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Mental Health Intervention within the Education System and the Importance of Developing a Quality Model of Services

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MENTAL HEALTH INTERVENTION WITHIN THE EDUCATION SYSTEM AND THE IMPORTANCE OF DEVELOPING A QUALITY MODEL OF SERVICES

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Abstract

The purpose of this thesis was to determine what schools are currently doing with the rise of mental health issues in youth. As schools continue to enroll more and more children suffering from possible mental health issues, districts must be equipped to provide appropriate care. Many factors need to be taken into account before support can be provided within the school, such as training, programming, staffing, and much more. Without proper services, adolescents can encounter many issues that will affect them the rest of their lives. This thesis will provide further information on how schools are currently providing care and intervention support, also, how schools could potentially move forward based on research from various articles around the issue of mental health in schools.

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CHAPTER I: INTRODUCTION

Connecting School and Mental Health

Public schools can personalize their individual district goals with their vision and mission statement. Many schools touch on keeping kids safe and providing formal education among many other things. Some of the larger school districts within Minnesota mission statements are as follows: Minneapolis Public Schools, "We exist to ensure that all students learn. We support their growth into knowledgeable, skilled, and confident citizens capable of succeeding in their work, personal, family, and community lives into the 21st century." Saint Paul Public Schools, "Inspire students to think critically, pursue their dreams, and change the world," and according to Anoka-Hennepin School District mission statement and purpose, "...to effectively educate each of our students for success…" (Saint Paul Public Schools, Minneapolis Public Schools, and Anoka Hennepin Public Schools, 2019).

In Minnesota, students are generally in school an average of 176 calendar days, 6.28 hours per day, five days a week. Children spend the majority of their day within the walls of their school. It is no question that schools have a tremendous responsibility. They hold a significant role in the development of today's youth. It is becoming more challenging to achieve the high expectations that are placed on schools as the mental health crisis in adolescents continues to rise. As society and culture continue to change, so must the demands of schools. School personnel plays a crucial role in identifying early warning signs of possible emerging mental health conditions. They also can link students with adequate services and supports if available. Considering the amount of time students spend at school there could be potential growth opportunities for schools to treat and

support mental health conditions in an environment that children are familiar with, like their school.

According to The National Alliance of Mental Illness (NAMI), the start of many mental health conditions and illnesses occur in adolescence. The research found that children who experience learning and attention issues are more likely than their peers to worry about school, social activities, and changes. These children have a higher chance of developing anxiety within their elementary-aged years. Also, NAMI's statistics tell us that one in five children live with a mental health condition. Moreover, one in ten has a condition so severe it will impair their functioning at home and school. However, less than half of these adolescents are receiving the support or services they need (NAMI, n.d.).

In-School Support and Outside of School

As mentioned earlier, school personnel have a significant role in the intervention and identification of the early warning signs of emerging mental health conditions and in connecting children to the effective services and supports both in school and in some extreme circumstances outside of school. Because of the increase of mental health conditions within adolescence, schools are starting to recognize the importance of understanding the relationship between mental health and school success for children in both general and special education. (Splett et al., 2018). Children spend most of their day at school, and it only makes sense to allow the services to be a part of their school day. Many schools are unable to require the necessary staff members to address such needs because of budget cuts, lack of professionals available, and supply and demand.

Current Mental Health Screening, Intervention, and Support within Schools

Early intervention is vital with both special education and mental health issues. Some issues may surface later, which can make the early intervention process a bit more challenging; however, schools should keep a close eye on their students and be aware of changes. Districts have steps in place to watch students within the school and follow the step-by-step system to provide additional support. This prevention and intervention plan in schools is typically called a Multi-Tiered System of Support (MTSS). The process of the MTSS team within schools is to identify students who may have behavioral, academic, social, or functional concerns and develop steps moving forward to support their education further. According to the Minnesota Department of Education, "...MTSS is a safety net to prevent school failure. The critical features of this school-wide framework include assessments, highly-quality evidence-based instruction, core instruction, tier 2 or supplemental interventions, and data-based decision making…" across team members associated with the MTSS in each school (Minnesota Department of Education, n.d.).

Steps may include beginning or revisiting current interventions or modifications that a child may or may not already be receiving, moving forward with an individual education evaluation, or collecting more data and waiting to see how the students' scores increase or decrease in the weeks or months to come. These steps are extensive and follow a serial protocol. Most MTSS teams within schools are still not incorporating the use of Universal Mental Health Screening (UMHS) Splett et al. (2018).

Support for students receiving special education services can include: academics, speech/language, communication, social skills, behavioral skills, emotional regulation,

physical therapy, functional support, and the list goes on. Special education teachers' job responsibilities are to support individual students with outside mental health diagnoses with coping and intervention skills that are beyond educational deficits. Additional responsibilities include behavioral modifications and skill training for skills needed in their general education classrooms. Without those critical skills in working through certain conditions, students will have a tough time making much needed educational gains. Some school districts have contracts with outside therapists, where students have the opportunity to receive support from a family therapist that comes to the school. Other support within schools could include a student advocate, social worker, and school psychologist. The support within schools varies greatly depending on funds, budgets, amount of staff, and many other factors.

Considering the population of most schools and looking at the previous NAMI statistic telling us 1 in 5 children are currently struggling with some mental health issue, are schools providing enough support? How could schools be better equipped to supply the demand for mental health issues within the school setting? Alternatively, should this strictly be something that parents should handle outside of school? How can the two work as one to provide the best outcome?

Family involvement and support is also a significant factor in the support/service a child may receive. If a family is willing to seek outside support, they have the chance. This researcher has experienced working across different districts; some families are unwilling to move forward with outside support regardless of encouragement from school personnel. In cases where families refuse outside support, schools become the primary

provider for support and skills in areas that may look like mental health support but may instead be functional skills.

Moving Forward

It is evident that schools are beginning to understand the need for such personnel within buildings; however, schools appear to be more concerned about providing the best and most up to date curriculum for literacy and math so that districts achieve higher test scores, and closing the achievement gap. Though these issues are of equal importance, the academics of a student will continue to be at a standstill unless the basic foundational needs met. Students must have mental, emotional, and behavioral stability first.

This researcher will obtain information through various articles, research, and data to prioritize and continue to emphasize that this problem is only going to get worse and that schools need to come up with a plan soon to develop and train their educators to work with such needs. This thesis writer understands how impossible it may seem with district budget cuts, low-income schools, and the disparities between different districts. Nevertheless, there needs to be a separate interest when it comes to mental health within the school system. Working in special education has taught this researcher that the current method of support within schools regarding supporting children with mental health concerns and conditions is not working. There is an inclusion model to make sure all students are welcome and feel they are a part of the classroom family. The children that experience such extreme cases of behavior and mental health conditions are not benefiting from such a model. This model was in place at a different time, and there needs to be a change.

Thesis Questions

According to Fazel, Hoagwood, Stephan, and Ford (2014), school is a central part of a child's development. Developmental areas that happen in school include social relationships, peer communication, academic teaching, emotional control, understanding rules, and behavior expectations, and so much more, which are all affected by mental health.

This thesis will explore the questions: What is the current connection between schools and mental health? What should mental health services look like in the school setting? How significant is the role of environmental factors (social context) in students identified under special education or mental health issues? What pre-interventions can be put into place to support students considering the increase in mental health disorders in children? What kind of staff training should be required in schools concerning mental health issues and the implementation of interventions? Moving forward, how can schools work with mental health agencies to support students with mental health needs?

