A STUDY OF COMMUNITY COLLEGE SUPPORT SERVICES FOR STUDENTS WHO SUFFER FROM MENTAL DISORDERS

By

DONNIE L. NERO

Bachelor of Science
East Central State College
Ada, Oklahoma
1971

Master of Education
Oklahoma State University
Stillwater, Oklahoma
1977

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Thesis Approved:

Ray C. Sanders

Thesis Adviser

Clyde B Knight

Harry Oakley

Kenneth St. Clair

Thomas C. Collins

Dean of Graduate College

DEDICATION

During this time of elation and respite, it is also a time of sadness when I reflect back on a person who was very inspirational to me throughout this study. Once my uncle realized I was pursuing my doctorate degree, he was very enthusiastic and encouraged me to strive for excellence. He also desired to read this study and expand his knowledge, something he did until he took his last breath on December 23, 1992. Although time ran out for his stay on earth, his influence was a great incentive for me to complete this study.

Uncle "Boots", Willie Boone Jr.
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TABLE OF CONTENTS

Chapter		Page
I.	INTRODUCTION AND BACKGROUND	1
	Introduction	1
	Background	4
	The Problem	8
	Purpose	11
	Research Questions	12
	Scope and Limitation	11
	Assumptions	12
	Definitions	12
II.	LITERATURE REVIEW	16
	Identification of the Population	16
	Services Provided	23
	Level of Preparation by Providers	29
	Agency Assistance	33
	Summary	42
III.	METHODOLOGY	45
	Introduction	45
	Gathering of Base-line Data.	45
	Selection of Study Group	46
	Conduct of the Study	48
	Analysis of Data	49
IV.	RESULTS OF THE STUDY	51
	Overview	51
	Analysis of the Data	52
	Summary	71
V.	SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	73
	Introduction	73
	Summary of Findings	74
	Conclusions	76
	Recommendations	79
BIBLIOGRAPHY		81

Chapter Page

APPENDIXES 89

APPENDIX A - A.D.A. FACT SHEET 90

APPENDIX B - DISTRIBUTION OF STUDENTS WITH DISABILITIES IN HIGHER EDUCATION 99

APPENDIX C - MAP OF PARTICIPATING STATES BY COLLEGES WITHIN THE NORTH CENTRAL ACCREDITATION ASSOCIATION 101

APPENDIX D - RESEARCH INSTRUMENT 103

APPENDIX E - COVER LETTERS 106

APPENDIX F - STATES WITHIN ACCREDITATION ASSOCIATIONS 112

APPENDIX G - MAP OF ACCREDITATION ASSOCIATION 114

APPENDIX H - INSTITUTIONAL REVIEW BOARD APPLICATION . . 116

LIST OF TABLES

Table		Page
I.	Participation of Community and Junior Colleges by State and Response Rate	53
II.	Perceptions of Service Providers' Regarding Mental Illness Being Recognized on Campus	54
III.	Service Providers' Perceptions of Having Institutional Policies to Assist the Mentally Disabled	55
IV.	Providers' Perceptions of a Designated Coordinator on Campus	56
V.	Providers' Perceptions of How Students in Need of Psychological Services Are Identified	57
VI.	Primary Service Area Responsible for Providing Assistance to the Mentally Disabled	58
VII.	Description of Employment Status of Staff Providing Services	58
VIII.	Types of Support Services Currently Being Provided for the Mentally Disabled Population	60
IX.	Providers' Perceptions of a Periodic Evaluation of Services Provided	60
X.	Providers' Perceptions of the Quality of Services Provided as Compared to Services Provided for Other Disabled Populations	61
XI.	Providers' Perceptions of the Availability of Services Provided for the Mentally Disabled Population	62
XII.	Service Provider Job Titles Related to the Mentally Disabled Population	63
XIII.	Service Provider Position Related to Professional Training	64
XIV.	Service Providers' Occupational Experiences Related to Current Position	65

Table Page

XV. Service Providers' Perceptions of Staff Development Programs Offered for Awareness/Education 66

XVI. Providers' Perceptions of an Existing Community Referral Process for the Mentally Disabled 67

XVII. Service Providers' Perceptions of a Periodic Evaluation of the Community Referral Process 67

XVIII. Service Providers' Responses Regarding Meeting With Community Mental Health Professionals 68

XIX. Service Providers' Perceptions of Having a Designated Person to Coordinate Community Referrals 69

XX. Additional Comments Provided Which Could Improve Services to Students with Mental Disorders 70

CHAPTER I

INTRODUCTION AND BACKGROUND

Introduction

A mission of community colleges has been to provide its residents an opportunity to take advantage of its educational offerings and services. They have provided a variety of opportunities and accommodations for many individuals who made the decision to engage in some form of learning. After the passage of the Higher Education Act in 1965, there were 654 2-year colleges in the United States, 30% of the total number of institutions of higher education. Twenty years later, there were 1,350 2-year colleges, constituting 40% of all institutions of higher education (Adelman, 1992). Most of the growth in community colleges took place within the first ten years following the passage of the Higher Education Act.

The community college is often viewed as a microcosm of its community, thus needs and services provided in the community often compliment, if not dictate, what community colleges offer. Many community resource programs focus on comprehensive prevention and intervention services aimed at meeting local and area needs of their clients, thus community college missions should directly or indirectly correspond to such needs. Community colleges have

traditionally offered the lower division of the four year degree, technical degree training, and remedial and developmental opportunities. Support services, provided externally to the academic realm have often been viewed as secondary to obtaining a degree.

According to the American Association of Community Colleges (1992), two year colleges enroll the highest percentage of students with disabilities. According to the U.S. Department of Education's 1989-90 National Postsecondary Survey, 12.4 percent of public community college students report having a disability, compared with 7.1 percent in public four year institutions. This means that 63 percent of all students with disabilities are enrolled in community colleges and 37 percent are enrolled in four year colleges and universities.

Prior to 1990, the major legal mandate concerning educational institutions and the handicapped population was Section 504 of the Vocational Rehabilitation Act of 1973. This act provided handicapped Americans with opportunities for education, transportation, and other services provided by institutions receiving federal dollars (Rothstein, 1991). This act sought to end exclusionary practices by making all services available, meaningful, and effective in meeting the needs of disabled persons. Prior to the enactment of the Americans With Disabilities Act (hereafter "the A.D.A."), 36 states had some laws on the books protecting disabled persons; none has been as potentially far-reaching as guidelines within the A.D.A. (Community College Week, 1992). The A.D.A. stipulates not only accommodations for the physically impaired,

hearing impaired, or visually impaired, but also mandates the elimination of discrimination against all individuals with disabilities and also provides a forum for enforceable standards addressing discrimination toward persons with disabilities. The key difference between Section 504 of the Vocational Rehabilitation Act of 1973 and the A.D.A. is the process for complaints. Under 504 complaints were brought to federal agencies for investigation, whereas under the A.D.A. regulations one can sue the institution directly. As defined by the U.S. Architectural and Transportation Barriers Compliance Board (1990), there are five separate titles included within the A.D.A. which are detailed in appendix A.

The A.D.A. defines "disability" as a physical or mental impairment that substantially limits one or more of the major life activities. Major life activities have been defined as: caring for one's self, hearing, seeing, working, performing manual tasks, speaking, breathing, and walking. "Physical or mental impairments" that fall within discrimination prohibitions include: (1) any psychological disorder of condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine, or (2) any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes but is not limited to such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease,

diabetes, mental retardation, emotional illness, and drug addiction and alcoholism (Handicapped Requirement Handbook 1987). Unfortunately, services provided to those with mental disorders in educational institutions are often limited to services provided to the visually impaired, hearing impaired, or physically limited populations.

As a more diverse population enters community colleges and federal guidelines are mandated, services once provided may not be adequate for current needs and requirements. One such population is comprised of those who may suffer from the disability of mental or psychological disorders. There must be a re-evaluation among the resources of time, expenditures, and staffing to this emerging population.

As stated by Unger (1991),

> disability groups such as people with physical disabilities, learning disabilities or acquired brain injury have been recognized as needing additional services in order to have access to and to be successful in the postsecondary environment. Student services for people with these disabilities are available on most campuses, while people with psychiatric disabilities have not been included in these services (p. 10).

Background

According to the American Association of Community Colleges (AACC), community colleges enroll nearly two out of every three students with disabilities who attend a postsecondary institution. This reflects the fact that approximately 63 percent of all public higher education students with disabilities who are enrolled at a two year institution (Appendix B). Those disabilities reported

were: learning disabilities, 34 percent; orthopedic or mobility disabilities, 21 percent; chronic and other serious illnesses, 15 percent; hearing impairment or deafness, seven percent; developmental disabilities, seven percent; visual impairments, five percent; emotional/behavioral disorders, five percent; head injuries; four percent; and speech/language disorders, two percent (Barnett, Reinhard, 1992).

According to the National Institute for Occupational Safety and Health, psychological disorder is recognized as one of the ten leading work-related diseases and injuries in the United States. Job related stress is currently receiving an increasing amount of attention, and research has indicated that stress related conditions may be among the most important problems in the 90's (Millar, 1990).

What does the term "mental disorder" mean? A disorder lies on the boundary between the given natural world and the constructed social world; a disorder exists when failure of a person's internal mechanisms to perform their functions as designed by nature impinges harmfully on his well-being as defined by social values and meanings. The order that is disturbed when one has a disorder is thus simultaneously biological and social, neither alone is sufficient to justify the label disorder (Wakefield, 1992). It is also reported that mental disorders refers to a broad range of psychiatric disorders that reflect a deviation from normal thought and behavioral patterns (World Book, 1988).

According to the American Psychiatric Association: (1988)

- Approximately 12 million children under 18 suffer from mental disorders such as autism, depression and hyperactivity.

- Some 8 million to 14 million Americans suffer from depression each year. As many as 2 out of 10 Americans will suffer at least one episode of major depression during their lifetimes.
- 20 percent of the ailments for which Americans seek a doctor's care are related to anxiety disorders, such as panic attacks, that interfere with their ability to live normal lives.
- 1.5 million Americans suffer from schizophrenic disorders and 30,000 new cases occur each year.
- 13 million Americans, including 3 million children, suffer from alcohol abuse or dependance and another 12.5 million suffer from drug abuse or dependence.
- Nearly one-fourth of the elderly who are labeled senile actually suffer some form of mental illness that can be effectively treated.

The term mental disorders does not reflect the seriousness of one's problem due to the complexity and diagnosis related to each individual. Mental disorders can be categorized by two types, those related to physical causes such as brain injuries and those associated with psychological causes such as anxiety or schizophrenia. Mental disorder in its many forms is a treatable disease and may not be recognized from the onset. For this reason, many who suffer from these disorders rarely seek help, resulting in further complications and symptoms. Traditionally, the task of mapping abnormality has fallen to psychiatrists and others who treat psychic ills. In their hands, formally appointed categories of mental disorders have been multiplying. In 1917, the classification system used by the American Psychiatric Association (APA) included only 59 forms of mental complaint; by 1952, when the first APA Diagnostic and Statistical Manual of Mental Disorders appeared, there were 106. The latest version of the manual, which is employed widely by mental-health professionals, insurance companies and the courts, lists 292 possible diagnoses, from "Major Depression" and

"Schizophrenia," to more arcane designations like "Hypoactive Sexual Desire Disorders" (Goode, 1992). Because a diagnosis of mental illness can be acquired in various ways, it creates uncertainties for those given the responsibility in higher education, specifically community colleges, to identify those in need of accommodations. These uncertainties, coupled with a lack of training and preparation by those usually given the task of providing services, may often result in incongruencies among client expectations and provider ability to address such expectations.

Isolated and infrequent incidents on campus or in the community magnify many misconceptions and fears about mental illness. As a result, college personnel are often reluctant to approach students realistically because of fears that the students are fragile or violent. In reality, people with mental illness do not commit more violent crimes than the rest of the population (Unger, 1991). A recent study indicated that slightly more than 11% of the mentally ill are prone to violence compared to the same percentage as in the general population. This study also reported the person who is mentally ill is generally withdrawn, frightened and passive (Willwerth, 1993). It is important to note when assisting students with mental disorders that there must be a differentiation and clear distinction of these students from those that may be in a crisis situation or those generally disruptive. Many students in the latter categories may acquire the label as mentally ill because of convenience and lack of understanding. However, several studies have been conducted relating mental disorder with violent behavior.

According to Monahan (1992)

> There are two ways to determine whether a relationship exists between mental disorder and violent behavior, and if it does, to what extent is the strength of relationship. If being mentally disordered arises the likelihood that a person will commit a violent act, that is, if mental disorder is a risk factor for the occurrence of violent behavior--then the actual (or true) prevalence rate for violence should be higher among disordered than among non--disordered population. As to the extent that mental disorder is a contributing cause to the occurrence of violence, the true prevalence rate of mental disorder should be higher among people who commit violent acts than among people who do not.

Service providers must be able to distinguish between behavior that represents a functional limitation and behavior that does not meet an institution's code of conduct (Parten, 1992).

Mental disorders should not be associated or confused with mental retardation. Mental retardation denotes subnormal intelligence. It may be caused by lack of development of the brain or injury or illness to the brain at birth or in early childhood development. Mental retardation is usually categorized as mild, moderate, or severe. Down's syndrome is an example of retardation.

What does "mental disorders" imply? It makes an inference that educational institutions, community agencies, support groups, and individuals must commit to recognizing this disability as any ther when attempting to evaluate, accommodate, and provide assistance for those in need. Higher education plays a vital role in the rehabilitation of the mentally ill, thus providers of education must come to the forefront and create opportunities for the mentally ill, allowing them to take advantage of the resources within the school and community.

