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School Based Mental Health Services

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by

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Abstract

Mental health impacts children socially, emotionally, and academically. While one of every five children/adolescents has a diagnosed mental health disorder. It is also estimated that one out of five children who need mental health services do not receive them (Van Landeghem, & Hess, 2005). Almost all children attend school for some time in their lives; therefore, school is the ideal setting for implementing collaborative interventions aimed at improving a child's emotional development and overall mental health. Schools have become one of the largest providers of mental health services with many different stakeholders (Barrett, Eber, & Weist, 2013). This study seeks to examine the overall lived experience of five different categories of these stakeholders: teachers, administrators, schools social workers, co-located mental health practitioners, and parents/caregivers. Qualitative interviews were conducted with one school teacher, two school administrators, two school social workers, one co-located mental health practitioner, and two parents/caregivers. The interviews explored the school based mental health stakeholders' experiences and six distinct themes were developed: (a) Relationship, (b) Current Needs and Assessments, (c) Interventions, (d) Staff and Parent Development, (e) Coordination of Care, and (f) Funding and Liability Dynamics. The findings of this study suggest that school based mental health programs can vary significantly from school district to school district. Findings also indicate that the overall implementation of mental health services in public schools is insufficient to support the needs of children. While exploratory in nature, this study holds implications for social work practice in schools. Implications also include the delivery of school based mental health policy as well as future research regarding the effectiveness of interventions.

Keywords: schools, mental health, co-located, qualitative

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In addition, I would like to thank all participants of the study and your willingness to share both your lived experience as well as your passion for children's mental health with me. I would like to especially thank the parents/caregivers that participated in this study. I will never forget your level of love, commitment, and resiliency. Your stories have touched me in ways that are hard to put into words. It is my hope that the experiences that you shared in this study will positively impact the lives of children and families.

A special thank you is extended to my friends and families who supported me through this journey. Thank you for understanding my limited free time and listening to me vent and complain along the way. Your support has allowed me to stretch my limits of personal fortitude and faith. Finally, this project is dedicated to all the children and families who struggle getting the mental health support that they so desperately need.

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School Based Mental Health Services

Mental health impacts children socially, emotionally, and academically. While one of every five children/adolescents has a diagnosed mental health disorder, one out of ten has a serious emotional disturbance that affects daily functioning, such as school performance. One out of five children who need mental health services do not receive them (Van Landeghem, & Hess, 2005). Almost all children attend school for some time in their lives; therefore, school is the ideal setting for implementing collaborative interventions aimed at increasing a child's emotional development and mental health. In the school setting, students are held to compulsory education laws. The multidisciplinary staff are trained to work effectively with youth and families that they have contact with almost daily (Powers, & Swick, 2013). The implementation of the No Child Left Behind Act of 2001 (NCLB) holds school accountable for student academic progress, and the Individuals with Disabilities Education Improvement Act of 2004 highlights the importance of using scientifically based research for interventions.

However, for the last few decade's researchers, administrators, and practitioners have described the implementation of mental health services in public schools as insufficient to support the mental health needs of children. Services have been described as fragmented, operating in silos, and narrow in focus (Barrett, Eber, Weist, 2013). Yet, Maagm Katsiyannis states, "over the last decade schools have become the major provider of mental health services" (Barrett, Eber, Weist, 2013, pg. 1). School staff have the ability to implement collaborative mental health and preventative services to children at risk that are efficient and successful.

In response to state and federal policy encouraging interagency collaboration, many schools today operate with a combination of school and agency based mental health professionals on school grounds (Bronstein, Ball, Mellin, Wade-Mdivanian, & Anderson-

Butcher 2011; Taylor & Adelman 2000). This service model is often called *co-located mental health services*. This can involve several variations of agency based and school based mental health professionals working collaboratively to address the mental health needs of students. In addition to agencies working together, emergent literature is addressing the importance of student, family and teacher involvement in mental health initiatives (Bowers et al., 2013).

The primary focus of this paper is to evaluate current school based mental health interventions as a means to program development that will likely reflect current best practice. Particular attention will be given to current mental health trends/diagnosis. This research will seek to answer the following questions: (1) What is the meaning of mental health interventions for students in the k-12 classroom, and (2) What are the experiences of stakeholders of mental health interventions in schools (i.e., teachers, administrators, school social workers, co-located mental health practitioners, and parents/caregivers).

Literature Review

In light of recent federal and state mandates in the area of school mental health, numerous studies have been done on the effectiveness of school based mental health interventions (Capp, 2015; Kang-Yi, Mandell, & Hadley, 2011; Taylor, Howard, & Adelman, 2000; Wiest, Lever, Stephans, et al., 2009). For the purpose of this study, the literature reviewed centered around the sustainability efforts of mental health interventions in schools. Key themes emerged throughout this literature review: (a) care coordination, (b) assessment of current needs, (c) organization climate, and (d) practice/interventions.

Care Coordination

Research supports the need for coordination of all the mental health stakeholders to evaluate the ever changing needs of the system (Taylor & Adelman, 2000).   In Lee et al.'s

(2013) quantitative study, they found that system collaboration with schools led to numerous positive mental health outcomes for students. This included a positive correlation to children's behavior outcomes and parental competence and overall family functioning. A common term used to describe this approach is called *wraparound*. Quinn and Lee (2007) describe wraparound as an individualized support plan that provides trusting, well informed, and supportive relationships (as cited in Maag & Katsiyannis, 2010, p. 177). Care coordination was addressed in the literature in a variety of ways but can be summarized into two critical sections: a) coordination between the community based co-located mental health worker and school staff, and b) parent and family involvement.

One common challenge for collaborative models such as ones that involve the use of co-located mental health workers, is developing a path that promotes a collaborative work environment between school and agency employed mental health professionals that improves the life of children and families (Bronstein et al., 2011). Bronstein and colleagues (2011) found that school based employees had less training in collaborating with outside resources and community based employees, and had less training in policies and laws. Additionally, agency employed mental health workers are often confined to billable services only which limits contact with children, families, and school staff.

However, Bronstein and colleagues (2011) point out that the co-located mental health model also offers opportunities for the school based mental health professionals and the co-located worker to advocate to administration for the need of expanded service delivery options leading to policy changes. Bronstein and colleagues (2011) also found in their mixed methods comparison study that the difference between the two types of workers (co-located and school based mental health staff) offers opportunities for cross agency collaboration.

In addition to school based mental health workers, administrators and teachers are also important stakeholders within the school system. Administrators and teachers are critical stakeholders to include in the process of developing and implementing any sort of mental health initiatives (Weist et al. 2009, Taylor & Adelman 2007). In Lehrmann, Forman, Martin, and Palmieri's (2008) qualitative research study that included the perspectives of school staff resistance to school based mental health initiatives, too many school initiatives and lack of administrative direction were among the key barriers to sustainability of school based mental health initiatives (as cited in, Bambara, Nonemacher, & Kern, 2009, p. 162). Taylor, Howard, & Adelman (2000) also state that the lack of involvement by teachers and administration is one of the most common forms of fragmentation in school based mental health approaches.

Another important component of care coordination is involving parents and families in the delivery of children's mental health services (Weist et al., 2009; Brookman-Frazee, 2004). In Hoagwood's (2005) systematic review of over 400 articles and 43 studies that involved parent involvement, she found that studies that involve parent and families in mental health interventions are an emerging area because they point out the roles of families as active caregivers for seeking and giving care. Furthermore, Farahmand and colleagues (2012) highlight that working with kids in their environment is a strength of community based mental health interventions in general.