CHAPTER II: LITERATURE REVIEW

To locate the literature for this thesis, searches were conducted through Bethel University's academic library search tool and focused on databases such as PsychINFO, EBSCOhost, and ERIC. Only academic, peer-reviewed articles ranging from 1992-2019 were used. Search terms included: special education, intervention, mental health, mental health issues, and school.

A Growing Issue

Mental health is a growing issue in our schools. Researching this topic through many articles made it clear that the intervention process for supporting these students within the school still has a long way to go. Though most schools already implement an MTSS (Multi-Tiered System of Support) program Splett et al., (2018) conducted a study with the importance of including and implementing a kind of UMHS (Universal Mental Health Screening). The purpose of this screening was to become proactive in the early detection process to reduce the risk of children developing mental health disorders/conditions. As mental health demands continue to increase, so do the needs of the schools, and their hope to move in the direction of having adequate plans in place for intervention support based on the need (Splett et al., 2018).

The use of UMHS resulted in an increase of those students at risk (180.1%) for those already being serviced for emotional, social, or behavioral needs (Splett et al., 2018). Schools were serving only 10% of the special education student population before the use of the UMHS in the screening process. Adding those identified by the screener only increased the percentage to 26%. There continues to be an over-identification with male students over females. There were many instances within the study that were not

significant predictors. Students identified by the screener have a high-risk profile, but not as severe as those identified by the school, which is inconsistent with previous research. The data concluded that schools that add a UMHS within their process might provide an opportunity for early intervention and prevention by detecting a group of students with elevated concern with mental health considerations. Research from Bruns, Walrath, Glass-Siegel, & Weist (2004) suggested that the availability of mental health professionals within the schools through Expanded School Mental Health (ESMH) would reduce possible inappropriate referrals made by educators and provide preventative services (Splett et al., 2018). With the availability of professionals during the MTSS process, accurately assessing students under the UMHS data could take a turn in the school-wide readings.

According to Brueck (2016) and the Center for Disease Control and Prevention (CDC), one in five children experiences a mental health disorder. Diagnosis of mental health disorders has a severe impact on changes in the way children typically learn, behave, or handle emotions (Splett et al., 2018). With these alarming statistics, there is no reason schools should not be implementing and training their staff to use UMHS within their multi-tiered intervention processes. Schools are continuing the process (Splett et al., 2018) but continue to be slow to progress in the tools and instruments to support findings from the UMHS data.

Europe has done similar studies due to the increase in mental health issues. According to the World Health Organization's (WHO) declaration in 2005, mental-ill health has become Europe's biggest epidemic raising its awareness and importance on political and social agendas. (World Health Organization [WHO], 2005). A study

conducted by Danby and Hamilton (2016), identified the increase in mental health in Europe in children due to higher awareness resulting in easily identified adolescents, and possibly more adolescents willing to come forward due to signs of distress. Discussions of changes made towards the DSM (Diagnostic and Statistical Manual of Mental Disorders) were considered at the time due to new behaviors exhibited by youth, suggesting that behaviors once considered normal could now be identified as harmful disorders to understand and support the younger population. An increase in negative social changes in the 21st century has resulted in negative impacts on youth today including school expectations, cyber-bullying, perfect body, owning the latest technology, parental involvement, parental relationships, and more. The higher the potential increase of exposure to multiple risk factors surrounding youth today, the higher the possibility of developing poor mental well-being.

School obligations in this growing issue are to address certain aspects through curriculum related to social and personal education; however, at the time of the study, there was no requirement for schools to include any mental health policy to address or teach individuals specific strategies or provide interventions. Europe's government understands the need, however, due to budget cuts and lack of funding in order to train and support staff within buildings have resulted in schools struggling to meet the needs of students. In some cases, this lack of funding has resulted in schools being required to reach out to emergency personnel in cases where mental health needs were far too significant. Another speed bump in moving forward continues to be the misunderstanding and stigma of the definition of mental health and well being, leading to misdiagnosis and referrals. Because of these issues, Danby and Hamilton's (2016) focus was, "...gaining

insight into the experiences of school practitioners, on how children's mental health and well-being was understood, supported and promoted" (Danby and Hamilton, 2016, p. 93).

Results from the study found that the overall definition of mental health in relation to students was very misunderstood and interpreted, because of this finding Danby and Hamilton described their results with the statement, "it is very much the elephant in the room," in relation to the reluctance and thoughts of school practitioners opinion on the term mental health and relating it with children. Practitioners recognize mental health to be a pressing matter; however, they believed children still needed to be sheltered from specific terms or issues. The discussion of mental health within schools is often avoided because of the sensitive material shared and discussed.

The fear from these results is that those children suffering from mental health issues may feel they cannot come forward to receive help. The concluding suggestions are to move towards a change of philosophy, "...one which makes mental health part of everyday conversation with children and young people...schools most likely to be effective in achieving this are those that place mental health as a core aim…" (Danby & Hamilton, 2016, p. 100). The goal is to continue to keep children safe with equal amounts of support and equal amounts of protection.

Most schools are struggling at this time in providing support students need when it comes to mental health, youth that are at the most risk could potentially face higher rates of dropout, increased mental health issues, and incarceration. According to The Hechinger Report, “When the special education system fails youth, they end up in jail, many stay there for years or decades...students with emotional disabilities are three times

more likely to be arrested before leaving high school than the general population" (Mader and Butrymowicz, 2014).

Concerning this data Krezmien, Mulcahy, & Leone (2008) completed a study around youth detained and committed; they examined the differences in achievement, mental health needs, and special education status. More specifically, they investigated if an intake with specific questions related to school and health history obtained can predict whether youths' special education status and proper placement within programming.

According to Krezmien, Mulcahy, & Leone (2008) detained and committed youth within juvenile and detention centers can experience higher rates of failure in school, identification of special educational needs and mental health needs, than peers within their community. They believe if juvenile and detention systems knew more about the specific needs of the students that were entering their facilities, there could be more effective planning. Also, the development of appropriate services provided, which is the same within schools. The more information and background knowledge, an evaluation team has access to the better the chances for proper planning of individualized support. Diagnostic tools and standardized assessments are used to assess and determine these services within the schools. However, in the juvenile justice system, there is no way of determining if students are eligible for services under the Individuals with Disabilities Education Improvement Act (IDEIA). Students eligibility under IDEIA directly affects the access and services to mental health care in public and juvenile correction settings. Most adolescents with such severe needs may already have stopped attending a school, which diminishes access to such services under IDEIA.

As mentioned earlier Krezmien, Mulcahy, & Leone (2008) believe in the importance of understanding the individual youth needs in academics, special education, and mental health needs to develop a comprehensive approach for services and support which may or may not include re-entry into the public school system. Each area of need exhibits different characteristics within a child, and understanding those differences is vital for planning.

Kreziment, Mulchay, & Leone believe using a comprehensive screening tool during intake that would include: "(a) an interview that allows personnel to obtain information about a student's current and past educational, medical, and mental health status; and (b) a standardized, norm-referenced educational assessment battery."(Krezimen, Mulchay, & Leone, 2008, p. 448). Their study consisted of participants using such an intake procedure during their placement within a juvenile correction facility. Intake covered topics of the interview (health and school history), demographics, reading and math achievement scores (Woodcock Johnson-III), and mental health.

