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Development and Implementation of a Comprehensive School-Based Mental Health Program

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Development and Implementation of a Comprehensive School-Based Mental Health Program

by

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A Project submitted in partial satisfaction of
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Each person whose signature appears below certifies that this doctoral project in her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Marital and Family Therapy

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ABBREVIATIONS

CBT	Cognitive Behavioral Therapy
CDC	Centers for Disease Control and Prevention
SBMH	School-Based Mental Health

ABSTRACT OF THE DOCTORAL PROJECT

Development and Implementation of a Comprehensive
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by

Melissa Harris

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Department of Counseling and Family Sciences
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Dr. Winetta Oloo, Chairperson

The existing literature on youth experiencing challenges with mental health problems throughout their educational journey is growing. These challenges may result in children displaying a lack of social interaction, emotional and behavioral problems. The purpose of this project is to develop and implement a school-based mental program for preschool-aged children who are experiencing these challenges. The program will be designed by obtaining feedback from stakeholders within the school district. The participants will be male and female, between the ages of 4 and 5 years within Loma Linda, CA. The program involves the use of doctoral and master's level marriage and family therapist students and professional clinical counselor trainees under clinical supervision by licensed MFTs at LLU.

CHAPTER ONE

PROBLEM STATEMENT

There are many studies conducted on behavioral, emotional, and social issues and its effects on school-age children. According to the Centers for Disease Control and Prevention (CDC) 2019 report, mental, behavioral, and developmental disorders begin in early childhood. 1 in 6 U.S. children aged 2–8 years (17.4%) had a diagnosed mental, behavioral, or developmental disorder and discovered behavior problems were more common among children aged 6–11 years than younger or older children (CDC, 2019). Experts recommended behavioral health therapy as the best treatment option to help manage mental health illness.

A study conducted by Barkauskien & Bieliauskaite (2002) found that children had significantly more internal (somatic complaints, isolation, anxiety, and depression) and external (aggression and delinquency) as well as attention and social problems. Furthermore, school-age children tend to demonstrate internal and external difficulties based on undiagnosed mental health problems. In contrast, children may develop internalizing behavior problems such as being withdrawn, anxious, inhibited, and depressed behaviors, problems that more centrally affect the child's internal psychological environment rather than the external world (Campbell, Shaw, & Gilliom, 2000; Eisenberg et al., 2001). The construct of externalizing behavior problems refers to a grouping of behavior problems that are manifested in children's outward behavior and reflect the child negatively acting on the external environment (Campbell, Shaw, & Gilliom, 2000; Eisenberg et al., 2001).

These problems may lead to long-term social, emotional, behavioral problems and

overall distress. Over time, these problems can affect the child's ability to function effectively among their peers, adults, and within society. As such, mental health problems are a major concern and can become a nationwide crisis if the child's needs are not addressed.

Impacts of Insufficient Mental Health Care

The impacts of poor mental health often start during early childhood development. It can follow the child during their education journey and create challenges throughout their daily life. Children with mental health problems can experience serious challenges. The problems may include but are not limited to: struggles with social interactions, problematic relationships, learning delays, behavioral problems, and substantial distress. Consequently, mental disorders in childhood can negatively affect healthy development by interfering with children's ability to achieve social, emotional, cognitive, and academic milestones and to function in daily settings (Ghandour, Sherman, Vladutiu, Ali, Lynch, Bitsko, and Blumberg, 2018).

The consequences of insufficient mental health services have been chronicled for decades and can be seen in the form of poor educational attainment, juvenile delinquency, compromised physical health, substance abuse, underemployment, and ultimately premature mortality (Brooks, Harris, Thrall & Woods, 2002; Cicchetti & Rogosch, 2002; Halfon & Newacheck, 1999). Specifically, students who have been determined susceptible to having an emotional or behavioral disorder perform in the lowest quartile academically on standardized tests, and high school dropout approaches 50% (Frey & George-Nichols, 2003; Osher, Morrison, & Baily, 2003). Substance abuse

and criminality are widespread, with a 50% arrest rate among students with social, emotional, and behavioral problems. Suicide is the tenth leading cause of death in the the USA, yet it is the second leading cause of death for youth between the ages of 10 and 24 (CDC, 2015). Consideration of these statistics enhanced the focus of mental health awareness, interventions, and school-based program delivery to address students' needs.

Integrating Mental Health Services in School Settings

Seeking mental health services can be challenging to some families due to poverty, location, insurance coverage, and availability. However, children spend most of their day in school which makes school-based programs logical and convenient access for the students. School-based services provide an opportunity to integrate mental health awareness, resiliency within the educational curriculum, and access to early mental health intervention and treatment. This allows the students to obtain better outcomes, and more efficient and coordinated care while attending school. This process is most effective based on the student's familiar environment, feelings of safety, lack of transportation concerns, and working with a trustworthy professional.

Providing mental health services in schools is beneficial, and even necessary, to provide students (1) a safe learning and social environment, (2) an opportunity to grow and develop socially and academically, and (3) access to mental health services for some children who would otherwise not receive it (Shepard, Shahidullah & Carlson, 2013). The integration of a mental health program into an educational setting provides multitiered support for students. Several studies document evidence of strong positive associations between school mental health services, access to care, and academic success.

School mental health services, when done well, are associated with strong satisfaction by diverse groups Nabors, Reynolds & Weist, 2000). Furthermore, they are associated with improvement in student emotional and behavioral outcomes (e.g. symptom reduction, decreased disciplinary referrals, increased pro-social behavior, improved attendance, enhanced engagement), positive family and school outcomes (school climate, reducing bullying, decreased special education referrals) (Nabors, Reynolds & Weist, 2000).

The Current State of the Problem

The aforementioned research offers consistent and compelling evidence that the mental health needs of our population are not being met and that educators are increasingly recognizing the need for school-based mental health services (SBMHS). (Kern, Mathur, Albrecht, Poland, Rozalski and Skiba, 2017). For instance, a CDC study examined mental health challenges throughout the United States school districts during 2014–2018. The data indicated behavioral, emotional, and social impairments within school-age children. The impairments were described as serious challenges that can interfere with the child's overall health and relationships throughout their life. The data recognized few school-age children and youth receive services that could prevent or reduce the symptoms associated with the most prevalent disorders and impairments.

The data explained, that even though school-based mental health services are commonly available within a school setting, services are rarely utilized or accommodate the student's needs. Students and parents are uneducated on the importance of mental health services, therefore the program engagement becomes inconsistent and noneffective. Besides this, most students attend one to two sessions, the program ends

prematurely, or the students are referred out with no follow-up. Consequently, the school-based service reviews were commonly defined as poor quality of care which resulted in the students consulting with their peers and implementing learned behavior.

The data identifies that mental health problems start during early childhood. Therefore, implementing early preventive interventions need to be established as an important component of school-based care. It is evident, that the early onset of mental health problems in children is treatable (citation), however, most students do not receive treatment due to barriers (citation). The barriers include mental health stigma, cultural barriers, familial socioeconomic status, and financial problems. Most people hesitate to address mental health needs and suffer through their problems or believe their problems would get better over time. However, when mental health problems are left untreated, they can create greater risk and impact the student's behavior, emotions, and social interactions. As a result, lack of care can cause mental health problems to progress into severe problems across many areas of a child's life.

It would appear that the provision of support for students struggling with behavioral, emotional, and social problems relies upon having access to mental health services, addressing mental health challenges, and creating a strategic plan to assist and meet the student's needs. The plan entails eliminating the barriers, improving program quality, program accessibility, identifying effective interventions, family involvement, and implementing mental health awareness. The ideal strategy will close the gap by identifying early interventions to prevent the onset of the symptoms.

It is imperative to improve the efforts related to early recognition and mental health needs in children. This provides awareness of early warning signs to properly assist the student. (Stagman Cooper, 2010). Maintaining mental health awareness is critical and encompasses social, emotional, and behavioral aspects to help cope

with life’s challenges.

This is a program development project structured to address mental health needs. This project is designed as an ongoing program development with an evaluation component for elementary-aged students struggling with behavioral, emotional, and social problems. The program's goal is to decrease the impact of early onset of mental illness and decrease problematic challenges for these students. To assess the potential of the program’s effectiveness and weaknesses, seven stakeholders provide feedback. Three stakeholders are school district officials, another is a school superintendent, and the remaining four are school psychologists. The stakeholders will complete one-on-one interviews with the program coordinator and complete surveys to share their feedback.

CHAPTER TWO

LITERATURE REVIEW

To assess the effectiveness of mental health programs in a school setting a review of the literature and historical background were utilized in this project. The literature review will examine the need to implement mental health services and discuss the effectiveness of the program for students experiencing difficulties with social interaction, emotional, and behavioral problems.

Early Intervention

Given that the majority of youth spend a substantial amount of time within a school setting, they have become a natural venue for mental health programs. Schools identified mental health needs and became a necessity to integrate care. By incorporating on-site services, schools provided consistent access to the relevance of services, which addresses the youth's mental health needs and created a support system in the school setting.

A body of robust evidence shows school-based programs as an early intervention. It has a significant impact on child development and later life outcomes (O'Neill, 2009). Early intervention is recognized as a crucial element in reducing the onset of behavior problems and risk factors that often start in early childhood (O'Neill, 2009) and addresses the importance of adding school-based programs to decrease the risk factors. O'Neill (2009) notes that early childhood interventions, particularly at the preschool level, have proven effective in overcoming long-term disadvantages. It is estimated that students with disabilities who receive services early for mental health issues have the lowest rates

of problematic outcomes and the highest levels of positive school-related outcomes (Cumming, 2018). It also views, school settings as a structured environment to facilitate early identification, prevention, and intervention to prevent escalation of mental health issues in a timely manner (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011).

A study conducted by Dery, Toupin, Pauze, Verlaan (2004) explained the importance of applying school-based mental health as an early intervention. It showed how the problem was structured to identify and treat early-onset mental health problems to help the youth transition through life. The study found school-aged children, displaying disruptive behavior disorders were due to undiagnosed learning disabilities and behavioral problems. The research study identified school-aged children were suffering from mental health issues such as trauma, depression, generalized anxiety disorder, ADHD, and ODD. However, children who experienced trauma display similar symptoms that can be confused with symptoms of other common childhood mental health conditions such as "inability to concentrate, and lashing out verbally and physically" within the classroom setting (Sitler, 2008, p.120). By offering school-based programs, the children's behavioral problems decreased dramatically based on a unique the advantage to help engage youth and treat their mental health needs at the same time.

Development of School-Based Mental Health

School-based services were developed during the early part of the 20th century as a response to a majority of youth who failed to receive adequate treatment and an increased group of baby boomers. School officials placed over 45,000 nurses in the schools to focus on health services. The general services focused primarily on

immunizations, vision, and hearing screening. The American Medical Association and the United States (U.S.) Office of Technology Assessment reported positive impacts for school health services, however, the reports acknowledged untreated psychological and educational concerns among the youth.

The American Medical Association reported several factors that influenced the initiation to implement mental health services within a school setting. In some areas, these services have augmented existing health services and in other areas, mental health programs have predated the implementation of comprehensive health services. These factors include: 1) rising rates of problems associated with risk-taking such as teen pregnancy, sexually transmitted diseases (including HIV infection), and drug and alcohol abuse (Bambara, L., & Kern, L. (Eds.). (2005) increasing levels of adolescent suicide (the the second leading cause of death for teenagers) and homicide (the leading cause of death for black males between the ages of 15 to 24) (Puskar, Lamb, & Norton, 1990); and 3) drop-out rates that approach 80% in some urban areas (Rhodes & Jason, 1988). Widespread concerns and recognition to implement mental health services become a necessity to address the challenges and problems the youth endured.

According to the United States (U.S.) Office of Technology Assessment (OTA) (1986) stated that the most conservative estimate is that 7.5 million out of 63 million children need mental health services; half of these, about 3 million, are thought to present serious disturbance. The OTA estimated that of the above numbers, only two million children a year received mental health treatment, reporting: "The majority of children with mental health problems fail to receive appropriate treatment. OTA stated many of the six to eight million children in our nation who need

mental health interventions receive no care; other children, perhaps 50 percent of those in need of treatment, receive care that is inappropriate for their situation." statistics from the OTA (1991-1995) indicates that 12% to 15% of adolescents present emotional/behavioral problems at levels warranting intervention, but less than one-third of these youth actually receive mental health services. Given the greater emphasis on elementary-aged children, more recent statistics show nearly 78.1% with depression, 59.3% with anxiety, and 53.5% with behavior disorders have received treatment to manage their mental health needs (CDC, 2019).

The OTA assessment completed in 1994-1995 identified a need for mental health due to multiple stressors, the youth endured. They experienced problems related to their family dynamics, conflicts with their peers, and academic failures. These stressors created psychological harm within the youth's school environment and household dynamics. As the youth tried to cope with their problems the underlying signs of mental the illness started to emerge. The youth started experiencing symptoms related to depression, anxiety, behavioral problems, and emotional disturbances. These symptoms caused the youth to have difficulties learning and display an inability to thrive due to a lack of mental health care. Addressing the need and raising awareness became an important a component within the school system. The awareness created an urgency to address the mental health concerns provided a considerable boost to the development of school-based mental health services.

Legal mandates have also served to encourage the development of school-based mental health services. For example, Public Law 94-142, the Education for All Handicapped Children Act of 1975, states that each school system must provide an

appropriate educational program for all handicapped children in the least restrictive setting possible. This law strengthened the obligation of schools to provide appropriate educational services to children with emotional problems, leading to expanded mental health services for youth in special education (Thomas & Texidor, 1987). This led school officials to partner with medical and mental health systems. The services were offered by the community and students to provide easy access to the youth. General mental health concerns initiated the grounds to implement more community and school-based services.

Community and School-Based Programs

In 1994, the Secondary and Elementary Education Act funded school-based programs to assist at-risk youth. The program interventions consist of two categories with different concepts, such as community-based and school-based programs. Community-based programs are known for their major advantages. It is a program where facilitators and youth meet within the community to engage in social, recreational, and emotional support. The program provides an opportunity for youth to interact with peers within their neighboring area, offering local student integrations and community immersion. School-based programs are known for not producing relationships with the same type of closeness as community-based mentoring programs. However, they are known for providing structure and guidance for at-risk youth. School-based programs consist of school personnel meeting with the youth within a school setting to address their mental health needs. These programs allow the youth to work on social interaction, behavioral problems, and emotional difficulties.

In the operation of school-based services, mental health was adapted to address the increasing number of students struggling with psychological, behavioral, and emotional problems. In 1995, the School Mental Health Project of the University of California at Los Angeles was one of the first to create a program to include many aspects of mental health problems and treatment. The program address psychoeducational problems to increase the likelihood of students' success in school. All registered students were provided full access to the school-based services. The program contains seven components: 1) Psychological and psychiatric evaluation and consultation 2) Individual therapy 3) Group therapy 4) Substance and Alcohol abuse counseling 5) A volunteer who worked one-on-one with the students for three to five hours per week 6) Support groups conducted with the parents to address the student's needs 7) Discussions held with the teachers to help engage the students. These preventive services were formatted as a class presentation or group session to discuss relatable issues. However, due to increased costs and budget cuts, the programs were dissolved in 2000, and the youth experiencing emotional and behavioral health problems were placed in a limited access treatment forum.

