

2017

Therapists' Perceptions of School-based Mental Health Services: A Qualitative Evaluation of two Behavioral Health Models

Sheina Costa

Osayande Osagiede

Jason Rose

Kimberly A. Allen

Aaron Spaulding

See next page for additional authors

Follow this and additional works at: <https://digitalcommons.unf.edu/fphr>

Part of the [Public Health Commons](#), and the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Costa, Sheina; Osagiede, Osayande; Rose, Jason; Allen, Kimberly A.; Spaulding, Aaron; Rose, Mary; and Apatu, Emma (2017) "Therapists' Perceptions of School-based Mental Health Services: A Qualitative Evaluation of two Behavioral Health Models," *Florida Public Health Review*: Vol. 14, Article 8.

Available at: <https://digitalcommons.unf.edu/fphr/vol14/iss1/8>

This Research Article is brought to you for free and open access by the Brooks College of Health at UNF Digital Commons. It has been accepted for inclusion in Florida Public Health Review by an authorized administrator of UNF Digital Commons. For more information, please contact [Digital Projects](#).

© All Rights Reserved

Footer Logo

Therapists' Perceptions of School-based Mental Health Services: A Qualitative Evaluation of two Behavioral Health Models

Authors

Sheina Costa, Osayande Osagiede, Jason Rose, Kimberly A. Allen, Aaron Spaulding, Mary Rose, and Emma Apatu

Therapists' Perceptions of School-based Mental Health Services: A Qualitative Evaluation of two Behavioral Health Models

Sheina Costa MPH; Osayande Osagiede, MD, MPH; Jason Rose, PhD; Kimberly A. Allen, PhD; Aaron Spaulding, PhD; Mary Rose, PhD; Emma Apatu, DrPH

ABSTRACT

Therapists' perceptions of school-based mental health programs are considered to be an important factor in determining the effectiveness of a school based behavioral health model. This qualitative evaluation summarizes the perceptions of participant therapists on two different behavioral health models called Full Service Schools (FSS) and Full-Service Schools (FSS) Plus model that are currently being implemented in a large school district in Florida. FSS therapists provide therapy at a hub location whereas FSS Plus therapists work at one particular school. The study utilizes therapists' views of their respective programs to compare and contrast the effectiveness of each of the behavioral health models. Five focus groups involving 24 therapists from both models were held at five separate locations. Nvivo version 10 was used to conduct a thematic analysis of collected data. Study findings revealed better results for the FSS Plus model as compared to the FSS model in terms of successful elimination of barriers such as transportation and lack of physical space to provide therapy. This study suggests that improved and effective behavioral health services can be provided to students by assigning a designated therapist at each school.

Florida Public Health Review, 2017; 14, 67-80.

BACKGROUND

Irrespective of gender, ethnic/racial backgrounds and location, school-aged children across the United States (U.S.) suffer from mental health disorders (Lindo et al., 2014; Mental Health America, 2016). It is estimated that 1 in 5 youth in the U.S. suffers a mental disorder in their lifetime (Merikangas et al., 2010). Additionally, 50% of all lifetime cases of mental illness begin by age 14 and 75% by age 24 (National Alliance on Mental Illness (NAMI), 2016). Furthermore, the lifetime prevalence of a mental health disorder among 13-to-18-year-olds was reported as 46.3% in 2010 (Merikangas et al., 2010). According to the National Research Council and Institute report (2016), the expenditure on childhood mental disorders is estimated to be \$247 billion each year (Centers for Disease and Control Prevention, 2016). Given that mental health disorders impact millions, including children, families, and communities; more comprehensive approaches are needed to treat and prevent mental health disorders among children.

One way to improve the problem of increasing mental health disorders among children is to provide School-Based Mental Health (SBMH) Services. It is essential for mental health support to be available in

schools, because childhood mental health disorders can worsen in adulthood (NAMI, 2016). These disorders are treatable and if detected at an early stage can be dealt with through various interventions. SBMH services have proven to be effective since children spend majority of their day in school (NAMI, 2016). Schools provide an ideal setting for improving mental health services based on a public health framework (Dowdy et al., 2010). SBMH services have been known to play an important role in improving academic performance and emotional well-being of school children (Jacob & Coustasse, 2008). In addition, staff members within schools play an important role in identifying early warning signs of emerging mental health conditions and can direct students to effective services and support within the community (Langley et al., 2010). Other important factors that affect SBMH services are school structure, policies and norms of the school, administrative leadership, and other existing resources at the schools (Atkins et al., 2003). Overall, additional support provided in schools can help children improve resilience and give them the ability to succeed in school (Association for Children's Mental Health (ACMH), 2016).

