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Abstract

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Through in-depth semi-structured interviews with 12 community based providers of an intensive school-based mental health program, Therapeutic Day Treatment (TDT); it was the aim of this qualitative study to examine the training needs of community mental health providers whose provision of services occur in a school setting. Given the limited literature on the topic, this study provided first hand accounts from direct providers not only of their needs, but how their setting impacts the provision of service.

This study examined TDT clinicians' perceptions of mental health concerns for children in their program, barriers to service provision, the preparedness and roles, and the perceived gaps in services and training. Five major themes, each comprised of a number of interrelated sub-themes, were identified: role/service clarification, preparedness for the school environment, practice techniques, family dynamics, and conflicts within the school context.

Results of this study suggests that the delivery of an intensive community mental health program in school settings poses a unique set of challenges and points to the lack of adequate training. The data underscores the training needs of TDT clinicians and interventions tailored to suit the school context in order to improve care for children with serious emotional disturbances (SED).

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The Training Needs of Community Service Providers of an Intensive Mental Health

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Cristina Vanessa Reamon, LCSW

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By

Cristina Vanessa Reamon, LCSW

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DEDICATION

I would like to thank Jehovah, first and foremost, for choosing this path for me; without him all of this would have not been possible. He gave my life a second chance. I praise Him for His reassurance, mercy, and grace as well as for His listening ear during those sleepless nights.

I dedicate this dissertation to my loving husband, Charles Reamon, for being by my side through this entire journey, which has been a very rigorous process that I would have not been able to complete if I did not have him beside me. His words of encouragement were extremely powerful in order to keep me pushing forward. I love my husband very much, and taking on such a journey together is one of the most memorable experiences any couple can go through. Although there were several detours on this journey, you remained the person I could go to and discuss my frustrations, insecurities and excitements.

To my children, Charles, Soraya and Adrianna, thank you for being so supportive of your mother and for the understanding you have shown me during this process. I love you all more than words can express and I cannot wait to see each of you continue to grow and achieve all of your hopes and dreams. Thank you for always bringing happiness and love into my life.

I also dedicate this dissertation to my parents, Candido and Aurora Tejada, for instilling the importance of hard work and higher education. My parents went through some difficult times as first generation immigrants, and no words can express my thankfulness for their sacrifices. Thank you for instilling in me the will to keep going and never give up. I also want to thank my siblings, Marcus, Noelia, Kiomara and Aaron, as

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TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

The Training Needs of Community Service Providers of an Intensive Mental Health

Program in Virginia's Public School Settings

Chapter 1

INTRODUCTION

Introduction and Background

According to U.S. Department of Health and Human Services, Substance Abuse

and Mental Health Services Administration (SAMHSA, 2003), 1 in 5 children birth to 18

has a diagnosable mental disorder and 1 in 10 youth has serious mental health problems

that are severe enough to impair how they function at home, in school, or in the

community. Serious emotional, behavioral and social problems are often manifested as

defiant, disruptive, aggressive and/or destructive behaviors. These behaviors can interfere

with the classroom environment, resulting in "substantial challenges to schools, teachers,

parents, and their peers" (Gresham, 2005, p. 328). Unfortunately, these behaviors can

produce "chaotic school and classroom environments" and impact the "disciplinary,

instructional, and interpersonal domains" (Gresham, 2005, p. 328). In the course of the

school year, children with mental health problems may miss as many as 18 to 22 days

and their rates of suspension and expulsion are 3 times higher than those of their peers

(Blackorby & Cameto, 2004). In addition, these children and youth are at increased risk

for lower academic achievement and higher school dropout rates (Stagman & Cooper,

2010). According to the U.S Department of Human Services, Substance Abuse and

Mental Health Services Administration (2012), there were 2.9 million youths aged 12 to

17 in 2010 who received mental health services in an educational setting. Those receiving

services were reported to feeling depressed (34.9%); having problems at school

(22.3%); breaking rules and acting out (20.6%); problems with home or family (20.5%), and having problems with peers (19.0%).

Reduced funding and movement from residential and inpatient treatment to lesser restrictive settings have made schools the "de facto" mental health service provider (Roberts, Vernberg, Biggs, Randall and Jacobs, 2008; Splett & Maras, 2011). Furthermore, polices such as Individuals with Disabilities Education Act, No Child Left Behind as well as incidents such as the Virginia Tech, Columbine, Sandy Hook, and Isla Vista shootings have charged schools and mental health organizations with the responsibility for the provision of adequate mental health services.

School age children spend an average of 6 to 7 hours daily in school; spending more hours in the school setting than in any other social context (Powers, Bower, Weber, & Martinson, 2011). Schools have become the likely place for the provision of mental health services for its strategic setting (Burnett-Zeigler & Lyons, 2012). Schools provide the accessibility to children and school personnel who often refer children for mental health services. Provision of mental health services in a school setting creates the opportunity for the observation of behaviors, screening, and assessment of children in their natural setting. In addition, it removes the stigma as services are seen part of the educational component (Ballard et al., 2014; Beehler, Birman & Campbell, 2012; Powell et al., 2011). These services are often provided by community mental health and/or private mental health agencies in a school setting (Foster et al., 2005).

The primary goal of school-based mental health intervention programs is to address the mental, emotional, and behavioral health needs that create a barrier to the student's effective learning and socialization. Programs vary according to the evidence

practice model to which they ascribe. In the state of Virginia, one of those programs is Therapeutic Day Treatment (TDT). Therapeutic Day Treatment Service is an intensive and specialized clinical treatment program for children and adolescents whose serious emotional and behavioral difficulties in school place them at risk for requiring more intensive placements. These services are targeted and time-limited interventions for children who are at-risk due to significant behavioral or mental health issues. TDT services are designed to enable individuals with significant mental, behavioral, or emotional illness to achieve stability and independence in the most appropriate, least restrictive environment. TDT services are primarily hosted in public school settings.

Problem Statement

Treatment of children with severe emotional disturbance (SED) can be overwhelming, difficult to treat, and challenging for schools (Roberts, Vernberg, Biggs, Randall, & Jacobs, 2008). The term "serious emotional disturbance" is used in a variety of federal statutes that refers to a diagnosable mental health problem that severely disrupts a youth's ability to function socially, academically, and emotionally. These children are the most complex, demanding and expensive students in public schools to educate (Reddy & Richardson, 2006). Despite the unique and complex needs of this "at risk" population as well as the opportunities and challenges created by the school environment, very sparse literature exists on the training needs of school-based mental health providers. Research on severe emotional disturbance is ubiquitous, unfortunately research literature on the training and/or professional development of those treating this population is scarce, even more limited at a school environment.

Most of the existing literature is restricted to studies related to school personnel such as teachers, school psychologists and school social workers. This imbalance created by the limited literature warrants the need for further exploration into the training needs of community mental health providers in a school setting who are outside school providers.

Although, school psychologists, social workers and counselors work with students with severe emotional disturbances, they are also responsible for the care and well being of all other students and the school as a whole. Those who provide Therapeutic Day Treatment (TDT) services work specifically with those students designated as severely emotionally disturbed. Community professionals who provide TDT services are typically contracted by the public school system for services and regulated by the Department of Medical Assistance Services (DMAS). They are not considered school personnel; rather they are employees of the community agency that has been contracted to provide a highly structured clinical program designed to address students with severe emotional disturbance.

School counselors, social workers and psychologists, according to Virginia's Department of Education Licensure Regulations for School Personnel (2013), are required to demonstrate competency through completion of at a minimum a Master's degree from an approved and/or accredited college or university in addition to practicum, and work experience related to their field. Despite the graduate education and practicum requirements for the aforementioned school personnel, several studies point to the inadequacy in training and/or education for the provision of mental health in schools.

Berzin and O'Connor (2010) examined school social work syllabi from MSW programs and found that although course content was geared for clinical content, it demonstrated a lack of adequacy in preparing school social workers for trends that affect student mental health and its interventions, educational trends (i.e. school reform, policy changes), and limited content on general education outcomes and goals. Perfect and Morris (2011) outline their recommendations of key areas in which they believe are necessary for school psychologists to provide school mental health services. They proposed a sequence of graduate study that includes training in school-based mental health service delivery such as theories of learning, developmental psychology, biological bases of behavior, child psychopathology, behavioral assessment and intervention in the schools and cultural diversity, to name a few. Other studies point to the limited training of specific interventions for school psychologists such as crisis intervention, (Allen et al., 2002).

In sharp contrast, the minimum requirements of community providers who provide TDT services are a Bachelor's level education in a related human health field (such as social work, psychology, counseling) with a minimum of one year of clinical experience with children and adolescents. Those who meet the aforementioned criteria are designated as qualified mental health practitioners (QMHP). Qualified mental health practitioners provide the direct care of youth whose behaviors place them at risk for out of school placement including suspension and/or expulsion. It is a mistake to assume that providers of TDT services have all the necessary skills and knowledge to work with the SED population in a school setting. In the absence of credentialing or graduate degrees,

TDT providers may lack the know how to support this population resulting in ineffective intervention, risking the chance of doing more harm than good.

The provision of community mental health services in a school-based context presents advantages as well as challenges. As indicated earlier, provision of services in a school setting provides the accessibility to those in need who would otherwise not seek services. However, the interplay of community mental health and school systems present with some challenges in part due to "unique histories, distinct value sets, principles and beliefs" (Ringeisen, Henderson, & Hoagwood, 2003, p. 153). With educational reforms focusing on student outcomes and accountability, it is often the case that schools' primary priorities are on teaching and learning (Ringeisen, Henderson, & Hoagwood, 2003). As a result, the school's mission and policies may not be aligned and may often compete with the social, emotional, and behavioral goals of mental health providers (Domitrovich et al., 2008; Langley, Nadeem, Katoaka, Stein, & Jaycox, 2010). Thereby provision of intensive mental health services may be viewed as a hindrance to the school's educational goals, particularly if students are taken out of class for services (Domitrovich, et al 2008). Additional factors impacting the delivery of community mental health intervention programs may include school climate, culture, organizational health, as well as the physical characteristics of a school; for example urban versus rural, race, gender, social economic status, and structure of the school (Domitrovich, et al, 2008). While it was anticipated that the school context would indeed affect service delivery, the study provided an understanding of how and to what extent the delivery of community mental health services is impacted. It is the hope that this knowledge will assist in making necessary adaptations to mental health interventions and services such as supportive

services, mentorship programming as well as advocacy for change at an administrative/legislative level if needed.

One of the seven critical success factors outlined by Virginia Department of Behavioral Health and Developmental Services (2009) necessary to "realize the vision of a recovery and resilience-oriented and person-centered system of services and supports" is to have a workforce that is "competent and well-trained" (p.25). As studies point to the need for additional training for those with greater competency such as school social workers, psychologists and school counselors, then clearly those with an undergraduate degree and limited work experience would warrant a greater demand for additional training related to the provision of a highly intensive mental health program geared towards those with severe emotional disturbance.

This study examines the training needs of community mental health providers (QMHPs) in the service delivery of a predominately Medicaid funded community mental health program based in public schools.

Purpose of the Study

This study presents findings from an exploratory study of the mental health skills and training needs of staff from community organizations that serve elementary school aged children in a public school setting. A better understanding of the training needs of community mental health providers that serve children with emotional disturbances in school settings can lead to more targeted and effective curriculum training development.

Study Overview

Practitioners working with severely emotionally disturbed children in a school setting are often called to work from an evidence-based practice framework in addressing

complex needs and issues. Provision of services necessitates the understanding and applicability of interventions and resources needed to serve this population. An understanding of underlying factors such as family dynamics, trauma and development is necessary to improve service delivery and student outcomes. Additionally, practitioners should understand the impact the school setting has on their practice, ethical dilemmas that may arise as well as the need for collaboration among school personnel, families and other mental health professionals.

The current study focused on understanding these issues through in-depth interviews of community mental health providers, specifically qualified mental health practitioners (QMHPs) in a public school-based setting in the state of Virginia. A qualitative study was beneficial in garnering rich data on the training needs from the perspectives of school-based mental health providers. Qualitative interviews provide "thick descriptions of social life recounted by their participants" (Hesse-Biber & Leavy, 2011, p. 95) as well as provide knowledge-producing information that is "contextual, linguistic, narrative and pragmatic" (Kvale & Brinkmann, 2009, p. 95). Interviews explored the roles of TDT treatment providers, relationships with students, teachers, staff and parents as well as treatment interventions. Interviews examined the training needs of providers including work with specific SED populations, other content/subjects areas as well as how can these trainings best be delivered and in what format. In addition, interviews explored factors impacting their practice, capacity for knowledge, and identify other trainings specific to service delivery in school settings.

Research Questions

Specifically, the study addressed the following research questions:

1. What are the training requirements of school-based mental health providers, specifically therapeutic day treatment clinicians?

2. How well are they prepared to provide mental health services in a school setting?

3. What are the barriers to adequate mental health training for those providing services in a school setting and how can these trainings best be delivered (what content or subject need to be learned, when should theses trainings occur and should a minimum required training standard exist for TDT programs)?

4. From the providers' perspectives what are the presenting problems and needs of the population being served?

5. From the providers' perspectives what are the presenting problems and needs for the provision of services?

6. How best to deliver mental health services in a school setting (in or out of school, during or after school hours, individual therapy, family therapy, and/or group therapy, etc.)?

The answers to these questions would be important to a community mental health practitioner seeking to practice in a school-based setting. Answering these research questions will benefit researchers and training/curriculum developers by beginning to identify potential limitations, gaps, barriers and needs of community mental health providers whose services occur within the context of public schools.

Chapter 2

LITERATURE REVIEW

Definition of Serious Emotional Disturbance

Serious emotional disturbance (SED) is a term defined by a variety of state and federal statutes to identify children whose emotional and behavioral problems create substantial difficulties across a number of domains such as socially, academically, and emotionally. SED is not a formal mental health diagnosis, but rather a term to describe a population in need for services. Definitions of SED are bound by federal legislation and regulation to which they ascribe. The following section will outline the differing definitions of SED including those from the Individuals with Disabilities Education Act (IDEA) and Center for Mental Health Services (CMHS). In addition, as states may provide their own definitions with additional guidelines to professionals; Virginia's definition of SED will be examined as its definition varies from the aforementioned regulations.

The Individuals with Disabilities Education Act (IDEA) mandates that all children exhibiting severe behavioral and psychological disorders receive free and adequate public education in a regular and least restrictive setting as possible. In accordance with the nation's special education law, emotional disturbance is 1 of 12 disability categories specified under the Individuals with Disabilities Education Act (IDEA). "Emotional disturbance" is defined in subsection 300.8(c)(4) of Title 34 Code of Federal Regulations, Subpart A as follows:

"…a condition exhibiting one or more of the following characteristics over a long

period of time and to a marked degree that adversely affects a child's educational

performance:

(A) An inability to learn that cannot be explained by intellectual, sensory,

or health factors.

(B) An inability to build or maintain satisfactory interpersonal

relationships with peers and teachers.

(C) Inappropriate types of behavior or feelings under normal

circumstances.

(D) A general pervasive mood of unhappiness or depression.

(E) A tendency to develop physical symptoms or fears associated with

personal or school problems." (2006, Title 34, §300.8(c)(4)(i))

As defined by IDEA, emotional disturbance includes schizophrenia but does not

apply to children who are socially maladjusted, unless it is determined it is in addition to

an emotional disturbance. (2006, Title 34, §300.8(c)(4)(ii)).

The Center for Mental Health Services (CMHS) was established within the

Substance Abuse and Mental Health Services Administration (SAMHSA) to coordinate

Federal efforts in the prevention and treatment of mental illnesses and the promotion of

mental health. The Center for Mental Health Services (CMHS) awards states with

Federal block grant funds for the provision of mental health services to both children with

a "serious emotional disturbance" and adults with a serious mental illness.

The Center for Mental Health Services (CMHS) defines children with "serious

emotional disturbance" as persons:

- From birth to 21 years of age.

- Who currently or anytime within the past year has had an emotional, socio-emotional, behavioral or mental disorder to meet diagnostic criteria specified within the *DSM-V* or its *ICD-10-CM* equivalents, or subsequent revisions.

  o For children 4 years of age and older, the *Diagnostic Interview Schedule for Children* (*DISC)* may be used as an alternative to the *DSM-V*.

  o *DSM -V* V codes, substance use disorders and developmental disorders are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

- Significant functional impairment whereby the ability to function in the family, school or community, or in a combination of these settings are impacted. Or, impairment is significant enough to require multiple interventions involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care.

- The duration of the impairment must have been present for at least 1 year or, on the basis of diagnosis, severity or multiagency intervention, is expected to last more than 1 year.

The CMHS goes on to delineate functional impairment as difficulties that substantially interfere with achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. The

functional impairments are not temporary or an expected response to stressful events rather they are described as "episodic, recurrent, and continuous (p. 29425).

Similarly, Virginia's Department of Behavioral Health and Developmental Services (DBHDS, 2009) outlines the criteria for SED as the Center for Mental Health Services however Virginia's definition limits the age from birth through age 17, requires that problems in personality development and social functioning have been exhibited over at least one year's time, problems are significantly disabling based on social functioning of most children of the child's age, and have become more disabling over time. Additionally, DBHDS makes a distinction and outlines the definition and requirements for children "at-risk" of serious emotional disturbance as (DBHDS, 2009, p. 14):

> **Children "At-Risk" of Serious Emotional Disturbance** means a condition experienced by a child, from birth through age 7, which meets at least one of the following criteria:
>
> - The child exhibits behavior or maturity is significantly different from most children of the child's age, and is not due to developmental or intellectual disability, or
> - Parents or persons responsible for the child's care have predisposing factors themselves, such as inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, that could result in the child developing serious emotional or behavior problems, or
> - The child has experienced physical or psychological stressors, such as living in poverty, parental neglect, or physical or emotional abuse, which put him at risk for serious emotional or behavior problems.

In order to qualify for TDT services, a child must meet criteria for SED as set forth by Virginia's Department of Behavioral Health and Developmental Services. A child who meets SED qualifications under the aforementioned entity is eligible for services even if the child does not receive a SED designation by the school under IDEA regulations; however, a child who has been identified by the school as SED may not necessarily qualify for TDT.

Characteristics of Children with Serious Emotional Disturbance

Prevalence. Previous studies report that as many as 5% to 20% of all children and adolescents experience serious mental health difficulties (Adelman & Taylor, 2006; Costello, Messer, Bird, Cohen & Reinherz, 1998; Merikangas et al, 2010; Perfect & Morris, 2011; Powers, Edwards, Blackman, & Wegmann, 2013; Roberts, Jacobs, Puddy, Nyre, & Vernberg, 2003; Weist, Goldstein, Morris & Bryant, 2003). Those with severe emotional disturbance have impaired functioning across home, school, and community settings (SAMHSA's National Mental Health Information Center, 2004). In the state of Virginia, between 85,129 and 104,046 children and adolescents have a serious emotional disturbance, with between 47,294 and 66,211 exhibiting extreme impairment (Virginia's Department of Behavioral Health and Developmental Services, 2009). These numbers account for those who either sought or received services through community services centers. This does not account for those who receive services through private insurance and/or private providers.