The Problem

Demographics and services within community colleges are in constant change dictated by societal needs. Among these changing services, the perception exists that there is a lack of support services and qualified professionals within community colleges to assist students with mental disorders. It must be understood that mental disorders are usually characterized by emotional liability due to environmental, hereditary or mixed factors. Mental illness afflicts both men and women, many of whom may be in attendance at community colleges throughout the United States. Anyone, no matter what age, economic status or race, can develop an emotional problem. At any given time, between 30 million and 45 million Americans -- nearly one in five -- suffer from a clearly diagnosable mental disorder involving a degree of incapacity that interferes with employment, attendance at school or daily life, (American Psychiatric Association, 1988). When the Americans With Disabilities Act became a law, new requirements did not mandate many changes for colleges, but it heightened disabled peoples' awareness of their rights (Rothstein, 1991). Section 504 of the Vocational Rehabilitation Act defined a handicapped person as "one who has a substantial physical or mental impairment, or is regarded as having some impairment" thus, the A.D.A. was enacted to curtail discriminatory practices. (U. S. Architectural and Transportation Barriers Compliance Board, 1990).

Extensive efforts must be coordinated among community college professionals and community health professionals to provide

assistance to those suffering from mental disorders. While various services are being provided in community colleges to assist students with recognizable disabilities, there is insufficient evidence to suggest that comparable services are being provided by qualified professionals for students with mental disorders.

Purpose of the Study

In the sixties the focus of human equality and civil rights was at the forefront of issues faced by the United States. Today, issues of health care and accessibility for the elderly and disabled are being mandated.

The purpose of this research study is to determine if a population of students who suffer from mental disorders reside on community college campuses within the North Central Accreditation Association and if services are being provided to them. This study also sought to determine if service providers position was related to professional training, and if a community referral process exists with mental health professionals.

Research Questions

The research questions directed to student services providers within the North Central Accreditation Association were: Are there students with mental disorders on community colleges campuses? What services are provided to students with Mental disorders on community colleges campuses? Are service providers positions related to professional training? Does a referral process exist with community mental health professionals?

Scope and Limitations

Community and Junior colleges in the United States currently provide a wide range of services and programs for disabled students. Within the North Central educational accreditation association as outlined in (Appendix C), there are currently 357 public-two year community colleges. It is the largest of the accreditation regions, comprising nineteen states, the smallest being the Northwest region which consists of seven states and 96 colleges. A limitation of the study is, all data from institutions were combined regardless of the institution's size. This may skew the findings somewhat because of this factor.

Assumptions

A major assumption of this research was services provided to the disabled population were only being facilitated by student services support staff, which disregards services that may have been provided by other areas within an institution. This may have been a factor in the number of repeated requests being made to institutions for survey completion, although instructions advised the receiver to forward the survey to the person(s) or area responsible for support services.

A second assumption was that the persons/office surveyed would have some knowledge about mental disorders, and possessed that necessary qualities to supply information pertinent to this study.

Definitions

The following definitions of terms are to provide a better understanding and consistency throughout this research study.

Accessible Facilities - Making existing facilities accessible and usable which may include the modification of work stations so one can perform the essential functions of a job.

Accommodations - Refers to the removal of any type of barrier which may limit participation.

American Association of Community and Junior Colleges (AACJC) - A systematic group of educational institutions consisting of community, technical and junior colleges, serving the public in many aspirations and endeavors. One of the primary missions of this national association is to provide support to state affiliated organizations.

Americans With Disabilities Act - Legislation providing broad fundamental protection to an estimated 43 million disabled persons in access to employment, telecommunications and public services and accommodations.

Auxiliary Services - Wide range of support services and devices for ensuring effective communication.

Community College - Institution of higher education designed to offer the lower two years of a four year or technical degree along with providing developmental assistance and meeting unique educational needs of the local community.

Community Health Center - Designed to offer comprehensive programs to help individuals with multiple psychiatric problems,

chemical abuse and related disorders. Transforming the lives of people suffering from emotional pain into lives of purpose.

Community Health Professional - Individual or agencies which act on behalf of persons with psychological disorders through advocacy, education, support services, and referrals working to improve the quality of life by those affected.

Confidentiality - Compelled not to disclose confiding information or trust related to the welfare of an individual or subject.

Council of North Central Community and Junior Colleges (CNCCJC) - A membership representing public Junior Colleges, Technical Colleges, Community Colleges, Vocational Entities, Tribal related Colleges and University Branch Campuses. These institutional types represent approximately 90 percent of all the public and private institutions within the 19 state North Central Accreditation Region.

Disability - Refers to a physical or mental impairment that limits one or more of the major life activities.

Dysfunctional - A functional abnormality or impairment which may cause one to cease normal functions or activities.

Handicapped - Term "handicapped" has been updated to decrease stereotypes and prejudices. Individual conditions are currently referred to as "disability."

Mental or Psychological Disorders - Refers to impairments affecting normal mental processes or emotional stability.

Mental Health - The basis for personal happiness, including the ability to develop relationships and gain satisfaction from work,

leisure and other aspects of life.

Mental Illness - A relative term which does not, in and of itself, reflect the seriousness of one's problems. It represents a broad range of psychiatric disorders reflecting some deviation from normal thought and behavioral patterns.

Mental Impairment - Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

North Central Association of Colleges and Schools (NCA) - One of the six regional accreditation agencies within the United States. The NCA is the largest of the six regions.

Physical Impairment - Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more neurological, or musculoskeletal organs.

Psychiatric Disorders - Mental or emotional impairment which often results in a loss of contact with reality and personality degeneration.

Psychiatrists - Trained medical professionals uniquely qualified to assess both the mental and physical aspects of emotional distress.

Reasonable Accommodations - Any change in the work environment or the way things are customarily done which allows an individual with a disability equal employment opportunity.

Service Providers - Those individuals identified throughout this study who were responsible for providing services to the mental disabled population.

Student Services Professionals - Usually associated with those individuals given the responsibility of providing support/auxiliary services to students within a college setting.

Supported Services/Education - Education in an integrated setting for people with psychiatric disabilities for whom post secondary education has not traditionally occurred, who because of their disability need ongoing support services to be successful in the education environment.

Vocational Rehabilitation Act of 1973 - Act which protected handicapped persons from discrimination based on their handicap status.

CHAPTER II

LITERATURE REVIEW

The review of the literature to expand upon this study will focus upon: 1) the identification of the mental disorders population; 2) services provided to the mental disorders population; 3) the level of preparation by service providers; and 4) community agencies assistance provided.

Identification of the Mental Disorders Population

Recent attempts to define the mentally ill population have utilized a three-dimensional concept based on diagnosis, level of disability, and duration. Although they are useful for analytic purposes one must be aware that even these indices do not delimit precisely the population of individuals who suffer prolonged mental illness (Frazier, 1985).

The treatment and identification of those that may suffer from symptoms of depression should always begin with a thorough assessment. An adequate evaluation which includes interviewing the client is essential but not conclusive. Often times the client will give a better account of symptoms related to internal experiences, whereas parents or others may report only overt behavioral patterns. Many diagnoses for adolescents are being made by using adult diagnosis criteria (Harrington, 1992).

In the United States, pathology is often equated with the presence of some type of disorder and the diagnostic criteria incorporated in structured interviews within the Diagnostic and Statistical Manual (DSM-III; American Psychiatric Association). These structured interviews result in a more homogeneous sample within and across studies in diagnostic areas. Research has found that states in choosing an interview, a critical issue is the degree to which the psychometric data available on the measure are likely to generalize to the specific research application. Thus, the "best" interview would be one that has demonstrated reliability and validity for the specific population and for the outcome variables which are to be generated (Hodges, 1993).

Usually, individuals experiencing mental problems have reached the level of illness as a result of earlier experiences. These experiences distort normal emotional responses and create inappropriate and ineffectual ways of dealing with life situations (Blai, 1983).

The University of California at Los Angeles (UCLA) student psychological services has identified signs and symptoms of a student that may be in distress:

- Excessive procrastination and very poorly prepared work, especially if this is inconsistent with previous work
- Infrequent class attendance with little or no work completed
- Dependency, e.g., the student who hangs around you, or makes excessive appointments to see you during office hours
- Listlessness, lack of energy, or frequently falling asleep in class
- Marked changes in personal hygiene
- Repeated requests for special consideration, e.g., deadline extensions

- Impaired speech or garbled, disjointed thoughts
- Homicidal threats
- Behavior which regularly interferes with the decorum or effective management of your class
- Overtly suicidal thoughts, e.g., referring to suicide as a current option
- High levels of irritability, including unruly, aggressive, violent, or abrasive behavior
- Inability to make decisions despite your repeated attempts to clarify and to encourage
- Dramatic weight loss or weight gain
- Bizarre or strange behavior which is obviously inappropriate to the situation, e.g., talking to "invisible" people
- Normal emotions that are displayed to an extreme degree or for a prolonged period of time, e.g., fearfulness, tearfulness, nervousness

According to the American Psychological Association (1985), warning signs of mental illness are often diagnosable by 1) personality changes, 2) inability to cope with problems and daily activities, 3) strange or grandiose ideas, 4) excessive anxieties, 5) prolonged depression and apathy, 6) changes in eating -sleeping patterns, 7) discussion of suicide, 8) extreme highs and lows, 9) alcohol-drug abuse, 10) excessive anger, hostility or violent behavior.

Another method of identification and detection of mental disorders has been defined as developmental screening. This process represents a fundamental shift from reactive detection by parents to proactive detection by professionals. Currently there are more than one hundred developmental screening test available for facilitating detection and early treatment (Hall, 1992). As with any assessment tool it must be utilized properly for the task it is designed to measure.

Often times the processes involved in defining appropriate services and procedures for sub-population identification are unclear. In a study conducted by Frank (1990) among those who suffer with chronic mental illness, an effort was made to determine when an intervention to a specific population was beneficial and when decisions regarding distribution of the intervention should be utilized for planning implementation and service delivery. This study also explored analysis to identify characteristics which may distinguish specific sub-populations who are likely to benefit from case management service, despite conflicting findings regarding its effectiveness.

This emerging issue must also be addressed by institutions of higher education due to the increasing nature of its clients (Rothstein, 1986). Roles of postsecondary institutions must include preparing the foundation for an environment that is supportive of this disabled population. McGee (1989) revealed that attitudes and beliefs among university administrators and faculty members toward disabled students differ tremendously. A questionnaire revealed that administrators had a more positive attitude toward helping the disabled student to succeed than did faculty members. A relatively stable ranking of acceptability of handicapping conditions was found. Moderate hearing and vision impairments were generally considered less debilitating while quadriplegia and schizophrenia were rated most debilitating. Findings also indicated that faculty appeared not to have a clear understanding of the many educational implications of some disabilities.

As an older population enters many community colleges, the basis for referral of those with mental disorders differ from the traditional population and referral process. Many referrals for younger clients frequently involve school systems, employers or physicians while many older adults often remain unidentified and unserved. The question then posed by the researchers of one study was, "If psychologists aren't seeing the older adults with psychological problems, who is?" Some of the answers lie among physicians, nursing home staffs, police, social workers and home health care providers and homemaker services (Santos, Hubbard, McIntosh, Eisner, 1984).

In an effort to identify students who may be mentally impaired, an instrument was developed by Haberman (1988) to assess health practices among college students. The instrument identified four content areas: emotional health, nutritional health, alcohol and drug use, and sexual health. This instrument was validated to identify the nature and extent of health practice deficiencies among students which will hopefully enable college health professionals to provide programs responsive to student needs.

In a study conducted by Koot and Verhulst (1992) it was of particular interest to know whether children from the general population who were deviant during an initial assessment would remain so as predicted by the next scheduled assessment. Results indicated that children who scored in the high range of aggressive behavior and attention/depressed conditions scored in the same range four years later. The researcher's findings also suggest that especially problems which are vexing, intense, and persistent,

encourage important reassurances for adults to seek help for the child, and the persistence of problem behavior seems to be of special importance with regard to referral to mental health services.

A study conducted to determine why families of potential psychological disorder patients who made contact with a mental health treatment source did not follow through on any form of treatment revealed, that more families probably inquire about a source of treatment than actually receive it. This group of inquirers also described as "teaser's", generally had children older than those who took advantage of mental health services, had demonstrated problems earlier than the client group, and the parents of the "teasers" were slightly older. The study also revealed that mental health agencies should evaluate their criteria to determine possible client deterrents (Lowman, DeLange, Roberts, Brady, 1984).

In an attempt to explain inadequate mental health services to clients with a psychopathological disorder and mental retardation, researchers have investigated possible diagnostic errors made by clinicians. One such error has been labeled as "diagnostic overshadowing," which is defined as a tendency to overlook, minimize, or misinterpret psychopathology when one appears to have other obvious disabling conditions. Findings indicated that "diagnostic overshadowing" of psychopathology with mental retardation would be less likely to occur when information related to psychopathology was presented prior to measures of intellectual functioning, and when the psychopathology disorder was a higher severity disorder (Wittman, 1989).

In PL94-142, Congressional action has confirmed there is a need for valid assessment practices for students with emotional and behavioral difficulties. Ostrander (1989) conducted a study to examine the variations in assessment practices of school psychologists whether, the type of training affected the assessment practices of school psychologists, and the nature of referrals by psychologists. The findings indicated that psychologists in states using a behavioral criteria found behavioral assessment approaches more valuable that their colleagues practicing under federal definition. It was also revealed that "on the job" experiences were the most typical source of training in objective assessment procedures while graduate school was endorsed as the most highly vaunted source of training in assessment approaches. Psychologists also varied their assessment practices based upon changes in the nature of referral, especially when the referral focused upon developmental issues rather than those of emotional or behavioral considerations.

A study conducted by Halter, Bond, and DeGraaf-Kaser (1992) also determined that textbooks used in undergraduate psychology curricula have a high impact on shaping opinions and attitudes of instructors and students in regard to those with mental illness. Much information imparted through the textbooks reinforces incorrect stereotypes and methods of treatment, hypothesizing that textbooks often lack recent research in the area of psychiatric rehabilitation.

The conclusion of the matter is, institutions that cannot provide evidence of individual assessment of students with

disabilities will lose, and for those that can and do provide proper assessment, the courts will often show deference in their attempt to provide services (Jaschik, 1993).

Services Provided

When it comes to health care on many community college campuses, students are largely on their own to find any assistance. Community college officials from around the country revealed that the absence of such services is a matter of cost. As budgets and programming decrease, college officials deem it to be difficult to provide clinics without students bearing the brunt of the expense (Barnes, 1993).