Previous literature has shown several benefits as

well as challenges in the implementation of SBMH services. In a study of 150 elementary, middle, and high schools in the state of Minnesota, results demonstrated that the student's mental health had significantly improved due to SBMH services. The social workers and psychologists participating in the study reported that their SBMH programs increased access to many students that were in need (Kline, 2012). Other benefits included: positive behavior, decreased stress for parents and teachers, enhanced collaboration between schools and providers, and availability during the school day. School psychologists outlined lack of financial support, inadequate support from school staff, parent consent for care, and communication between parents and therapists as the biggest challenges to successful implementation of their SBMH program (Kline, 2012). In a qualitative study that addressed various barriers and facilitators to implementation of evidence based SBMH program found that coordinating with school staff, lack of parent engagement and lack of support from administrators and teachers were the major barriers to implementation of their Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program (Langley et al., 2010). Langley and colleagues also discussed that the school set up was such that it was difficult to acquire space and time to conduct therapy. This appeared to be one of the most important logistical barriers that stood in the way of successful implementation of the program.

In recent years, a rise in mental health disorders has been seen across southeastern U.S., particularly in Florida. Compared to other states in the U.S, Florida has a lower percentage of children with an emotional, behavioral, or developmental issue. Yet, children in Florida have limited access to behavioral health treatment (MHA, 2015). An estimated 181,000 Floridian children live with serious mental health conditions (NAMI 2010). According to the Youth Risk Behavior Surveillance System (YRBS), 26% of high school students in Florida reported feeling sad and hopeless in 2015. Similarly, approximately 11% of adolescents ages 12-17 reported of having at least one major depressive episode (HHS, 2015).

Given the increasing rates of mental health disorders among students in Florida, it is vital to provide sufficient in-school mental health therapy to students. Research SBMH services shows that therapists within schools have a positive impact on children. School counselling programs are known to have significant influence on discipline problems. Students involved in a school counselling program have less inappropriate behaviors and more positive attitudes toward school as compared to students that do not (Baker & Gerler, 2001).

Limited research has examined therapists' perception in evaluating and improving mental health

programs. Previous literature includes data on the perceptions of students, parents and teachers on school based behavioral health programs but lacks sufficient information on therapists' understanding and view on school based behavioral health models.

Current Study

The current study was conducted in a large school district in Florida. It is a part of a larger evaluation that also involved teachers, administrators, students, and parents. The school district in this study utilizes two models in the provision of behavioral health services to students. In the traditional model, also known as the Full-Service Schools (FSS) program, feeder schools connect to a central hub of therapists who provide behavioral health services to these schools. In this model, the therapists provide services to students by appointment and then return to the hub location. On the other hand, the revised program (Full Service Schools Plus) has a designated therapist assigned to each school. The therapist in the Plus model is a part of the school team and is available to provide behavioral health services during the school day. The FSS Plus program was implemented to supplement as well as eliminate the current gaps in the traditional model. Currently, the Plus model has been implemented in 12 pilot schools in the district.

Scope of the Study

The purpose of this study is to describe therapists' perceptions of the two behavioral health models in improving SBMH services to children in the school district. Understanding the benefits and barriers involved with each of these models will help authorities decide which model would be ideal to expand in all schools within the school district.

Based on the evaluation needs of the school district, the major research questions included (RQ1): Does the Plus model provide improved capacity to meet the needs of students in pilot schools? (RQ2): What emotional, behavioral, or academic student outcomes are affected by program capacity changes? (RQ3): What are the observable differences in school climate following the implementation of the Plus model as compared to the traditional model? (RQ4): What are the barriers faced by therapists in the successful implementation of the program?

METHODS

Study Participants

Mental health therapists from both behavioral health models were contacted by their immediate supervisors and were informed about the opportunity to participate in this evaluation. These therapists included school psychologists and licensed clinical social workers. The study group included 9 therapists from the 12 pilot schools under the FSS Plus model. The comparison group consisted of 15 therapists

from 4 different hub locations under the traditional model.

been ranked in order of the frequency with which they were discussed by participants in both groups.

Study Procedure

Five focus groups which lasted 45-60 minutes were held across 5 different locations in the school district. The first focus group discussion was conducted at FSS Plus site and included 9 female therapists. The next 4 focus groups were held at 4 different FSS hub sites including one elementary, one middle and two high schools. At each focus group session, therapists were first given a brief overview and the objective of the study was explained. Participation in the focus group was voluntary and written consent was taken from every therapist prior to beginning the focus group discussion. Maximum participation was encouraged by the focus group facilitator in making sure that one participant did not dominate the discussion and every therapist had a chance to share his/her opinion. The facilitator also sought to observe therapists' thoughts and ideas using a naturalistic process of asking open-ended questions. Each focus group discussion consisted of 9 questions. Table 1 provides a list of the focus group questions. Every focus group was recorded using an audio recorder and handwritten notes were taken.

Thematic Analysis

Focus group audio files were transcribed for the purpose of code development. Thematic analysis was conducted on the collected focus group transcripts. Research team members individually reviewed each transcript and identified important themes. Common themes were noted by each reviewer and discussed with other members of the research team. Upon agreement, parent as well as child/sub nodes were preliminarily developed using NVivo Version 10. Thereafter, the research team discussed the coding scheme and refined the list of nodes by expanding, collapsing, or eliminating nodes which did not have sufficient data to back it up. The final parent nodes which were agreed upon included (1) Barriers in Service Provision (2) Observable Differences since Program Implementation (3) Program Benefits and (4) Changes in School Climate. Table 2 provides an outline of the themes and subthemes which were identified during thematic analysis.