Assessment of Current Needs

Poor assessment strategies and lack of resources has been correlated with the outcomes of mental health programs being inconsistent (Kang-Yi, Mandell, & Hadley, 2011). There is a trend toward moving from individual assessment and treatment to a public health model. This stems from the ecological model which states that all systems are interactive and impact each other

(Dowdy, Ritchey, & Kamphaus, 2010). This population based delivery model has taken on the form of the three tier system of response to intervention (RTI). Traditionally used for academic intervention, research has pointed in the direction of using this three tier model for mental health and behavior concerns as well. Unfortunately, limited population based data forces mental health professionals in schools to rely on individual assessments and interventions.

Mental health concerns are most typically assessed on an individual level in public education through the special education process and the individualized education program (IEP); (Dowdy, Ritchey, & Kamphaus, 2010). Dowdy and colleagues (2010) state that moving from individual to population shifts attention from reactive to preventive.

A common reactive data collection tool used in the school system is using office discipline referrals (Burke, Davis, Hagan-Burke, Lee, & Forgarty, 2014). Burke and colleagues (2011) found that a problem with the approach of tracking conduct problems, although practical for schools, is that students often need several office referrals to get additional mental health services that are not being offered to the main student population.

In addition, positive school based mental health outcomes are more closely correlated with internalized mental health concerns as opposed to externalized mental health concerns (Farahmand et al., 2012). Farahmand and colleagues (2012) define externalized mental health concerns as conduct problem such as the ones that are commonly tracked in office referrals. Frohman and colleagues (2012) identify internalized problems as problems such as depression. In their qualitative analysis of 468 children aged 6-17 enrolled in two different school based mental health programs, Frohman and colleagues found that the programs that specifically addressed internalized problems on the universal level had the most positive effect size.

Similarly, this qualitative review showed that universal approaches of externalized behaviors had a larger positive effect size than interventions that were done on an individual basis.

Furthermore, presenting behaviors and concerns have to be properly assessed. According to Van der Kolk (2005), trauma is one of the most common factors associated with mental health problems in children (as cited in Hansel et al., 2010). Hansel and colleagues (2010) found that the process of education of school staff, parents and community members both on basic trauma education and the role of trauma services were critical components in their quantitative study of a rural school based trauma treatment program. Proper assessment and specific trauma focused diagnostic assessment tools were also critical components (Hansel, et al., 2010). Poor assessment can lead to misinformed response to mental health needs.

A positive of agency employed mental health professionals is that they often do diagnostic assessments in schools that can expedite mental health interventions (Bronstein, Ball, Mellin, Wade-Wdivanian, & Anderson-Butcher, 2011). Whereas, school based mental health professionals often use functional behavior assessments. Functional assessments conducted in schools sometimes occur through the narrow lens of attaching functions of escape, avoidance, control, and attention (K. Harrison & Harrison, 2009). Constable & Thomas (2006), Eber et al., (2008); & Germain, (2002) find that school based mental health workers can use their clinical experience in system analysis to deepen assessments traditionally used in schools (as cited in K. Harrison & Harrison, 2009).

The literature also supports universal supports with at risk populations such as low income and homeless youth. Ginzler, Garret, Baer, & Peterson's quantitative study identified 86% of homeless youth met diagnostic criteria for mental health disorders (as cited in Sulkowski & Michael, 2014, p. 146). The president's New Freedom Commission on Mental Health (2003)

highlights discrepancies in mental health service delivery for at risk populations. This includes

rural based communities. Rural based communities are more likely to be associated with low

income, and lack of mental health resources (Hansel et al., 2010). Sulkowski and Michael

(2014) point out the importance of coordinating with outside agencies to assess current needs and

interventions in place. For example, homeless youth often are involved in many systems of care

such as county social services, court services, and community based mental health services.

Need assessment practices could include observation, behavior rating scales and specific

diagnostic assessments. The goal with this approach is to triangulate multiple system

involvement to get an accurate picture of the child's emotional and behavioral functioning

(Sulkowski & Michael 2014). Regarding homeless youth, the school's homeless liaison as

outlined in the McKinney-Vento Act is an important collaborating partner when developing

assessments for the homeless population. "Failure to assess or provide services to homeless

students with suspected disabilities or needs that warrant the provision of targeted interventions,

actually violates their right to a free and appropriate public education under the No Child Left

Behind Act and the McKinney Vento act" (Sulkowski & Michael, 2014 pg. 148).

Additional at risk populations that warrant further investigation are youth who are

receiving special education services. Santiago, Kataoka, Forness, and Miranda (2014) conducted

a collaborative study where they surveyed 55 clinicians within the special education system with

a focus on students who were receiving related service counseling as a mandated component of

their individualized education plan. Santiago et al. (2014) found that there were gaps in the

number of students who were identified in the emotional disturbance (ED) category, the

prevalence of these ED students receiving counseling as a mandated service on their IEP, and the

quality of treatment. These findings coincide with findings that less than 1 percent of children

are identified in this ED category and approximately 12 percent of school-age children have at

least moderate to severe emotional or behavioral disorders (Forness, Freeman, Paparella,

Kauffman, & Walker, 2012). It stands to reason that these children who eventually make it to

the ED category would warrant counseling as a related service. Although, Santiago and

colleagues' (2014) findings indicate that these children seldom get the quality of care intended.

Santiago, et al. found common roadblocks to these children receiving counseling as a related

service on the individualized education plan.   These roadblocks include understanding of policy,

staff training, proper diagnostic assessments in the schools setting, and general lack of resource

allocation.

Assessment and evaluation of school wide behavioral supports is also a critical area of

research. McIntosh et al. (2011) state that in the age of increased accountability of schools, the

practice of implementing new school based mental health practices each year rather than

sustaining effective programs with fidelity is a common practice. This process not only taxes

already limited resources, but it also impacts the willingness of staff to try new approaches

(McIntosh et al., 2011). McIntosh and colleagues' examined the effectiveness of a research tool

to measure the school's capacity to sustained school-wide positive behavior supports. The tool,

School-Wide Universal Behavior Sustainability Index-School Teams (SUBSIST), was found to

be an effective and reliable measure that had "strong psychometric properties for assessing

sustainability" (McIntosh et al., 2011, p. 208).

Organization Climate

In Bambara and colleagues (2009) qualitative interview study around the sustainability of

positive behavior supports in schools, they found that the most prevalent theme that emerged was

the significance of establishing a school culture around the understanding and the appreciation of

school based mental health supports across systems. Similarly, Hansel and colleague's (2010)

study of a trauma treatment program in a rural school, cites the importance of spending resources

including time and money on building relationships to increase involvement across systems. One

important factor for building supports across systems include building relationships with

community stakeholders (Hansel et al, 2010).   Powers, Wegmann, Blackman, and Swick (2014)

describe a community engagement framework that includes stakeholders in both the mental

health care and school systems. Mellin & Weist (2011) found that the relationships with these

stakeholders greatly impact the success of school mental health programs (as cited in Powers,

Wegmann, Backman, and Swick, pg. 76). These partnerships are thought to be not only

beneficial to success, but the lack of creating a cooperative environment among systems could

actually create negative effects (Farahmand et al. 2012).

The importance of school systems effectively working with the family system is a

recurring theme in the literature. Despite studies that show the effectiveness of coordinating

with parents, Brookman-Frazee (2004) found that few studies explicitly show how to increase

parent involvement in education.   Brookman-Frazee (2004) used a repeated reversal design to

compare parent education programs focusing on parent empowerment and ecocultural literature

to a professional driven model that does not include these factors. Results of the research showed

that both parents and the children showed positive affect and increased involvement when the

parents were active parts of the intervention process (Brookman-Frazee, 2004). Furthermore,

Hoagwood's (2005) study of empirically supported approaches to working with families

highlights the importance of empowering parents to be involved in systems of care at the highest

level.

In Bowers, Manion, Papadopoulos, & Gauvreau's (2013) quantitative study of stigma in

school-based mental health service delivery, they highlighted the importance of involving

students in service delivery. They found that a greater portion of young people, rather than

providers, reported stigma as the largest barrier to accessing mental health services.   This data

could help explain the Surgeon General's 1999 report that 70% of young people who have a

mental health need do not access mental health services (as cited in Bowers, Manion,

Papadopoulos, & Gauvreau, pg. 168).