It is a misguided kindness, as well as being ethically unwise and legally risky, to attempt to carry out a treatment mission with inadequate resources out of compassion for the mentally ill client. This introduces the question of adequate resources for treatment. It is incumbent upon counseling center professional to wrestle with this question and formulate their own answers (Gilbert, 1992).

In regard to what is and is not included as "reasonable accommodations" by the A.D.A., the reasonableness must be considered on a case by case basis. Factors entering into the "accommodation equation" include:

- the individual's needs and desires for accommodation;
- the individual's abilities and limitations in relation to performing the essential functions of the job;
- the nature of the business and of the job;
- the resources of the employer;
- the options for accommodation; and,
- the extent of hardship for the employer in making the accommodation(s) (Pimentel, Bissonnette, Lofito, 1992).

Mental health counselors should be cognizant of the need to deal with the roots of many existing individual problems in behavior. They should also become familiar with symptoms and troublesome behavior, with prevention as well as with treatment, with help to make policies and institutions more humane and growth producing, thus providing visions that inspire people to feel competent and find meaning as well as a sense of community for themselves (Herr, 1991).

The helping professionals of the American Association for Counseling and Development (AACD) serve more mental health clients than all other combined - medical, psychologists, family therapists, and social workers. These services are provided within community agencies, schools, private and governmental settings. The AACD has defined what is distinctive about the practice of counseling and development as provided by mental health counselors in (4) conceptual models: (1) medical - focuses upon the body with emphasis on organic remediation and repair, (2) educational/ developmental - focuses upon the drawing out what is already there in a person or system and is a critical component in families, groups and organizations, (3) psychological - emphasizes the mind and spirit of the individual, and (4) family systems - focuses upon the individual in context, recognizing the role of human interaction and international feedback in regard to behavior (Ivey, Rigazio-DiGilio, 1991).

Upon entering institutions of higher education, students who suffer from mental disorders should be provided reasonable accommodations as any other disability group. This relatively new

phenomenon of serving students with psychiatric disorders provides the following, based on existing knowledge:

- assistance with orientation/registration/ financial aid forms
- assistance choosing classes and instructors
- extended time for exams/test proctoring
- change of location for exams
- special parking
- mobility assistance
- notetakers, readers, tape recorders
- modifications in seating arrangements
- beverages allowed in class
- peer support
- identified, non-threatening place on campus for meeting before or after class
- incompletes or late withdrawals rather than failures in the event of prolonged illness-related absences
- time management and study skills tutoring
- special topic courses (e.g., college survival, personal psychology, disability rights, career exploration)

These accommodations are identical to those provided by disabled student services for other disability groups (Unger, 1991).

These services should include, but not be limited too, proper access, counseling services, and referral procedures. Often, there is a reluctance to provide services to these students, due to the beliefs that more time is required and other erroneous beliefs.

Hoyes (1990) in a study conducted among two-year colleges in Indiana, Illinois, Minnesota, Ohio, and Wisconsin, revealed that the enrollment of students with disabilities was related significantly to state and control, and the types of students with disabilities attending two year colleges also was significant to state, control and institutional size. Hoyes concluded that there was a core of services being provided to the disabled population along with other service components depending on institution size and budgets.

Funding and federal legislation has resulted in a profound impact upon providing services for the disabled. The Carl Perkins Vocational Education Act of 1984 was designed to assure that vocational educational programs were provided for the disabled students assuring accessibility. Research conducted within the California community college districts to identify services and disability groups, revealed the majority of the Vocational Education Act funds were used to supplement and support services for disabled students. Students with physical disabilities and learning disabilities received the most services, while fewer services were provided for students with acquired brain injuries, psychiatric disabilities, and substance abuse difficulties (Sargent, 1998).

According to a recent study conducted by the American Association of Community Colleges (1992) the ten most prevalent services being provided in reference to support services in order were:

- registration assistance
- counseling
- alternative exam formats
- notetaking services
- learning center labs
- disabled student services offices
- adapted equipment
- taped texts
- tutoring
- job placement

Seventy percent of all colleges surveyed by the (AACC), maintained an office for disabled students.

A study of services provided for disabled students recently conducted at Pennsylvania State University, sought to identify institutional structure, availability of services, and delivery of

programs for the disabled population. This study revealed a complex organizational structure composed of three subunits: administrative, academic and external agencies. It was reveled that each subunit had different service priorities and diverse styles of operation. Findings indicated that students with manifest and latent-physical disabilities, were likely to receive assistance from external agencies that provided for their needs or making the proper contacts with campus services. In contrast, those students with latent-educational disabilities had problems making service contacts with the external and campus services, thus receiving fewer accommodations (Albert, 1989).

Cusick (1980) asserts that many community college students experience emotional distress and may not have access to adequate mental health services. This is often due to the amount of stress and pressure exerted on students, while many are unable to adjust to such pressures. This study also identified a need for mental health services concluding that female students experienced more emotional related problems than males and younger students experienced more problems than the older college students.

Procedures for developing policies to accommodate these students should be an institutional priority (Sewell, 1984). To accommodate this population, adequate staff, facilities and proper evaluation is a necessity. Once educational institutions recognize more indepth evaluations may be required for an individual, referrals should be made to community mental health professionals (Blai, 1983).

All area community colleges within the Washington D. C. area

are represented in a consortium known as the Nations Capital Area Disability Support Services Coalition, which is composed of coordinators and directors of disability programs. Their main objective is to do a better job serving the disabled population (Wiley, 1992).

An alternative to the traditional delivery of services and programs was proposed in a study conducted by Glines (1988). It was proposed there should be alternatives to existing degree programs. Innovative approaches as should be outlined for students who have learning and emotional disabilities empowering them to become physically and emotionally healthy, thus enabling them to acquire entry level professional positions in human and social services organizations. The researcher also asserts for this to be accomplished, alternative teaching strategies, the use of individually guided courses, field work placements, and related academic policies must be reviewed and sometimes modified.

Crisis guidelines should be developed along with a formal working relationship with local community health centers, in order to deal effectively with and follow-up on campus crisis situations. The development of such guidelines should include a large segment of campus personnel, i.e., security, college relations, health services. A working crisis team should be appointed and presided over by the Chief Student Affairs officers to provide guidance and implementation of crisis guidelines (Dewitt, 1989). One of the most important decisions college leaders can make in regard to serving students with disabilities is to designate a person to be responsible for implementing the plans for disability

compliance.

Level of Preparation by Providers

Serving students with psychological disabilities on campus is a new role for many disabled student counselors. Some may reject this role because of a feeling of being unskilled or lacking expertise to serve their population. Others may be fearful that they do not understand mental illness and the symptoms of being mentally disabled. Some may often feel overwhelmed because of an already heavy work load, and realize that the students with psychiatric disabilities needs personal attention particularly important in the student/counselor relationship. One must ask the questions: 1) How would I solve this problem if the person had a physical disability? 2) What reasonable accommodations needs to be made? 3) Is this an educational or a treatment issue? 4) Do I need to make a referral to a community or campus resource? 5) Has there been a violation of the student code of conduct? 6) Am I working harder on this problem than the student who presented the problem? These questions which are related to the three principles of practice, separate treatment issues from education issues, work with students with psychiatric disabilities as one would students with physical disabilities, helping them become aware of the behavior requirements on campus (Unger, 1992).

Current standards for Counselor qualifications has reflected the changing role, and provided professional expertise to the field. According to the Council for Accreditation and Counseling Related Educational Programs (1988) preparation standards specify a 48 hour

master's program in school counseling that includes a core curriculum of development theory, social and cultural foundation, helping relationships, appraisals and so on. These preparation standards provide consistent and comprehensive curricula that prepare school counselors for their complex and varied function. It is also important to note that those who supervise counselors, should also be qualified or possess some background in counseling supervision and development (American Association of Counseling Development, 1989). Counseling staffs often interact with other professional personnel, (psychologists, nurses, social workers) concerning particular student needs. To enhance the goal of serving students, these relationships should be characterized by mutual respect, collaboration, and cooperation (Gysbers & Henderson, 1988).

Graduate programs in counseling should consider offering course work in areas of therapy, substance abuse treatment, and crisis management. Seminars on managed care should be held allowing students and practicing professionals a better understanding of the basic principles of a mental health delivery system (Bistline, Sheridan, Winegar, 1991).

Campus providers of mental health should utilize various approaches when working with other staff and faculty members. Expectations and roles clarification are essential during this collaborative process (Glazer, 1979).

Despite the recent emphasis on the development and educational roles of college counselors (Delworth & Hanson, 1989) the provision of direct mental health counseling services remains a central responsibility of the community college counselor. Today's

counselors must be well prepared to provide effective short-term mental health interventions in a variety of circumstances. One method of preparation would be to allow a clinical consultant provide the expertise often required when interventions are warranted (McAuliffe, 1986).

Counselors need to be able to move from spending too much time assisting people with developmental issues, interpersonal conflicts, and problem solving. When a client presents himself as one in need of psychological assistance, counselors should feel confident to recommend an effective and flexible treatment plan in a timely manner without alienating the client from existing social supports. Recommended treatment should be based upon logical analysis rather than avoidance of conflict, or fear of responsibility (Johnston, 1988).

A study conducted among community college counselors in California revealed, because of changes in recent legislation and demographics, counselors responsibilities and competencies have to change immensely to meet the challenges of the 1990's. Roles have to be modified to meet the needs of the older population and those with limited English skills. These findings also indicated that counselors will be more involved in the process-oriented activities versus information dissemination. More emphasis will be put on evaluation, retention and institutional policy development (Vela, 1989).

Residency training is essential for mental health providers. Training should include a formal experience in the management and psychiatric emergencies (Fauman, Fauman, 1980). Those employees who

directly provide services should also be provided staff development training opportunities on a regular basis.

In order for mental health counselors (MHCs) to gain recognition as care providers of mental health services, it is important that counselors respond positively to changes in the health care delivery system. One of the most important changes to occur is the emphasis being placed on providing time-limited mental health counseling. Employee assistance programs (EAPs), health maintenance organizations (HMOs), and preferred provider organizations (PPOs), as well as other third-party payers, are mandating short-term counseling through limits placed on the total number of reimbursable sessions. Clients have become more astute consumers of mental health services, and therefore, seek competitive fees with a keen eye toward the total cost or time needed to resolve treatment issues. In addition, the setting (e.g., school, hospital, social service agency) within which many clients are receiving services, requires the employment of short-term counseling because of limited client contact (Getner, 1991).

Mental health counseling need to focus on the total system, the family, and various groups and organizations that affect the individual. The professional mental health counselor should look beyond individual change to assist the individual, and also consider the many variables within the system surrounding the individual (Dinkmeyer, 1991).

Agency Assistance

In 1955 Congress enacted the Mental Health Study Act, which

created the Joint Commission on Mental Illness and Health. This commission studied the problem of mental health, and concluded to close many of the so-called psychiatric warehouses, and initiate the development of preventive mental health services to communities. Later in 1963, Congress passed the Mental Health Center Act of 1963 providing funding for the development of community mental health centers (Kane, 1984).

Detailed assessments of the national mental health service system for the Presidents Commission on Mental Health in 1977, revealed severe disorganization of services at the national and state levels. This assessment of services concluded there was little or no coordination among agencies to provide mental health services (Rieger, 1992).

Much attention has been given to mental illness and the role of the federal, state, and local governments in relation to providing services. A U. S. hearing on health care (1986) emphasized the roles of the family, and community health programs in providing care to those in need. Senator Edward Kennedy's initiative stated several key features that an effective community-based system of care should include:

--case management, so that someone is responsible for seeing that each chronically mentally individual gets the care and support services he needs;
--a program of habilitation and rehabilitation, which would provide services to the chronically mentally ill appropriate for their level of functioning and responsive to their individual needs. Needed activities can range from regular social contact to vocational training, supervised work, or assistance in obtaining and keeping competitive employment;
--medical treatment, which would provide treatment ranging in intensity from day hospitalization to a periodic appointment with a psychiatrist to check on and adjust

medication;
--assistance to families, who often provide the front-line care for the mentally ill in the community and have too often been left to cope with the severe strains of mental illness without any assistance from the society at large; and
--housing services, ranging from halfway houses with staff in residence providing continuous supervision to largely independent living.

Currently efforts are being coordinated by some institutions of higher education professionals and community health professionals. Patients who are stabilized enough to attend college, often receive assistance in family relations, drug education and economics (Goodman, 1981).

It has been proposed by some state officials that institutions of higher education and mental health agencies coordinate research in clinical, socio-epidemiological, evaluative, program evaluation and policies. Institutions should provide as much of the basic research and clinical research, while the operating agencies should be responsible for setting up program research and evaluation (McPheeters, 1982). A study which examined everyday life for a community-based chronically mentally disabled population in a residential inner-city area, revealed that clients coping well in the community were involved in substantial activities, had enough to do, had several significant others, and were more involved in mental health services. Those most satisfied were older and were more residentially stable (Kearns, 1987). A finding related to adults disabled by traumatic brain injury in the state of Virginia, also indicated that a small fraction of this population were able to obtain community services promoting their maximum productivity and independence. It was also found that a void existed in public

policy and the delivery of human services (Veldheer, 1989). The need for general medical care for the mentally ill population is becoming clearly documented. In comparing patients health between those residing in twenty four hour sheltered care facilities to those residing in a general community dwellings, those under constant supervision did better than their counterparts. The sheltered care residents also showed more residential stability and a positive outlook on services being provided (Liese, 1990).

As community mental health centers have become more dependent on local support due to dwindling federal funds, they have become more visible and open for scrutiny by those "footing the bill." In a study to determine the awareness and impact a mental health center had on its community, it was determined that fewer residents within the community were aware of actual services being provided than those considered to be gatekeepers, (i.e., counselors, police, clergy). A conclusion of this study was that community mental health centers need to make an assertive effort in increasing the awareness and utilization of support services (Scott, Balch, Flynn, 1984).