RESULTS

Table 3 provides demographic information on FSS and FSS Plus therapists that participated in the study.

Barriers in Service Provision

The four main barriers that were consistent among both groups were parent involvement, program awareness, student availability, and communication gaps. Table 4 provides a rank ordered list of the top 4 barriers in service provision. These barriers have

Parent Involvement

Many of the therapists believed that the lack of parent participation in treatment plans was the biggest challenge that they faced in providing quality and consistent care to students. Therapists from both the groups described the process of getting the parent to consent and sign a treatment plan to be difficult.

"Maybe 65 to 70 percent of the time, I'm having a really hard time getting my parents to really participate and be in this with us." (FSS therapist)

"I literally have to check the parent down to come in and sign and sit with me and go over the treatment plan with them and actually sign it." (FSS Plus therapist)

"Changing their mindset and changing their mentality can be challenging. It's not impossible, but it's challenging." (FSS therapist)

Program Awareness

Therapists described program awareness as another major barrier in service provision. Parents, teachers, and administrators were described as having difficulties in determining who to approach when their children or students were having behavioral and emotional issues.

"They don't even know who we are. They're putting a referral in first service that they kind of know little bit about, but have no idea what it does." (FSS therapist)

"A lot of people don't know the right person to approach for that particular thing, since they don't understand the role clearly as therapist in the school." (FSS Plus therapist)

Likewise, an aspect of program awareness that was proving difficult for both teachers and parents to understand was how the referral process works.

"Some of them are still kind of confused as to even where to get a referral form from or where to put them or where my office is." (FSS Plus therapist)

Table 1
List of Focus Group Questions

<i>Question Number and Content</i>	
1	Do you consider these services to be helpful? a. If so, how have they helped? b. If not, why do you believe they are not helpful?
2	Do you feel the program promotes benefits to the students behaviorally, emotionally or academically? a. Can you provide some examples?
3	Do you feel the program promotes changes to the school climate? a. Can you provide some examples?
4	Have you encountered or do you perceive any barriers to students successfully using the services?
5	Have you encountered or do you perceive any barriers to these services continually being offered in the school?
6	Do you feel school staff, teachers and administrators have been well educated about the offerings provided through DCPS related to Behavioral Health?
7	Do you feel parents and students have been well educated about the offerings provided through DCPS related to Behavioral Health?
8	Do you recognize any observable difference in student's behavior since implementation or utilization of the Full Service Behavioral Health Initiative?
9	What are your thoughts about in-school Behavioral and Mental Health Services?

Table 2
Outline of Themes and Sub-themes from Focus Group Discussions

<i>Themes and Sub-themes</i>	<i>Number of items (N= 33)</i>
Program Benefits	n = 11
<ul style="list-style-type: none"> • Broad coverage • Crisis Management • Improved Access • Consistency in service provision • Evidence based practice • Familiar environment • Empowerment/Training • Open Communication • Improved Support • Emotional Support • Advocacy 	
Observable Differences since Program Implementation	n = 4
<ul style="list-style-type: none"> • Academic Improvement • Behavior Changes • Improved Skills • Decreased Referrals 	
Barriers in Service Provision	n = 13
<ul style="list-style-type: none"> • Program Awareness • Multiple Providers • School schedule/Testing • Communication Gaps • Parent engagement • Disruptive home environment • Student Availability • Safety & Confidentiality • Co-operation difficulties • Referral process difficulties • Physical Space & Tools • Displacement • Paperwork 	n= 5
Changes in School Climate	
<ul style="list-style-type: none"> • Improved relationships • Collaborative effort • Attitude changes • Administrative Support • Smooth Referrals 	

Table 3
Demographic Information

(N = 24)	# of FSS Therapists	# of FSS Plus Therapists
GENDER		
Male	2	0
Female	13	9
YEARS WORKED AT CURRENT SCHOOL		
Less than 4 years	14	9
4 years or more	1	0
YEARS WORKED AT THE SCHOOL DISTRICT		
Less than 4 years	11	7
4 years or more	4	2
YEARS OF PRACTICE AS A CHILD THERAPIST		
Less than 4 years	9	6
4 years or more	6	3

Table 4
Rank Order of Top 4 Barriers in Service Provision

Rank	Barrier
1	Parent Involvement
2	Program Awareness
3	Student Availability
4	Communication Gaps

“they’re not exactly familiar with how the referral process goes, so some of them will just come and be like “Do you work with such and such kid?” and then leave it at that.” (FSS Plus therapist)

Some therapists believed that program awareness varied from school to school. While some schools had a good awareness of the program, others did not.

“Some teachers are on board, and some teachers could care less.” (FSS therapist)

Student Availability

School schedule, testing, and student absenteeism were the factors that were most frequently mentioned by the therapist to affect student availability.