Socioeconomic Status. Low socioeconomic status is the strongest predictor of early childhood emotional problems (Werner & Smith, 1992) and psychiatric disorders (Costello et al. 1998; Leventhal & Brooks-Gunn, 2003; Martel, 2013) with children in

poor families having a higher rate of mental health problems than their "near-poor" and "non- poor" families (Howell, 2004). Youth living below 200 percent of the poverty level are 1.6 times more at risk for emotional disturbance than all youth (Mark & Buck, 2006). Additionally, poverty is associated with a higher prevalence of externalizing disorders such as attention deficit hyperactivity disorder, oppositional defiance, conduct disorders and aggressive behaviors (Bradely & Corwyn, 2002; Costello, Compton, Keeler, & Angold, 2003; Martel, 2013).

It is important to highlight that the primary funding source for Therapeutic Day Treatment programs is Medicaid. Medicaid finances mental health services for low-income individuals.

Race. Although the majority of children and youths designated as SED are white, they are over-represented among Blacks and Hispanics (Mark & Buck, 2006). A study by Mark and Buck (2006) utilized data from the 2001 National Health Interview Survey (NHIS) to describe the sociodemographic features of youth with serious emotional disturbance living in the United States (n= 13,579). Youths with serious emotional disturbance were identified through their scores on the Strengths and Difficulties Questionnaire (SDQ), which is a 25 item behavioral screening questionnaire. Although African American youth constituted only 14.9 percent of the total study sample, 21.2 percent of the 14.9 percent of African American youth were identified with serious emotional disturbance. Serious emotional disturbance was also overrepresented in Hispanics youth, 19.1 percent of the 16 percent of Hispanics youth were identified with serious emotional disturbance. This study did not examine other implicating factors such as sex or age.

Along similar lines, the U.S. Department of Education's 30th Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act estimated that black students are 2.28 times more likely to be served under IDEA, for emotional disturbance than all other racial/ethnic groups combined (US Department of Education, 2011). This further implicates the impact of race in the designation of emotional disturbance.

Gender. Similarly, utilizing data analysis from the 2001–2007 National Health Interview Survey, the emotional and behavioral problems, characteristics, conditions, and service use of children aged 4–17 years were identified (Pastor, Reuben, & Duran, 2012). Utilizing two measures, Strengths and Difficulties Questionnaire and parents' reported overall serious emotional and behavioral difficulties, found that males and children with Medicaid coverage were more likely to have serious overall difficulties than females and children with private health insurance coverage (Pastor, Reuben, & Duran, 2012).

Furthermore, research utilizing data from the 2010-2012 National Health Interview Survey indicate that about 1 in every 3 adolescents, ages 12-17, received both school and non-school, non-medication mental health services for serious emotional or behavioral disturbances (Jones, Pastor, Simon, & Reuben, 2014). Over 55% of adolescents with serious emotional or behavioral difficulties received school services with a higher percentage of boys (60.5%) being more likely than girls (48.9%) to receive non-medication mental health services in school settings (Jones, et al., 2014). The identification of serious emotional or behavioral disturbances was not based on an actual diagnosis or meeting definitions set forth by the aforementioned federal statutes. Instead, criteria for serious emotional or behavioral difficulties were based on a yes response to

"Overall, do you think that [sample child's name] has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people?" (Jones, et al., 2014, p. 5).

The higher prevalence of boys with serious emotional or behavioral difficulties and school-based interventions may be due in part to the tendency for boys to present with externalizing and developmental conditions such as attention deficit hyperactivity disorder (ADHD) and autism spectrum disorders (Jones, et al., 2014). Externalizing behaviors are more likely to disrupt the classroom milieu requiring interventions from school personnel. Examples of externalizing behaviors include behavioral outbursts, arguing with those in authority and/or peers, oppositionalism, difficulties with peer relationships, destructive behaviors, and/or aggressiveness. Boys are 3 times more likely to be diagnosed with ADHD when compared to girls (American Psychiatric Association, 2000; Egger & Angold, 2006) with boys exhibiting higher levels of hyperactivity (Gershon, 2002; Hartung, Willcutt, Lahey, Pelham, Loney, et al., 2002). Emotional disturbance is diagnosed 4 times as often in boys as in girls (Bradley, Henderson, & Monfore, 2004; Coutinho & Oswald, 2005). Whereas results from studies indicate that girls are more likely to present with internalizing behaviors (Cullinan, Evans, Epstein, & Ryser, 2003; Gage, 2013; Gresham, Lane, MacMillan, & Bocian, 1999; Zahn-Waxler, 2000). Internalizing behaviors include anxiety, depression, low-esteem, and other behaviors that may not disrupt the classroom.

Therapeutic Day Treatment

Overview. In the state of Virginia, Therapeutic Day Treatment (TDT) is an intensive community-based mental health treatment program that is funded and regulated

by the Department of Medical Assistance Services (DMAS), the state organization that administers Medicaid. Unlike traditional services such as medication management, inpatient mental health and outpatient therapy, therapeutic day treatment is considered non-traditional along with residential treatment and community-based substance abuse services (DMAS, 2014). It is one of the most intensive publicly funded community based mental health services available to children in Virginia; many of the children and adolescents in the program require crisis intervention and support to de-escalate mental health crises that may arise in school.

Community mental health agencies that provide mental health programming in school settings address the needs of these children, as historically school systems have been unable to meet the high demands of this at risk population. These community mental health treatment programs housed in public schools are alternatives to partial day treatment programs and residential programs. In addition, Medicaid shifts the burden from state funded schools to a shared fiscal responsibility with the federal government (Wulf-Heller, 2015). They provide a least restrictive setting for severely emotionally disturbed children in that services are provided in the child's school; it is an "ecologically sensitive and cost-effective alternative" (Vernberg, Roberts, Randall, Biggs, Nyre & Jacobs, 2006, p. 423). This is in response to the deinstitutionalization trend from residential and inpatient treatment settings to a "school-based, community-oriented programming for educational, emotional, and behavioral needs for children with SED [severe emotional disturbance]" (Vernberg et al., p. 420). In response to the needs and trends, programs have been created to "provide comprehensive school-based interventions for children with SED [severe emotional disturbance], which include staff

and services usually accessed in community mental health, child welfare, and private practice arenas" (Roberts et al., 2003, p. 948). Furthermore, treatment in their natural setting provides the opportunity to observe the student's behaviors and provision of interventions (Powell, et al 2011). This is also in line with recent shifts in treatment approaches such as person centered and family focused modalities (Wulf-Heller, 2015).

Policy Leadership Cadre for Mental Health in Schools (2001) described 5 formats of mental health service delivery in a school setting which include:

- School-financed student support services: professional staff (school psychologists, counselors, and social workers) financed by school districts such as school psychologists, counselors, and social workers.

- Formal agreements with community mental health services: a community service agency or private provider provides services.

- School or district-supported mental health units or clinics: mental health clinics financed and supported by school district.

- Classroom-based curricula: interventions are provided by school teacher/personnel.

- Comprehensive, multifaceted, and integrated approaches: integrative and collective approach that brings together providers, case management and wrap-around services that are provided to children with mental health problems and their families via partnerships among various child-serving systems.

A national survey of mental health services, found that out of a representative sample of 83,000 public elementary, middle, and high schools and school districts in the

United States, over half of the schools reported that they had formal arrangements with "county mental health agencies, followed by community health centers, individual providers, and juvenile justice systems" for student mental health services (Foster et al., 2005, p. 27).

For the purpose of this study the focus was on the partnership of schools or school districts and community service providers in terms of service delivery. Therefore, the study focused on the community mental health providers who provide services at the school. In addition, the term Therapeutic Day Treatment is the term utilized in the state of Virginia to describe the intensive community mental health program that occurs in public school settings, therefore the two terms will be utilized interchangeably throughout this paper. This is not to be confused with partial day treatment programs designed to provide educational and rehabilitative services off school site. Therapeutic Day Treatment services are provided at the child's school through community providers. It is primarily a Medicaid funded program.

Therapeutic Day Treatment is a community-based mental health treatment program, primarily in public school settings designed specifically to address mental health, emotional and behavioral issues of children and adolescents. TDT programs are highly structured treatment services with interventions that include individual, family, and group counseling, collaboration with school personnel, and potentially other mental health providers. Other therapeutic interventions include: modeling, implementing and coaching of pro-social skills (i.e. anger management, behavior management, conflict resolution), crisis intervention, medication education, classroom observation,

assessment/evaluation of clinical needs, and implementation of behavior modification

(Department of Medical Assistance Services (DMAS), 2011).

Services are provided at a minimum of two hours daily with at a minimum of two

therapeutic interventions provided on each day of service (see Appendix B). Unless

offered after school, typically these services are provided during school hours and are

five or more hours in duration.

Eligibility. Eligibility for therapeutic day treatment program includes children

and adolescents whose serious mental health, behavioral and emotional difficulties have

resulted in significant functional impairments in comparison to the social functioning of

most children who are the same age. Specifically, they have caused impairment in major

life activities and have become increasingly disabling over time requiring frequent,

supportive and intensive interventions (DMAS, 2011). These children are often times at

risk for an out-of-home placement, removal from their school, demonstrate difficulties

with interpersonal relationships and require recurrent interventions at home, school

and/or in the community. Appendix B provides a more detailed list of the eligibility

requirements. A major component of the eligibility, as outlined in Appendix B, is the

intensity of the program, as failed repetitive interventions are needed in order to qualify

for therapeutic day treatment services.

Funding. Funding for Virginia's public behavioral health and developmental

services, including Therapeutic Day Treatment services, comes from a variety of sources,

including state general funds, local matching dollars, federal grants, fees, and Medicaid.

TDT services are primarily funded by Medicaid reimbursement, which has reportedly

grown steadily over the last four biennia (VDBHDS, 2009). Medicaid enrollment of low-

income children in Virginia has grown rapidly in the past several years; from 429,081 in 2004 to 563,370 children enrolled in Medicaid in 2010 (Virginia Voices for Children, 2011).

Qualified Mental Health Practitioners

According to the Virginia Department of Behavioral Health and Developmental Services (2011), in order for a professional in the children's behavioral health field "to support quality service provision and assure consistency, training is needed to assure that service providers have the knowledge and skills that are required to be effective" (DBHDS, 2011, p. 17).

According to the Department of Medical Assistance Services (DMAS, 2011), "at a minimum, services are provided by a Qualified Mental Health Practitioners (QMHP)" (p. 21). According to the Department of Behavioral Health and Developmental Services Office of Licensing, a Qualified Mental Health Professional (QMHP) means a person in the "human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness" (DBHDS, 2012). Specifically a QMHP:

- has a social work Bachelor's from an accredited college or university with at least one year of documented clinical experience with children or adolescents;

- be a registered nurse with at least one year of clinical experience with children and adolescents;

- has at least a Bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents (DBHDS, 2012, p. 1).

For the purpose of this study, those with the minimum qualifications for QMHP will be included in the study. Masters level and licensed social workers and psychologists as well as doctors of medicine or osteopathy licensed in Virginia are also considered QMHPs; however, it is more frequent that they are in supervisory, management and leadership positions while bachelor's level professionals tend to provide the direct care in Therapeutic Day Treatment programs.

Training Needs

"Training is the best intervention for promoting the most effective interactions between staff and the children and families they serve (Meyers, Kaufman, & Goldman, 1999, p. 23)."

Michael Hoge, in his keynote address at the Annapolis Conference on Behavioral Health Workforce Education and Training (2002), argues that transformations in health care have "outpaced" changes in educational and training programs offered to the behavioral health workforce. These training gaps have resulted in "graduate students, working professionals, and other direct care providers inadequately prepared for practice in the current health care environment" (Hoge, 2002, p. 305). He describes the training gaps as an "acute crisis" that impedes the delivery of "effective and efficient mental health and addiction services" (Hoge, 2002, p. 305). Of interest to this current qualitative study is Hoge's description of the gaps that exists in the training needs of direct care staff. Although Hoge does not specifically address those who provide school based community mental health services, he does refer to those without advanced professional degrees including non-degreed and Bachelor's degreed providers. These non-degreed and Bachelor's degreed providers make up 40% of the behavioral health organizational

workforce and 60% of direct care staff in state and county psychiatric hospitals

(Manderscheid et al., 2001); it is therefore essential that gaps in training are addressed.

In spite of the growing size of this group, there continues to be minimal training

and orientation that are often limited to accreditation requirements such as fire safety,

ethics, and violence in the work place (Hoge, 2002). These trainings often occur in the

absence of context specific curriculum. Additionally, budgetary constraints, time

limitations as well as staff turnovers have impacted the quality and quantity of training.

Hoge goes on to argue that recent trends in behavioral health have focused on

appropriate, cost-benefit, efficient and effective evidence based practices. Evidenced

based practices are being employed in school based mental health settings; however just

like other evidenced based practices within other contexts, they are being employed often

in the absence of adequate training and/or support. As a result, providers are taxed with

independently digesting a "rapidly expanding and increasingly complex body of

knowledge about mental and addictive disorders and their treatments" (Hoge, 2002, p.

306).

Besides meeting the aforementioned minimum requirements as a Qualified Mental

Health Practitioner (QMHP), currently there is no system in place for assuring minimal

standards of competence such as a formal training certification. In other words, there is

no system in place that specifically sets the standard for ensuring adequate delivery of

mental health services in a school based setting.

A search of literature revealed relatively very few published articles on the topic

of the training of community mental health providers whose provision of services occur

in school based settings. In fact, a search of EBSCO MegaFile, ProQuest, Social Work

Abstracts and PsycInfo using the key words "school interventions" and "training;" "school-based mental health;" "school based interventions" and "providers;" "emotional disturbance" and "school interventions" produced very few relevant citations.

Some of the studies examined university course syllabi to determine whether curriculum content incorporated relevant trends in education, service delivery (Berzin & O'Connor, 2010) and standards relating to the certification of school social workers (Mumm & Bye, 2011). In their review of preparation and training needs of school psychologists, Perfect and Morris (2011), identified key areas in training necessary specifically for the provision of school mental health services to include ethics, competency, and interventions. Recognizing the unique needs the school and students present, they propose a sequence of graduate study that includes training in school-based mental health service delivery, as well as continuing education courses and workshops.

Likewise, a qualitative study of teachers and school-based mental health professionals (psychologists and social workers) point to the lack of highly trained staff as the greatest barrier to effectively intervening with students who present with mental health problems (Powers, Bower, Webber & Martinson, 2011). School social work research point to the lack of training, knowledge and awareness as perceived barriers in school-based social work practice interventions (Teasley, Canifield, Archuleta, Crutchfield & McCullough, 2012; Teasley, Gourdine, & Canfield 2010). Additionally, through survey content analysis, Teasley et al (2012) found that knowledge, awareness and training were identified as the second most listed practice facilitator category, aiding in the provision of school social work practice. Specifically, under this category, the following items were included "in-service trainings", "continuing education", "having a

broad knowledge base", "willingness to learn about others" and "community visits to understand people" as being important (Teasley, et al, 2012, p. 150). As indicated previously, unlike school social workers and school psychologists, therapeutic day treatment clinicians work independently from the schools in which services are provided. This creates additional challenges for the TDT provider.

Practicing evidence-based treatment has been proposed as the new gold standard in service delivery (Institute of Medicine, Committee on Quality of Health Care in America, 2001; Drake, Goldman, et al., 2001). In spite of this as well as the existence of several "evidence-based" practices pertinent to this population, factors such as insufficient knowledge, time and resources as well as training and support impact the effective delivery of such interventions (Kratochwill, 2007; Reinke, Herman, Stormont, Brooks, & Darney, 2010).

Utilizing case studies, Nadeem, Jacyox & Stein (2011) examined contributing factors and processes of the successful implementation of a school-based trauma intervention, Cognitive Behavioral Intervention for Trauma (CBITS). They found that support system elements, such as training from expert trainers; ongoing coaching through clinical and logistical support; promotion of fidelity of the intervention; implementation to fit the service context; and value on child outcomes contributed to the successful implementation. The sites which included Jersey City Public Schools, New Jersey and Mercy Family Center, Louisiana, were selected based on their adherence to intervention delivery as well as improved pre- and post-treatment outcomes that demonstrated decreases in trauma symptomatology. Although this study was limited to only two case studies and it did not delineate the providers' educational background and/or prior

experience; they were able to examine the processes involved. This is helpful in that it begins to look at how concepts of training and support contribute to the success of school based mental health program.

Another study examined evidence-based, cognitive-behavioral preschool and elementary programs in addressing aggressive and conduct problems (Powell, Boxmeyer, Baden, Stromeyer, Minney, Mushtaq, & Lochman, 2011). They found that the type of training, support and the characteristics of the clinicians and the school climate as contributing factors to the overall quality and implementation of the programs (Powell, Boxmeyer, Baden et al., 2011).

In a study of the dissemination of an evidenced based treatment/practice, Coping Power, the nature of training was examined and compared to treatment outcomes for elementary school aged children (Lochman, Boxmeyer, Powell, Qu, Wells, & Windle, 2009). In the Coping Power Program, clinicians were assigned to two training conditions (intensive training or basic training). Both training groups were required to attend three workshop days prior to service delivery and participation in monthly supervision sessions; however, the intensive training group received two additional training components. These included one-on-one support via email and telephone hotline that provided support and problem solving with any issues arising from program implementation; secondly child and parent sessions were audio taped and feedback was provided to counselors. Results indicated that those in the intensive training component had significant impact on children's outcome to include increased behavioral control (via feedback from parent, teacher and youth ratings) and improved social, cognitive, and academic skills as compared to the other groups (Lochman, et al, 2009). It is worthy to

note that the children of the basic training group didn't exhibit any behavioral improvements. It appears that the intensity of training impacted the overall efficacy of the evidenced based program; however, lacking is the composition of each group of trained personnel in terms of discipline, education or field experience. There is no way to ascertain if those factors may have impacted the outcomes for either group.

The Committee on Quality of Health Care in America, Institute of Medicine (2001), describes the gap between the health we have and the care we should have as a "chasm" which is partially due to in its inability to translate knowledge into practice. There is a need to develop training that is effective in assuring that providers are competent in the knowledge, skill set, values and attitudes needed to practice (Meyers, Kaufman, Goldman, & Sybil, 1999)

Theoretical Framework and Perspective

Several theories pertinent to the training needs of community mental health providers in school settings will be outlined as they relate to the population they serve. Specifically, theories of trauma/complex trauma and attachment theory from a developmental perspective will be explored. The following sections will explore trauma, its definition, and its impact. This will be followed by attachment theory and the impact of trauma.

