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Integrating Mental Health Therapy Into the School Environment

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Integrating mental health therapy into the school environment

By

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MSW Clinical Research Paper

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. The project is neither a Master's thesis nor a dissertation.

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Abstract

The need for school-based mental health services has increased over the past decade but little has been researched surrounding school-based mental health therapists and how they are integrating mental health into the school environment. This research will focus on how school-based therapists are integrating mental health therapy into the school environment. This research interviews 8 school-based therapists and 2 school-based therapists' supervisors. The interviews consist of qualitative questions that focused on gathering information on integrating mental health. The results indicate the uniqueness of this position, the openness to the position, the differences in the purpose of the environment, the scale of parent involvement and additional results. This research indicates the need for implications in social work policy, practice and research.

Key words: school, school-based therapist, school-based therapy, children mental health

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Recently, legislators have recognized the need for extra support for students in schools. This need for extra support appears to be correlating with the increase in children that are being diagnosed with a mental health condition. Mental health in children consists of attention-deficit/hyperactivity disorder (ADHD), Tourette syndrome, mood and anxiety disorders, behavior disorders, substance use disorder, eating disorders, etc. (CDC, 2013). Studies in 2009 indicated that an estimated 13 to 20 percent of children living in the United States experience mental health in any given year (CDC, 2013). Other studies have estimated that 1 out of every 5 children will experience mental health issues (Whitman, Aldinger, Xin-Wei Zhang, & Magner, 2008). More recent studies have estimated that 20 percent to 40 percent of children under the age of 18 have been diagnosed with a mental health disorder (Becker, Buckingham & Brandt, 2015). The number of children identified as having a mental health disorder continues to rise as we identify many of the children that are undiagnosed and untreated (Neil & Christensen, 2009; Becker, Buckingham & Brandt, 2015; Thompson & Trice-Black, 2012).

Though there is an increase in children being diagnosed with mental health conditions, there are still untreated children who are not seeking treatment for their mental health condition. There are many barriers that a family may have preventing them from seeking therapeutic services for their children. For instance, if a parent has less than a high school education, he/she is less likely to seek services for their child due to the lack of understanding and knowledge of the need for treatment (Benedict, 2006). Other household barriers include “poor social support systems, priority for food and shelter, transportation needs, childcare needs and parental stressors” (Mifsud & Rapee, 2005, p. 997). This shows that the socioeconomic level of a household can significantly impact the number of obstacles preventing a child from receiving therapeutic services. Furthermore, a barrier schools experience is typically children with severe

problems that are negatively impacting their education are assessed, while children with mental health concerns that are unnoticed or assumed to be minor are left unassessed (Benningfield & Stephan, 2015).

Mental health disorders affect the home, the school, the cognitive development and relational development of children (Stephan, Sugai, Lever & Connors, 2015). The relationships and effects of these four areas are intertwined. Therefore, schools are seeing a need for more mental health professions in the school environments. They are hiring mental health therapists, contracting with agencies that have in school-based therapist programs or partnering with outside mental health clinics (Weist & Evans, 2005; Weist, Ambrose & Lewis, 2006; Whitman, Aldinger, Zhang & Magner, 2008). Though schools are seeing this need and accessing resources to help serve these students, they lack understanding of the integration of the therapeutic environment into a school environment.

The school environment is a learning environment. Its main goal is to teach children basic curriculum with the result that they will master certain concepts and skills. Teachers focus on teaching children how to read, write, do math, and understand science and history. Teachers hope to develop lifelong learners who will go to college and further their education. It is an environment where children are expected to learn and gain information. The mental well-being of a child is critical when it comes to learning (Gearity, 2014). If a child is struggling with mental health issues they are unable to focus and learn. Their distress disrupts their learning, social development and involvement (Gearity, 2014). The question remains, how do adults help distressed children learn to stabilize themselves and be academically successful?

The therapeutic environment has a different focus. It focuses on the individual client and the vulnerable state he/she is currently processing. It recognizes that each client is different and

has endured different trauma or mental health condition; it is person-centered. Therefore, the treatment is altered based on the needs of client. The environment allows for a client to process through his/her trauma and/or mental health issues. The therapist is a holding container for the client's emotions and story. The therapist is also used as a regulator for the client to gather his/her emotions during and after processing trauma. A therapeutic environment is treated separately from the learning environment when school-based interventions are not present (Whitman, Aldinger, Zhang & Magner, 2008). The literature indicates that school-based programs are more preventative in nature than programs implemented in community-based mental health (Weist, Myers, Hastings, Ghuman, & Han, 1999). This indicates that community-based interventions work with more severe cases of mental health. Mental health interventions in schools are considerably different from interventions in a traditional setting and school staff need to be aware of these differences (Weist & Evans, 2005).

Interventions for mental health in a school environment look very different than interventions in a mental health clinic or physicality (Weist & Evans, 2005). It is critical that the mental health staff understand the different dimensions of a school environment (Weist & Evans, 2005). A school environment is typically seen as a place of learning not for mental health; though many of the early signs of mental health are seen and identified by school staff (Lynn, McKay & Atkins, 2003). Since early signs of mental health are seen and identified by school staff and staff have ready accessibility to students, the school environment has been identified as a great place for mental health interventions. The school is viewed as having consistent contact with children and the opportunity to reach unidentified and untreated children (Neil & Christensen, 2009). Though the school environment is a great place for early invention, it is still

important for the school to make sure a child is receiving the support they need for their mental health while still expecting them to learn and develop.

Research lacks the conversation around integrating these two environments. Rather, the literature discusses interventions that have been done. Researchers have studied early or preventive interventions in schools (Neil & Christensen, 2009; Mifsud & Rapee, 2005). They have found that these early interventions are successful in reducing mental health symptoms. The literature also discusses universal school-based mental health interventions that have been performed (Essau, Conradt, Sasagawa, & Ollendick, 2012; Wells, Barlow & Stewart-Brown, 2015; Lendrum, Humphrey & Wigelsworth, 2013). The literature has shown mixed results of effectiveness with universal school-based settings. Universal school-based settings are school-wide mental health interventions. The literature also discussed crisis/brief interventions in a school-based setting (Franklin, Moore & Hopson, 2008; Wei, Szumilas & Kutcher 2015). Similar to universal interventions, research has shown mixed results with crisis/brief interventions.

The previous school-based interventions relied on staff that were untrained in mental health interventions or school social workers that have limited time for long-term interventions (Staudt, 1991; Lynn, McKay & Atkins, 2003). Though the role of a school social worker can be different from school to school, most school social workers spend a majority of their time working with children in crisis or children who are identified as special education (Weist, Ambrose & Lewis, 2006; Straudt, 1991). This leaves the general school population without someone to assist with mental health concerns. This is where a school mental health therapist would be helpful. Recently, there has been a need identified for schools to hire a mental health therapist or partner with an organization that provide school-based mental health therapists

(Stephan, Sugai, Lever & Connors, 2015). Schools are doing this to help catch children that are unidentified and untreated.

When looking at how a client transitions from processing trauma to learning, we need to look at what happens to a brain in trauma. When a person experiences stress, their body has bio-chemicals, such as dopamine, norepinephrine, endogenous opioids, and glucocorticoids, that are released (Corolino, 2002). With prolonged stress, such as trauma, these bio-chemicals' baselines are changed which can cause long-term psychological conditions (Corolino, 2002). The limbic system is where a person holds their feelings. It is often thought of as the emotional brain (Rosenthal, 2013). When people are processing trauma they often start in their emotional brain, and until they are regulated, cannot move to their thinking brain. The amygdala is found in the limbic system and is linked to the fight, flight or freeze response of a person. When a person experiences prolonged stress, their amygdala slows down and it takes longer for their body to respond (Rosenthal, 2013).

The frontal lobe is the part of the brain used when learning at school. This is the part of the brain that helps us think and process information. When a person processes his/her trauma, he/she often recreates or relives their trauma. When people relive trauma they can cause damage to their frontal lobe, causing them to have trouble thinking and processing (Rosenthal, 2013). When people experience trauma they can get stuck in their limbic system and cannot make sense of their current experience. As therapists our job is to help our clients regulate so they can make sense of their trauma. The question remains how clients transition from processing trauma to the learning environment.

