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School Based Mental Health Supports

For Students with Special Needs

by

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A Starred Paper Proposal

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of

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Chapter I: Introduction

According to Climie (2015) throughout the world more children are getting diagnosed with emotional/behavioral disorder (EBD), children as young as 3 or 4 years of age, which is an increasing trend in mental health concerns. Climie (2015) spoke about concern and knowing that over half the children that are identified with having EBD are not receiving treatment. When children are not receiving treatment, they are left to cope with their illness without support.

According to Climie (2015) in the article 'Building Capacity in School-Based Intervention' it mentioned that statistics are looking at increasing children's support at getting treatment by incorporating treatment programs into the educational systems. By incorporating them into schools this will provide students with mental health support throughout the day and increase their access to services and treatment programs.

According to Climie (2015) they stated that bringing mental health services into the school will allow the student to spend more time in school and on their schoolwork, then traveling to appointments. This would also help parents not having to miss work to bring their child to an appointment.

According to Conboy (2021) schools are named as an optimal setting for early intervention for mental health and guidance stresses the importance of a whole school approach.

According to Hodgdon et al. (2013) each year in the United States, millions of children experience maltreatment, violence and severe neglect, the majority of which occurs within the family environment. One form of substitute care for families in residential treatment where the student can still attend school however, with higher costs their treatment is less quality. There is success in implementing trauma-informed treatment in residential settings.

Research Questions

One major question that guides this literature review:

1. What are the outcomes of having mental health professional programs in the schools, compared to not having them in the schools?

Focus of Paper

I have identified 10 studies for Chapter II literature review. With mental health workers in the school setting being a fairly new study in the United States I expanded my search to other countries. I have researched how school-based therapy is starting to be a part of the educational setting.

There are many different programs in the United States that are currently in schools that support school, family, and community. I am gathering information from the journals to help identify the impact it has on students and their success with trauma and handling it while in school.

Importance of the Topic

As a licensed EBD special education teacher, I have had the opportunity to experience first-hand having a therapist available for students in distress at school. I have gotten to work side by side with therapists from the Wilder Foundation who have clients and families in my classroom. When my students are experiencing high behaviors or unexpected behaviors, I am able to talk with their therapist and also, they are able to go talk to their therapist and work through the situation. I have been able to work side by side with mending relationships between students because of the Wilder therapist being easily available to me and able to talk to families faster than I would be able to. In many situations if a child is having family problems at home, I am not always able to figure out what is going on but with Wilders help they are able to make home visits and not only help the student and their families in getting the help they need.

Historical Background

Most traumatic experiences in children and adolescents occur in their immediate social environment (Schmid et al., 2013). Childhood traumatization leads to a significantly higher risk of suffering other trauma in adult life (Schmid et al., 2013). Children and adolescents also suffer from depression. According to Breland-Noble, depression has long been recognized as a mental health concern of great consequence to individual physical health and emotional well-being. Depression is linked to multiple health problems (like obesity and high blood pressure) and is recognized as a contributing factor to suicide in adolescents (Breland-Noble et al., 2010).

Definition of Terms

African American Knowledge Optimized for Mindfully Healthy Adolescents (AAKOMA): This is a two-phase clinical treatment development trial that develops motivational interviewing (MI) intervention to improve treatment engagement of depressed African American youth and their families (Breland-Noble et al., 2010, p. 869).

Attention-deficit/hyperactivity disorder (ADHD): “Is a chronic condition that affects millions of children and often continues into adulthood. ADHD includes a combination of persistent problems, such as difficulty sustaining attention, hyperactivity, and impulsive behavior” (Mayo Clinic, 2019).

Child Protective Services (CPS): “Is a service that provides protection for children who are at risk of, or are experiencing neglect, physical, sexual, or emotional abuse. The focus is on the safety of the child and supports for parents to strengthen families and promote safe nurturing homes for children” (County of Santa Cruz Human Services Department).

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS): “This is a skills-based, child group intervention that is aimed at relieving symptoms of posttraumatic stress disorder,

depression, and general anxiety among children exposed to multiple forms of trauma" (NCTSN, 2012).

Emotional and Behavioral disorder (EBD): "A condition in which behavioral or emotional responses of an individual in school are so different from his/her generally accepted, age appropriate, ethnic, or cultural norms that they adversely affect performance in such areas as self-care, social relationships, personal adjustment, academic progress, classroom behavior, or work adjustment" (Lehr, n.d).

Federal Emergency Management Agency (FEMA): "The Federal Emergency Management Agency (FEMA) supports citizens and emergency personnel to build, sustain, and improve the nation's capability to prepare for, protect against, respond to, recover from, and mitigate all hazards" (USA.gov, n.d).

FRIENDS: "Is a group-oriented CBT selected anxiety prevention program that targets students with mild to moderate anxiety disorders" (Cooley-Strickland et al., 2011, p. 3).

I have a future Program (IHAF): "A community-based service in Tennessee that focuses on career development in urban African American youths" (Harvey & Hill, 2004, p 67).

Incredible Years (IY): This is a treatment that emphasized training children skills such as emotional literacy, empathy or perspective taking, friendship and communication skills, anger management, interpersonal problem solving, school rules, and how to be successful at school (LaForett et al., 2019).

Leadership, Education, Achievement, and Development (LEAD): "Is a program that is delivered as an enhancement strategy to strengthen children's ability to cope, make decisions, and engage in prosocial activities" (Shelton & Lyon-Jenkins, 2006, p. 8).

Multitiered System for Supports (MTSS): “Is an integrated system of high quality, standards-based instruction and interventions that are matched to students’ academic, social-emotional, and behavioral needs” (Amherst H. Wilder Foundation, 2021).

Oppositional Defiant Disorder (ODD): “Is a type of behavior disorder. It is mostly diagnosed in childhood” (Johns Hopkins Medicine, 2023).

Post-Traumatic Stress Disorder (PTSD): “Is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or set of circumstances” (Taylor-Desir, 2022).

Positive Adolescent Choices Training (PACT): “A program that is designed to teach social skills and reduce and prevent violence. PACT included 10 to 12 students who received training in peer interactions to address behavioral concerns such as managing aggression and victimization by violence” (Harvey & Hill, 2004, p. 67).

School Based Mental Health Therapy: is any mental health support either brought in by outside sources or in the school that happens right at the school.

The World Health Organization (WHO): “The World health organization sets standards for disease control, health care, and medicines; conducts education and research programs; and publishes scientific papers and reports” (National Cancer Institute, n.d).

The Strengths and Difficulties questionnaire (SDQ): “Is one of the most widely used screening instruments. The SDQ consists of 25 items equally divided across five scales measuring emotional symptoms, conduct problems, hyperactivity-inattention, peer problems, and prosocial behavior” (Stone et al., 2015).

The Attitudes Related to Trauma-Informed Care (ARTIC) Scale: "Is a validated tool used by organizations and service systems to measure staff attitude toward trauma-informed care" (Trauma-Informed Care Implementation Resource Center, n.d).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): This addressed the mental health needs of children, adolescents, and families suffering from the destructive effects of early trauma (Psychology Today, n.d).

Chapter II: Review of Literature

The purpose of this review of literature is to determine what the outcomes are when having mental health professional programs in the schools, which allows students to seek treatment in school, over not having them in the schools and seeking treatment outside of school. The first section includes studies that affect African American Youth both in schools and in the community. The second section includes studies that examine how mental health professionals help students and families in the child's school setting. Studies within both sections are organized in chronological order starting with the oldest study. I located 10 studies that discuss different programs that are available to students with special needs in many different schools across the world. Table 5 and Table 6 summarize the findings of these studies. The findings are presented in chronological order from oldest to the most recent.

Effects of Mental Health in African American Youth

African American young men are under siege. In schools they have the highest rates of detention, suspension, expulsion, and special education placements. (Harvey & Hill, 2004). Recent literature has begun to examine the relationship between mental disorders and criminal behavior in children (Shelton & Lyon-Jenkins, 2005).

Harvey & Hill (2004)

Harvey & Hill (2004) talked about the effects on Africentric youth and family rites of passage program on at-risk African American youths and their parents. Data was collected from a three-year evaluation of youth rites of passage demonstration projects using therapeutic intervention based on Africentric principles. A three-year program was designed to help Africentric Adolescents and families in reducing substance abuse, and antisocial attitudes in African American youth between the ages of 11.5 and 14.5. The demonstration helps people

understand the importance of allowing youth to express their frustrations in. Harvey & Hill (2004) suggested allowing the students to express themselves at the beginning of the school day which would allow immediate intervention to help the student recuperate and move on with their day. This program also helps youth with their self-efficiency and self-esteem development. They were also given opportunities they might not have been a part of before such as sports and incentives for the teenage girls who may have become pregnant to stay in school.

This program offered many interventions for the youth to be a part of some of the interventions included mentoring, church-based programs, social skills training, career development education, HIV/AIDS prevention, and substance abuse prevention and reduction.

This literature spoke about many different programs that were offered to African American youth from community programs, church programs, and after-school programs. One of the programs they analyzed was Positive Adolescents Choices Training (PACT) which is designed to teach social skills and reduce and prevent violence. PACT included groups of 10 to 12 students who received training in peer interaction to address behavioral concerns such as managing aggression and “victimization by violone”. Harvey & Hill (2004) shared that the results of PACT showed that youths improved in each of the desired “target skill areas”: giving positive feedback, giving negative feedback, accepting negative feedback, resisting peer pressure, solving problems and negotiation.

Along with the PACT program the African-centered rites of passage program was also researched. There have been 87 rites of passage programs between 1984 and 1992 that have initiated 1,616 youths. Ninety percent of the respondents indicated that knowledge of self and culture is crucial for youth in confronting the problems they face. The rites of passage program has many interventions in a variety of places such as working with the individual themselves,

peer groups, immediate family, extended family, and their community. The program has three interventions: (1) an after-school component, (2) family enhancement and empowerment activities, and (3) individual and family counseling (Harvey & Hill, 2004).