School-Based Mental Health Program Evaluations

As of 2019, only a few school-based program evaluations have been conducted. These evaluations were conducted in rural and urban areas to address limited access to mental health resources. They found major impacts on school-related issues such as decreasing behavioral referrals and improvement in social and emotional regulations. The charts below show evaluations provided from research data and supported evidence from

multiple program evaluators.

The following section will provide a brief overview of the most recent school-based mental program (SBMH) evaluation results. The overview will highlight the participant's age, intensity (degree of participant need), duration of the program, type of program and type of clinician.

School	At Risk	Age	Intensity (degree of participant need)	Duration	Program	Clinician
Clark Elementary	Minority, Behavior	4-11	High	12 month	SBMH	Mental health specialists
Magnolia Elementary	Minority, Behavior	4-11	High	10-12 months	SBMH	Mental health specialists
Carter Elementary	Minority, Behavior	4-11	High	16 months	SBMH	Mental health specialists
Arcata Elementary	Minority, Behavior	4-11	High	10-12 months	SBMH	Mental health specialists

Figure 1. Garmy Evalation ***SBMH: School-Based Mental Health**

Garmy (2015) evaluated a secondary prevention model of school-based mental health programs within a rural area. The schools were chosen based on the student-teacher evaluation and much-needed support the school district was unable to provide. The participants consist of 520 at-risk students in kindergarten – fifth grades. The

evaluation focused on the student's daily interactions and rated their behavior throughout the school period. The students received a reward every time they demonstrated positive behavior. The evaluation identified program effectiveness based on the interventions applied to decrease negative behavior. The results showed the students displayed antisocial behavior and implied cultural factors that influence the student's behavior. The students were referred to seek mental health treatment. However, no further follow-up on their treatment was revealed.

School	At Risk	Age	Intensity	Duration	Program	Clinician
Kipp Elementary	Poverty, Minority, Academics, Behavior	4-12	High	10-12 months	SBMH	Parent Volunteer
Nixon Elementary	Poverty, Minority, Academics, Behavior	4-12	High	6-12 months	SBMH	Parent Volunteer
Hays Elementary	Poverty, Minority, Academics, Behavior	4-12	High	12 months	SBMH	Parent Volunteer
Woodside Elementary	Poverty, Minority, Academics, Behavior	4-12	High	10-12 months	SBMH	Parent Volunteer

Figure 2. Nabors & Reynolds Evaluation ***SBMH: School-Based Mental Health**

Nabors & Reynolds (2012) evaluated a secondary school-based mental health program. The school was chosen based on multiple complaints the district received regarding the students' behavior. A total of 330 students in kindergarten – to sixth grade participated in the program. The instructors were volunteers who met with the students

after school. The students learned how to decrease problematic behavior and ways to form positive relationships among their peers and adults. The program evaluation determined positive outcomes for reiterating positive behavior. The findings identified concrete impacts for students who lacked family support and resources. The program emphasized building trust, and personal development, and decreasing behavioral and emotional problems. However, the results implied a high need for continuous and long-term mental health services within the school setting. However, the program was dissolved due to la ack of funding and no referrals were completed for the students to receive outside mental health services.

School	At Risk	Age	Intensity	Duration	Program	Clinician
Weaver Elementary	Academics, Behavior	4-12	High	10 months	SBMH	Mental Health therapist
Lee Elementary	Academics, Behavior	4-12	High	12 months	SBMH	Mental Health therapist
Palm Crest Elementary	Academics, Behavior	4-12	High	12 months	SBMH	Mental Health therapist
Pacific Elementary	Academics, Behavior	4-12	High	12 months	SBMH	Mental Health therapist
Vista Grande Elementary	Academics, Behavior	4-12	High	10 months	SBMH	Mental Health therapist

Figure 3. Kang-Yi, Mandell, & Hadley ***SBMH: School-Based Mental Health**

Kang-Yi, Mandell, & Hadley (2013) evaluated a school-based mentoring program within an elementary school. The evaluation consists of 400 at-risk student participants ranging from kindergarten – to sixth grade. The program identified the student's daily routine was interrupted by attending the mental health program. The students met on campus with designated teachers and mental health specialists. The program implemented evidence-based interventions to demonstrate positive interaction and address academic needs. The program was successful due to consistent participation and a decrease in disruptive behavior. However, the program was unable to continue due to limited funding. The evaluation suggested for the students be referred for mental health treatment. Although, follow-up was not completed once the students obtained the referral for mental health services.

Findings from multiple evaluations of school-based mental health programs indicate teachers and mental health specialists created interventions aimed at increasing attendance, attainment, and antibullying for at-risk students (Raposa et al. 2019). The evaluation explains when it's combined meta-analytically, it shows the benefits of program participation on a range of social, emotional, behavioral, and academic outcomes for youth (DuBois et al. 2002, 2011; Raposa et al. 2019). However, the evaluation identifies positive program effects and identified the program's full impacts and potential. The evaluations suggest the importance of understanding the student's development and addressing the student's mental health needs. The program efforts were premised on the idea that school-based programs can assist students academically and socially, as well as meet their behavioral and mental health needs. It recommends for students seek individual and family therapy with a trained mental health specialist for

further assistance to identify and address the student's mental health needs to enhance their academic experience. However, the evaluations of school-based programs concluded that the program did not provide significant long-term effects due to inconsistent behavioral and mental health.

Emotional, Behavioral, and Social Outcomes

School-based programs were developed as a correlation to treat emotional, behavioral, and educational outcomes for at-risk students. As an emotional outcome, Holt, Bry, and Johnson (2008) found that school connectedness was enhanced through participation in a school-based program. Moreover, Herrera, Grossman, Kauh, and McMaken (2011) showed that participation in school-based programs resulted in significant improvement in self-perception as a learner. Strong emotional foundations, such as positive self-perception and school connectedness, are critical to positive behavioral outcomes. From a behavioral perspective, Converse and Lignugaris-Kraft (2009) and Kolar and McBride (2011) demonstrated that school-based programs were correlated with reduced disciplinary referrals. The students were engaged in learning to achieve positive educational outcomes. School-based programs aim to strengthen attachment, improve social competence, and increase social capital by introducing new connections (Boeck, Fleming, & Kemshall, 2006).

From a social perspective, a strong attachment with a peer and caring adult may help build resilience (Jenkins, 2014). Several studies have found that social support predicts healthy behavior and academic achievement (Dubow, Tisak, Causey, Hryshko, & Reid, 1991; Hall, 2003), and improved academic performance may be a distal outcome

of mentoring (Rhodes, Grossman, & Resch, 2000). In addition, some studies suggest that mentoring has modest effects on attendance (Hall, 2003), academic performance, employment, and behavior (DuBois, Holloway, Valentine, & Cooper, 2002). Nonetheless, while the academic and social needs were met, the mentors expressed concerns regarding the student's home life and mental and behavioral health. The mentors were not trained to accommodate the student's needs; therefore the students were provided a referral to seek proper treatment.

Mental Health Outcomes

Based on the literature review, the evaluation reported the youth who participated in the program experienced problems that warrant mental health treatment. The youth displayed symptoms related to depression, anxiety, and behavioral problems. Their challenges consist of depressed mood, negative thinking, poor relationships, and lack of coping skills. Severe mental health problems interfere with the youth's academics, social activities, and overall health.

The evaluation suggested identifying early mental health symptoms can provide a significant effect. The chart below indicates symptoms the youth displayed at different age ranges:

Table 1. Symptoms by Age Range

Age	Behaviors	Precursors
Preschoolers (Ages 2-5)	Anger, irritability, tantrums Excessive crying, sad expressions Loss of interest in favorite toys/activities Complains of physical symptoms like stomachaches and headaches	Family history of depression and mental illness Family history of suicidal ideation and attempts Family stressors such as divorce, loved one's death Chronic, physical illness
Middle Childhood (Ages 6-12)	Prefers to be alone rather than with family or friends Bullying, or being bullied Sleep problems Eating problems such as no appetite, weight loss Difficulty concentrating Separation anxiety from a parental figure Refusing to attend school Poor school performance Thoughts of worthlessness, hurting oneself	Low parent/peer social support Inconsistent parenting Bullying, or being bullied Social isolation/rejection High academic pressure Other mental illnesses such as anxiety Learning disorders, substance abuse
Adolescence (Ages 13-18)	No interest and enjoyment in activities Low self-esteem and self-worth Runs away from home Substance abuse Thinks plans, or attempts to hurt oneself	Onset of puberty Parent-child conflict due to increased independence

The chart shows preschool-aged youth had difficulties verbalizing their emotions and recognizable behavior such as irritability and early signs of depression. Middle age youth struggled to talk about their feelings. They exhibit disruptive behavior and struggle

to maintain peer relationships. Adolescents showed risks of depression which increased during puberty. The teens engaged in risky behavior based on their friendships and lack of positive role models. While the youth exhibited different behaviors at different ages, each behavior identified a mental health need that impacted learning and social relationship.

The evaluation notably acknowledged school-based mental health programs are an effective way to address the needs of the youth. The programs provide youth access to mental health specialists. The specialists collaborated with the teachers to implement evidence-based interventions and effective services. The evaluation indicates that few school-age children and youth receive services that could prevent or reduce the symptoms associated with the most prevalent disorders (State & Kern 2017). It is estimated that students with disabilities who receive services early for mental health issues have the lowest rates of problematic outcomes and the highest levels of positive school-related outcomes (Cumming et al., 2018). It also views, school settings as a structured environment to facilitate early identification, prevention, and intervention to prevent escalation of mental health issues promptly (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Unfortunately, due to limited specialists and large caseloads, most of the youth did not receive adequate services. Although volunteers were put in place train, limitations, and accessibility to work with youth in a school the setting became a major issue.

Supportive Relationships

In a review of empirically derived risk and protective factors associated with

academic and behavioral problems at the beginning of school, Stormshak & Webster-Stratton (1999) identified that having a positive school experience and supportive relationships are important protective factors for young children. In addition, Stormshak & Webster-Stratton (1999) suggested a positive adult, child, and peer relationships built on trust, understanding, and caring will foster children's cooperation and motivation and increase their positive outcomes at school.

The fundamental components of building supportive relationships were illustrated by school-based programs. The program is attributed to building supportive and co-regulation relationships among peers and adults. The evaluation noted at-risk youth experience life-challenging obstacles which include stressful changes and adjustments within their household and school dynamics. The quality of the school-based program predicted many aspects the youth endured during their life experience including social and familial influences. The programs held a critical component of the youth's social, emotional and behavioral development. It helped to increase the youth's school engagement, motivation, and academic competencies. The experience increased the youth's self-worth, self-esteem, and social relationships that navigated through their educational journey.

Literature Evaluation Summary

The program's overall experience shows an increase in youth's self-worth, self- esteem, and social relationships which help navigate them through their educational journey. However, there are several limitations to school-based mental health program evaluations that should be noted. The evaluations addressed in the literature review did not discuss

mental health follow up, resources in the school, or behavioral interventions when integrating the service. It is crucial to provide school-based program evaluation outcomes, to address mental health-related issues with a solid evaluation for at-risk youth. School-based programs provide limited information regarding mental health programs that have not been formally evaluated. Barnett, Niebuhr, Baldwin, and Levine (1992) pointed out: school-based mental health programs "outcomes often have been poorly documented because of the public demand for quick remedies. As a result, these programs consume time without producing convincing results.

The literature review showed mental health programs reduced barriers related to parents taking time off work to care for their child, no issues with transportation and benefits from free programs. However, the scope of mental health was left untreated due to lack of funding within school settings. The programs provided became too costly for the school districts to maintain and the programs were demolished. This increased referrals to outside mental health services which placed sole responsibility on the parents and lack of follow-up from the schools. As a result, students who are diagnosed with behavioral, emotional, and social problems were left without follow-through, and mental health problems untreated. The consequences of insufficient mental health formed poor educational attainment, juvenile delinquency, compromised physical health, substance abuse, underemployment, and ultimately premature mortality (Brooks, Harris, Thrall & Woods, 2002).

Given all of the above, this project proposes to place higher emphasis on addressing the youth's mental health needs. The project will fill current gaps by implementing a program that creates a continuum of integrative care to improve both

mental health and educational attainment for at-risk youth.

CHAPTER THREE

PURPOSE OF THE PROJECT

There has been an increasing desire for understanding disruptive behavior in elementary classrooms (McCarthy, Lambert, O'Donnell, & Melendres, 2009; Finn, Pannozzo, & Voelkl, 2004) These behaviors include but are not limited to: "destructive and aggressive behavior, defiance, temper tantrums, impulsive and hyperactive behaviors" (Henricsson, & Rydell, 2004, p.112). Without intervention, all of these problems may become more serious and entrenched throughout the child's growth and development (Miller, 2006). Given that children are at risk of developing long-term problems that can be identified at preschool age (cite) and that the developmental pathways for these problems in childhood and during the adolescence stage are well known (cite), it is imperative to intervene as early as possible. Research has shown that if treated early, problems at preschool age can be prevented from developing into full-scale, severe, long-term mental health problems (Finn, Pannozzo, & Voelkl, 2004).

Need for School-Based Programs

Mental health problems begin during the early childhood stage and often follows the youth throughout their education journey. The number of children and adolescents identified with mental health diagnoses has continually increased (Olfson, Blanco, Wang, Laje, & Correll, 2014) and this is predicted to be a major barrier in the future to prevent children from reaching their full potential. Studies suggest that as many as 14-25% (over 800,000) children and youth experience significant mental health issues (Waddell, Shepherd, Chen, & Boyle, 2013) but are left untreated due to mental health stigma.

Mental Health Strategy for California is an assessmentt conducted once a year by public and mental health professionals, to score school mental health in each state. The assessment report is provided to the schools and used as a roadmap to areas that need to be addressed.

The report highlighted the importance of schools in California promoting mental health awareness to help reduce the stigma and recognition of mental health problems. It explains how students who experience school-related problems because of mental health issues, and do not receive services are at an increased risk for dropping out of school, being expelled from school, and engaging in health risk behavior (e.g., aggression toward others, substance abuse, self-harm, overall wellness (Cumming et al., 2018). Lack of mental health services can disrupt the student's developing age-appropriate thinking, regulation of behavior, feelings, and emotions. These problems could enhance distress and interrupt the child's capability to represent oneself. It interferes with their ability to function properly within their family dynamics, school-related activities, and difficulties coping with life challenges. The report recognizes the link between mental health, academic performance and recommends school-based services to help prevent and reduce the risk. The report has also identified how school-based services that integrate mental health services can positively impact mental health issues in children (Marsh, 2016).

Project Rationale

The literature review demonstrates a need for school-based services among at-risk youth. Current research highlights the effectiveness of the programs and identifies positive impacts for school-based mental health services. Even though the

DespitetheDespite the program fostered a level of commitment to operating a successful program. The program struggled to find a proper place within the school environment. The programs were not being provided and lack follow-up services to address the youth's mental health needs.