The therapy world is very different from the school environment. Understanding this difference will benefit social workers who work with children. The ability to explain mental

health jargon to educators in ways that encourages them will increase the benefits for our clients/students. Integrating these two worlds is a complex and delicate relationship that needs a careful balance of education and therapy for the children.

Literature Review

Interventions

Researchers have studied different interventions to find ways to help children with their mental health and well-being. The literature discusses different types of interventions. For instance, early or preventive interventions intended to address or prevent mental health symptoms from exacerbating. The literature also discusses universal school-based mental health interventions that involve the whole school. The literature also discusses crisis/brief intervention and its effectiveness. In the paragraphs below I will discuss each type of intervention and the results that were found by researchers.

Early interventions. As teachers and school staff begin to notice that the mental health and well-being of their students is affecting each student's learning, they have been looking into methods for prevention and early interventions. Research to date has shown that interventions were being done with children in late elementary to high school instead of studying a range of children (Neil & Christensen, 2009; Mifsud & Rapee, 2005). Neil and Christensen (2009) did a systematic review on intervention programs that are school-based preventative and early interventions for anxiety. They found that teenagers responded well to preventative interventions, with a result of over three-quarters of the study reporting significant reduction in anxiety symptoms. They found that the effects of the program did not rely on the type of intervention but whether it was performed by a teacher, another school staff member or type of group. The biggest factor was the attitude of the program leader. If they were not prepared or not

interested in the program, the intervention did not have as effective results. Other studies found that there was significant differences in results depending on the leader of the intervention (Baskin, Slaten, Sorenson & Glover-Russell, 2010)

Early interventions have been successful in reducing anxiety symptoms for children. Mifsud and Rapee (2005) evaluated a specific intervention called Cool Kids. Cool Kids is an active intervention for managing anxiety disorders. It educates children about anxiety, restriction of their thought patterns to challenge anxious thoughts and exposure to fear-related and social skills to deal with bullying and assertiveness. The Cool Kids program worked with children ages 8 to 11 years old on an early intervention to reduce anxiety symptoms. These children came from low socioeconomic households and were identified to have high levels of anxiety. Mifsud and Rapee (2005) found that, despite the poverty that these children endured, they responded well to the intervention. Some of the advantages of this intervention was that it was a short eight week program that could be done in one term. Also, with the sustainability, it was more cost effective which was beneficial for schools. Mifsud and Rapee (2005) did find some limitations to their study. One of their limitations that their study found was that parent involvement was very low, which is often a characteristic of school-based programs. They thought that a better understanding of the intervention would maximize parent involvement. Early intervention helps to be proactive and prevents late mental health concerns with children.

Whole school/universal school-based interventions. Another invention that the literature discusses is a universal or whole school-based approach. These whole school-based interventions implemented programs for all students no matter the diagnosis of mental health. Some of the studies about universal school-based interventions reported results of improvement for children dealing with mental health (Essau, Conradt, Sasagawa & Ollendick, 2012). While

improvement may have been evident, other studies identified numerous barriers to universal school-based programs (Lendrum, Humphrey & Wigelsworth, 2013; Wells, Barlow & Stewart-Brown, 2015). These barriers often make it difficult to see if the improvement are affective in the long-term.

Essau et al. (2012) performed a study on children ages nine to twelve years old to prevent anxiety symptoms. It was a universal school-based trial that was conducted in Germany. The specific program they used in their study was called FRIENDS. FRIENDS is a Cognitive Behavior Therapy based intervention that teaches children ways of coping with anxiety and challenging difficult situations. FRIENDS is an acronym that helps children remember the strategies they were taught: “F= feeling worried?; R= relax and feel good; I=inner thoughts; E=explore plans; N=nice work, reward yourself; D= don’t forget to practice; S= stay calm” (Essau et al., 2012, p. 455). Essau et al. (2012) found that this intervention helped to lower the levels of children’s anxiety. In fact, forty-eight children that were treated individually and forty-one percent of the children treated in groups no longer qualified for any anxiety disorders after treatment. They also found that after six to twelve months of treatment the children also had lower depressive symptoms than those children not receiving treatment. The encouraging results were not gender specific; both genders showed improved with anxiety and depressive symptoms.

Unlike Essau et al. (2012), other studies found universally school-based programs to have barriers instead of being helpful. Lendrum, Humphrey and Wigelsworth performed a study to evaluate a program called Social and emotional aspects of learning (SEAL). They studied ten secondary schools from England. Their focus was to analyze the potential threats of implementing a SEAL mental health program in a school setting. One of the barriers they found from the implementation of SEAL is the flexibility that SEAL provides. Though flexibility can

help tailor the program to the school, it also left unclear instructions of how to implement and deliver the program. The flexibility also had unclear guidelines around utilizing the program. They encouraged future programmers to have adaptability, but it is essential to provide clear instructions on how to implement. Another barrier they found was the lack of confidence and competence for teachers to implement the program. The teachers felt unprepared and untrained to perform mental health interventions. They also found that implementing a child-centered program is difficult in a secondary school because of the size and structure of the school. Though they found many barriers when implementing a universal school-based program, their study demonstrated a need for more awareness of mental health in schools and interventions that are successful.

Research on universal programs have shown that generally students benefit from these interventions. Wells, Barlow and Stewart-Brown (2003) performed a systematic review on universal approaches to mental health in schools. They found that school-based interventions focused on conflict resolution, prosocial and antisocial behavior, depression and suicide prevention, self-esteem promotion, self-concept emotional literacy, enhancement of understanding, and acceptance of self and others. Of the studies they examined, more than half of the studies showed positive improvements for the children involved. The interventions that were the most successful were implemented over a continuous extensive period of time. Wells, Barlow and Stewart-Brown (2003) found that, in order for whole school-based programs to be successful, school staff need to change their belief, attitude and behavior to implement the intervention consistently. The research has had mixed reviews on whole school-based interventions. Some show that universal school-based programs benefit students while others reveal difficulties and challenges. They found, that while many studies had shown improvement

in a child's mental health, there does not exist a "measure that covers the entire spectrum of positive mental health" (Wells et al., 2003, p. 217). They believe there is a need for this measure so that school staff can see if children are actually making gains.

Crisis/brief. Brief or crisis intervention is another form of mental health program that is being implemented in schools. The research is divided over whether brief or crisis interventions are effective in schools. It appears that it depends on the intervention and the mental stability of the client before the intervention. Specifically, Wei, Szumilas and Kutcher (2010) did a systematic review of crisis interventions that are commonly used in schools. These interventions include critical incident stress debriefing (CISD), critical incident stress management (CISM), psychological debriefing (PD). Even though there was limited amount of research on these interventions in a school setting, Wei et al. (2010) determined that they are ineffective interventions. They made this determination based on the research that shows the potential harmful effects in adults. The research they found showed that working with trauma clients too quickly can cause survivors to not be able to process their whole trauma story or to completely avoid processing their trauma.

On the other hand, there is research on brief therapy interventions that have shown to be successful for students. Franklin, Moore, and Hopson (2008) studied the effectiveness of solution focused brief therapy in a school setting. They evaluated sixty-seven children that had been identified by teachers and school staff as benefiting from solutions focused behavior interventions. These students attended five to seven sessions and ranged from 10 years old to 12 years old. During these sessions students were asked questions that helped them find different strategies to improve their behavior while building on an existing strength (Franklin, Moore, & Hopson, 2008). They found that Solution Focused Brief Treatment was successful in reducing

the behaviors in the classroom. Over time this intervention showed improvement on the “teacher’s report of internalizing behavior, teacher’s report of externalizing behavior and student’s report of externalizing behavior” (Franklin, Moore, & Hopson, 2008, p.23). The intervention did fail to report on internalizing the behavior and its effectiveness. Researchers disagree as to whether brief/crisis interventions are beneficial in a school-based setting

School-based wellness center. With the increase in childhood mental health conditions, some schools are implementing a school-based wellness center. Guerra and Williams (2003) performed a program evaluation on a school-based wellness center that was implemented in Riverside, California. The program was specifically called Healthy Places/Healthy People (HP/HP) and was implemented in five wellness centers in the elementary, middle and high school. The program emerged from a collaboration of school, community and mental health personals. The primary focus of the program was preventions of school violence and promoting an understanding of mental health. Guerra and Williams (2003) found that the HP/HP program was successful in increasing the children’s development and reducing school violence.