The afterschool component of the program taught students different skills from interpersonal, positive peer relationships and allowed for the students to gain higher self-esteem. The program was three days a week for three hours each time. Harvey & Hill (2004) the after-school component consisted of three major activities: (1) the knowledge and behavior for living activity; (2) the learning motivation activity; and (3) the creative arts activity. The knowledge and behavior provided knowledge and behavior of a healthy self, family, and community, which focused on dangers of drug and alcohol abuse; strategies to avoid contracting HIV/AIDS and sexually transmitted diseases' holistic health practices and nutrition (Harvey & Hill 2004).

Each participant in the program both youth and their families were given a pretest and a post test. They were not given the test at the beginning of the program but after the first eight weeks of it during a retreat. If they were given the pretest at the start of the program the pretest scores may have looked different because they would not have already received some of the information and understanding.

Table 1

Outcomes of At-Risk Youths in MAAT Adolescent and Family Rites of Passage Program

As seen in the article by Harvey & Hill (2004)

	% above Median Score		
	Pretest (N = 57)	**Posttest (N = 36)**	***p***
1. Self-esteem	**40**	**81**	**.05**
2. Academic orientation	**60**	**58**	**NS**
3. Drug knowledge	**60**	**85**	**.05**
4. Racial identity	**49**	**57**	**NS**

5. Cultural awareness	50	61	NS

Note. NS = nonsignificant and refers to relationships that are greater than .05.

Table 2

Outcomes for Parents of At-Risk Youths in MAAT Adolescent and Family Rites of Passage Program

As seen in the article by Harvey & Hill (2004)

% above Median Score			
	Pretest (N = 12)	**Posttest (N = 10**	**Significance Level**
1. Parenting skills	**33**	**70**	**NS**
2. Community Involvement	**42**	**67**	**NS**
3. Racial identity	**55**	**86**	**NS**
4. Parental advocacy	**36**	**40**	**NS**
5. Attend PTA	**83**	**90**	**NS**

Note. NS = nonsignificant and refers to relationships that are greater than .05.

The Family Rites of Passage Program helps youth grate a positive peer group by creating a positive relationship with their peers in the group. Parents also had a positive experience and increased their involvement in community activities, parenting skills and being culturally aware. Evaluations have revealed that the most effective youth interventions are holistic or multifaceted approaches that focus on the individual family, peer group and community (Harvey & Hill, 2004).

Shelton & Lyon-Jenkins (2006)

This literature talks about vulnerable African American Youth, vulnerable populations are those who are “at risk” of poor physical, psychological, and/or social health. (Shelton & Lyon-Jenkins, 2006). Underlying this definition of vulnerability is the epidemiological concept of risk found to be associated with a variety of individuals, family, and community characteristics. When it comes to providing resources to help “at risk” or vulnerable students,

especially those who are identified as a minority, the resources are limited compared to other groups of people. According to Shelton & Lyon-Jenkins (2006) children display difficulties in different ways such as misbehavior, which if not addressed are known to become more severe in nature and are so destructive that they come to the attention of juvenile justice authorities. When these children are viewed as a problem and when nobody wants to deal with them anymore or help them anymore, one of the only resources they have left is to become part of the juvenile justice system.

When looking to project Shelton & Lyon-Jenkins (2006) studies they found that children of color, particularly African American youth. These children are going to the doors of the justice system at higher rates than they should be, which provides a need to focus programming early to help prevent or reduce the risk of juvenile justice involvement. With children getting thrown into the juvenile justice system early the LEAD (Leadership, Education, Achievement, and Development) program was introduced. LEAD was a 3-year study with the first year being looked at. Within the first year there were two main objectives. Shelton & Lyon-Jenkins (2006) targeted the two main objectives as (1) identify expressive arts activities that were culturally appropriate for middle school-age African American youth, (2) test the curriculum design by examining outcomes of behavioral self-control, self-esteem, resilience, and protective factors in the children who participate in the program. The effective programs begin early and are integrated into the daily lives of children. The goal of the LEAD program is to help children be successful in their everyday lives and be able to meet any challenge they might encounter. LEAD helps children build their confidence and self-awareness which allows children to have better self-esteem about themselves. The LEAD program offers both emotional literacy and cognitive behavioral interventions. Shelton & Lyon-Jenkins (2006) states that emotional literacy

can help children learn to control impulses and emotions, especially anger and aggression, and develop self-awareness. Cognitive behavioral intervention is designed to translate these feelings of “learned helplessness” into what is called “learned resourcefulness or “self-efficacy”. Cognitive-behavioral methods help individuals learn how to anticipate, notice, interrupt, self-regulate, and cop with stressors (Shelton & Lyon-Jenkins, 2006).

Different studies have focused on different aspects of the child’s life such as internal and external factors. They have shown how a family member’s act could be a factor on the child’s behavior. They also looked into the school environment the child was in. When trying to figure out protective factors to help children, Shelton & Lyon-Jenkins (2006) stated that having a teacher who acts as a mentor, realistic educational and vocational goals, self-efficacy, intellectual capability, and an easy-going temperament act as protective factors for adolescents. When adolescents have a positive adult role model especially in the educational setting, they show less behavior and reduced delinquency.

The LEAD program was designed to follow the school schedule, it gave a pre-test and a post-test to the 56 African American youth both male and female who were between the ages of 10-14 who all lived in the same community. Of the 56 African American youth participating in the study, 28 of them were considered the intervention group and 28 were considered the control group who met after school. There were slightly more boys (60%) in the intervention group than the control group with (70%) females. Of the students that were in the intervention group half of them were in the group with their siblings (Shelton & Lyon-Jenkins, 2006).

The LEAD program had a proposed curriculum model and activities that they would follow that uses ecological structure to focus on various weekly activities, this model can be seen in Table 3 of this literature. Table 4 will show both groups the intervention group and the

control groups scores after the 14-week program. The students participating in the group would recommend the LEAD program to people they know. During the program the students whose only option was the juvenile system had no interactions with police. During the first six sessions the participants had little self-control and were arguing with each other. Once the leaders of the program realized they needed to set strict boundaries they were able to tackle the issues at hand.

The LEAD program was successful for the youth that were involved however, until a parent liaison was added parent involvement was still lacking. Once the liaison was able to meet with the parents, they realized that the parents also needed help and were unable to get it for themselves. A partnership with a local mental health provider was established for referrals as needed and one child was referred (Shelton & Lyon-Jenkins, 2006). Parents were also given the opportunity for mental health help, but they declined. After the LEAD program ended, they held a celebration party and parent involvement grew during that time.

Table 3

Proposed Curriculum Model and Activities

As seen in the article by Shelton & Lyon-Jenkins (2006)

Week	Focus	Session	Activity
1	Introduction	**1**	Name game
	Rules and Guidelines	**2**	Going on a picnic
		3	Buddy scavenger hunt
2	Coping skills and relaxation	**1**	Affirmations
		2	Journal writing
		3	Relaxation skills: Happy place, counting freeze
3	Exploration of Self	**1**	Collage
		2	Mirror-mirror
		3	Welcome mat
4	Self-Identity	**1**	Unfair game
		2	My button
		3	In the bag

5	Uniqueness of the Individual	**1** **2** **3**	Tree Story of my life Body tracing
6	Exploring Self within the Family and Environment	**1** **2** **3**	The wind blows Stepping stones Eco-maps
7	Exploring Self within the Family and Environment	**1** **2** **3**	Weakest Link Family photos New endings
8	Exploring Self within the Family and Environment	**1** **2** **3**	Social network bingo Zone of perception Count-off
9	Exploring Self within the Family and Environment: new Responses to Violence – Part I	**1** **2** **3**	On the stage This & that Sticky moments
10	Exploring Self within the Family and Environment: new Responses to Violence – Part 2	**1** **2** **3**	Drumming ABCDE model Safety skills: Mental rehearsal, self-talk mentor
11	Exploration of Self with the Context of Society	**1** **2** **3**	Wished for awards You see, I see (masks) Who would I like to be?
12	Exploration of Self with the Context of Society	**1** **2** **3**	1 to 20 The interview Line up like this, No – like that
13	Exploration of Self with the Context of Society	**1** **2** **3**	TV commercials Snack food ingredients Today's heroes
14	Exploration of Self with the Context of Society	**1** **2** **3**	Goodbye books Leaving a legacy – Community service Cultural celebration

Table 4

Intervention and Control Group Comparisons for Year 1

As seen in the article by Shelton & Lyon-Jenkins (2006)

Measure	Mean	SD	Min-Max	Mann-Whitney U
Self esteem	2.17857	4.12578	-8.00, 10.00	U = 372.5 *p* = .7478
Self-control	1.37500	2.92054	4.00, 8.00	U = 236.5 *p* = .0094
Protective factors	-.92857	4.64311	.13.00, 7.00	U = 255.5 *p* = .0243
Resilience	2.91071	10.51800	-21.00, 28.00	U = 245.5 *p* = .0161

Experimental group N = 28

Control group N = 28

Breland-Noble et al. (2010)

Breland-Noble et al. (2010) says depression has long been recognized as a mental health concern of great consequence to individual physical health and emotional well-being. Among adolescents specifically, depression is linked to multiple health problems (like obesity and high blood pressure) and is recognized as a contributing factor to suicide. Suicide is one of the top three causes of death among 10–19-year-olds. It is said that we need to gain a better understanding of adolescent depression in African American you and any youth of color. The project that was designed to help African American youth and their families, was The African American Knowledge Optimized for Mindfully Healthy Adolescents (AAKOMA). This project was designed to help depressed African American your improved treatment opportunities. The project had 2 phases, the first phase used data that was collected from the community and was a

sample of African American adolescents and adults regarding their perspectives on adolescent depression perceptions, youth underutilization of depression treatment, and lower participation rates in research (Breland-Noble et al., 2010). Phase 2 was focused on the development and testing of a manualized treatment (built on motivational interviewing and the data collected in phase 1) to improve depressed African American adolescent readiness to participate in depression treatment. Phase 1 was composed of 28 African American youth grouped by their age by younger and older youth. The focus groups were co-led by two trained facilitators. Phase 2 had twenty-one of the youth participate in the focus group while seven elected to participate in individual interviews (Breland-Noble et al., 2010).