In some instances, state and local communities have been expected to develop and fund community based mental health services, although many state governments have been unwilling to allocate funds to develop these services. Many community support services have yet to be developed to meet the needs of the chronically mentally ill client. All too often, many chronic mentally ill clients have been relegated to unstable living conditions in often hostile community surroundings (Kane, 1984). The National Institute

of Mental Health recently issued pertinent research on homeless mentally ill adults. The finding are:

- Approximately one third of the homeless population have severe mental illnesses such as schizophrenia, schizoaffective disorders, and mood disorders.
- The homeless mentally ill population is a multi-need population; in some studies as much as 50% of homeless mentally ill individuals also have a current alcohol or other substance abuse problem.
- A sizeable number of homeless mentally ill people have had involvements with the criminal justice system; these arrests, were often associated with such offences as theft and loitering.
- Many homeless mentally ill persons have never received mental health treatment, and many homeless mentally ill persons formerly in treatment are no longer disabled by mental illness.
- A significant proportion of the population is interested in receiving help, but their perceptions of their own service needs often differ from the perception of service providers. Not surprisingly, homeless mentally ill persons tend to place a high priority on meeting their basic subsistence needs first before addressing their mental health needs whereas mental health professionals often place a higher priority on providing traditional mental health treatment.

These findings indicate the need for a comprehensive system of care for the welfare of the homeless mentally ill (Levine, Rog, 1990).

In an attempt to provide a better and more effective community health approach, a study examined the possibility of diffusing information concerning older adults and mental health, from the state hospital psychiatric staff, to county mental health and senior service staff, to direct service providers in local communities. While the effects were minimal, program evaluations revealed issues that should be addressed in regard to intervention, services, and the community services network (Winter, 1990).

There is much uncertainty about the treatment of clients that may be diagnosed as having one or more illnesses and prescribed

treatment. It has been suggested by Polcin (1992)

> That broadening the theoretical and treatment perspectives used by professional training programs it would reflect a sensitivity to the significant problems that clinicians in community mental health currently face in working with dual diagnosis clients. It would also reflect an increasing sensitivity to the existing professional literature, replacing treatment based on outdated models that may have little utility in community programs. Clinicians would be better prepared for work with dual diagnosis clients because they would have a group of relevant issues and current treatment choices that are available to them.

Clinical professionals have recently organized psychological counseling services for a large number of students without the cost being expensive. Factors that further or hinder progress at different stages of therapy have been explored in determining how a holistic concept of neurosis and health can be applied to counseling students. Clinical professionals through this process must maintain the trust of clients, and increase the numbers of hours working with students rather than in meetings or doing paperwork (Hanfmann, 1978).

Several factors have been related to training that have reduced the number of available Psychiatrists who are adequately trained for public and community practice. These include: (1) psychiatry is frequently less valued as a medical discipline by medical students, (2) public psychiatric work is often less valued by psychiatric residents, (3) there are fewer remaining psychiatric residency training programs based in public facilities, (4) social and community psychiatry training programs are few in number and sometimes not well organized. They must often compete with other areas of focus in psychiatric training, such as biologic psychiatry, outpatient psychotherapy, or consultation-liaison services,

(5) there are too few academic psychiatrists who are capable of adequately teaching community mental health principles and practice. The psychiatrists who are capable often are not in academic settings, but instead are working in community mental health programs, (6) there are numerous systems issues, such as conflicting missions within the training facility, bureaucratic red tape, geographic barriers to getting trainees to public training sites, and weak links between psychiatric training programs and public sector mental health programs, and (7) finally, there are issues related to values conflicts, socio/political factors, and economic conditions that discourage psychiatrists from practicing in community settings (Cutler, 1985).

Greco (1988) revealed many mental health centers are dealing with the disheartening facts that one half of all patients who begin out patient treatments will terminate in four or fewer sessions. In a study to identify factors which distinguish those who continue in mental health treatment from those who did not, the researcher attempted to introduce efficient and reliable procedures which would aid in the identification of those who terminated services. Findings indicated that many factors related to therapy duration were specific to individual agency, and reasons for short term consultation varied as related to client and agency interaction. The conclusion of this study was that the identification of those who usually terminated services would best be accomplished by a periodic assessment of the programs and agency guidelines.

According to Pallak (1990) the partnership and coordination necessary between patients, families, professionals, and community

services has crystallized within the context of providing effective services for the mentally ill. There is an obvious need for the development of community-based treatment strategies to implement policies in the least restrictive environment.

It is often difficult for the parents of an individual with a psychological disorder and clinical professional to develop a balanced relationship. Such a relationship should allow parents to maintain the responsibility for managing the needs and service for the child, while allowing the clinician's to render professional decisions within their expertise (Halpern, 1983). There must be a cooperative effort between family and providers with the intent of increasing the capabilities of the individual to identify and satisfy his needs.

Community mental health professionals often lack the skills, time, and ability in forming an alliance with families of people with mental illness. Mental health professional must try to understand and identify the views and burdens shared by families of mentally ill clients to provide a better and continuous care (Hanson, Rapp, 1992). One form of assistance is self-help groups, a form of preventive intervention which attempts to reduce the possibilities of further emotional distress. These groups have emerged out of need for mutual support, problem solving, or assisting those coping with a problems. Self-help groups currently exist for almost every major illness, condition, or life crisis, leading many health professionals to become more skeptical than supportive of this method of assistance (Newton, 1984). Halpern (1983) describes a program known as directive services, the goal

being to assist disabled individuals and their families in locating and acquiring services to meet their ongoing needs. Three key ingredients of this program are:

- a comprehensive information system describing in detail the services available to disabled individuals living in a certain geographic area:
- a team of people who work with disabled individuals, the parents, children and agencies serving them, to ascertain service needs, facilitate the process of arranging services to meet those needs, and periodically check to make sure needs continue to be met: and
- teamwork with various local agencies serving the disabled to identify gaps in the local service system and research possible resources to fill those gaps.

During a time when resources and services are in demand, it has become evident that the disabled individual's and their families are in need of additional assistance.

In adapting to the changing demographics and clients being served, one study revealed that Mexican American were more reluctant to utilize mental health services than Anglo-Americans (Quintans, 1990). This study was based on the conceptual formulation that suggested, cultural displacement along with other cultural and historical considerations provide a better understanding. Findings revealed that Mexican American perceived that any personal treatment had to be relatively straight forward as "medical" in nature. They also perceived, there was less value in pursuing psychological services as compared to the Anglo-American. This is an indication that mental health providers need to modify treatment approaches to better serve the needs of other cultures as well as Mexican-Americans (Quintana, 1990).

The development of community treatment alternatives for persons with mental disabilities must be explored to improve services which

focus upon individual needs and developing community support skills. While many traditional psychiatric approaches may be effective in reducing psychiatric symptoms, some suggest that they have minimal effects on community functioning. The incorporation of services to address the development of skills that people with severe disabling mental illness need are vital (Ryan, 1989).

Summary

The identification and diagnosis of one who may be in need of psychological services is not always clearly defined. In many case, a guardian or the juvenile justice system brings this to the attention of clinicians or therapists. Any decision regarding who is in need of therapy, must be made on the basis of a thorough assessment with related factors taken into consideration (Kendall, Morris, 1991). The decision for placement must be with the parents, when applicable, and therapists working as co-clients. Counseling provided by a professional therapist will aid the family to cope with situations that may deteriorate the parent-child relationship.

Developing and identifying effective treatments for one who may suffer from an emotional disorder must be a major objective for mental health professionals. Often, treatment effectiveness is likely to depend on more than one prescribed technique and type of disorder. Once a technique has been determined, the evaluation of treatment requires the clinician to have a clear understanding of developmental issues relevant for identification and prescribed treatment (Kazin, 1991).

Research has identified groups of individuals that are considered high risk for developing mental disorders. These risk factors may include adverse life events, genetic heritage, and factors related to family stability. According to Aronen (1993) in an attempt to predict children future mental development factors related to the family situations, family situations were not a risk factor as a predictor of mental development. In essence not all individuals exposed to one or several types of risk factors will encounter a psychological disorder.

Mental health encompasses the absence of dysfunction in psychological, emotional, behavioral, and social spheres. It also can refer to optimal functioning or well-being in psychological and social domains. Both domains are obviously related and can usually be assessed using similar diagnostic criteria. Many identified disorders in childhood are likely to continue into adolescence and adulthood. The continuity of such disorders indicates there is a need for early intervention in development (Kazin, 1993).

Institutions should establish performance standards related to serving those with psychological disabilities. As referenced within section three of the Americans With Disabilities Act, institutions are obligated to make "reasonable accommodations" unless it imposes an "undue hardship". Most accommodations may require little or no cost to institutions with the understanding that most organizations have students with psychological disabilities. Nonetheless, many providers often lack the knowledge of such conditions and proper methods of treatment. Institutions must consider providing accommodations that pose the least restricted environment as

possible and make the proper referral to community professionals when necessary. The needed changes in recent legislation for those with mental disorders hopefully will provide an avenue for the disabled to communicate their needs to service providers (Pimental, Bissonnette, Lotito, 1992).

Takanishi (1993) states, the major cause of disability among adolescents between the ages of ten and eighteen is mental disorders. The adolescents in the United States are unique among other adolescents in developed nations in their exposure of violence, pregnancy rates, and currently the threat of human immunodeficiency virus (HIV). This age group can be characterized as a period of great risk to healthy development. Related, the development of policies to accommodate and address the need of health care, many pieces of legislation are often introduced but very few ever approved. Future development of policies related to assist those with diagnosed health problems based upon existing research should include:

- A comprehensive approach that recognizes specific health problems are interrelated and that mental health is very possible an important contributor to overall adolescent health status.
- An integrated approach that recognizes that merely providing information and teaching skills is not sufficient for healthy development. The network of family peers, and caring adults are essential.
- The essential partnership of pivotal socializing institutions in the lives of adolescents and the powerful influences of these combined institutions, families, schools, media, and peers of the course of optimal development.
- The preparation of those all who are in contact with those who may mentally disabled, educators, health professionals, and youth workers should be knowledgeable and responsive to the development needs and

- Community-generated and community-based programs that take into account the diversity of local conditions and populations.

The cost of mental health in 1983 was $33 billion. Approximately one half of this amount was spent in specialty mental health care settings, such as community mental health centers and psychiatric hospitals. It is unclear that assistance provided by the health, juvenile justice, and educational programs are coordinated to the extent that those who may suffer from mental illness are protected (Dougherty, 1988).

Dougherty (1993) revealed there is minimal information or knowledge about the need and availability of services provided to many adolescents. Also when services are provided, may providers do not feel appropriately trained to assist clients, lacking the training and specialization. Currently the federal government supports only six programs in interdisciplinary training for health care providers, and evidence suggest that many who are trained are not utilizing such expertise and are focusing on administrative task rather than on assisting those in need of psychological diagnoses and treatment.

CHAPTER III

METHODOLOGY

Introduction

The purpose of this study was to determine if a population of students who suffer from mental disorders reside on community college campuses and if services were being provided to them. It was also sought to determine if service providers positions related to professional training, and if a community referral process existed. The attitudes and opinions were quantified in terms of survey participants responses to a questionnaire and analyzed by utilizing descriptive research techniques. Descriptive research is used to obtain information concerning the current status of the phenomena and its methods are to describe "what exists" with respect to variables or conditions in a situation (Key, 1992).

This chapter presents the methods and procedures utilized in completing this research. Components of this chapter include baseline data collection, selection of the study group, instrument, and procedures used in collecting and analyzing data.

Gathering of Baseline Data

Part one of the project involved gathering "baseline data" to determine if there were students who suffer from mental disorders within community colleges. There seemed to be a prevalent need at

Tulsa Junior College to better identify and provide comparable services to this sometimes difficult to recognize population. Thus, many with the responsibility of providing services to this disabled population often became frustrated with the lack of identifiable assessment procedures and guidelines.

Local institutional student services professionals were asked if there seemed to be a concern with the identification of students who may suffer from mental disorders. They were also asked if these students were identifiable, and were services in place to assist them. The majority of the staff members agreed that this population was difficult to diagnose, and services were limited or nonexistent. Once determined that students with mental disorders may be among those being served, it was of interest to determine what services were being provided by other community colleges within the North Central Accreditation Association. In the processing of obtaining information relevant to this study, it also became evident that those providing services to this population had concerns about the skills obtained to assist these students, and what assistance may be available within the local community.

Selection of Study Group

It was crucial to determine what other community colleges were doing within the same region, thus the North Central Accreditation Association was selected for this study. The selection of the North Central Accreditation association was appropriate because it is the largest among the (6) accreditation regions. According to the Council of North Central Community and Junior Colleges (CNCCJC)

(1990), there were 357 two-year colleges with established membership.

A total of 179 institutional responses are included in this study. An attempt was made to have equal participation among the states within the North Central Accreditation Association, although some states had a larger number of two year colleges than others. By utilizing the computerized Guidance Information System (GIS) of two year colleges, institutional enrollments were confirmed. There were seventeen colleges with enrollments of ten thousand or more students, all were surveyed and fifteen were returned and are included in this study. The remaining one hundred and sixty four colleges included in this study had enrollments of less than ten thousand students. A map of the states and number of colleges that participated from the North Central Accreditation Association are reflected in Appendix C. After determining and selecting the seventeen colleges with enrollments of then thousand or more, other institutions were selected according to the numbers of colleges represented within each state. Those states having institutions selected because of having ten thousand students or more, were also considered in the number of colleges selected within each state. Surveys were sent to each college in states with ten community colleges or less in an attempt to provide an overall accreditation association representation. Two hundred and twenty-eight institutions were surveyed, and one hundred and seventy nine were returned constituting a sample of the 50 percent within the North Central Accreditation Association.

Conduct of the Study

The questionnaire (Appendix D) was designed to reveal specific information sought which had not been developed by other instruments. The questionnaire was a five part multiple choice restricted format. This type of format allowed for short responses or item checking. The instrument was validated by making it available to other student services and academic personnel for critiquing. These individuals provided input and modifications which were essential in constructing the instrument. The cover letters were written on institutional letterhead addressed to the Dean of Student Affairs Administrator. Realizing that some institutions may not have a person in this capacity, the text of the cover letter asked to have the questionnaire sent to the person responsible for coordinating services for the disabled students. The purpose of the study was stated at the top of the questionnaire along with instructions for completion. The clarification of the terms mental illness and mental disorders for this study was provided. The respondents were asked to answer all questions based on their perceptions and experiences.