School staff also plays an important part in the school community. Teachers are found to

have a significant impact on the service delivery of evidence based practiced (Reinke, Stormont,

Herman, Puri, and Goel, 2011). In Reinke et al. study of 292 teachers' perspectives of mental

health service delivery, they found that 89 percent of the respondents either agreed or strongly

agreed that schools should be involved in addressing the mental health issues of students.

Similarly, an environment that encourages and facilitates cohesive work practices among all

school staff has been shown to improve school based mental health prevention (Teasey, Canfield,

Archuleta, Crutchfield, & Chavis, 2012). Research also shows that programs such as Positive

Interventions and Supports (PBIS) may have even more impact than well integrated mental

health approaches on staff attitudes (Kang, C., Mandell, D., & Hadley, 2013).

Furthermore, school staff members' overall mental health and their sense of belonging is

a strong factor towards positive mental health outcomes for students. Research has linked staff

perceived workloads/time restraints as the number one factor impacting their ability to do their

jobs (Santiago, Kataoka, Forness, & Miranda, 2014; Teasey, et al., 2012). Teasey and colleagues

(2012) found that the biggest perceived facilitators of mental health service delivery among the

284 school social workers surveyed in their mixed methods study were collaboration,

communication, cooperation, and attitudes of school staff.

Interventions

Weist and colleagues (2009) make a clear distinction between Evidence Based Practice (EBP) and Evidence Based Interventions (EBI). They point out that EBP is a process where as EBI is a product or a specific intervention. What may be the intentions of a researched based intervention that was conducted in control trials rarely gets implemented with fidelity (Kang-Yi, Mandell, & Hadley, 2013). The reality is, too many interventions that are taking place in school that are being branded researched based are "piecemeal approaches" to complex problems (Taylor & Adelman, 2007).

Research reflects the benefit of the process focus of EBP's to lead better outcomes than well intended individual interventions (Kang-Yi, Mandell, & Hadley 2013). Positive Behavior Support (PBS) is a well documented policy and practice for effective school based mental health programs (Walker, Cheney, Stage, and Blum, 2005).

A common approach for evaluating mental health interventions used in the literature is adapted in some respects from the Response to Intervention (RTI). As stated in Hale (2008), this three tiered continuum of service model of intervention was adapted to provide research based interventions and data collection methods for students with educational challenges. Similar to RTI is the Multi-Tiered System of Support (MTSS). Since 2012, the educational community has moved away from RTI to MTSS, although, the terms and resources of RTI and MTSS are commonly used interchangeably ("Critical components of MTSS." 2010). Tier 1 represents universal behavior and instructional supports, Tier 2 represents targeted or group wide prevention, and Tier 3 represents intensive individual student interventions (as cited in Sabitino, Kelly, Moriarity, & Lean, 2013, p. 213).

Similar to the literature pointing to the importance of universal assessment strategies of mental health delivery, findings in studies also point to the positive outcomes of universal approaches to mental health delivery in schools (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Greenberg et. al, 2003). Elias and colleagues (1991) quantitative two year study of an elementary based program aimed at the promotion of social competence, showed promising results compared to control groups. Results from the study suggested that those students who received the two year social decision making and problem solving program in elementary schools showed a higher level of prosocial behaviors and a lower level of antisocial behaviors after being followed up in school four to six years later than those students in the control group who did not receive the program (Elias, et al, 1991). Elias and colleagues (1991) study also pointed out the importance of long term interventions that addressed developmental stages and stressors across the scope of multiple grades.

Increased societal risk factors and general mental health needs has led to the inundation of well-intentioned prevention and promotion programs (Greenberg et al, 2003). Greenberg and colleagues (2003) state that many of these programs are often poorly coordinated, fragmented and are often not adequately supported by administration which leads to poor staff development and training.

The Fetzer group first introduced the term social and emotional learning (SEL) in a 1994 meeting of school based researchers and other school based advocates (Greenberg, et al, 2013). They believed that SEL could address the underlying problem behaviors or skill deficits while supporting academic achievement. A new organization by the name of the Collaborative for Academic, Social, and Emotional Learning (CASEL) also emerged from this meeting.

CASEL (2003) found that similar to academic skills, SEL skills could systematically be taught to students to help them negotiate challenges at each developmental level ranging from preschool through high school (as cited in Greenberg et al, 2013, p. 468). In Durlak and colleagues (2011) meta-analysis of 213 school based, universal SEL programs, they found that there was a general agreement that programs are likely to be effective if they "use a sequenced step by step training approach, use active forms of learning, focus sufficient time on skill development, and have explicit learning goals" (p. 408). In an effort to make SEL instruction more concrete, CASEL (2005) found that the overall goal of SEL programs is to foster skill development in 5 specific skill competencies: a) self-awareness, b) self-management, c) social awareness, d) relationship skills, and e) responsible decision making (as cited in Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011).

Research also points to the link between evidence based SEL programs and academic success (Elias, et al, 1991; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). In Durlak and colleagues meta-analysis of 213 school based universal SEL programs involving 270,034 kindergarten through high school students, they found an 11-percentile gain in academic performance on standardized testing compared to control groups. Comparably, Elias and colleague's (1991) two year intensive longitudinal study of a preventive school based SEL program also showed academic gains compared to control groups after a five and six year follow up.

Another emerging area in SEL literature is mindfulness. Brown and Ryan (2003) describe *mindfulness* as a way of being that is derived from eastern reflective practices that involves attending to the present moment in a sustained and present fashion (as cited in Gould, Dariotis, Mendelson, & Greenberg, 2012). Although, further research is needed in this area,

mindfulness as a universal practice (school wide), has shown positive outcomes in the area of self-regulation for youth in schools (Kuyken et al., 2013; Gould et al., 2012). Furthermore, mindfulness training and practice among school teachers has also suggested positive mental health outcomes for teachers (Gold et al., 2010).

In summary, the literature review highlights key elements in the sustainability of school based mental health initiatives. The current state of fragmentation of mental health initiatives and the importance of the process of service delivery is evident throughout this review. The value of the coordination of multiple systems of care was also apparent. These concepts form an integral framework that can be used to evaluate the sustainability of mental health service delivery in schools: (a) care coordination, (b) assessment of current needs, (c) organization climate, and (d) practice/interventions.

Conceptual Framework

We all have a lens in which we interpret events. This lens is usually filtered through our experiences which help form our values and belief systems. A researcher has both an ethical responsibility to examine this lens for subjectivity, and connect the lens to prior thought and theories. In the area of children's mental health, this lens can dramatically change the course of treatment approaches. The lens of this researcher can be conceptualized into three different parts: (a) theoretical lens b) professional lens and c) a personal lens.

Theoretical Lens

In attempting to understand the complexities of children's mental health, it helps to see the topic in context of social relationships. The ecological system theory provides one approach to answering the question of how a child's mental health is influenced by the world around them. Ecological system theory was developed by psychologist, Urie Bronfenbrenner. Bronfenbrenner

believed that we all act and behave in relationship to our experiences in different systems. In

Bronfenbrenner's early work, *The Ecology of Human Development: Experiments by Nature and*

Design (1979), he stated that everything is interrelated and bounded in the context of culture,

history, and the environment in general (Darling, 2007). In the context of children's mental

health, a child's experience at home influences their experiences at school. For example, the

literature review reflects that there is a strong correlation between traumatic experiences such as

violence in the home and mental health outcomes observed in the school system. This is

particularly important to keep in mind not only in the context of school mental health but the

impact on public health in general (Low & Mulford, 2013). Similarly, the literature review

reflects that relationships between a child's teacher and their parents also influence mental health

outcomes. For example, Bronfenbrenner argued that parents willingness to listen to expert advice

of pediatricians or researcher changes between different social economic circles as well as the

advice changing throughout time (Darling, 2007). This offers understanding to the view of

mental health within culture. Specifically, if mental health is viewed through an educational lens

(preventative) or a medical view (reactive). This simple shift can radically change the direction

of the approach of mental health interventions in schools.