The research team identified five themes regarding African American adolescent depression and treatment, including the following: adolescent pluralism in depression management, triggers and outcomes, impressions of treatment, trust and frustration, and recommendations (Breland-Noble et al., 2010). In the adolescent pluralism in depression management stage the youth described different ways they took care of themselves when they felt depressed. In the triggers and outcomes stage the youth shared what they felt were the triggers of their depression such as romantic relationship problems, academic problems, bereavement, and stress. The stage of impressions of treatments the youth talked about how they felt about being medicated or working with clinicians and they felt the clinician didn’t understand them and just wanted to give them medications. Youth felt a high amount of frustration with their peers, adults, and clinicians who they believed failed to help or in some cases exacerbated their depressive symptoms in the trust and frustration stage (Breland-Noble et al., 2010). Youth felt there should be an open-door policy and a policy to protect their privacy

when it came to treatment recommendations. The youth felt they should not have to leave class and make their depression known to the whole class.

When it comes to youth and their depression, they have mixed feelings on it being labeled as a medical disease. This program proposed many different opportunities for the community to be actively engaged in providing opportunities for youth and their families to learn more about depression. Some of the suggestions were providing psychoeducational opportunities regarding adolescent depression with events such as seminars, school events and training with community-based organization to “spread the word” about depression and its impact on African American youth (Breland-Noble et al., 2010).

This study provided opportunities for the community to grow and provided proposals for how they can actively get the awareness that depression is real in youth and have a higher rate in African American youth. Breland-Noble et al. (2010) suggested that school mental health professionals to make sure they are screening youth as soon as they have a negative or acting-out behavior. Breland-Noble et al. (2010) also suggested that African American youth get screened for depression as part of their annual exams.

Table 5

Summary of Chapter II section I Findings

Authors	Study Design	Participants	Procedure	Findings
Harvey A., & Hill R. (2004)	Quantitative	At risk African American boys between ages 11.5 and 14.5 years old	This was a three-year evaluation of youth rites of passage using therapeutic interventions based on Afrocentric principles.	• Participants showed gains in self-esteem and accurate knowledge of dangers of drug abuse. • Participation from programs, family, staff, and students showed success.

Shelton D., & Lyon-Jenkins N. (2006)	Quantitative	Fifty-six African American youth between the ages of 10 and 14 years of age	This was a 14-week community-based expressive arts program designed for youth at risk.	• Some of the program's aspects were achieved and others were not. • Having African American role models and mentors was necessary for the boys in the study.
Breland-Noble A., Burriss A., Poole H. (2010)	Qualitative	Twenty-one youth participated in focus groups and individual groups. Seven youth were part of individual interviews	Using grounded theory and transcript-based analysis 5 themes that described African American adolescents' who have experienced depression.	• The research team helped youth identify depression as a mental disease and helped the youth accept it by showing examples of famous people they may know.

Mental Health Professionals in a School Setting

According to Climie (2015) children with emotional/behavioral (EBD) has had a significant increase, and it is imperative that innovative ways of addressing these concerns are explored. It is necessary to ensure that school-based personnel have the required training and understanding of mental health issues so that children may be appropriately supported (Climie, 2015).

Jaycox et al. (2010)

When a natural disaster hits, communities are affected and face a lot of challenges along the way. Children in particular face many challenges and have limited resources they can get to help them especially when it comes to their mental health. Jaycox et al. (2010) stated that a significant proportion of children develop posttraumatic stress disorder (PTSD) symptoms related to natural disasters. School children participated in an assessment and field trial of two interventions 15 months after Hurricane Katrina (Jaycox et al. 2010). Jaycox et al. (2010) stated

that children (*N* = 195) reported on hurricane exposure, lifetime trauma exposure, peer and parent support, posttraumatic stress disorder (PTSD), and depressive symptoms. In order to help prevent negative outcomes for children who develop PTSD they need to be treated as soon as possible. In this literature Jaycox et al. (2010) stated that the teachers reported on the student's behavior, and at a baseline, 60.5% screened positive for PTSD symptoms and were offered group interventions at school or individual treatment at a mental health clinic. Students who accepted the group intervention at school were significantly higher than those that chose individual interventions at a clinic.

When children's mental health is affected by a natural disaster or a trauma that they may have faced, most of their communities do not have enough trained professionals to help them. When there are limited resources or professionals trained to individually help a person, children in particular they focus on groups based on the needs of the children's needs and provide group therapy. The more severe the child or children are offered a more aggressive therapy.

This study talked about a project that was formed and aimed to identify students with elevated symptoms, offer them one of the interventions, which were two evidence-based interventions: The Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) or the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Jaycox et al., 2010). The students are observed on how they fared in each intervention according to their risk and resilience factors, including symptoms of PTSD and Depression, social support from friends and family, and their exposure to the hurricanes and to other lifetime traumas. The students were randomly placed in each intervention and monitored how they used the available services. The students who took part in each intervention were expected to show improved symptoms, based on either demonstration of effects of interventions, the students with additional trauma exposure would

show more modest improvement, and those with social support would show more robust improvement (Jaycox et al., 2010).

Table 6 looked at the three schools that participated in the study based on their diverse size, racial and socioeconomic makeup, and diversity of hurricane, evacuation, and post-hurricane experiences, and based on their willingness to participate (Jaycox et al., 2010).

Table 6

Description of School Sites

As seen in the article by Jaycox et al. (2010)

	School 1	**School 2**	**School 3**
Size	158 students (85 4th – 8th grade)	796 students (397 4th – 8th grade)	261 students (127 4th – 9th grade)
Location	New Orleans, LA	Metairie, LA	New Orleans, LA
Hurricane Damage	Moderate damage to roof and part of the school could not be used during the 2005 – 1006 school year.	No damage to school, but surrounding neighborhood damaged by wind.	Four to six feet of flooding, water damage to first floor, replaced furniture and books.
Race and ethnicity	Predominately African American (74%)	Preeminently Caucasian (90%)	Predominately African American (97%)
Participation in free/reduced lunch program	75%	11%	80%
Student living situations	Many students did not evacuate and live in trailers, hotels, and cruise ships immediately after the hurricane.	Mandy students lived in FEMA trailers for months after returning to school.	Many students travel nearly an hour to get to school, having relocated to other towns outside of New Orleans after the storm.

Introduction letters were sent home with 609 students along with consent forms; 195 students participated in the study. The intervention was randomized, 58 students were offered CBITS, and 60 students were offered the TF-CBT (Jaycox et al. 2010).

Measurements were taken by assessing students at baseline, at 5-months, and at 10-months. As cited by Foa et al. (2001), in Jaycox et al. (2010) PTSD symptoms in the past month were assessed using the Child PTSD Symptom Scale. The misuse had a good convergence (r = .80) and discriminant validity and high reliability (a = .89). Children who met a score of >11, indicating elevated symptoms, were randomly assigned to receive one of the two treatments (Jaycox et al., 2010).

CBITS is a 10-group session and 1-3 individual session intervention designed specifically for use in schools. As cited by Kataoka et al., and Stein et al., in Jaycox et al. (2010) there were two effective control trials, and it has been successfully implemented with children of many different cultural groups and who have suffered multiple forms of trauma. TF-CBT is a 12-session individual or conjoint intervention that includes child and parent and typically is delivered in clinics (Jaycox et al., 2010). TF-CBT has demonstrated effectiveness in improving PTSD and other symptoms in children experiencing sexual abuse, multiple traumas, and disaster in multiple randomized trials. Both the CBITS and TF-CBT have similar skills they observe such as psychoeducation, relaxation skills, affective modulation skills, cognitive coping skills, trauma narrative, and enhancing safety. These assessments also have differences, the CBITS is for children only whereas the TF-CBT is for both parent and child.

For individuals participating in these assessments, treatment was provided to them free of charge by therapists that were trained in both assessment options. The participants who were

offered to participate in the CBITS assessment had group meetings that were held at the schools during the student's school day.

According to Jaycox et al. (2010), the students who participated in the assessments consisted of slightly more girls than boys (girls 55.9%; boys 44.1%), with average age 11.6 years old (SD = 1.4). Forty-eight percent of children were non-Hispanic White, 46% were African American or Black, 5% were Hispanic, and 2% were from other racial/ethnic backgrounds (Jaycox et al. 2010). Of those determined to be "at-risk" based on PTSD symptoms scores, there were more girls (63%) than boys (37%), with an average age of 11.5 (SD = 1.5; median = 11.3; range 9.0 – 15.5) (Jaycox et al. 2010). Fifty-two percent of students were African American or Black, 42% were non-Hispanic White, 4% were Hispanic, and 2% were from other racial/ethnic backgrounds.

According to Table 7 the students had a common experience that was having seen something upsetting or being separated from their parents. Table 8 shows PTSD, depression, and behavior problems. (Jaycox et al., 2010).