“We were going to the school, and they’re not there. Or the other thing is where a lot of times I run into, especially the high school – going into the high school, the kids are skipping classes. There’s no way of controlling that. That’s out of our control.” (FSS therapist)

“I think for me, that is the biggest challenge – actually going into the school and to see a child for therapy services, but they’re not at school that day.” (FSS therapist)

“I think because kids are absent from school fairly often, transportation is another barrier.” (FSS therapist)

Therapists from both groups also reported that the absence of a standard schedule for providing therapy at schools was a challenge that they face regularly:

“We don’t have a set date. We don’t have a certain school that we go to on a certain day where we can be very clear about who we’re going to see her what school we’re going to be at.” (FSS therapist)

All therapists described testing as another problem that affected service provision in schools. Even if a child is not testing, but classrooms in proximity to it are being used for testing, it makes it difficult for the therapist to provide therapy to the client.

“And with testing, even though my particular experience is that elementary level – my particular client might not be in testing, but the classroom right next to them might. So, I can’t even pull my client because the classroom right next to them is testing, and the whole hall is shut down for being able to kind of enter or leave because of interruption.” (FSS therapist)

Communication Gaps

An aspect of service provision particularly affected by the gaps in communication was keeping appointments and difficulties in communicating with parents via phone calls.

“They will make appointments. Not all of them keep the appointment. That’s a breakdown in the communication.” (FSS Plus therapist)

“One of the things we struggle with is also in this population, having a good phone number. That’s a barrier to being able to provide good service. You may have the number when you first start the referral, but then somewhere down the line the number has got changed and they are not communicating it throughout everyone that’s working with the kid. That becomes a barrier.” (FSS therapist)

The impact of this breakdown in communication between therapist and parents is an inconsistency in therapeutic outcomes.

“Well, if you and I had communicated a little bit more and you would return my phone calls and we had met more than once every 60 days or once every 90 days, then you would see the same behavior at home.” (FSS Plus therapist)

Differences were observed between the two groups with regards to safety and confidentiality; physical space and tools; and referral process

difficulties. These barriers were generally more prominent among the traditional model schools in comparison to the FSS Plus model.

Safety and Confidentiality

FSS therapists described having difficulties with safety and confidentiality during therapy sessions. In contrast, this was not a significant problem with the FSS Plus model.

"I've had school principals come into a session and say "One of your other kids, her mom is up front. Do you want to talk to her?" I'm like "There is a do not disturb sign on the door." (FSS therapist)

"I've had to meet in the nurse's station, which also doubles as the staff lunch room. They come in. Even with the confidential sign on, they will come in and heat up their food and leave." (FSS therapist)

Though, issues of confidentiality were not very common in the FSS Plus Model, however, a few cases of interruption of therapy sessions were mentioned.

"We have some incidents where the actual administration will open your door with a sign on the door. I'm having a breakthrough with his child. You've just destroyed it because you're trying to make your priority my priority." (FSS Plus therapist)

However, these incidents did not occur with the same regularity they happened in the traditional model.

Physical Space and Tools

Many FSS therapists reported that because there is no fixed location for them to provide therapy to children every week, they must spend extra time trying to find a place in the school that meets the standards of a therapeutic session or forfeit their confidentiality and privacy policies by providing therapy in any room or space available on the school campus.

"There are times when we have literally met in closets. When we do individualized therapy, it needs to be private. Interruptions happen, and we understand that. We're very flexible with that. However, when you are so many interruptions happening in a therapeutic setting, becomes non-therapeutic." (FSS

therapist)

"We sometimes have to if there's no space at the schools; we have to counsel in a parking lot, in the back of the cafeteria." (FSS therapist)

Therapists also described the lack of assessment tools for them to provide quality service to their clients.

"If we had some assessment tools, more assessment tools, some assessment tools, increased assessment tools here at our level, we could probably do a lot of screening initially that might help us in the treatment process as we move down the process." (FSS therapist)

Referral Process

FSS therapists reported having an incomplete complicated referral process where parents and teachers are not sure who to approach when clients are having mental health issues.

"I've had some complaints from parents and families, like "I tried getting hold of you guys a while ago, and nobody ever contacted" or whatever. I have to apologize because it's not on us because we're the last step here. I've heard that complain a little bit over here." (FSS therapist)

"I don't think that everyone really understands that we're there. We're available. They're not really informed on the process." (FSS therapist)

Some delays in referral also arise from the unwillingness of teachers to refer due to the fear of being seen as incompetent.

"It's almost like 'we know the services that are there, but if we get your services, then it looks like we can't handle things. So, let's not even do it'." (FSS therapist)

On the other hand, FSS Plus therapists described having a smooth referral process where most people involved were well educated on how the referral process works.

"All of them are educated on the

process and what to do. I have them coming down with it, saying "I have referrals." (FSS Plus therapist)

"The referral process is simple. Anyone can do it. It's just – are they willing to?" (FSS Plus therapist)

Observable Differences since Program Implementation

There were several improvements seen after the implementation of the program in both models. Many of the observed improvements were common to both groups.

Academic Improvement

Therapists described academic improvement as a direct outcome of the therapy that was being provided to the students. Therapists stated that students receiving therapy were now able to focus better, weed out distractions and channel their energy in positive ways, leading to improved attendance and improved grades.

"We've seen grades. We have kids to go from F's to A's, B's, C's." (FSS Plus therapist)

"He academically has improved by the fact that on Friday his reading went up 175 percent over what he'd been doing last year, and his ability to stay in class has improved significantly." (FSS therapist)

Overall, therapists were satisfied with improvement in academics among their clients. Many of the students that benefitted from therapy were now mentoring other students that needed help.