The majority of the programs were dissolved due to a lack of coordination and limited scope to meet funding requirements that reduced the program cost and service. School-based programs had difficulty garnering the support of administrators, teachers, and other school personnel who view the program as one more item to add to their already full list of responsibilities (Arbreton, Bradshaw, Goldsmith, Jucovy, Pepper & Sheldon, J. S, 2008). It also became difficult for school-based programs to find ongoing funding for the program within the context of shrinking school budgets and extreme competition for funds (Arbreton, Bradshaw, Goldsmith, Jucovy, Pepper& Sheldon, J. S, 2008).

In addition, effective interventions were put in place, but not all youth were exposed to them and the programs were not utilized effectively during the school year. For example, several recent large-scale studies examining service utilization have consistently reported that as few as 20% of youth receive services for their mental health needs (Langer, Wood, Wood, Garland, Landsverk, & Hough, 2011). Furthermore 40–60% of families who begin community and school mental health services prematurely end those services, with most attending only one or two sessions (Armbruster & Fallon, 1994; McKay, Pennington, Lynn, & McCadam, 2001). With constant program interruptions, multiple youths were left with untreated mental health-related problems and no access to crucial school-based services despite.

Despite some inherent challenges, a school-based program is an innovative supplement to the traditional learning that takes place in schools, providing potentially underserved students with another avenue through which they might feel more confident about their schoolwork, improve their attitudes and commitment to learning, and develop more fully as a person (Arbreton, Bradshaw, Goldsmith, Jucovy, Pepper& Sheldon, J. S, 2008). The programs held a critical component of the youth's social, emotional, and behavioral development. It helped to increase the youth's school engagement, motivation, and academic competencies. The program experience increased the youth's self-worth, self-esteem, and social relationships that were navigated through their educational journey.

Therefore, addressing and resolving these issues early on can provide the youth a successful educational outcome and address their mental health need. This project proposes to fill the gap by implementing school mental health services and creating a continuum of integrative care that improves both mental health and educational attainment for at-risk youth.

Implementing School-Based Programs

School-based programs are used as a major movement in delivering mental health services to reach early-stage development, elementary, junior high, high school and college-level students. School-based programs have been promoted as a way of addressing unmet mental health needs, especially among students with limited access to health care services (Anglin, Naylor, & Kaplan, 1996). Implementing school-based mental health would respond to recognize and treat behavioral, emotional and

social isolation problems during early childhood development.

This program will identify school-based programs as an early intervention by providing services to at-risk youth and addressing their mental health challenges. It will address the unmet needs of students struggling with behavioral, emotional, and social interaction issues. The programs will be created to structure the youth's behavior. It will be used to reiterate positive behavior for youth who are struggling academically, displaying behavioral issues, and lack of social interaction. Additionally, it will foster the resiliency is necessary to help them succeed, despite the presence of at-risk social factors.

Early-Onset Mental Health Problems

More than two decades of research have also identified several high-quality programs for parents and teachers which have been shown to reduce childhood conduct problems and strengthen social competence and in turn prevent secondary outcomes involving crime and violence (Snyder, 2001). Rather the greatest challenge for public schools are to select, implement, and sustain these programs with fidelity. Dissemination of evidence-based programs is often compromised by low adherence to protocols, misapplication to wrong populations, inadequate resources, and poor infrastructure, support, training, and planning (Fixsen & Blase, 2018).

Implementing mental health services within a school setting can create a continuum of integrative care that improves both mental health and educational attainment for at-risk youth. The program can strengthen the academic continuum and mental health systems by providing evidence-based practices combined with classroom-

level interventions. This project aims to add to the body of research on school-based mental programs at the preschool grade level and extend the research on interventions within an elementary school, middle school high school setting. The program will promote awareness to assist at-risk youth who struggle with diagnosed and undiagnosed mental illness. It will focus on improving known determinants of the program engagement by placing mental health professionals in a school setting. The clinicians will advocate mental health services by instructing early interventions and evidence-based approaches to address barriers in a school setting

CHAPTER FOUR

CONCEPTUAL FRAMEWORK

School-based mental health programs are used as a prevention and interventionfor at-risk youth. Schools have recognized the importance of mental health awareness byproviding a comprehensive approach to developing a mental health framework. School-based programs were developed on the assumption that when a youth's mental health needs are met, they can meet their educational goals. With the collaboration of a mental health clinician, the youth can learn how to recognize early signs ofmental health, obtain resourceful information and reduce challenges they endure duringtheir everyday life.

Program Framework

Effective school mental health programs mainly target the promotion of social and emotional learning (SEL) and resilience as well as the prevention of social, emotional, and behavioral difficulties, including risk behaviors (Weare, 2010). Studies on evidence-based practices and interventions provide positive outcomes for at-risk youth. It helps to improve resilience outcomes for youth struggling with emotional, behavioral, and social interaction problems. This project adopts a conceptual framework to help support at-risk youth who are struggling with emotional, behavioral, and social interaction problems. The framework is structured to reduce the mental health barrier by integrating the attachment theory, social-emotional development, and cognitive-behavioral theory. This is intended to help at-risk youth understand the way they think, behave and reiterate positive behavior. This will help them to see and apply alternate perspectives by learning useful techniques to help change the negative

behavior.

Attachment Theory

In 1958, the psychological theory of attachment was developed by John Bowlby. Bowlby was a psychoanalyst who researched the attachment theory in infants during the first 18 months of the child's life. The research study focused on the effects of separation between infants and their parents. Bowlby noticed the infant's behaviors quickly changed when they were separated from their parents and placed in an unfamiliar place. Bowley's identified four attachment stages based on the child's early interaction with their parents. The attachment stages formed a continuum of secure, anxious, avoidant, and fearful regulations when the child was reunited with their parents.

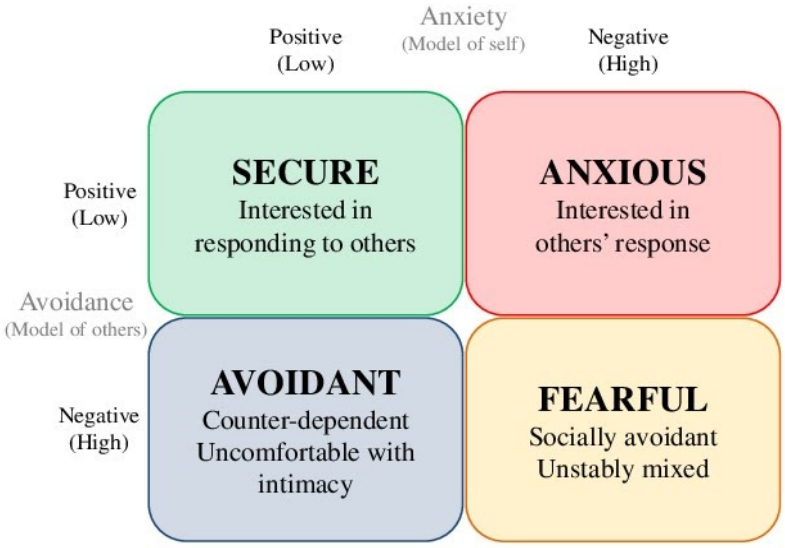


Figure 4. Attachment Theory

- Secure attachment: The infants showed distress when they were separated from their parents but sought comfort when their parents returned.

- Anxious-resistant attachment: The infants experience high levels of distress and anxiety until their parents returned.

- Avoidant attachment: The infants show no reaction or minimal stress upon separating from their parents and they ignored their parents when they were reunited.

- Fearful attachment**:** The infants exhibit fearful reactions when they didn't feel safe or felt like their parents were not meeting their needs.

According to Bowlby, internal working models of attachment help to explain "the many forms of emotional distress and personality disturbances, including anxiety, anger, depression, and emotional detachment, to which unwilling separations and loss give rise" (p. 201). A child's childhood attachment underlies the "later capacity to make affectional bonds as well as a whole range of adult dysfunctions" including "marital problems and trouble with children, as well as neurotic symptoms and personality disorders" (p. 206). Thus, Bowlby postulated that early attachment experiences have long-lasting effects that tend to persist across the lifespan, are among the major determinants of personality organization, and have specific clinical relevance.

Children who struggle with behavioral, emotional, and social problems

commonly experience difficulties. These children may have a hard time maintaining relationships with peers and adults due to their lack of trust, and anxiety, and demonstrate the aggressive type of behavior. They present a high risk of developing a mental health problem and unsecured attachments. By applying the attachment theory, clinicians will have a better understanding of how attachment stages and relationships shape the experiences in the child's life. Attachment theories provide a direct link between disturbances in the mother, and father and the pathology in the child. Such life experiences form the basic assertion that early attachment difficulties increase vulnerability to later psychopathology.

Attachment Theory Assumptions

The core of Bowlby's attachment theory is based on psychopathology and normal socio-emotional development. The theory is an early relationship that develops between the infant and caregiver provides the foundation for later development (Bowlby, 1989). Bowlby's theory attempts to explain how the early relationship contributes to psychological well-being or later Psychopathology (Bowlby, 1989).

The attachment theory is often used to understand the relationship between an adult and a child. The attachment theory consists of 4 key assumptions. The first assumptions in children examine how bonding behavior can increase the capacity for survival. The assumption looks at the child's behavior and inclination to adjoin with familiar individuals. The assumptions coincide with how unfamiliar events or objects can activate the attachment system which invokes behavior that's proximal to their parental guardian. The second assumption focuses on the early childhood stages and development. It explains how specific phases in life and events can shape or affect a child's growth

and development. The third assumption shows the preference of individuals toward specific figures, such as their parents, is not inherent (Bowlby, 1989). Instead, children develop this need to seek their primary attachment figure as a consequence of their experiences with this person (Bowlby, 1989). The fourth assumption explains the hierarchy of the child-adult relationship which ranges from the child's preference. This position diverges slightly from previous perspectives, promulgated by Bowlby (1989, called monotherapy, which assumed that infants primarily seek support from a single individual, usually the mother.

The key assumptions explain the attachment and bonding behavior children learn how to adapt to. Research has explored the security of the attachment theory during early childhood (Bowlby, 1989). It predicts every aspect of the child's social development during the early childhood and adolescence stages of life. The theory analysis secure attachment such as empathy social competence and behavior problem. It predicts developmental outcomes and insecure attachment behaviors and relationship difficulties. The secure attachment is a major factor to help children function in a competent fashioncompetently and face adversity.

Social-Emotional Development

Social-emotional development differs from attachment theory since it begins when children start to understand who they are, how they are feeling, and how to interact with others. During early social and emotional development, young children (ages 0–5) develop the ability to "form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways and explore the environment and learn all in the context of family, community, and culture" (Yates &

Gamble 2002). Social and emotional experiences with other children and adults early in life set the stage for future academic and personal outcomes and undergird other areas of development (Denham & Brown, 2010). This provides a way for children to understand their feelings, understand who they are, and how to interact with others.

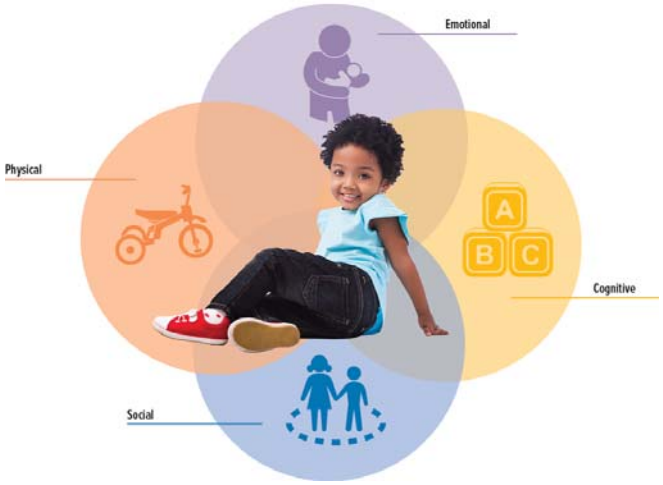


Figure 5. Social-Emotional Development

By applying social-emotional development, children acquire social and emotional skills to help them regulate their emotions and form positive social relationships. These types of skills are essential for students who are transitioning from social play, classroom lessons, and school-based programs. Each of these skills is developed based on the child's timeline and ability to learn. As children develop social and emotional skills, they gain the confidence and competence needed to build relationships, problem-solve, and cope with emotions (Parlakian, 2003). Social and emotional competencies as they relate to school readiness have gained enormous attention for school-based programs. Research indicates that social skills and accompanying process skills (e.g., attention

and approaches to learning) evident at school entry (i.e. by about age 5) is the best predictors of later social and emotional competencies, such as managing behavior, making social connections, and tolerating frustration with peers (Halle, Hair, Burchinal, Anderson, & Zaslow, 2012).

Cognitive-Behavioral Theory

In 1960, Aaron Beck developed cognitive behavior therapy (CBT). Beck extensively researched and found to be effective in a large number of outcome studies for psychiatric disorders including depression, anxiety disorders, eating disorders, substance abuse, and personality disorders (Chand, Kuckel & Huecker, 2021). It also has been demonstrated to be effective as an adjunctive treatment to medication for serious mental disorders such as bipolar disorder and schizophrenia. (Chand, Kuckel & Huecker, 2021). CBT has been adapted and studied for children, adolescents, adults, couples, and families (Chand, Kuckel & Huecker, 2021).

Cognitive-behavioral therapy (CBT) generally consists of (a) behavior modification, behavior therapy, and (b) cognitive-behavioral treatments. Behavior modification/behavior therapy focuses on arranging contingencies of positive reinforcement to develop and maintain appropriate patterns of behavior (Bandura, 1969; Skinner, 1953). CBT is used as a form of talk therapy designed based on negative thoughts and behavioral issues. It is utilized as a behavioral modification to help reinforce and structure positive behavior.

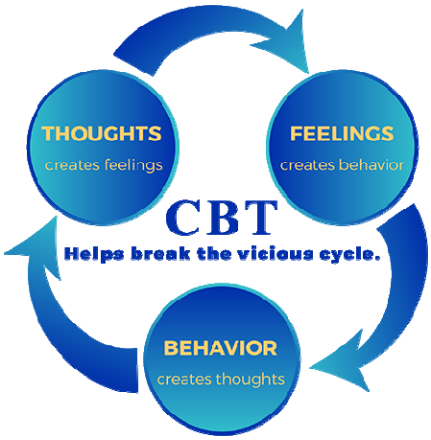


Figure 6. Cognitive-Behavioral Theory

Clinicians will incorporate play therapy skills, specifically cognitive-behavioral play therapy by integrating evidence-based interventions into the school-based program. Play therapy can become an integrated part of the responsive services indicated for school-based programs clinicians (ASCA, 2012). According to Fazio-Griffith & Marino, the play of children can be more fully appreciated when recognized as their natural mode of communication. Children express themselves more directly and fully through the use of self-initiated play. (Fazio-Griffith, & Marino, 2017). Play can be considered a medium of exchange and restricting children to only verbal expression can create a barrier to effective communication and resolution of childhood issues. (Fazio-Griffith, & Marino, 2017). Play therapy and interventions in the school settings are encouraged to meet a Ba broad range of developmental needs of children including social and emotional needs (Fazio-Griffith, & Marino, 2017).