Table 7

Exposure to Hurricanes and Other Traumas Among "At-Risk" Students (N = 118)

As seen in the article by Jaycox et al. (2010)

Hurricane experiences	**%**
Trapped in a flooded house	6.0
Walked or swam through floodwater to escape	7.6
Got out by boat	4.2

Got out by helicopter	3.4
Stayed in the Superdome of Convention Center	3.4
Slept overnight on a street (including the I-10)	5.1
Saw something really upsetting, like dead bodies	74.6
Separated from parents or usual adult caretakers	28.8
Other traumatic experiences (lifetime)	**%**
Natural disaster (fire, tornado, flood, or hurricane)	53.4
Bad accident	31.6
Been in a warzone	5.9
Victim of violence at home	26.7
Witness to family violence	29.3
Victim of community violence	26.7
Witness to community violence	53.0
Seen a dead body	42.6
Adult touch or treatment that made you feel uncomfortable	14.9
Learned about death or serious injury of a loved one	71.2
Painful and scary medical treatment	41.9

Table 8

Exposures and Symptoms among "At-risk" Students at Baseline (15 months post-Katrina):

As seen in the article by Jaycox et al. (2010)

	Overall (N = 118)		**CBITS (n = 58)**		**TF-CBT (n = 60)**		***t***
	M	***SD***	***M***	***SD***	***M***	***SD***	
Exposure to hurricane-related trauma	1.3	1.1	1.2	1.1	1.4	1.2	<1
Exposure to lifetime traumatic events	4.0	2.1	3.8	2.1	4.2	2.2	-1.0

Self-reported PTSD symptoms	22.3	8.0	21.9	7.9	22.6	8.2	<1
Re-experiencing symptoms	6.6	3.1	6.9	2.7	6.4	3.4	<1
Avoidance symptoms	7.0	3.7	6.7	3.9	7.2	3.5	<1
Arousal symptoms	8.7	3.5	8.4	3.5	9.0	3.6	-1.0
Self-reported depressive symptoms	13.4	7.9	13.5	8.4	13.3	7.5	<1
Teacher-reported behavior problems	8.0	7.3	9.0	7.8	6.9	6.7	1.3

The Children who were randomized and offered to participate in the CBITS in their school 57/58 (98%) began treatment, and 53 (91%) completed treatment. For children randomized to be offered TF-CBT twenty-two of the 60 (37%) attended the initial assessment, which occurred weeks to months after the baseline assessment. As seen on Table 9, PTSD scores at 10 months improved in both interventions including all students that began treatment, as compared to baseline scores (Jaycox et al., 2010).

Table 9

Changes Observed Among Intervention Starters:

As seen in the article by Jaycox et al. (2010)

	Baseline Mean (*SD*)	**10-Months Mean (*SD*)**	**Difference (*t*)**
CBITS Starters *I* (*n = 57)*			
PTSD Score	**22.0 (7.9)**	**15.8 (9.3)**	**-4.85*****
Depression Score	**13.4 (8.5)**	**9.7 (9.0)**	**-4.30*****
TF-CBT starters (*n* = 14)			
PTSD Score	**22.9 (8.3)**	**12.0 (10.4)**	**-3.07****
Depression Score	**15.4 (7.6)**	**11.1 (10.5)**	**-1.37**

Note.

*** $p < .001$;

**$p < .01$.

CBITS refers to the Cognitive Behavioral Intervention for Trauma in Schools Program. TF-CBT refers to Trauma-Focused Cognitive-Behavioral Therapy.

I Changes within the CBITS group control for clustering within the CBITS intervention groups.

Based on this study and the two interventions that were used it showed a significant improvement in students that originally showed PTSD symptoms. Families also participated in these studies; however, most parents did not access therapy that was offered in their communities but did access services that were offered at their child school (Jaycox et al., 2010). Parents that participated in these studies asked if they could participate at their child's school instead of trying to assess therapy at a clinic.

In conclusion, the study helps show that children need to have access to therapy or assessments at school especially if they have witnessed a natural disaster. When screening for PTSD after a natural disaster there was evidence that the children were experiencing more trauma than just the disaster and after being offered treatment during their school day the symptoms subsided.

Cooley-Strickland et al. (2011)

According to WHO (2002) in Cooley-Strickland et al. (2011), Community violence in schools, neighborhoods, and communities is a major public health problem. Children hearing, witnessing, and even experiencing violence has been a critical issue for many years. When a child is exposed to any type of violence it can greatly affect their development in many areas from early ages to adolescence and even beyond. For example, studies have found a positive association between community violence exposure and anxiety and that anxiety interferes with children's ability to concentrate, thus potentially disrupting their academic performance (Cooley-Strickland et al., 2011). Children that have been exposed to community violence should have

access to developmentally appropriate interventions early. Violence in communities affects every person in that community and all racial and ethnic groups, the group that is affected more than European Americans is African Americans who live in a low-income urban neighborhood. Constant worry about one's own or loved ones' safety or health likely interferes with low income, urban children's ability to function in developmentally appropriate, academically successful, and healthy ways and may be a source of anxiety and oppositional-aggressive behavior as an attempt to exert control and chaotic environments (Cooley-Strickland et al., 2011). One of children's serious mental health problems is anxiety which is occurring at very high rates. They are the most frequently experienced mental health disorders among children and adolescents and are experienced by about 13 out of every 100 children from ages 9 to 17 years, with approximately half of them suffering from additional mental health disorders. If anxiety in children is left untreated, they are likely to develop other psychological disorders along with poor social skills, low self-esteem and possibly even substance abuse.

When it comes to receiving treatment for anxiety problems in children, European American are more likely to get treatment than African Americans. School-based treatment and preventative interventions are needed for youth exposed to chronic community violence. Cooley-Strickland et al. (2011) cited Cooley and Lambert (2006) and stated that providing interventions in schools improves attendance at sessions, reduces stigma associated with therapy and delivers the services in communities where resources may be sparse. Studies have demonstrated that cognitive-behavioral treatment (CBT) is effective for reducing childhood anxiety and group-based CBT had proven to be effective for treating childhood anxiety (Cooley-Strickland et al., 2011). CBT has been proven to be effective for Latino/Hispanic and African

American students in a school-based setting but has little research for it being effective with diverse populations.

This intervention incorporated the FRIENDS CBT program. The participants (n = 93) were African American (92%) and biracial (8%) students 8 to 12 years old (grades 3-5; 48% female), in two Title I public elementary schools located in Baltimore, MD. Both schools were located in economically disadvantaged urban communities (average of 90% of the student bodies received free or reduced lunch) characterized by high crime (Cooley-Strickland et al., 2011).

There are many different factors in the FRIENDS program however, the cognitive, physiological, and behavioral components of the program teach students strategies to help them with anxiety. These factors also help students with their problem-solving skills and skills to cope with fearful stimuli. When incorporating FRIENDS, students were given lessons during their sessions, and they were able to role play after the lessons were taught to help them practice the new skill they learned. Students were given weekly homework assignments to help generalize the skills they learned to the classroom and home environment (Cooley-Strickland et al., 2011). In the sessions students were taught how to identify symptoms of anxiety such as how their body was when the anxiety started. They were learned some tips to help them relax such as deep breathing. Students were engaged to feel positive feelings, thoughts, and even self-talk to help them face the challenges and fears they had.

Students who participated in the FRIENDS group also learned the acronym and the skills that go with it. FRIENDS (F-Feeling worried? R- Relax and feel good; I- Inner thoughts; E-Explore plans; N-Nice work so reward yourself; D-Don't forget to practice; and S-Stay calm, you know how to cope now). This program was modified for the students, so it was culturally and contextually appropriate for ethnically diverse urban American children, particularly African

Americans (Cooley-Strickland et al., 2011). The program had adaptations for students, so they were able to comprehend and also relate to the content.

All of the leaders in the FRIENDS program were supervised by a licensed psychologist and received training and curriculum for each session. FRIENDS consisted of a 13 biweekly, one-hour sessions which was led by a doctoral level African American group leader and African American or European American co-leader with at least a bachelor's degree (Cooley-Strickland et al., 2011). Groups were small with 8-10 students and were given as a pull-out program during the student's school day and each participant attended at least 12 of the 13 sessions. Parents were also involved in this program, and less than half of the parents were involved. In the parent sessions they were able to review their child's skills they were learning, and they were encouraged to help their child use these skills in all aspects of their lives.

In Table 10 you will see the outcomes of students who participated in the FRIENDS program. These students were given an assessment to determine their baseline and again at the end of the sessions. With-in the group there were changes on their community violence exposure, academic performance, and psychosocial outcomes (Cooley-Strickland et al., 2011). Both groups the intervention group and the control group showed a significant reduction overall with their anxiety and their reading performance improved. When it came to their performance in math the students that were in the intervention group showed improvement where the students in the control group did not.

Overall, this study showed advantages of offering school-based therapy inside of schools. The therapy offered is scheduled into the student's school-day therefore, they do not have to seek treatment outside of school, they receive it during their normal school day.