There were some challenges with implementing the HP/HP program, such as funding and the timing of using those funds as a school. Typically, grant funds are required to be used within a certain timeframe. This is often difficult for schools to do since they typically begin planning after they have secured the funds. Another challenge that Guerra and Williams (2003) found was the school staff members were unable to invest consistent time into the Wellness center since they had responsibilities to attend elsewhere in the school. Another challenge they found was the change in thinking for staff. Staff needed to shift from thinking about programs and problems to think outside the box.

Collaboration

Researchers have studied how school staff, mental health therapist and parents have collaborated for mental health interventions. They have defined the involvement of each staff member in the different interventions. They have researched the benefits and challenges of collaborating. Researchers have also discussed how untrained and inadequate staff affect the intervention's success. In the following paragraphs I will discuss what the literature has found about collaboration and school-based mental health interventions.

Parent involvement. Researchers have discussed the importance of having parent involvement in school-based mental health. Researchers are finding that even though there are results for interventions when the parents are not involved, there is more success when they are involved. A previous study, which was researching universal school-based interventions performed by Essau et al. (2012), found that when parents are involved in more of the sessions, the more effective the intervention was on reducing anxiety in children. They could not clearly state why the intervention was more effective when parents were involved, but the research showed that parent involvement does affect the success of the intervention.

Researchers have found that in school-based interventions parent involvement is significantly low (Mifsud & Rapee, 2005). They believe that low parent involvement put a huge limitation on the method and its effectiveness of their intervention. They concluded that a better understanding of the intervention implemented could maximize the involvement of parents especially when dealing with low socioeconomic families that might be dealing with high levels of stress. Greenberg, Domitrovich and Bumbarger (2001) found that prevention programs are more successful when there is a consistent change in both the school environment and the home environment.

Teacher/other school staff involvement. The literature discusses the involvement of teachers and other school staff in mental health interventions. The research has shown mixed results in the effectiveness of teachers and other school staff involvement when it comes to school-based mental health interventions. In universal interventions teachers' involvement is essential for the implementation of the program. Other interventions have revealed different levels of involvement and different levels of effectiveness.

Some research found that there were gaps when the studies analyzed teacher involvement in the interventions. Franklin, Kim, Ryan, Kelly, and Montgomery (2012) performed a systematic review of teacher involvement in school-based interventions. They found the active participation of teachers has not been investigated enough in empirical studies. Therefore, they hope to address this gap of knowledge and give information around who is providing the interventions and how effective the interventions are being implemented. Franklin et al. (2012) found that of the forty-nine studies they reviewed 40.8 percent of mental health interventions had active participation from teachers. They also found that out those forty-nine studies 18.4 percent of the interventions were solely implemented by teachers. They found that most of the interventions were universal and implemented in the classroom. In their systematic review they found that some interventions implemented by teachers or mental health professionals did not seem to have huge differences in effectiveness. Conversely, other interventions found that teachers and other school staff interventions did not have as great of effectiveness as those performed by mental health professionals. They concluded that one reason mental health professionals are more effective might be the difference in the focus. An intervention that focused on psychotherapy versus psychosocial intervention may yield a greater result or vice versa (Baskin, Slaten, Sorenson, Glover-Russell, & Merson, 2010).

Some research discovered the need to collaborate. Lynn, McKay and Atkins (2003) found in their study that it is essential to have teachers and other school staff to collaborate on school-based mental health services. They performed a systematic review of school social workers collaborating with teachers and other school staff to implement mental health interventions. They concluded that teachers and students are greatly influenced by the community around them so it is essential to have teacher involvement in mental health interventions. They found that establishing a positive, non-judgmental environment where everyone is working towards the same goal of the intervention can benefit the implementation of the mental health method. Consistent communication and contact will ensure that the intervention is being implemented effectively. Specifically, Lynn et al. (2003) concluded that school social workers need to understand a teacher's expertise and utilize the expertise effectively to implement the interventions. They concluded that collaboration between teachers and school-based mental health professionals is essential for the change in the mental well-being of the students.

Community care approach. Collaborating with teachers, other school staff members and parents is important when treating children with mental health concerns. Another aspect of collaboration that mental health professionals can do is to collaborate with the communities surrounding both the school and the child. Powers, Webber, and Bowers (2011) performed a small qualitative study to identify the benefits and challenges of implementing a system of care approach (SOC). An SOC approach is collaborating with the agencies in the community to provide interventions and services to improve the mental health of children (Powers, Webber, & Bowers, 2011). SOC is not a specific program but rather a philosophy of how mental health programs should be implemented. They found that SOC is a multi-layered system that includes providers, services offered and governance structures. They found that to navigate this multi-

layered system a common consent form is beneficial so they can share information amongst the different agencies to better serve the child. They also found that having stable leadership and direction were a great need in implementing the philosophy of SOC. Lastly, they found that the greatest challenge is integration and sustainability. This is the greatest challenge because it comes down to whether it becomes a philosophy and operates within the community in a way that is sustainable in the relationship between the community and the school environment.

Untrained/Inadequate Staff

Though the literature discusses the importance of collaboration between parents, teachers, other school staff and mental health professions, it also discusses the concerns of untrained and inadequate staff trying to implement mental health interventions. There are concerns about how teachers who are not trained in mental health are trying to implement interventions. The literature explains that many teachers feel inadequate when implementing mental health interventions and would benefit from training (Kidger, Gunnell, Biddle, Campbell & Donovan, 2010; Loades & Mastroyannopoulou, 2010; Rothi, Leavey, & Best, 2008). Teachers are only required to receive continuing education in understanding warning signs of early-onset mental health in children and teenagers (Revisor of Statutes, 2015). The continuing education requirement is only a small part of the number of continuing education requirements. This is the disadvantage of not fully training staff on the interventions that are being implemented.

Another systematic review done by Baskin, Slatan, Sorenson, Glover-Russell and Merson (2010) found there were large differences between teachers and other school staff implementing an intervention versus a mental health professional. They also found that interventions that were implemented by graduate interns were likely to have less results than either the interventions implemented by teachers or mental health professionals. The literature reveals a gap in training

for mental health professionals. Performing therapy in a therapeutic environment is one thing but implementing the same concept in a learning environment is a totally different expertise. There is no literature on how to integrate a therapeutic concept into a learning environment. Colleges are not teaching on this subject, leaving many students ill-prepared for school-based mental therapy.

The literature discusses the importance of the specific program leader of the intervention and how who is leading can often affect the results. In a previous study mentioned above, Neil and Christensen (2009) concluded that there was a higher percentage of effectiveness in reducing anxiety when the program leader was a teacher. Though they saw the same effect with teachers leading the intervention versus mental health professional, they also concluded that teachers have less knowledge and experience with delivering the psychological interventions. Other researchers concluded different results; studies found that interventions conducted by teachers have smaller effect than those implemented by mental health professionals (Andrews, Szabo, & Burns, 2002; Mifsud & Rapee, 2005). Since the literature conflicts over the effectiveness of the knowledge and experience with mental health for the program leader, further research is needed.

Care and Treatment Schools

Unlike a general education school, care and treatment schools are primarily focused on the mental health of the children who are attending their school. The children are typically there for certain amount of time to focus on the mental health issues that led them to the care and treatment school. Care and treatment schools are staffed with well-treated, trauma-educated staff who can provide a consistent, structured environment while the students work on their mental health (Kagan & Spinazzola, 2013). Instead of being concerned about the education of the student, mental health placements are focused on growing the student's "attunement and security with caring adults and the development of positive self-regard, co-regulation and coping skills

for children who have experienced relational trauma” (Kagan & Spinazzola, 2013, p.713). Care and treatment schools have the ability to put greater focus on the mental health concerns than the child’s ability to function in a classroom after processing trauma. Although both are important the focus depends on the purpose of the setting.