Social capital theory offers a further framework for how relationships influence

children's learning and school success (Fram & Altshuler, 2009). Similar to Bronfenbrenner's

ecological systems theory, social capital theory stresses the value of experience within norms and

beliefs within a specific social location (Fram & Altshuler, 2009). However, Fram and Altshuler

(2009) point out that one of the founding principles of social capital theory is that we exist in a

social cast system that is rooted in systematic injustices. The literature review has shown that the

cooperative nature of a child's network of relationship both independently and interdependently

lead to positive mental health outcomes. For example, in Coleman's (1988) work on social capital he found that parents play an important role in their child's life when they are connected socially with the same systems that their children are connected with.   Those systems include school teachers and other community members to ensure that children receive consistent message of expectations for school success (as cited in Fram & Altshuler, 2009).

When children's mental health is filtered through these lenses it offers a better understanding of not only systematic oppression, but also an understanding of the power of relationships changing the system from within. It was important to include multiple systems while choosing who to interview (teachers, administrators, parents, school mental health providers as well as mental health providers outside of the school). This can offer a valuable outside perspective on service delivery within the school system. A person's beliefs and values can change according to the system in which they are operating. I am an employee of the school system and I could reflect biases to protect the views and beliefs of the school culture.

Professional Lens

The social work profession is rooted in a set of core values. These core values lead to a code of ethics and a code of conduct that influences me on a professional level. The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty (NASW Code of Ethics). My professional perspective as a school social worker is rooted in these beliefs and values and influences how I see mental health service delivery in the school system that I work in. In my professional experience, I have seen the fragmentation of mental health service delivery.   I have also seen special education students and others with documented and undocumented mental health needs

being suspended for their behavior, further separating the relationship between the family and the school and severing valuable social connections. Professionally, I interpret children and families with mental health concerns as disenfranchised. Ethically, I have a responsibility to advocate for best practices in mental health service delivery that are rooted in social justice and self-determination. However, I have to be cautious of keeping this research exploratory in nature rather than merely interpreting the results through prior professional experiences. For this reason, I thought it was important not to include perspectives exclusively through the lens of school social workers when considering sample participants.

Personal Lens

As a school social worker, I feel that I can be biased in my role. I need to keep in mind the value of the family system as a vehicle of change. My bias may undervalue the role of other mental health professionals as a vehicle of change as well. My personal experience of being a professional social worker may cloud my judgment, thinking that I have all the answers and not personally understanding the dynamics of the systematic injustices at play. There is value in broadening my personal lens to the unknown and to being open to different perspectives of mental health service delivery in schools. As a researcher, my personal experience as a social worker or an "expert" in the field may undervalue the perspectives of others roles and perspectives of mental health service delivery in schools. Part of my personal bias is rooted in a male, white, and middle class perspective. This perspective which is ripe with systematic privilege, has to be continually evaluated for bias while working with a topic such as children's mental health in schools.

In summary, this researcher's theoretical, professional, and personal lenses are all integrated into this project. This collected world view honors all human experiences and is often

seamless.   Conceptualization of these lenses, while valuing the experiences of others, is critical

within the method of this research study, and in the interpretation of the results. This synergetic

process is part of the whole that I bring to this research project.

Methods

Study Design

A qualitative approach was specifically chosen to gather the lived experiences of

professionals and parents/caregivers involved with mental health service delivery in schools. A

grounded theory approach was used by first using open coding then by using axial coding

strategies to induce emerging themes from the interview transcripts of the participants (Padgett,

2008). Controversial themes developed from the literature review were also used to critically

analyze the data. This design is more exploratory in nature meaning that the researcher used data

gathered to provide meaning and structure to the perceptions of the participants (Monette,

Sullivan, Dejong, & Hilton, 2014). In this study, participants were asked open-ended questions

to elicit their experiences of mental health service deliver in schools. A *verstehen* approach was

used while utilizing varying roles within the school system to get a subjective understanding of

the participants' lived experiences (Monette et al., 2014).

Sample and Sampling Procedures

The participants of this study included school administrators, school teachers, school

social workers, co-located mental health workers, and parents/caregivers. The sample size

consisted of two school administrators, one school teacher, two school social workers, one co-

located mental health worker, and two parents/caregivers. A snowball sampling approach was

used to recruit participants for this study. A snowball sampling approach was found to be useful

because the participants may have been unlikely to cooperate without a referral from within their

social or professional network (Padgett, 2008). The researcher used a network of school social

workers employed in four different school districts to elicit referrals. Once the researcher found

a participant he gave them an information sheet and asked them to forward the information sheet

to people who might be interested in the study. The researcher distributed an e-mail (Appendix

A) to recruit study participants. The researcher used an e-mail script (Appendix B) when

participants responded to recruitment and attached an information and consent form (Appendix

C).

Protection of Human Subjects

Some of the participants in the research study had some concerns with confidentiality and

how their responses would be used. The purpose of the study was explained verbally to the

participants. The researcher protected the identity of the participants by using nondescript

information in the study. The consent form explained in detail the measures used to protect the

confidentiality of the participants and the extent taken to remove identifying content from all of

the findings. The researcher conducted the phone interview from a private location. In addition,

the study was conducted under the supervision of Dr. Catherine Marrs Fuchsel. The participants

were also encouraged to contact the chair of the Human Subjects Institutional Review Board

through St. Catherine University with any questions or concerns related to the study.

Data Collection

Data was collected using semi-structured interviews that were completed over the phone.

The questions were open ended and around a narrow topic. The questions were designed to

probe into the participants' specific experience of mental health service delivery in schools. The

interview questions were designed to be conversational, sometimes asked out of order, and

allowed the researcher the freedom to ask follow up questions. Monette et al. (2014) state that

non-schedule-standardized interviews allow the participants to have more freedom of expression.

The interview questions were designed to be open ended, objective, and allowed the researcher

to guide the conversation to accurately measure the lived experience of the participants. The

interview consisted of 7 questions (Appendix D-Appendix H). Which addressed the strengths

and challenges of mental health service delivery in school. Some of the questions that were

asked include: *Tell me about your role? What are some of the best parts? What are some of the*

primary mental health needs/challenges that you see children facing? What are some key

components that you feel are important while implementing mental health interventions? What

are some of the advantages of providing mental health services in the school? What are some of

the challenges of providing mental health services in the public school system? If resources were

not an obstacle…what to you see as the "ideal" service model for providing mental health

interventions in the school system? The interview was audio-recorded and the interview was

transcribed. The interview tool place over the phone.

Validity and Reliability of Data

Once the interviews were completed, the researcher will transcribe the audio-recorded

interviews verbatim. Content analysis was used to develop codes and themes that emerge from

the interview transcripts (Monette et al., 2014). A grounded theory approach was used by first

using open coding then by using axial coding strategies to induce emerging themes from the

interview transcripts of the participants (Padgett, 2008). In addition, the researcher utilized field

notes as a reliability check.   The research questions were analyzed and reviewed by the

researcher and the research committee, to make sure the questions are valid, reflected the

experience of the participants, and answered the research questions.

Strengths and Limitations of Study

   Strengths of this study include the sample of diverse participants across the spectrum of

mental health service delivery in schools. The study included the lived experiences of

administrators, teachers, parents/caregivers, school social workers, and co-located mental health

workers. The study examined themes that emerged through the qualitative design and compare

and contrast themes in the literature review. This research is important because the literature

reflects the increasing fragmentation of mental health service delivery in schools as well the

importance of the process of mental health service delivery. This process includes tapping into

the lived experiences and perspectives of the stakeholders across roles and systems of care.