The results showed that student academic and mental health characteristics revealed strong predictors for special education status. More specifically, the results showed higher rates of diagnosis of EBD (Emotional Behavior Disorder) and SLD (Specific Learning Disability) as well as higher percentages of those diagnosed EBD with comorbid mental health problems requiring substantial support relating to behavior. Youth receiving special education services within some juvenile correction facilities are much higher compared to those in public schools. Higher rates of academic underachievement and report of possible prior therapy could have been as a result of

misdiagnosed with a disability. Krezmien, Mulcahy, & Leone (2008) suggested investigating the effectiveness of comprehensive mental health screening procedures and protocols as part of student intake processes, as well as making sure special educators and related providers need to have access to the tools to identify student's educational and mental health needs accurately. With the proper intake measures available, the higher the chance of accuracy in identifying student needs, and improving educational and mental health services in addition to making sure its a collaborative effort amongst the teams that work with the child.

Co-morbidity of Special Education and Mental Health Issues

The intervention process of identifying students stresses the importance of early intervention, to decrease the chances of poor outcomes later in a student's school experience. According to George, Zaheer, Kern, & Evans (2018), "...unmet mental health needs place youth at risk for experiencing (further) impairment in successful school functioning, like poor attendance, disciplinary referrals, and suspensions and poor grades which decrease the likelihood of educational attainment."(George, Zaheer, Kern, & Evans, 2018, p. 119). Students within school receive extra support through a diagnosis of special education criteria qualifications; Emotional Behavioral Disorder (EBD), Specific Learning Disability (SLD), Other Health Disability (OHD), Developmental Cognitive Delay (DCD), Autism Spectrum Disorder (ASD), and Developmental Delay (DD) for those under the age of seven. The criteria for qualifying for specific mental health disorders come from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Criteria generally neglect the characteristics that schools will use in order to identify adolescence for school mental health services for example; socio emotional behavior

screening tools and indicators of school functioning, which can be a significant determinant of school impairment.

A study conducted by George et al., (2018), looked into mental health service use in adolescents who experienced emotional and behavioral problems and school impairment. Of the 647 students that participated in the study, nearly half (48.5%) qualified for special education services with the main disability label being SLD (49.6%), followed by EBD (25.4%), and OHD (19.1%). Students began receiving services at an average age of 11.6. Results from the study indicated that of the total participants, 69% had received mental health services during their lifetime for emotional/behavioral problems. Services included community psychosocial, school-based psychosocial, pharmacological, and inpatient services. Of the data collected, 31% of adolescents had never received any mental health services despite significant challenges reported by personnel that would contribute to impairment in school functioning. Participants in the sample continued to experience difficulties at the time of referral, suggesting services may have been inappropriate or insufficient.

Despite understanding the importance of early intervention, the beginning age of support started at 11.6 years (5th-6th grade) suggesting the possible absence of preventive interventions and support that could have impacted services received, and the success of the services provided. School-based psychosocial services covered only 28.6% of adolescents, which was heavily determined by school referrals and personnel. One crucial factor that researchers considered in this study was parent involvement and the idea that parents with children identified under special education may seek out additional support to help their child. This study concluded with the idea that there should be an

increase in access to students within the school involving the use of school-based mental health services and enhancing applications for access.

More and more children today are meeting the criteria for special education support and services within the school sector. Of the students qualifying for support, there is a steady increase in the co-morbidity of diagnosis with an underlying behavioral disorder. According to Greenberg, Weissberg, O'Brien, Zins, Fredericks, Resnik, & Elias (2003), school-based interventions are most beneficial when simultaneously paired with student's personal and social assets, to improve the environment where students are educated (Greenberg et al., 2003). For this reason, Déry, Toupin, Pauzé, & Verlaan (2004) conducted a study in which to find the prevalence and frequency of disruptive behavioral disorders and internalized disorders within a sample of elementary school-aged subjects receiving special education support for behavioral difficulties. Three hundred and twenty-four children participated in the study that included information gathered by the teacher, parent, and student reports using diagnostic interviews based on the DSM-IV criteria. Diagnostic interviews and health surveys were used to determine the extent of disruptive behavioral disorders amongst the samples collected. Data was also collected and analyzed about gender and age with the occurrence of the disorder. The data collected revealed high rates of students presenting with both a disruptive behavior disorder as well as internalized disorder. An alarming result from the data found that girls experience disruptive behaviors as high as boys. Attention needs to be on the internalized disorders in children, and there needs to be an emphasis on intensive programming for younger children.

According to Pastor & Reuban (2009), mental health disorders are recognized as the leading health concerns for youth in the United States. Students are developing criteria severe enough for DSM-IV criteria and diagnosis according to results. There needs to be a way to develop a collaboration between the mental health and education sectors. Further studies will need to document these disorders across a child's development and their overall effects.

As students grow older and move into the workforce, the comorbidity of their disorder can have significant impacts. A study done by Mykelebust & Mykelebust (2017) of Norway followed a group of youth starting in their teens and collected data into their mid-30's who had received support under special education criteria. The purpose of their study was to monitor the effects of receiving special education services while in school, the presence of mental health issues, and moving into adulthood with or without the need for assistance (social security). Students receiving modified or specially adapted teachings from lower (8th-10th grade) to upper secondary school (11-12th grade) generally resulted in difficulties with physical, psychosocial or social nature, affecting the potential for mental health issues as they grew older (Mykelebust & Mykelebust, 2017).

Many things influence an individual's life, including past and present opportunities, events, and restrictions. Receiving special education in any capacity can be an influencer as well as receiving support for a mental health diagnosis. According to Bjelland, Krokstad, Mykletun, Dahl, Tell, & Tambs (2008), low educational achievement can increase the risk for the development of mental disorders later in life. Mykelebust & Mykelebust (2017), research was able to find a pattern from their results. The presence of psychosocial difficulties and or psychosocial stress at the age of 17 years indicated

mental distress by the age of 33 years, and the lower the functional achievement measured at 17 years would result in the potential higher rates of mental distress reported by the age of 33 years. They also found that students who had worked with a teacher's assistant in the classroom during upper secondary education had mental distress at the age of 33 years more frequently than students who did not. Also, students who received social security benefits by the age of 28 years had a greater impact of potential mental health disorders five years later (Mykelebust & Mykelebust, 2017, p. 133).

According to Mykelebust & Mykelebust (2017), "...disabilities owing to mental problems have become more common in the past 20 years and are occurring at a younger age than other diagnoses, thus resulting in more lost working years than for any other diagnostic group." (Mykelebust & Mykelebust, 2017, p. 127). Due to medical diseases or some disability that affects someone's ability to gain employment, social security benefits may be an option for individuals as long as individuals are unable to support themselves financially. In this study, the participants that had received support under special education along with some comorbid health-related problems received social security benefits in their late 20's and had a higher chance of experiencing mental distress by their mid-30's. Unemployment rates were higher among the individuals studied; however, it was unclear if this was a result of mental health problems or health-related problems.

Impact of Environmental and Social Factors

There is no one cause for mental illness. Mental health issues can be genetic, biological, or a result of some traumatic experience. There is no way of telling whether someone may grow up and be affected somehow by mental illness. Past experiences that may cause a mental illness include: neglect, death/loss of loved one, abuse (physical,

sexual, emotional), dysfunctional family life, poor nutrition, and the list can go on. Without knowing the cause of mental illness researching the importance of environmental effects during adolescents and the link with mental illness and special education statistics with services provided within schools drove the research on this topic.