Benefits of using interventions in schools

Though school is typically thought of as a learning environment, it is still seen as being a great place for mental health interventions. The literature identified that a school setting is ideal for early identification of mental health concerns and early interventions (Mifsud & Rapee, 2005; Benningfield & Stephan, 2015). The ideal nature of schools for interventions exist because they have access to all these students and the students have supportive staff and services that were accessible to them (Thompson & Trice-Black, 2012; Whitman, Aldinger, Zhang, & Magner, 2008). Other reasons the literature stated for schools being ideal were that they helped to remove barriers to mental health treatment (Powers, Webber & Bower, 2011; Mifsud & Rapee, 2005) Barriers included transportation, financial difficulties, lack of identification, lack of trust and the stigma (Stephan, Weist, Katoka, Adelsheim & Mills, 2007; Mifsud & Rapee, 2005). Schools are focusing on the mental health of students because teachers and staff are identifying how the well-being of the children affects their ability to learn and develop (Benningfield & Stephan, 2015; Gearity, 2014; Thompson & Trice-Black, 2012). Schools provide an interdisciplinary approach to mental health where mental health personals and school personals collaborate to find the most effective path of intervention for the child struggling with mental health (Mifsud & Rapee, 2005). “Schools have the potential to decrease the duration of untreated psychosis by providing education, screening, and access to early intervention.” (Benningfield & Stephan, 2015, p. xvi)

Though schools have this potential it is important to recognize that schools cannot be used to meet every mental health need of every students (Paternit, 2005). It is important for schools to be aware of their limitations and understand how they need to grow. It is important for them to understand that the development of children dealing with stress is delayed and in order for those children to continue developing they need age appropriate interventions (Gearity, 2014). It is necessary for them to also understand how students experience stress. Stress affects both the child's body and mind causing the child to spend his or her energy towards reacting to stressors instead of learning (Gearity, 2014). It is important for schools to also understand that trauma can cloud your perspective of people around you. Often children can perceive danger when there is no present threat (Gearity, 2014). Lastly, it is important for schools to understand that attunement, attachment and self-regulation are the bases for development. If a child has never experienced these, they must have an adult who can teach them these skills before they can do it independently (Gearity, 2014). Essentially, it is important for schools to understand how mental health therapists are integrating the therapeutic environment into the school environment.

Conceptual Framework

This study seeks to examine how school-based mental health therapist are integrating mental health into a school environment through the lens of Systems Theory. The Systems Theory looks at human behavior as a result of their interactions with other people linked into the environment (Hutchison, 2011). When looking at how mental health therapists integrate a therapeutic environment into a learning environment, we need to examine how the different parts of the system interrelate to each other. This is what System Theory examines; it looks at how the interrelated parts interact with each other and affect each other (Hutchison, 2011).

The System Theory has many subsystems. The System Theory examines how the environment or ecological system affects the client; it looks at different roles in the system, how the different people in the system affect each other, and how the different parts of the system link together (Hutchison, 2011). To examine this study carefully, it is important to look at the different subsystems of the System Theory.

The ecological perspective allows social workers to examine people in their environment (Forte, 2007). In studying how school-based mental health therapists integrate a therapeutic environment into a learning environment, we are allowed to see how therapists need to adapt to the environment they work in. We see the relationship between the therapist and the environment it provides therapy in. In this study, we seek to see the challenges and benefits between a therapist and the school environment.

The Systems Theory also examines the different roles in a system. For this study I will examine how those roles interact with each other and how they affect each other. School-based mental health therapists are not exempt from being affected by the other school staff members. Each member of the school has a certain role he or she plays in the school system as a whole. The Systems Theory examines how those roles interact with each other and how they affect each other. It assumes that these different parts cannot be separated without destroying the assets of the system as a whole (Forte, 2007). When studied school-based mental health therapists, we need to examine how other school staff's different roles affect the school-based therapists' role in the system. We cannot separate them from the system to gain an understanding they function and interact. Rather, we need to examine their environment by seeking to understand how the system around them has impacted them and their work.

Another important part of the Systems Theory that impacts my study is critical feedback. Feedback is what guides a system to change or alter its course (Forte, 2007). The Systems Theory recognizes both negative and positive feedback (Hutchison, 2011). As I look at the interviews and conversations I had with the school-based therapists, I gained an understanding of the feedback they have received both inside the system and outside the system. As well as how the feedback has changed and guided their work in the school.

Systems Theory has been used in the past literature for examining studies in schools. Since the literature has utilized the Systems Theory when studying schools, I thought it would be a good theory to guide my study. It reminds the reader that the school is a system that has many different aspects that interact with each other. It reminds us that we are studying how a system functions (Forte, 2007). This is why I chose the Systems Theory to be my perspective. It will allow me to see how mental health therapists are functioning in the school.

The Systems Theory guided my interview questions by reminding me to ask questions about how the learning environment has affected their work. I asked questions about how the different roles have affected mental health therapists' work. I asked questions about how the feedback from both inside the system and outside the system have benefitted or challenged that therapeutic environment. I asked questions about how the mental health therapists have adapted to their new environment and how the learning environment has altered how they implement therapy. Overall, I used the Systems Theory to remind the reader that these mental health therapists are affected by the environment where they are providing services.

Methods

My research question was: How are school-based mental health therapists integrating

the therapeutic environment into the school environment? My hypothesis was that it is not an easy task to integrate the therapeutic environment into the school environment. My thoughts were that therapy is altered based on the learning environment. My study was a retrospective in nature because I asked my subjects to reflect back on their experience. I examined how school-based mental health therapists have adapted to the environment where they are providing therapy and altered their procedures. My study was a qualitative study using in-person interviews with professionals.

Sampling

I looked at different agencies' websites that are providing in school-based mental health programs to gather contact information for school-based therapists. I chose these organizations because they are organizations that have been working with mental health clients for a number of years and saw a need for school-based mental health therapists. I also looked for school-based mental therapists on school districts' websites to interview staff that work with students with mental health concerns. I chose to contact these school staff members because some of the school-based mental health therapists are hired directly from the schools. I have interviewed 8 school mental health therapists and 2 supervisors of school mental health therapists. Within the organizations I connected with I did a snowball sampling. I contacted four or five school-based mental health therapists and asked them to provide contact information for other school-based therapists that might be interested in the interviews.

Measures

I interviewed school-based mental health therapists with open-ended qualitative questions to measure how mental health therapists are adapting the therapeutic environment to fit the learning environment. The interview was done in person. The interviews collected demographic

information about the mental health therapists and about the schools. The interviews looked at gathering the benefits and challenges to integrating the therapeutic and school environments. Interviews allowed for a thorough explanation of how therapists are integrating these two very different environments.

The interview questions began with asking demographical information about the therapist and the school where they work. The questions examined the research question within the environment the mental health therapist works. The questions focused on how the school environment has affected the therapy provided by the school-based mental health therapists. I asked questions about the collaboration with other staff and community members. The questions focused on what the therapists foresee for the future of therapy in the school environment. The interview guide is in Appendix B and C.

Human Subjects Protections

My study was reviewed by the IRB before I began the interviews. This maintains the confidentiality of the identities of the subjects I interviewed. This was also done so my study was in accordance to the regulations and rules when studying human beings.

Analysis

I analyzed my qualitative study through a phenomenology thematic approach. I analyzed my study by following these steps. First, I looked for themes that appeared throughout my interviews. The discovery of themes were made through multiple readings of my interviews. Second, I looked for patterns in these themes. As the patterns emerged from the themes, I organized them by giving them a code. Third, I went back and looked at where each theme appeared. I was looking at the context they appeared in and the population of clients. Fourth, I looked for similarities in the context where these themes appeared. I looked at the circumstances

surround the themes and analyzed if it is similar in most of the interviews. Fifth, I looked for differences in the content when themes do not appear. I analyzed these differences to understand when there were struggles and challenges. Lastly, I looked for quotes that support the themes I found in my interviews. I also looked for quotes that identify the differences when themes are appearing. The quotes are the evidence that helped develop the themes in the research's findings.

