students are dealing with and some of them are much more complex than an academic counselor or an advisor or maybe a tutor can help them with, so having the services I think balances what everybody has to do in their lives so that they can be successful.

Dean Vines: Yes, absolutely. Sometimes therapy is what it takes for the student to continue on and continue functioning. So absolutely, sometimes I think it will help just because the student knows they have an appointment. So they will be here, on campus, they will come when they are going through hard times. So I think without a doubt the therapist does help and I think our counselors help as well. Being in a helping field, helping people to move on and continue to function during difficult times, I think they (counselors) do help people remain in school.

Director Ghous: Definitely, just like a physical injury that prevents students from continuing school, a mental health injury does the same, the faster the recuperation, the faster the return to academic plans.

MFTI Kirkland: Absolutely! A therapist can help a student manage their anxiety and depression regarding the stresses of school.

No. However, a student may be experiencing a more significant impairment that may result in dropping school until they get help.

PHN Robinson: Yes, a therapist is very supportive to students who a juggling many life issues. The more support a student has the more successful they can be in achieving their goals.

HA Huerls-Washington: Yes. Without access to a therapist many would drop out because of other life issues/crisis happening in their lives.

Deborah Summers-Collins: Describe what your vision of what an excellent mental health service includes.

Dr. Laguerre: I think number one it needs to be welcoming. It needs to not have any stigma attached to it. The fact that someone may need mental health services does not mean that the person is out of control or has lost his or her mind. Nott attaching any stigma to the services is important. Also in terms of excellent services one would make sure that you have people who are competent. People who can provide the services, people who are caring, and people who are

genuinely interested in the wellbeing of the human being. This is not any different from having a good physician. I think if you have a good physician, a good clinic to go to, you have a physician who wants to talk with you about your issues and partner with you to solve the issues. You tend to go back to that physician often you look forward to going there. So to me this is not where, we want the students to always be, but it is a good thing as long as they need the service. I think we want for them to feel that yes this is the place for me to go because I feel better about myself after.

Mayor Price: An excellent mental health service is one that meets the changing needs of the changing student body on a regular basis. It is a service that makes its programs readily available. We talk about coaches, whether they are speech, debate coaches, whether they are athletic coaches, or they're life skills coaches. Coaches are gifted that's why they become coaches; they have something to offer that students want and students will follow a coach's lead. So you take the example of the very successful football coach again at Penn State University, Joe Paterno who unfortunately had apparently an assistant coach who seemed to have the most altruistic ideas in life when he created a program for at risk troubled kids and sadly there were apparently some abuses so it has become synonymous now with the name Sandusky, the coach and you think of the terrible, terrible tragedies of those lives. You think of the pedophiles for example in education and in religion and if there were the mental health available the victims wouldn't have to wait until they're in their twenties, or their thirties, or even older before they realize what is happening and that they need some help. The pedophiles need that treatment, too.

VP Reyes: I think I touched on some of that. Helping people deal with the issues that they are having or the problems they may be having so that they can be good students. So that they can succeed and become successful citizens in society. But I think if I had to look at an excellent or ideal mental health service I think it would also mean providing services that welcome other students, that empower other students even in the area of diversity or equity so that every student that comes on the campus no matter who they are or what they bring with them or the issues they may be having is part of the culture, is part of the campus. So it is not, the ideal is the students who is getting an A and is taking transfer level math; that is probably five percent of our student population. The ideal mental health program would make sure that all students on our campus, even those that maybe taking one or two classes that are basic skills and maybe struggling to get a D or C in those classes because they are dealing with other issues, that both of those groups would feel just as important to the college. So it is not just about fixing people or making people feel good or be okay. I think it is about empowering them and letting them know there is just as much honor in going to see a counselor or see someone in financial aid or see someone because they are an honors student, as there is in going to get mental health services they are all contributors to our college. So I think that whatever that group could do, whatever the organization could do, the agency could do to promote that feeling amongst all students would help us. Because I think some of the students are just anxious about being here, just about whether they fit in to society, whether they fit in to the county, whether they fit in to our college,

whether they belong in school, belong in those classes. So, I think that in the best case that is what the service would be able to provide as well.

Dean Vines: Serving all students, period, with any and all crisis. Providing access to a trained, talented therapist and never turning anyone away. Moving students on to independence when that can happen, there needs to be a process to ensure their distress is not a place where they stay. It should help them move along, maybe they would need to come back in the future, but it would help develop people if their illness allows.

Director Ghous: To have a department all by itself. If we had a million dollars for a couple of years we could provide a stand-alone center to provide mental health service from 8:00am to 5:00pm daily. The center would also provide workshops for students, staff, and faculty in-house. The center would also serve seasonal and/or temporary employees who don't have benefits in addition to serving anyone who is a current student.

MFTI Kirkland: The availability of having a mental health practitioner on campus for access when needed.

PHN Robinson: I am still in the process of formulating this vision, but I would like it to:

1) Include all students
2) Be available at the Health Center as well as the Main Campus
3) Be available Monday-Friday
4) Be in separate sound-proof therapy offices.

I would also like the therapy staff to be involved in the campus community and Student Health Center activities.

HA Huerls-Washington: Mental health services/counselor available 3 times per week, 2-3 hours /day. Services available to everyone regardless of insurance affiliation.

Deborah Summers-Collins: Would you like to share anything else?

Dr. Laguerre: Well I want to applaud the Health Center for the vision, the thought and acceptance of adding this particular service to what it already offers. Because in this case it tries to support the students from a more holistic standpoint than if it were simply to check on fever and other things it traditionally provides.

Mayor Price: I had a very successful teaching career working with high school students such as you. One of the things I learned early on was that teaching English, that was my job. But I chose to change the approach that I worked with, it just wasn't the subject matter, it was the student. And, not all students can function at the same level. Not all students could achieve but you take a student from where ever he is, he enters your classroom and you take him as far as he will allow

himself to go to become a successful human being. Someone like you, someone who is finishing her third Master's degree, someone who is giving back to a community and therefore you become a very important part, not only of your family, but of our greater community and those institutions. You make an old teacher proud.

VP Arturo Reyes: I just think we are very privileged to have the program on campus. I know that recently I have had the opportunity to visit other colleges and one of the things many of the counselors feel real proud of was that they have mental health services on campus. Because I know that sometimes it is a struggle to make a referral, you do not know what going to happen, where students are going to go, what the outcome is going to be. So I just think that we are very lucky to have you on campus, the whole, the group, I think we are lucky, but I think the students probably appreciate a lot I think that are very fortunate to have the services on campus.

Dean Vines: I think it is a great service that it provides for our students and the students use it. Being in my position I run into a number of students that need the services and so it is nice know we have services available for the students.

Director Ghous: It's wonderful that we took on the project with [nonprofit agency]. We've also tossed around the idea of having a doctor on-site.

MFTI Kirkland: Students (ages 20-30) are a high risk for suicide. They don't always ask for help or know how to help others dealing with mental health issues. Having a trained professional on campus may help in reducing suicide among students.

PHN Robinson: Thank you for this opportunity to participate in your research.

HA Huerls-Washington: The response to recent mental health services at the Student Health Center has been well received by the students. We have had to turn a few students away because they have insurance.

Deborah Summers-Collins: Thank you so much