Behavioral Changes

Therapists agreed that they observed a decrease in negative behavior among students. Additionally, therapists noted an improvement in self-confidence and self-esteem among students.

"You no longer have that kid throwing desks and chairs or being aggressively physically with their peers or with an authority figure." (FSS therapist)

"Decrease in lying and stealing...a lot of decrease in oppositional and negative behavior." (FSS Plus therapist)

"Their self-confidence of course is going to go up" (FSS Plus therapist)

Decreased Referrals

The introduction of the FSS Plus model has also led to decreased referrals overall. Therapists from both models observed that there were undoubtedly less referrals than before.

"You see empirically that there are fewer referrals to [ATOS], to the afterschool program." (FSS Plus therapist)

"I just checked today with the school to see if she has any referrals, and they were like "No, not to my knowledge." (FSS therapist)

Improved Skills

Therapists described observing improvement in communication skills, socialization skills and coping skills among their clients. Additionally, an improvement in parenting skills was seen.

"You're going to see their socialization skills improve." (FSS therapist)

"They're able to communicate a lot better than having all these feelings of being irritated and it coming out in aggression." (FSS Plus therapist)

"They can use the skills that we teach them and use them independently outside of therapy." (FSS Plus therapist)

Changes in School Climate

Some changes noted were common to both groups, while others were unique to each group. FSS therapists reported improved relationships and rapport building as well as collaboration and team approach in their schools. While FSS Plus therapists observed improved administrative support and attitude changes.

Improved Relationships and Rapport Building

FSS therapists described the program to be instrumental in improving relationships between students and their parents as well as students and their teachers. Additionally, therapists also have been able to build a rapport with the teachers, staff, and parents through the program. Therapists described the

role they play in enhancing better student-teacher and student-parent relationships.

“You see kids who will verbalize “My teacher doesn’t like me” at the start of services. By the time services are over, they feel like that teacher is somebody they could go to in need. You find parent to come in, and yes them ‘Tell me some good things about your kid.’ Cannot do it in that first session. By the time you close, they’re able to give you a list of positive qualities in their child.” (FSS therapist)

“I would also say the relationship with the client and their parents, huge change. Family relationship, where the child used to isolate themselves. Now they’re starting to be involved more in family activities.” (FSS therapist)

The FSS model allowed therapists to develop relationships with teachers and staff in several schools which ultimately helped bring in more referrals. FSS therapists also indicated the importance of leadership buy-in for them to be successful with the administration at each school.

Collaboration and Team Approach

FSS therapists identified improved collaboration among all those involved in providing care for the kids as an important change in the school climate since program implementation.

“Working with the teacher, working with the guidance counsellor, working with the mom to just change the family dynamics and the dynamics between her and the teacher.” (FSS therapist)

“I see the collaboration enhancing the services between the home and the school life.....it’s providing more holistic care to the child, and I think that’s a benefit of the school-based counselling.” (FSS therapist)

“Most of my kids have been successfully terminated with behavioral problems, because we have that connection between parent and teacher.” (FSS therapist)

Improved Administrative Support

Although an improvement was seen in terms of administrative support, some teachers in this model still remained less cooperative.

“As far as administration, they’re very appreciative. I have awesome administration of my school. Some of the teachers, like I said, some are on board, and some are like “Whatever. You’re here. Okay.” (FSS Plus therapist)

Overall, administrators were reported to *“have been very supportive”* and *“very happy that the services are here.”*

Attitude Changes

FSS Plus therapists described observing positive changes in teachers' attitudes toward mental health issues since the implementation of the program.

“The FSS Plus model has made some of the teachers a tad more empathetic to the students.” (FSS Plus therapist)

“A teacher changed her mind set from thinking that “A counsellor’s here because we don’t know how to handle our students” to “Wow. This is a totally different service.” (FSS Plus therapist)

“People originally that did not like me being in there are now coming to me and giving me children and asking different questions.” (FSS Plus therapist)

Program Benefits

Some of the frequently discussed benefits that were common to both models were open communication, improved access, and emotional support. FSS therapists stated that empowerment and training was a benefit of the FSS model. On the other hand, FSS Plus therapists mentioned advocacy as a benefit of the Plus model.

Open communication. According to therapists from both groups, since the implementation of the program, students can articulate their feelings in a better way than before.

“They become a lot more articulate and are able to say “This makes me feel this way. This makes me feel that way. I don’t like it when this

happens." (FSS therapist)

(FSS therapist)

"I think we're able to be that link for the parent, bring the parents into teacher conferences so that it starts open communication with the teachers and starts open communication with the guidance counsellors." (FSS therapist)

"They're getting from us something that they're not getting from anyone else – which is some individualized one-on-one attention, simply a matter of a place of being heard." (FSS therapist)

'Just giving both parties that resource to say "Communicate. Just communicate." It's so simple.' (FSS Plus therapist)

Therapists can create a trust filled relationship with students and be just another positive person in their life. Therapists also expressed their willingness to "go the extra mile" as a huge support for their clients.