Findings

The school-based therapists and supervising therapists participating in this study were asked twelve open ended questions regarding their experience with integrating mental health into the school environment. They were also asked some basic demographic information. The questions were designed to gather information on how the therapist provides mental health services in an educational setting. It also looked at the differences from a mental health clinic vs. school-based therapy. The research also gathered information about the specific trainings or qualifications of a school-based therapist or school-based therapy program. Participants were licensed in various fields such as Licensed Graduate Social Worker, Licensed Independent Clinical Social Worker, Licensed Associate Marriage Family Therapist, Licensed Marriage Family Therapist, and Licensed Professional Clinical Counselor. Participants that were interviewed broke down to two supervisors, three elementary schools, two middle schools, two high schools and one joined middle and high school. This was strategically done to gather a wide range of data across licensure and school age groups.

Uniqueness of this position

Several times throughout the interviews statements were made regarding the uniqueness of this position. Statements regarding certain characteristic traits or qualifications that are needed for a school-based therapist to possess in order to successful implement the program in a school

environment. There also were statements regarding the uniqueness of this position and the duties that are fulfilled. There were also unique challenges about the position that continually presented themselves throughout the interviews. The following sub themes continually presented themselves throughout the interviews: isolation, differences in jargon spoken between the school-based therapist and educational staff, the need for a mental health team and the difficulty in ethical decision making.

Isolation. The first subtheme that emerged in regards to the uniqueness of the position was the isolation of the position. This theme was prevalent throughout the answers to the open-ended questions by the majority of the school-based therapists. A school-based therapist identifies the isolation in the following quote:

You are the only person who truly knows what is going on in your position. You don't have the opportunity where your boss is next door or is just down the hallway or a co-worker is down the hall to simply A: ask a question, B: consult or C: check in.

This response identifies how the isolation is felt by the school-based therapist. They stated that you are not able to consult or interact with a supervisor or a co-worker. The majority of the school-based therapists shared how they felt that decisions were based on their own judgment. The following quote was stated about the isolation that school-based therapist feel when it comes to the decisions they make:

There are not the clinicians that can say, 'Hey, together should we call an ambulance or are they okay?' It comes down to your sole judgment of what you are going to do and how are you going to manage that.

The weight that the school-based therapist feels when making decision helps to develop this theme of isolation. Knowing that the decision you make are weighted on your sole judgment and

that you do not have the ability to consult can add to the pressure and disconnect for fellow co-workers and their supervisors.

Not only do therapists feel disconnected from other therapists and supervisor, they feel separated from other key support staff in a clinic. The following quote adds to the development of isolation from key support staff:

I don't have a billing department right here and I don't have someone to check in with. I don't have a secretary or a receptionist so everything is remote which I guess is another one of the challenges of being school-based.

This response alludes to how the therapist feels isolated from other staff in a typical clinic. Staff that support their role are not available to consult, aid in answering questions or help to fix a problem. Further research surrounding this concept would help us to develop a better understanding of the isolation felt by the school-based therapists.

These quotes, that have helped to develop the theme of isolation, indicate that school-based therapists feel disconnected from their other mental health co-workers and supervisors. These responses show that a school-based therapist feels that the decision making is based on his or her judgement and there is less ability to consult with another co-worker or supervisor about a situation or duties.

Another part of the isolation piece was how school-based therapists feel this isolation even though they are working in a place full of people. A school-based therapist stated:

I think sometimes even though I am in the school I am still very isolated...So even though I am in the school, I can be very separate from it as well.

Another school-based therapist spoke about the difficulty of being the only person from your agency or company.

Because you are the only person from the company and you are the only person that can advocate to the school... why you are not doing something you feel as a therapist that you are responsible to do because there is a lot of outside pressure.

A school-based therapist shared how it is difficult to feel so distant from school staff because of this disconnect in the understanding of the duties of the position. Another school-based therapist stated:

No one has said this, 'I feel distance from the school and it feels icky.' I am in the school and I am in my office and no one knows what I am doing because my job is to be a therapist and work with kids.

This response portrays this isolation and not because other mental health staff are not present at the workplace but also this feeling of not being understood or having your duties not be understood.

These responses describe how the school-based therapist can be in midst of many educational staff but still feel very disconnected from the environment where they provide services. They indicate the need to integrate the therapist more into the school staff to help them feel connected and integrated in the environment they serve.

Differences in jargon spoken. The second subtheme that emerged regarding the uniqueness of the position was the difference in jargon spoken between the school-based therapist and the educational staff. The theme was mentioned by some of the school-based therapists when they were answering the question about the benefits and challenges of collaborating with other school professionals to treat mental health. One school based therapist explained this theme by stating:

There are definitely so many similarities with education and social work but our

language is incredibly different. So we might be trying the same things but our social work jargon and our teachers [jargon]. They won't understand it, but if you simply rephrase it in teacher's language, they understand it is completely different. I think a huge part of communicating with a different working professional is really understanding a lot of the foundations of education.

Another explained how it is not just the teachers that do not understand the language spoken by therapist. It is also administrator and district staff. This is explained in the following quote:

It is the mental health language they don't always have, and when you are the administrator overseeing the whole program and you don't have the language that I am speaking, it doesn't connect.

A supervisor explained it with discussing the different perspective we that guide how we talk about different circumstances. The supervisor stated:

We might see things differently. Understand things differently. And then really figure out how to be respectful and how to support the family and the child and communicate in a clear way.

This response describes how the communication needs to be clear. It is something that needs to be understood by the family and the staff working with the student.

Many of the responses indicate that having a different jargon spoken by each professional created a gap in the communication between a school-based therapist and the school staff. When you have two different professionals coming from two different educational backgrounds trying to communicate about the same thing, it can cause confusion and barriers to accomplish the same goal. Many of the school-based therapists spoke about how it would be helpful or is helpful that they understand some teachers' jargon so they could rephrase it in terms that they understand. A

few stated that they wish there were educational programs that blended education and therapy together to give school-based therapists understanding into the environment they will be working and providing services.

Mental health team. The third subtheme that emerged in regards to the uniqueness of this position was the need for a mental health team that would work together to treat mental health. Every school-based therapist and supervisor spoke in some capacity of the importance of having a mental health team that works together to treat mental health. There were some school-based therapists that had a team of people that worked with them and they spoke about the benefits of having these multiple perspectives to treat mental health. There were also school-based therapists who did not have a team at their schools and they would speak about the need and helpfulness of having other perspectives or other treating different parts of mental health.

There are schools that don't even have a social worker and in order for our model to work and I think for the larger hope of schools embracing mental health on a larger scale the social worker component needs to be there because it can't just be. Really what we are providing is outpatient therapy services and some extra support where there needs to be larger mental health support in the building.

This school-based therapist shares about how their model works efficiently when there is a school social worker or other mental health staff involved.

Several of the school-based therapists shared about the importance of this mental health team. One therapist stated:

But I feel like school social workers, school counselors, and then school based mental therapists really work together to provide a well-rounded service when they are available

in a district. We identify kids that need short term school counseling or who need more of the long term, intense therapy or who need resources.

This therapist indicated how have a team of people would give them the ability to identify students' needs in therapy and be able to service them appropriately.

There were a few that indicate the importance of a nurse on the mental health team. One therapist stated:

The nurse is on the task team too. The nice thing about having her on there is you maybe wouldn't think about it but people don't experience their mental health problems as mental health problems.

This response gives us understanding as the value of this mental health team. That it could be a team of people that not only have an understanding of mental health but treat mental health from different perspectives. Having these different perspective would allow for more collaboration and insight on the students' mental health.

These responses indicate the importance of having a mental health team approach to mental health. It speaks about having other people who understand mental health that work in different capacities throughout the school. Having school social workers, counselors, nurses, and family liaisons help to provide the school with a well-rounded view of the mental health of their students.

As the participants spoke about the importance of having this mental health team, they also spoke about the need to clarify or define roles that they each play in the interdisciplinary team. One school-based therapist stated:

More of a team integrative approach. One thing I see is all schools have a nurse but the nurse isn't very involved in the meetings. ... If you take a look at the nurse's role over

time in schools and what it used to look like to what it looks like now. How the nurse relates so much to my role and we haven't been integrated. I feel like a huge piece that we are missing. ... We don't connect the mental health pieces to the physical piece. ... Having more of an integrative approach social worker, nurse and therapist and then connecting what other providers are there too.