Cognitive-Behavioral Assumptions

Cognitive-behavioral theory (CBT) is a significant therapeutic intervention that is commonly used in programs for at-risk youth. CBT is used to alter negative behavioral

problems, reduce psychological distress and help to develop alternate ways of thinking. CBT consists of two fundamental assumptions. The assumption explains the cognitive processes and content that are accessible.

CBT examines the links between the individual's behavior and emotions. The cognitive approach believes that mental illness stems from faulty cognitions based on others and the people we interact with. This faulty thinking maybe through cognitive deficiencies or cognitive distortions (Padesky & Beck, 2003). This approach is commonly used to treat people who are in distress or need help developing more adaptive cognitions and the effects which influence the behavior. Each of the cognitions serves as mediating response through behavioral responses and initial stimuli. Once applied the behavior is interpreted by how the people interact and react with one another.

Attachment theory - Social-Emotional Development

The relationship between the youth, peer, and clinician advocates the development of social and emotional well-being. The relationships specify the following: (1) opportunities for fun and escape from daily stresses, (2) corrective emotional experiences that may generalize to and improve youths' other social relationships, and (3) assistance with emotion regulation (Rhodes, 2005). The relationships enhance the opportunities for the youth to participate in a diversity of social interactions with their peers and adults. In addition, the activities sustained in the program promote the importance of withstanding a positive relationship. Such activities may provide both welcome respite and enjoyable experiences for youth who typically must contend with disadvantages and difficult circumstances. Recent research

on social support highlights involvement in mutually pleasurable social activities as a distinct aspect of supportive relationships that has been referred to as companionship (Sarason & Sarason, 2001).

Social support motivates the students to "purely enjoyable interaction, such as the pleasure in sharing leisure activities, trading life stories and humorous anecdotes, and engaging in playful spontaneous activities" (Rook & Fisher, 1995). Supportive relationships have the capability of providing students with positive social experiences to improve their social interactions skills and healthy relationships with their peers. Students need genuine support from peers and adults to maintain strong relationships. Therefore, the clinicians need to present themselves as a positive role model to demonstrate what a healthy and positive should look like.

According to Olds, Kitzman, Cole & Robinson (1997) The supportive relationship can thus become a "corrective experience" for those youth who may have experienced unsatisfactory relationships with their parents. This experience may then generalize, enabling youth to perceive their proximal relationships as more forthcoming and helpful (Journal of Community Psychology, 2006). As Kohut (1984) has argued, close relationships can be therapeutic in and of themselves, helping individuals realize "that the sustaining echo of empathic resonance is indeed available in the world". The hypothesized potential of positive relationships to modify youths' perceptions of other relationships is suggested by attachment theory (Bowlby, 1989).

Cognitive Behavioral Theory Framework

Cognitive Behavioral Theory (CBT) intermingles behavioral and cognitive theories about human behavior, familial, peer influences, psychopathology, and the setting of emotions. CBT has been scientifically proven as a method of treatment that works effectively for young children. (Goldenberg & Goldenberg, 2008). The cognitive-behavioral theory is often used in conjunction with behavioral therapy to help young children break the cycle of behavioral and emotional problems. (Goldenberg & Goldenberg, 2008). It is assumed disruptive behavior, feelings, and emotions are developed through cognitive processes which are acquired by a child's interaction. CBT has become a conventional part of psychotherapy to help alter a child's thoughts and actions by modifying their conscious thought patterns (Goldenberg & Goldenberg, 2008). The distinct influence of this approach has been its determination to employ a rigorous, scientific set of methods that is regularly and consistently scrutinized (Goldenberg & Goldenberg, 2008). CBT exhibits positive outcomes as compare compared to other therapeutic approaches for preschool-age children. CBT consists of relegating emotional distress and psychological symptoms by modifying underlying factors which include negative thoughts of errors in interpretation, coping strategies, and behaviors that may inadvertently reinforce these feelings and symptoms. The goals of CBT demonstrate coping skills and provide opportunities within a school setting to help practice these skills. Therefore, the skills typically exhibited in CBT identify and modify negative patterns of thinking, develop problem-solving skills and improve social interactions.

Overall Framework

By incorporating the attachment theory, social-emotional development, and cognitive-behavioral theory the school-based program can implement universal interventions. In schools, interventions to prevent behavioral, emotional, and social problems usually target such conditions as depression, anxiety, social withdrawal, substance use, self-harm, rule-breaking, delinquency, and aggressive behavior (Cooper & Jacobs, 2011). Interventions may be implemented at the universal level, that is to say, with all students, or at the targeted level, with students at particular risk of developing, or already manifesting, mild mental health difficulties (Weare, 2010). Prevention of behavioral, emotional, and social problems, emotional, and behavioral difficulties comprise a broad spectrum of behaviors that school children can develop to varying degrees, and that may be either internalizing (directed at the self), or externalizing (directed at the external environment) (Achenbach, 2017).

CHAPTER FIVE

METHODOLOGY

School-based mental health programs are a popular form within America and makeup 80% of the formal school programs in the United States (Dessoff, 2007). School-based programs have been used as an intervention for at-risk youth for many years (OLLDP, 2010). The development of youth-focused programs has been most prevalent by showing positive effects on at-risk youth. Offering school-based programs provide a a unique advantage to help engage at-risk youth and treat unmet mental health needs.

Schools are under pressure to improve student academic performance and decrease disruptive behavior, but lack effectiveness without a mental health professional in place (NCLB, 2005). Effective school mental health programs mainly target the promotion of social and emotional learning (SEL) and resilience as well as the prevention of social, emotional, and behavioral difficulties, including risk behaviors (O'Reilly, Dogra, Whiteman, Hughes, Eruyar, & Reilly, 2018). Some examples of positive outcomes include increases in the following: positive self-concept, increases in educational attainment, improvements in peer relationships, and mental health treatment (Grossman & Tierney, 1998). By implementing a mental health-focused program, youth will be able to obtain support to alleviate their problematic behavior and address their mental health needs. Such a program would also provide data to inform future research studies.

Development of Program

Based on the needs assessment results and personal interests, stakeholders from the Redlands Unified School District were assigned by the District to explore the benefits of adding a mental health component within a school setting. The needs assessment highlighted mental health as a top concern due to poor academic performance, special education referrals, behavioral programs among the peers and lack of supported friendships. The report identified the youth spent the majority of their time at school due to parent(s) being working professionals, parent(s) attending classes or in training, The assessment demonstrated the youth engaged in disruptive behavior may also be attributed to a lack of attention, problems within their household dynamics, rule inconsistencies, and untreated mental health problems. Even though these concerns seemed foreign to preschool-level youth, the problems became greater. The program director expressed concerns when mental health problems go untreated and the consequences the youth will endure once they attend kindergarten in the elementary campus. The school-based program was put in a place to address the need and decrease the youth's academic challenges.

I CAN Program

The program was implemented in a school setting during the pre-initial stage in order to address the areas of need. The program entitled I CAN was selected based on the focus on promoting self-regulation and interventions to cope with mental health difficulties. The program was conducted during the youth's instructional period and after school hours to accommodate the youth's availability. The program involved 3

components: (a) 10 one on one sessions (b) weekly updates and meetings with the parent(s) and (c) weekly updates and meetings with the teacher and program director.

Program Structure

The program is structured to build social relationships among the youth to help them work together while providing guidance and support while treating their mental health needs. The youth and clinician will spend two hours a day addressing the youth's needs.

The youth and clinicians will complete indoor and outdoor activities to enhance social interaction and behavior regulation. The activities will consist of team building, role-playing, and play therapy. The use of evidence-based interventions will help the youth to enhance and promote positive behavior while learning how to form long-lasting friendships with their peers.

Description of Settings

The I CAN program was pilotedted in a private school setting located in Loma Linda, CA. The school grounds consist of a Children's Center, Elementary, Junior High, and High School in their areas of the campus. The school follows a mission that emphasizes the importance of education, healthcare, and mental health to help improve people's lives.

The pilot program took place at the Children's Center with preschool children ranging from 4 – to 5 years old. A total of 21 students participated in the program. The target group consisted of students who presented with behavior regulation issues, an

inability to manage their emotions, and difficulties forming friendships. The ethnic distribution of the student is as follows: 86% Caucasian, 8% African American, 4% Hispanic, and 2% Multiracial. Approximately, 70% of the students were considered high class, 20% of the students were middle class and 10% were considered to be lower class.

Student Selection

Each participant was enrolled as a full-time student and preparing to transition to kindergarten on the elementary campus within the private school. The participants were selected by the teachers based on their classroom observations or reports directly obtained by the parent(s). Each student was expected and committed to finishing the program in its entirety for adequate intervention and data collection.

Program Procedures

Permission was obtained from the school's superintendent and program director to implement the program. Letters explaining the program parameters were given to parents as an invitation to have their child participate in the program. Each parent(s) was allowed to disclose problems and concerns they have observed within their household. Each participant was assured that the information provided would be confidential. Specific instructions regarding the program were given without the student's name listed. During the program, specific precautions and administrative safeguards were put in place to ensure safety and confidentiality.

Protection of the Participants

There were minimal risks associated with the program. The participants in the program were voluntary. All participants had the right to withdraw at any time. Confidentiality for all participants was maintained throughout the program. No information that would compromise the students was collected. All of the program's data was collected and stored in a secured location per IRB guidelines. Administrative safeguards were put in place to protect the student's identity. All identifying information will be removed from the survey data which will be stored on a secured LLU server. Participants will only be identified by the number on the transcripts.

Roles and Responsibilities

This section provides the program elements for the I CAN programs. It consists of describing the formal roles and responsibilities so that each of the program tasks is managed accordingly. The I CAN program was conducted by a program coordinator, graduate-level clinicians, specific school personnel (i.e., teacher and program director), and parent(s).

Program Coordinator's Role

The problem coordinator will serve as a liaison to ensure that lines of communication remain open between the school personnel, clinicians and parents. The coordinator will meet with a planning team to discuss potential legal and liability issues, develop insurance coverage, and create procedures for reporting and tracking any

incidents that occur during the initial program. The planning team should discuss and agree on the following:

- The number of graduate-level clinicians to be involved
- The length of the program/sessions
- Program activities
- Use of school or program resources
- Program outcomes

The coordinator will oversee the interview and screening of the youth's confidentiality and safety. The coordinator will confirm all of the program's policies meet the alignment with the school district policies. The coordinator will be responsible for the program's tasks and operations which will include clinician and youth recruitment, orientation, promoting the program, and participating in matching the youth and clinician.

The program activities will be documented every week to examine the process and outcomes. The coordinator will meet with the stakeholders to obtain their feedback on the program's strengths, weaknesses, and areas of need. The coordinator will be responsible for providing the feedback details in writing. The stakeholder's recommendations will include measuring the program's accomplishments and effectiveness of the program and identifying whether the program's goals were met.

Clinician Eligibility

The program will consist of mental health clinicians who are doctoral and master's level marriage and family therapist students and professional clinical counselor

trainees under clinical supervision by licensed MFTs at LLU. All clinicians will undergo professional training and background checks through LLU.

Clinician's Role

The clinician's primary responsibility will be based on the day-to-day operation of the I CAN program. The clinician will devote five days per week to meeting with the selected youth. The clinician will implement therapeutic evidence-based interventions to reiterate positive behavior, improve social skills, and manage emotions. The clinician will document the youth's process during each session and provide the parent(s), teacher, and program coordinator with a weekly progress report discussing the youth's day-to-day progression.

Program Director and Teacher's Role

The role of the program director and teachers is essential to have to make the program effective. However, the program director and teachers will have a key role to play by:

- Adapting to additional help within the classroom
- Referring the youth
- Assist with support and communicating with the clinician

The program director will be encouraged to approve the activities, and orient the teachers and clinicians about the program requirements.

The teacher's role is to create a safe classroom environment to help the youth apply problem-solving skills, learn independently and adapt to the program structure. Teachers are not assigned by the I CAN program.

Parent's Role

Before the program begins, the program coordinator will inform the parent(s) about the program. The program description will be provided in a letter to outline the program's details. The parent(s) will play a significant role in the youth's participation by reiterating techniques and interventions learned in the I CAN program. The clinician and program coordinator will maintain open communication with the youth's parents by providing feedback and answering questions related to the program and the youth's progression.

Program Evaluation

The purpose of this project was to develop and implement a pilot of the I CAN school-based mental health program. This program is designed to add to the limited research on the impacts of school-based mental health programs. This project will address the program's effectiveness and implementation accordingly based on the results from the stakeholder's feedback.

The stakeholders will complete a survey through Survey Monkey to address the following questions: (see appendix)

1. What are the stakeholder's perceptions of the I CAN program?
2. What are the stakeholder's perceptions of the program's effectiveness?

3. What was the impact on the student's mental health after completing the I CAN program?

Program Design

This project is designed as an ongoing program development with an evaluation component to test the effectiveness of the school-based mental health program. The project aims to demonstrate how treating mental health problems can improve the youth's academic success, decrease behavioral issues and increase social interaction. The program is designed to enhance and strengthen preschool-age children's social interaction, decrease behavioral problems and resolve conflict resolution issues. The program set out to teach the youth effective problem-solving strategies, anger management, social skills, and positive behavior techniques for the classroom setting.

Perceptions from the stakeholders are the basis for this evaluation. Stakeholders will review the program and provide the perception of the program's details, impacts, and effectiveness. The program coordinator will conduct one on one interviews with the stakeholders to further discuss the focus of the I CAN program and areas that need improvement. The results of this study will contribute to the growing research on school-based mental health programs.

Instrumentation

According to Creswell (2009), qualitative research is expressed in words by descriptions, understanding of thoughts, concepts, experiences, and interviews with open-

ended questions. The program coordinator will collect data through one-on-one interviews as a method of qualitative research.

The stakeholders played a vital role throughout the entire program development process, as they expressed interest in implementing a mental health component within a school-based program. The stakeholders were present at the school site to provide their interest, input, and view of the program. The program coordinator organized all meetings and interviews to be conducted at the school site, during the initial engagement, during the project, and delivery of the findings. The program coordinator met with each stakeholder one-on-one, typically between30 minutes and an hour, on a daily and weekly basis throughout the entirety of the program. The stakeholder provided their feedback during each meeting to identify the strengths, weaknesses, and the programs' outcomes.

Data Processing and Analysis

Data processing and analysis results will serve two purposes: improving the program delivery and enhancing the program's impact. The data processing and analysis section will include the following: interpreting the interviews, qualitative and quantitative methodology from feedback provided by the stakeholder. In addition, the qualitative and quantitative data obtained from the stakeholder's survey will be used to measure the initiative and assess if the program is on track to meet the goals.

The results from the stakeholder's feedback will be interpreted by line-by-line coding. The findings are written in a narrative report that describes the impact by using the descriptions from the interviews and qualitative data (Creswell, 2009).

The stakeholders were invited to engage in the conversation with the researcher to provide their input on the program. These conversations did not follow a standardized format or interview guide due to time constraints. This allowed the stakeholders the opportunity to share their ideas in an open discussion and provided a way for the researcher to ask follow-up questions.

Summary

This chapter discussed the program methodology that was used for this project and outlines how the program was implemented. This project is explanatory as it evaluates the effectiveness of the I CAN program. This chapter also addressed the roles and procedures used to collect the data and how the youth's confidentiality was protected.