The questionnaire consisted of one page, front and back, with a total of 19 possible responses. The front page consisted of Part I, Identifying the Disability (4 questions) and Part II, Assistance Provided (6 questions). Responses required a simple check or short answer.

The back page consisted of Part III, Service Providers Preparation (4 questions), and Part IV, Community Assistance (4

questions). These questions required the same types of responses. Also on the back page, Part V asked for any valued comments in regard to mental disorders, and also allowed respondents to request the results of this study.

The first cover letter (Appendix E) was mailed to the Student Affairs administrators on June 16 1992. This letter requested that the completed questionnaire be returned in an enclosed self-addressed, stamped envelop. All surveys were coded with a number to determine those returned and those not returned.

Institutions that had not responded by August 17 1992, were sent another copy of the original questionnaire. It was requested to return these by October 5 1992. A postcard was also sent as a reminder to those not returned on October 8 1992, once again stating the crucial need for each institution to be included within the study. Two more requests were forwarded on November 5 1992 and January 20 1993 stating the final date to return the questionnaire was February 8 1993. A total of two hundred and twenty eight questionnaires were mailed and one hundred and seventy nine returned for a 50 percent return rate.

Analysis of Data

Following the last request for surveys, collected data were entered in a Lotus database which then was downloaded to the SPSS operations systems for data analysis. The analyzed data were formatted to identify variables, number of records for each variable and columns in each identified variable. Variables were analyzed by

descriptive statistical operation which provided measures of central tendencies. These results are presented and interpreted in the following chapter.

CHAPTER IV

RESULTS OF THE STUDY

Overview

The purpose of this study was to determine if a population of students who suffer from mental disorders reside on community college campuses within the North Central Accreditation Association, if services were being provided to them, if service providers' positions related to professional training, and if a community referral process existed with mental health professionals.

Information was sought by requesting two year institutions of higher education within the North Central Accreditation region to respond to a brief questionnaire. Those within each institution responsible for providing services to those who may suffer from mental illness were asked: How students with mental disorders are identified? What services are provided? What is the preparation of those providing services? What services are provided through community agencies?

Specifically for this study the four research questions under investigation were:

Research Question I - Are there students with mental disorders on community college campuses?

Research Question II - What services are provided to students with mental disorders on community college campuses?

Research Question III - Are service providers' positions related to professional training?

Research Question IV - Does a referral process exist with community mental health professionals?

The method utilized to assess this population within the North Central Accreditation Association was by means of a survey questionnaire. An assessment is an evaluative process measuring a defined criteria for the purpose of information or improvement. For this study a self-developed instrument was utilized to answer the four research questions.

Analysis of the Data

The population as defined in the study consisted of 357 two-year institutions within the North Central Accreditation Association. Individuals responding to this study were those professionals responsible for providing services to those who may suffer from mental disorders. Nineteen states are included in the membership of this region. Two hundred and twenty-eight institutions were surveyed and one hundred and seventy nine instruments being returned for an 78 percent response rate among those surveyed which also constitutes a 50 percent participation rate within the North Central Accreditation Association.

Respondents had an opportunity in Part V, the valued comments section, to add any information pertinent to the study. Many supplied additional information related to the study as well as requesting the results of the study.

Table I defines the institutions that participated in the North Central Accreditation Association study. Surveys were received from each state within the region with a response rate ranging from 46 percent to 100 percent of the surveys mailed. Four states participating in the study had a 100 percent response rate. Two hundred and twenty-eight surveys were mailed and 179 were returned for a 78 percent return rate.

TABLE I

PARTICIPATION OF COMMUNITY AND JUNIOR COLLEGES BY STATE AND RESPONSE RATE

State	Surveys Mailed	Surveys Returned	Response Percentage Rate
Arizona	13	6	46%
Arkansas	8	5	62%
Colorado	12	9	75%
Illinois	27	25	92%
Indiana	10	8	80%
Iowa	9	9	100%
Kansas	16	12	75%
Michigan	23	20	87%
Minnesota	15	10	67%
Missouri	13	10	77%
Nebraska	9	8	89%
New Mexico	6	6	100%
North Dakota	5	5	100%
Ohio	24	17	71%
Oklahoma	8	4	50%
South Dakota	4	4	100%
West Virginia	10	9	90%
Wisconsin	9	7	78%
Wyoming	6	5	83%

Considering the other types of disabilities that may exist on campuses, Table II reflects approximately 56 percent of providers agreed that mental disorders were a recognized disability. If this group were combined with those that strongly agreed that mental disorders were recognized, 87 percent of all respondents replied favorably. Approximately 12 percent of the providers disagreed that students with mental disorders are a recognized population. Missing responses in tables reflect duplication of responses or a lack of response.

TABLE II

PERCEPTION OF SERVICE PROVIDERS' REGARDING MENTAL ILLNESS BEING RECOGNIZED ON CAMPUS

Value	Frequency	Percent	Cumulative Percent
Disagree Strongly	6	3.4	4.5
Disagree	16	8.9	13.4
Agree	100	55.9	69.3
Agree Strongly	55	30.7	100.0
Missing	2	1.1	-

One of the major objectives of an institution in providing services to any population is to have a policy related to services being offered. Table III reflects service provider perception of

TABLE III

SERVICE PROVIDERS' PERCEPTIONS OF HAVING INSTITUTIONAL POLICIES TO ASSIST THE MENTALLY DISABLED

Value	Frequency	Percent	Cumulative Percent
Disagree Strongly	7	3.9	2.3
Disagree	49	27.4	34.6
Agree	88	49.2	83.8
Agree Strongly	29	16.2	100.0
Missing	6	3.4	-

having institutional policies to serve the mentally disabled population. Approximately 49 percent of the providers agreed that policies were in place while 16 percent strongly agreed, combining for approximately 65 percent of the total providers. Although the majority of the providers agreed to having an institutional policy, it is of importance to discern that approximately 31 percent disagreed that a policy existed.

Table IV illustrates providers' perception of having a coordinator to assist this population. Approximately 71 percent stated there was a coordinator responsible for services while 24 percent stated there was not such a position. It can be assumed if there was not a designated coordinator, responsibilities may be incorporated into other support service areas.

TABLE IV

PROVIDERS' PERCEPTIONS OF A DESIGNATED COORDINATOR ON CAMPUS

Value	Frequency	Percent	Cumulative Percent
No	43	24.0	25.1
Unaware	7	3.9	29.1
Yes	127	70.9	100.0
Missing	2	1.1	-

Table V reveals the possible methods of identifying those who may be in need of psychological services. Findings show that a combination of methods used in identification of this population accounted for approximately 42 percent of methods utilized. Student and self-identification methods accounted for approximately 27 percent while 14 percent were verified by a statement of eligibility. Approximately 7 percent of the mentally disabled were identified by the service providers.

Table VI identifies the position job titles of the providers obtained from the study. Eleven areas were reported, which included student services providers and academic support services.

TABLE V

PROVIDERS' PERCEPTIONS OF HOW STUDENTS IN NEED OF PSYCHOLOGICAL SERVICES ARE IDENTIFIED

Value	Frequency	Percent	Cumulative Percent
Statement of Eligibility	26	14.5	17.0
Self Identification	48	26.8	44.7
Staff Identification	12	6.7	51.4
Other Methods	12	6.7	58.1
Combination of Methods	75	41.9	100.0
Missing	6	3.4	-

Approximately 31 percent of the respondents revealed that the primary area responsible for providing services came from within the institutional counseling area. It was also found that approximately 24 percent of the services were provided within the student services areas. The category of disabled student services ranked third in service providers' with 18 percent of the total population. This study also sought to determine the employment status of providers if this population existed on campus. Table VII reveals approximately 61 percent were employed fulltime, in comparison to 22 percent being employed on a parttime basis. The category "other" accounted for approximately 11 percent of the total responses.

TABLE VI

PRIMARY SERVICE AREA RESPONSIBLE FOR PROVIDING ASSISTANCE TO THE MENTALLY DISABLED

Service Areas Providing Services	Frequency	Percent	Rank
Counseling	56	30.7	1
Student Services	43	24.0	2
Disabled Student Services	33	18.4	3
No Response	13	7.2	4
Special Needs Coordinator	12	6.7	5
Academic Support Services	10	5.5	6
Private Community Assistance	3	1.6	7
Dean of Students	2	1.1	8
Adult Resource Center	2	1.1	8
Center for Physically Disabled	2	1.1	8
Vocational Rehabilitation	2	1.1	8
Admissions	1	0.5	9

TABLE VII

DESCRIPTION OF EMPLOYMENT STATUS OF STAFF PROVIDING SERVICES

Value	Frequency	Percent	Cumulative Percent
Fulltime	109	60.9	67.6
Parttime	39	21.8	89.4
Other	19	10.6	100.0
Missing	12	6.7	-

Part II of this study specifically asked, how is assistance being provided to those with a mental disorder? Table VIII shows the types of assistance provided by institutional staff by means of on-site management or community referrals. Twenty-five programs/services were identified. The services ranged from personal counseling to special housing, along with workshops being offered for faculty, staff, and students. Approximately 28 percent of the identified services were in the counseling area. Interesting enough, findings revealed 17 percent of the available services were community referrals. Tutoring services also accounted for 16 percent of the identified services, and eleven institutions stated that support groups for the mentally disabled were available at their institution.

The perception of services provided and evaluated on a periodic basis are illustrated in Table IX. Of the services offered, 65 percent of providers stated a periodic evaluation occurred. Approximately 16 percent stated there was no evaluation process in place, and if combined with the 14 percent who were unaware of an evaluation process, 30 percent of the service providers reported negatively about an existing evaluation process.

With the understanding that other disabled populations on campuses were provided services, it was worth investigating how services being offered compared to services offered to the psychologically disabled population. Table X reflects the providers' perception of how such services compare. Approximately 64 percent of the providers perceived that services were comparable

TABLE VIII

TYPES OF SUPPORT SERVICES CURRENTLY BEING PROVIDED FOR THE MENTALLY DISABLED POPULATION

Program/Service	Frequency	Rank
Counseling	98	1
Community Referrals	61	2
Tutoring	55	3
Academic Support	25	4
Testing Accommodations	24	5
Notetaking	15	6
Support Groups	11	7
Facility Accommodations	11	7
Assessment Services	8	8
Crisis Intervention	8	8
Early Registration	6	9
Career Planning	6	9
Basic/Social Skills	4	10
Nursing Assistance	4	10
Program Modifications	3	11
Mentoring	3	11
Audio-Visual Assistance	3	11
Family Consultation	1	12
Special Programs	1	13
I.D. (Identification Card)	1	13
I.E.P. (Individualized Educational Plan)	1	13
Special Housing	1	13
Workshops for Faculty/Staff/Students	1	13
Orientation Class	1	13

Institutions often reported several types of services being provided.

TABLE IX

PROVIDERS' PERCEPTIONS OF A PERIODIC EVALUATION OF SERVICES PROVIDED

Value	Frequency	Percent	Cumulative Percent
No	29	16.2	20.7
Unaware	25	14.5	34.6
Yes	117	65.4	100.0
Missing	8	4.5	-

to other disabled populations, while 19 percent perceived they were not. Twelve percent were unaware of any differences among services for this population.

TABLE X

PROVIDERS' PERCEPTIONS OF THE QUALITY OF SERVICES PROVIDED AS COMPARED TO SERVICES PROVIDED FOR OTHER DISABLED POPULATIONS

Value	Frequency	Percent	Cumulative Percent
No	34	19.0	24.0
Unaware	21	11.7	35.8
Yes	115	64.2	100.0
Missing	9	5.0	-

Table XI illustrates the perception of the availability of services provided for the mentally disabled students. Approximately 20 percent of the providers perceived that service availability

TABLE XI

PROVIDERS PERCEPTIONS OF THE AVAILABILITY OF SERVICES PROVIDED FOR THE MENTALLY DISABLED POPULATION

Value	Frequency	Percent	Cumulative Percent
Very Poor	2	1.1	3.4
Poor	35	19.6	22.9
Satisfactory	66	36.9	59.8
Good	37	20.7	80.4
Very Good	35	19.6	100.0
Missing	4	2.2	-

was very good and 21 percent believed they were good. These combined, accounted for approximately 41 percent of the providers perception's. Approximately 37 percent perceived the availability of services to be satisfactory and a cumulative total of 21 percent described the availability of services as being very poor or poor.

Table XII reflects the titles of those individuals providing services to those who suffer from mental disorders. Twenty-two title headings, some related and some distinct, provided evidence of the numerous areas which services are available. Approximately 22 percent of the primary services were provided by the Dean of Student Services compared to 17 percent being provided by the

TABLE XII

SERVICE PROVIDER JOB TITLES RELATED TO THE MENTALLY DISABLED POPULATION

Title of Provider	Frequency	Percent	Rank
Dean of Student Services	40	22.3	1
Director of Student Support Services	32	17.8	2
Coordinator of Disabled Student Services	22	12.2	3
Campus Counselor	21	11.7	4
Vice President for Student Services	13	7.2	5
Director of Counseling	12	6.7	6
Special Populations Counselor	7	3.9	7
Disabled Student Program Manager	4	2.2	8
Director of Special Needs	4	2.2	8
Academic Assessment Coordinator	3	1.6	9
Special Needs Instructor	3	1.6	9
Director of Learning Skills Center	3	1.6	9
Coordinator for Non-traditional Students	2	1.1	10
Special Needs Counselor	1	0.5	11
Coordinator of Physically Limited & L.D.	1	0.5	11
Instructional Support Services Manager	1	0.5	11
Learning Disabled Student Services	1	0.5	11
Program Specialist	1	0.5	11
Career Placement Counselor	1	0.5	11
Vice President for Admissions	1	0.5	11
Admissions Counselor	1	0.5	11
Director of Vocational Rehabilitation	1	0.5	11
No Response	4		-

Director of Support Services. The Office of Coordinator of Disabled Student Services, and Campus Counselor, each accounted for 12 percent of the service responsibilities. An interesting finding also revealed that the Vice President for Student Services accounted for 7 percent of the services being provided. It was also of importance to determine if providers' current positions were related to professional training while serving those who suffer from mental

disorders. Table XIII reveals approximately 50 percent of the providers stated their position was definitely related to previous training, while 28 percent perceived training was related. Findings illustrate only 9 percent were serving in a capacity not related to previous training. Overall, 87 percent of those providing services had acquired training related to their current position.