   One limitation of the study includes the small sample size. There was limited participants in

the identified roles in school based mental health service delivery. Limitation may also include

professional and personal bias. The researcher is a school social worker providing mental health

services in schools. The researcher may reflect the values and experiences of the school social

work profession as well as the school culture. For the purpose of protecting the vulnerability of

participants, students were not interviewed. However, literature reflects the value of including

the perceptions of students in the implementation of mental health services in schools.

<div align="center">

Findings

</div>

   In this section, the characteristics of the participants will be discussed as well as the findings

of the study based on the participants' responses. There were eight participants in the study that

included: (a) two school social workers one of which identified as a duel role (mental health

practitioner and school social worker), (b) one co-located community based mental health

worker, (c)two parents of students that received school based mental health services, (d) one

school teacher, and two school administrators. To protect the identity of the participants they

were identified by their role only and to further protect the confidentiality of the participants, all identifying geographical information was either changed or deleted. The main themes identified through the research included: (a) Relationship, (b) Current Needs and Assessments, (c) Interventions, (d) Staff and Parent Development, (e) Coordination of Care, and (f) Funding and Liability Dynamics.

Relationship

The first identifiable theme that emerged in the study was 'relationships'. When asked "What is the favorite part of your role, or your involvement with mental health services?" the overwhelming answer by the participants revolved around the importance of the relationship with the child. A common answer was working with and getting to know the child. One of the school administrators in the study remarked that his favorite part of being a building principal was greeting the students in the hallway as they came to school or seeing the kids in the lunchroom. He commented, "I would tell you the reason why these things are the best part is because it keeps me grounded as to all the decisions that I make." One of the parents that were interviewed commented on how hard it was for her to see her child go through so many mental health struggles in the school and how important it was for her that her child feels comfortable with the staff that works with him. The co-located mental health therapist shared how important it was for children to feel safe with the teacher before they enforce classroom rules and procedures. She made the following statement:

> Relationships come first and compliance comes secondary. 'I trust you and feel
>
> safe with you and so I can listen to what you are asking me to do because I feel safe' that
>
> safety and security and trust and their ability to process it and their ability to use their
>
> frontal lobe skills versus being stuck in their emotional place.

Similarly, one of the parents in the study remarked on how important it was for her that her daughter feels safe with and supported by the people that work with her.

Current Needs and Assessment

The majority of the participants in the study identified anxiety as the main mental health concern in schools. When asked what was the primary mental health need of the students, one of the administrators that was interviewed for the study remarked "anxiety is a big need". This participant went on to say that through his 26 years of experience in the schools he thought anxiety has dramatically increased since the introduction of social media. However, two different participants noted that anxiety can present itself in different forms. The co-located mental health worker had this to say:

> The biggest thread that I see throughout the kids that I work with is trauma, some
>
> sort of disruptive attachment or family stressor that leads to a lack of a regulating
>
> presence in their lives which manifests itself into anxiety or depression or
>
> chemical dependency or behaviors issues.

This idea was echoed when one of participants remarked:

> As a school social worker we can only do what we can to ease the anxiety and stress.
>
> Teach strategies and kind of move on but there seems to be so much from outside
>
> environments that is brought into the schools.

This school social worker also shared she is seeing a high rate of "bio parents" leaving the home and grandparents becoming the primary caregiver.

This leads into the need for proper assessment strategies. One of the participants shared, "I don't think we are getting to the root of the problem, we have the same school meetings and coming up with these 'problem behaviors'." The lack of assessment strategies was also shared by

one of the parents that were interviewed. She told her story of how it took multiple years in the

public school system to get help for her son who is now in residential treatment. This three year

journey is marked by several school suspensions for problem behaviors. It took a violent act

towards his father to place him in the residential treatment setting. The participant stated, "I

have to get outside resources and the school should be the number one that knows where we are

supposed to go for help." This experience coincides with the co-located therapist that stated, "I

can make recommendations for a psychiatric consult, medical evaluation, partial hospitalization

and coordinate some of those higher level of care services in a different way then maybe school

can or would." There was two distinct assessment approaches that emerged from the data: (a)

diagnostic assessment and (b) the special education assessment process.

      Diagnostic assessments. One assessment strategy that emerged was school staff doing

diagnostic assessments themselves. The school social worker that was part of this model

reported that in their school district they are able to provide therapeutic services for "kids that

need it". This model involves the school psychologist doing a diagnostic assessment, writing up

a detailed treatment plan that often involves individual skills training (school social worker

administered), and weekly meetings with the therapist that is employed by the district (school

psychologist). This approach was referred by the school social worker as "CTSS" (Children

Therapeutic Services and Supports) which she explained took a special certification process

through "DHS" (Department of Human Services). The social worker that was involved in the

district where they could do the diagnostic assessments remarked that they are often able to do

the diagnostic assessment as part of the special education assessment to offer that detailed family

history when "there is a lot of significant stuff going on at home". This approach was unique for

this study, while the common mental health assessment strategies in schools that the participants

were familiar with involved the special education evaluation process.

        Special education assessments. The participants shared that the special education

assessments that they were associated with were often found to be rooted in functional behavior

analysis and often took several months or up to a year before services were in place. The co-

located mental health worker shared, "Sometimes behavior interventions (derived from school

assessments) don't work really well on kids who are experiencing some trauma or disruption in

the family where school may not know about it." Similarly, one of the school social workers

mentioned that the mental health or social skills deficits derived from the special education

assessment, (without doing the diagnostic assessment) often appeared not to reflect the ongoing

needs of the students that she worked with. Another parent told her story of how it took two

years of both school based interventions and outside mental health services that started during 4th

grade before her daughter qualified for special education under the Emotional Behavior Disorder

(EBD) category.   The final event that occurred during 6th grade that seemed to expedite services

at school, was her daughter throwing a scissors in the classroom. This parent also described how

her daughter shared with the community based mental health therapist in 4th grade that she was

touched by a family friend, but the therapist at the time determined that there was no need to

report the incident. During 6th grade, her daughter shared the experience with a different

community based mental health therapist who reported it to the authorities. Investigations

determined that her daughter was sexually abused and the perpetrator is currently serving a

prison sentence for the incident. This concept of abuse is also underscored by one of the school

administrator's responses to the question, "What is the primary mental health need that you see

in your school" and he responded "abuse, whether it is mental, physical, or sexual in the home

environment is a common problem." The collocated mental health worker shared that often these

needs can lead to acting out behaviors that can lead to suspensions. The participants shared the

importance of doing proper assessments to determine what was driving the current needs that

presented themselves through behaviors. The participants also expressed the importance of this

process to adequately determine the proper intervention to pursue.

Interventions

A few different mental health service models emerged from the study. This included an

integrations of the following: (a) school wide interventions, (b) school based social workers and

counselors, (c) having a co-located mental health therapist emerged into the school on a full time

basis, (d) having the mental health therapist being employed by the school, and (e) school

districts contracting with community based mental health services to have the practitioner

coming in on a weekly basis. Study participants shared pros and cons on the various intervention

approaches that are identified in the appropriate section.

School wide interventions. Positive behavior and supports were mentioned as school

wide strategies by two different participants. This included developing a positive climate. One

of the school administrators noted, "Our number one intervention is first of all making this a

place of the students, for the students and by the students, as simple as that." He went on to say,

"Kids get beaten down on a regular basis. And you got to work with them to build them back

up." Conversely, one the school social workers mentioned that they do a "RTI" (response to

intervention) and also "PBIS" (Positive Behavior Interventions and Supports), but she

commented that both of these approaches do not seem to get to the "root" of the problems. The

school social worker mentioned that the main school mental health intervention that they have in

their school is direct service time provided by either herself (the school social worker) or the

school counselor.