Improved access. Therapists from both models noted an improvement in access to mental health services for students.

"One of the primary things I see is access. Many of these children would not be receiving any services for counselling if it wasn't for the ability to go into the schools to see them." (FSS therapist)

"This model is really beneficial in the sense of letting the kids know there is at least one adult that cares about him, even though he feels a lot of adults don't." (FSS Plus therapist)

"The thought of putting mental health services, removing any barrier for any student or any parent to receive the services, is fantastic." (FSS therapist)

"It shows that we care. We want to see them succeed. Sometimes we might be the only ones that tell them that they can or "You can do this." (FSS Plus therapist)

"It's good that we're able to go to the schools to go and see the kids. That way they don't have to come to us." (FSS therapist)

Empowerment and training. Therapists described providing training for parents and school staff about mental health issues.

"We can see them [clients] in their natural environment." (FSS Plus therapist)

"It's an opportunity for us to do workshops and provide them with trainings and information on how to handle kids who might have a variety of mental health issues." (FSS therapist)

School-based programs overcome this barrier of transportation problems in neighborhoods:

"A major barrier for the community I work in is transportation. I think one major improvement is that the service is right there in the school." (FSS Plus therapist)

"We aid in providing understanding to what's happening with that child – whether it's familial or biological or whatever, medical, no matter what it is". (FSS Plus therapist)

Emotional support. Therapists described themselves to be strongly supportive of students.

"Constantly motivating the child, constantly being that encouragement, constantly trying to change that child's mind set."

"Another good opportunity that has come out of this [school-based counselling] is teacher trainings and parenting classes..." (FSS therapist)

"We're constantly going through trainings. I just went through a trauma-focused CBT training. Everything in my treatment plan is evidenced-based." (FSS Plus therapist)

DISCUSSION

Given the increasing importance of SBMH services around the country and in Florida, there is a need to have an improved understanding of therapists' perceptions about behavioral health programs they are involved in. This study provides new insight on therapists' perception of the factors associated with implementation of a behavioral health model in schools. We found several benefits and barriers that affected the successful implementation of both models in their respective schools. Therapists reported observable differences and changes in school climate after each of programs had been implemented. Many of the barriers and benefits that were outlined by the therapists were common to both the groups. While some of them were unique to each individual model.

Like the findings of a study conducted by Langley et al (2010), we found that lack of parent engagement was the biggest barrier to implementation of FSS as well as FSS Plus model. Poor involvement of parents in the treatment plan for their children was a big challenge faced by therapists from both models. Therapists believed that getting parents to actively participate in their child's therapy will be beneficial in ensuring a smooth treatment process and better outcomes for the child undergoing therapy.

Interestingly, lack of program awareness was a common barrier to the implementation of both models and was ranked #2 by both FSS and FSS Plus therapists. Although FSS Plus therapists were designated to one particular school and were permanently located in the same school, they reported poor awareness of their services among the teachers, administrators, and other staff at the school. Essentially, the presence of a designated therapist in each school did not affect the awareness of the program among staff at the school. Therapists from both the models emphasized the need for an increase in the understanding of their role among staff at their respective schools.

Logistical barriers such as lack of teacher buy-in and inadequate space and time for providing therapy have been previously known to affect service provision (Langley et al., 2010). FSS and FSS Plus therapists perceived lack of teacher buy-in to be an important barrier to service provision. Elimination of logistical barriers has been known to be vital for a program's successful implementation (Fixsen et al., 2005). Because of the growing need for reducing implementation barriers it is important to improve the involvement of teachers in the behavioral health program and increase their overall awareness of the services being offered at the school. Regarding service provision in FSS Plus schools, therapists revealed that being assigned to one particular school and having a designated office was instrumental in eliminating the inadequate space barrier. On the

contrary, FSS therapists described the lack of space to be one of the biggest challenges to successful implementation of their program. Findings from this study highlight a major difference among the two models in terms of logistical barriers. The presence of a designated on-site therapist is beneficial in eliminating majority of the logistical barriers and contributes to the success of the program.

Furthermore, this study found that there were large communication gaps between therapists, teachers, administrators, and parents that were causing delays and problems with program implementation. Lack of communication by parents was a common barrier in both the FSS as well as FSS Plus programs. Therapists believed that there was an urgent need for improved collaboration among teachers, parents, administrators, and themselves. Surprisingly, although FSS Plus model had a more organized referral process, FSS Plus therapists still seemed to struggle with communicating effectively about their services and treatment plans with school staff and parents. These findings suggest that on-site therapy is not a distinguishing factor when it comes to effective communication between therapists and other staff members.

Because of the lack of physical space to provide therapy in FSS schools, FSS therapists faced the problem of not being able to provide safe and confidential sessions to their students. They described the situation to be challenging and difficult. Sometimes they had to provide therapy in odd spaces such as parking lots, nursing stations and closets. FSS Plus therapists rarely faced problems with having a confidential and safe environment for providing therapy. This was because they had a designated location to organize a therapy session. These results indicate an important distinguishing factor between the two behavioral health models and emphasize the importance of having a safe and confidential environment for improved therapy outcomes.