Table 10

Within group baseline and post-intervention differences (N=93):

As seen in the article by Cooley-Strickland et al. (2011)

Measure	**Intervention (n = 48)**			**Control (n = 45)**		
	Baseline Mean (SD)	**Post-intervention Mean (SD)**	**Pre/Post Paired Mean Difference (SD)**	**Baseline Mean (SD)**	**Post-intervention Mean (SD)**	**Pre/Post Paired Mean Difference (SD)**
CREV Total	33.7 (13.4)	19.4 (14.0)	-14.3 (17.3) **	36.0 (18.1)	25.6 (15.0)	-10.4 (16.7) **
CREV Victimization	1.8 (2.1)	0.6 (1.2)	-1.1 (1.9) **	1.7 (1.6)	1.0 (1.7)	-0.6 (2.3)
RCMAS Total	17.1 (4.7)	12.1 (6.5)	-5.0 (6.7) **	15.8 (5.3)	10.9 (4.7)	-5.0 (5.9) **
WIAT Reading (Age equivalent)	9.5 (1.4)	10.2 (1.9)	0.7 (0.9) **	9.9 (1.4)	10.3 (1.7)	0.4 (0.8) **
WIAT Math (Age equivalent)	9.6 (1.9)	10.0 (1.8)	0.4 (0.9) **	9.7 (1.3)	9.8 (1.3)	0.2 (0.6)
MESA total	17.4 (9.2)	12.7 (12.4)	-4.7 (9.5) **	18.6 (9.6)	14.8 (11.4)	-3.9 (12.3)

T $p<0.10$

* $p<0.05$

** $p<0.01$

Alicea et al. (2012)

African American and Latino youth who reside in inner-city communities are at heightened risk for compromised health, as their neighborhoods are too often associated with serious stressors, including elevated rates of poverty, substance abuse, community violence, as well as scarce youth-supportive resources, and mental health care options (Alicea et al., 2012). When adolescents' mental health is elevated, they may use impaired judgment, poor problem-solving skills, and conflicted interpersonal relationships, these may also lead to unsafe behavior sexually and with drug use. People who live in urban areas tend to avoid mental health help.

Alicea et al. (2012) looked into a program called Step-Up, this is a high school-based mental health service delivered model, that has been developed to bolster key school, family and

youth processes related to youth mental health and positive youth development. The Step-Up model was developed specifically for inner-city urban minority high school aged (14-18 years) youth experiencing serious behavioral and/or academic difficulties. This program was designed to target key factors in youths' mental health from school, family, and community. The Step-Up program provides opportunities for youth to increase their social problem-solving and life skills.

Urban African American and Latino youth are at particular risk for the development of mental health difficulties, as they are much more likely to grow up in disadvantaged neighborhoods with acute, environmental stressors, including racism, poverty, substance abuse, exposure to high levels of community violence, deteriorating youth-supportive resources, and serious shortage of mental health services. When adolescents have elevated mental health needs are more likely to show impaired judgment, have poor problem-solving skills, and have conflicts in interpersonal relationships, which result in disruptive behavior that could potentially make their mental health concerns worse than their peers that are non-disordered. Disruptive behavioral difficulties can also be especially problematic in low-income, inner-city contexts, as the consequences of behavioral missteps can place the youth's safety and well-being in serious jeopardy (Alicea et al., 2012).

Mental health services may exist in inner cities however, they are not always effectively integrated with the current community structure or resources. Teens frequently avoid traditional mental health care services so many of them miss opportunities to address their needs since they do not have appropriate contact with clinical services. Minority adolescents manifesting serious mental health needs and risk-taking behaviors without linkage to mental health care during this critical developmental juncture may be on a negative trajectory just prior to the translon to early adulthood. Alicea et al. (2012) suggests that youth who are able to take advantage of course-

correcting resources during adolescence can be redirected into healthier pathways into adulthood. Some key factors that may need to be addressed when helping youth with their mental health such as motivation to be successful in the future, gaining adult support both in their family and outside of their family, and look at both work and community opportunities for them to participate in.

Overall, there is a serious need to prioritize the development and expansion of culturally sensitive, contextually relevant, and effective mental health and youth development services for urban, low-income African American and Latino adolescents (Alicea et al., 2012).

Families play an important role in adolescents' lives whether it is a biological parent or a primary caregiver. When there is a strong positive relationship between family members there are positive outcomes on adolescents' development and mental health. Youth who believe they are an important member of their family tend to have higher self-esteem, healthier self-concepts, less depression, greater overall well-being, perform better in school, and are more likely to pursue further education. Alicea et al. (2012) stated that there is evidence that clearly links positive youth outcomes and high family functioning, which is often related to families' access to resources.

When children are in a low-income family, they often face many challenges such as a lack of basic resources, no health insurance, language barriers along with negative views on mental health services. Families also sometimes struggle with accessing the resources and support their child or family needs. If communities provide opportunities for low-income families to help with their needs there may be a reduction of feeling isolated, stressed and also help decrease youth mental health concerns.

In the study done by Alicea et al. (2012) they described a teenage girl who was in a low-income family and the struggles she faced daily. This teenager was referred to the Step-Up program where she received a one-on-one staff member for both her and her family. The one-on-one staff member met with both the teenager and her mother in her home. Once meeting with the staff member the teenager and their mother were able to describe stressors in their life. Once meeting with the mother the staff member realized the stressors the family was in and provided the family support. Throughout the year this teenager showed greater self-confidence and participated more in activities Step-Up provided.

School-based mental health service approaches are growing. Related research suggests school-based mental health programs can reduce the stigma of seeking services and may be more accessible to youth in comparison to community-based clinic care models (Alicea et al., 2012). Some researchers feel that the current school-based mode is not a true match to help those in urban schools. When a school-based program is structured and collaborative it can provide mental health benefits to adolescents living in urban poverty.

The Step-Up school-based program consists of team members that reflect the student's community. Each team member in the Step-Up is responsible for the same core components of the program: youth board group facilitation, curriculum development, One-on-One mental health sessions with youth, and family home visits. Step-Up tries to include key school staff members and family members as an essential part of the collaborative planning and implementation teams (Alicea et al., 2012).

Part of the Step-Up program is strong collaboration between the schools they are a part of and the functioning of the program. Step-Up staff participate in monthly guidance meetings to monitor: (1) student academic progress; (2) issues and concerns related to academic progress and

potential avenues for intervention; (3) crisis management and intervention; and (4) logistics related to program delivery on school premises (Alicea et al., 2012). Participating schools are in constant communication with the Step-Up team through e-mail and phone calls, if a student has a crisis during the school day the Step-Up staff is immediately informed and able to provide support to that student and intervene if necessary.

Some of the components that go into the Step-Up program are (1) youth group board meetings centered around a life skills curriculum; (2) One-on-One meetings between Step-Up staff and youth; (3) academic incentives; (4) trips and retreats; and (5) summer internships (Alicea et al., 2012). The youth board meetings are held once a week for 2 hours at a time that is held right after school. Table 11 provides detailed information regarding five of the twenty rotating sessions the Step-Up program consists of.

Table 11

Youth board curriculum session topics and goals:

As seen in article by Alicea et al. (2012)

Session topic	Specific skill(s)	Life skill category	Examples of informational content
Communication	Communication	Social	Identifying communication techniques Learning effective ways to communicate Understanding body language
Gender	Critical thinking, self-evaluation, Identity exploration, empathy and Perspective taking	Cognitive and social	Defining biological sex, gender and sexual orientation Identifying stereotypes associated with biological sex, gender and sexual orientation

			Fostering tolerance and respect in regards to gender and sexual orientation
Conflict resolution (handling anger)	Managing feelings and stress, problem solving, decision making, communication, assertiveness, negotiation	Emotional coping, cognitive, social	Identifying reactions to anger Understanding roles of the aggressor, victim, and bystander Learning how to prevent anger from leading to violence
HIV/STD	Communication, negotiation, Problem solving, Assertiveness, Managing feelings, Identity exploration	Emotional coping, cognitive, social	Determining what defines a risky behavior Developing and understanding of risky behavior, in relation to HIV/STDs Understanding the consequences of participation in risky behavior
Careers/goal setting	Goal setting, decision making, Critical thinking, Identity exploration, Prioritizing, Interviewing, Communication	Vocational, cognitive, social	Developing a plan for post-high school Designing ways to implement a plan Identifying when goals are achieved

Staff in the Step-Up program meet One-on-One with their assigned student. During these meetings the staff and student go over the progress and goals for the student, they also discuss any concerns there might be. There is also an incentive piece for students enrolled in the program to maintain a positive grade on their report cards. The youth also take monthly trips that involve a two-weekend team building retreat. Along with the incentives, and retreats students are also provided with summer internships where they are able to practice the skills they learned in the program.

Family involvement is a key factor in the Step-Up program. Some of the strategies to sustain engagement with families include (1) home visits; (2) parent workshops; (3) follow-up phone calls and meetings; (4) parent newsletter; (5) family weekend retreat; and (6) the parent contract (Alicea et al., 2012). Families face obstacles with utilizing mental health services, with the Step-Up program families are able to meet on their terms and where they want to meet which is often in their homes after work. By meeting at their home, it eliminates issues that may arise such as childcare or transportation.

The Step-Up program involved two cohorts of students at two New York City urban high schools located in East Harlem and the South Bronx (Alicea et al., 2012). There were a total of 91 youth that consented in participating in the program and of those 91, 88 of them attended at least the first 2 sessions. Of those students that participated there was a success of 89% in the two cohorts. Most of the students in the cohort graduated high school or successfully completed the program in the 1 year they were a part of it.

Climie (2015)

There has been a significant increase with children identifying having emotional/behavioral disorders (EBD). It is imperative that there is a way of addressing these concerns and exploring options on ways to help these children. One option for increasing children's access to mental health service looks at incorporating treatment programs into educational systems, thereby allowing more children to access a greater variety of services (Climie, 2015). One important factor when thinking about adding a treatment program into the educational setting is to make sure all the school personnel have the proper training and also be able to understand mental health issues, which will allow children to get the best support possible.

As cited from Luby et al. in Climie (2015) recent statistics point to an increasing trend in mental health concerns in children throughout the world. Children as young as 3 or 4 years of age are being identified as having emotional/behavioral disorders (EBD) such as anxiety or depression. With children getting diagnosed with having EBD at such a young age it is alarming and very important for them to be able to access enhanced support. As cited from Smetanin et al., in Climie (2015), Mental health issues affect one in five Canadians, representing 6.9 million people within the country. Children in Canada between the ages of 4 and 17 are representing 14% of the children battling clinically identifiable mental health disorders at any given time. As cited by Greenberg et al. in Climie (2015) it is broadly speaking, 10% to 15% of children are identified with EBD and fewer than half of these children actually receive mental health services or treatment. It is clear that there needs to be more screenings for mental health, and the children who are suffering from it are able to get access.