TABLE XIII

SERVICE PROVIDER POSITION RELATED TO PROFESSIONAL TRAINING

Value	Frequency	Percent	Cumulative Percent
No	17	9.5	12.8
Yes, related	50	27.9	40.8
Yes, definitely related	106	59.2	100.0
Missing	6	3.4	-

It was also important to determine if previous occupational experiences were related to current position. Often times one's occupational experiences are held in highest esteem when providing services to a specific population. Table XIV identifies providers' perception of occupational experiences as they relate to current position. Approximately 56 percent of the providers indicated that their occupational experiences were directly related to their

current position, while 23 percent perceived their experiences were related. Only 7 percent indicated that experiences were not related to their current position. Fourteen percent of the responses were missing due to the duplication of responses.

TABLE XIV

SERVICE PROVIDERS' OCCUPATIONAL EXPERIENCES RELATED TO CURRENT POSITION

Value	Frequency	Percent	Cumulative Percent
No	12	6.7	20.7
Yes, Directly Related	100	55.9	76.5
Yes, Related	41	22.9	99.4
Other	1	0.6	100.0
Missing	25	14.0	-

Table XV reveals the providers' perception of staff development programs offered bringing about awareness and education on campuses. Findings indicate only 48 percent of the providers rarely had an opportunity to take advantage of staff development programs. Those

TABLE XV

SERVICE PROVIDERS' PERCEPTIONS OF STAFF DEVELOPMENT PROGRAMS OFFERED FOR AWARENESS/EDUCATION

Value	Frequency	Percent	Cumulative Percent
Never	32	17.9	25.7
Rarely Offered	86	48.0	73.7
Regularly	47	26.3	100.0
Missing	14	7.8	-

that regularly took advantage of programs accounted for 26 percent of the providers. Thirty-two of the participating institutions stated, staff development programs were never offered as a means of awareness or education.

As reflected in Table XVI, 93 percent of the providers reported that a referral process existed, compared to 3 percent that reported not having a referral process. Since a referral process existed, it was crucial to ask if an evaluation of the referral process was conducted on a regular basis. Table XVII reveals that 41 percent of the providers regularly evaluated the referral process, while 43 percent rarely conducted an evaluation. When taken into consideration the providers that never evaluated the referral process, 9 percent, and those that rarely evaluated the process 43 percent, it can be stated that 52 percent of the providers' did not perceive this process as a priority.

TABLE XVI

PROVIDERS PERCEPTIONS OF AN EXISTING COMMUNITY REFERRAL PROCESS FOR THE MENTALLY DISABLED

Value	Frequency	Percent	Cumulative Percent
No	5	2.8	4.5
Unaware	5	2.8	7.3
Yes	166	92.7	100.0
Missing	3	1.7	-

TABLE XVII

SERVICE PROVIDERS' PERCEPTIONS OF A PERIODIC EVALUATION OF THE COMMUNITY REFERRAL PROCESS

Value	Frequency	Percent	Cumulative Percent
Never	16	8.9	16.2
Rarely	77	43.0	59.2
Regularly	73	40.8	100.0
Missing	13	7.3	-

Table XVIII reflects providers' perception of meetings being held with community mental health professional. Regular meetings were held by 32 percent of the providers with community professionals, compared to 52 percent that rarely held meetings.

Nineteen service providers reported that meetings were never held with community mental health providers. Although the majority of providers stated they rarely met with community professionals, it was also revealed that 57 percent of the providers had a designated person on campus to coordinate such meetings as revealed in Table XIX. Table XIX also substantiates that 30 percent of the providers did not have a designated person to coordinate community referrals.

TABLE XVIII

SERVICE PROVIDERS' RESPONSES REGARDING MEETING WITH COMMUNITY MENTAL HEALTH PROFESSIONALS

Value	Frequency	Percent	Cumulative Percent
Never	19	10.6	15.1
Rarely	94	52.5	67.6
Regularly	58	32.4	100.0
Missing	8	4.5	-

TABLE XIX

SERVICE PROVIDERS' PERCEPTIONS OF HAVING A DESIGNATED PERSON TO COORDINATE COMMUNITY REFERRALS

Value	Frequency	Percent	Cumulative Percent
No	54	30.2	34.6
Unaware	15	8.4	43.0
Yes	102	57.0	100.0
Missing	8	4.5	-

Part V of the instrument requested valued comments from institutions in regard to what can be done to improve services to this population as reflected in Table XX. A majority of the responses revealed that staff development seminars and training should be offered bringing about awareness of this population. Many providers indicated that a qualified person on campus was a necessity, because of the lack of knowledge and expertise by staff members. Comparisons among institutions related to size, location, residential or non-residential, revealed there were differences in need and perspective related to serving this population. Institutional representatives also expressed a sense of hopelessness because of the inability to know what to expect, and the lack of appropriate identification procedures.

A couple of providers reflected negatively about the mentally disabled revealing "this population should not be considered as

TABLE XX

ADDITIONAL COMMENTS PROVIDED WHICH COULD IMPROVE SERVICES TO STUDENTS WITH MENTAL DISORDERS

Value
Coordination with community mental health centers.
Designating an individual or office for responsibility.
Ensure qualified mental health practioners provide services.
Work closely with faculty, develop awareness and instructional accommodations.
A case manager to work close and consistently with this population.
Better programming and support services.
Mental disorders should not be considered a disability because of the violent and antisocial behavior.
More recognition of the responsibility to serve.
Have firm policies, and procedures in place and force all faculty members to follow them.
More staff inservice, sensitivity training.
Advocacy for mental disabled.
Campus based support groups.
More education about mental disorder.
Improve articulation between the college and community resources.
Difficult to identify this population.
Have a person from department of mental health on campus.
Meet then where they are; take them to the place they can go.
We have had very positive feedback on services to this population.
The college needs to make a more serious commitment in time and money to students.
We need an in-house mental health specialist to serve students rather than referral. Once referred there are often extensive waiting lists.
There isn't much more we can reasonably do.
We have no therapist or psychologist and have no discrete way of knowing the existence of the mental health problem of a student.
Nothing, this is not a A.D.A. area. We cannot deal with these people. We don't have the resources nor is it within our mission.
As with many adults with disabilities early self-identification does not happen in a school term.
Develop consortium of psychiatric referrals: training for helping professionals such as resident assistants to recognize potential students.
We are only staffed two days per week; we need clinical personnel present five days.
Identification and referrals we do both poorly.
We should recognize that this disorder does exist and develop services to assist this population.
Time and money.

TABLE XX (Continued)

Value
Well qualified staff, many resources to handle this population.
A support network would be beneficial; information about medication side-effects.
Change administrative attitudes.
Additional contact staff.

disabled because of their violent nature". Another stated, "mental disorders is not considered under the A.D.A. and "they could not deal with such populations, and it was not in their mission". Overall the comments were supportive to meeting the needs of the mentally disabled.

Summary

The purpose of the study was to determine if a population of students who suffer from mental disorders reside on community college campuses, and if services were being provided to them. This study also sought to determine if service providers positions related to professional training, and if a community referral process existed.

In part one of the survey which addressed the question of are there students on campus who suffer from mental disorders, the majority of providers agreed that students with mental disorders

were an identifiable population, and a process of identification was utilized.

Part two of the survey addressed the question if services were being provided. It was revealed that services ranged from tutoring, to support groups offered by different segments of the institutions. Along with the many services being provided, findings indicated program assessment and modifications occurred regularly. Counseling services rated as the number one service being provided.

Part three of the survey addressed the question of what was the level of preparation by the providers. Most providers, stated their current position was definitely related to educational attainment or occupational experiences. The majority also stated their current positions were related to professional training.

Part four of the survey addressed the question of what community assistance was in place to assist this population. Approximately 40 percent stated there were periodic evaluations of the referral processes while only a third of the providers reported there were regular coordinated meetings among community professionals.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of this study was to define methods of identification, services provided, related preparation by providers, and community assistance given to those who suffer from mental disorders.

Data relevant to students with psychological disorders were requested from service providers in the community college settings within the North Central Accreditation Association. Providers were requested to supply information pertaining to: If mental illness was recognized as a disability on their campus? How were students identified as having a psychological order? What was the primary service areas responsible for providing assistance? What were some of the services to be provided? Were the provider's positions related to educational training? Was there a community referral process in place? Did regular meetings occur with community mental health professionals?

Specifically, the research question to be answered in this study were:

Research Question I - Are there students with mental disorders on community college campuses?

Research Question II - What services are provided to students with mental disorders on community college campuses?

Research Question III - Are service providers positions related to professional training?

Research Question IV - Does a referral process exist with community mental health professionals?

Summary of Findings

The total population of community and junior colleges within the 19 state North Central Accreditation Association is 357 institutions. For this study 228 institutions were sampled and 179 usable surveys were returned for an 78 percent response rate among those participating in the study. This constituted a 50 percent participation rate among community colleges within the North Central accreditation region.

In part I of the study, providers were asked to indicate the methods utilized for identifying the mentally disabled population. Approximately 85 percent agreed that students with mental disorders comprised an identifiable population on campuses, while approximately 12 percent of the providers replied that this population was not recognized on campus. Institutional policies had been developed in the majority of the organizations while approximately 30 percent had no existing policy. They also indicated that most students were identified as having a disability by the method of self-identification.

In part II of the study, it was revealed that the majority of services were being provided by counseling personnel, followed by the student services area. A majority of the providers stated that the office of disabled student services existed, and ranked third among the providers. More than half of the providers were fulltime, providing major services such as counseling, community referral assistance, tutoring, academic support and testing accommodations.

In part III of the study, some providers were classified as Deans of Students, Directors of Support Services, Coordinators of Disabled Student Services, Campus Counselors, and Vice Presidents for Student Services. It was disclosed that 87 percent of providers held positions related to their professional training while approximately 79 percent stated their occupational experiences were related to their current position. Staff development sessions were rarely or never offered providing education and awareness to this population.

In part IV of the study, ninety two percent of the providers perceived that the community referral process was effective. While the perception of the referral process seemed favorable, periodic evaluations of the process was conducted less than 50 percent of the time among institutions. Coordinated meetings among institutional and community professionals occurred only one out of three places (32 percent).

Part V of the study provided the opportunity for respondents to furnish additional comments related to serving the mentally disabled students. The recommendations addressed the need for continued services provided by institutional and community

professionals. Most of the recommendations were based on adequate resources to better assist this population, not only within the student support areas but academic area as well. Respondents also noted that staff development and training were essential in providing awareness for identification, acceptance and advocacy. A relevant factor revealed in this study was some providers refused to accept and recognize that mentally disabled as a disabled population within the A.D.A.; and concluded that this population should not be allowed on campuses.

Conclusions

The purpose of this study was to determine if a population of students who suffer from mental disorders reside on community college campuses within the North Central Accreditation Association, if services are being provided to them, were the providers positions related to their training and if a community referral process exists. There are 19 states within this region, all were included within this study, and a total of 179 usable instruments were collected creating the database for this study.

The review of the literature substantiates the challenges and opportunities community colleges will be confronted with as a result of legislation and the deinstitutionalization of those who suffer from mental disorders. Studies have indicated this population's enrollment in institutions has increased immensely compared to many others. The review of the literature also reveals that only a few within this population will exhibit behavior of a violent nature. Furthermore, this population does not exhibit violent behavior any

more than the so called "normal" student. Procedures for dealing with the behaviors of this population should be thoroughly evaluated as with any other disabled population.

Services being provided to students with mental disorders were documented by the majority of institutions. A wide range of services were provided, with the most coming from the student services/support areas.

This study investigated four research questions related to serving the mentally disabled in community colleges with the following conclusions being made. The identification of the population should entail a thorough assessment process for determining accommodations. The majority of the providers perceptions were, mental disorders were a recognized disability and institutional polices did exist. Most students were identified by the method of self-identification or a combination of identifiable methods. Thus, it is concluded that institutions are aware of this populations existence on campus, and methods of identification should be maintained in providing reasonable services. As stated by Jaschik (1993), those institutions that cannot provide evidence of individual assessment of those with a disability will lose, and those that can and do provide proper assessment, the courts will often show deference.

A second finding extracted from the study is a number of areas within institutions provided numerous services. Most services were provided by counseling services and student services staff respectively. The majority of services were provided by fulltime staff and were evaluated for effectiveness by the majority of

providers. Most agreed that services were comparable to other disabled populations. Based upon these findings it is concluded that institutional support and resources should be devoted to the student services area, specifically counseling. Also, fulltime staff training should be updated regularly for effective identification and treatment.

A third finding is service providers educational and occupational experiences are indeed related to current positions. Based upon these findings it is concluded that most service providers have the expertise and training to accommodate this population acquired through educational or job related experiences. This was somewhat inconsistent with the literature review by Unger, (1992) who stated, many of today's providers may reject this new role because of a feeling of being unskilled or lacking the expertise to serve this population. McAuliffe (1986) also stated that today's counselors must be well prepared to provide effective short-term mental health interventions in a variety of circumstances.

A final finding is a community referral process existed among a majority of the institutions but there was not a stated procedure for an evaluation of the referral process. This fact concludes that although there was a referral process, the process was minus evaluative procedures. As a result, providers may lack critical data relevant in modifying or critiquing the referral process. Also, meetings were not regularly scheduled among institution and community professionals which contradicts the effectiveness of an referral process. This also was inconsistent with institutions

having a person on campus to coordinate such activities. If there were coordinators of the referral process, regularly scheduled meetings and evaluation procedures should exist.

Considering the growth of community colleges, institutional leaders and providers must come to the realization that a revamping of not only services must occur, but also the underlying philosophy of servicing those students with psychological disorders.