This response defined the importance of having an integrative team that understands mental health. It also indicates how understanding the physical part of mental health is valuable when treating mental health. Another therapist stated the need to clarify the roles as follows:

Explaining I don't do the homeless program. I would love to know from my social worker who is in the homeless program because some of them could probably benefit. I am so close to my social worker, and the team of the two of us really clarifying for everyone our roles and how we bounce between each other. We kind of have a pack where I don't take on new kids unless I have connected with her.

This response indicates how the clarification is needed amongst all staff in the school.

It seems to be more than one area of staff that are having a difficult time understanding the differences in roles and duties. Another therapist defined a school social worker's role in the following way:

I really see a school social worker has a much bigger caseload whether a sped focus or general focus. Sometimes it is entire school as well as staff and so I think a school social worker can help to facilitate that referrals process. He or she can help to build those relationships with the school staff to help folks to buy into what this mental health focus means.

This response gives weight to the need for both school-based mental health therapists and school social workers. They would serve the school in different capacity to treat mental health but would also work together.

These responses show the need to clarify and define these roles within the mental health team. Nearly, every participant spoke in some form or fashion to the need to define and clarify roles. This was especially mentioned when it came to other school staff that have similar roles to a school based therapist such as the school social worker, the school counselor or social service support staff. Having the roles clearly defined allows for each role to bring their skills and knowledge to the table to help treat the mental health of the students in the school they service.

Ethical decision making. The last subtheme that emerged about the uniqueness of this position was the ethical decision making surrounding confidentiality. Almost every one of their clients has releases on file for the school-based therapist to collaborate with the school staff. Even though these releases are filled out it is up to the judgment of the school-based therapist to decide what is “need to know” information for the school staff. One supervisor stated the following about the difficult with confidentiality:

I think some of the challenges are around confidentiality and what needs to be shared with others and really that challenge, what should be shared? What is appropriate to share? Who needs to know this information? What needs to remain confidential and in the therapeutic relationship?

Being the one that decides what needs to be shared and what needs to be kept private is a gray area. Each therapist might respond to differently. The supervisor also shared:

For a school-based therapist it is an added challenge to really be always mindful and aware of the need-to-know bases, who needs to know, what is outlined in the release of

information and really evaluating is this going to benefit the student or family that I am working with if I doing this collaboration or communicating in this way. That is a consistent question that comes up for therapists.

This brings understanding to the thoughtfulness that goes in the ethical decisions surrounding disclosing for school-based therapists.

Another school-based therapist spoke about the difficulty with this ethical decision in regards to school staff and the typical school staff culture.

Often times and well-intended, schools want to know everything and want to be informed of everything that is happening in the process and that has been one of the challenges of them being able to embrace a staff in our building that I can't necessarily talk to the staff person in the same way I can as with the rest of the staff.

Understanding the differences in culture of the environment helps guide school-based therapists as they make decisions about what information to disclose. It also helps to give them understanding to the staff they are working with and their different perspective surrounding disclosure.

These responses identify the importance of ethical decision making that is part of the role of a school-based therapist. This became evident in the first few interviews when I actually decided to add a question regarding confidentiality. Since it continually presented itself as a theme in the uniqueness of this position. They were not stating that other therapists do not have to make ethical decisions in regards to confidentiality but since they have releases signed for the school staff and collaborate with the school staff, it is a continual process of deciding what need-to-know information is and how sharing that information will benefit their clients.

Openness to the position

The second theme that was found in the interviews conducted was the openness of staff to this position. Statements would define school staff as varying in their openness depending on their experience and knowledge of mental health. There were school staff that found value in the position and in return utilized the position to the capacity of which it was meant to be used; meanwhile, other staff struggled with the position and its purpose. This created two sub themes for the openness to the position. Those sub themes are finding value in the position and not understanding the purpose of the position.

Finding value in the position. School-based therapists and supervisors continually stated throughout the interviews that if staff found value in the position then they were able to perform their duties to the fullest extent. As they spoke about other staff finding value in their position, they would often relate it to understanding or experience with mental health. They felt that if school staff had experiences with mental health they understood their position more and were willing to utilize them. One school-based therapist stated:

The more that a staff member is interested in mental health, the more that they understand it is a huge component in the school and it is continuing to be a huge component in the schools. Then I am allowed to be more in that role.

This response indicates that correlation between a staff member's understanding of mental health and them finding value in the position. Another school-based therapist stated:

The principal checks in with me regularly and asks my opinion about how kids are doing. He reaches out to a lot of the kids in the school who are struggling with mental health and so he will check in with me sometimes about maybe the best way to approach a kid or just want to bounce ideas off of me.

This statement alludes to when a staff member finds value in mental health that they are more open to consult. This allows for the therapist to be utilized to their fullest capacity.

The following quote was revealed by a therapist in regards to how differences in valuing mental health can have a different perspective on the therapist's role.

People don't realize in the moment what is happening here is a relational trigger or it was like mental health requires these weekly meetings. And the reason she is doing good in school is because she has been seeing me for a year and a half at multiple points.

Whereas other teachers have seen her over the year and a half that this kid is getting better or stronger emotional, or more capable of managing limits or redirection or if they are wrong.

This quote also alludes to this correlation between staff members' value in mental health and value in the school-based therapist position.

These responses indicate positive views of the school-based therapist position. The positive responses were indicated by fewer participants than struggling with staff to find value in their position. Numerous times it was mentioned that if the administration valued their position it was easier for the other staff to also appreciate their role in the school. They also spoke to the experience of the teacher. This was in regards to the number of years they have taught, the experience they have had with mental health, and improvements they have seen in the students who are receiving services.

Not understanding the purpose of the position. A second sub theme of the openness to the position was the participants sharing that school staff did not understand the purpose of this position. There were several statements made by participants surrounding school staff not understanding the purpose of this position. One school-based therapist stated:

Social workers are not always open to mental health people coming in. They say it is encroaching on my job and how dare you bring someone in to do my job.

This perspective of “encroaching on my job” gives research an indication of not understanding the position. Every participant indicate that there are differences in these roles. Another school-based therapist stated:

But there definitely were some territorial pieces of why are you bringing in mental health therapists to the services we provide and to really be able to differentiate between [roles].

No, actually both roles are much needed and what do each fulfill within the school.

This statement indicates that the therapists find value in both roles but there seems to be some territorial tension that is arising in other school staff. Typically, a lack of understanding can lead to tension and confusion. Clarification of these roles would help to give perspective to the value of both positions. Another therapist stated:

The social worker got cut and I don't know if it is because of this position. Happened at another school too. I don't know if it is a misunderstanding about this position. I don't know if they are related but that is what they need. Someone who can see kids as needed.

This response indicates that the misunderstanding surrounding the role of a school-based therapist is seen on many different levels in a school. Lastly, a school-based therapist explained:

They weren't really told what your position was. You are getting this therapist but it wasn't clarified this is an outpatient therapist whose role is to see their caseload of clients. They kind of thought it was an extra support role for the school to use, which makes sense because you are told you are getting a staff in your building.

If staff are not given a clear explanation surrounding a new role in their school than it would be understandable for them to treat the role differently.

This lack of understanding of the purpose of the position has school-based therapists not being utilized to their fullest potential. It seems to also create territorial situations where other school staff feel this position is encroaching on their roles. When in fact every one of the participants shared that their role was very different and in order to serve mental health to the fullest capacity, they need the other roles in the school. The roles that seem to be misunderstood are school social workers, school counselors, family liaisons, and guidance counselors. Several of the participants shared a need for clarifying the roles to define the importance and need for each position.

Differences in the purpose of the environments

The fourth theme that arose from the data is the differences in the purpose of the environment between mental health and school. Participants would speak to the blending of two different environments that are meant for two different purposes. Mental health does not cease to exist once a student walks through the doors of a school, it is not always understood or welcomed in that environment. Putting a school-based mental health therapist in the schools reminds people that mental health exists and it is not going to just go away. One school-based therapist stated:

I think sometimes it is hard because it is in a school. At a clinic if you have a family session, usually those are later in the day, and if a child gets triggered and runs away, you are in a clinic setting. There are other therapists and mental health professionals who can help contain the situation and manage the client and the family. But in a school it is so different.