Besides the common challenges faced by therapists from both models, they also mentioned several benefits of their program that were consistent with findings from previous studies. There is growing literature that supports the idea of a correlation between a positive learning environment, improved behavior, and the expansion of SBMH services (Walter et al., 2011). Additionally, several studies have described the link between mental health and academic improvement in the past (Cappella et al., 2008). Similarly, FSS and FSS Plus therapists described academic improvement as a direct outcome of providing therapy. Therapists had students that went from F's to A's after going through a few months of therapy. According to therapists, positive behavior change, improvement in social skills, open communication, access to care, and emotional support were benefits that came as a result of

providing therapy to students. Therapists reported that they had seen a steady decrease in negative behavior among students who had received therapy. Additionally, after few therapy sessions, students' socialization skills improved and they could communicate more effectively while being able to articulate their feelings in an effective manner. As reported in previous studies, providing on-site therapy greatly improves students' access to care, especially children in the lower socio-economic bracket (Kline, 2012). Therapists from both groups reported access to care as a benefit to students. But being able to receive therapy at school itself helped students in the Plus model overcome barriers such as transportation costs.

Lastly, therapists from both models described changes in school climate after the implementation of their respective programs. Some of the common changes noted by therapists from both models were improved relationships and team approach. It was not uncommon to see better student-teacher and student-parent relationships after program implementation. Therapists were responsible for improved family relationships as well. Another common change that was noticed by all therapists was the development of a team approach to care. Although, improved communication was essential to the success of the program, the implementation of the program had already created an ideal setting in which there was a collaboration between multiple stakeholder groups. Teachers, therapists, parents, and other school staff had to be involved in the therapy process to ensure better therapeutic outcomes. Some of the changes that were unique to the Plus model were improved administrative support and attitude changes among the teachers. Thus, evaluation findings suggested better administrative support in the FSS Plus model. Also, more positive attitude changes were noted among FSS Plus teachers as compared to the FSS teachers. Therapists reported a change of mindset among FSS Plus teachers that made them more empathetic to the students. These results point to better changes in school climate under the FSS Plus model. In terms of program success, having a therapist on-site proves to be more beneficial than having one therapist assigned for several schools in the vicinity.

There are some limitations to this study that are important to consider. These findings may not be generalizable because the sample sizes of the two models were not equal. In addition, the therapists that participated in the study may not be representative of the entire group of FSS and FSS Plus therapists. The inclusion of all therapists from both models would have been more illuminating. Yet, this study provides useful insight on some of the benefits and challenges perceived by therapists that are involved in the implementation of a behavioral health model.

Furthermore, it also examines some of the key differences observed in terms of provision of services on-site versus multiple hub locations. More focused studies are needed to better understand the most important barriers faced by on-site therapists so that those barriers can be eliminated and students in schools will be able to benefit from an improved and effective behavioral health model.

Overall, our study found multiple benefits and barriers that came with the implementation of both behavioral health models. The presence of a designated therapist at each school under the FSS Plus model led to elimination of barriers such as transportation and lack of physical space to provide therapy. This made it the more effective model of the two. Given that the evidence from our study suggests that the FSS Plus model eliminates more barriers than the FSS model, it would be ideal to call for an expansion of the new Plus model in other schools within the district.

The findings from this study can be used by other school districts to improvise on an existing school based behavioral health program or develop a new behavioral health program while keeping in mind the advantages of having a designated therapist at each school. Therapists in other school districts will also benefit from getting a comparative understanding of therapists' experiences with two different types of behavioral health models. Further research is needed to explore the conditions that cause barriers such as parent involvement, lack of communication and student availability which consistently affect service provision irrespective of therapists' location. Future research being focused on ways to eliminate common barriers is vital to finding the most effective and beneficial form of SBMH services.

Ethical Approval

The Institutional Review Board of the University of North Florida approved all procedures performed in this study.

Acknowledgements

This study is supported by a grant from the Chartrand Family Fund at the Community Foundation for Northeast Florida. The authors would also like to thank all the therapists that participated in the study.

REFERENCES

- Association for Children's Mental Health (ACMH). (2016). Problems at School. Retrieved from <http://www.acmh-mi.org/get-help/navigating/problems-at-school/>.
- Atkins, M.S., Frazier, S.L., Adil, J.A., & Talbott, E. (2003). School-based mental health services in urban communities. In M.D. Weist, S.W. Evans, & N.A. Lever (Eds.), *Handbook of school mental*

health: *Advancing practice and research. Issues in clinical child psychology* (pp. 165–178). New York, NY: Kluwer Academic/Plenum.

Baker, S.B., & Gerler, E.R. (2001). *Counseling in schools: The handbook of counseling*. Thousand Oaks, CA: Sage Publications.

Burns, B.J., Costello, E.J., Angold, A., Tweed, D., Stangl, D., Farmer, E.M., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs*, 14(3), 147-159.

Cappella, E., Frazier, S.L., Atkins, M.S., Schoenwald, S.K., & Glisson, C. (2008). Enhancing schools' capacity to support children in poverty: An ecological model of school-based mental health services. *Administration and Policy in Mental Health*, 35(5), 395-409.