One positive way to help support children with EBD and allow them easy access to treatment is to have a school-based mental health intervention. In these programs, services are delivered by school-based personnel (e.g., school counselors) or by professionals associated with school jurisdiction (e.g., school psychologist) or local health region (e.g., mental health therapists), with the goal of providing comprehensive support for the child in his or her school environment (Climie, 2015). It is important for school staff to be aware of key signs that a child may have a mental health concern and be able to help them get the assessment or treatment they need. There is a significant reliance on teachers and school staff to have the training and/or expertise to (a) identify children with possible mental health issues, (b) know what to do when they suspect emotional disabilities in these children (e.g., making appropriate referrals to school counselors or psychologists), and (c) take action to support these students within the school

environment. It is important for educational professionals to have access to resources, so they are able to help the child get the proper diagnosis and care needed. It is important for educational professionals to not overlook or forget about learning the importance of children's mental health.

Within Canada, there exists an initiative to involve school-based mental health supports within the educational system and provide greater wraparound care for vulnerable youth (Climie, 2015). In Canada it is up to the school district to decide what programming is allowed in their schools, with that being said, it is important for all educational staff to know the importance of children's mental health concerns to try to make sure the support is added to their district. The importance of mental health is emerging in Canada. According to Schwean & Rodger (2013) the acknowledgement the of importance of supporting children with EBD and the need to bring services to them directly have resulted in a call to action and have inspired a number of specific programs and centers that focus directly on school-based mental health service across Canada. With the increase and the importance of children's mental health there has been an increased emphasis at university level and has helped create programs that are designed to help educate future educational professionals on children's mental health.

It is important to help children with their mental health disorders and provide them with opportunities to support as soon as possible. It is important to help identify children in their school setting so that support can be implemented as soon as possible (Climie, 2015).

Reinbergs & Fefer (2018)

In the United States each year there are hundreds of thousands of children that are confronted with traumatic experiences. According to Reinbergs & Fefer (2018) they stated as trauma-informed care begins to take hold in schools, school mental health providers (e.g., school

psychologists, counselors, and social workers) desire concrete service-delivery options for students affected by trauma.

As stated by the U.S. Department of Health and Human Services, in Reinbergs & Fefer (2018), in 2015, the United States, child protective services (CPS) agencies collectively substantiated approximately 680,000 cases of child maltreatment and received 4 million reports of suspected maltreatment. In the lifetime of children one in four experience abuse or neglect up to the age of 18. According to Wildman et al. (2014) in Reinbergs & Fefer (2018), data was collected by state CPS agencies, and it stated that one in eight children in the United States experience substantiated maltreatment by the age of 18. When you factor in other traumas such as car accidents, community violence, and natural disasters, the number increases. Not every child who experiences a traumatic experience develop traumatic stress symptoms, many develop a variety of psychological concerns that interfere with their educational performance, including but not limited to posttraumatic stress disorder (PTSD) (Reinbergs & Fefer, 2018). The economic estimated cost for one confirmed can survived case of maltreatment is ~$210,000, including ~$8,000 towards special education. It is argued that schools hold a tremendous promise to serve students who have been maltreated when they employ a multitiered system of support (MTSS) to organize and deliver appropriate instruction and interventions for all students.

MTSS is a commonly adopted public health approach to school-based service provision that blends tiered models of academic, behavioral, and mental health service delivery (Reinbergs & Fefer, 2018). In the MTSS frameworks, services are organized into three tiers of increasing intensity (tier 1 or universal, tier 2 or selective, and tier 3 or indicated).

Each tier provides the same components, assessment, intervention, and practitioner support. There are many assessments that can be used, one free one that is available that has

good psychometrics is the Strengths and Difficulties Questionnaire (SDQ). This assessment has been used in over 4,000 studies, is also available in 70 different languages, and has a national norm for 10 countries that includes the United States. This assessment has teacher rating forms for children 2-4, 5-17, and 18+, along with a parent and self-report form.

All the assessments that are used include protocols for multiple informants across multiple contexts and have a number of subscales that portray a wide range of social, emotional, and behavioral concerns (Reinbergs & Fefer, 2018). Trauma assessments that evaluate a wide variety of symptoms and impairments may be an appropriate tier 2 assessment when a traumatic exposure is confirmed.

When screening for potentially traumatic events and for trauma symptomatology it raised a lot of challenges. There are many unanswered questions about the efficacy and ethics of universal screening for adverse childhood experiences. Some screeners may fear the mandatory reporting concerns for adverse childhood experiences. Many school only have the resources to dedicate to one social/emotional/behavioral screening method, and broad screening might better serve the needs of all students, including those who have experienced trauma.

Another free screening option is the 10-item Child Trauma Screening Questionnaire (CTSQ). This tool was shown to have adequate reliability (a=.69), and evidence of convergent validity, sensitivity, and specificity. The screening has been used successfully in the school context (Reinbergs & Fefer, 2018).

School staff, regardless of their level of training, are cautioned against conducting investigatory or forensic interviews as they are the purview of CPS and/or legal authorities. Great care should be taken not to interfere with or otherwise compromise an ongoing CPS

investigation and school staff are cautioned against conducting trauma assessments while an investigation is ongoing.

The second part of each tier is intervention. Intervention in tier 1 has two well-supported approaches to broad mental health prevention and promotion in schools which included universal social-emotional learning (SEL) curricula and school-wide Positive Behavior Interventions and Supports (PBIS). The SEL approach in tier 1 emphasizes increasing success and well-being for all students by directly teaching about emotion identification, emotion regulation, and social problem-solving (Reinbergs & Fefer, 2018). PBIS promotes prosocial behaviors by developing and teaching consistent expectations and increasing rates of positive teacher-to-student interactions.

In addition to the components of PBIS and SEL, trauma-informed teaching practices serve as a foundation to addressing the needs of traumatized students within the classroom. Trauma-informed teaching recognizes the frequency and classroom impacts of childhood trauma, focuses on relationship building and emotional regulation instruction instead of punishment, and emotional safety and consistency, and tries to support the “whole student” in the classroom.

It is important for schools to have a system I place through which teachers ask for and receive clinical consultation when needed. This clinical support is likely crucial in guarding against secondary traumatic stress in teachers. This support system is essential because teachers may not have enough opportunities for support outside of potential evaluation contexts.

The last component of tiers is practitioner support. Stated by Han and Weiss (2005) in Reinbergs & Fefer (2018) they suggest that school-based mental health interventions requiring implementation by teachers are only sustainable when they are supported by administrators, acceptable to teachers, viewed as effective, are flexible and adaptable, and are feasible to

implement with limited support/resources. Teachers must be involved in prevention and intervention approaches and receive training related to trauma. A tool that may help understand staff readiness for trauma-informed practices is the Attitudes Related to Trauma-Informed Care (ARTIC) scale. The scale is filled out by school staff to help school systems-change agents more thoroughly understand school readiness for trauma services to address implementation barriers and monitor changes in staff attitudes as interventions are put in place.

LaForett et al. (2019)

Young children with self-regulation difficulties are unable to manage frustration and other strong emotions, interfering with their ability to follow expectations and rules; inhibit inappropriate, impulsive, and aggressive behaviors; solve problems; appropriately express emotions; and organize behavior to achieve goals (LaForett et al., 2019). When a child shows dysregulated behaviors, it creates impairment at home and with peers, and remarkably increases risk for school suspensions, special education referrals, and substance use and violence. Children who are diagnosed with Attention-Deficit/Hyperactivity Disorder and Oppositional Defiant Disorder, and other mental health disorders their self-regulation is affected. Self-regulation is considered a central process underlying mental health.

The ideal setting to provide young children who are at right for mental health disorder is the school setting. This setting provides a great opportunity to help children learn and generalize social and emotional skills to enhance their academic and cooperative learning. About half of children needing mental health services receive them and students who come from an ethnic minority group are likely underserved, therefore schools have a potential for addressing significant gaps in children's mental health service delivery. As stated by Farmer et al. (2003) in

the LaForett et al. (2019) documentation, schools provide mental health services to more students than clinics and reduce financial and structural access barriers.

School-based mental health interventions can be effective and many evidence-based programs can be implemented in schools (LaForett et al., 2019). There are challenges that are faced when trying to implement clinic-based mental health services in the school setting. Some challenges are gaining teacher and administrators buy-in, limited school personnel time and resources, misalignment with school philosophy, limited space, and limited parent involvement. One of the main challenges is that many of the programs were developed for delivery in clinics, raising questions about adaptations and implementation support that may be needed to address contextual differences in settings. School staff may not have the same level of clinical training as licensed mental health clinicians; however, schools offer opportunities for staff to prompt, monitor, and praise children's use of targeted skills, and provide access to teachers to reinforce children's skills in the classroom as well as to implement behavior plans.

The Incredible Years Small Group Dina Dinosaur Treatment Program (IY) is a program that is delivered in schools and has demonstrated efficacy with clinical samples as a small group program. There are other programs that are adapted for schools from clinic-based models that address behaviors in young students; however, the IY program helps support students who do not respond to universal interventions but may not require individual services.

IY is part of a comprehensive series of preventative and treatment programs for parents teachers, and children ages 3-8 years with or at risk for conduct problems of ADHD (LaForett et al., 2019). IY is delivered in groups using collaborative processes, some aspects explicitly target self-regulation difficulties with strategies to inhibit impulsivity, increase persistence and

frustration tolerance, use emotion language and calm-down methods, and identify and solve social problems.