I CAN Program
Training Manual

Table of Contents

“ Every child deserves a champion, an adult who will never give up on them. Who understands the power of connection, and insists that they become the best that they can be.”

Rita Pierson

Lesson 1 - Why School-Based Mental Health Programs?

Within today's society, school-age youth face significant mental health difficulties. According to the Surgeon General's Report on Mental Health (1999), an estimated one in five students will experience a mental health problem during their school years, with 11% experiencing a significant mental health impairment. Schools provide a single point of access for mental health services for a majority of children, some of whom otherwise would not receive these services (Kutash, Duchnowski, & Lynn, April 2007). Therefore, schools are viewed as a secondary location for coordinating mental health services within the school setting.

Mental health services are recognized as important resources schools provide for youth to help benefit their mental health and academic studies. When mental health services are implemented, schools offer an environment to help youth have an opportunity to learn, grow and build long-lasting self-improvement and relationship skills. By removing the mental health barriers, youth will have the opportunity to see the school environment in a different light. The youth would be able to receive the aid he or she needs by engaging in mental health interventions. According to the No Child Left Behind Act of 2020, research supports the effects of mental health interventions in a positive school climate that will contribute to improved student achievement. It shares that the best way to prevent and intervene early with youth who are struggling with social, emotional, and behavioral problems is by providing consistent support. For instance, youth who experience long-standing behavior problems require more intensive and consistent types of therapies. In this case, having the youth work directly with mental health professionals on campus is a plus. It allows the youth to address their needs and

obtain immediate support. Therefore, by increasing the early identification of mental health problems, the youth will have better educational outcomes.

This manual is a guide for the delivery of the I CAN program which promotes mental health awareness for school-age youth. The purpose of the training guide is to familiarize the clinicians with common problems encountered in a school. It will be used as a resource for implementing the I CAN mental health component within a school setting. The manual will provide information on early childhood development to help youth who are struggling with social, emotional, and behavioral problems. The manual is formulated through a review of research studies to identify procedures, training materials, and practical suggestions to help support at-risk youth with specific mental health difficulties.

Lesson 2 - Overview of Behavioral, Emotional, and Social Issues

There is increasing recognition of the need to intervene at an early stage with children exhibiting aggression and behavioral problems (Campbell, 2014). Research has shown that such problems become very resistant to change as the child gets older and are likely to lead to violence, substance abuse, and delinquency in adolescence and adulthood. Therapeutic interventions are much more effective in treating conduct problems when children are very young, below the age of 8 years (Campbell, 2014). Research also points to the fact that aggression in young children is on the increase, with between 7 and 25% of pre-school and early school-age children being diagnosed with behavioral disorders (Campbell, 2014). Despite this knowledge, psychological and family support services for children tend to be understaffed resulting in long waiting times for families (Campbell, 2014). By the time clinicians are in a position to assist, the children are older, behavioral difficulties tend to have escalated, and to are less amenable to treatment (Hodgkinson, Godoy, Beers & Lewin, 2017).

Behavioral, Emotional, and Social Problems in Young Children

Behavioral and emotional problems are common in young children, with reports ranging from 6-15% of boys and girls aged 3-12 years having clinically significant emotional or behavioral problems (Egger & Angold, 2006; Sawyer et al., 2006) and as high as 35% reported for young children in economically-disadvantaged families (Webster-Stratton & Hammond, 1998). Young children with early-onset behavioral and emotional difficulties have been shown to have an increased risk of developing severe adjustment difficulties, school dropout, violence, and drug abuse in adolescence and adulthood (Costello, Foley, & Angold, 2006; Egger & Angold, 2006). Early intervention with an evidence-based parent, teacher, and child programs has been shown to prevent

and reduce the development of conduct problems and in turn prevent secondary risk factors from developing (Kazdin & Weisz, 2010; Snyder, 2001).

During the early childhood stage, children will acquire an understanding of behavioral patterns, social interactions, and how to self-regulate. Nevertheless, there is a significant number of children who will exhibit behavior that will be alarming to their parents and teachers. In 2003, New Freedom Commission on Mental Health, conducted a research study to identify how critical emotional and social well-being in school readiness and the negative trajectories of early problem behavior stressed the importance of providing prevention and intervention services to young children with challenging behavior and their families (New Freedom Commission on Mental Health, 2003).

The prevalence of aggressive behavior problems in preschool and early school-age children is about 10%, and may be as high as 25% for socio-economically disadvantaged children (Rimm-Kaufman, Pianta, & Cox, 2000; Webster-Stratton, 1998; Webster-Stratton, Reid, & Hammond, 2001). Evidence suggests that without early intervention, emotional, social, and behavioral problems (particularly, aggression and oppositional behavior) in young children are key risk factors or "red flags" that mark the beginning of escalating academic problems, grade retention, school dropout, and antisocial behavior (Snyder, 2001; Tremblay, Mass, Pagani, & Vitaro, 1996). Preventing, reducing, and halting aggressive behavior at school entry, when children's behavior is most malleable, is a beneficial and cost-effective means of interrupting the progression from early conduct problems to later delinquency and academic failure (Webster-Stratton & Reid, 2004). Social competence and emotional well-being in young children have received much attention in recent years as they link to language development and early

school adjustment and learning (Miller-Lewis, Baghurst, Sawyer, Prior, Clark, Arney & Carbone, 2006; Phillips & Lonigan, 2010; Pike, Iervolino, Eley, Price & Plomin, 2006). Young children cannot maintain their behavior and emotions; therefore they need to uphold a strong secure relationship with their parents, caregiver, or teacher to help teach positive behavior. Once young children learn and display positive behavior and emotions they will have a greater chance of academic success and prepare for school readiness.

Lesson 3 - Theories of Change

In the past 20 years, the application of behavioral and cognitive-behavioral techniques to the social, behavioral, and emotional problems of children in schools has been well-documented based on the theories of change (Kendall & Braswell, 1985). Effective theories of change for children mainly target the promotion of social and emotional learning (SEL) and resilience as well as the prevention of social, emotional, and behavioral difficulties, including risk behaviors (Cefai et al., 2018). These types of techniques and interventions focused on decreasing impulsivity and inattention to increase academic performance and mental health awareness.

By applying evidence-based theories, clinicians can track the efficacy of the mental health treatment plan. Psychotherapy teaches the youth ways to manage their symptoms, the importance of having a voice, and how to seek help when needed. Therapy helps youth become more aware of their behavior and explains how their behavior is influenced. The following sections of this manual will explain how applying social-emotional development and cognitive behavior therapy (CBT) can help at-risk youth get through their most challenging times.

Social-Emotional Development

Social-emotional development explores early social and emotional development as the emerging ability of young children (ages 0–5) to "form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways; and explore the environment and learn all in the context of family, community, and culture" (Yates et al., 2008, p. 2). Social and emotional experiences with primary caregivers as well as interactions with other children and adults early in life set

the stage for future academic and personal outcomes, and undergird other areas of development (Denham, 2006; Denham & Brown, 2010; Konold & Pianta, 2005; National Research Council & Institute of Medicine, 2000). As children develop social and emotional skills, they gain the confidence and competence needed to build relationships, problem-solve, and cope with emotions (National Research Council & Institute of Medicine, 2000).

Social-emotional development helps youth understand the feelings of others, the ability to control their feelings and emotions as well as how to get along with their peers. For youth to understand the intervention, they would need to learn the basic theory skills. For instance, social-emotional development begins with trust and creating a bond with the youth. This allows the youth to open up to the clinician and feel safe during the therapeutic process. This sets up the foundation for the youth to develop socially and emotionally, helping them to form secure relationships. By applying aspects of social-emotional development, youth will have the opportunity to develop strong relationships with their parents, teachers, and peers. They would learn how to be active learners and get along with others by understanding how their temperament can affect the way they communicate and interact with others.

Cognitive Behavior Therapy (CBT)

The relationship between the clinician and youth represents an essential function of the cognitive-developmental processes. Research on collaborative learning, for example, points to interactions with clinicians as vehicles through which children and adolescents can acquire and refine new thinking skills, becoming more receptive to adult values, advice, and perspectives (Radziszewska & Rogoff, 1991). Research on the role of

social support in fostering cognitive development similarly underscores the social nature of learning. Feelings of closeness with teachers, for example, have been associated with more positive academic adjustment for children and adolescents (Cadima, Leal, & Burchinal, 2010; Reddy, Rhodes, & Mulhall, 2003). Similarly, close, enduring ties with naturally occurring clinicians in the lives of youth have been found to predict improvements in academic and vocational outcomes (DuBois & Silverthorn, 2005; Klaw, Rhodes, & Fitzgerald, 2003). It appears, too, that meaningful guidance and instruction can occur when the youth have a strong model directing them (Karcher, 2005) and effective interactions take place in group settings as well as in the one-on-one therapeutic contexts (Hirsch, 2005).

Lesson 4 - Recognizing & Treating Mental Disorders

Within a school environment, teachers are often in a position to observe the youth's behavior. However, there is uncertainty for the teachers to identify the difference between normal behavior and a mental health problem, which results in them consulting with a mental health clinician. The clinician may assist in determining whether or not the behavior was developed appropriately or due to a factor in the youth's life. These factors may display implications for many areas in their life that may interfere with activities at home and school.

A high priority has recently been placed on addressing the mental health needs of children and adolescents (Department of Health, 2020) due to the following issues:

- Notable changes may consist of missing multiple days of school or difficulties getting along with peers or family members
- Changes in mood/behavior such as aggressive behavior, anger outburst, or isolation
- Conservations about death or desire to die
- The use of alcohol or controlled substances
- Mental health difficulties among youth can cause distress and great impacts on their life.
- The impact can affect the youth's emotional development, which may cause low academic grades and difficulties with social interaction.

Once negative behavior is identified the clinician will utilize evidence-based interventions to help decrease the behavior by incorporating treatment guidelines.

Guidelines for Change

The following guidelines are intended to provide the clinician with ways to implement the interventions. The guidelines tend to be relevant for school-age youth who are struggling primarily with emotional, behavioral, or social interaction issues.

Connecting with the youth

There are a variety of ways to connect with at-risk youth within a school setting. The main aspect of the therapeutic process is keeping the youth engaged by identifying their interest of choice. Exploring the youth's interest provides a way for the clinician to obtain trust and apply the intervention effectively. This process helps the youth to feel valued and provides reassurance that their voice should be heard.

Problem Solving Approach

The best way to view the youth's difficulties is looking to look at the issue through a problem-solving lens (cite). This approach helps reduce problematic behavior by helping the youth understand the triggers behind the behavior they are displaying. For example, the triggers can be overt behavior caused by internal thoughts from prior experiences, feelings of boredom, or a need to maintain power and control. By discussing these triggers in detail, the clinician can explain the reasoning behind the behavior.

Treatment Integrity

Treatment integrity refers to the degree to which the treatment is implemented as it was intended. Higher levels of treatment integrity have been linked to more effective interventions (Gable, Henderickson & Van Acker 2001). This will ensure the interventions put in place are practical, effective, and attainable. For example, in a study of the integrity of treatments for adolescents using controlled substances, intermediate

levels of treatment adherence led to the best outcome (Hogue, 2008). This suggests if an intervention is placed correctly the youth would have an opportunity for a positive change. However, if the intervention is placed incorrectly the intervention would be less effective.

Obtain Feedback

Seeking the youth's feedback through each intervention is the key to knowing whether or not the intervention is working or not working. The youth feedback can be in written form or a verbal conversation. This allows the youth to participate in the discussion about the interventions used to help them. For example, if the clinician is doing a reward-based intervention, the youth should have input on what the prize would be to help motivate positive behavior. What may be a reward to one youth may not be a reward to the other. It is best to obtain the youth's feedback, to obtain effective results.

Lesson 5 - Play Therapy

Play is a natural component of child development. Clinicians use play therapy to help the youth find the words to express how they are feeling. Understanding the characteristics of the youth's age range is an important component. The following outline is the typical developmental characteristics of children ranging between 4 – and 5 years of age. Knowing the youth's age characteristics can help in designing appropriate training sessions and activities.

Four to Five-Year-Olds Developmental Characteristics

General Characteristics	Eager to learn; easily fatigued; short periods of interest. Learn best when they are active while learning. Self-assertive, boastful; less cooperative, more competitive.
Physical Characteristics	Very active; need frequent breaks from tasks to do things that are energetic and fun for them. Need rest periods; good quiet activities include reading books together or doing simple art projects. Enjoy building models with small and large pieces. May tend to be accident-prone.
Social Characteristics	Enjoy organized games and are very concerned about following rules and always want to be first. Can be very competitive which may lead them to cheat at games. Very imaginative and involved in fantasy playing. Self-assertive, aggressive, boastful, becoming less cooperative.
Emotional Characteristics	Alert to feelings of others but unaware of how their own actions affect others. Very sensitive to praise and recognition; feelings are easily hurt.

	Inconsistent in the level of maturity; regress when tired; often less mature at home than with outsiders (Schaefer & Drewes, 2014).

Play therapy is viewed as a form of therapy that is primarily used when working with youth. It provides an opportunity for the youth to articulate their position and discuss the problems they are enduring. In a therapeutic setting play therapy may look like an ordinary play environment. However, the clinician can use the play activity to observe and obtain insights and reasoning into the youth's behavior and emotions. Through play therapy, the youth will learn coping skills and coping mechanisms to help restructure negative behavior. For instance, some of the benefits of play therapy consist of the following:

- Allows the youth to take more responsibility for their behavior
- Helps the youth to develop coping strategies
- Teaches the youth problem-solving skills
- Learn ways to express feelings and understand the components of empathy
- By learning self-respect and how to respect others
- Learn social skills and ways to build strong relationships (Schaefer & Drewes, 2014).

Therapeutic Benefits of Play Therapy

The therapeutic benefits of play therapy start by implementing the foundational components. Foundational to play therapy is the belief that play behaviors are active forces that initiate, facilitate, or strengthen behavior change (Schaefer & Drewes, 2014). Therefore, youth need to gain insight into their inner conflicts which consist of self-control, self-respect, modifying problematic behaviors, and communication skills.

Through play, the clinician can teach the youth helpful behavior to understand the triggers toof their behavior and emotions.

How Play Therapy Can Make a Difference

There are four therapeutic powers of play such as self-expression, creative problem solving, self-regulation, and social competence. By applying these therapeutic inner parts of the powers of play the clinician will be able to produce a change in the youth.

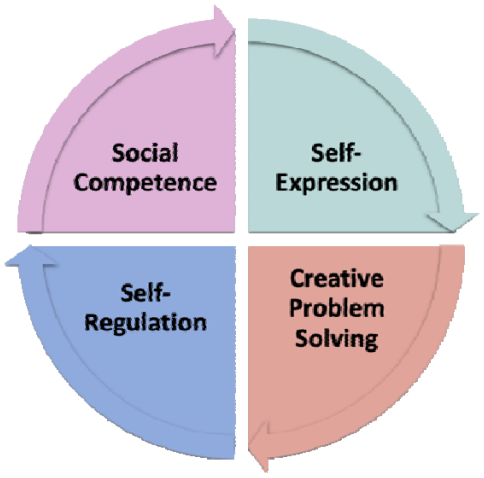


Figure 7: Four Therapeutic Powers of Play

Self-Expression

Self-expression is viewed as a therapeutic orientation model used along the continuum of directive, non-directive, and integrative approaches. Landreth (2012) shared that children are naturally comfortable with using play activities, materials, and toys as ways to express themselves through the self-expression model. It allows the youth the opportunity to be creative and create whatever their heart desires. Play therapy

is an intervention most clinicians incorporate to allow the youth to open up during the therapeutic process by engaging in a play activity. Through the play activity, the youth may invite the clinician to join them, or they can build a barrier that excludes the clinician completely.