Trauma. Trauma significantly impacts the learning, behavioral, social, emotional and psychological functioning of school aged children (Raider, 2010). It is reported that children in community behavioral health care have severe emotional and behavioral health issues, due in part to trauma as well as their caregiver's reaction to the traumatic exposure (SAMHSA, 2012). School-based mental health programs are aimed at

addressing the needs of these children; therefore, providers need to have an understanding of the impact of trauma on the population they serve.

Trauma has been studied under a variety of rubrics, post traumatic stress disorder, complex trauma, developmental trauma, interpersonal trauma, and complex stress disorder, just to name a few. Although the concepts overlap in some aspects and are often used interchangeably; for the purpose of this study, complex trauma will be discussed within a developmental context.

By the age of 16, roughly 1 in 4 children will experience a traumatic event and 28% of these children will experience 2 or more traumatic events (Costello, Werkanli, Fairbank, & Angold, 2002). At community mental health settings, children and youth experienced, on average, about 2 or more types of trauma prior to intake, with nearly one-fourth (23.5 percent) having experienced 4 or more types (SAMHSA, 2012). Traumatic events that are single-incidents "Acts of God", occurring unexpectedly or "out of the blue" such as a natural disaster, a terrorist attack, single episode of abuse or assault are referred to as Type I trauma (Courtois & Goldman, 2009). Whereas Type II traumas are "human induced," repetitive and prolonged in nature such as physical, sexual, psychological/emotional abuse; neglect; war; domestic violence; peer assaults; community violence; serious illness or injury; human trafficking; and loss or separation from a caretaker or significant other including death, incarceration, from substance use/abuse, and removal from the home (Cook, Spinazzola & Ford, 2005; Courtois & Gold, 2009).

Complex trauma is defined as repeated or prolonged exposure to traumatic events that involve harm in the context of primary relationships occurring at developmentally

vulnerable times in the child's life (Cook, Blaustein, Spinazzola, & van der Kolk, 2005; Courtois & Ford, 2009). This type of trauma is "extreme due to its nature and time" (Courtois, & Ford, 2009, p. 2) compromising the course of childhood development in attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept domains (Cook et al 2003; van der Kolk, 2005). The effects of complex trauma exposure on children will be briefly highlighted.

Affect regulation and behavioral control. Disturbance of affect regulation following exposure to complex trauma may manifest as difficulties with describing feelings and internal experiences, difficulties interpreting emotions, difficulties with communicating wishes and desires, and lack of acknowledgement of internal states (D'Andrea, Ford, Stolbach, Spinazzola & van der Kolk, 2012; van der Kolk, 2005). Difficulties in regulating their emotional state(s) and inability to self-soothe, results in negative behaviors such as impulse control (Cook et al. 2005; van der Kolk, 2005). Intense emotions and affect such as explosive anger, lability or numbed affect can be seen behaviorally in externalizing behaviors (i.e. aggressions, oppositional defiance, compulsive behaviors) and internalizing behaviors (i.e. withdrawal, self-destructive behavior). For example, a student with complex trauma exposure presenting with difficulties managing her anger becomes overwhelmed with frustration as limits are set by her teacher (i.e. asking the student to wait her turn, informing the student that her time is up on the computer). Her inability to regulate her emotions or to self-soothe, results in the student responding to her teacher's directives by yelling, tossing chairs around and becoming aggressive towards her teacher; subsequently disrupting the entire class.

Biological dysregulation. The developing brain learns and adapts to its environment (Blaustein and Kinniburgh, 2007). Therefore repeated trauma exposure in the developing years can result in alterations to brain structures, function and regulatory systems (D'Andrea et al., 2012). According to van der Kolk (2005), trauma can interfere with the integration of left hemisphere (how one makes sense of themselves, analytical capacities) and right hemisphere (how one responds to environment, feeling and sensory). The tendency to react only from the right brain often results in reacting without thought or planning; this could come across as irrational, impulsive and/or defiant behaviors. This inability to integrate both spheres may result in a child's difficulties in negotiating their environments such as the school environment (Aviles, Anderson, & Davila, 2006). Other biological impacts of trauma include hypersensitivity to physical contact; problems with coordination, balance, and body tone; somatization (headaches, stomach aches); sensorimotor or developmental problems; and/or insensitivity (Cook et al., 2003; van der Kolk, 2005).

Cognition. Developmental problems and/or delays caused by biological alteration as a result of trauma, also impact the cognitive developmental domain. Impairments in cognition include: difficulties with attention regulation and functioning; impaired ability to sustain curiosity and focus; learning difficulties; problems with language development; problems with orientation in time and space; difficulties processing information; difficulties in planning, anticipating and completing tasks; and problems identifying one's own contribution to problems (Cook et al., 2003, p. 7). Maltreated children are more likely to present with poor academic and standardized test performance (Sieger, Rojas-Viilches, McKinney, & Renk, 2004). They may present with difficulties

understanding schoolwork, may lack focus to complete assigned tasks and difficulties

understanding or processing their own contribution to problems encountered in the

classroom.

  Dissociation. Dissociation in children has been associated with histories of

complex trauma (Agargun, Kara, Ozzer, Selvi, Kiran, & Kiran, 2003; Courtois and

Goldman, 2009; Dominguez, Cohen, & Brom, 2004). In one's attempt to cope with the

conscious awareness, helplessness and pain associated with trauma, dissociation serves as

a defense mechanism (Courtois and Ford, 2009). Such defense is triggered in response to

extreme overwhelming events and/or traumatic stimuli. Dissociation involves the

separation and detachment of emotions, thoughts, awareness and perceptions in an

unconscious manner (Courtois and Ford, 2009). Disturbances of consciousness following

complex trauma exposure may manifest as alterations in states of consciousness,

amnesia, depersonalization and derealization (Cook et al., 2003). Dissociation can be

used adaptively with traumatized children in that it allows for the automatic response

without judgment, planning or organization; secondly it isolates painful affects and

memories; and lastly it disconnects awareness of feelings and the self (Cook et al., 2005).

  Unfortunately, what serves as a survival and self-preservation mechanism can

prevent integration of other memories and experiences. For example, in a school setting a

student with a history of complex trauma may appear dazed and/or lost in thought;

present with difficulties remembering learned material or may lack awareness or control

of behavioral enactments (Cook et. al., 2005). Due to the limited knowledge of

dissociation among professionals, symptoms of dissociation may be misdiagnosed as

Attention Deficit Hyperactivity Disorder (ADHD) or other disruptive behaviors (Courtois

and Ford, 2009). For example, in one study, Endo, Sugiyama & Someya (2006) found that among abused children, dissociative disordered children met criteria for ADHD; however, they found that non-maltreated children with ADHD did not met criteria for dissociate disorders.

   Self-concepts. Pearlman and Courtois (2005) posit that exposure to complex trauma results in negative perceptions of self and others as well as experiences of lack of trust and re-victimization. The distorted sense of self and environment of traumatized children results in feelings of shame and guilt and low self-worth and self-efficacy (D'Andrea et al., 2012). This is due in part to the internalization of the repetitive traumatic experiences of harm, betrayal and rejection that can lead children to believe that they are bad, not good enough or not worthy of love (Cook et al., 2003). Deficits in self-concept can manifest as: feelings of powerlessness, incompetence, helplessness, or unloved; lack of a predictable and continuous sense of self; poor sense of separateness; and body image disturbances (Cook et al., 2003, p. 7).

   Attachment. The development of patterns of attachment and ways of responding are determined by the early caregiving relationships. These patterns and modes of responses can be referred to as internal working models and purportedly will guide the individual's feelings, thoughts and expectations in other relationships (Slade, 2000).

   Children exposed to complex trauma experience disruptions in the attachment relationship whereby the caregiver is the actual source of the trauma and/or the caregiver fails to protect and regulate their child from the trauma. This results in the impairment in the ability to regulate emotional and physical states. Other impairments in the attachment domain include uncertainty about the reliability and predictability of the world; problems

with boundaries; distrust and suspiciousness; social isolation; interpersonal difficulties;

difficulties attuning to other people's emotional states; difficulties with understanding

another's perspective; and difficulties enlisting and relying on others as allies (Cook et

al., 2003, p. 7).

Information from a survey on complex trauma exposure by the National Child

Traumatic Stress Network (Spinazzola, Ford, & Zucker, 2005) revealed that 78% of their

sample of children and families receiving comprehensive services has been exposed to

multiple traumas and/or prolonged trauma. This same sample reported an average onset

of trauma at 5 years of age and presented with disturbance in: affect regulation (61.5%);

attention and concentration (59.2%); negative self-image (57.9%); impulse control

(53.1%); and aggression or risk taking (45.8%). Yet another study found that 80% of a

national sample of 1,467 children and adolescents were exposed to trauma with an

average of 3.7 types of trauma per individual (Finkelhor, Ormrod, & Turner, 2009). For

example, a child who was physically assaulted in the past year would be 5 times as likely

also to have been sexually victimized and more than 4 times as likely also to have been

maltreated during that period.

Research has associated complex trauma with a wide range of adverse outcomes;

however, these psychological, emotional and behavioral symptoms and problems go

beyond the criteria for post-traumatic stress disorder (Cook et al 2005; Courtois & Ford,

2009; van der Kolk, 2005). These include mood disorders (Benjet, Borges & Medina-

Mora, 2010; Cloitre, Stolbach, Herman, van der Kolk, Pynoos, Wang, & Petkova, 2009;

Lieberman, Chu, van Horn, & Harris, 2011; Shenk, Nolla, Putnamb, & Trickett, 2010);

dissociation (Silvern & Griese, 2012); aggression (Silvern & Griese, 2012); self-injurious

or self-endangering behaviors such as suicidality or self-mutilation (Lieberman et al 2011; Wanner, Vitaro, Tremblay, & Turecki, 2012); cognitive difficulties (Kira, Somers, Lewandowski, & Chiodo, 2012); substance use (Benjet et al 2010; Lieberman et al 2011) and externalizing behaviors/disorders such as oppositional defiant disorder, conduct disorder, and attention deficit/hyperactivity disorder (Benjet et al 2010; Copeland, Keeler, Angold, & Costello, 2007; Henry, Sloane, & Black-Pond, 2007; Muller, Vascotto, Konanur, & Rosenkranz, 2013).

A study of chronic child adversity and onset of psychopathology during three life stages found that in particular, family dysfunction (parental mental illness, substance use, and crime; family violence; abuse/neglect) when compared to other childhood adversities (i.e. interpersonal loss, physical illness) was more likely to be associated with the onset of mood, anxiety, substance use and externalizing psychopathologies across childhood, adolescence and adulthood life stages (Benjet et al 2010).

Emotional abuse in childhood has been found to have significant impact on child trauma symptoms and long-terms effects on mental outcomes into adulthood, more so than physical forms of abuse (Chapman, Whitfield, Felitti, Dube, Edwards, et al., 2004; Turner, Finkelhor, Ormrod, Hamby, Leeb, Mercy & Holt, 2012; Wright, Crawford, & Del Castillo, 2009). In addition, inconsistent and hostile parenting is associated with child trauma symptoms, emotional and behavioral problems (Repetti, Taylor, & Seeman, 2002; Turner et al, 2012). This information is important in that TDT interventions should take note and address interaction between parents and children including providing psycho-education on parenting skills, parental support and referral for needed services.

Trauma inhibits the social-emotional development in children, which in turns impacts their overall academic success. It is critical that clinicians have the skillset and understanding necessary to provide effective services.

Attachment Theory. The intersection between trauma and attachment is particularly relevant during childhood. The impact of complex trauma on attachment as well as the traumatic impact of disrupted attachments is significant; therefore this section will provide a more in depth discussion of attachment theory and its intersection with trauma.

Attachment theory began with the work of John Bowlby, psychoanalyst, in the 1950's. His work on attachment theory originated from his observations as a volunteer in a home for delinquent boys. These boys had significant disruptions such as early losses or traumatic abandonments by their caregivers (Fonagy, 2001; Slade, 2000). He noted the implications of such disruptions to include delinquent and behavioral problems.

Attachment theory views the development and preservation of attachments as a driving force needed for survival (Blaustein, & Kinniburgh 2007; Slade, 2000). In his theory, Bowlby defined a series of developmental phases based on the child and primary caregiver bond (i.e. mother, father). Attachment describes the interaction between children and their caregivers that have a long-term impact on development. Early childhood experience plays a crucial role in the development of patterns of attachment and ways of responding. The attachment system allows for children to explore their world and consequently develop emotional and biological regulating abilities (Schore, 2001). Feelings of joy, security and love are fostered when an attachment is established,

maintained and renewed. Anxiety, grief and depression are brought about by impaired attachments (Bowlby, 1969).

Bowlby believed that the development of patterns of attachment and ways of response in children, beginning in infancy, are determined by parental behavior. These patterns and modes of responses can be referred to as internal working models and will guide the individual's feelings, thoughts and expectations in later relationships (Slade, 2000). In other words, these internal working models of the self and others will serve as prototypes for future close relationships such as in the form of the student and teacher dyad or the student and TDT clinician (Fonagy, Gergely, Jurist & Target, 2002).

The following are the key assumption of Bowlby's attachment theory (Slade 2000):

1. A child is born "highly motivated," predisposed, to form attachments to his/her caregivers (p. 1149); we are born this way.

2. A child would adapt/organize his/her behaviors and thinking to match his caregiver's actions in order to maintain these attachment relationships, which are central to his/her psychological and physical survival.

3. The child will often maintain such relationships at great cost to his/her own functioning, "even when doing so requires distortions of his most inherent responses" (p. 149) and adoption of a "false and distorted self" (p. 1150).

4. The distortions in feeling and thinking that stem from early disturbances in attachment occur most often in response to the parents' inability to meet the child's needs for comfort, security and emotional reassurance.

5. Distortions in thinking and feeling are often at the root of much psychopathology, because of the child being exposed to environmental failures such as rejection, abandonment, abuse, emotional unavailability or overt trauma.

Through the work of Ainsworth and others, the theory was expanded to include four attachment styles including secure, anxious-avoidant, anxious-ambivalent, and disorganized (Fonagy e t al., 2002). Children who are provided with a secure base and encouragement to explore by their caregivers, develop a representational model of himself that is "secure and self-reliant, and to be trusting, co-operative and helpful towards others" (Bowlby, 1977, p. 206). In contrast, a child who repeatedly cries with no response from his/her parents will develop a model of expecting people not to be available when in distress. In addition, a child with a working model of the caregiver as rejecting, will develop a working model of the self as "unlovable, unworthy and flawed" (Fonagy, 2001).

The secure attachment style is characterized by trust, high self-esteem, and comfort with intimacy, independence. According to Blaustein & Kinniburgh (2007), a secure attachment can act "as a buffer to mitigate the impact of overwhelming stressors, and to support recovery and healing" (p. 48). It has been associated with lower anxiety (Collins & Read, 1990), greater resiliency and better emotional management through the ability to relate to others (Kobak & Sceery, 1988). When attachment systems are impaired, children tend to make adaptation in order to keep them safe and/or survive. Therefore, in contrast to secure attachments, these adaptations impair the ability to achieve developmental competencies some of which will be discussed below (Blaustein & Kinniburgh, 2007).

For example, the anxious child is characterized as fearing rejection and abandonment, and preoccupation with intimacy; the clingy, crying baby (Shilkret & Shilkret, 2011). As a result of the failure to develop appropriate self-capacities, they function on strong emotions and relate to others in that same way. Since their attachment experiences were inconsistent and unreliable, they tend to engage in risk-taking behaviors and cling to unhealthy relationships out of fear of being alone (Pearlman & Courtois, 2005). The avoidant attachment style is characterized by distrust of others' motives; they are dismissive, emotionally guarded and uncomfortable with intimacy (Drake, 2009). Through their experiences of rejection with primary relationships, they have learned to deny and minimize their own feelings (Pearlman & Courtois, 2005). Those with avoidant attachment styles fear rejection and present with feelings of incompetence, discomfort, and anger (Pearlman & Courtois, 2005).

Those who have experienced a pattern of extreme insufficient care and prolonged/repeated abuse are referred to as disorganized/disoriented attached child. The caregiver is seen as a source of both fear and reassurance (Fonagy et al., 2002) or comfort and danger (Pearlman & Courtois, 2005) creating strong opposing motivations. This results in the simultaneous longing for and fear of closeness to the child's caregiver (Cook et al., 2005). In turn, the child anticipate the same from others such as teachers, school personnel and TDT clinicians. For their survival, children spend their resources on attuning to their caregiver's mental states at the expense of their own. They subsequently, exhibit: difficulties organizing and structuring their own thoughts and emotions; poor impulse control; dissociation; chronic hopelessness; and extreme impairment (Fonagy et al., 2002; Liotti, 2004; Pearlman & Courtois, 2005).

According to the attachment framework, attachment patterns of how children relate to others and self-regulate are brought into a therapeutic relationship (Fonagy et al., 2002; Pearlman & Courtois, 2005). Although these working attachment models were based on past infant-caregiver experiences, they will present in the therapeutic dyad between the child and the clinician. Having the adequate knowledge of internal attachment models will facilitate the necessary understanding and subsequent interventions. According to Bowlby, these working models can be molded through new relationship experiences such as the therapeutic relationship (Bowlby, 1973). Consequently, TDT clinicians with an adequate understanding can provide the means to "rework attachment difficulties" (Pearlman & Courtois, 2005).

Existing research indicates that attachment may impact a child's capacities for self-regulation. Children with secured attachments have been associated with greater self-regulatory skills (Belsky & Cassidy, 1994; Drake, Belsky, & Fearon, 2014; Kochanska, Philibert & Barry, 2009). In their longitudinal study, Drake, Belsky, and Fearon (2014) found that early attachment experiences impacted later development of self-regulation and school engagement with learning. They recommend that those working with children should take into account students' primary relationships as this will aid in the understanding of the processes involved with a student's readiness to "navigate the social and cognitive challenges" created by school environment (p. 1358). Specifically, SED children encounter social and cognitive challenges that impact school engagement with learning that subsequently place them at great danger of out of home and/or out of school placement. It is therefore important that TDT clinicians are aware of how to promote

developmental relationships among the SED children they serve and the impact it has on the attachment and internal working models.

Developmental relationships that include emotional attachment, reciprocity, progressive complexity and balance of power have been characterized as "active ingredients" that result in effective interventions for at-risk youth across settings (Li & Julian, 2012). Having an understanding of the impact of attachment and trauma on the overall functioning for children with severe emotional disturbances will assist in ensuring effective interventions and service outcomes as well as reducing long-term distress.

Chapter 3

METHODS

The current qualitative study used in depth interviews to understand the training needs of mental health providers of therapeutic day treatment services in public elementary school setting, specifically those who are credentialed as qualified mental health practitioners (QMHP). At the cusp of in-depth interviewing is "an interest in understanding of the lived experience of other people and the meaning they make of that experience" (Seidman, 2013 p. 9). Social abstractions like education and training are "best understood through the experiences of the individuals whose work and lives are the stuff upon which the abstractions are built" (Ferrarotti, 1981, p. 24).