Having different purposes for each environment allows for confusion and discomfort when there are things that take place that do not typically show up in a school environment. Another school-based therapist stated:

It seems like in a school there is this need to be safe. There is this idea that the school needs to feel safe. The teachers need to be safe. And the kids need to learn how to contain it and be safe. You don't tell everyone about your trauma. You can't do that here and learn how to be safe.

This builds on the differences in the purpose of the two environment. It can be confusing for staff and students when reactions to work within therapy are seen in an environment they are not normally seen. This defines the uniqueness of integrating these two very different environments to serve mental health.

There were two participants who indicated the value in both educational and mental health purpose. One supervisor stated:

I think also to give credit to educators that they are so overwhelmed with and their first goal is to educate students, and so when any kind of behavior comes into play, they want to kind of nip it in the butt. They want to go the discipline route vs. exploring what could be underneath the behavior just because they don't have the time and capacity.

Finding value in both the educational and mental health purpose is essential when integrating these two environments. The following quote was stated by a participant:

Teachers are held to a certain standard and kids need to be taught what they are going to be tested on. And if they are keeping them from being pulled for things, some teachers really struggle with that. Then the timing too. Like it's hard to find a 50 minute or 45-minute block because they keep their kids moving in different subjects.

The differences in purpose of these two environment needs to be approached with flexibility. Being opened minded about how to integrate two environments that serve different purposes would be beneficial to both mental health and school staff.

These responses indicate how integrating mental health into a school environment requires adjustments and innovative ideas. It also speaks to the mental health stigma that is in our society and how it affects schools. The school-based therapists spoke about how they would give time for their client to relax or transition so that when they step back into the learning environment they are ready to be fully present. They also shared the benefits of being flexible to provide therapy when the student is available versus feeling stuck to a certain time and day. Though these are two very different environments it is beautiful when they can collaborate and integrate with each other to educate the students.

Scale of parent involvement

The last theme that emerged from the data was the scale of parent involvement. School-based therapists spoke that parents have a choice in their involvement with the treatment of their child. Minimum involvement requires signing paperwork and treatment plans, but beyond that it is the parent's decision. One school-based therapist stated:

Parent are less involved because they don't have to bring their child to therapy. If a parent has to bring their child to therapy, they are 1) invested and 2) they are there. So they are going to be a part of at least a portion of the session.

That response indicates that similarities that brought the parent to bring the child to therapy adds to the level of involvement of the parent.

Another school-based therapist explained how they do some work with families and other ones they do not do therapy. The following statement gives weight to the development of this theme:

So having the parents do more reflection in the school is not what they came here to do and that is a really interesting dynamic that continues to grow. But there are families that I do see on a weekly base for family therapy on top of individual therapy which doesn't seem to be a problem. So it really depends on family.

This response alludes to the scale of parent involvement might have to do with the placement of the therapy. Understanding that parents have a different perspective and comfortability with the school and will have different reactions to family therapy being offered in a school. Lastly, another school-based therapist explained about the involvement he or she sees:

I had probably less involvement with the families than I would have liked and I think part of it is just the nature of doing school based.... They don't have to bring them every week. It is just the matter of the child getting to school.

This response indicates that school-based therapists would prefer more involvement with parents but are concerned if that is part of the environment where they are providing services.

These responses indicate that parents choose how involved they are in their child's treatment with school-based therapy. Though there is a scale of parent involvement in school-based therapy, nearly every participant shared that having parent involvement helps children to grow in their therapy. They are able to connect things to home and implement the skills they are learning across settings. Many of the school-based therapists wondered if parent involvement was low because they were in a school. School-based therapists wondered the following: Did parents feel that it was not their choice or idea to start therapy? Did parents feel uncomfortable in

the school environment? Did parents think the treatment is about school and they simply do not need to be involved? I think this is a topic that needs further research.

Additional results

There were additional themes that emerged throughout the interviews. Other themes that appeared throughout the interview were challenges with scheduling, office space and location, funding, and lack of training and educational programs. There was also a theme of responding to the mental health shift in the school environment.

Scheduling. Participants spoke about the challenges in scheduling therapy during the school day. Trying to find a block of time that can be billed to insurance can be an issue. They also felt that there were limited times they could pull students. Since they are supposed to be there for their core classes and other teachers do not want them to be continually be pulled from their classes. Though there is more flexibility in the schedule of the therapist, it becomes difficult to find a workable time to pull the student to provide therapy.

Office space and location. School-based therapists spoke about the challenges with the physical space and location in the school. Some found that they were concerned about the confidentiality of the clients they served. They felt that the walls were paper thin and the placement of their office caused students to walk by many other staff just to be seen in their office. Some felt that this might be hindering families from participating in therapy and wondered if a more exclusive location would offer more involvement. Some also shared about the lack of space in a school and the difficulty in that schools were not designed for therapy.

Funding. Funding seems to present itself in many research projects. This study is no different except that school-based therapists spoke passionately about the importance of long term investments and the potential options to fund it. Though most of the funding comes from

insurance several school-based therapists provide what they call ancillary hours. This is crisis interventions, consultations, collaboration with other professionals or training students or staff. These hours are currently funded by the school district or by grants. Without these hours school-based therapists are not able to perform their job to their fullest capacity. Finding the funding to continue providing these services in an environment that is always short on funding and always cutting services provides barriers and obstacles for the future.

Lack of training and educational programs. Several school-based therapists and supervisors spoke about the lack of training and educational programs that are available to school-based therapists. Many spoke about how most of their training is hands on experience. Some spoke about how their agencies are trying to make more workshops available about school-based therapy, although many did speak about how there are more available now than in the past. There were also therapists who questioned the absence of a blended graduate program for school-based therapists. In their opinion, a successful program would teach the foundations of education, the differences in jargon, collaboration with school professionals, and implementation of therapy in an educational environment.

Responding to the mental health shift. Every one of the participants stated that school-based therapy was responding to the mental health shift in schools. They spoke about how they saw this integration growing and developing more. They shared about the need for a better understanding of mental health in school environments. They disclosed how families, communities and schools were becoming more open and willing to integrate mental health into the school environment. In the therapists' opinions, school-based therapy was responding to the growth of mental health.

Strengths/limitations

My study contained both strengths and limitations. A limitation of this study is that it was a small study. Being a small study, it is not generalizable. Qualitative research typically looks for more in depth, complex issues rather than large generalizable data. Within the small sample, only two people in supervisory positions were interviewed which limited the input of information from other supervisors. Another limitation was that the majority of participants came from one agency. This is because most agencies did not have their school-based therapists' contact information available publically. Though this caused some dilemma in locating other therapists from other agencies; the researcher connected with three other agencies to help provide a wide range of input. It would have been helpful though to have more input from other agencies to provide a wider range of information.

A strength of this study was that it spanned a wide range of licenses for school-based therapists and supervisors. This study also interviewed participants in elementary, middle and high schools. This allowed for a wide range of input about how school-based therapy is integrated in different age groups. This study also tried to interview participants from more than one agency to gather different views of how other agencies are integrating mental health into the school environment. These strengths combined with looking at the more in depth, complex issues allowed for themes to be brought up that are missing in the literature.

Discussion

The purpose of this study was to understand how school-based therapists are integrating mental health into the school environment. Another goal of this study was to understand how school-based therapists blend two very different environments to serve the mental health needs of students. The findings suggest that there is a uniqueness about this position that can leave the

therapist feeling isolated, unable to communicate because of the differences in jargon, and stressed over making some difficult ethical decisions about need to know information. Previous research has not studied the uniqueness of this position. Therefore, the findings about the uniqueness of the position add to the literature. The findings also suggests the value of having a mental health team collaborate to serves the students. Previous research has shared more about the collaboration of teachers and social service staff than the specific findings of having a team of people who understand mental health.

School-based therapy requires the collaboration of a mental health therapist and other school professionals. This collaboration can be beneficial to the treatment or can cause difficulties and barriers. Previous research has studied the importance of this collaboration between mental health staff and school staff (Lynn, McKay & Atkins, 2003). Lynn et al. (2003) found that it was valuable for this collaboration to take place. The findings suggest that collaboration is effective when the school staff understands the purpose of the position and finds value in therapy. The reasons as to why some find value and others do not is still unknown. Some participants suggested that it might have to do with the staff's personal experience with mental health but this would need further research. Findings also suggested that not all school staff understand the purpose of the position and further training and explanation would be beneficial to the collaboration that takes place.