There are seven units in the curriculum which are learning school rules, have to be successful in school (e.g., raising your hand, checking your work, keeping eyes on the teacher, not talking out), detecting and understanding feelings, problem-solving steps, controlling anger, friendship skills, and how to talk with friends. Group leaders teach the lessons to the students with methods that are developmentally appropriate for young children (e.g., video-modeling, sociodramatic play with puppets, role play, singing) and small group activities designed to support skill application and scaffolding of skills through explicit feedback and reinforcement (or "coaching"). Sessions include a whole group circle time lesson, a small group activity, snack, and coached playtime.

IY uses a discipling hierarchy that relies on high doses of positive reinforcement with frequent labeled praise for positive behaviors (LaForett et al., 2019). The students receive tangible reinforcements for positive behavior such as a hand stamp, stickers, scented markers, fish crackers. They are also given special privileges such as getting to be the line leader, wiggle breaks, being a helper, having a special job, or wearing a cape. Children are also able to earn chips for positive behaviors and they are able to trade them in for a small prize at every group meeting. These positive reinforcements are kept separate from punishment strategies, once a student earns an incentive it is not taken away.

When group leaders are addressing negative behaviors, they primarily use strategies such as redirection, distraction, and selective ignoring to extinguish unwanted behaviors, accompanied by differential attention and praise given to other student's positive behaviors. Some of the other discipline strategies include logical and natural consequences, and privileges removed, time-out

is used for unsafe behavior that cannot be ignored such as aggression. Time-out is a space where children go to calm down and use coping strategies such as deep breathing, self-talk, positive imagery, to help them self-regulate. When letting the child know what the behavior was that earned them their time-out several steps are used such as warning, privileges removed, time-out "on the spot" where the rest of the group is moved to a different part of the room. Videos and practice prior to implementing time-out is used.

IY strongly encourage group leaders to have a background in mental health, child development, and teaching. Before the program is delivered, leaders participate in an authorized 3-day training to learn to deliver curriculum content and reinforce and manage children's behavior. Training includes discussion, video and live modeling, and behavioral practice.

Table 12 shows the adaptations that were made to make IY more feasible for school-based delivery. Adapted model involved conducting sessions twice a week for 45 minutes each rather than one 2-hour, weekly session clinic session. Coaching is important to help children recognize their skills, "recess coaching" was provided in the school setting which helped support children's use of skills in a natural context and also helped strengthen the relationship between the coach and the child. With the coaching piece added to the school-based model it was a closer model to the clinic-based model.

One important piece to the school-based model was pairing a school counselor with a team clinician to help create a partnership between school and community clinicians. The conjoined delivery model reflects an integrated, inter-agency approach to supporting school mental health with community resources, an approach (LaForett et al., 2019).

School counselors are an ideal partner because of their roles that involve supporting children's social-emotional skills through classroom guidance lessons, small group programs and 1:1 support.

Caregivers are important in supporting children's learning in the IY model which includes activities to engage teachers and parents and encourages them to support students' generalization of skills to the classroom and home setting. Group leaders provide 1:1 in-person or phone consultation to teachers with students in the program at least bi-monthly and involve sharing information about the skills students are learning which in turn helps teachers support their students to use the skills in the classroom. Teachers are also provided with two hours of teacher in-service meetings focused on young children's self-regulation development and how teachers can support this learning, drawing from material provided to them.

When IY is delivered in a clinic parents attend parent programs, in the school-based adapted model there are three parent meetings where information about what students were learning in the program and video of their child's group are shared. Parent meetings also include a brief parent-child activity so parents are able to practice giving their child positive attention and reinforcement. Parents received consultation calls from group leaders at least bi-monthly in both models.

One important support is having a strong working relationship with a district liaison, typically an administrator who supervises the school counselors (LaForett et al., 2019). The partnership is maintained through regular and proactive communication, including in-person meetings, and by being responsive to school requests and concerns.

This study enrolled and randomized 172 students, of whom 86 participated in IY across 17 intervention groups. Written parent permission was obtained with support from school

counselors for 57% of student nominated by their teachers as needing intervention, and 63% met full inclusion criteria including elevated social behavioral difficulties (>12 on the Strengths and Difficulties Questionnaire), which provides a clear risk threshold often used for inclusion of students needing intervention in research studies (LaForett et al., 2019). According to Danismann et al. (2016) in LaForett et al. (2019) the negativity/liability scale was 2.39 which is considerably higher (worse) than a normative preschool sample (M = 1.42). The average Emotional Regulation total was 2.69, which is lower (worse) than the average for 7- and 10-year-olds in a large geographically representative sample (M = 3.32) according to Blair et al. (2015) (LaForett et al., 2019). Some students were not included in this intervention such as students with autism spectrum disorder, full-time placement in special education classrooms, significant intellectual deficits, and non-proficiency in English because it was not designed for each student.

The intervention samples were racially-ethnically diverse (56% Black, 23% White, 14% Latinx, and 7% Multiracial). Most of the students received free or reduced lunch (73%) and were male (67%) (LaForett et al., 2019). Based off the parent's report, 24% had been diagnosed with a mental health disorder; 65% of these with ADHD.

Table 13 provides an overall summary of intervention dosage results relative to intervention delivery It took an average of 35 sessions for a group to complete all 18 IY lessons (range = 32-40), with 36 expected given the group structure (LaForett et al., 2019). Six of the 86 students (7%) attended less than 70% of the sessions, which was most commonly associated with a high number of absences from school or moving out of the school where the intervention was provided.

For the 1:1 teacher consultation session facilitated by study clinicians, there was an average of 6.78 contacts per year for each teacher (range = 2-16), about one per month lasting 6-10 minutes each on average (LaForett et al., 2019).

Based on the responses from parents (*n* = 66 of 86), most were satisfied or very satisfied (>6 on 1-7 scale) with the overall program (93%), and the parent meetings (95%). Also, 95% of the parents reported that talking with the study clinician was helpful or very helpful, and 97% would recommend the program to others.

Based on the teacher satisfaction surveys focused on specific students who participated in the intervention (*n* = 84 of 86 possible students, based on 77 teacher ratings), 48% were satisfied with the students' progress in the intervention (>6 on 1-7 scale) and 68% were at least somewhat satisfied (>5) (LaForett et al., 2019). Most teachers were satisfied or highly satisfied with the 1:1 consultation and in-service meetings (82% and 71%, respectively), and 71% would recommend the program to another teacher or parent (LaForett et al., 2019).

Counselors' satisfaction ratings showed relatively high ratings overall for the ease of use (average rating 5.2 on 1-7 scale) and helpfulness of methods (5.9 on 1-7 scale) (LaForett et al., 2019). Counselors also gave feedback on how their participation as a group co-leader benefited their professional development, reporting on an increase in their skills to manage behavior and more effectively praise and ignore students.

IY can be delivered in school with a moderate to high level of fidelity expected to produce positive results with highly skilled clinical research staff partnered with school counselors (LaForett et al., 2019).

One important consideration for future delivery of IY in schools is parent, teacher, and counselor satisfaction, which may impact district administrators' decisions to support the

program (LaForett et al., 2019). The parent meeting attendance was 54% overall, which is better than average for school-based interventions. Most of the parents had some involvement and were quite satisfied with the program and their child's participation, and it did not vary by the poverty or urbanicity of the school. Because of this study parents were engaged in their schools in a positive way for the first time and they praised the program at unrelated school and district meetings.

Many counselors developed clinical skills in intensive behavior management needs for young students with significant self-regulation difficulties because of the intervention. One of the biggest challenges for many counselors was understanding the behavioral principles underlying the positive reinforcement system and strategies to reduce inappropriate behavior (LaForett et al., 2019).

One of the biggest implementation challenges that were encountered was navigating differing philosophies between the IY positive discipline approach to managing behavior and schools' discipline policies (LaForett et al., 2019).

Counselors reported clear professional development benefits and rated all therapeutic methods as at least somewhat useful and the majority as useful. They also stated that applying knowledge and skills learned in the program to other students, programs, and practices may increase schools' capacity for providing effective social-emotional learning supports.

One of the biggest challenges for many counselors was understanding the behavioral principles underlying the positive reinforcement system and strategies to reduce inappropriate behavior. They struggled with the rationale of rewarding children for expected behaviors, the high reinforcement rates needed to shape behavior, and resisting the urge to mix reward and punishment systems (LaForett et al., 2019).

One of the most important lessons learned is that the conjoint delivery approach with school counselors appears valuable, particularly for building long-term mental health capacity in schools. Elementary school counselors are ideal group leaders in many ways given their backgrounds and roles within the school.

There is great potential for the translation of clinical programs to school settings. The potential benefits of doing so to increase service reach and improve children's mental health outcomes are great, warranting continued efforts to identify and address implementation challenges such as those that were encountered in this study (LaForett et al., 2019).

Table 12

Comparison of Clinic Model and Adapted Model for School-Based Delivery

As seen in article by LaForett et al. (2019)

Clinic Model	Adapted Model for School-Based Delivery
• 18 2-hour lessons delivered weekly over 18-20 weeks	• 36 45-minute sessions delivered twice a week over 6 months. • Instead of including coached play during the session, weekly recess coaching (about 30 minutes per student). • Bi-monthly check-in calls for parents. • Three parent meetings. • Monthly 1:1 teacher consultation meetings. • In-service sessions for teachers on topics related to young children's self-regulation (2 hours total).
• Co-leaders typically are licensed mental health professionals	• Co-leaders are a mental health professional of trainees from research team, paired with a school counselor.
• Originally developed for children with ODD and Conduct Disorder	• Students nominated by teachers as having broadly defined self-regulation difficulties. • Enrolled students must have an SDQ Total Difficulties score >12, in addition to meeting other inclusion criteria.

• Parents bring children to group and pick them up	• Group leaders' contact with parents is typically by phone or through parent meetings.