School based social workers and counselors. School based mental health professions such as school counselors and school social workers seemed to be the most common intervention that was shared by the participants. This ranged from the school social worker doing "skills work" and the school counselor offering "therapeutic services" under the CTSS model, as well as school social workers and school psychologist outside the specific CTSS certification process through DHS. One of the school administrators in the study reported that having school social workers on hand in his buildings' is the "primary mental health intervention". He went on to share that having school social workers on hand that are "properly trained in mental health" is a valuable resource. This includes being skilled in the area of helping students to process appropriately and help them learn how to access their "tools for the tool box". Conversely, a different school administrator shared that one of the down sides of having school counselors and school social workers as the "only" mental health supports in the school, is burn out and personality conflicts with students that may arise.

Co-located mental health workers. A common model of mental health intervention in the schools shared by the study participants included the district contracting with outside mental health agencies to bring a therapist into the school (i.e., co-located mental health worker). Among the experiences of the participants, this model ranged from the co-located mental health worker being embedded into the school district five days a week and the district contracting with one to several co-located mental health workers that often only spent one day a week in the district.

Like other interventions, the co-located models had mixed reviews. One of the school social workers interviewed shared that her experience has been tainted by inconsistencies with therapists and poor communication between the community provider and school staff. This

participant shared, "to be honest, my experience (working with co-located mental health workers) hasn't been that great. There has been a lot of inconsistency with who is coming and when they are coming". One of the school administrators shared that they have not had a lot challenges with having co-located workers come in to their school, although, he went on to say:

> One of the challenges that we had was a therapist that was no longer with the clinic anymore. So we have suddenly had six students that we had to transfer to someone else and those kids had grief and abandonment issues."

The school teacher that was interviewed for the study shared an experience that she had with a therapist that came into the school. She shared that the school staff would not know what the co-located mental health worker and the student were working on and it wasn't "skill based". Although, this school teacher also shared that her school district is currently contracting with a different therapist that is working out well. She went on to say that the therapist is doing a great job connecting with one specific student who is under the educational category of autism that she works with, and she sees this particular student making remarkable progress and he is able to generalize the skills worked on during therapy to the classroom setting. The school teacher participated in the therapy sessions with the co-located worker and the student. The teacher had this to say:

> And he [the co-located mental health worker] lets us [teachers] come in and as long as we have releases I go sit in with the kids and say 'here are the issues we are having and what do you think we should do'. Ever since then the student has come up with a couple of different strategies that he is able to try during the week."

The school administrator, whose school had multiple co-located mental health workers, described many benefits to this particular model. This includes having multiple providers to

meet the diverse needs and personalities of students. These thoughts coincide with the view of a

parent when she shared her experiences with a co-located mental health provider that came into

the school to work with her son. She explained, "She [co-located mental health worker] did a lot

of talking with him about what to do when he got mad. This lady was wonderful but they didn't

click".

The collocated mental health worker that is emerged in the district five days a week had a

lot of positive things to share about her experience with the school district. She described her

relationship with the district that she works in as "unique". She has been with the district for

over 16 years in some capacity and she states "they know me and I understand the culture of the

schools." She explained that she often hears from some other of her colleagues that are co-

located mental health workers, that they have a difficult time integrating in the schools. She

reiterates, "They [schools] run very different than outpatient therapy and look different than a lot

of the different environments. That is part of the battle is knowing the culture and knowing how

to become a part of it" In short, the participants shared the importance of proper training and

support for key stakeholders that is specific to their individual needs/resources.

Staff and Parent Training

Another theme that presented itself through the data was the need for staff and parent

training. The collocated mental health worker shared that she often is able to do trainings and in-

services with both parents and teachers. The co-located mental health worker stated that she sees

an on-going need for trauma informed care for both parents and teachers. One of the school

administrators shared that one thing his school is doing is looking at the staff development

calendar for next year to have the co-located mental health workers do trainings for their

teachers. One of the parent participants of the study shared how important it was for her to know

what the school is doing with her child. She commented, "We [family] need to know exactly

what they are doing so we don't regress."   Special consideration for the coordination of training

was also evident in the data.

Coordination of Care

The importance of coordination of care was expressed by all of the participants in the

study in different ways. The collocated therapist had this to say:

> There is so much about building that relationship. And those skills, that ability to
>
> regulate themselves and I couldn't do the work that I do without having the team. Or in
>
> home or that physician, or the family, everybody supports mental health. So, I don't
>
> think only I can do mental health work, it such a team.

While, both of the school social workers talked about how it important it was to get the family

system involved. Similarly, one of the parent participants shared her story of how hard it was for

her to move from state to state and how she had to "start over" with accessing services. When

asked how she found out about various mental health services for her son who had severe

behavior difficulties she commented "That is the problem, if you don't know someone that

knows someone you don't get answers. You have to find out through the grapevine what is

available." The lack of proper care coordination was evident in her testimony.

One service model that developed through the co-located workers' shared experience

included using a "school linked" grant to bill for care coordination. She shared:

> Currently, I am part of the school linked mental health grant that covers all of my care
>
> coordination. This includes meeting with parents, attending IEP meetings, and
>
> trainings can be billed through the grant for middle school and high school and all
>
> that collateral contact is billable.

The co-located worker went on to share that the elementary schools are not currently covered under the grant and declared "but we are working to change that". The importance of proper coordination between the different stakeholders in school based mental health service delivery was evident throughout the data. However, the research also showed that this coordination of care can be associated with funding and liability concerns.

Funding and Liability Dynamics

When asked the question around what they would do if they had a "magic wand" and were able to design their own school based mental health delivery system, the most common answer was around the theme of lack of funding and or resources. All of the participants shared in one way or another that they it would be nice to have more mental health staff to deliver quality services that would revolve around the importance of relationships, coordination of care, and staff and parent development.

Insurance and billing concerns also fell under the "funding and liability dynamics". One funding stream that was unique compared to others in this study was shared by the school social worker who was part of the CTSS. When asked a follow up question regarding the billing structure of this model she replied:

> Because we [her school district] are a licensed therapeutic facility, we are contracted as a facility to provide mental health services almost like a counseling center within the school because we have the professional [herself] and the practitioner [school psychologist with appropriate license] as part of the staff would provide some one on one therapeutic services if the students need it. Or she is the one that does the DA [diagnostic assessment] and then we would write up treatment plans. And I would administer the services to the student with some supervision by her. And then for third party billing we

can bill on all of those things; diagnostic, individual skills, and therapeutic.

She went on to share that students on certain medical plans such as medical assistance would be

considered "third party billable" and the funds would go back to the school district. The common

approach for billing therapeutic services in school setting that emerged from the participants'

experiences involved the co-located therapist billing private insurance. Both of the school

administrators remarked that one benefit of having a co-located mental health worker contracted

to come into the school to do therapeutic services is that they take care of all the insurance paper

work. There was also a common perception of the participants that schools are hesitant to

recommend mental health services in fear of being liable for the expense. The collected mental

health worker echoed this sentiment when she shared, "If I was employed by the school district

and I recommended therapy, technically, the school would have to pay for it". On commenting

on the many roles of school based staff, the school teacher that was interviewed had this to share:

> I have to meet these standards and I have to do this for my license it turns into not what is
>
> best for kids but what works for our politics. I wish we could focus on kids and not so
>
> much what is going to make our lawyers and everyone else happy.

Funding concerns and liability apprehensions were prevalent throughout this study.

The eight participants who were interviewed for this study had varying views and

experiences with school based mental health services. The researcher developed main themes

throughout the data. These themes included: (a) Relationship, (b) Current Needs and

Assessments, (c) Interventions, (d) Staff and Parent Development, (e) Coordination of Care, and

(f) Funding and Liability Dynamics. In the following section, the researcher will review how the

findings compare to research, the strengths and limitations of this study, and will consider the

implications that the current study has on social work practice, policy, and future research.