The most common play activity for preschool-age youth is building structures and using their imagination. These activities include but are not limited to playing with blocks, cars, action figures, puppets, or exploring the outdoors. The structure can be used as a symbolic representation to help the youth explain their experiences and express their thoughts and feelings. It is viewed as an emotional release for the youth to talk about comfortable and uncomfortable life experiences.

Creative Problem Solving

Bagiati and Evangelou (2015) found that young children demonstrated considerable problem-solving knowledge during block play. Block play allows youth to practice both divergent and convergent thinking to apply logic and problem-solving skills. As the youth move through the play activity stages, such as block stacking and elaborate design. They learn to adapt new skills by making mistakes, identifying the problem, and finding the solution. The youth learn how to assess why the event occurred and apply decision-making skills on how to proceed positively.

The ability to problem-solve requires the ability to think flexibly, which may be difficult and beneficial for some children who are in therapy (Russ & Wallace, 2014). Youth who struggle within the therapeutic setting may have difficulties with self-regulation. By applying play therapy, the clinician can provide support by directing the therapeutic interventions through block play. This type of intervention requires the youth to mentally process the issue while navigating to identify the solution.

Self-Regulation

Bodrova and Leong (2005) defined self-regulation as a deep internal mechanism that underlies the mindful, intentional, and thoughtful behaviors of children (p. 32). Self-regulated children can suppress their impulses long enough to think about the possible consequences of their behavior and to consider different actions that may be more appropriate (Bodrova and Leong, 2005). This ability to be intentional, thoughtful, and futuristic involves both thinking and behavioral skills (Blair, 2002).

To help manage self-regulation, the clinician applies block building to help teach the youth ways to manage their emotions and behaviors. Block building inherently requires planning, frustration tolerance, and impulse control (Schaefer, 2015). It helps the youth solve environmental and familial challenges by learning persistence and how to cope with feelings, anger, and emotions. For impulsive youth who tend to act first, they would remember what they should have or could have done later, the opportunity to playfully practice cognitive planning and impulse control is valuable (Schaefer, 2015).

Social Competence

Social competence trains the youth on ways to increase their social interaction. Through block building, the youth can engage in social activities to acquire and practice socially necessary skills. This allows the youth to obtain knowledge and social interactions skills through play interventions. They can engage and interact with their peers by understanding the elements of social situations. Block play provides ways to foster social development as the youth work together in groups to understand different perspectives through play activities. When youth complete the blocking activities they can make, implement and negotiate with their peers by navigating critical skills.

Lesson 6 - Reporting Suspected Child Abuse

The purpose of this section is to discuss the signs and symptoms of child abuse. Please note a child can experience more than one form of abuse at a time. Child abuse can be identified as physical, emotional, sexual, and neglect of a child by a parent, guardian, or caregiver, which resulted in physical injury, emotional instability, and/or psychological harm to the child.

As clinicians, we are mandated to report suspected child abuse or neglect. Reporting the abuse can help the youth and provide help to the family. Please be cautious of youth who are displaying signs of maltreatment because any reasonable suspicion is sufficient. If at any time, you feel doubtful about a situation, please seek advisement from the program coordinator or supervisor. Following that consultation, you may be required to submit a suspected child abuse report. A copy of this report with submission instructions is included below.

There is a combination of indicators, signs, and symptoms of abuse to be aware of. The following are descriptions, but not limited to the types of abuse to look out for.

Signs and Symptoms of Abuse

Physical Abuse: Physical abuse is the deliberate use of force on a child's body that may result in an injury. Physical Abuse is the deliberate use of force on a child's body that may result in bodily harm or injury. Physical abuse can be connected to punishment or a method of discipline. Signs that a child may have experienced physical abuse include the following:

- Unexplained bruises, welts, lacerations, or abrasions on the face, torso, back, buttocks, and backs of the legs

- Unexplained small circular burns (cigarette burns) on the soles of the feet and palms of the hands.
- Unwillingness to tell you how an injury occurred
- Serious physical injuries that are left untreated
- Extreme behaviors such as aggressiveness or withdrawal

Neglect: Neglect consists of the parent's or caregiver's inability to provide the basic necessities to a child. Signs that a child may have experienced neglect include the following:

- Lack of sufficient food, clothing, shelter, adequate medical care, or adequate supervision to prevent injury.
- May appear hungry, tired, have poor personal hygiene, and unattended physical or medical needs receive inadequate childcare arrangements which place the child at risk or is left at home without any supervision
- Frequently misses school
- Parent, guardian, or caregiver misses appointments and does not follow through on school requests
- Craves physical contact with others
- Fails to thrive despite lack of disease or abnormality.

Emotional Abuse: Emotional abuse is a persistent attack on a child's sense of self. Emotional abuse destroys a child's self-image. A child who has been emotionally abused will often say "I can't" and gets overly upset if they make a mistake. The child may be afraid of new situations and changes and may have the inability to trust others. Signs that a child may have experienced emotional abuse include the following:

- Acts older or younger than the appropriate stage of development
- Displays a range of behaviors from aggressiveness and being out of control to being withdrawn and depressed
- States they are being blamed or belittled regularly by parent(s) or guardian(s) seek constant approval and have an unusual need to please adults
- Feels responsible for parent's difficulties and/or disappointments
- Arrives early for school and make excuses, as o why they can't go home,
- Has unusual fear of consequences of an action which often leads to lying.

Sexual Abuse: Sexual abuse includes any sexual exploitation of a child, whether or not it is consented to. Sexual abuse includes the behavior of a sexual nature towards a child by another child or adult. Signs that a child may have experienced sexual abuse include the following:

- Complaints of pain or itching in the genital area
- Has detailed knowledge of sexual behavior inappropriate for the child's age
- Exhibits sexually precocious behavior, or, creates artwork involving sexually explicit body parts or sexually abusive details
- Dresses inappropriately (wear clothing that covers their arms and legs even in hot weather or wears provocative clothing
- Receives unexplained gifts or money
- Seems sad, and has poor self-esteem
- Runs away from home often or talks about wanting to run away
- Is discouraged from having contact with others and has poor peer relationships

- Is reluctant to go to a particular place or be with a particular person

(www.cdss.ca.gov)

Print

SUSPECTED CHILD ABUSE REPORT

Reset Form

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS — Street / City / Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services) — AGENCY

ADDRESS — Street / City / Zip — DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED - TITLE — TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip			TELEPHONE ( )		
PRESENT LOCATION OF VICTIM		SCHOOL	CLASS		GRADE
PHYSICALLY DISABLED? ❒ YES ❒ NO	DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME		
IN FOSTER CARE? ❒ YES ❒ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)		
RELATIONSHIP TO SUSPECT		PHOTOS TAKEN? ❒ YES ❒ NO	DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK		

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip		HOME PHONE ( )	BUSINESS PHONE ( )		
NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip		HOME PHONE ( )	BUSINESS PHONE ( )		

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip			TELEPHONE ( )		
OTHER RELEVANT INFORMATION					

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ❒ — *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

SUSPECTED CHILD ABUSE REPORT
(Pursuant to Penal Code section 11166)

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM BCIA 8572

All Penal Code (PC) references are located in Article 2.5 of the California PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://leginfo.legislature.ca.gov/faces/codes.xhtml (specify "Penal Code" and search for sections 11164-11174.3). A mandated reporter must complete and submit form BCIA 8572 even if some of the requested information is not known. (PC section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

Mandated child abuse reporters include all those individuals and entities listed in PC section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC section 11165.9.)

III. REPORTING RESPONSIBILITIES

Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof ***within 36 hours*** of receiving the information concerning the incident. (PC section 11166(a).)

No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC section 11172(a).)

IV. INSTRUCTIONS

SECTION A – REPORTING PARTY: Enter the mandated reporter's name, title, category (from PC section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes/no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (*continued*)

SECTION B – REPORT NOTIFICATION: Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.

SECTION C – VICTIM (One Report per Victim): Enter the victim's name, birthdate or approximate age, sex, ethnicity, address, telephone number, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes/no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes/no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes/no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.

SECTION D – INVOLVED PARTIES: Enter the requested information for Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).

SECTION E – INCIDENT INFORMATION: If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

Reporting Party: After completing form BCIA 8572, retain a copy for your records and submit copies to the designated agency.

Designated Agency: ***Within 36 hours*** of receipt of form BCIA 8572, the initial designated agency will send a copy of the completed form to the district attorney and any additional designated agencies in compliance with PC sections 11166(j) and 11166(k).

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

Lesson 7: I CAN Program

The following modules are intended to provide clinicians with conceptualized and effective interventions. The modules tend to be relevant in and out of the classroom settings and applied to interventions that are delivered directly by the clinicians. The program will consist of 10 modules. The interventions will be divided into 3 sections and list the materials needed to complete each activity. The first session will begin with engagement and assessment activities to help the clinician to evaluate the student. The second section will provide therapeutic techniques to help guide the student to work through their identified problem. The last section will review the program interventions and lead toward the completion of the program. Each intervention will outline a specific goal for the student to achieve. A variety of interactions provided in each section will allow the clinician to choose which intervention fits the youth's specific needs based on the identified behavior to change.

Section One:

Engagement and Assessment

Module 1: It's All About ME

Age Range: 4 and Up

Time: 30 minutes

Goals:

- Gather information to learn about the youth (For example: likes, dislikes and behaviors.)
- Discuss the responsibilities and struggles they endure

Materials:

- Paper
- Crayons

Description:

The clinician will ask the youth to draw a picture of themselves. The clinician will manage an open discussion by describing who are they are and what are their likes and dislikes.

Process questions and prompts can include:

- Tell me about yourself…
- What are your likes?
- What are your dislikes?
- How do you react in certain situations (When you are happy, sad, angry, or get emotional?
- Explore to identify the youth's perceptions and feelings about themselves and how they treat others.

Discussion:

The module facilitates an open discussion to provide insight into the youth and behaviors that need to be addressed.

Module 2: My Family Dynamics

Age Range: 4 and Up

Time: 30 minutes

Goals:

- Gather information to learn about the youth and their family members
- Obtain an understanding of the youth's role within his/her family dynamics
- Discuss the youth's responsibilities and limitations of their role
- Identify the youth's perceptions and feelings about each family member to identify any attachment difficulties

Materials:

- Paper
- Crayons

Description:

Explain each phrase by having the youth draw themselves and each family member in their household. Manage an open discussion by describing each person, their relation to the youth and describes how they interact/feel around them.

Process questions can include:

- Tell me about each family member in your home?
- How is your relationship with each family member?
- How do they treat you?
- How do you treat them?
- How do you feel about each family member?
- How do you interact with them?

Discussion:

The module facilitates an open discussion to provide insight into the youth's life family dynamics, attachment difficulties, and behaviors that need to be addressed.

Module 3: What About Your Friends?

Age Range: 4 and Up

Time: 30 minutes

Goals:

- Gather information to learn about the youth's school dynamics (For example: likes, dislikes and behaviors.)
- Discuss the role the youth has in various locations (For example: in and out of the classroom setting, with the teachers and their peer relationships).
- Discuss the responsibilities and limitations of their role.

Materials:

- Paper
- Crayons

Description:

Explain each phrase by having the youth draw themselves, teachers, and peers. Manage an open discussion by describing each person and describes how they interact with their teachers and peers.

Process questions can include:

- Tell me about friends?
- Tell me about your school? (For example: What are your likes and dislikes about school?
- Tell me about your relationship with your friends and teachers?
- How do they treat you?
- How do you treat them?
- How do you interact with them?)

Discussion:

The module facilitates an open discussion to provide insight into the youth's school dynamics, attachment difficulties, and behaviors that need to be addressed.

Module 4: Problem Solving

Age Range: 4 and Up

Time: 30 minutes

Goals:

- The clinician will provide insight into the youth's behavior based on the information gathered during the prior 3 meetings.
- Have an open discussion about the clinician's assessment and possibilities for change
- Provide encouragement and hopefulness for the behavior change

Description:

The clinician will explain each phrase to help the youth develop new insight into the possibilities of changing their behavior.

Process questions can include:

- The clinician and youth will discuss the assessment results
- The clinician will discuss the effects of negative and positive behavior
- The clinician and youth will discuss examples of negative and positive behavior
- The clinician and youth will discuss ways to improve their behaviors

Discussion:

The module facilitates will serve as a therapeutic discussion on the possibilities of change. The clinician will explain the effects of continuous negative behavior, reinforcements to implement appropriate behavior, and outcomes for establishing positive behavior.

Section Two:

Applying Treatment Interventions

Module 5: My Feelings Matter

Age Range: 4 and Up

Time: 30 minutes

Goals:

- Discuss the behavior identified in the youth's assessment.
- The clinician and youth will discuss the difference between positive and negative behavior
- The clinician will support and encourage the youth on the possibility of changing the identified behavior.

Materials:

- Heart templates are cut out in the following colors: (Red, happy) (Yellow, sad/hurt) (Blue, emotional) (Black, angry) (Gray, felt alone)
- Paper
- Crayons

Description:

The youth and clinician will discuss the list of emotions (happy, sad/hurt, emotional, angry, and felt alone) and the difference between positive and negative behaviors. The clinician will instruct the youth to think about a situation when they displayed each emotion and explain why they felt that way. The clinician will help the youth change their color style to match the happy emotion (Red heart).

Process questions can include:

- Tell me about a time when you were sad/hurt, angry, alone, or emotional?
- How did you react in that situation?
- Did your reaction lead to a positive or negative outcome?
- What would you do differently in the situation?
- The clinician and youth will discuss ways to change to a happy emotion.

Discussion:

The module facilitates an open discussion to provide insight into a situation where the youth displayed positive and negative behavior.

Module 6: Feeling Expression

Age Range: 4 and Up

Time: 30 minutes

Goals:

- Discuss the behavior identified in the youth's assessment.
- The clinician and youth will discuss feeling expressions
- The clinician will support and encourage the youth on the possibility of changing the identified behavior.

Description:

The youth and clinician will have an open discussion on the different emotions the youth experiences. The youth and clinician will discuss feeling expressions. The clinician will instruct the youth to provide examples of positive and negative behavior. The clinician and youth will discuss ways to implement positive behavior.

Process questions can include:

- Tell me a time when you felt sad, angry, or emotional? (select identified behavior)
- How did you react to your feelings?
- How did you express your feelings verbally? Physically? Emotionally?
- How did your reaction affect you?
- How did your reaction affect other people?
- The clinician and youth will discuss ways to implement positive behavior.

Discussion:

The module facilitates an open discussion to provide insight into how the youth's reactions made them feel, how it made other people feel, and ways to improve their behavior.

Module 7: What Triggers My Behavior?