The findings mirror similar results in previous literature with parent involvement (Mifsud and Rapee, 2005). In school-based therapy there tends to be a lower number of parents involved in the treatment. The findings indicate that there is a scale of parent involvement; it differs from previous research that has indicated low to no involvement. Though the findings still point to a lower involvement of parents than mental health therapists would prefer to have involved, the

research finds similar results to previous research, the treatment or interventions is more effective when parents are involved (Essau et. al., 2012). It is still unknown as to the scale of parent involvement; the question remains as to why some have low involvement and some have high involvement. It would be beneficial to research the reasons as to why there is a scale of parent involvement.

Implications

Policy. School-based therapy provides mental health services to a larger number of students who typically would not have access to services. Though it removes the barriers of transportation, accessibility and affordability, there are still barriers that need to be addressed on a macro level. Currently, the program is funded by a mixture of insurance, grant money and school funds. The program cannot fully function on insurance alone. Therefore, funding on a larger scale needs to be address. Legislators need to understand the benefits of school-based therapy to designate funds to schools to continue the program. The implementation of school-based therapy needs to be recognized by the top down. If the Minnesota Department of Education and the legislators do not understand the purpose or find value in the program, it will be difficult for schools to continue allocating funds towards this position.

On a macro level, we as social workers need to advocate to legislators the differences between student support services as well as advocating for the need of mental health education and awareness in schools. As social workers we need to describe the differences between school counselors, paraprofessionals, social workers and mental health therapists. Indicating these differences will hopefully encourage a balanced need for each one of these support occupations depending on the needs of the school and students.

Practice. School-based therapists play an essential role in integrating mental health services into the school environment. This integration can be successful or difficult. Providing school-based therapists or future school-based therapists with more training and tools to understand the school environment would benefit the collaboration with teachers and school staff. It would also be beneficial for educational programs to look at adding a blended program to help trained therapists work in school environments. Beneficial classes would specifically address the differences in the purpose of the environment, the differences in jargon and the uniqueness of the position.

Helping school staff understand the purpose of this position will help school-based therapists fulfill their roles in the school environment effectively. Therapy practice will also benefit from more intentional thought around placement of office and space provided to therapists to perform therapy. Building a team of mental health support services such as a school social worker, a nurse, school-based therapists and guidance counselor will bridge the gap between an educational setting and a mental health setting. This will provide the therapist with more mental health staff to collaborate with and staff that have an understanding of the purpose of their position. This will hopefully aid in counteracting the isolation and disconnect that school-based therapists feel towards their co-workers and supervisors.

Research. Combining this study with previous research, there are some implications for social work. One suggestion is to further the research of the integration of mental health into the school environment. Researching the benefits and challenges from both the therapist/school social worker perspective and the students' view. Gaining the input of the family would also benefit further research. This research would give current school workers a process to implement mental health and further knowledge of the benefits and challenges.

Little research is done about the uniqueness of the position and the benefits of having a mental health team to serve the students. Further research in regards to how the school-based therapist experiences their position would be beneficial. Understanding why some staff value the position while others do not find value in the position would provide further understanding of how to help staff understand the position. Sufficient research has been done indicating that parent involvement is lower than outpatient therapy, but little research has been done surrounding the reasons as to why parent involvement is lower in school-based therapy. Further research surrounding school-based therapy would help us gain a better understanding of how to integrate mental health into the school environment.

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Appendix A.



UNIVERSITY of ST. THOMAS
MINNESOTA

Consent Form

Integrating therapy into a school environment

IRBNet Tracking Number: 826711-1

You are invited to participate in a research study about how school-based mental health therapists are integrating therapy into the school environment. I invite you to participate in this research. You were selected as a possible participant because you are a licensed school-based mental health therapist. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Jeanette McGie, from the School of Social work at the University of St. Thomas/St. Catherine University. My advisor is Ande Nesmith from the School of Social work at the University of St. Thomas/St. Catherine University. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

The purpose of this study is to understand how school-based mental health therapists are providing therapy in a school environment. My research question is “how are school-based, mental health therapist integrating therapy into a school environment?” Since this is a qualitative research there is no hypotheses.

Procedures

If you agree to participate in this study, I will ask you to do the following things: Participate in an in-person, one hour interview that will be audio recorded in a private location of your choice.

Risks and Benefits of Being in the Study

There is a possibility of confidentiality of data breach. Because I will ask personal questions regarding your work, there is a possible risk of a data breach regarding your employment. Recognizing that risk, I will make every effort to safeguard the data to make sure no one can link you to the data I present in my final report. I will not document your specific place of employment and any names of people or places you may mention will not be transcribed from the interview recordings. Additionally, all data will be stored on a password-protected computer

that is either in my possession in or a locked room. There are no direct benefits you will receive for participating.

Privacy

Your privacy will be protected while you participate in this study. The consent form will be kept separate from the transcripts, notes and audio recordings to provide privacy of participants' data. I will have a private calendar that will be on my computer locked by a password. This will be the only place where I will indicate the location, time and interviewee. All identifiable information will be destroyed after interview is completed. Participation will be kept private and all information gathered will be kept confidential.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include consent forms, notes from the interviews, transcripts, audio recordings, and notes saved on my computer. The consent forms, notes from the interviews, transcripts and audio recordings will be kept in a locked filing cabinet. The notes saved on my computer will be kept locked under a password. I will be the one to have access to all items. All items except consent forms will be destroyed June 2016. Consent forms need to be kept for 3 years therefore, they will be destroyed June 2019. All audio recording of the interviews will be erased in June 2016. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the school or agency you work for or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used in my research. You can withdraw by email at any point during the research. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Jeanette McGie. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at 612-203-4458 and olse4490@stthomas.edu. My advisor is Ande Nesmith and you may contact her at 651-962-5805. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

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

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix B

Questions for School-based therapists

Questions for Interview

1. Demographic Information
 - a. Name:
 - b. Job title:
 - c. Agency:
 - d. Race:
 - e. Gender:
 - f. Licensure:
2. How long work as a school mental health therapist?
3. How do other teachers, staff and administration view your job and utilize you?
4. Describe to me how you collaborate with other school professionals to treat mental health?
5. Tell me about the benefits and challenges of collaborating with other school professionals?
6. Tell me how confidentiality is dealt with every day and how it is effected by working in a school?
7. Describe to me how the school environment affect the mental health of students?
8. Tell me the percentage of clients' parents that are involved in their treatment? Explain the difference you have seen between clients that have parents involved and those who don't have parental involvement.
9. Have you noticed that therapy is performed differently in your current field vs. past positions? Tell me an example where this was noticed.
10. Have you received any special training or teaching to implement therapy in a school environment?
11. What are the challenges and benefits of integrating mental health into a school environment?

12. What do you foreseen as the future for the relationship between mental health therapy and schools? And how does school social work fit in this relationship?

Appendix C

Questions for Supervisors

1. Demographic Information
 - a. Name:
 - b. Job title:
 - c. Agency:
 - d. Race:
 - e. Gender:
 - f. Licensure:
2. How long work as a supervisor of school-based mental health therapists?
3. How do your supervisees utilize you to provide therapy to the clients they serve? How is this different or the same from how a supervisee uses a supervisor in other therapeutic settings?
4. How do other teachers, staff and administration view your job and utilize you?
5. Tell me about the benefits and challenges of collaborating with other school professionals?
6. Tell me how confidentiality is dealt with every day and how it is effected by working in a school?
7. Describe to me how the school environment affect the mental health of students?
8. How does a school development and connect with a school-based therapists to begin providing services for their students?
9. How have you seen schools find the funding to pay for a school-based mental health therapist?
10. Have you noticed that therapy is performed differently in your current field vs. past positions? Tell me an example where this was noticed.
11. Have you received any special training or teaching to implement therapy in a school environment?
12. What are the challenges and benefits of integrating mental health into a school environment?

13. What do you foreseen as the future for the relationship between mental health therapy and schools? And how does school social work fit in this relationship?