Our own personal biological, psychological, and environmental factors shape who we become. Today there are many definitions of what "family" could be as well as different kinds of circumstances and situations that children come into the world. In current society today, children are being born in poverty-stricken homes, in the middle of wars, and many other factors that as a researcher cannot even imagine. Children today are far more consumed with social media than ever before, according to Pew Research Center, "...95% of teens have access to a smartphone, and 45% say they are online 'almost constantly'..." (Anderson & Jiang, 2018).

There have been many studies done on the effects of social media use and its impact on adolescents. The National Center for Research published an online article claiming symptoms of anxiety and depression increased with the increased use of social media platforms (Twitter, Facebook, Instagram, YouTube, etc.) adolescents had accessed from their devices. (Mir & Novas, 2016).

Positive self-esteem can be considered a fundamental feature of mental health as well as a protective agent in some cases as it contributes to better health and positive social behavior. According to Mann, Hosman, Schaalma, & de Vries (2004), "...an unstable self-concept and poor self-esteem can play a critical role in the development of an array of mental disorders and social problems, such as depression...anxiety...and high-

risk behaviors." (Mann, Hosman, Schaalma & de Vries, 2004, p. 358). An individual's self-esteem can shape their ideas and core values about themselves, as it develops, which can become another contributing factor when considering the potential for mental health diagnosis and prognosis.

Family environment and parent involvement can play a more significant role in the potential diagnosis and support for mental health disorders in adolescents. According to Reijneveld, Wiegersma, Ormel, Verhulst, Vollerbergh, & Jansen (2014), parent(s) can face different kinds of problems that may impact their children, "...social and economic problems such as parents' divorce and unemployment have been shown to lead to adolescent mental health problems" (Reijneveld et al., 2014, p. 9). Noticing differences in their child may spark a parent to consider the idea that there might be something they need to look at closer. The potential movement towards receiving a diagnosis and services for a mental health issue in school and clinical settings must first begin with parent/guardian consent. Parents that are involved and advocating for support for their children can alter the care that is received.

Researchers carefully examined the relationship between behavior problems and academic difficulties and the importance of the background of students and their socio-economic status. Schools within three separate districts appeared within the research study. According to Kutash & Duchnowski (2004), one in five children have a diagnosable mental illness that interferes with some aspect of their functioning; however, only a small percentage of these children in need receive services. New strategies and approaches continue to be developed to address needs within schools. With the continuing growth and need for support, and the endless amount of children being

diagnosed, the process strategies are being refined to achieve success at a significant scale level.

There have been many different but similar studies researched and conducted covering this topic describing youths who have emotional disturbances, the consistent limitation and lack of representation of youths who reside in large metropolitan areas. According to Greenbaum, Dedrick, Friedman, Kutash, Brown, Lardieri, & Pugh (1996) students who experience emotional disturbances are described as a male in the clinical range and on measures of emotional functioning. Their intelligence scores were low average to average and roughly two years behind peers in academic achievement. They generally exhibit comorbid disorders related to conduct and oppositional disorders (Kutash & Duchnowski, 2004).

Schools that were served as primary mental health support are required under IDEIA to provide such services for students under the emotional disturbance category and qualify for services. When there is no other source for support or outside agencies, the schools rely on their staff and resources to supply them. According to Forness & Knitzer (1992), some have proposed there may be a strain on some schools to provide these services on account of the under-identification of students in this disability category (Kutash & Duchnowski, 2004).

The majority of students in the study were black males from inner cities that exhibited elevated scores on the CBCL (The Child Behavior Checklist) indicating a high level of symptomatology interfering with functioning. Also, a majority of students studied were behind the same-aged peers in both cognitive and academic functioning. The students came from families that are below the poverty level (42%), which are risk

factors that indicate they require a range of support services and should receive appropriate placement in a special education program. On average, those studied exhibited symptoms around the age of 5.4; however, they did not receive support until the age of 7. By the time they were eight years old, the average child had received outpatient counseling, and six months later, they had been placed in an inpatient psychiatric facility (Kutash & Duchnowski 2004). The study was considered a detailed report of the characteristics of children identified as having emotional disturbances by schools that serve inner-city communities.

In some extreme cases, students' behaviors impact their education so much that they are unable to attend the public/regular educational setting. The research was conducted and designed for an extreme behaviorally challenged population of students, students that would have no other choice in the area of educational settings. The two students that participated in this research had strict upbringings, and while they were receiving extensive support, they continued to fail within their special education programming. Each participant required extensive support to make gains both mentally, socially, and educationally. The study was designed to answer the question if elementary-age students could have positive outcomes in terms of return to and maintenance in public educational settings. For this reason, Butler, Boivin, & Campbell (2010) conducted a data-driven study based around two individuals both suffering from extreme cases of behavioral and emotional disorder within the private therapeutic setting.

According to Atkins, Hoagwood, Kutash, & Seidman (2010), current school-based mental health options remain overly focused on conventional definitions and provide inadequate attention to issues influencing both school and mental health issues.

How can students that exceed the definition of mental health disorder and trauma benefit from such inadequate support and practice? Two children participated in the study that included interviews, progress notes, and progress data. Data and documents were reviewed, and baseline changes included the following: quarterly review reports on goals and objectives, daily tracking, psychosocial history, clinical notes, occupational therapy and speech-language testing, psychiatric notes, educational plan progress, and review reports. Staff interviews were conducted on each participant's social worker, primary educator, psychiatrist, speech-language pathologist and supervisor to collect data and clarify any ambiguous data within the files (Butler et al., 2010). The results showed records in the following areas: improved health, medical appointments, physical activity, illness management, violent, aggressive behaviors, sexually aggressive behaviors, adaptive behavior, safety holds, communication and social skills, educational skills, and community involvement.

Overall results revealed that at the beginning of the trial research, each student appeared to exhibit overall higher levels of anxiety, refusal, and aggression. Once the study began, and programming started, many positive changes began to take place with both subject students. There were substantial changes in categories related to aggression, self-injury, and aggressive behavior in both students. Each student was able to learn valuable communication and social skills to increase communication with peers as well as advocating for themselves. Academically both students made gains in reading and math. This programming showed very beneficial results for the two subjects who were provided services in extreme circumstances (Butler et al., 2010).

Successful gains included the following tactics for each participant: constant vigilance regarding interventions, aligning the right staff in the right jobs, understanding Autism Spectrum Disorders and mental retardation, planning, and structuring the environment. The authors concluded that although the program is very new, these two students were deemed non-educable across other special education settings (Butler et al., 2010). Moreover, with careful interventions and specifically designed support, these two students were able to make these gains with such successful rates of improvement. Youth are helped one child at a time, and future work will include scientific rigor and adding formalized interviews to expand the sample and include all youth in the program (Butler et al., 2010).

According to Babyak & Koorland (2001), there needs to be a collaborative approach between multiple services to meet the complex needs of students experiencing behavioral disorders. Overall results from this study continue to demonstrate the importance of a supportive and collaborative team as well as the planning process to carry out different programming options and services for students, which many times can pose as quite a challenge within the school setting due to time constraints or lack of support.

Another factor that should be looked into when looking at environmental factors and their impact on students is that poverty is considered one of the most significant contributing factors with diagnoses of mental health disorders and the potential comorbidity of another possible diagnosis/disorder. Current Student-Based Health Centers (SBHC) are generally in rural/urban areas where families are at or below the poverty level. Considering this factor, Costello, Messer, Bird, Cohen, & Reinherz (1998),

looked deeper into the prevalence of Serious Emotional Disturbance (SED) and certain risk factors related to age, gender, race/ethnicity, and poverty. With the potential to enhance possible services in the area of mental health administration based on the public law 102-321 and Block Grant funds.