Age Range: 4 and Up

Time: 30 minutes

Goals:

- The clinician and youth will discuss what triggers their behavior.
- The clinician and youth will identify and discuss appropriate coping skills to help the youth manage their behavior.
- The clinician will support and encourage the youth on the possibility of changing the identified behavior.

Materials:

- Paper
- Crayons

Description:

The clinician will ask the youth to draw and color themselves on paper. After completing the picture, the clinician will explain what worrying and triggers mean. The youth will describe what worries them and what triggers their behavior. The clinician will explain coping skills based on the youth's age range. (For example: taking a break, asking for help, or taking responsibility for the situation). The clinician and youth will discuss and demonstrated how to implement coping skills.

Process questions can include:

- What triggers your behavior?
- Did you feel unsafe, unheard, or worried?
- How did your reaction make you feel?
- How would your reaction be different after applying a coping skill?
- The clinician and youth will discuss ways to change the negative behavior.

Discussion:

The module facilitates an open discussion to provide insight into what triggers the youth's behavior and how the behavior can change by applying coping skills.

Module 8: Verbalizing My Feelings

Age Range: 4 and Up

Time: 30 minutes

Goals:

- The clinician and youth will discuss words to describe their feelings.
- The clinician and youth will discuss ways to verbalize their feelings.
- The clinician and youth will discuss ways to apply effective communication skills.

Materials:

- Paper
- Crayons

Description:

The clinician will write down 5 – 10 words to express their feelings. (For example: happy, afraid, sad, frustrated, angry etc). The clinician will explain ways to verbalize their feeling based on the youth's age range. (For example: "I feel sad when… or I feel happy when….") The clinician and youth will discuss and demonstrated how to apply effective communication skills.

Process questions can include:

- Tell me about a time when you were sad?
- What was your reaction? Did you verbalize your feeling or emotions?
- Tell me about a time when you were happy?
- What was your reaction? Did you verbalize your feeling or emotions?
- What is an effective way to express your feelings?
- The clinician and youth will discuss ways to verbalize their feelings and how to manage their emotions.

Discussion:

The module facilitates an open discussion to provide insight into what triggers the youth's behavior and how the behavior can change by applying coping skills.

Section Three:

Program Review

Module 9: Support System

Age Range: 4 and Up

Time: 30 minutes

Goals:

- The clinician will explain support systems
- The clinician will explain ways to utilize their support system from their family
- The youth will identify qualities they find helpful to support their need.

Materials:

- Paper
- Crayons or pencils

Description:

The clinician will explain what a support system is and how they can provide support to the youth. The clinician will instruct the youth to write down people in their lives that support them. The clinician and youth will discuss the importance of utilizing support from their family members.

Process questions can include:

- What is a support system?
- What qualifies do you need for someone to help you?
- Who can you count on in your family?
- Tell me about a time when they were able to help you?
- How do they support you?

Discussion:

The clinician and youth will brainstorm to make a list of people that are helpful during their time of need. The clinician and youth will discuss qualities they find helpful to them. (For example: Active listeners, motivators, help/support them when they make a mistake).

As the program becomes close to ending, it would be essential for youth to have/form a support system outside of the program. This would provide a structured way to connect the youth with their supportive family members to continue working on the identified behavior.

Module 10: Accomplishments

Age Range: 4 and Up

Time: 30 minutes

Goals:

- The clinician and youth will review the topics and therapeutic interventions discussed in the program
- The clinician will provide a report explaining the youth's progress and overall accomplishments.
- The clinician will support and encourage the youth on the possibility of changing the identified behavior.

Materials:

- Paper
- Crayons or pencils

Description:

The clinician will explain this is the last meeting. The clinician will provide the module materials to review the topics discussed in the program.

Process questions can include:

- Write down the behavior identified to change.
- Write down the coping skills you will use when you are sad, angry, or emotional.
- Draw a picture of yourself using the coping skills.
- Draw a picture of your support system and explain how they will help you.

Discussion:

This activity will serve as a reminder to apply the therapeutic interventions the youth can use to increase positive behavior. It will facilitate the skills practices and goals the youth achieve in the program.

Lesson 8 - I CAN Program Evaluation

The following is an evaluation that the clinicians will conduct as part of the completion of the I CAN program. This component was added post stakeholder feedback and provided as a recommendation for ongoing program development.

The evaluation methodology will be completed as followed. The metrics can best be supplied by qualitative data to help understand the program concept and experience of participants. Nevertheless, a combination of anonymous surveys or in-person interviews conducted by a neutral party will also provide data on perceptions and personal experiences regarding the school-based program. The program coordinator will gather the evaluated information about the program and then provide detailed information about areas of strength and growth.

I CAN Evaluation Survey

Short Answer Questions: Please provide detailed responses based on the mental health interventions utilized as a part of this program.

1. What are the strengths of this program?	
2. What specific interventions and strategies were effective in the classroom?	

3. How did these interventions or strategies help you better understand the behavioral problem(s) of children you worked with? How did these interventions help you to assist the youth in demonstrating prosocial behaviors in the classroom?	
4. What interventions and strategies were not effective in developing prosocial behaviors of the children in your classroom?	
5. What strategies or interventions need to be used more or more consistently during the execution of this program or the training of the mentors?	
6. What are your thoughts about the amount of time the clinician met with the student(s) displaying disruptive behaviors?	
7. Did the I CAN program meet your expectations?	

8. What was least satisfying about the mentoring program?	

Scaling Questions: Circle one

1. How would you rate the overall effectiveness of the program in reducing aggressive behavior in your classroom?	Excellent	Very Good	Good	Fair	Poor
2. Did the program help the youth decrease aggressive behavior?	Excellent	Very Good	Good	Fair	Poor
3. How well prepared were the clinicians to work with youth in your classroom?	Excellent	Very Good	Good	Fair	Poor
4. How clearly defined were the clinicians responsibilities?	Excellent	Very Good	Good	Fair	Poor
5. Did you have accessibility to the Program Coordinator for access to support/advice?	Excellent	Very Good	Good	Fair	Poor
6. Was the time the clinician spent with the youth(s) sufficient in addressing aggressive or problematic behaviors?	Excellent	Very Good	Good	Fair	Poor

Collaborations and Communications

In the evaluation approach, it is essential for the clinicians to collaborate and maintain clear and frequent communication. By providing updates and obtaining

feedback from the teachers, parents, school administration, and the program coordinator regarding the program satisfaction, program goals, and the youth's achievements. Applying this approach, the effectiveness of the program can be measured in terms of obtaining limitations, satisfaction, or dissatisfaction with the program. The collection of this information helps the evaluation by identifying the positive and negative views that can help the program coordinator remove less effective materials and implement more effective interventions to fit the youth's area of need. It can also help to promote the program by providing qualitative data and obtaining additional stakeholders to help support and fund the program.

CHAPTER SEVEN

SUMMARY AND APPLICATIONS

This chapter will discuss the results of the stakeholder interviews and qualitative research. In addition, it will discuss the implications of the research questions, explain the program's limitations and suggestions for current and future research on school-based mental health programs.

Discussion

The purpose of this chapter is to discuss stakeholders' perceptions of the I CAN program. The program outlines a mental health school-based program, instructed by doctoral and masters' level marriage and family therapist students and professional clinical counselor trainees under clinical supervision by licensed MFTs from Loma Linda University (LLU). The evaluation will determine the effectiveness and impacts of a school-based mental health program proposed to facilitate the achievement of pre-school-age students. An in-depth understanding of the program is gained through the use of interviews and qualitative data provided by stakeholders representing the population served.

Stakeholder's Characteristics

To obtain the perceptions of stakeholders regarding the I CAN program, seven stakeholders completed one on one interviews and responded to qualitative questions for the evaluation. Each stakeholder was provided a copy of the school-based mental health training manual. The stakeholders were given ample time to read and review the manual and program outcomes before providing their feedback on the program.

The graph below describes the stakeholder's characteristics. The graph shows the demographic information about the stakeholders and their qualifications.

Stakeholder's Characteristics	Total
Gender	
Female	4
Male	3
Race / Ethnicity	
Caucasian	2
Black	2
Hispanic	2
Asian	1
Age	
25 - 30 years old	1
31 - 35 years old	3
36 - 40 years old	2
41 - 45 years old	1
Educational Levels	
Masters	2
Doctorate	5
Job Positions	
School District Officials	2
School Superintendent	1
School Psychologists	4

Figure 8 Stakeholder's Characteristics

Feedback Results and Findings

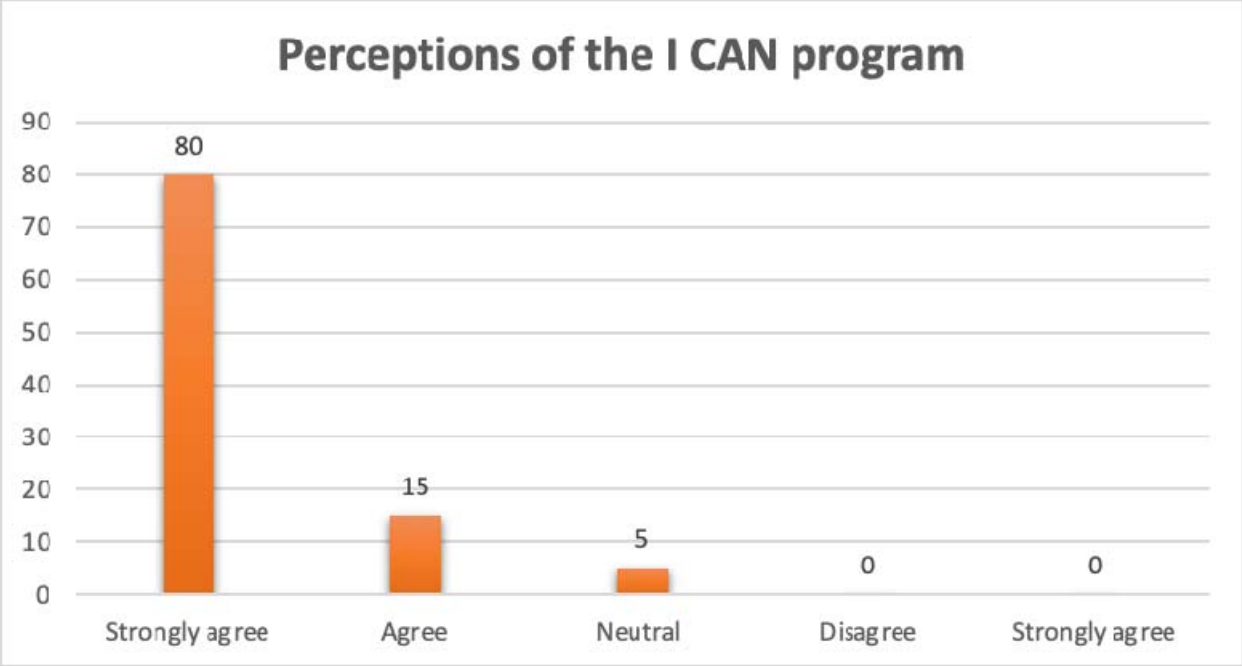
This section will summarize the data gathered through the stakeholder interviews and qualitative data. A 5-item Likert-type scale ranging from strongly agree to strongly disagree was used to rate the stakeholder's responses. The stakeholders provided their

perspectives based on their professional experience, personal opinions, and view of the school-based program.

Feedback Question One

What are the stakeholder's perceptions of the I CAN program?

Table 2. Feedback Question One



At least 80% of the stakeholders strongly agreed, 15% agreed and 5% were neutral about the aspects of the I CAN program. This bore out in the qualitative feedback. The strongest correlation found in the evaluation was implementing a program with a mental health component within a school setting. The stakeholders greatly emphasized how mentally healthy children are more successful when all of their needs are met, especially when it comes to addressing mental health issues. One stakeholder noted, "It is

important to apply mental health services in the student's educational journey, especially for students who are struggling with social, emotional, and behavioral problems. These are three problem areas that could hinder a student if the problems are not addressed early on." Stakeholders expressed encouragement for having behavioral health clinicians work in a school environment. "This will help youth understand the cause of the behavior, learn how to change the behavior, and apply techniques to fix the problems. It is important to change behavioral problems in school since that's where it's affected the most." One stakeholder mentioned, "Having behavioral health professionals on-site would be amazing. Most of the students I work with were referred out to receive mental health services within 30 days, compared to obtaining immediate mental health services on the school campus. Sometimes the parents would follow through and seek treatment for their child, while others don't. It's unfortunate since the school officials have no way of knowing if the student received the service they need." The stakeholder explained, "As a parent and school official, I believe in having someone, especially a mental health professional, to work one on one with the student. I believe the student's participation and cooperation would be greater. I would feel comfortable knowing my child or the student is getting regular help to decrease disruptive behavior and learning how to create healthy long-lasting friendships." Another stakeholder acknowledged, "Having mental health professionals would create a balance for schools. The clinician would have the ability to observe negative behavior, diagnose the problem, and work together one on one to help the student learn how to address their problems with their peers." A fourth stakeholder mentioned, "Mental and behavioral health problems are some things that are kept quiet. School-based mental health programs should be encouraged in a school setting to bring awareness. The parents and students need to understand and be aware of

potential behavior, emotional and social difficulties early on, to avoid continuous struggles throughout secondary and higher education."

Weaknesses of the I CAN Program

The weakest correlation found in the evaluation was based on the 5% neutral rating. The neutral rating was due to the timeframe for the program. The stakeholder stated, "I can see the benefits of school-based mental health programs. However, the only default would be, that it's only available during the instructional period or after school. This service should be available to the students during the summertime, where the students can have access to more time with the clinician."

The stakeholders provided suggestions based on the youth's age range. "School-based programs should be structured based on the youth's age and grade level. For example, adding the preschool students to "the points and reward system" would create more interest and engagement. Young children have a short attention span, so providing attention grabbers such as rewards would be beneficial. The rewards will help the students to remember the rules, modified behavior, and use common sense manners. Therefore, the reward system can be on a daily progress report. The report would be conducted to document the youth's progress during each meeting with the clinician, to receive the grand reward at the end of the week."