Discussion

The purpose of this study was to survey current mental health interventions and to examine the overall experiences of key stakeholders involved in the delivery of school based mental health services. The research questions addressed were: (1) What is the meaning of mental health interventions for students in the k-12 classroom, and (2) What are the experiences of stakeholders of mental health interventions in schools (i.e., teachers, administrators, school social workers, co-located mental health practitioners, and parents/caregivers). The researcher was able to answer the research questions by conducting qualitative interviews with eight stakeholders within the categories described. In the following discussion portion, the findings will be discussed as they relate to the current literature. Furthermore, the researcher will address the strengths and limitations of the study and will discuss the implications that this study has on social work practice, policy, and future research. The themes that developed in this study show some similarities and some differences compared to the existing literature on school based mental health service delivery. Some of the differences included some unique service models that did not emerge in the literature. Overall, the themes and general findings of this study were consistent with the studies in the literature review.

Comparison to the Research

The purpose of this section is to compare the findings of this study to the findings of previous research studies reviewed in the literature and to find similarities and differences in the two. All of the participants in the study, had extensive experience with some sort of mental health interventions. This is consistent with the work of Barrett, Eber and Weist (2013) that highlights the prevalence towards schools providing mental health interventions. Furthermore the theme of 'coordination of care' was present throughout the data. Bronstein et al. (2011) found in

their research that co-located mental health workers often had more training than school employees in the area of collaborating with area resources. This coincided with the research of this study that indicated that co-located mental health workers would often do more referrals to "higher levels of care".

Additional similarities of this study compared to existing studies reviewed fell under the theme of 'assessments'.   The present study showed the trends of individual assessment strategies as opposed to population focused assessment tools. This corresponds with one study that found that mental health concerns are typically assessed on an individual level rather than using population based assessment tools that are driven by community needs (Dowdy, Ritchey, & Kamphaus, 2010). Correspondingly, Burke and colleagues' (2011) pointed out in their study that the problem with this approach is that the office referrals need to increase in order to get needed mental health services. This correlates with the both of the parents interviewed in this study that shared that the behaviors of their children increased dramatically before they received additional mental health services in the schools.

Additional similarities with this study compared to the literature reviewed includes the topic of traumatic events. The majority of the participants of this study indicated the prevalence of traumatic events. This coincides with Beechler, Birman, and Campbell's (2012) study that highlighted the importance of trauma informed practices. Hansel and colleagues (2010) also pointed out the link between children experiencing traumatic events and the mental health concerns presenting themselves in the school system.

The topic of assessment practices also developed in the findings of this study as well as the studies in the literature reviewed. The school social workers and the co-located mental health worker that were interviewed as part of this research, indicated that the common assessment

practices in schools can miss underlying mental health needs. This coincides with K. Harrison &

Harrison's (2009) work that indicated that functional assessments that are commonly used in

schools occur through too narrow of a lens.

One difference between the current study and the literature reviewed included the

versatility of various service models available to school districts while contracting with

community based mental health providers (co-located mental health workers). Three different

approaches of using co-located mental health workers in varying schools districts emerged

through this study. These included an embedded collocated worker that operated in part by grant

money, several co-located workers representing several community based mental health

facilitates, and one co-located worker being placed in the district on an intermittent basis. While

Bronstein and colleagues' (2014) comparison study between school and agency employed school

based mental health workers provided a comprehensive analysis of the two entities working

together, they were not able to evaluate the multiple service models of contracting with

community based mental health professionals.

Another difference between the current findings and the studies reviewed through the

literature was the absence of screening tools as well as the absence of researched based

interventions. In this recent research, there was little mention of systematic approaches and

social and emotional curriculum used school wide. Although the research reviewed highlighted

the importance of not only research based practice, but also the importance of integrating

research based interventions into school based mental health service delivery (Elias, et al, 1991,

& Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011).

Overall, the findings of this study were consistent with the findings included in the

literature reviewed. There were many similarities in the areas of current needs and trends present

in mental health service delivery. This includes the need for trauma informed practice and the need for proper assessment strategies. Gaps identified in the findings of this current study and the literature include using integrative approaches in coordination efforts with community mental health providers as well as gaps in the area of integrating research based interventions into school settings.

Further Impressions

The researcher developed several thoughts and ideas through the course of this study. This was especially true in regards to the qualitative nature of the study and the analysis of the participants' lived experiences. In the literature review, a few of the studies acknowledged the gap between researched based interventions and the "real world" practice. The participants lived experiences provided in-depth insight on the complexities of the dynamics of mental health service delivery in schools. The importance of researched based practice was also evident to the researcher. Without exception, every one of the participants' good intentions in regards to children mental health was evident. The importance of coordination and staff education was highly evident throughout the themes as they emerged through the research process. This was marked by lack of knowledge of the different stakeholder's role in the various school districts. Often one stakeholder was unsure of exactly what the role and responsibility was of the other stakeholders. It seems that schools can become bureaucratic by nature and overly focused on education outcomes. This can lead to overlooking the individual complexities of human relationships.

The parent's perspectives were an especially valuable portion of the research. There needs to be ongoing and better coordination and assessment. For example, education and defining mental health interventions and roles and responsibilities of various stakeholders is

needed and important. This includes the complexities to funding options and the gap between policy and practice. It is the impression of the researcher that it would be advantageous to explore the different avenues of mental health awareness and coordination between all of the stakeholders involved in mental health service delivery. Next, the strengths and limitations of this study will be discussed.

Strengths and Limitations of the Study

The purpose of this study was to offer a greater understanding of mental health service delivery in schools. This was done by using a qualitative approach to examine the lived experiences of the participants. These experiences can offer social workers and other school based mental health professional insight on service delivery that meets their specific needs. This includes not using a canned approach and the need to explore and collaborate. All the while delegating resources to this important endeavor.

There were several strengths found in this study. First, the qualitative nature of the study evaluated the lived experiences of several stakeholders. Gathering these multiple perspectives offered a well-rounded view of the intricacies of program development. Likewise, using different perspectives from different demographical areas offered a picture of how different systems/cultures can operate.

Limitations also exist in this study. The major limitation of this study is the small sample size. The small sample size may not represent the views and lived experiences of the population that participants represent. The study is limited in views from school teachers. Unfortunately, this study includes only one school teacher. It would have enriched the study to get the perspective of a classroom teachers that presents the developmental needs of students in k-12. Finally, a limitation of the study included the possibility of researcher bias in the area of school

based mental health service delivery. The researcher is a white middle class male that has been employed by a school district for several years. It is possible that this lens could have caused bias while interpreting the data. To ensure that the bias was minimal field notes and other ethical consideration was given.

Implications for Social Work Practice

This study has implications for social work practice and school based mental health service delivery. The findings of this study indicate the need for social workers to receive the proper training and education to meet the current trends in mental health. This includes receiving the proper training/certification and supervision to offer researched based therapy practices in the school setting. The findings of this study also indicate the fragmentation of program development.   This should include intentional planning within individual school districts that involve the lived experiences of all stakeholders. Each school district should have a mental health coordinator on staff whose sole responsibility is to use these lived experiences to promote and sustain mental health best practice into the district.

This includes the importance of social workers advocating for the coordination of mental health resources to meet the specific needs of each community. This macro level of service is crucial to meet the individual mental health needs of children. Community wide collaborative relationships need to be formed to promote the sustainability of resources. This includes area community mental health providers as well as school based mental health providers advocating for mental health policy development.

Implications for Policy

This study also has implications for policy development as well as policy implementation in the area of school based mental health service delivery. This includes policy change in the

areas of how schools are accountable to meet the mental health needs of all students.   District

mental health coordinators can meet state wide to discuss how state and federal policy impacts

the needs of their district. Policy also needs to be in place that allow schools the freedom to

advocate for the best needs of students without the fear of overstepping their bounds. Assigned

school district mental health coordinators should be required to sit on county wide mental health

collaborative teams. This would offer a system of accountability and support to ensure that

children's mental health policy is implemented with fidelity. Mental health professionals have an

ethical responsibility to promote system change.