Centers for Disease and Control Prevention. (2016). Children's Mental Health Report. Retrieved from <http://www.cdc.gov/features/childrensmentalhealth/http://www.cdc.gov/features/childrensmentalhealth/>

Dowdy, E., Ritchey, K., & Kamphaus, R.W. (2010). School-based screening: A population-based approach to inform and monitor children's mental health needs. *School Mental Health*, 2(4), 166-176.

Duval County Health Department. (2012). *Community Health Assessment and Community Health Improvement Plan*. Retrieved from <http://duval.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/documents/chip.pdfhttp://duval.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/documents/chip.pdf>

Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

U.S Department of Health and Human Services. (2015). Florida Adolescent Mental Health Facts. Retrieved from <http://www.hhs.gov/ash/oah/adolescent-health-topics/mental-health/fact-sheets/state.html?s=floridahttp://www.hhs.gov/ash/oah/adolescent-health-topics/mental-health/fact-sheets/state.html?s=florida>

Jacksonville Community Council, I. J. (2016). Full Service Schools Plus Pilot Program Making a Difference. Retrieved from <http://www.jcci.org/single-post/2016/02/08/Full-Service-Schools-Plus-Pilot-Program-Making-a-Differencehttp://www.jcci.org/single-post/2016/02/08/Full-Service-Schools-Plus-Pilot-Program-Making-a-Difference>

Jacob, S., & Coustasse, A. (2008). School-based mental health: A *de facto* mental health system for children. *Journal of Hospital Marketing & Public Relations*, 18(2), 197-211.

Kline, H. (2012). *Evaluating the Effectiveness and Utilization of School-Based Mental Health Programs*. (Master of Social Work Master of Social Work Clinical Research Papers). St. Paul, MN: St. Catherine University. Retrieved from http://sophia.stkate.edu/msw_papers/119

Langley, A.K., Nadeem, E., Kataoka, S.H., Stein, B.D., & Jaycox, L.H. (2010). Evidence-based mental health programs in schools: Barriers and facilitators of successful implementation. *School Mental Health*, 2(3), 105-113.

Lindo, N.A., Dillman Taylor, D., Meany-Walen, K.K., Purswell, K., Jayne, K., Gonzales, T., et al. (2014). Teachers as therapeutic agents: perceptions of a school-based mental health initiative. *British Journal of Guidance & Counselling*, 42(3), 284-296.

Mental Health America. (2015). *Ranking the States*. Retrieved from <http://www.mentalhealthamerica.net/issues/ranking-states>

Mental Health America (2016). Recognizing Mental Health Problems in Children. Retrieved from <http://www.mentalhealthamerica.net/recognizing-mental-health-problems-children>.

Merikangas, K.R., He, J.-p., Burstein, M., Swanson, S.A., Avenevoli, S., Cui, L., . . . Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(10), 980-989.

National Alliance on Mental Illness (NAMI). (2016). Mental Health in Schools. Retrieved from <http://www.nami.org/Learn-More/Public-Policy/Mental-Health-in-Schoolshhttp://www.nami.org/Learn-More/Public-Policy/Mental-Health-in-Schoolsh>

National Institute of Mental Health. (2016). Any Disorder Among Children. Retrieved from <https://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtmlhttps://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>

U.S Interagency Working Group on Youth Programs (IWGYP). (2016). Prevalence. Retrieved from <http://youth.gov/youth-topics/youth-mental-health/prevalence-mental-health-disorders-among-youthhttp://youth.gov/youth-topics/youth-mental-health/prevalence-mental-health-disorders-among-youth>

UF Health Jacksonville. (2015). *Community Health Needs Assessment*. Retrieved from <http://ufhealthjax.org/community/documents/chna->

[2015.pdfhttp://ufhealthjax.org/community/documents/chna-2015.pdf](http://ufhealthjax.org/community/documents/chna-2015.pdf)

Walter, H., Gouze, K., Cicchetti, C., Arend, R., Mehta, T., Schmidt, J., & Skvarla, M. (2011). A pilot demonstration of comprehensive mental health services in inner-city public schools. *Journal of School Health, 81*(4), 185-193.

Sheina Costa is a public health intern, Mayo Clinic, Jacksonville, FL. Email at n00960322@ospreys.unf.edu. Osayande Osagiede is a graduate student in the MPH program at the University of North Florida, Jacksonville, FL. Email at n00972190@ospreys.unf.edu. Jason Rose is Vice President, Data and Research, Jacksonville Public Education Fund, Jacksonville, FL. Email at jason@jaxpef.org. Kimberly A. Allen is a Research Analyst, Jacksonville Public Education Fund, Jacksonville, FL. Email at kimberly@jaxpef.org. Aaron Spaulding is an Associate Consultant, Department of Health Sciences Research, Mayo Clinic, Jacksonville, FL. Email at Spaulding.Aaron@mayo.edu. Mary Rose is Director of Service Learning and Civic Engagement, Florida State College, Jacksonville, FL. Email at mary.rose@fscj.edu. Emma Apatu (corresponding author) is Assistant Professor, University of North Florida, Jacksonville, FL. Email at emma.apatu@unf.edu.

Copyright 2017 by the *Florida Public Health Review*.