The reauthorization bill (PL 102-321) for Alcohol, Drug Abuse, and Mental Health Administration established funding for Community Mental Health Services (CMHS) through Block Grant Funds, as long as eligibility was determined. The focus of funds was towards services provided through CMHS to children with SED, which the law defined as: "...children with serious emotional disturbance...birth to age 18...currently or any time in the past year...diagnosable mental, behavioral, or emotional disorder...resulting in functional impairment…"(U.S. Government, 1993, p. 29425) (Article, p. 412). Funding for special service support would be available if all criteria were met.

Costello et al. (1998) determined specific trends that affected the prevalence of SED among youth. Across all areas measured, children over 12 years of age, showed higher rates of SED. In regard to gender, there did not seem to be much of a difference with prevalence among males and females, which was similar findings with rates related to race/ethnicity. As stated earlier results indicated considerable disproportions related to socio-economic status (SES). The prevalence of SED was two to three times more prevalent in lower-income children compared to higher-income youth. Lower SES youths also tended to receive more support. According to Costello et al. (1995), "This re-analysis of several communities based data sets indicates that we can expect between 1 child in 13 and one child in 20 to meet the Federal criteria for SED...meaning some 3 million

children and adolescents aged 4-17 would be classified as SED…”(Costello et al., 1995, p. 426). Results from this study showed one out of every four children meeting the SED criteria were receiving support based on the funding through PL 102-321, and CMHS cites. “This can be interpreted as meaning that only 700,000 of the three million children with SED across the United States are in current or recent receipt of care” (Costello et al., 1995, p. 430).

Training Staff to Support

Mental health providers have a significant role in the implementation of support and interventions within the schools when they are available; however, so do staff hired to work within the school. According to Adelman and Taylor (1998), “...all (members hired) can and should be part of efforts to address mental health and psychosocial concerns…”(Adelman and Taylor, 1998, p. 178). Training and resources should be made available to all staff, volunteers, family members, etc.to provide the proper implementation of strategies and interventions of support. According to Burns et al., (1995), a staggering 50-80% of children accessing mental health care are receiving that support within their school setting.

For this reason, Hustus & Owens (2018), conducted a study to find out whether administrators, teachers, and SMH are willing to make the changes needed to implement new services, and how the staff feels about implementing initiatives that are evidence-based in areas of mental health and behavior. The research was done to draw attention to the high statistics surrounding school-aged children that have a diagnosable mental health disorder, and how the staff that is working with these students feel in regards to being able to support them within the school setting. The study was designed to address several

limitations related to the role of readiness within schools. The questions focused on whether organizations felt prepared and trained to implement School Mental Health (SMH) initiatives within their classrooms and the readiness and willingness to change to implement new initiatives.

According to Armenakis, Harris, & Mossholder (1993), readiness for change can be defined as the cognitive precursor to the behaviors of either resistance to or support for a change effort and successful implementation. They argue that up to 50% of large-scale organizational change fails because adequate readiness has not yet been established. This study found many additional limitations and gaps in regard to readiness and the relationship to implementing such evidence-based services to support school-aged children who require mental health or behavioral support while in school. Based on these findings, the study results were then broken into three different Aims, which addressed specific limitations. Aim 1 examined readiness in schools accounting for the unique organizational structure that is present within school districts and the difference between informants and the communities. Aim 2 provided the first examination of the relationship between readiness scores and the rate of implementation and uptake of specific SMH programs. Aim 3 examined the ability of the modified COS (Change Orientation Scale) to identify the differences between schools reported levels of readiness (Hustus & Owens 2018).

The participants in this study included responses from 194 general education teachers, 47 SMH staff, and 13 building level administrators from 11 different elementary school districts in Ohio. Each participant completed the Change Orientation Scale (COS) totaling 28 questions with each item containing a Likert-type response ranging from

strongly disagree to agree strongly, and higher scores reflect greater readiness of the community being questioned (Hustus & Owens 2018). The COS measures and assesses the willingness and receptivity to change in school teachers and principals. All participants were also invited to be a part of an evidence-based classroom intervention that addresses explicitly behaviors called the Daily Report Card (DRC), which is considered a tier 2 intervention that was working towards improving academic and behavioral outcomes for elementary-aged students.

Results were then broken down according to the three Aims. Aim 1 focused on the difference between informants and communities. Results found several comparisons specifically in regards to building administration and principals' rating "principal community" more favorable than did either teachers or SMH staff. All participants rated teachers as less ready than principals, teachers were perceived as less ready than SMH staff, and both principal and SMH staff generally viewed teachers as less ready in regard to readiness, implementation, and uptake (Hustus & Owens 2018). Aim 2 focused on the relationship between readiness and intervention uptake and implementation. Results showed a positive connection with PBS (Positive Behavior Strategies) implementation but found no relationship with the use of the DRC intervention. Teacher readiness was significantly related to the implementation of PBS tools currently being used by the teacher and principal accountability to the implementation of PBS within the school. Principal readiness was correlated with the teacher use of PBS and the PBS practices, and SMH staff readiness was also associated with PBS and principals' overall accountability to PBS practices within classrooms and the school environment (Hustus & Owens 2018). Aim 3 addressed the differences between schools; however, uniformity of variance came

across as a violation, and findings indicated a significant variability among the 11 elementary schools tested.

This study resulted in promising preliminary evidence suggesting a prospective relationship between readiness and the ability to adapt and implement mental health initiatives. Using the COS would be recommended for the use of future studies with the topic of staff readiness and mental health concerns in school-aged children.

Staff willingness to educate themselves in the best practices moving forward to support mental health issues in youth is the first step. Schools need to consider the potential for moving towards school-based mental health support within buildings, an essential factor to consider would also be the training of school personnel. According to Marsh (2016), "...educators may be required to act as the first line of prevention" (Marsh, 2016, p. 319). Prevention and early intervention are the first steps when considering a plan to support an adolescent suffering from mental health issues. Classroom teachers spend the most time with the students within their school day and provide the most one-on-one support, which provides the best opportunity for observation and collecting data.

Teachers should be made aware of possible displays of externalizing behaviors that are directed outward toward a social environment and internalizing behaviors, which are more internal and directed toward the individual. Externalizing behaviors are more natural for classroom teachers to observe and may appear as aggression, difficult temperament, and behavior impulsivity. These types of behaviors are typically associated with ADHD (Attention-deficit/hyperactivity disorder), CD (Conduct Disorder), and ODD (Oppositional defiant disorder). Internalizing behaviors often can go unnoticed by adults

due to their subtle nature. Internalizing behaviors can include anxiety-related disorders and mood disorders.

Students typically receiving support through IDEIA (Individuals with Disabilities Act, 1997) related to mental health are eligible for special education services qualifying under the EBD (emotional, behavioral disorder) or OHD (other health disability) categories. According to a study by Talbott & Flemming (2003), students who exhibited more internalizing problems and comorbid mental health issues identified as LD (Learning Disability). Students identified and students un-identified can experience similar mental health issues, which are again the reason the awareness of teachers is an abundant element for getting students the proper support.