In this study, in depth interviews provided the opportunity to gain a better understanding of the training needs of therapeutic day treatment mental health providers who serve children with emotional disturbances in elementary school settings.

Grounded Theory

This exploratory qualitative study utilized a modified grounded theory approach. The grounded theory approach was selected as a result of the lack of knowledge in regards to the training needs of community mental health providers who deliver therapeutic day treatment services in a school-based setting. This qualitative approach is often used in areas of "inquiry where theory is sparse and/or underdeveloped" (Romona p. 43). The grounded theory approach helps to generate hypotheses, general explanations that are defined through the words of the participants; theory is grounded from the data (Creswell, 2013). Creswell (2013) outlined the features of grounded theory as:

- The research focuses on a process or an action that has distinct step phases

that occur over time. It has "movement" or some action that the researcher is attempting to explain.

- The researcher also seeks, in the end, to develop a theory of this process or action. This explanation or understanding is a drawing together, in grounded theory, of theoretical categories that are arrayed to show how the theory works.

- Memoing becomes part of developing the theory as the researcher writes down ideas as data are collected and analyzed. In these memos, the ideas as data are collected and analyzed. In these memos, the ideas attempt to formulate the process that is being seen by the researcher and to sketch out the flow of this process.

- The primary form of data collection is often interviewing in which the researcher is constantly comparing data gleaned from participants with ideas about the emerging theory. The process consists of going back and forth between the participants, gathering new interviews, and then returning to the evolving theory to fill in the gaps and to elaborate on how it works.

- Data can be structured and follow the pattern of developing open categories, selecting one category to be the focus of the theory, and then detailing additional categories (axial coding) to form a theoretical model. The intersection of the categories becomes the theory (called selective coding) (p. 85).

Recruitment and Sampling

A convenient sample of participants was recruited through community mental

health agencies, also known as community services boards (referred to as CSBs), that provide therapeutic day treatment programming in Virginia's public school settings. Executive directors of these mental health agencies were approached through emails. The directors, of whom had a TDT program, forwarded the information to their respective TDT clinical supervisors. Contact via face to face or telephone calls were made to the supervisors where they were informed about the research study, as well as the protocol. Additionally, they were provided with written research study information as well as consent forms for study participation. The supervisors were asked to forward emails of solicitation for participation to Therapeutic Day Treatment Providers within their organizations. Emails contained study information as well as contact information and compensation information. The researcher reached out to three Community Services Boards (CSBs), in the southeastern and central regions of Virginia; however only 2 agencies expanding over 8 cities in Virginia were utilized. Through two CSB's, a sample size of 12 community service providers who provide therapeutic day treatment programming in elementary school settings was identified.

In the state of Virginia there are 39 community services boards that are part of the state's public services system (Virginia Department of Behavioral Health and Developmental Services, 2009). Established by the local government, they are responsible for delivering publicly funded community behavioral health and developmental services either directly or through contracts with private providers (VDBHDS, 2009). For this study, community services boards that provide direct care were examined.

Participants were given a $30 gift card incentive for interviews that lasted at a

minimum an hour. Study interviews were held at a private office space. Four interviews were conducted over the telephone due to participants' preference given the time constraints.

Inclusion and Exclusion Criteria

The following criteria was used to guide the recruitment process:

Inclusion:

- Therapeutic Day Treatment Providers from community mental health agencies in the state of Virginia (Community Service Boards)

- Meet the qualifications of a Qualified Mental Health Practitioner (QMHP)

- Bachelor's level education

- Provider of direct care services in a school-based setting for a minimum of 6 months

- Provide direct care services at an elementary school setting

Exclusion:

- Therapeutic Day Treatment Providers who hold a graduate or higher degree

- Serve as a program supervisor/director;

- Employed less than 6 months

Data Collection

All potential participants were prescreened via telephone and/or email to ascertain appropriateness for study. Two potential participants who contacted researcher did not meet criteria due to one having a Masters degree and one potential participant last worked in an elementary school setting five years ago. Once potential participants met criteria,

written informed consent prior to participation was obtained as well as verbal consent at the start of the qualitative interview. After providing study information and consent, participants were provided with a face sheet containing demographic questions such as gender, race, and level of education. Semi-structured and open-ended questions were utilized to elicit the participants' thoughts and ideas' regarding their training needs in the provision of mental health services for severely emotionally disturbed youth in elementary schools who are part of an intensive mental health program. Prepared interview guides with questions and probes were utilized to elicit additional information as relevant. Questions were neutral rather than value-laden. Following the first set of questions designed to build rapport, questions and prompts were designed to explore training needs in terms of preparation, school context, knowledge of population and trauma/trauma informed practices. Examples of questions from the interview include "Please think back to your first month on the job," "Describe your preparation to perform the duties of a TDT clinician" and "What are your thoughts on your preparedness to deal with issues relating to trauma?" (See interview guide Appendix F).

The researcher conducted all the interviews and performed the data analysis. Interviews were digitally recorded, with participant permission, and transcribed verbatim. The researcher completed field notes during and after the interview to document key thoughts or ideas triggered by the interviews as well as making note of participant's nonverbal communication, demeanor, and any reactions if any during the interview. Originally all interviews were intended to be completed in person; however, 4 out of the 12 interviews were completed via telephone due to scheduling conflicts and feasibility on the part of the study participant.

Data Analysis

As previously stated, a modified grounded theory approach served as the basis for analysis. Each digitally recorded session was transcribed verbatim. Half of the interviews (n=6) were transcribed by a professional transcribing service agency. All transcriptions were checked against the original audio recordings for accuracy, changes were made when needed by researcher. Transcribing as well as checking transcripts back against the audio files, assisted in familiarizing myself with the data. Memos were made as ideas and identification of possible patterns were noted as data was read and re-read.

Transcriptions were then entered into NVivo 10, a computer assisted qualitative data analysis software. NVivo is software from Qualitative Solutions and Research (QSR) International that assists in storing, analyzing, organizing and managing qualitative data (Creswell & Creswell, 2013).

The responses were coded using the categories of open/initial, axial, and selective coding. Coding in data analysis involved the researcher generating constructs that symbolize and attribute meaning to capture the "content and essence" of the data for "purposes of detection, categorization, theory building, and other analytic process" (Saldaña, 2013, p. 4). Through a second and third pass through, codes were refined, combined or eliminated.

Coding of interviews, were initially organized by the question in the interview guide. For example, all responses to how can training help TDT clinicians to feel more confident and better equipped in their delivery of TDT services were compiled into one document. Those individual responses were then coded using the categories of open, axial, and selective coding (Strauss & Corbin, 1990).

During the first cycle of coding, interview transcripts were coded line by line utilizing In Vivo, Process and Initial Coding simultaneously. In Vivo Coding involved utilizing actual language found in the data to form codes of words or short phrases, in other words it uses the exact words employed by participants (Creswell & Creswell, 2013; Saldaña, 2013) such as "we're not babysitters." The goal is to "prioritize and honor the participant's voice" (Saldaña, 2013 p. 91). Process coding involves searching for the process and "consequences of action/interaction" (Saldaña, 2013, p. 96). Initial coding, also know as open coding, provides the opportunity for the researcher to break down the data and to reflect on the similarities/differences, and processes, contents, and nuances. Initial coding requires "staying close" to the data (Charmaz, 2006, p. 47), and line-by-line coding allows for new ways of looking at the data, diminishing researcher transference (Charmaz, 2006). A total of 1,771 initial codes were created utilizing the aforementioned techniques.

The second step of coding entailed "classifying, prioritizing, integrating, synthesizing, abstracting, conceptualizing and theory building" (Saldana, 2013, p. 58). Focused, axial, and theoretical coding was utilized during this second phase of coding. Focused coding involved examining thematic or conceptual similarities of codes from the first cycle (Saldaña, 2013). In addition, I searched for the most "frequent or significant coded data to develop the most salient categories" (Charmaz, 2006, p. 46). Axial coding involved examining the "category's properties and dimensions and explores how the categories and subcategories relate to each other" (Saldaña, 2013, p. 209). It also involved the reorganization of the data set where dominant codes and subcategories are determined, redundant codes are eliminated, and the "best representative codes are

selected" (Strauss & Corbin, 1998, p. 109).

Focused codes were grouped into 33 emerging categories that were used to organize and group codes into meaningful clusters (Patton, 2002). Categories were generated by in vivo codes characterized by embedded meanings, active and brief codes, and the themes and patterns of many codes (Charmaz, 2006). Categories were determined by both the content of the interviews and the literature review (Padgett, 2008) in the most relevant manner to the data (Charmaz, 2006).

Theoretical coding, also known as selective coding, was utilized to interpret the data and ascertain the central theme of the research by integrating and synthesizing the categories created (Creswell & Creswell, 2013; Saldana, 2013).

A third step of coding was done for the comparison of all created categories to all the interview data. Analytic memo writing and an audit trail were used to capture the thinking and decision processes regarding codes, categories, and themes developed throughout the data analysis.

In order to ensure fidelity to the respondents, I repeatedly returned to the original data to ensure that the categories and subsequent themes aligned with data offered by the TDT clinicians interviewed.

Methods of Rigor and Trustworthiness

In qualitative research, trustworthiness will ensure credibility, conformability, dependability and transferability. Trustworthiness "takes the place of truth" (Hess-Biber & Leavy, 2011). Therefore, to establish trustworthiness, the following measures were taken: prolonged engagement, observation, member checking, peer review, and detailed audit trail. In addition, direct quotes were utilized as much as possible to ground findings

and interpretations; giving voice to study participants (Lather & Smithies, 1997).

Triangulation of data occurs when the data and its interpretations are substantiated by two or more sources (Rubin & Babbie, 2011). Triangulation of data included peer review, member checking and audit trail. A peer with a doctoral degree in social work assisted in the peer review and reviewed 3 transcripts to independently code. Differences and similarities in coding were discussed along with any disagreements and consensus. These peer-debriefing sessions were documented. The peer reviews assisted in creating the opportunity to discuss thinking processes, clarify emerging ideas, and created new understandings (Saldaña, 2013). Additionally, since a professional transcribing company was utilized for half of the interviews, all transcripts were looked over and compared with recordings to ensure accuracy. Changes were made as needed.

Member checking involves asking research participants to verify the researcher's observations and analysis. Member checks were conducted with 2 study participants who were consulted during the analysis as a way of validating the findings. "Do the reported observations and interpretations ring true and have meaning to the participants?" were questions asked to confirm or disconfirm the accuracy (Rubin & Babbie, 2011, p. 452). Prior to the scheduling of interviews, it was arbitrarily decided that the first and eighth interviewed participant would be used for member checking. Both participants examined and confirmed the accurateness captured in the themes and categories.

Lastly, an audit trail was utilized to account for the process and development of the data analysis from the raw data to the results including reflection on decisions/thinking, approaches, and interpretations made throughout the analysis.

Human Subjects and Confidentiality

Care was taken to protect participants throughout the recruitment process, interview, as well as data collection and analysis. Approval for the research study including recruitment procedures and interview guide was obtained through the University of Pennsylvania's Institutional Review Board (See Appendix D). Although the interview did not occur in school settings, the participants' assigned schools were provided notification of the study. All potential participants provided informed consent via telephone screening interviews to ascertain study eligibility. Once they met criteria, written informed consent prior to participation was obtained, as well as verbal consent at the start of the qualitative interview. For the 3 telephone interviews, signed consent forms were scanned and emailed to the researcher in addition to the verbal consent. Participants were explained that participation was completely voluntarily, that they could withdraw from the study and/or refuse to answer any questions. In addition, they were explained that their decision regarding participation would not impact their employment status. In order to ensure anonymity of the participants, once interviews were transcribed, the digital recordings were destroyed. Additionally, all identifiable information was removed and information was maintained in a locked cabinet. Any electronic files were encrypted and password protected. The investigator was the only one to have access to locks and passwords.

Reflexivity Statement

The investigator has worked with severely emotionally disturbed (SED) children, adolescents and their families in acute and long term residential, community mental health, and child protective service settings for the past 15 years. It was the investigator's

role as the Clinical Supervisor of a day treatment program that sparked her interest in the research topic. Given the investigator's extensive experience as well as her education and licensure as a Licensed Clinical Social Worker, she was taken aback on how little she knew about the provision of mental health services in a school-based setting. School policies as well as the school environment with their implicit and explicit rules and norms heavily impacted the provision of services. The investigator learned rather quickly by engaging school personnel as well as by drawing on her education and experience. Unfortunately, the challenges faced by my employees, for who many had a bachelor's level education, this was a constant topic brought up during staff meetings as well as during supervision.

Chapter 4

FINDINGS

Demographic Information

Twelve Therapeutic Day Treatment (TDT) clinicians from the eastern and western regions of Virginia participated in the study. All participants were females; no males volunteered to participate. Participants rated themselves as the following ethnicities: of the sample 75% (n=9) were African American; Caucasian 17% (n=2); and Hispanic/Latino 8% (n=1). The participants ranged in age from 26 to 45. The average age was 31. In regards to highest level of education completed by the TDT clinician, they all had attained a bachelor's level degree; however three participants reported being enrolled in a master's level counseling program at an accredited university. In terms of degree concentrations, participants reported psychology (n=7); human service (n=1); special education (n=1); sociology (n=2); and counseling (n=1). All participants had 3 or more years of TDT work experience. Table 1 provides a brief description of the participants' race and ethnicity, Table 2 breaks down the description of the participants based on their pseudonym, age, race/ethnicity, and school setting experience (elementary, middle, and high school) while Table 3 highlights participants' employment experiences as well as current caseload.

Table 1

Description of Participants by Gender, Ethnicity, Education, and Degree Concentration (N=12)

Characteristics		N	%
Gender			
	Female	12	100
	Male	0	0
Ethnicity			
	African America	9	75
	Caucasian	2	17
	Hispanic/Latino	1	8
Level of Education			
	Bachelor Degree	9	75
	Some Graduate	3	25
Degree Concentration			
	Psychology	7	58
	Sociology	2	17
	Special Education	1	8
	Human Services	1	8
	Counseling	1	8

Table 2

Description of Participants by Pseudonym, Race/Ethnicity, Age, and School Experience

Pseudonym	Race/Ethnicity	Age	School
Sonya	African America	45	Elementary
Jennifer	African American	27	Elementary
Sarah	African American	29	Elementary
Meghan	African American	30	Elementary
Tiffany	African American	37	Elementary/Middle
Sofia	African American	27	Elementary
Angelica	African American	29	Elementary
Mandy	Hispanic/Latino	31	Elementary
Jenna	Caucasian	30	Elementary
Lisa	African American	28	Elementary
Deborah	African American	26	Elementary
Isabel	Caucasian	31	Elementary

Table 3

Caseload and Length of Experience

Characteristics		Mean ($\bar{x}$)	Standard Deviation std(X)
Current Caseload		6	0.95
Years of Experience	Current Agency	5.02	1.10
	Mental Health	8.10	4.64
	Child/Adolescent	6.64	2.79
	TDT Department	5.02	1.10

Quantitative Data

In an attempt to capture the participant's interest in each training subject matter, subjects were asked to rate, on a likert scale, discretely the importance of each content areas from least (one) to greatest (eight) if they were given an option to come to these trainings. Results indicate that all contents areas were rated on average 6.0 or more. Evidence Based Practices was rated with the greatest importance with 9 out of 12 participants (75%) rating it an eight. Table 4 summarizes the results from greatest to least individually rated content areas. All content training areas were rated of greatest importance (8) by at least 5 (42%) or more clinicians indicating an expressed relevance/need.

Table 4

Rated Training Content Areas

Training Content Areas	8	7	6	5	4	3	2	1
Evidence Based Practices	9		2	1				
Trauma Informed Care	7	2	2	1				
Developmental Theory	6	2	3	1				
Cognitive Behavioral	6	2	3	1				
Attachment Theory	5	2	2	2	1			
Trauma Theory	5	2	2	1	2			
Diagnosis	7	1		1	2	1		

Assessment/Evaluation	5	1		2	3	1		

Although all the training areas were deemed as important, due to limited funding, resources, and time research participants were asked to rank content training areas in comparison to all other training areas on a scale from 1 least (1) to greatest (8). Results indicated that the top four training areas were diagnosis, evidenced based practices, developmental theory and trauma theory. Table 5 summarizes the results from most ranked preferred to least ranked preferred.

Table 5

Ranked Training Content Areas

Training Content Areas	Ranks							
	8	**7**	**6**	**5**	**4**	**3**	**2**	**1**
Diagnosis	5	3	1	1			1	1
Evidence Based Practices	4	2	1	2	2		1	
Developmental Theory	3	1	1	2	2		3	
Trauma Theory			5	2	3		2	
Cognitive Behavioral	1	2	1	1	2	1	1	3
Trauma Informed Care	1	1	2	1	2	2	2	1
Attachment Theory		1	1		4	2	3	1
Assessment/Evaluation			2	1	2	2	1	4

Qualitative Data

The qualitative data presents the participants' reflective understanding of their training needs as TDT providers including the impact of their work within context of the school setting, preparedness for service delivery, understanding of their roles, and family dynamics. As such, 5 themes, each comprised of a number of interrelated sub-themes, were identified from the analysis. These were: 1) Role/Service Clarification; 2) Their preparedness for the School Environment; 3) Practice/Techniques; 4) Family Dynamics; and 5) Conflicts within the School Context.

Theme one addresses the ambiguity and confusion surrounding TDT services including the roles and responsibilities as reported by subjects. The second theme examines the subjects' challenges to performing their duties in a school setting including their preparation, and theme three focuses on what aspects of training were identified as essential for TDT providers to effectively deal with the children they serve. Theme four describes how family dynamics impact service delivery and program fidelity including the challenges and limitations, and, finally, the fifth theme focuses on how the school context with its prescribed norms and culture is often in conflict with those of TDT services.

These will now be presented to include subjects' quotes. All participants have been given common pseudonyms to protect their identity.

Role/Service Clarification

In reviewing the data, the role and service clarification of TDT providers was a concerned expressed by 8 participants. They reported a lack of understanding of their roles as TDT providers by family members, teachers and administration. For example as

Deborah pointed out "Some of the parents don't really understand what we do in the school." She went on to describe the difficulties she encountered as a new clinician in a school setting and the challenge it was in creating this understanding. As a result of the lack of role or service clarification, several clinicians indicated that they are reportedly assumed to perform duties/roles outside of their job description. This will be further reviewed in the subtheme perceived roles.

Perceived Roles. As a result of the lack of understanding or clarity, 7 out of the 12 participants reported being questioned about their responsibilities including being confronted by a parent regarding their child's grades or assumed to perform several functions outside their primary roles such as bus duty, hall monitor, etc. For example, one clinician spoke about the misconception that TDT providers are child protective service workers:

> When I started in the program, I started the program at my school, so a lot of the teachers and school staff thought we were part of Child Protective Services. They were very hesitant to recommend any of the kids, and the parents were very adamant that, 'No, you're not gonna take my child.' Trying to get the school to understand what we do, and then getting the parents to understand what we do was a really big challenge (Deborah).