Recommendations

A major reason this study was conducted among community colleges was, the majority of higher education enrollments are occurring in this setting. It is assumed that regional and comprehensive universities have made many adjustments to accommodate this population. Throughout this study, specifically during the review of the literature, inferences were made that this population had not been recognized as a protected class under the A.D.A. Also, those called upon to provide services may not be capable of assessing the needs of this population. A further study is recommended to address the issue of identification of this population as related to documentation and confidentiality. A question related to the furtherance of such research could consider the rights of providers, related to the need to know and disclosure of a disability.

Further studies should also be undertaken among the other accreditation regions. It would be of interest to compare what regions are doing to accommodate this population within community colleges.

The instrument for this study was sent to the student affairs administrator for completion, or forwarding to the office responsible for disabled student services. Findings indicated there were many support services being provided by the academic areas within institutions. A study could be conducted investigating faculty services and awareness, as related to legal responsibilities pertaining to confidentiality. Additionally, this study solicited the perception of the community college providers in relationship to community referral and assistance. As revealed in this study there seemed to be an aimless attempt to meet with community mental health professionals. A study of the perceptions of community mental health professionals may provide additional evidence concerning working relationships.

This study has revealed many strategies institutions could incorporate. Some are, the development of thorough assessment procedures, an attempt to acquire and maintain qualified staff to provide services, and a more assertive commitment to coordinate services with community professionals. In-service training for faculty and staff should also be offered, responding to the needs of students with mental disorders, an increasing population within the community college settings.

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APPENDIXES

APPENDIX A

A.D.A. FACT SHEET

Accessibility Requirements	Effective Date	Regulations and Enforcement
Title I - Employment		
Employers with 15 or more employees may not discriminate against qualified individuals with disabilities.	July 26, 1992 - for employers with 25 or more employees. July 26, 1994 - for employers with 15 to 24 employees.	EEOC to issue regulations by July 26, 1991. Individuals may file complaints with EEOC. Individuals may also file a private lawsuit after exhausting administrative remedies.
Employers must reasonably accommodate the disabilities of qualified applicants or employees, including modifying work stations and equipment, unless undue hardship would result.		Remedies are the same as available under Title VII of the Civil Rights Act of 1964. Court may order employer to hire or promote qualified individuals, reasonably accommodate their disabilities, and pay back wages and attorneys' fees.

Accessibility Requirements	Effective Date	Regulations and Enforcement
Title II - Public Services		
State and local governments may not discriminate against qualified individuals with disabilities. Newly constructed state and local government buildings, including transit facilities, must be accessible. Alterations to existing state and local government buildings must be done in an accessible manner. When alterations could affect accessibility to "primary function" areas of a facility, an accessible path of travel must be provided to the altered areas and the restrooms, drinking fountains, and telephones serving the altered areas must also be accessible, to the extent that the additional accessibility costs are not disproportionate to the overall alterations costs.	January 26, 1992 - unless otherwise noted below. (Recipients of Federal financial assistance are presently required to comply with similar requirements under Section 504 of the Rehabilitation Act of 1973.)	DOJ to issue regulations except for public transportation by July 26, 1991. DOT to issue regulations for public transportation by July 26, 1991. ATBCB to supplement MGRAD by April 26, 1991. DOJ and DOT regulations must be consistent with supplemental MGRAD and may incorporate the supplemental MGRAD. UFAS to be used as interim accessibility standard if final regulations have not been issued and if a building permit has been obtained prior to issuance of final regulations, work begins within one year of receipt of permit, and is completed under the terms of the permit. If final regulations have not been issued one year

New buses and rail vehicles for fixed route systems must be accessible.	Ordered after August 25, 1990.	after MGRAD had been supplemented, MGRAD to be used as interim accessibility standard.
New vehicles for demand responsive systems must be accessible unless the system must be accessible unless the system provides individuals with disabilities a level of service equivalent to that provided to the general public.	Ordered after August 25, 1990.	(Facilities constructed of altered with Federal funds are presently required to comply with UFAS under the Architectural Barriers Act of 1968. Facilities constructed or altered by recipients of Federal financial assistance are presently required to comply with UFAS or other applicable standards under Section 504 of the Rehabilitation Act of 1973.)
One car per train must be accessible.	By July 26, 1995.	Amtrak and commuter rail passenger cars must comply with MGRAD provisions for rail cars to the extent that they are in effect at the time the design of the cars is substantially completed, if final regulations have not been issued.
Existing "key stations" in rapid rail, commuter rail, and light rail systems must be accessible.	By July 26, 1993. Extensions may be granted up to July 26, 2010 (commuter rail) and July 26, 2020 (rapid and light rail) for stations needing extraordinarily expensive structural changes.	
Comparable paratransit must be provided to individuals who cannot use fixed route	By January 26, 1992.	Individuals may file complaints with DOT concerning public transportation and

bus service to the extent that an undue financial burden is not imposed.		with other designated Federal agencies concerning matters other than public transportation. Individuals may also file a private lawsuit.
All existing Amtrak stations must be accessible.	By July 2010.	Remedies are the same as available under Section 505 of the Rehabilitation Act of 1973. Court may order entity to make facilities accessible, provide auxiliary aids or services, modify policies, and pay attorney's fees.
Amtrak trains must have same number of seating spaces for individuals who use wheelchairs as would available if every car in the train were accessible to such individuals.	By July 26, 2000. Half of these seats must be available by July 26, 1995.	

Accessibility Requirements	Effective Date	Regulations and Enforcement
Title III - Public Accommodations		
Restaurants, hotels, theaters, shopping centers and malls, retail stores, museums, libraries, parks, private schools, day care centers, and other similar places of public accommodation may not discriminate on the basis of disability.	January 26, 1992 - unless otherwise noted below.	DOJ to issue regulations except for privately operated transportation by July 26, 1991. DOT to issue regulations for privately operated transportation by July 26, 1991.
Physical barriers in existing public accomodations must be removed if readily achievable (i.e., easily accomplishable and able to be carried out without much difficulty or expense). If not, alternative methods of providing services must be offered, if those methods are readily achievable.		ATBCB to supplement MGRAD by April 26, 1991. DOJ and DOT regulations must be consistent with supplemental MGRAD and may incorporate the supplemental MGRAD.
New construction in public accommodations and commercial facilities	Facilities designed and constructed for first occupancy after	UFAS to be used as interim accessibility standard if final regulations have not

(non-residential facilities affecting commerce) must be accessible.

January 26, 1993.

been issued and if a building permit has been obtained prior to issuance of final regulations, work begins within one year of receipt of permit, and is completed under the terms of the permit. If final regulations have not been issued one year after MGRAD to be used as interim accessibility standard.

Alterations to existing public accommodations and commercial facilities must be done in an accessible manner. When alterations could affect accessibility to "primary function" areas of a facility, an accessible path of travel must be provided to the altered areas and the rest rooms, telephones, and drinking fountains serving the altered areas must also be accessible, to the extent that the additional accessibility costs are not disproportionate to the overall alterations costs.

On application by State or locate government, Attorney General, in consultation with ATBCB, may certify that State or local building codes meet or exceed ADA accessibility requirements.

Individuals may file complaints with the Attorney General. Individuals may also file a private lawsuit.

Elevators are not required in newly constructed or altered buildings under three stories

Remedies are the same as available under Title II of the Civil Rights Act of 1964.

or with less than 3,000 square feet per floor, unless the building is a shopping center, mall or health providers office. The Attorney General may determine that additional categories of such buildings require elevators.		Court may order an entity to make facilities accessible, provide auxiliary aides or services, modify policies, and pay attorneys' fees.
New buses and other vehicles (except automobiles) operated by private entities must be accessible or system in which vehicles are used must provide individuals with disabilities a level of service equivalent to that provided to the general public depending on whether entity is primarily engaged in business of transporting people; whether system is fixed route or demand responsive; and vehicle seating capacity.	Ordered after August 25, 1990.	Court may award money damages and impose civil penalties in lawsuit filed by Attorney General but not in private lawsuit by individuals. Small businesses with 25 or fewer employees and gross receipts of $1 million or less may not be sued for violations occurring before July 26, 1992; and small businesses with 10 or fewer employees and gross receipts of $.5 million or less may not be sued for violations occurring before January 26, 1993. However, such small businesses may be sued for violations relating to new construction and alterations to facilities occurring after the effective date.
New over-the-road buses (buses with elevated passenger deck located over a baggage compartment) must be accessible.	Ordered after July 26, 1996 (July 26, 1997, for small companies). Date may be extended by one year after completion of a study.	

Accessibility Requirements	Effective Date	Regulations and Enforcement
Title IV - Telecommunications		
Telephone companies must provide telecommunications relay services for hearing-impaired and speech-impaired individuals 24 hours per day.	By July 26, 1993.	FCC to issue regulations by July 26, 1991. Individuals may file complaints with the FCC.

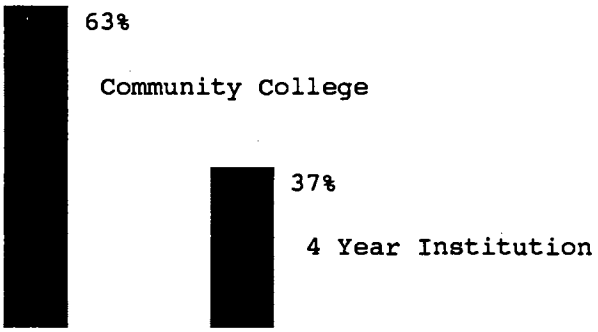
APPENDIX B

DISTRIBUTION OF STUDENTS WITH DISABILITIES

IN HGIHER EDUCATION

Distribution of Students With Disabilities In

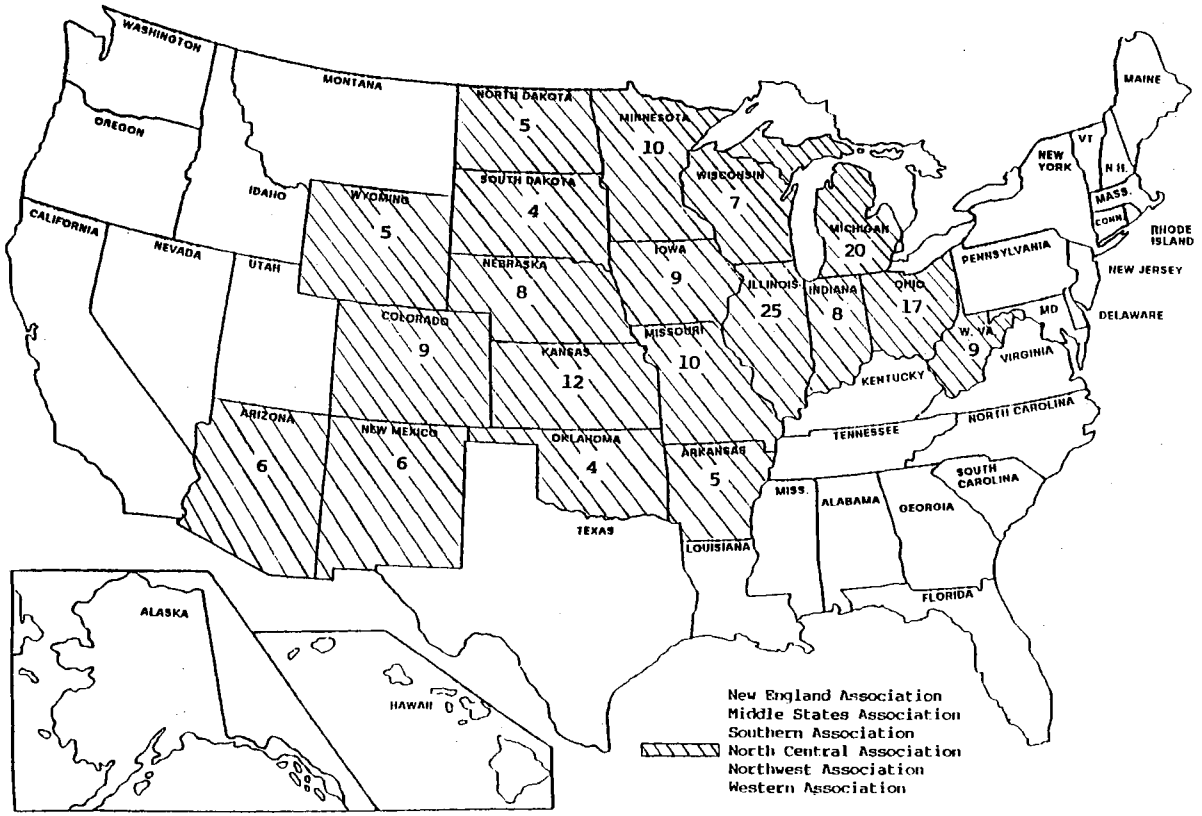
Public Institutions of Higher Education



American Association of Community Colleges (1992)

APPENDIX C

MAP OF PARTICIPATING STATES BY COLLEGES WITHIN THE NORTH CENTRAL ACCREDITATION ASSOCIATION


WASHINGTON
OREGON
CALIFORNIA
NEVADA
IDAHO
MONTANA
WYOMING
5
UTAH
ARIZONA
6
COLORADO
9
NEW MEXICO
6
NORTH DAKOTA
5
SOUTH DAKOTA
4
NEBRASKA
8
KANSAS
12
OKLAHOMA
4
TEXAS
MINNESOTA
10
IOWA
9
MISSOURI
10
ARKANSAS
5
LOUISIANA
WISCONSIN
7
ILLINOIS
25
MICHIGAN
20
INDIANA
8
OHIO
17
KENTUCKY
TENNESSEE
MISS.
ALABAMA
GEORGIA
FLORIDA
SOUTH CAROLINA
NORTH CAROLINA
VIRGINIA
W. VA.
9
PENNSYLVANIA
NEW YORK
MD
DELAWARE
NEW JERSEY
CONN.
MASS.
VT
N.H.
RHODE ISLAND
MAINE
ALASKA
HAWAII
New England Association
Middle States Association
Southern Association
North Central Association
Northwest Association
Western Association

APPENDIX D

RESEARCH INSTRUMENT

Tulsa Junior College
10300 E. 81st Street
Tulsa, OK 74133

Dear Colleague:

In an continuing effort to improve services for students, your assistance is requested in taking a few minutes to complete the following survey. Your responses will not be used individually, but will be grouped with other selected student service professionals. If you desire to know the results of this voluntary study, please indicate so in the comment section. The terms in this study mental illness and mental disorder will be used synonymously.