For most general education and special education teachers, the identification of these behaviors can still be an unfamiliar topic because of the lack of understanding or exposure. It can be hard for teachers to determine at times whether there is a more significant issue going on when a student may be exhibiting some defiant behaviors. The ability to understand behaviors and given the information to increase awareness will allow for better outcomes for students. Once awareness has been identified with the classroom teachers, the next step will be for teachers to understand the steps of bringing their concerns to the attention of the appropriate school team (MTSS), always keeping in mind the child as a whole.

According to Marsh (2016); "...schools are becoming the major service providers of many basic mental health treatment services, including assessment, behavior management, and specialized programs" (Marsh, 2016, p. 318). Schools are responsible for the students that reside within their care, and at this time, there are no comprehensive

reports in order to determine the extent of services for students with mental health issues. This is another reason it is imperative for educators that are the first line of support to be made aware and receive the proper training and support around what internalizing and externalizing behaviors may look like within the classroom, and what their next step is in the process for support. Being able to determine and see these signs will help educators to determine whether a student may be struggling with a mental health issue and would benefit from support.

Based on a majority of articles researched, school personnel working in classrooms are feeling under-qualified for supporting students with potential mental health needs. The mental health clinicians (MHC) currently working in buildings is something to research in current processes and feelings of readiness. Limited research has been collected in this area. Lyon, Ludwig, Knaster-Wasse, Bergstrom, Hendrix, & McCauley (2016) evaluated why and how mental health clinicians use Standardized Assessment (SA) tools within their work with children and families working within schools. SA tools are currently being used for initial assessments, measuring client outcomes, and service delivery methods. This research was designed to identify factors that could alter changes in current assessment practices within the school sector. Their study specifically looked into the results of how often mental health clinicians were using SA tools when working with youth. What factors influenced the use of SA tools and looking into the effectiveness of tools for students diagnosed with anxiety/depression.

Results from the study were similar to the school staff's feelings at times of underprepared and qualified to administer and implement specific SA tools without the proper training and support. Before receiving any training of SA tools, MHC were

inconsistent with the use of SA tools while working with youth. MHC found that the most critical factor of their SA tools within their time working with students was the routine use and consistency. Once they received the training to provide support to the youth, MHC's were 60% more likely to administer SA tools to their caseloads. Moving forward, "improving the use of routine, structured assessments in student mental health continues to hold considerable promise as a feasible target for quality improvement initiatives"(Lyon et al., 2016, p. 132). Further research into the current practices used by MHC would be beneficial as schools begin to implement SBHC and programs relating to mental health care.

Integration of Mental Health in Schools-Next Steps

As mentioned earlier in this chapter, schools currently rely on MTSS (Multi-tiered Systems of Supports) to address the needs of students in schools to prevent potential school failure. MTSS teams generally meet within their school building to discuss students that have been brought to the attention of the MTSS team usually by the classroom teacher because of academic, behavioral, emotional, or social concerns. The framework of MTSS, according to the Minnesota Department of Education's website, relies on five principles. Assessments need to monitor the progress and provide summative data about students; also, there needs to be high-quality, evidence-based instruction for students which should be happening at multiple levels. Along with core instruction within the general education curriculum that is delivered with high-fidelity, and to provide individualized supplemental (Tier 2) support for students that are not on track. Finally, use data obtained through the MTSS process to improve support and make a decision about students that may be at risk of not meeting expectations. (Minnesota

Department of Education (n.d.). The MTSS team is one way schools are currently working towards addressing specific student potential needs in the areas of academic and mental health support.

As stated earlier, student's are more likely to receive their mental health service support through their home school. According to the Carnegie Council on Adolescent Development's Task Force on Education of Young Adolescents (1989), "School systems are not responsible for meeting every need of their students; however, when the need directly affects learning, the school must meet the challenge" (Carnegie Council on Adolescent Development, 1989, p. 61). This quote was taken from a study done 30 years ago and the issue of services provided to students by schools continues to be discussed to this day. Students today are showing a need that interferes and affects their ability to learn.

According to Adelman and Taylor (1998), schools limit services to those that need it most because of the scarce resources; instead, they may provide fewer interventions to more students to serve a more substantial proportion of the student body. Students that have higher needs are not receiving adequate support based on the lack of resources available to schools. Resources could include but are not limited to curriculum, training, staff, support, and tools. Funding and policy changes for schools are huge contributing factors in what kind of support and amount of support students can receive. A change in policy is needed to make the mental health well-being of students the focus. Schools prioritize improving instruction and classroom management despite the growing barriers, all are contributing factors in the success of a school day to day running. Until the outside barriers are addressed learning will have a hard time moving forward.

Some schools have begun to implement some therapeutic/school-based centers within the US, according to the Health Resource & Service Administration, there are roughly 2,000 centers nationwide following the school-based health center approach. In Minnesota, there are 25 total Health Centers located in Hennepin County (15), Ramsey County (9), and Olmsted County (1), housed within the high school or transition centers.

Previous research was conducted regarding school-based health centers by researchers Bains & Diallo (2016). Their purpose was to find out the benefits from schools that were already implementing some school-based mental health center support and services within schools. Their findings were quite impressed with the amount of youth utilizing the services in elementary, middle, and high school settings. Mental health programming within schools is greatly affected nationally due to budget cuts within districts. Based on statistics from 2011, the most costly medical expenses among children was directly related to mental health conditions with a staggering $13.8 billion, with a mean average of $2,465 per child in the US. Based on these statistics alone partnerships between schools, community resources, and mental health services should be on the rise (Bains & Diaollo, 2016).

According to Bains & Diaollo (2016), “SBHC’s (School-Based Health Centers) provide comprehensive health care within schools and can promote partnerships with other community health care providers to overcome barriers to mental health care” (Bains & Diaollo, 2016, p. 9). Not only are schools that implement such programs provided with mental health services, but the centers are also able to provide comprehensive health care to those that may not be able to access it otherwise. Of the schools researched within the study, over 55% of the centers were located in urban low-income areas where the

population of students was far below the national poverty level. Services within current SBHC's include: crisis intervention, comprehensive individual evaluation and treatment, case management, behavior and learning support, substance abuse counseling, management of behavioral medications, peer mediation, prescriptions, and more.

Results from the research done by Bains & Diaollo (2016) found that depression was the highest reason for youth visiting the SBHC's. In one high school providing services, suicidal ideation was paired with depression in 80% of all cases. Students that were prone to visit the clinic more often had higher rates of lower academic achievement. Students that used services provided within the SBHC had steeper increases to their GPA compared to non-users within the school. Data collected showed that youth valued the services that the SBHC provided and found it easier to visit the centers within their school day compared to having to find the time outside of their school day. Most admitted that they probably would not have sought out assistance had the services not been available through the SBHC. The success of SBHC's services within schools also relies heavily on the willingness of the student, and also the collaboration with the team supporting and surrounding the individual student such as parents, guardians, school staff, mental health staff, and community providers. Support provided by SBHC within schools may be one of several approaches to providing children and adolescents with the foundation they require to access their full potential and to become productive members of their society.

Swick & Powers (2018) conducted additional research, around a different approach to implementing support within the schools that was formed through a school-community partnership, called the school based support (SBS) program. SBS was

initially started as a one-year trial partnering in a Southeastern school district in the US, a university, and the Local Mental Health Management Entity (LME).

The SBS program was designed to overcome obstacles that adolescents were experiencing in regard to mental health and behavioral challenges. Untreated mental health problems can lead to several current and future problems related to emotional, academic, social, physical, and behavioral issues. Swick & Powers (2018) looked into barriers that can affect whether an individual will receive mental health treatment. Such barriers included: family ability to access treatment based on time, location of services and transportation, cost, the stigma around mental health challenges, and previous negative experiences with mental health services. Because of these barriers individuals may experience, the emphasis of providing those services within a school was considered the best possible option as a primary treatment for youth.