Perceived roles will be broken down into two subsections, the misconceptions held by school personnel and the misconceptions held by the families.

School Personnel. As providers of a program that is intensive, targeted, time limited, and highly regulated by funding and licensure agencies, TDT providers are restricted by the duties they can and cannot perform. Several providers reported being seen or treated as "babysitters" and TDT programming's purpose as a "daycare center." Seven participants expressed these sentiments about school personnel and families alike:

And we're not babysitters. A lot of teachers think, okay, they're just going to take them down there, acting up or disrupting my classroom. I think they have to really come across as no, this is a therapeutic program, this is a job, it's not a babysitting service, there's specific requirements of the student, of the teacher and of the counselor. So I think that needs to be explained a little bit more too (Meghan).

In referencing some of the teachers she has worked with, Mandy expressed the same misconceptions of TDT providers. She described the fallacy in thinking that TDT clinician's primary role is to keep the child out of trouble. Even with the teachers who have an understanding of her roles and responsibilities, she described their attempts to utilize her in an educational way, which clearly goes against what are acceptable interventions of a TDT counselor per agency, licensing and funding agency requirements:

They think that we're a babysitting service. That we're supposed to come in the school and basically make sure the kids makes no mistakes. If they do have an issue—they believe that we're supposed to fix them very quickly… I think for the most part I have had great experiences with teachers being understanding of what we do. That can be a challenge because a lot of the time they want to treat you like you're a teacher assistant. They want to use you in an educational way (Mandy).

Sonya expressed the need for teachers to understand the limitations of TDT clinicians in terms of what duties they can and cannot perform:

I think there's a lot of challenges with the teachers. One big challenge we have is just making a clear line of this is where our job begins, and this is where our job ends. A lot of times the teachers look to us to deal with situations or to relay information that they just don't want to do themselves. I had a teacher who wanted me to call home and let the parent know that if missing library book money wasn't paid, the child couldn't go on the field trip. But there are times when you're going into that classroom and we get it both ways, either the teacher wants us to take care of all the problems or they don't want us to do anything. So you have to kind of balance it out with that and letting teacher know I'm not here as a bodyguard and I am here to assist the child … with doing that I'll help you but I'm not here solely to make your life easier. So that's some of the major challenges.

It is important that boundaries are clearly delineated and reinforced so that TDT providers are not overstepping their boundaries. One clinician spoke about the need to know how to break the barriers with school personnel in communicating and reinforcing the boundaries needed to effectively perform her job, "how do I explain… to these teachers and administrators that I can't do bus duty, I'm not your personal assistant. I can't sit there and help you do homework" (Isabel).

Some of the participants denoted that they have observed or experienced skepticism regarding their roles by school personnel. Deborah described the fear and insecurity a TDT clinician's presence may create for a teacher, "I think some of them believe we're in there to basically observe them, and basically report back to the principal or school administration on what they're doing in the class. When in actuality we're there for the student."

To further demonstrate the impact of role ambiguity, Tiffany, who described her experience with the guidance department as currently positive, spoke about the initial resistance exhibited from the department as a result of the lack of understanding of the role and purpose of a TDT provider. She indicated that the guidance counselors felt "threatened" because they believed that TDT clinicians were doing their jobs. This resulted in a "little animosity" and she reportedly had to let them know that "I'm not here to take your job."

Families. Participants described how misperceptions on the part of the family impact their interactions and interventions as well. Clinicians are reportedly affected because they have to clarify and at times repair the impact these misunderstandings have on the therapeutic relationship. One clinician spoke about the belief held by some

families that TDT providers share the same duties as school personnel. She described

being challenged by a parent regarding his/her child's grades:

> Sometimes the parents don't understand all the time what our role is. We'll have parents fussing at us about clients' grades, and why aren't we helping with their grades. We're like, well, we're not there to help them with their grades. We're there to make sure that they're coping well, and behaving appropriately, and not disruptive during class. If they [the students] are not understanding the materials, then that's the school side of things (Isabel).

> She went on to share other incidents whereby she was questioned in regards to

decisions made by the school and how she constantly has to differentiate TDT roles and

the school's roles:

> They have trouble understanding that we don't work for the school. We don't make the decision the school makes. Sometime they would refer to you like that, 'Y'all do this, and y'all do that.' You have to go back and remember, [that] I am not part of the school system. Those decisions they [the school] are making is on their own, and just kind of run that, recommend that, you may want to talk to the teacher. You may want to talk to the principal (Isabel).

> Additionally, families reportedly need to be made aware of the time limits of the

program as well. One clinician described a parent's preconceived notion regarding the

longevity and purpose of the program:

> Another challenge is getting to the parent. Getting them to understand what we're trying to do, and that the goal of the program is not for them to stay in TDT from kindergarten to 12th grade because it's another set of eyes on their child. That's a challenge. A lot of our parents are like, 'Oh, well when they go to high school will they have a TDT counselor?' Well my goal is that they won't need a TDT counselor (Meghan).

Preparedness for School Environment

One of the key goals of this research was to examine the participants'

preparedness to provide mental health services in school based settings. Understanding

the impact the school plays in the provision of mental health services is necessary;

unfortunately it is one area that many of the participants described as lacking. The

following subthemes, lack of preparation and learn as you go, reflect the participants' views on their preparedness in terms of training for the provision of services in a school setting.

Lack of Preparation. Eight of the 12 respondents reported no prior experience working with the SED population. Four of the participants described prior work experiences with the SED population; however out of those four only one had previous TDT service experience. It is also worth noting that three out of the twelve participants had some educational background/experience, but no experience working with the SED population and/or mental health. This section will describe their preparedness in regards to the provision of services in a school setting.

All interviewed participants reported agency wide and departmental trainings related to agency expectations regardless of the role or department. For example, they all described trainings on documentation, non-violent crisis intervention, fire safety, first aid, and standard agency policies. Some of the clinicians described trainings such as suicide prevention and other mental health topics; however, these trainings were, for the most part, offered to the agency as a whole and their applicability to the school setting were either not addressed or minimized.

> I would say we come we start working with the kids with very little training. I would say most of our training is agency related not TDT related. We did some training, I believe, on how to create notes, but they were more towards how to put them in the system than the how to (Mandy).

Those who reported trainings specific at a departmental level, indicated that they were special topics offered during times when they are not servicing clients, such as Christmas, Spring Break, Summer and other holiday breaks. Some reported learning from them while others complained about not getting the particulars on how to apply it

specifically in the delivery of TDT services. Additionally, if a clinician missed the

training or was hired after that particular topic was offered, the training generally would

not be repeated. Topics varied across cities and Community Services Boards.

> Crisis intervention was fairly useful, but a lot of the methods that we were taught in that training were catered to like adults. Um, even now when we are in there they'll show us few things for children. And I deal with small children and the elementary school kids and a lot of it is more catered to adults. So it was moderately helpful (Jennifer).

Along a similar vein, Isabel described the agency's training in the following way:

> We had a lot of training when we were first hired... we've had some autism spectrum training and suicide prevention. For providing services, I don't recall any new hire training specific to a school setting when I was first hired. I think that might be because our agency provides services in several different counties. As far as agency-wide training, they're more focused on the services themselves. Like I said, we did trainings on bullying. Usually there's an all-day session during spring break that has several different topics. Alcohol and drug prevention, things like that that can help you tweak your skills. Whether you're in a classroom, or out of classroom, or in the community, or at home.

Some participants described not being able to adequately intervene for the

children and their families, as they were unaware of the processes that occur in schools

such as how they can contribute and advocate for educational services.

Jennifer and Jenna expressed their feelings of inadequacy and incompetence in

regards to their preparation as TDT clinicians. Jennifer spoke about it being her "first real

job" experience outside graduating from college while Jenna questioned her abilities

following her first experience with the children. She proceeded to describe how on the

first day on the job she remembered asking herself "what did I just get myself into?"

As indicated previously, only four participants had previous work experience with

the SED population within other settings (in-home counseling, group home and

residential settings). These respondents still recounted some challenges created by the

school environment. In other words, they were able to shed light on the differences

created in the provision of services in various contexts and the marked impact the school

context had on the provision of services. For example, one clinician with over 10 years of

experience providing mental health services to children/adolescents in diverse contexts

acknowledged the shortcomings related to the preparation of services delivery:

> I think one of the things that TDT lack is you know you come up with this vast
> you know, wealth of training and all that. They still need ABC specific training on
> population that you serve. Like I said I work with a lot different population but
> okay, because I work with an ADHD person in a hospital setting or in a house it
> might not be the same or the rules doesn't always apply the same in the school
> setting. There is limitation, there is do's, there is don'ts. And they don't really
> train you for that (Sonya).

Learn as You Go. This subtheme reflects 7 out of the 12 participants' sentiments

regarding their experiences in acquiring knowledge of and/or skills related to TDT

programming. A majority of the clinicians used the following terms to describe their

experience and preparedness for the provision of services in the school setting: "thrown

to the wolves", "learn as you go", "feeling our way", "get thrown", and "sink or swim."

Angelica was one participant that echoed the same sentiment as her peers, she stated "It

was just you kind of get thrown in there and you figure it out. I don't think I was truly

prepared. Just kind of sink or swim type of deal."

Several other clinicians argued that the training they received did not prepare

them for the educational aspect as many of the children they serve either receive special

education services or may benefit from other services offered through the school. As

Sarah pointed out: "You learn as you go. Child studies, IEP's [Individualized Educational

Plans], the behavioral plans, having a place for the kids [for the provision of services], the

testing that you learn while you are in it; we didn't get any training for that."

As mentioned previously, three clinicians who reported no counseling experience with SED children narrated their educational work experiences as a teacher assistant, special education aid, and a substitute teacher. In spite of their experiences, they acknowledged encountering conflicts and/or highlighted the barriers their colleagues face in the provision of services such as mediating the differing roles and expectations between the mental health and school systems, time management, and collaboration with school personnel. Specifically, they all acknowledged a "learn as you go" and "find your own way" approach. Tiffany classified the lack of trainings to those who have "never set foot in a school" as a plausible motive for the high turn over rate as "a lot of people just cannot handle it's so overwhelming."

Processes/Techniques

The emotional and behavioral health problems of those receiving TDT services were identified by the participants as attention deficits, hyperactivity, difficulties with emotional regulation, oppositionalism, poor social skills, defiance, aggressiveness, destructiveness, anxiety, depression, trauma, and learning disorders. These difficulties negatively impact the student as well as the classroom environment subsequently compromising learning and teaching for all students. Given the complexities of the students as well as their evolving diagnoses, clinicians require the necessary skill set to effectively intervene.

Over half of the participants expressed the need or desire to obtain additional training specific to techniques and processes. They acknowledged the need to obtain the skillsets and techniques that will assist them specifically with the work they do. In terms of training needs, the first subtheme will discuss findings as most of the participants

66

described the need for techniques and training that specifically address their work with special populations including emerging diagnoses. Secondly, issues related to trauma will be discussed including the need for training interventions and self-care. The third subtheme, evidenced based practices, will highlight the lack of adequate training and dissemination of curriculum information including its applicability to school settings and with diverse groups. Lastly, training delivery including current practices will be the focus of the final subtheme.

Special Populations. All participants reported working with children and families from low income and at-risk communities. One participant spoke about the significant differences in the problems of children from low socioeconomic status encounter and the sharp contrast with her experience in working with middle to upper middle class children in schools:

> If I were to go to a wealthy area or an area where kids have that support, they have the picket fence, and then to come here is completely different. So, I think more so understanding the challenges that kids down here – I'd never know what kids go through if I did not come down here. And I think most of them, like, I don't even know how in the world I would have made it if I had to deal with some of the stuff they deal with here. So, I think being more understanding of different populations (Sofia).

She went on to describe how her college internship prevented her from being "completely blind sided" by the differences in the populations as well as her previous work experience in a group home and school based setting. Another clinician expressed the need for strategies for working with diverse populations:

> I think just more training, offering the trainings to work with the different cultures that we work with, always making sure that we are re-certified with everything yearly as they do. Maybe just giving us fresh ideas with the different populations, and the different diagnosis, and how to treat or work with people dealing with certain things (Lisa).

Additionally, participants either described insufficient or need for additional training in dealing with pervasive developmental disorders (PDD) specifically autism. They recognized the need for specific strategies when working with children with PDD.

Trauma. All the clinicians reported significant client trauma histories. Traumas associated with their clientele included: community violence, exposure to domestic violence, issues related to abandonment, parent incarceration, and abuse (physical, sexual, and emotional). As one participant specified "All our kids have a story. Sometimes you forget that working with them day to day. You just see them as they are today. You forget that they've got the stories, they've got the baggage, and the previous traumas that they're carrying with them today (Isabel)."

All participants indicated that trauma plays a big role in the behaviors they see on display with the students they serve, including "lack of focus," aggressiveness, "hoarding", anger, emotional dysregulation, and urinary and fecal incontinence.

> I think that the kids that I have dealt who have trauma, which definitely impacts their learning and their behavior in the school… sometimes I feel like the school is an outlet as far as the trauma. If the trauma is occurring at home, obviously they may feel that the school is more of an outlet where they release and it may affect their way that they respond to certain adults… it can affect their focus, you know there are several things… especially the way they respond to certain adults. I think trauma can have affect on that in a school setting (Jennifer).

In spite of the reported pervasiveness of trauma histories about 10 out of 12 participants (83%) reported inadequate or no training related to trauma, trauma informed care or secondary trauma. Some indicated that they learned how to deal with trauma through their own experience while others expressed their concern over their incompetence and the possibility of re-traumatizing or doing more damage to their clients.

One of my kid's dad died, and I was like I don't know what to do, what am I suppose to say to him? So, um they don't prepare us for trauma and stuff like that. Like I don't even know what my coworker did with the kid who told her, because that is who he opened up to, about his brother sexually assaulting him. Like I wouldn't know what to do or say (Sarah).

Mandy expressed her concern on the possible complications of not adequately intervening: "I have had kids who reveal the trauma in the middle of the lesson. If you don't know what to do, that child might feel that you ignored them. That child might feel that they're not important."

Some called for the need to expand the training associated with trauma, as it is essential for TDT clinicians who lack any experience or training. Specifically, they asked for training on techniques and approaches on how to discuss trauma, as it is a "sensitive subject," and "difficult to discuss." "If it's your first time dealing with it, you'll be completely clueless. And I don't think that they touch that enough when you do training. So, I think that really needs to be expanded upon (Meghan)."

When you see a child who is suffering from that [trauma], it's very difficult. Again, it's a subject that we probably could definitely use more training on, better ways to approach it and to get the child to feel comfortable enough with you to open up about their experience and how it truly has affected them (Jenna).

Although some indicated that they had training regarding self-care, half of the participants interviewed indicated no knowledge of secondary trauma and the impact it may have on the clinician and service delivery. One clinician described learning about secondary trauma and self-care through graduate school.

I learned about secondary trauma during my schooling, because I went back to school and now working on a Master's degree in Social Work. I learned a lot of that through school and not necessarily through my [TDT] program. I brought that kind of knowledge to my work now versus before I had no idea. We didn't really talk about it. We talked about taking care—self-care in conversation, but there was really no training provided on secondary trauma… when you're working with the kids you get wrapped up in a lot of the emotions and a lot of the stories that

you hear are so traumatic you can't help but as a human feel some kind of way about it. It starts to play a role into your services and how you provide services. Knowing how to separate your personal feelings versus what you're supposed to do as a clinician would be very beneficial to a lot of us (Deborah).

Evidenced Based Practices. All participants acknowledged either no formalized training in evidenced based practices (EBP) or a lack of understanding how to utilize EBP in a TDT and school environment. Several participants described being handed their department's corresponding evidenced based practice curriculum manual and told to abide by it. They also expressed the lack of knowledge or understanding on how to adapt EBP based on the child's development or if the child has been in the TDT program for an extended amount of time.

Some participants described being given a notebook, manual, or binder containing information such as group format and content; however many lacked the basic understanding of what is an evidenced based practice, the "rationale behind it," and "how you use it," and the training on the actual evidenced based curriculum being used by the TDT program.

> We did one [training], we did the CBT training, but it was kind of like an online training and it was just one that we had to do. So I don't think a lot [of] people were receptive to it. I never used that curriculum, unless I've skipped through it, I'm like, "Okay this is a good activity"… most of the curriculum they give us are just like books, they just give it to us… and once we start using that book, we have to go all the way through it. So we really have to search and make sure that your kids are going to be, is this what the kids are going to respond really well to this (Meghan).

One participant described the need for training on the applicability of evidenced based curriculum to not only a school based setting but more specifically to TDT services as TDT caseloads are limited as opposed to classroom-based EBP that are presented to an entire classroom:

I'm looking for practical tools that could be used in a school setting… a lot of the evidence based [curriculum] some of them are actually….for [use] in the classroom... We [TDT clinicians] don't have 20 kids to present the information, breaking them up into two groups, three groups we don't have that. We have to get creative when we are doing it. We need more things that…we can do within the school based. We don't have that, we have evidence based there but to meet our [TDT] requirements (Sonya).

One participant shared her understanding regarding evidenced based practices; however attributed the knowledge to her junior and senior undergraduate theory classes. Despite her background knowledge, she expressed similar sentiments regarding the lack of training/preparation of evidenced based curriculum utilized by the program:

They say this is the curriculum that we want you guys to work out of, have fun. So, and that's part of our day. I usually get to work early or I'll stay a little after, because I need to prepare for the next day or I need go through this and I need to know what we're talking about. So, no, you're pretty much on your own with the curriculum (Sofia).

Training Delivery. Eight participants expressed their desire to attend additional trainings on their own, but cited time constraints and financial expenses as the main reasons for their inability. As one participant cited, "I've been doing this for a while. And I want to continue to grow. I don't want to have the same knowledge as somebody just coming in. I want to be able to share with those coming in that are new to it. So I think it's very important to grow while you're on the job" (Angelica).

In addition to the initial training which mostly encompassed agency training, as described previously, yearly trainings occur during school breaks and school holidays. Trainings during these breaks varied across the different CSB's and were reportedly not repeated if someone were to miss training. For example, one clinician had a medical appointment and described missing the training related to trauma. She indicated that she was not required to make up the training, as it was not available.

Some of the trainings were described as being conducted by their program

supervisors and managers or by another department's supervisor. Other trainings were

purportedly offered by outside agencies such Child Protective Services. The most

memorable or effective trainings as reported by the participants were the ones that were

offered by licensed professionals who provided specific techniques in the intervention of

TDT services in a school setting. Several participants who attended training on play

therapy had high remarks about the delivery and applicability of the material.