Please complete this questionnaire as soon as possible and return it in the enclosed self-addressed, stamped envelop. Please make any comments which you believe will improve the quality of services offered to students. Thank you.

Donnie Nero
Dean of Student Services

Please answer the following questions based on your perception and experiences.

Mental Disorders Among Community College Students

PART I
-Identifying the Disability

1. Mental illness is recognized as a disability on my campus.

___ Strongly Agree ___ Agree
___ Disagree ___ Strongly Disagree

2. Institutional policies and procedures are in place to assist these students.

___ Strongly Agree ___ Agree
___ Disagree ___ Strongly Disagree

3. There is a designated person to coordinate these programs on my campus.

___ yes
___ unaware
___ no

4. Students in need of service are identified by:

___ Statement of eligibility regarding the disability
___ Self identification/assessment
___ Staff identification/assessment
___ Other (describe) _____
_____
_____

PART II
Assistance Provided

1. What is the primary service area responsible for providing assistance?

2. Which best describes staff providing services?
___ Full time
___ Part time
___ Other (describe) _____
_____

3. Please list support services provided.
1.
2.
3.

4. Are there periodic re-evaluations of services provided?
___ yes ___ unaware ___ no

5. Services provided are comparable to other disabled population services?
___ yes ___ unaware ___ no

6. How would you rate the availability of services to this population?
___ very good ___ good
___ satisfactory ___ poor
___ very poor

PART III
Service Providers Preparation

1. What is your current title?
   _____
   _____

2. Is your present position related to educational degrees acquired?
   ___ yes, definitely
   ___ yes, related
   ___ no If no, answer question #3

3. Have you been employed in an occupation related to your present position?
   ___ yes, directly related
   ___ yes, related
   ___ no

4. Staff development programs are provided for educational purpose related to this disability.
   ___ Rarely
   ___ Regularly
   ___ Never

PART IV
Community Assistance

1. A community referral process exist on my campus?
   ___ Yes ___ Unaware
   ___ No

2. There are periodic re-evaluation of community referrals?
   ___ Regularly
   ___ Rarely
   ___ Never

3. Regular meetings occur with community health professionals?
   ___ Never
   ___ Rarely
   ___ Regularly

4. A designated person coordinates community referrals?
   ___ yes
   ___ unaware
   ___ no

PART V
Valued Comments

In your opinion what can be done on your campus to improve services for students that may suffer from mental disorders?

APPENDIX E

COVER LETTERS

Tulsa Junior College

CENTRAL OFFICE
6111 East Skelly Drive
Tulsa, Oklahoma 74135
(918) 622-5100

METRO CAMPUS
909 South Boston Avenue
Tulsa, Oklahoma 74119
(918) 587-6561

NORTHEAST CAMPUS
3727 East Apache
Tulsa, Oklahoma 74115
(918) 834-5071

SOUTHEAST CAMPUS
10300 East 81st Street
Tulsa, Oklahoma 74133
(918) 250-9581

January 20, 1993

Dear Student Affairs Administrator;

Please take a few minutes to complete or forward this survey to the person on your campus responsible for serving disabled students. Your institutions responses are valuable to this study being conducted within the North Central Accreditation region, and will remain confidential with only the composite results being made available to requesting institutions. This research has been undertaken to better identify services provided to a population that may exist on college campuses. For your institution to be included in this study, it is essential this survey be returned. **Please return by February 8, 1993.** Your cooperation is appreciated.

Donnie L. Nero
Dean of Student Services
Southeast Campus
(918) 631-7668

DLN:bjb

Tulsa Junior College

CENTRAL OFFICE
6111 East Skelly Drive
Tulsa, Oklahoma 74135
(918) 622-8100

METRO CAMPUS
909 South Boston Avenue
Tulsa, Oklahoma 74119
(918) 587-6561

NORTHEAST CAMPUS
3727 East Apache
Tulsa, Oklahoma 74115
(918) 834-5071

SOUTHEAST CAMPUS
10300 East 81st Street
Tulsa, Oklahoma 74133
(918) 250-9581

November 5, 1992

Dear Colleague

Earlier this semester your institution received a survey on "identifying students with mental disorders". Unfortunately we have not received it to date. Please respond to this request or forward to the person responsible for coordinating your disabled student services programs. It is important that your institution participate in this North Central Accreditation region survey for Community and Junior Colleges. Your responses will remain confidential and only the composite results will be made available to requesting institutions. If your institution does not have an office for students with disabilities, please complete as much as possible and return by November 30, 1992.

Your prompt attention is appreciated.

Donnie L. Nero
Dean of Student Services
Southeast Campus
(918) 631-7668

DLN:bjb

Tulsa Junior College

CENTRAL OFFICE
6111 East Skelly Drive
Tulsa, Oklahoma 74135
(918) 622-5100

METRO CAMPUS
909 South Boston Avenue
Tulsa, Oklahoma 74119
(918) 587-6561

NORTHEAST CAMPUS
3727 East Apache
Tulsa, Oklahoma 74115
(918) 834-5071

SOUTHEAST CAMPUS
10300 East 81st Street
Tulsa, Oklahoma 74133
(918) 250-9581

August 17, 1992

Dear Student Affairs Administrator,

Please take a few minutes to complete and return this brief survey or forward to the coordinator of disabled student services on your campus. Your responses are valued and are an integral part of a regional study. For your institutions to be represented in this study, this survey must be returned by October 5, 1992.

I look forward to the acquisition of your campus responses.

Donnie L. Nero
Dean of Student Services
Southeast Campus

DLN:bjb

Tulsa Junior College

CENTRAL OFFICE
6111 East Skelly Drive
Tulsa, Oklahoma 74135
(918) 622-5100

METRO CAMPUS
909 South Boston Avenue
Tulsa, Oklahoma 74119
(918) 587-6561

NORTHEAST CAMPUS
3727 East Apache
Tulsa, Oklahoma 74115
(918) 834-5071

SOUTHEAST CAMPUS
10300 East 81st Street
Tulsa, Oklahoma 74133
(918) 250-9581

June 16, 1992

Dear Student Affairs Administrator,

Please take a few minutes to complete and return this brief questionnaire or forward to the coordinator of disabled student services on your campus. Your responses are valued and are an integral part of a nationwide study.

I look forward to the acquisition of your campus responses.

Donnie L. Nero
Dean of Student Services
Southeast Campus

DLN:bjb

10-8-92

Dear Colleague,

Recently you were sent a survey "Mental Disorders Among Community College Students". As of this date my records indicate that it has not been returned. For your institution to be included in this regional study, please return the survey as soon as possible.

Thank You

APPENDIX F

STATES WITHIN ACCREDITATION ASSOCIATIONS

Middle States Association of Colleges & Schools

Delaware
District of Columbia
Maryland
New Jersey
New York
Pennsylvania

North Central Association of Colleges & Schools

Arizona
Arkansas
Colorado
Illinois
Indiana
Iowa
Kansas
Michigan
Minnesota
Missouri
Nebraska
New Mexico
North Dakota
Ohio
Oklahoma
South Dakota
West Virginia
Wisconsin
Wyoming

New England Association of Schools & Colleges

Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

Northwest Association of Schools & Colleges

Alaska
Idaho
Montana
Nevada
Oregon
Utah
Washington

Southern Association of Colleges & Schools

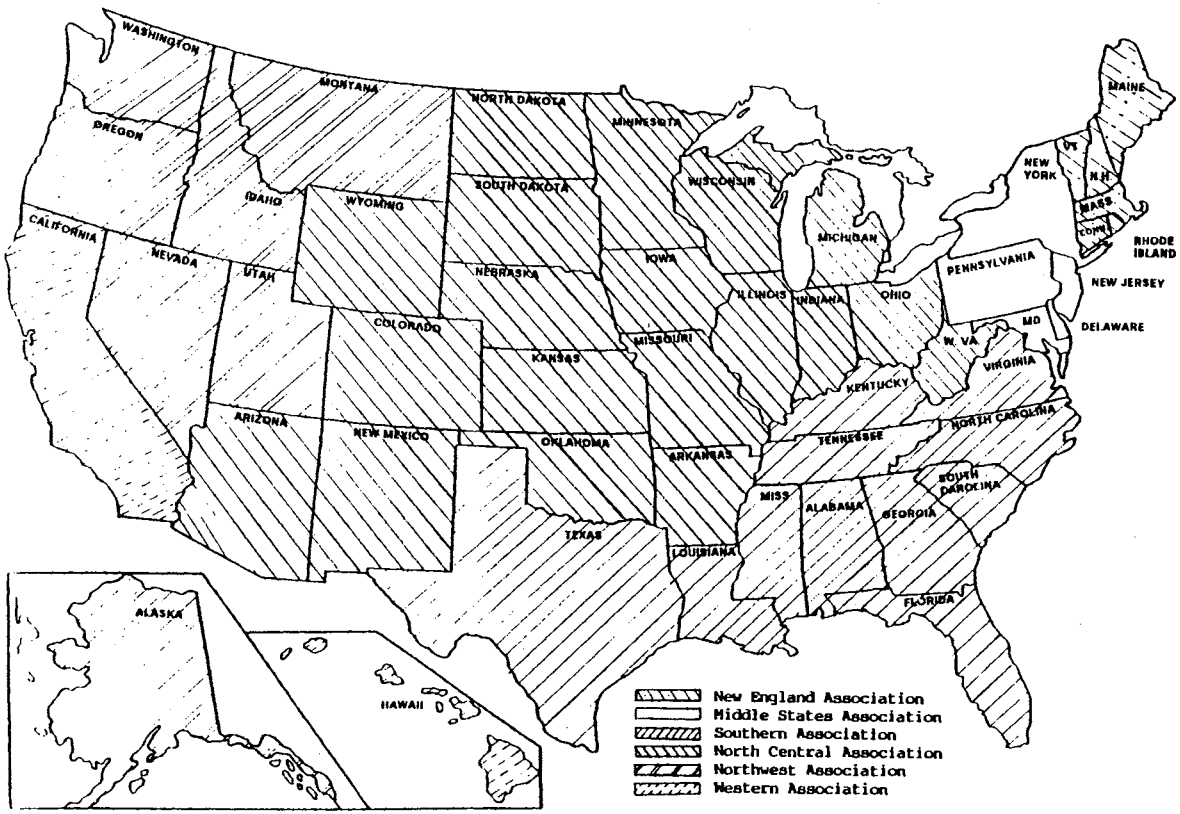
Alabama
Florida
Georgia
Kentucky
Louisiana
Mississippi
North Carolina
South Carolina
Tennessee
Texas
Virginia

Western Association of Schools & Colleges

California
Hawaii

APPENDIX G

MAP OF ACCREDITATION ASSOCIATION


WASHINGTON
OREGON
CALIFORNIA
NEVADA
IDAHO
MONTANA
WYOMING
UTAH
ARIZONA
COLORADO
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
MINNESOTA
IOWA
MISSOURI
ARKANSAS
LOUISIANA
WISCONSIN
ILLINOIS
MICHIGAN
INDIANA
OHIO
KENTUCKY
TENNESSEE
MISS
ALABAMA
GEORGIA
FLORIDA
SOUTH CAROLINA
NORTH CAROLINA
VIRGINIA
W. VA
PENNSYLVANIA
NEW YORK
MAINE
VT
N.H.
MASS
CONN
RHODE ISLAND
NEW JERSEY
MD
DELAWARE
ALASKA
HAWAII
New England Association
Middle States Association
Southern Association
North Central Association
Northwest Association
Western Association

APPENDIX H

INSTITUTIONAL REVIEW BOARD

APPLICATION

INSTITUTIONAL RESEARCH BOARD
FOR HUMAN SUBJECTS
OKLAHOMA STATE UNIVERSITY

Proposal Title: A Study of Community College Support Services Provided for Students that Suffer from Mental Disorders

Principle Investigator: Ray Sanders / Donnie Nero

Date: 5-7-92 IRB # ED-92-054

This application has been reviewed by the IRB and

Processed as: Exempt [x] Expedite [ ] Full Board Review [ ]

Renewal or Continuation [ ]

Approval Status: Approved [x]

Disapproved [ ]

Conditional [ ]

Deferred [ ]

Comments, Modifications/Conditions for Approval or Reason for Disapproval:

Signature: Maria L. Tilley Date: 5-15-92
Chair of University Board

VITA

Donnie L. Nero

Candidate for the Degree of

Doctor of Education

Thesis: A STUDY OF COMMUNITY COLLEGE SUPPORT SERVICES FOR STUDENTS WHO SUFFER FROM MENTAL DISORDERS

Major Field: Occupational and Adult Education

Biographical:

Personal Data: Born in Spencer, Oklahoma, May 15, 1949, Son of Berlin Sr., and Estella Nero.

Education: Graduated from Dunjee High School, Spencer, Oklahoma, May 1967; received the Bachelor of Science degree from East Central State College, Ada, Oklahoma, May 1971; received the Master of Science degree from Oklahoma State University in July, 1977; completed requirements for the Doctor of Education degree at Oklahoma State University in May 1993.

Professional Experience: Sapulpa Junior High, Teacher, Counselor, and Administrator, Sapulpa, Oklahoma, 1971-1980; Program Analyst, Rockwell International, Tulsa, Oklahoma, 1980-1982; Sapulpa High School, Assistant Principal, 1982-1985; Dean of Student Services, Tulsa Junior College, Southeast Campus, Tulsa, Oklahoma, 1985-present.

Honors and Achievements: Who's Who Among College and University Students, 1971; Student of the Month, East Central State College, 1971; Teacher of the Year, Sapulpa Junior High School, 1973; Member of Phi Delta Kappa, 1986; Graduate of Leadership Tulsa Class XVIII.