The SBS program was designed with an SBHC program. The difference and goals of the SBS program are: "...to (a) increase the capacity of elementary schools to recognize and meet the needs of students with mental health issues that threaten their school success; and (b) to improve the academic and social/behavioral outcomes for children with mental health needs" (Swick & Powers, 2018, p. 135). Researchers have found that partnerships between schools and community mental health agencies have been the most effective approach to meeting such needs. SBS program success depends upon a strong partnership with the school district and the surrounding community. Students that met the eligibility of the SBS services through referrals were eligible for services based on their needs. Services were in the areas of individual and small-group counseling, in-home visits, classroom observations, staff consultation, behavioral plans,

and individual education plans, tutoring and mentoring, and referrals to outside agencies for more intensive support. All services provided through SBS programming were 100% free to students and families.

Before SBS programs began, referrals for special education occurred at an alarming rate because ~~of~~ the lack of resources available to classroom teachers at the time resulted in students being unable to qualify for special education support based on mental health needs alone. The SBS program implemented SBS teams within schools to support classroom teachers and possible intervention ideas. The teams were similar to current MTSS teams, however, they included a full-time mental health professional and a parent liaison along with the school psychologist and school staff.

The study concluded with results from the use of the SBS trial after a one-year time frame. SBS support was proven to be useful in the area of academic gains, especially with youth who had previously met special education criteria, however only slight gains on social/behavioral goals. Moving forward Swick & Powers (2018) believe there are many different kinds of programming options available where the partnership between school districts and communities can form despite the limited resources that may be available. Specifically, partnerships that could include comprehensive mental health services to address children's mental health needs.

Partnerships between mental health sectors and educational sectors are a commonality between many studies. Organizations like the National Institute of Mental Health's (NIMH's) primary purpose is to develop systems for children and to combine the information about mental health service needs and the use in agencies that provide services like schools. For this reason, Burns, Costello, Angold, Tweek, Stangl, Farmer, &

Erkanli (1995) conducted a study to measure the roles of human service sectors and their association in providing mental health services to children. Their study consisted of annual interviews amongst families involved to collect ongoing data for one year. Service sectors discussed within this study included: mental health facilities, education sectors, health sectors, child welfare system, and juvenile justice systems. The purpose was to identify children and their families receiving support and find out if there were any trends in support.

The study results were then broken into three categories: demographic factors, clinical status/service usage, and service provision by multiple sectors. Demographics played a pretty substantial role, being male and living in poverty was the main predictor for mental health service support across all sectors, amongst the 20.3% who were diagnosed. Of 20.3%, the most common disorder diagnosed was anxiety (5.7%), followed by tic disorders (4.2%), and conduct disorders (3.3%). Children that were living in rural/urban areas were more likely to use services that were provided by any sector. Those children that were below the poverty line were more likely to reach out and utilize specialty mental health support over families that were at or above the poverty line. Clinical status and service use results revealed a small percentage of undiagnosed children (1.6%) using specialty mental health services, compared to 21.6% that had a diagnosable disorder based on the DSM-III-R along with an impairment (educational, functional, etc.). Children that were considered “severe” used 40% of the services provided. Service provision by multiple sectors showed, “Between 70 and 80 percent of children who received services for a mental health problem were seen by providers working within the education sector (mostly guidance counselors and school

psychologists). For the majority of children who received any mental health care, the education sector was the sole source of care"(Burns et al., 1995, p. 152). General health care systems were rarely used for mental health care services, and the welfare and juvenile system provided support for very few amounts of youth identified as seriously emotionally disturbed.

Considering the results from research Burns et al., (1995), there needs to be drastic organizational changes within schools and education. Questions about school personnel limited mental health experts should be taken into consideration to respond appropriately to the needs of emotionally and behaviorally disturbed children attending their schools. Improvements between schools and mental health centers need to be considered and the need for an increase in nationwide school-based mental health services where children can receive support from the convenience of their school. Advocates for mental health have pursued federal legislation in hopes of strengthening school-based services for the entire school population as well as approaching the idea that Medicaid or other demonstration projects could potentially pay school-based services.

As schools potentially move toward becoming community mental health centers with a mission to educate and provide development related to social and emotional functioning, the plan should develop with careful consideration to individual needs. Interest continues to support additional programming to provide more support to schools, students, and their families. SBHC was established initially as a means to begin this process; however, as Repie (2005) researched, most have failed to become fully integrated within their communities leading to the continued growth of deficiencies in school-based mental health support. The purpose of the study was to survey school

personnel (special education teachers, school counselors, school psychologists, and classroom teachers) on presenting problems of students, their available mental health services, and mental health services within schools.

Development of such programming and support for schools is a collaborative puzzle with many different pieces involved: communities, mental health agencies, schools and their districts, families, and consideration of funding sources. Schools-based programs generally grow out of community support (Repie, 2005). Even though the demand for supporting mental health services within schools may be present, the actual process of developing and designing a program may be harder to support based on funding, stigma, denial,

confidentiality, and a lack of knowledge. Findings from the results of the survey showed some disparities among the respondents and their feelings about current mental health support within their schools. More specifically, a majority of respondents felt that schools were ineffective in meeting the mental health needs of the students supported. As stated by Repie (2005), "Mental health care is expensive and often immediately (shows signs of) visible benefits. It is therefore easy to give in to the numerous barriers toward receiving help or to justify ignoring the need for help" (Repie, 2005, p. 296). Barriers that continue to affect effective mental health care could include the inadequacy of treatment resources available and inadequate insurance coverage for specific treatment options (Romer & McIntosh, 2019).

Additional support is needed in the identification of students and treatment for students in the schools, according to Romer & McIntosh (2019) who interviewed mental health professionals working within schools, "...roughly half of the mental health

professionals (47%) said that having more mental health professionals is one of the top ways that mental health services in schools could be improved" (Romer & McIntosh, 2019, p. 34). Interviewees felt their abilities at work were very limited due to time constraints and feeling "...hampered because of a lack of available support resources" (Romer & McIntosh, 2019, p. 34). Mental health professionals serve as the early identification and referral for mental health care within schools and could be in the best position to support and train school staff in the buildings to create and promote mental health (Romer & McIntosh, 2019).

According to Repie (2005), moving forward will require a shift with school systems and what services staff should be facilitating. Schools need to address problems faced by youth and the resources that should be made available to best support and assist them through their journey. Development of future programming needs to consider the positive mental health and mental health problems of students, their families, and school staff. "These services need to be presented separately, but may be integrated as part of a holistic, comprehensive, and multi-faceted continuum of programs and services schools need to enable effective learning and teaching" (Repie, 2005, p. 296). Moving towards the possibility of making services more readily available will be the most effective way to impact the outcomes of students and their families positively.

CHAPTER III: Summary and Conclusions

Summary of Results

Based on the results from a majority of the articles researched, providing mental health support for students within the school setting as a part of a student's regular school day is the best way to get the essential needs met. When students require services, the school has become the primary provider in the majority of cases researched. Services provided within the school environment are the best way for students struggling with a mental health condition to make gains towards graduation. The earlier the intervention and possible programming is started, the more favorable overall outcomes.