> And they gave us a different way to approach our kids that was much more
> effective, meaning the kids were much more receptive to the interventions. That
> was huge. So a lot of the stuff we took back to the schools, the kids loved it and
> they wanted us to keep doing it. And it made them more receptive to services also
> (Meghan).

In addition to the yearly trainings, all of the participants spoke about weekly one-

on-one clinical supervision with a lead clinician, clinical supervisor or program manager.

Over half of the participants described monthly group supervision with peers and clinical

supervisor whereby cases are discussed and/or role-played. Those who had either a

supervisor on site or at a nearby office reported feeling supported or shared incidents

where the supervisor was beneficial in helping with a client or school related dilemma.

Others reported that their supervisors lacked the experience and/or understanding of the

provision of TDT in a school setting.

> My issue is, I've had supervisors who never worked with TDT before. So, they
> are receptive to what you have to say, because you are there… That was an issue
> to me, because I feel like you can't supervise me, you've never experienced a
> school setting. You've worked in a residential setting. You don't have any
> knowledge of a school setting (Jennifer).

Family Dynamics

A crucial component of TDT programming is the interplay between the child, the family, and service provision. According to the Department of Medical Assistance Services (see Appendix B), at minimum weekly contacts are to be made with the family to include discussion of program treatment, progress, continuity of services as well to advocate for the families they serve. This next section will discuss the challenges identified by the clinicians regarding their interactions with the families they serve including the importance of the home and school connection, the role engagement plays in families' compliance with program expectations and the importance of collaboration with service providers for the benefit of the family.

Making the connection between home and school. Almost all of the participants agreed that it is essential to make the connection between the school and home environment for the success of their students; however they acknowledged the difficulties it presents. The following excerpt from an interview serves as an excellent overview to the "Making the connection between home and school" theme. One TDT clinician, Mandy, narrated a story about a crab (the student) and a turtle (the teacher). She reportedly shares this story with teachers to help them understand the impact families have on their students and the importance of making that connection with families:

> I heard this story one time where the turtle was trying to make the crabs walk in the straight line. They kept giving them classes. The crabs were doing and walking the straight line, but then the next day they will come in walking sideways… When they thought about what's going on, why they learned this skill every day, but they come back without it, they realized it's because they were not teaching the parents.

Similar to the turtle in the story, some of the clinicians expressed their frustrations over the loss of therapeutic gains with the children once they leave the school for the day, the weekend and/or holiday breaks; "They go back home and it's deleted" (Angelica).

Engagement. Getting the families to buy into services, to actively participate in treatment and to follow through with recommendations including weekly contact are challenges that were described by all clinicians. "So, there are times when we will go weeks without parent contact because we're still making those phone calls two, three times a week but it's up to them [the parents] if they are going to pick up the phone (Sonya)."

Although contact with family is an expectation of the program, most expressed frustration in their encounters with establishing and maintaining weekly face-to-face or telephone contacts with the families.

When asked what skills are effective when working with families, all pointed to the necessary skill of engaging families for improved/better treatment outcomes. The process of engagement requires client and clinician to construct a therapeutic relationship or alliance. Participants associated the following skills with being able to more effectively engage the parents with the TDT provider: "being a good listener," developing "patience," "empathy and "understanding," and being "knowledgeable of boundaries." Some of the participants indicated that they or their peers would benefit from training or additional training on engaging families.

It is a necessity that clinicians engage parents as soon as their children are enrolled into TDT programming. Being sensitive to the family dynamics including

cultural differences is critical and can be enhanced by a TDT provider's capacity to listen

and encourage communication, as one clinician indicated:

> Being a good listener, because sometimes they just need to vent. Um, being patient and also being consistent; like not giving up even when I feel like I'm not received well or they are not being receptive to my feedback, but if I'm just consistent sometimes you'll see the parent come around and be a little bit more open or involved (Isabel).

Numerous participants described their families' cognitive, financial and mental

health limitations that not only impact their parenting abilities, but their capacity to

engage in treatment. For example, Meghan recounted "several instances" where families

were forced to choose between providing food for the family and paying their telephone

bill. Oftentimes, she reported, the families have experienced interruptions in their phone

services "selling their bill money to get food in the house... they're selling their cell

phones just so they can pay their rent. How do you get in contact with them? They're just

not available in phone." Other participants described their families' issues with

transportation, substance abuse, mental health and cognitive limitations that impacted

contact and participation.

Collaboration. Although TDT participants pointed to the advantages of TDT

services in a school setting, most of the participants voiced the limitations in services in

regards to the family context. Partnerships with other service providers are essential in

extending the benefits of TDT services beyond its "four walls" and treating the whole

child. Sonya pointed to the disservice of not being linked to all providers:

> But if we're not connected with those lines we don't – a lot of times we miss what the child really needs because you know they're seeing one part and we're seeing another part, and clearly nobody is coming together to see – to put all the pieces together so then we miss a lot as far as working with the child. We miss a lot of opportunities for success because we are not working as a whole (Sonya).

Some participants described the successes they've had in their collaboration with school personnel, mentors, in home counseling providers, primary care physicians, psychiatrists, case managers, outpatient therapists and other providers associated with the child and/or the family. It is the ability to collaborate with the aforementioned that extends the benefits of TDT services and prevents the duplication or gaps in services and vital information. In addition, with multiple providers, the family may become easily overwhelmed with competing goals and expectations of each provider. As another clinician pointed out:

> Sometime it might be a little bit more added to your job, more contacts you have to make, but I honestly do not mind. I like the fact that we can all come together, and work that child in same page because the last thing you want to see is for the in home to be working on the goal, I'm working on another goal, and the school counselor's working on the Six Pillar of Character [other goals]. The kid is like, okay, where do I need to focus? (Mandy)

Conflicts within the School Context

The fifth theme focuses on how the school context, with its prescribed norms and culture is often in conflict with those of TDT services. Participants recognized the challenges of TDT service provision in school settings as territorial conflicts, time management/scheduling issues, opposing views, as well as ethical dilemmas.

Turf Wars. Provision of mental health services within a school context creates within itself the challenges of finding physical and symbolic spaces. About 83% of the participants either shared their own and/or their peers' experiences of entering the school, specifically the classroom(s), feeling unwelcomed. As mentioned previously under the theme "role clarification", some of the school personnel are unclear of the TDT clinicians' roles and functions and are often suspicious of a clinician's intentions when

76

they are just merely in the classroom observing the TDT student in their environment per

TDT standards.

This often results in turf wars between TDT providers and the teachers. Four

participants who reported positive relationships with their teachers, acknowledged the

teachers' initial reservations about having the TDT clinicians in their classrooms.

> Some teachers are not, like I said, are not receptive to the program. Some
> teachers don't want you in their classroom. Some teachers look at you as a
> distraction, some teachers don't even give you a chance, and it is up to them
> whether they want you in there or not. It, kind of, falls back on the school (Sofia).

Scheduling. Eight participants identified scheduling conflicts between academic

instruction and TDT services as a recurring struggle. As TDT clinicians are constantly

"fighting for the time" as services often are "impeding on their [student's] educational

time". "Being on a time constraint within the school because there are so many other

things going on in the school, as far as academics, the behavioral side is limited

(Deborah)."

Another participant described the varying expectations from the teachers as to

when TDT clinicians are able to schedule contact time with students:

> A lot of teachers are very specific as to when we can pull the students out. Some
> schools are specific as to when we can see the kids at all. You have to see the
> students first thing in the morning before class starts. Or you have to do it at the
> end. And that affects our day if it we're not able to see them during that time we'll
> have to make some moves or either not be able to provide those services to
> them… I think it is very difficult because you're impeding on their educational
> time. And I think that's -- as counselors we're always fighting for the time --
> either teachers are throwing them at you, take them. Or either you're fighting to
> get that time (Angelica).

TDT clinicians have agency expectations of what is required of their time to

include interventions with clients, collaboration with families and school personnel and

documentation. One participant described the challenges created with balancing the

agency's requirements on a school schedule. In addition to teachers' scheduling

preferences, mandatory standardized state testing impacts service delivery in that all

students, including TDT students, are required to complete testing over a course of days.

This limits the periods the students are available to be seen by the clinicians, as TDT

clinicians are not allowed to be present in the classroom during these times. As one

participant pointed out:

> But there are times when we can't provide services, say they have SOLs
> [Standards of Learning Testing] or they have benchmarks [types of assessment
> testing]; we're still expected to see the child but if the school say hey you can't
> pull a child on this time, you just can't pull a child at that time. And I don't see
> anything wrong with that, but there are times when they just might have issues
> with that so there are those kind of things (Sonya).

Opposing Views. The interplay between mental health and school systems often

result in tensions between competing agendas; mental health versus academics. This is

often the influence of incongruent goals, expectations, policies and climates. For

example, TDT clinicians working within the school system are assigned a set number of

students who meet specific qualifications and are accepted into the program. Whereas,

the TDT clinicians view their population as the students on their caseload, school

personnel see all students as their responsibility. In the following interview excerpt, the

participant describes the differing views between TDT providers and school

administration:

> "With me as far as with the administration sometimes they look at things
> differently also. You know we're looking at that child, they are looking at the
> population of the whole school. So as long as I can take that child somewhere and
> deal with them and they don't have to be bothered, they're fine with that. So it's
> like out of sight, out of mind. So just trying to get them to understand, okay this is
> your problem too, you we need to work on this together. So sometimes that could
> be challenging (Sonya)."

Clinicians with an educational background reported that their background gave them the experience on how to navigate the school system/culture etc. These experiences reportedly "helped a lot" specifically in the areas of communication, relating to school personnel, and understanding "how the school is run" including "understanding how classrooms and a school schedule goes." Although one of the clinicians interviewed lacked the experience of working with the SED population, she pointed out the advantage she had over her peers who don't come from a school setting:

> I do think it was helpful, because we're, a majority of our time is in the school, so having that knowledge of how the school works, how the chain of command works in the school, knowing resources that are available in the school really seem to help with the job. It also helps with co-workers who come in and aren't quite familiar with the school (Deborah).

Additionally, TDT providers described themselves being seen as "guests", "an outside entity", "outsiders" and "visitors". This forces them as one participant indicated, "to be mindful of the CSB's [the agency's] expectations and regulations, but you also have to be working within the expectations and regulations of the school system" (Jenna).

Ethical Issues. Some of the participants described ethical issues that frequently face TDT clinicians. One participant spoke about being asked to speak to other students who are not in the program, which reportedly goes against TDT's policy in part due to requiring parental consent.

> "So I think that needs to be explained a little bit more too. And I think the counselors need to be trained on the do's and don'ts of what they are required to do and what's acceptable and what's not acceptable, because the teachers, they are like, hey you, can you watch so and so for me? No, I cannot. Can you talk with so and so? No, I cannot (Meghan)."

Two other participants described issues related to confidentiality as school personnel either want to discuss issues related to student(s) in front of others or request

disclosure of confidential information without consent. One participant described her

experience as follows:

> "I can't tell you how many times I've seen the counselor or heard of the counselor break confidentiality, that's a huge no-no. So, a lot of things that could be confidential, they'll give out and I think that's very important that you have to recognize things that you can't talk to everybody about, mention how to handle those situations. Discuss with the teachers who aren't even involved emailing all the time, sometimes the teacher can't, some of the information can't be disclosed to the teacher. So that's important (Meghan)."

Chapter 5

DISCUSSION

Few studies to date have been conducted that depict the training needs of school based mental health providers. Specifically, this study was intended to understand the training needs of community mental health providers (TDT clinicians) in the service delivery of a predominately Medicaid funded community mental health program based in Virginia's public school settings.

This chapter discusses the significant findings as well as additional conclusions and interpretations resulting from analyses of the data from chapter seven. This will be done in the context of theory and relevant literature from chapters one and two of this dissertation. Next, the limitations and strengths of this study are discussed. Lastly, this chapter ends with a discussion of future scholarship in the areas of policy, practice, and research as well as clinical implications for social workers will be explored.

Training Needs

In order for Therapeutic Day Treatment clinicians to adequately provide mental health services in school settings, they must be competent to fulfill that role and function. This section addresses the study participant's view of training and the potential professional practice issues associated with the delivery of TDT services by community mental health clinicians. Based on the participants' responses, no uniform standards of training as it relates to the specific delivery of mental health services in a school setting were indicated. All described agency related training required of all employees regardless of position or department, while other trainings were described as generic, lacking program or context specific training. It was recognized that study clinicians did not have

all the necessary skills to provide comprehensive mental health services acquired during orientation training or annual in-service trainings.

Study participants expressed the need for increased support and training to effectively implement interventions that adequately address the academic, social-emotional, and behavioral needs of their students, rather than taking a "learn as you go" approach as described by over half of study participants. Allowing providers access to required training "will facilitate the adoption of the state-wide uniform practice models, [and] insure that providers deliver effective and proven services…" (VACSB, 2011, p. 3).

All participants in the study had 3 or more years of providing TDT services with a mean of 5.02 years (STD 1.0), with only 1/3 of the participants having school related experience. In spite of their experience, participants reported their self-perceived feelings of how inadequately trained and ill prepared they felt in their work in school base settings. The outcomes of this study suggests that significant gaps exist related to the practitioner's training and readiness to perform the duties of a TDT practitioner, highlighting training deficits in the level of preparedness, level of confidence and methods used to provide the necessary interventions. Their sentiments mirrors previous research literature that not only acknowledges the training needs for direct care staff due to insufficient knowledge, but the barriers it creates in effective provision of services as well (Hoge, 2002; Powers et al, 2011; Kratchowill, 2007; Teasley et al, 2012; Teasley et al, 2010; Reinke et al, 2010).

Additionally, given the minimal amount of reported training, there is no surprise that participants endorsed having limited knowledge and the confidence to work effectively with SED children within a school setting. The American Academy of

Pediatrics (2004) highlighted the need for "Mental health professionals providing services on site in school (whether hired, contracted, or invited to school sites to provide services) should have training specifically in child and adolescent mental health (appropriate for students' ages) and are competent to provide mental health services in the school setting" (American Academy of Pediatrics, 2004, p.1843).

 Role/Service Clarification. As noted previously, some of the participants recognized how a lack of or limited knowledge of TDT clinicians' roles including responsibilities and expectations impact their interactions with those they come in contact with, on a day to day basis, such as school personnel and the families of the children with whom they work. Clarifying roles and setting clear boundaries as school-based TDT providers is an important aspect of its program. Without it, unreasonable expectations and confusion may result as reported by the participants.

 Impediments to TDT professional roles and functions are numerous, and one such factor was identified as preconceptions on the part of school administrators and other personnel, families and as well as other professionals. Although, there is some overlap in the roles and responsibilities among all mental health professionals (i.e. social workers, psychologists), variations exist between school personnel and community based providers.

 The American Academy of Pediatrics Committee on School Health (2004) recommend that the "Roles of all the various mental health professionals who work on campus with students should be defined so that they are understood by students, families, all school staff members, and the mental health professionals themselves" (p. 1843).

The TDT clinicians in this study expressed feelings of frustration related to role ambiguity and inadequate understanding of their contributions and responsibilities to agency, funding sources and school system. With sufficient training and support, TDT clinicians should be made aware, early on, of their roles and contributions as well as how to effectively communicate them to the school staff/personnel. This would in turn, lay the "groundwork for improved working relations" and ensuring "tensions and feelings of threat are lessened" (Tracy & Evelyn, 2010 p. 14). With the awareness and understanding of the roles, TDT practitioners and school personnel will know exactly where they fit in and therefore can prioritize their work.

Process/Techniques. As mentioned previously, delivery of mental health services for severe emotional disturbance in a school setting requires integration of theory to include trauma, developmental and attachment theories, evidence based practice, ethics, and diversity. Study participants identified several key areas in which they believe training or additional training is necessary to provide school based mental health services. Study participants indicated that they wanted more opportunities for professional development in the areas of evidence base, trauma, etc. Over half of the participants, described their preference for profession specific practical skills with less theory oriented training; however when asked to rate training content areas (diagnosis, evidence based practice, developmental theory, cognitive behavioral treatment/theory, trauma theory, trauma informed care, attachment theory, assessment/evaluation), all content areas were rated on average 6 or more (8 being the greatest preference/need).

Similarly, a study by Miller & Jome (2008) found that many mental health professionals felt that it is very important that they have proper knowledge and

competency in treating children with internalizing disorders and over half of those study participants felt that further training was necessary and warranted to feel competent.

Trauma. In Mental Health: Culture, Race and Ethnicity (US Department of Health and Human Services, 2001), it was reported that minorities in treatment often receive a poorer quality of mental health care. Many mental health professionals and agencies that provide mental health services to traumatized children lack the awareness, training, and experience necessary to deliver research-proven interventions. This lack of knowledge may be associated with a lack of sufficient experience, training, or support (Reinke et al., 2011).

Eighty three percent of the clinicians interviewed reported inadequate or no training related to trauma, trauma informed care or secondary trauma. Considering that all the clinicians in this study reported having students with significant histories of trauma to include community and domestic violence, sexual assault, neglect, and sexual and physical abuse, it would seem appropriate to include mandatory and ongoing trauma training, expanding TDT clinicians' abilities to intervene and help the students they serve. Study participants reported being unprepared to address trauma-related issues. Some described their struggle in addressing trauma effectively, within their agency, TDT program, and within the context of the school environment. Several clinicians expressed their reluctance to engage in such discussions and interventions due to a lack of trauma training and feelings of incompetence. Likewise, the Center for Substance Abuse Treatment (2014) point out that many treatment providers "may not ask questions that elicit a client's history of trauma, may feel unprepared to address trauma-related issues proactively, or may struggle to address traumatic stress effectively within the limitations

of their treatment program, the program's clinical orientation, or their agency's directives" (p. 3).

Despite the growing knowledge about trauma, public awareness of re-traumatizing events and the developmental impact caused by psychological trauma, Courtois and Gold (2009) point out that there is a dearth of training about trauma in graduate education in psychology, social work, and other professions. This is even more remarkable since TDT clinicians in this study did not have a graduate education and the minimum educational qualifications of TDT clinicians are undergraduate degrees, which only further emphasizes the need for trauma training.

Given the disproportionate prevalence of trauma in community mental health settings, clinicians must have a thorough understanding of how trauma impacts the children and families they serve. Research has demonstrated that children exposed to trauma are especially vulnerable to a range of psychological, behavioral, and emotional problems (Cook et al 2005; Courtois & Ford, 2009; Paolucci, Genuis, & Violato, 2001; van der Kolk, 2005), social maladjustment (Schwartz & Proctor, 2000), and academic failure (Delaney-Black, Covington, Ondersma, Nordstrom-Klee, Templin, Ager et al., 2002). Trauma inhibits the social-emotional development in children, which in turns impacts their overall academic success. Through education, trauma awareness can be enhanced among clinicians who provide direct care, avoiding missteps in working with traumatized children that could potentially re-traumatize them.