Implications for Future Research

In general more research is needed in the area of the importance of researched based best

practices in the area of school based mental health service delivery. This includes research in the

area of implementing researched based interventions into the school system with proper

resources in place that aid in the fidelity of the intervention that is specifically relative to social

economic status and rural vs urban settings. This includes examining the pros and cons of school

districts becoming a "mental health provider" under CTSS as it relates to these demographics.

Additional qualitative research is also needed to further examine the lived experiences of key

stakeholders. This includes examining the perspectives of students. In addition, quantitative

research is needed to further promote the need of mental health interventions in schools.

In conclusion, the findings of this study are similar to the findings of previous studies on

the school based mental health services. However, variety of service models represented in such

a small sample size is unique. This study offers the lived experiences of key stakeholders

involved in the mental service delivery in schools. Although the sample size is small, the views

and themes developed were consistent among all the participants. Furthermore, this study

presents implications for social work practice, policy, and future research. It is imperative that

research continues in the area of school based mental health services to minimalize the

fragmentation of much needed resources.

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Appendix A

Email Script to Key Stakeholders

Hi, my name is Scott Graham and I am a graduate student in the School of Social Work at St. Catherine University and the University of St. Thomas. I am conducting a qualitative research project on the experience of mental health service delivery in schools. The research project will seek to answer the questions: (1) What is the meaning of mental health interventions for students in the k-12 classroom, and (2) What are the experiences of stakeholders of mental health interventions in schools (i.e., teachers, administrators, school social worker, co-located mental health practitioners, and parents/caregivers). The current study will consider the current trends of offering mental health services in schools and the difficulties associated with the sustainability of mental health services in schools.

I am writing you to request your assistance in recruiting participants for the study. I am looking for school social workers, school principals, school teachers, co-located mental health professionals providing mental health services in schools, and parents/caregivers of children receiving mental health interventions in the school setting. The interview will be from 30 minutes to 45 minutes long. If you have any appropriate participants for my study please forward this letter and or give them my information.

Thank you for your time and consideration,

Scott Graham, LSW
MSW Clinical Research Student
xxx-xxx-xxxx
xxx@xxx

Appendix B

Follow up Email

Thank you for your interest in my research project regarding the experiences of mental health service delivery in schools. Next steps:

1. Please Review the attached information and consent form that explains the details of your participation.

2. If you agree to participate in the study please sign, date, scan, and email the consent form back to this email address.

3. Once I receive the information and consent form, I will contact you to schedule the 30-45minute interview.

Please do not hesitate to contact me via phone or email if you have any questions regarding this process.

Respectfully,

Scott Graham, LSW
MSW Clinical Research Student
xxx-xxx-xxx

Appendix C

Information and Consent Form

I am conducting a study about school based mental health programs. I invite you to participate in this research. You were selected as a possible participant because of your experiences in the field. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Scott Graham, a graduate student at the School of Social Work, St Catherine University and the University of St. Thomas and supervised by Dr. Catherine Marrs Fuchsel, faculty member in the School of Social Work.

Background Information:

The purpose of this study is to get an inside perspective of the experience of school based mental health service delivery. School teachers, school social workers, co-located mental health workers, and parents /caregivers who have experiences with school based mental health services will participate in this study. Approximately 8-10 people are expected to participate in this research.

Procedures:

If you agree to be in this study, the researcher will ask you to participate in a one hour interview. The questions will be around your perception of mental health service deliver in schools. There will be scripted questions that will be provided to you prior to the interview. The interview will be audio taped to capture the details of the interview and transcribed at a later date. Participation in the interview is strictly voluntary. You may choose to answer all or a portion of the questions without impacting your relationship with St. Catherine University and the University of St. Thomas or the organization that you are affiliated with.

Risks and Benefits of Being in the Study:

The study has no risks. This study will add to the much needed research on mental health service delivery in public schools.   This study will also help educate community school districts on ways to sustain mental health initiatives.

Confidentiality:

Any information obtained in connection with this research study that could be identified with the participants will be kept confidential. In any written reports or publications, no one will be identified and only nondescript information will be shared.

I will keep the research results on a password protected computer and only I, my research partner, and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May18th, 2016. I will then destroy all original reports and identifying information that can be linked back to the participants of the study.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used.

Contacts and Questions

My name is Scott Graham. You may ask any questions you have now. If you have questions later, you may contact me at xxx-xxx-xxx or Dr. Catherine Marrs Fuchsel: xxx-xxx-xxx, the research chair/instructor. You can also contact Dr. John Schmidt: xxx-xxx-xxx, the chair of the IRB.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

_____   _____

Signature of Study Participant   **Date**

_____   _____

Print Name of Study Participant   **Phone Number of Participant**

_____   _____

Signature of Researcher   **Date**

Appendix D

Interview Questions for Co-Located Mental Health Workers

1.   Tell me about your role? What are some of the best parts?

2.   What are some of the primary mental health needs/challenges that you see children
      facing?

3.   How do you define *mental health interventions* in schools? What are some key
      components that you feel are important while implementing mental health interventions?

4.   What are some of the advantages of providing co-located mental health services in th
      school?

5.   What are some of the challenges of providing co-located mental health services in the
      public school system?

6.   If resources were not an obstacle…what do you see as the "ideal" service model for
      providing mental health interventions in the school system?

7.   Do you have any further information or questions that you feel would help my research?

Appendix E

Interview Questions for School Social Workers

1.   Tell me about your role? What are some of the best parts?

2.   What are some of the primary mental health needs/challenges that you see children

       facing?

3.   How do you define mental *health interventions in schools*? What are some key

       components that you feel are important while implementing mental health interventions

       in the school system?

4.   What are some of the advantages of providing mental health services in the public

       school system?

5.   What are some of the challenges of providing mental health services in the public school

       system?

6.   If resources were not an obstacle…what do you see as the "ideal" service model for

       providing mental health interventions in the school system?

7.   Do you have any further information or questions that you feel would help my research?

Appendix F

Interview Questions for School Administrators

1. Tell me about your role? What are some of the best parts?

2. What are some of the primary mental health needs/challenges that you see children facing?

3. From your experience, what is your definition of *mental health interventions in schools*? What are some key components that you feel are important while implementing mental health interventions?

4. What are some of the advantages of providing mental health services in the school?

5. What are some of the challenges of providing mental health services in the public school system?

6. If resources were not an obstacle…what to you see as the "ideal" service model for providing mental health interventions in the school system?

7. Do you have any further information or questions that you feel would help my research?

Appendix G

Interview Questions for Parents/Caregivers

1.   Tell me about your role? What are some of the best parts?

2.   What are some of the primary mental health needs/challenges that you see children

      facing?

3.   From your experience, what is your definition of *mental health interventions in schools*?

      What are some key components that you feel are important while implementing mental

      health interventions?

4.   What are some of the advantages of providing mental health services in the school?

5.   What are some of the challenges of providing mental health services in the public school

      system?

6.   If resources were not an obstacle…what do you see as the "ideal" service model for

      providing mental health interventions in the school system?

7.   Do you have any further information or questions that you feel would help my research?

Appendix H

Interview Questions for School Teachers

1. Tell me about your role? What are some of the best parts?

2. What are some of the primary mental health needs/challenges that you see children facing?

3. From your experience, what is your definition of *mental health interventions in schools*? What are some key components that you feel are important while implementing mental health interventions?

4. What are some of the advantages of providing mental health services in the school?

5. What are some of the challenges of providing mental health services in the public school system?

6. If resources were not an obstacle…what do you see as the "ideal" service model for providing mental health interventions in the school system?

7. Do you have any further information or questions that you feel would help my research?