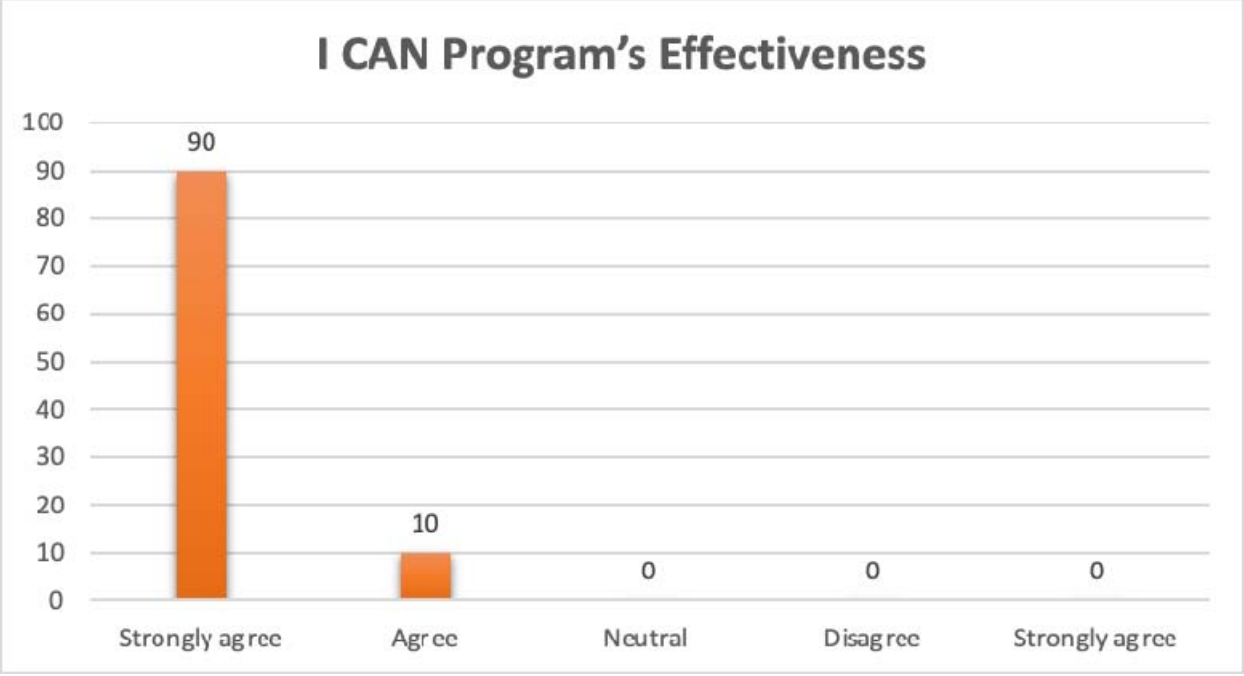
The stakeholder expressed an essential need to add an academic component. The stakeholder believes the youth would be more motivated to work on change by receiving additional help such as tutoring services for reading and math, to assist with their academic difficulties. The stakeholder suggested the academic component can also

identify the early onset of learning disabilities and mental health diagnoses. The stakeholder explained, “I see value in the school-based mental health programs. Adding an academic approach to this program would be a game-changer and make the program more effective. I see the importance of focusing on social interaction, behavioral problems, and emotional issues but with an academic approach I would see more teachers, parents, and students excited about the program because the student would benefit in every aspect to prepare them for their life’s journey.”

Feedback Question Two

What are the stakeholder’s perceptions of the program’s effectiveness?

Table 2. Feedback Question Two



The results from the evaluation determined that 90% of the stakeholders strongly agreed and 10% agreed with the program's effectiveness. The stakeholders identified significant impacts on the student's outcomes after completing the I CAN Program. The impacts included higher academic scores, a decrease in absences, peer-to-peer friendships, and a decrease in behavioral problems. The stakeholders described the I CAN program as a school-based program that focuses on "The Whole Child". The feedback explains the program addressed the youth's needs by building their self-esteem, providing mental health awareness, and treatment, and being a positive force during the student's preschool-age years.

The stakeholders suggested the school-based program would help to create a culture of awareness in the school community and help in the early detection and prevention of issues affecting the students. The stakeholder stated "I have reviewed several research studies showing school-based mental health programs. The results of the program support the notion that state school-based school-based mental health maintains a positive outcome. However, additional research is needed to acquire more information and more evidence is needed to demonstrate the benefits and impacts of school-based mental health programs. School-based mental health programs have improved the student's behavior, attitudes, and self-confidence. It also revealed how the student's received higher grades, and maintained better relationships with teachers and peers. This program is a prime example of how the improvement could take place."

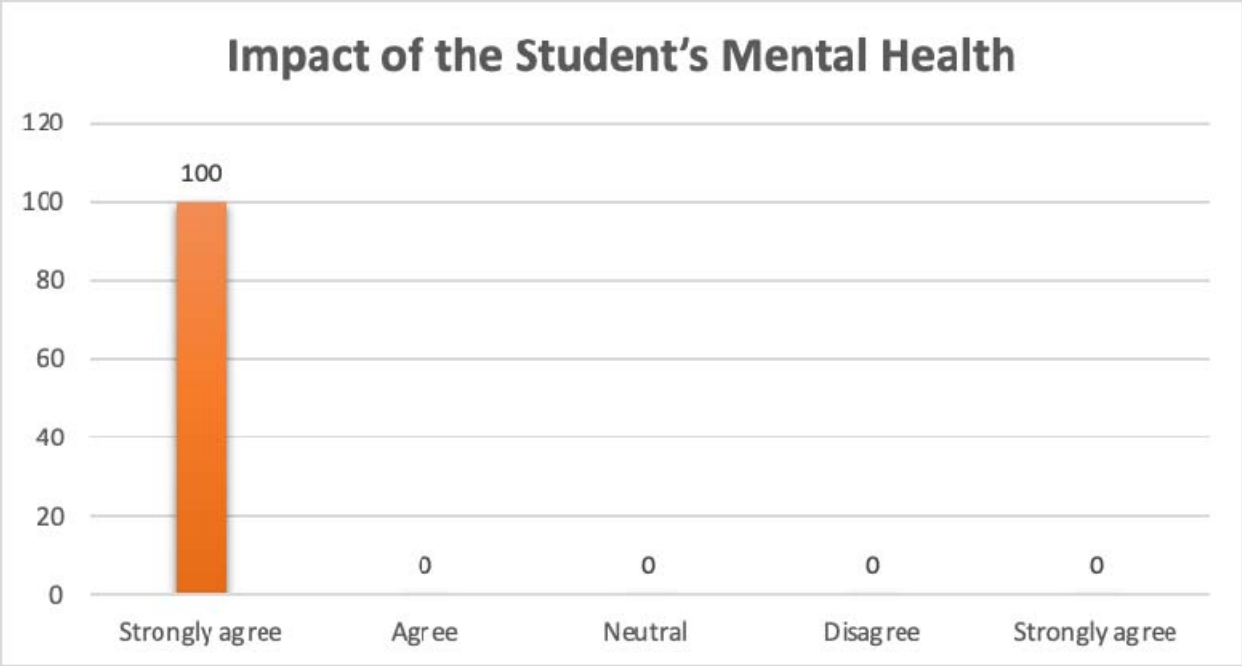
In addition, stakeholders were pleased to see weekly communication to notify the parent, guardian, or caregiver of the youth's progress, which they stated was not common in school-based programs. "Having open communication with parents is a plus. As a parent

myself, I would be curious as to how my child is improving or not improving. I would like to know what interventions were placed to enhance positive behavior so I can implement them in the home. Children need consistency during early childhood development to apply change effectively."

Feedback Question Three:

What was the impact on the student's mental health after completing the I CAN program?

Table 3. Feedback Question Three



Results about the stakeholder's perceptions of the I CAN program indicate 100% of the stakeholders strongly agreed on the impacts on the student's mental health. No stakeholder disagreed with the statement. Stakeholders believed school-based mental health programs would be a link for creating interventions and preventing of early onset

of behavior problems, social interaction, and emotional issues. The stakeholder mentioned, “60% of the students in this district suffer from behavior, social or emotional problems. Some seek treatment, while others don’t. I strongly believe therapy is a dynamic process. I can see the benefits of having a behavioral health or mental health professional incorporated into a school system. All students would have access to the service and get their individual needs met.”

Several stakeholders suggested that it may be more profitable to consider school-based mental health programs for higher grade levels as a continuous component for school-age children. One stakeholder recommended, “It would be extremely helpful for a student to have support throughout their entire educational path. For example, having a graduate-level clinician assigned to the student during the primary education stage. I think the graduate level clinician can be more relatable to the student, instead of the teacher and parent. Especially, when it comes to, talking about how to balance their academics, issues with mental health, and problems among peers. Having someone whom the student looks up to and relates to their struggles, can benefit the student’s progress since they would be on similar paths of their education journey.”

A stakeholder stated, “Typical teachers are used to identifying problems the students are experiencing. However, identifying mental health difficulties is not in the teacher’s scope. Teachers often worry about their students, but they can’t help them especially when the issues pertain to behavioral, emotional, or mental health problems. Therefore, having a school-based mental health professional on campus can provide immediate and direct support to students who are at risk of mental health issues. With the differentiation roles put in place, the mental health clinician would have more knowledge

about the student's behavior by observing and working with the student daily. The clinician would have the opportunity to get a closer look at the student's behavior concerns and change in moods As well as, detect the cause of the problem and identify a solution."

Challenges and Limitations in School-Based Mental Health Program

Stakeholders stated a school-based mental health program can be a key determinant in altering negative behavior and implementing positive outcomes for at-risk youth. However, more up-to-date research is needed to identify how effective school-based mental health programs are.

Based on the short program implementation, stakeholders highly suggested adding a pre and post-behavioral survey and comprehensive evaluation be implemented. The pre and post-test design will be used to measure the youth's progress, engagement, development, and post-treatment measures. This would help to obtain more research into school-based programs by evaluating the youth's academic performance, attendance rate, and the severity of the student's behavior to identify or explain the effectiveness of the youth's progress throughout each grade level.

Nevertheless, stakeholders provided feedback on developing a section in the manual on how culture, age, and gender can influence social interaction, behaviors, and emotional issues. The focus on these specific topics would provide guidelines on how to recognize the differences in the youth's communication styles, languages, culture, customs, and traditions. It would provide more in-depth information and insight into the youth's life and help the clinician apply the appropriate type of interventions.

Stakeholders identified school-based programs as having long-term benefits in assisting at-risk youth. However, the stakeholders noted the clinician for the school-based programs are considered student volunteers and would constantly change due to their student or intern status. Some stakeholders expressed concerns since many of the clinicians may not pursue a long-term commitment, or express long-term interest in assisting the youth once they graduate. One stakeholder stated, "While the clinician is striving and working towards obtaining their career goal and becoming licensed, the youth may get pushed to the side and their mental health need is left untreated. The school system and youth need licensed clinicians who are focused on growing their careers within the school environment and willing to work with at-risk youth. Retaining licensed clinicians for the program's entity would be a key component to creating effective relationships and effective program outcomes."

Recommendations

Due to the high prevalence rate among school-age children and mental health issues, continued research and program development are needed to assist this at-risk population. School-based mental health programs are effective, but there is a lack of evidence to support the continuous impact on the youth's overall educational journey and mental health needs. Such programs can provide a greater impact while addressing untreated mental health needs more efficiently.

However, feedback on the I CAN program identifies the need to continue research on the effectiveness of school-based mental health programs as well. In addition, it was strongly recommended: "to have ongoing evaluations of the program to make additional

improvements to enhance the impacts of the program." Nevertheless, "ongoing training for the clinicians was suggested to keep up to date on the latest interventions and research studies to apply more evidence-based techniques." The evaluation generalizes the effects addressing mental health issues has on overall student achievement. Consequently, more research is needed to make school-based programs more effective, in order to continue addressing the mental health needs of the at-risk youth populations.

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APPENDIX A

STAKEHOLDERS SURVEY

I CAN Program

The program coordinator is requesting your feedback regarding the I CAN program. This is to help identify the program's strengths, weaknesses, and areas of improvement. Please complete the survey thoroughly and provide a brief comment indicating areas of growth. Thank you for your time and feedback.

1. What are the stakeholder's perceptions of the I CAN program?

Strongly agree	○	○	○	○	○
Agree	○	○	○	○	○
Neutral	○	○	○	○	○
Disagree	○	○	○	○	○
Strongly disagree	○	○	○	○	○

2. Following up to the previous question, why do you feel that way?

3. What are the stakeholder's perceptions of the program's effectiveness?

Strongly agree	☐	☐	☐	☐	☐
Agree	☐	☐	☐	☐	☐
Neutral	☐	☐	☐	☐	☐
Disagree	☐	☐	☐	☐	☐
Strongly disagree	☐	☐	☐	☐	☐

4. Following up to the previous question, why do you feel that way?

5. What was the impact on the student's mental health after completing the I CAN program?

Strongly agree	◯	◯	◯	◯	◯
Agree	◯	◯	◯	◯	◯
Neutral	◯	◯	◯	◯	◯
Disagree	◯	◯	◯	◯	◯
Strongly disagree	◯	◯	◯	◯	◯

6. Following up to the previous question, why do you feel that way?

7. What is your gender?

- ◯ Female
- ◯ Male

8. What is your age?

- ◯ 18 to 24
- ◯ 25 to 34
- ◯ 35 to 44
- ◯ 45 to 54
- ◯ 55 to 64
- ◯ 65 to 74
- ◯ 75 or older

9. Are you:

- ◯ White
- ◯ Black
- ◯ Hispanic
- ◯ Asian
- ◯ Other

APPENDIX B

PARENTS OR GAURDIAN CONSENT LETTER

Information Letter and Consent Form for Parents or Guardians
Permission for Research with Children

Dear **Parent(s) or Guardian(s**):

I am writing to ask your permission for your child to participate in a pilot program for my doctoral project. The program will be conducted at Loma Linda Academy Children's Center over the next several weeks. The project in which your child has been invited to participate is expected to be an enjoyable experience and will run conjunctly during the instructional time.

The study sets out to analyze a school-based mental health program and identify the impacts the on the child's behavior, emotions, and social interactions. Feedback from stakeholder within the school district to access the program's strengths, weaknesses and areas of improvement. The program's component includes: quality of services and activities, outcomes and behaviors of the youth, and increased knowledge.

The mental health program affiliated with your child's school is coordinated by students from Loma Linda University. The program will consist of clinicians who are doctoral and masters' level marriage and family therapist students and professional clinical counselor trainees under clinical supervision by licensed MFTs from LLU. All clinicians will go through a training process with the organization and have a background check through Loma Linda University.

All children's performances are considered confidential. Only children who have parental permission will be involved in the study. Also, children or parents may withdraw their permission at any time during the study without penalty by indicating this decision to the researcher. There are no known or anticipated risks to participation in this study.

I would like to assure you that this study has been reviewed and approved by the Institutional Review Board (IRB) at Loma Linda University. In addition, it has the support of the director and teacher at your child's school. However, the final decision about the participation is yours. Should you have any concerns or comments resulting from your child's participation in this study, please contact:

Melissa Harris, M.S.
Loma Linda University, Doctor of Marriage and Family student
909-558-9552 ext. 39172
mmharris@llu.edu

APPENDIX C

CHILD CONSENT FORM

(Accompanies the information letter about the study)

I have read the information letter concerning the pilot program project. I have had the opportunity to ask questions and receive any additional details I wanted about the study.

I acknowledge that all information gathered on this project will be used for research purposes only and will be considered confidential. I am aware that permission may be withdrawn at any time without penalty by advising the researchers and that I may contact the researcher if I have any comments or concerns about my son or daughter's involvement in the study.

If I have any questions about the study I can feel free to call the researcher

Melissa Harris
Loma Linda University, Doctorate of Marriage and Family (DMFT) student
909-558-9552 ext. 39172
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☐ Yes – I would like my child to participate in this study

☐ No – I would not like my child to participate in this study.

Child's Name **(please print)**

_____

Child's Birth Date _____ Gender of Child ____ Male ____ Female

Parent or Guardian Signature _____ Date _____

Researcher's Signature _____ Date _____

Researcher's Title _____ Department _____

Faculty Advisor Signature _____ Date _____

Faculty Advisor
Title_____Department_____