Clinicians would benefit from learning about trauma in a clinical and practical way that is relevant to their clinical work with SED children including training that addresses a variety of issues that are essential to trauma competency in clinical work

including assessing and addressing trauma in an effective and sensitive manner, comprehension of pragmatic approaches and interventions, awareness of characteristics associated with trauma exposed students, and how to manage professional development issues including secondary/vicarious trauma and self-care.

Over half of the study participants reported having little to no knowledge of secondary trauma or its potential impact with compassion fatigue or professional burnout. Literature often uses the terms secondary trauma, compassion fatigue, and vicarious traumatization interchangeably to describe exposure to trauma by service providers whether direct or indirect (Center for Substance Abuse Treatment, 2014; McHolm, 2006; Sprang, Clark, & Whitt, 2007). The potential for secondary traumatic stress or compassion fatigue arises from professionals working in difficult environments directly with traumatized children and/or in a position to hear the recounting of traumatic experiences (McHolm, 2006).

Direct care providers can be influenced by exposure to "trauma-related affect and content" when working with clients and therefore it is necessary that all providers (direct or indirect) be educated on secondary trauma (Center for Substance Abuse Treatment, 2014, p. 3). Knowledge and training may offer protection against the "effects of trauma exposure" (Sprang, Clark, & Whitt, 2007, p. 272) as it encourages the processing of trauma related content through peer related opportunities, supervision as well as learning and engaging in effective coping mechanisms. Additionally, previous research point to lower risks of compassion fatigue among professionals with specialized training in trauma and speculate that with specialized training, assessment and treatment skills,

treatment outcomes were "superior to their counterparts with less expertise in trauma work" (Sprang, Clark, & Whitt, 2014, p. 272).

Many mental health professionals, including those in this study reported the lack of awareness, training, and experience necessary to deliver mental health services to traumatized children. Since trauma happens in the context of interpersonal relationships, therapeutic relationships are the primary agent of change and healing (Schore & Schore, 2008; Stiver, 1992). By the nature of their work, TDT clinicians must be aware that exposure to the trauma of others has the potential to cause psychological harm and may impede the therapeutic process. Training in this area may serve as a protective factor in providing clinicians the know how in working with this population, self-care, and post-secondary trauma.

Evidenced Based Practices. There has been tremendous emphasis on dissemination and implementation of evidence-based treatments in children's mental health (Fixsen et al. 2005, Hunsley & Lee, 2007). The uptake and adherence to EBP's have been associated with better outcomes for youth with behavioral problems (Elliott & Mihalic, 2004) as well as produce better workforce outcomes including reduction in burnout for providers (Aarons et al. 2009). TDT clinicians are responsible for the application of EBP's and interventions; therefore, it's essential that they have the necessary resources, training and education to effectively deliver EBP's with SED children within a school setting.

One issue that has recently received increased attention is that of provider training in evidence-based practices (EBPs). Research in this area suggests a large discrepancy between training-as-usual practices and empirically based training recommendations.

Research literature in the area of provider training in evidence-based practices (EBPs) found that although most evidenced based program developers provided manuals and initial training sessions, very few offered mechanisms for the quality assurance such as ongoing monitoring of implementation (Fixsen et al., 2005; Greenberg, Domitrovich, Graczyk, & Zins, 2004). This echoed the research participants' descriptions of their experiences receiving training manuals with little to no training on EBP's to which their program(s) utilized. Both the National Implementation Research Network (Fixsen et al., 2005) and the Prevention Research Center for the Promotion of Human Development at Penn State (Greenberg et al., 2004) concluded that providing training to staff in the absence of adequate follow-up, such as supervision and coaching, is essentially ineffective. Inadequate continued support for clinicians has the potential to adversely impact the application and consequently the outcomes of evidenced based interventions.

Weiz, Ugueto, Cheron, & Heren (2013), in their application of EBP's, found that the challenges they faced in "everyday treatment" were due in part to the differing treatment contexts; from an experimental context into a multi-layered "complex and dynamic youth mental health eco-system" (p. 276). As it relates to this current study, several clinicians endorsed the difficulties and challenges they encountered in their real-world application of EBP's within the context of community mental health that is further compounded by the educational context. Several of the components and characteristics of practitioners that impact the use of EBP's as described by Weiz et al (2013), also represented the research participants of this study. These include differences in educational background and theoretical orientations; limited to no exposure to EBPs; diverse caseload with wide-ranging problems; minimal to no time for treatment

preparation, supervision, and additional training; and high productivity requirements such as the need to maximize billable hours.

Along similar lines, several studies identified barriers to implementation of EBP specifically within educational settings as limited experience, insufficient knowledge, limited time and resources as well as inadequate training and support (Domitrovich et al 2008; Reinke, Herman, Stormont, Brooks, & Darney, 2010; Kratochwill, 2007).

Research recommends that successful dissemination and implementation of EBP's includes a combination of supportive policies, community involvement, an alignment with organizational infrastructure/settings, development of support systems for implementers, ability to supply post-training support and conduct process and program outcome evaluations as well as visibility of these outcomes (Domitrovich et al., 2008; Aarons, Glisson, et al., 2012; Fixsen et al., 2005; Forman, Olin, Hoagwood, Crowe, & Saka, 2009; Kendall & Beidas, 2007).

Additionally, several study participants verbalized the barriers associated with incorporating EBPs to fit TDT program function, priorities, mission, and needs as well as practice setting contexts. Numerous studies have documented these same' concerns, that manualized treatments are too rigid and do not allow for flexibility and individualizing interventions for complex everyday patients in real world settings (Addis & Krasnow, 2000; Addis, Wade, & Hatgis, 1999; Baumann, Kolko, Collins, & Herschell, 2006; Kendall & Beidas, 2007; Nelson & Steele, 2008; Nelson, Steele, & Mize, 2006; Powell et al, 2011; Walrath, Sheehan, Holden, Hernandez, & Blau, 2006). For instance, shorter school class periods may prevent efforts to follow an intervention manual that was initially developed for 60 minute outpatient sessions (Beidas et al., 2012) or as one TDT

clinician described her frustration over EBP manual instructions to break students into 3
or 4 groups when she only has 8 students on her caseload. Providing opportunities for
flexibility to improve fit is key (Kendall & Beidas, 2007).

In addressing the necessity to strike a better balance between process and outcome
research, Capella, Reinke, & Hoagwood (2011) proposed an organizing model of
previous and current research that takes into consideration the multiple layers involved in
intervention development/research to include stakeholder support and engagement,
intervention and context fit, and training, content and ongoing consultation.

Figure 1 *Application of Capella, Reinke, & Hoagwood (2011) Organizing Model of
Intervention Development and Research*
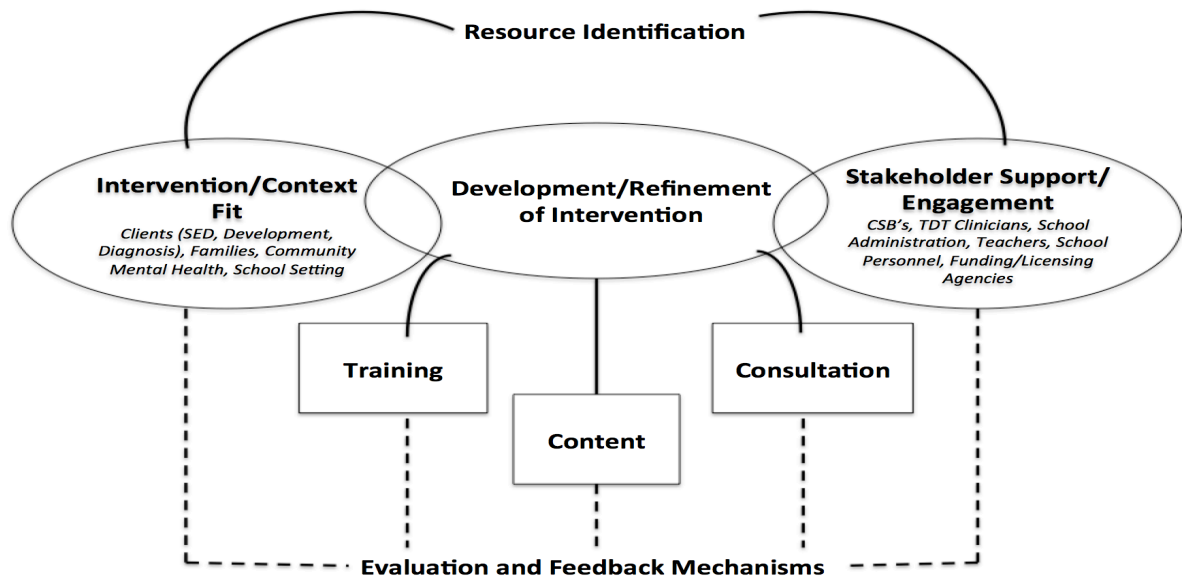
Applying the model of Capella, Reinke, & Hoagwood (2011), the stakeholders
and those engaged in the interventions, as it relates to this study, would be identified as
the Community Services Board, Therapeutic Day Treatment program providers, and

school administrators, teachers and other personnel (i.e. school social worker,

psychologist, nurse, etc.) (See Figure 1). The stakeholders would assist with the input in

regards to the relevance and acceptability of the EBP interventions, clarifying the

enablers and barriers to engagement and involvement of the stakeholders and clients. The

shared collaborative dialogue with program developers, practitioners, and researchers

would inform and possibly impact the development, evaluation, dissemination and

scaling up of evidence based interventions. Continuous feedback and evaluation in

regards to its applicability and feasibility could essentially enhance the ecological fit of

TDT interventions so they meet the specific needs of SED children and their families

within a school context. This in turn would inform the development and modification of

the intervention.

Although some of the findings from this study support prior research, this study

offers a distinctive perspective on the unique challenges that TDT clinicians experience

in regards to the application of evidenced based practices/interventions within the

constructs of TDT service provision and a school environment. From a TDT clinicians'

perspective facilitation of interventions, development, dissemination, and training of

evidenced based practices should be more responsive to the preferences and needs of

SED children and their families, the specific program needs as well as taking into to

account the context of the environment with its multiple levels, and diverse priorities and

goals. Additionally, the lack of training and support along with pragmatic issues such as

lack of resources, space, time and applicability to differing interventions (i.e. individual,

group, or family interventions) are concerns that were also addressed by study

participants. The aforementioned should be taken into consideration by

supervisors/administrators of community services board and school systems alike. As

such, it is fundamentally important to adapt EBP curriculum(s) to child serving

professionals (including TDT clinicians and school personnel) in school based care

settings and disseminate the program via extensive training.

Since the majority of study clinicians have not received adequate training on

EBPs, training the trainer may be more financially feasible to the agency. Supervisors can

be trained to effectively train, consult and support TDT clinicians in the use of EBPs.

Subsequently, the trained supervisors and/or the trained clinicians can further educate

school personnel on their service delivery, interventions and assist in collaboration.

The following section highlights the current training delivery as well as explores

other modalities of training.

Training Delivery. Clinicians identified the delivery of training as follows:

treatment manuals, workshops, bimonthly group supervision, as well as weekly informal

and formal individual supervision. Yearly trainings were reported to occur during school

breaks; trainings during these breaks varied across the different community agencies and

were reportedly not repeated if someone were to miss the training. Study clinicians

reported that they had a strong desire for continual and comprehensive training to better

serve the children with SED on their caseload. Sixty-seven percent of those sampled

expressed their desire to attend training through attendance of conferences and trainings

outside their agencies to better equip them; however financial and time constraints were

identified as some of the barriers.

The workshop approach is a primary method used to train therapists in treatment

models; however, research has found it to be ineffective at changing provider behavior or

insufficient in ensuring application of treatment modalities (Beidas & Kendall, 2010; Grimshaw et al., 2001; Herschell, Kolko, Baumann, & Davis, 2010). TDT clinicians described their training as typically involving brief didactic presentations, relying on passive training approaches and involving little to no follow-up after the training day. Studies have found that training workshops in the absence of any other techniques or follow-up were ineffective in establishing competence (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Institute of Medicine, 2010; Sholomskas Syracuse-Siewert & Rounsaville, 2005).

Training can occur through a range of modalities including courses, supervision, coaching, mentoring, internships, certification, and degree programs. A literature review of training modalities concluded that a multicomponent approach produced far more superior training outcomes (e.g., improvements in therapist knowledge, acceptable fidelity ratings, child outcomes) than other forms of training (Herschell et al., 2010). A multicomponent approach involves hours of multi-modal learning experiences over extended time periods with heavy organizational support (Beidas & Kendall, 2010; Herschell et al., 2010; Rakovshik & McManus, 2010). Clinicians in this study who had a supervisor on site or nearby reported feeling more supported and better prepared than those clinicians whose supervisor were off site or lacked the experience and/or understanding of the provision of TDT in a school setting.

The findings corresponds to the work of Powell, Boxmeyer, Baden et al (2011) which found that an intensive multi modal training group that involved post workshop one on one support and video taped feedback had a significant positive impact on the

children's treatment outcomes versus the usual training group that was comprised of the workshop and monthly supervision.

Working within a predominately Medicaid funded program, with children from low income and high risk communities as well as new emerging diagnosis and trauma related experiences, clinicians must be equipped to not only understand the nuances, but to be able to effectively intervene. Inadequate training could essentially lead to re-traumatization of clients, secondary trauma exposure and possible provider burn out. This section highlighted the training needs of TDT clinicians such as awareness of roles/contributions as outside community providers, knowledge of school environment, specific practical techniques that address the unique needs of their SED students whom have been exposed to trauma, poverty etc. including real world application of evidenced best practices. Professional development is often conceptualized as an "ongoing process rather than as a single event that is aligned and integrated into professional work" (Domitrovich, et al, 2008, p.10). As such, training should be ongoing, responding to emerging needs and building knowledge that contributes to services to children, youth, and their families understanding these dynamics and unique needs. As supported by reports and prior research, training should be delivered via a multi modal approach with adequate support.

Family Dynamics

Mandatory to enrollment in TDT programming and continued program qualification, parents/guardians agree to participate in treatment planning meetings and weekly family telephone contact with the clinician and to complete daily point sheets, behavior rating scales, and other outcome assessments. Despite these minimal

requirements of parents, clinicians reported that families varied in the degree of commitment to and involvement in the TDT programming of their children. The positive impact of engaging families has been demonstrated in the published literature (Spencer et al., 2010). Most outcome studies on family engagement have explored service use and retention in services (i.e. attendance at appointments and participation in services over time) as outcomes (Chovil, 2009; Hoagwood, 2005). Although family engagement involves much more than simply having families participate in care, research shows that family engagement is consistently associated with higher retention in services (Ingoldsby, 2010; Staudt, 2007). Since client retention is a significant issue in child and youth mental health services, helping to promote retention through family engagement is important (Ingoldsby, 2010; Steib, 2004).

Engagement. Engaging families into mental health treatment "remains a serious challenge" (Gopalan, Goldstein, Klingenstein, Sicher, Blake & McKay, 2010, p. 1). Engaging families to buy into services, to actively participate in treatment and to follow through with recommendations are challenges that were described by all clinicians in this study. They described their experiences and frustrations in attempting to establish and maintain the necessary contacts with the families on their caseload who appear unwilling or unable to participate.

Study participants endorsed specific barriers impeding successful engagement with families they serve such as logistical (transportation, limited resources, contact-cell phone) and poor therapeutic alliance. These findings correspond to previous research that found similar logistical and perceptual barriers in engaging and retaining families in child mental health treatment (Garcia & Weiz, 2002; Kerkorian, McKay & Bannon, 2006;

McKay & Bannon, 2004; Robbins, Liddle, Turner, Dakof, Alexander, & Kogan, 2006). In a study of family participation in a school-based community program for SED children, Roberts et al (2008) found similar factors influencing family involvement including trust, demands, and stressors affecting the family as well as "psychopathology and functioning" (p. 282). They found that sensitivity, communication, and social skills on the behalf of the clinician was integral in building effective working relationships with the families they served. It is important to note that, unlike the clinicians in the current study, the clinicians in the Roberts et al (2008) study were master's level therapists. In spite of their graduate education, they reported similar challenges in their encounters with the families.

If TDT strategies are to be truly effective, parent involvement and support are crucial. It is imperative that families are engaged as one clinician stated it "makes for a better service, cause everybody knows what, we all know what we are trying to do versus kids who the parents are uninvolved a lot of times, you may not see a lot of behavioral changes" (Jennifer). The process of engagement is the most important step in ensuring successful treatment outcomes (Jenkins, 1990; Miller, Hubble and Duncan, 1995), higher retention in services (Ingoldsby, 2010; Staudt, 2007), improved child and youth psychological adjustment (Bellin, Osteen, Heffernan, Levy & Snyder-Vogel, 2011), quicker recovery process (Robst et al., 2013), and enhanced caregiver psychological well-being, efficacy, and competency (Bellin et al., 2011; MacKean et al., 2012; Slaton, Cecil, Lambert, King & Pearson, 2012).

Successful therapeutic engagement embraces distrust and resistance that is normative in the early stages of treatment. Parental feelings of embarrassment, shame and

guilt, and perceived stigma, often hinder a family's willingness to consider involvement in their child's treatment (Schladale, 2002). Understanding the child and family's background including the family's goals for treatment is essential. Additionally, the acceptance of differences in families is necessary for each child and parent to feel a sense of belonging to the program. As Adams and Baronberg (2005) point out "Mutual respect, cooperation, shared responsibility, and negotiation of differences in opinion between parents and care and education professionals are necessary to achieve shared goals related to the guidance and education of young children" (p. 15-16). This is in accordance with basic family therapy principles; key elements include warmth, empathy, genuineness, and a nonjudgmental attitude (Miller, Hubble and Duncan, 1995).

Effective training should equip clinicians with applicable engagement strategies, including having a clear understanding of barriers to successful engagement, and increasing their ability in identifying, developing and implementing plans for addressing barriers to treatment adherence and participation (Nock & Kazdin, 2005). Family engagement is important because families have expert and intimate knowledge of not only their child, but personal knowledge of how the system and its services work, and how they may be improved (Gross et al., 2014; Nock & Kazdin (2005). All these factors are critically important in TDT planning and tailoring delivery that fits families' needs and preferences.

Making the connection between school and home. While all clinicians indicated that a majority of the children were involved with multiple providers, very few mentioned collaborating with the differing systems. Some of the difficulties were outlined as time constraints, differing agendas and roles as well as a lack of training

related on how to engage/collaborate efficiently with other professionals/providers. Children and their families serviced by community mental health agencies are often involved with multiple service systems other than mental health (e.g., law enforcement, child welfare, the courts, schools, primary care) (U.S. Department of Health and Human Services, 2003). Additionally, working within a school system, the necessity exists in making the connection between the school and home.