Table 13

Summary of Intervention Dosage Relative to Intervention Delivery

As seen in article by LaForett et al. (2019)

Intervention Component	Implementation*	Intervention Dosage		
		Mean	**SD**	**Range**
Child group attendance	36 groups per child	88%	18%	0-100%
Child recess coaching sessions	Weekly sessions	13.22	3.73	2-20
Teacher consultation sessions	Monthly sessions	6.78	2.64	2-16
Parent meeting attendance	3 meetings per child	54%	39%	0-100%

* Implementation occurred over an 18–20-week period

Conboy (2021)

The prevalence of mental health disorders in children is increasing in England, which is reflected by an increase of referrals to Child and Adolescent Mental Health Services (CAMHSs). With the increased demand, it has resulted in high threshold criteria and little or not follow-up for children who do not meet the criteria. With the lack of support available for all children and young people's (CAYP's) mental health it has been said that schools are being cited as a resolution for supporting children's mental health.

Schools are named as optimal settings for early intervention for CAYP's mental health and guidance stresses the importance of a whole school approach. Government reforms in England have demonstrated an emphasis on both primary and secondary schools to promote the mental health of CAYP and has become a priority for the Department of Education (DfE).

Teaching assistants (TAs) are often designed to work with children with special educational needs and disabilities (SEND). SEND children are more likely to have mental health difficulties; 35.6% of children with mental health disorders have SEND (Conboy, 2021). TAs are often required to work directly with children with mental health needs, 35% of the primary school workforce are TAs. This represents a large proportion of adults that children come into contact with at school.

Seven TAs were selected and were in mainstream primary schools; they were required to have worked for at least one year prior to participating in the study and be working in a role that involved supporting multiple children in the classroom. There were four themes discussed in this study and they were (1) Perception and knowledge of children's mental health, (2) How TAs support children's mental health, (3) Working within the school system, and (4) The emotional experience.

In the Perception and knowledge of mental health theme TAs stated that anxiety as a major theme. The TAs were not as comfortable with naming depression or low mood in children. TAs stated that experience was one thing that helped them in their role such as experience of successfully supporting children's mental health, experience of being a parent, and experience of having mental health difficulties in their own family. TAs had a desire to gain more knowledge and training to be able to help recognize mental health difficulties and understand the need to support them.

The theme of how TAs support children's mental health the biggest way was having a relationship with the child. The TAs had a caring approach with working with children that sometimes felt like they were parenting the child. The TAs had a close and caring relationship with the child which sometimes felt like a parent's role but in the school setting. Knowing the

child and understanding them the TAs know the best approach to take with each child. TAs were able to develop a rapport with children and the children would then approach them more often than they would their teachers when they had a problem. TAs were a practical support for the students and were able to talk with the student to support their mental health. A particular type of talking used was normalizing worries; for instance, by discussing worries with groups of children and giving examples of children sharing the same worries (Conboy, 2021).

In the theme of working within the school system safeguarding was a topic. When TAs were asked about children's mental health some of them talked about instances of safeguarding concerns. Some TAs solutions for safeguarding were for issues to be passed on to a person that has more experience. TAs expressed how other staff members were able to support them who played a specific role in supporting mental health.

In the last theme of emotional experience, the TAs expressed that the key element of their role was to help children. The TAs enjoyed their role and found it very rewarding however, they showed some fear when helping children with their mental health difficulties.

TAs view themselves as supporting children's mental health; particularly through forming close relationships with children (Conboy, 2021). There are some difficulties TAs face in their role such as their desire to know more about children's mental health, so they are able to better support the child.

Table 14

Summary of Chapter II section II Findings:

Authors	Study Design	Participants	Procedure	Findings
Jaycox L., Cohen J.,	Quantitative	195 students from 3	Students were put into 3 different	• Findings showed students reported

Mannarino A., Walker D., Langley A., Gegenheimer K., Scott M., & Schonlau M. (2010)		different schools in grades 4-8	groups and assessed at 5 months, and 10 months to determine the trauma they faced after Hurricane Katrina.	having upsetting experiences. • Lifetime Trauma exposure was common. • Results showed treatments showed significant improvement in post-traumatic stress disorder (PTSD) symptoms.
Cooley-Strickland M., Griffin R., Darney D., Otte K., & Ko J. (2011)	Quantitative	Ninety-eight 3-5th grade students ages 8-12	Students who participated in this study attended 13 bi-weekly one-hour group sessions of a modified cognitive-behavioral anxiety intervention program.	• A significant decrease in anxiety was shown in both the intervention group and the control group. • Reading performance improved in both groups.
Alicea S., Pardo G., Conover K., Gopalan G., & McKay M. (2012)	Qualitative	High School Students ages 14-18 years old	Step-Up is a high school-based mental health service delivery model to help school, family, and youth related to youth mental health.	• Students in low-income communities do not receive the proper mental health care. • The flexibility of having formal and informal contact with youth and families enhanced engagement and normalize seeking help with mental health needs
Climie, E.A. (2015)	Qualitative	Children who identify with having EBD	Setting up treatment programs in students' educational settings.	• Less than half of the students who identify with a mental illness receive treatment. • One option to increase is to offer treatment into the student's school day.

Reinbergs E. J., & Fefer S. A. (2018)	Qualitative	Children who have been traumatized	Setting up a school-based trauma service-delivery option	• Hundreds of thousands of children in the United States are traumatized each year. • Schools recognize the need for support in school.
LaForett D., Murray D., Reed J., Kurian J., Mills-Brantley R., & Webster-Stratton C. (2019)	Quantitative	17 intervention groups across 3 cohorts and 11 schools	Adaptations were delivered to 17 intervention groups across 3 cohorts and 11 schools.	• Results show that supported implemented models can be put into schools. • Satisfaction of school personnel was high.
Conboy I. (2021)	Quantitative	Seven TAs were recruited from mainstream primary schools for the study	The TAs were studied from 18 to over 20 months to determine how they can support children's mental health.	• Some of the issues seen were passed on to the safeguarding officer. • The Safeguarding officers helped "sort things out" for the students.

Chapter III: Summary of Findings

The purpose of this review of literature was to examine the outcomes of having mental health professional programs in the schools, allowing students to seek treatment in school, over not having them in the schools and having to seek treatment outside of school. I wanted to understand the importance of treating mental health issues in adolescents and the impact mental health has on our students in all aspects of their life (school, home, community). Chapter I included background information on mental health and the rationale for research. Chapter II was a review of literature. In this chapter I will share my findings, recommendations, and implications from research.

Conclusions

Overall, my research has shown me the importance of having mental health staff in the educational setting. All students that participated in the different studies I researched about showed major gains in their mental health status. When students were able to access therapists at school when they were having a problem, they were able to use their resources and coping strategies they learned to help them better understand the situation they were in. When the studies added families and parents in the mix there was a bigger positive outcome.

Families were more willing to access mental health support when they were able to choose when and where they met. Most families did one-on-one sessions in their homes after their workday. When activities were offered at their child's school the parent participation slightly increased. I feel having mental health support from outside sources enter the educational setting especially in the communities that are low-income will show a positive impact on adolescent mental health and positive family engagement in their child's life.

Recommendations for Future Research

One recommendation according to Harvey & Hill (2004) would be to allow for more research both qualitative and quantitate with a larger population to test the significance of culturally competent programs such as the Family Rites of Passage program. Another recommendation according to Cooley-Strickland et al. (2011) would be to potentially have an after-school program, and also resource-intensive interventions; both these recommendations would be ideal resources for the school setting. In the article by Alicea et al. (2012) it seems that there needs to be more research into the benefits of school-based mental health programs that collaborate between and within individual, family, school, and community level systems at the high school level.

According to Reinbergs & Fefer (2018) some necessary topics to be looked at further would include laws and ethics around confidentiality and mandatory reporting, informed consent, the clinical skills, and sensitivities needed for trauma-informed counseling and assessments, psychopharmacological options, and the complexities of partnering with families who have experienced trauma.

According to Conboy (2021) staff need more training and knowledge on mental health to be able to better serve the students they work with. Most staff who work with students who have a mental health disorder do not have enough experience or training to know what the best option is to help the child be successful.

Overall, I feel more research should be done on the benefits of having mental health facilities not only in low-income neighborhood schools but in all schools to help with the increasing number of adolescents' mental health crisis. Also, data should be taken on all genders, ethnicities, economic status, and between special education and regular education students.

Implications for Practice

School Staff should be trained on mental health situations and be able to work with the mental health staff regarding the student that is a part of the program. I have got to experience a similar program to the Step-Up program at my special education school. In the younger grades (K- 4) students are in a classroom with a mental health therapist along with educational assistants and a classroom teacher. In the older grades (5-8) students still have access to their therapist, just no in the classroom setting all day. Students meet with their therapist once a week during the school day, the therapist also meets with the studies families at any time and location convenient for them. I know I have utilized the therapist a lot this year with the students that are still part of the program. The therapist is able to offer support or recommendations to help the students when they are in a crisis situation both at school and at home.

Summary

Based on my research question of "What are the outcomes of having mental health professional programs in the schools, allowing students to seek treatment in school, over not having them in the schools and seeking treatment outside of school"? Having mental health professionals in the schools allowed students to get the mental health support they needed during the school day, they did not have to leave the school building to access support in a clinic. Based on my research students accessed support more when they were in the school then seeking treatment outside of the school. Families also accepted the support from the mental health professionals that were in their child's school since it was more convenient for them, and they were able to talk with and meet them when it was convenient for the family.

Overall, schools all over the world should look into allowing mental health support from outside companies to be a part of their districts to help students get the mental health support

they need since many families can either not afford to take them or are not able to get to the clinic in the hours that are available. When supported in the school's students will be able to access their therapist during their school day and not have to seek outside treatment.

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