Many articles frequently brought up some of the current struggles impacting the delivery of school support: funds, proper training of staff, stigma related to mental health, and access to tools for assessments. It would take planning and resources; however, the benefits would out way the costs for not providing such services to the current and future generations. Unmet mental health conditions increase the risk of school failure, drug and alcohol abuse, truancy, and many more severe risks. Services provided may include: diagnosis/assessment, behavioral management/strategies, medication management, disorder education, social skills, functional skills support, and so much more.

Undiagnosed and untreated mental health conditions can significantly affect a child's ability to learn, grow, and develop. Based on data and statistics, schools should be moving towards school-based support programs accessible to all in need to support the needs that are currently in the schools; however, it is not just something that schools can approach lightly. Articles had positive and negative results from current school-based health centers currently running within the US. Districts must consider their needs and

move forward with proper implementation and creation for what the best fit is for their current and future student populations.

The current method of supporting students that most schools use is the MTSS (Multi-Tiered System of Support) which is an excellent way of starting the process and making sure students who need extra support are identified. Once the process is complete there seems to still be some confusion as to what to do next with mental health problems and how to best address and support within the school system. Alternatively, who in the school should be providing the support? Generally, school psychologists and social workers within the building are the primary providers, along with school counselors and special education teachers.

Speaking as an educator working in a building with a full-time school advocate (social worker) and part-time school psychologist, we have found that it takes a collaborative team to develop and implement a plan for just one student. Based on the statistics of 1 in 5 adolescents having a mental health disorder diagnosis from NAMI (National Alliance of Mental Health (n.d.), in a class of 25, there is the potential for 5 of those children minimum suffering from a mental health disorder. Mental health within schools is an issue that should be at the top of the legislative and school policy agendas. The school this educator works for, along with many other schools, implements a responsive classroom approach.

A responsive classroom is a student-centered approach that combines social and emotional aspects with academics (Responsive Classroom, n.d.). Responsive classes pay attention to four specific domains engaging academics, positive community, effective management (take a break, buddy room, etc.), and developmentally responsive teaching.

There has never been this large of a focus on self-regulation and behavior management within schools before. These kinds of approaches are ways for schools to work towards the beginning stages of therapeutic typesetting within the classroom. Therapeutic typesetting is the direction schools, and legislative should be moving towards no matter what the cost.

One Approach within Minnesota

Intermediate District 287's North Education Center in New Hope, Minnesota Superintendent Sandra Lewandowski worked with a team to develop a therapeutic teaching model to blend services between educational learning targets the needs of students with mental health issues. According to Sandra Lewanski, "The time for mental health and education working in separate silos is passed. We need to increase access. We need to blend our services. We need to work together...legislators need to understand the profound impact of childhood trauma. It is probably the biggest public health crisis we have in this country" (Hinrich's 2018). This district and model can provide services to children with some of the greatest social-emotional needs and learning disabilities that come from neighboring districts. Without this education center, these children may not have had anywhere to go for schooling. Classrooms typically consist of a classroom teacher and a full-time therapist within the rooms.

At this time the model is used with a program size of 10 elementary (K-3) aged students who have experienced complex trauma. They hope to support self-regulation skills and decreasing overall safety concerns so students can enjoy their school day. Services provided within the school day include individual/family therapy, self-regulation support, resource navigator support for families within the comfort and convenience of

their school. If there was not a building like this, the current children attending this program might not have access to schooling. This approach is providing a successful school experience for kids who may not have had the same outcome in a regular school.

Limitations with Study

Based on a majority of the articles researched, various limitations ~~that~~ hindered findings. Common examples of restrictions related to the time frame of analysis, ages of participants, and length of studies. Sample sizes were also a significant restriction within most studies researched because there were too many of a certain age or demographic and not enough of another sampling. In other articles, some of the interventions implemented could be difficult to perform in a larger school setting, because of the amount of intensive one-on-one support.

Another possible limitation of this research study could be the background of the researcher. As an educator working in my current school district, I see first hand the effects of students who are not receiving the support they require. They are not only hindering their own educational experiences but, at times, the peers around them. I have seen families refuse to take children to outside agencies for further support when our school has not been able to address the need at hand. Financial obligations and responsibilities are the main reason. Families should not have to make such a difficult decision. My views are very one-sided on this issue, schools should be providing these services. Because of my views, I do feel there needs to be a drastic change in what districts see as priorities. I understand test scores and curriculum in some instances can be quite valuable; however, when kids are noticeably struggling behaviorally and emotionally, then there should be changes made.

Future Research

Future research with more extended time frames would be beneficial to see. Specifically, results of trialed methods for improvements to mental health problems paying specific attention to interventions provided within younger students and following their growth over the years with support within the school. This data would give a clear direction to move to support mental health needs.

It is clear from this research that there needs to be additional support. An increase in the implementation and collaboration with mental health professionals should be the first trial involving extensive research. Practitioners need to be a part of the schools' curriculum and planning to support having mental health housed within schools. There is a need for future research over a long period with extensive data collected defining positive and negative effects for improvement. It will take more than one approach for legislature moving forward at this time to change the way students receive mental health support within schools. I believe our state is going to be trying to catch-up with this epidemic as more and more adolescents become diagnosed and affected with mental health issues. Experiencing mental health problems is more common for adolescents nowadays than it has ever been. The need for action is now. Schools are to provide students the opportunity to become their best selves so they may succeed once they are out in the real world. Legislature must continue to research and determine the benefits of mental health embedded support and curriculum in the schools, and make sure all students who are in need have access.

Conclusion and Implications for Future Research

In conclusion, schools need an upgrade for mental health support provided within the school day. Adolescents all around are having negative school experiences consisting of academic failure as a result of unmet needs regarding mental health. Schools need to develop a more appropriate way of providing consistency with services and supports. This writer would love to take part in further approaches and studies in the area.

Identification of students through the MTSS team-seems to be the universal approach developed as a state-wide initiative; however, what to do once the diagnosis is made is an area that needs more attention. More specifically, the development of a curriculum for specific disorders and individualized plans for meeting the student's specific needs could be one step moving forward.

Adequate staffing available in buildings is another area that should be developed and made as a requirement within districts and buildings. Each school needs, at a minimum, a full-time employee who is strictly for providing in-school mental health support services and education to students who meet the criteria. There have been studies done on the needs of children, the positive benefits for meeting those needs, and their long term effects. Schools have a responsibility to provide education to develop academic behaviors further, but the case can be made at this time that their responsibility is also to develop students into their best potential selves with success in social, emotional, and physical mindsets.

School districts provide separate settings based on special educational needs so that students have access to education; however, before obtaining any of these services a student must first qualify for special education under one of the disability categories

(SLD, DCD, ASD, OHD, and EBD). For our students who have more mental health disorder characteristics based on the research, students are generally identified under the EBD or SLD category. As an educator, I have to wonder if there needs to be an additional qualifying category for mental health disorder or MHD. I believe as the need continues to rise, we need to make sure we train and develop upcoming educators in mental health disorders. Additionally, we should provide in-school support that would make a huge difference, and could quite possibly change the approach to providing services. On the other hand, would that mean more and more students would meet the criteria for special education services? Is that the direction schools would like to move?

Behavior management in the classroom has always been something that teachers have been working to increase. This educator remembers the elementary classroom and having a classroom incentive (marble jar) that we as a class would get so excited about. If one student made us lose our marbles, we would be crushed. Schools have continued to work on this approach and strategized different models of supporting students' success with behaviors in the classroom. There should not be a price on the health and well being of our children.

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