Literature across professions that provide related services to children in the school setting indicated the need for coordinated, evidence-based intervention, with all professions observing the need to ensure that students' academic and emotional needs are met (Becker & Domitrovich, 2011; Kelly et al., 2010; McClanahan & Weismuller, 2014). Unfortunately, amid multiple providers and their competing priorities and expectations, the potential exists for children and their families to become overwhelmed or receive mixed/confusing messages or fall through the cracks. Collaboration is central in enhancing treatment gains and to increase consistency across systems, as one study participant described the process of collaboration as "putting the pieces together." Furthermore, as described by study clinicians, collaboration extends the benefits of TDT services and prevents the duplication or gaps in services delivery and key information.

In reflecting upon their experiences/challenges of implementing and maintaining a school-based community oriented program for SED children, Roberts, Vernberg, Biggs, Randall & Jacob (2008) found that successful collaboration and mutual commitment to "improving the quality of educational and psychological lives of the children was essential and smoothed most difficult interactions" (p. 279). Successful collaboration as defined by Roberts et al (2008) was contingent on all involved parties being open to

collaboration, respectful of each other's expertise and willingness "to reduce their own egos of personalities and professional orientations" (p. 279).

Several participants described the successes they've had in their collaboration with school personnel and other providers associated with the child and/or the family. They indicated that it assisted in improving the identification of those in need of services, providing opportunities for improved insight over family dynamics, treating the "whole child" thus extending TDT's range of services beyond its "four walls." One clinician spoke about linking some of her students to extracurricular activities such as football and collaborating with coaches to ensure continuity of treatment goals (i.e. improved social skills etc).

Collaboration can assist in improvements in the management of cases, making the most of service delivery in such a way that can "result in a clear direction and path of treatment for a child with serious mental health issues" (U.S. Department of Health and Human Services, 2003). It is advantageous that clinicians have the know how to effectively collaborate with school personnel and other outside agencies in such a way that promotes cooperative relationships between the home, school, and community (Taras et al., 2004).

Conflicts within School Context

It is important to understand the complexity and challenges posed in providing comprehensive therapeutic day treatment services between two differing systems, community mental health and school systems. One of the unique features of the TDT program is its location in the school, which provides the accessibility and identification of those in need of services for children with SED. Additionally, it readily provides access

to the identified child's behavioral and emotional functioning through direct observation as well as contact with school personnel. In spite of its advantages, participants recognized the challenges that provision of mental health services within a host setting, the school, creates.

Both the TDT clinician and the host school each have their own culture with their respective implicit and explicit rules that impact assessment, treatment planning and service delivery. Many of the study participants described the impact the differences in the organizational cultures between the school and community mental health systems has on service delivery. Specifically, participants identified challenges as territorial conflicts, time management/scheduling issues, opposing philosophical views as well as ethical dilemmas.

When mental health teams are employed by a community agency, they may be confused about roles and responsibilities if the priorities of the school district and the community mental health agency are not aligned (Eiraldi, Wolk, Locke, & Beidas, p. 7). Additionally, according to the Research and Training Center for Children's Mental Health (Kutash, Duchnowski, & Lynn, 2006) "confusion in roles and responsibility between education and mental health persists to this day in many communities and the renewed interest in school-based mental heath services has, for some, triggered renewed conflict between the two systems" (p. 3).

The following sections will explore the conflicts identified by study clinicians as well as recommendations to address the barriers associated with the complexity of providing TDT services within the school context.

Turf Wars. Ten out of the twelve study participants described their personal or their peers' experiences as "outside providers" entering the school system. For several of them, entering the schools were unchartered territories. They described feeling "unwelcomed," as outsiders and being met with reluctance and suspicion by school personnel. They described the feeling of encroachment by school teachers who some in turn would not allow clinicians into their turf, the classrooms. This mirrors previous research by Roberts et al (2008) whereby they identified challenges clinicians of a school based program faced in their interaction with the school such as the need to "defend their ''turf,'' when differences in training or personality led to differences in opinion, when members of the team felt their expertise was underappreciated, or when one's ownership of the program was threatened" (p. 278). These turf wars expanded to other avenues as well. One clinician, unlike her peers, would have to sign in and sign out as a "guest" before entering and exiting the school building. Additionally, she spoke about having to gain preapproval from the administration before her supervisor could come to visit. This created as she described an "us" versus "them" feeling.

Creating understanding and building relationships so as to decrease suspicion of a clinician's intentions can be particularly beneficial when entering a new system. Although one study participant described the initial reluctance of school personnel, specifically from guidance counselors, she described the process that assisted in bridging the gap between the two systems. She spoke about working collaboratively with the school and partaking in training that included the creation and participation in role-plays for annual teacher training. She indicated that the support from the school administration

was beneficial; unfortunately, her peers reportedly didn't have similar support from the administration of their schools.

Turn-overs and changes to staff allocation, shifts in staff, whereby staff are relocated to another school in response to shifts in caseloads; resulting in therapeutic ruptures with current caseloads and often time closure is not facilitated or understood adequately. Some staff are asked to split their time with two different schools which may have two differing cultures, which are further complicated by changes in policies and regulations issued in responses to licensing and/or fiscals changes. The politics, the culture, the way things are done in different settings, can create confusion for providers who split their time in multiple locations.

Different schools have different perceptions of TDT roles which leads to different expectations in their respective schools in terms of what the provider is suppose to do or not do. The environment makes the situation a little bit more challenging adding an additional layer of complexity. Constant negotiation of roles and the need to protect one's own turf is a waste of energy. Instead the energy and time can be better allocated to finding ways to bridge the community mental health and school systems. For example, creating awareness through TDT supervisors, team meetings with school personnel, and provision of psychoeducational information/training regarding services, roles and expectations can be addressed.

An important piece in the training that would have to be addressed is to assist clinicians who are in these roles and how to introduce school personnel to the practice to ensure continuity of care. Training curriculum for TDT clinicians should incorporate the

clarification of the roles and responsibilities as well as how to effectively communicate them to their clients, families and school personnel.

Scheduling/Time conflicts. Three quarters of study participants identified the struggles associated with provision of services within the school's schedule. School limitations on time outside of the classroom included infringing on academic instruction, teachers' preferential times, and mandatory state testing, which severely limits access and creates difficulties for study participants in scheduling contact time with their students. This is further compounded by the agency's productivity standards and expectations for billing as outlined by state and funding agencies; which often leads the clinicians to fight for time.

Another dilemma associated with conflicts in scheduling, as outlined by study participants, is that clinicians are faced with pulling students during lunch times and specials which may include recess, free time, or other elective courses such as music, computer, etc. It is at those times that students can utilize and practice learned social and coping skills in their interaction with peers; unfortunately pulling students during those times limits the opportunity. Additionally, students are more reluctant to leave with clinicians at the risk missing out. Just as significant, to note that some clinicians described teachers as "throwing" their students at them, contacting clinicians over trivial matters or requesting that clinician take certain students, at times unaware that clinicians have other students they have to meet with, crises that are a priority, and other responsibilities such as documentation and collaborating with families and other providers.

Partnering with administration in both schools and agencies early on is recommended. In doing so, it creates the opportunity to discuss and problem solve the anticipated barriers/challenges at an administrative level so that TDT clinicians and school personnel are supported and adequately prepared to handle challenges as they arise.

Opposing philosophical views. All interviewed discussed being impacted by agency mandates, public-funding constraints as well as state and federal policies. Explicitly they described the constraints created by the program's and state's definition of allowable (billable) services; restricting their services to the students on their caseload that meet the qualifications for TDT intervention. Additionally, study clinicians described being governed by agency and funding productivity standards and expectations that limits their ability to assist the school with non-billable tasks such as bus duty, hall monitor, academic tutoring etc. Along similar lines, changes to educational practice to raise standards has led to a focus on accountability, curriculum requirements, assessment testing, and examination results (Darling- Hammond et al. 2003; Fitz 2003; Koshoreck 2004; Lam 2005; Timperley and Phillips 2003). Unfortunately, these academic objectives do not always align well with the aims of mental health practices. Since the major emphasis of the schools is on instruction and academic outcomes (Adelman & Taylor, 1998; Massey et al, 2005), most schools and their cultures are not primarily organized to facilitate the provision of mental health services (Cunningham & Cunningham, 2001).

TDT clinicians cannot be effective in their mental health service delivery without consideration and attention to their implementation context. Training competency should encompass clinical practices that take into account organizational and systems variables

characterizing their practice environments that according to study clinicians vary from school to school. They must be able to understand and appreciate the varied and complex characteristics between the differing systems; without it TDT clinicians can be left with more questions than answers. Policies, definitions, and allowable services should be clarified, and clarifications should be broadly disseminated between the two systems. These clarifications may require involvement of multiple levels such as community services boards and school districts; TDT program directors/supervisors and school administrations; and TDT clinicians and school personnel.

Ethical Issues. Ethical considerations can be "complicated" when working with children in schools (Fazel, Hoagwood, Stephan and Ford, 2014 p. 12). Privacy and confidentiality practices that govern work with students and families varies across the differing systems as they are governed by differing policies including the Family Educational Rights and Privacy Act (FERPA; http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html) and the Health Insurance Portability and Accountability Act (HIPAA; http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html).

TDT clinicians are responsible for the confidentiality of all clinical information to ensure its consistency with state and federal regulations. For example, mental health services have specific pathways and requirements to gain consent and inform caregivers. In schools, the services offered might be viewed as general school provision and individual consent for specific services might not be perceived as necessary. For example, a child might see a school social worker, guidance counselor or nurse without parental knowledge or consent. Unlike school personnel, TDT clinicians are only

permitted to have access to students whose guardians have provided permission to treat.

Several of the participants described instances where they experienced dilemmas

associated with being asked to speak with non-TDT students, provide TDT interventions

without informed consent from parents, or to share private clinical information about

existing clients both formally and informally.

According to Fazel et al (2014), "Clear protocols are important to allow

information sharing, which might prove beneficial to both academic and health outcomes,

but privacy and confidentiality are essential to maintain therapeutic boundaries" (p. 12).

Role clarity and boundaries are essential to avoid inappropriate disclosure of information

and confusion of treatment functions that can compromise the therapeutic relationship

and compound clients' and their families' mistrust in the systems.

TDT supervisors can assist by maintaining regular contact with the schools to

remain current on changes in laws and professional standards and to ensure the

compliance with policies and procedures regarding the release and sharing of information

with the school system. This may be done through collaboration with the school social

worker, psychologist, counselor, and/or school administration. Supervisors should be able

to provide guidance on ethical issues such as violations of confidentiality, professional

boundaries and blurring of roles. Additionally, training curriculum should incorporate

ethics specifically with the application in a school setting with its differing practices.

Results of this study underscore the complexity associated with the provision of

TDT services within its host setting with its own structural, political, and cultural

standards/expectations. The relationship between TDT clinicians and school personnel

varies from school to school and therefore aside from having the content area knowledge,

107

understanding school systems is important to stay in compliance. Adequate training should provide TDT clinicians a clear method for navigating these waters.

TDT supervisors can further assist by linking up with the school systems to ensure that treatment aspects of the TDT program are understood and the scope of care is defined including specific populations to be served. Training and supervision should be continually monitored and evaluated for its appropriateness particularly as staff turnovers and staff relocation may cause shifts in need. The supervisor must possess the knowledge of systems, trauma-informed and evidence-based practices that will allow the supervisor to continually monitor and evaluate the appropriateness and quality of mental health services to TDT clients.

TDT clinicians, through direct intervention with children and families and consultation with other systems (schools, in home counseling, psychiatrist, etc.) play an important role in ensuring that TDT services are carried out in a developmentally sensitive and appropriate way. In addition to direct interventions to ameliorate such symptoms such as anxiety and depression, provision of adequately trained and quality mental health care provides the opportunity for those served to master effective techniques for coping, emotional regulation and helping to improve psychosocial functioning and academics.

Training may necessitate time away from the agency to attend trainings or paying for training to come to the agency, which could be costly; as such it is key to prioritize the trainings to meet the specific needs of TDT clinicians. The information garnered in this study helped to see that all of the training content areas were considered as important, but with some of the barriers identified by clinicians such as limited funding and

resources as well as time constraints, clinicians were asked to rank the trainings against each other to ascertain their top preferences. Ranking them in relation to each other assisted in identifying the top 4 training areas were diagnosis, evidenced based practices, developmental theory and trauma theory.

The qualitative results assisted in gaining a clearer picture, flushing out what each content training area meant for TDT clinicians as well as ascertain the importance of its relevance in the day-to-day application. The information gained can assist when developing a training curriculum; it was through their stories that the most information was gained as it provided a clearer view of their distinct experiences. Based on the issues reflected in the qualitative data, topics may have to be incorporated concurrently as opposed to separate trainings. In developing their ability to deliver treatment appropriate to age, development, and diagnosis; theories of attachment, developmental, etc. should guide the development of a trauma informed school based training curriculum, specific to the unique needs of TDT children. The application of conceptual frameworks of attachment, developmental, and trauma theory would assist clinicians to become more effective facilitators of growth and healing in their work.

Additionally, clinicians should have an understanding of how disruptions in attachment, stress, trauma, and adverse experiences affect child development and subsequent emotional modulation. The school setting provides an opportunity for the adequately trained clinician to view how the children's interactions and relationships with school personnel and clinician is an extension of the child's relationship with caregiver(s). Ensuring that training in attachment, developmental and trauma explains that when attachment systems and relationships are compromised in any way, children

develop adaptations that keep them safe at the expense of failing to adequately develop competencies, most importantly the "failure to regulate emotions and experience" (Blaustein & Kinniburg, 2007). The lack of age appropriate coping abilities becomes most noticeable when children enter preschool and elementary schools.

Training curriculum for interventions should focus on building clinicians' knowledge and skills to promote the use of effective strategies that are developmentally appropriate and supportive of children's emotional and behavioral growth. Application of attachment, development, and cognitive behavioral principles in their work with children and families in a school setting is crucial, therefore, the training curriculum should take TDT clinicians beyond theories and demonstrate how to apply principles within the delivery of TDT services to improve treatment outcomes. The training curriculum should teach clinical strategies that help treat critical behavioral problems stemming from poor emotional regulation, poor attachment and possible trauma in high-risk communities. The curriculum/training should address the treatment of children with SED within the context of the child's school as well as the family system.

Training curriculum will have to ensure that TDT clinicians have core competencies that include (a) a firm foundation in philosophy of different theoretical and disciplinary perspectives appropriate to their work; (b) application of theoretical models of traumatic stress, creating an understanding of traumatic stress, secondary trauma, grief and loss and their sequalae; (c) an understanding of the varied and complex characteristics of TDT populations (d) attend to and have the appreciation for the structural, procedural, and philosophical aspects of the diverse contexts and delivery systems that provision of service occur, and the inherent strengths, biases, and limitations

of these views; (e) techniques and efforts used to increase the engagement and retention

of the child and family systems as well the administrative and organizational systems

involved in service delivery, and establish collaborative relationships with the school and

other providers associated with TDT population; and (f) an understanding of the

knowledge about EBP currently available, the essential practice and contextual aspects

necessary to effectively implement an intervention in a school setting, and the strengths

and limitations of EBP.

Personal Observations of the Researcher

By the time I became the clinical supervisor of a TDT program in the state

Virginia, I was a Masters level clinician with one year into my licensure supervision and

over 7 years of experience working with SED children in a residential psychiatric setting.

In spite of my education and experience, it took me a while to find my own way in

understanding TDT services and its provision within the school context including the

educational rights of our clients, the school culture, and the impact it had on clinical staff.

In some schools my staff and I were seen as a part of their system, while in other schools

I felt like a visitor. Although, I no longer serve in the capacity of TDT clinical supervisor,

I was surprised that study participants also voiced some of the issues I encountered and

that some of the same issues are still present today as they were over 7 years ago. Given

the limited and insufficient training and education of TDT clinicians, it is no surprise that

study clinicians expressed feeling ill prepared to face similar the challenges.

Chapter 6

LIMITATIONS, IMPLICATIONS, AND FUTURE RESEARCH

Several limitations exist in conducting this study that indicate the need for additional research. One limitation that exists in this study is that saturation of data was not reached, which was partly due to the small sample size of twelve subjects. Another limitation was the time constraints (school year ending) that did not permit further sampling.

Another limitation that exists in this study relates to participant recruitment. The participants were recruited via referral from local community-based services mental health center participating in a specific program, Therapeutic Day Treatment program. The population sample was limited to community mental health TDT service providers in elementary public school settings within two different regions in Virginia. Community Service Boards TDT providers may differ significantly from private contracting providers whose training and accountability standards vary across agencies. In addition, due to the inclusion of only public elementary schools in only two regions of the state, it is not possible to generalize these results to TDT clinicians who services provision occurs in middle school, high school, private, or independent schools or to TDT providers in public schools in other areas of the state and country. Additionally, the fact that the study participants voluntarily elected to participate in this study may have attracted participants who were more vested in the program.

A final limitation that exists in this study is the fact that the majority of the participants in the study sample had experience with at least 3 or more years of experience providing TDT services upon interview. It is possible that the training

experiences of these participants are not representative of training experiences of clinicians who have less than 3 years in the program.

As a result, given the exploratory nature of the study, the recruitment strategy and the sample size impacts the external validity. Given the threats to external validity of this study, conclusions and/or inferences cannot be generalized to other contexts or other populations. Although we may not be able generalize from findings of data collected, we surely can learn from it.

In light of the limitations, the results of this study have important implications to mental health policy-makers, service administrators and to frontline service providers, and for future research. They will be discussed in the following section.

One thing to note is that in qualitative studies, human subjectivity is unavoidable as the researcher is the human instrument that provides the interpretation. As such, it is important to acknowledge that my interpretations are but one perspective in a myriad of "multiple ways of interpreting findings" (Bloomberg & Volpe, 2012).

Research Implications

Despite the foregoing limitations, the findings provide preliminary evidence supporting the need for adequate training in the delivery of school-based mental health services. This study highlighted some of the unique needs and challenges of community mental health providers whose provision of services occurs within school environments.

It is the hope of the researcher that the identified gaps between available and needed mental health competencies will aid in the development of an intensive school-based mental health preparation and training curriculum to be used in preparing school-based community mental health providers who work with emotionally disturbed children.

TDT supervisors and directors should be aware of the unique challenges TDT clinicians face and assist by developing training and supervision that will meet their needs. Additionally, they can assist by periodically meeting with school administrators and leadership to define and refine the roles of TDT clinicians and how policy/agency changes may impact service delivery and the delineation of responsibilities.

The results of this study provide a starting baseline for future training curriculum development, training, and research. Training through the lens of applicable theories such as trauma, development, attachment etc. and its application of evidenced based practices/interventions can assist clinicians in their day-to-day work. This and future research efforts will lead to the establishment of clear training standards for agencies, that provide TDT services, to follow and better equip new incoming and seasoned TDT clinicians in the competent provision of these services.

Since respect for, and care of, both the client, families, the treatment providers and the contexts are critical, on a mezzo level, Community Services Boards and School District Boards should consider the adaptation of a trauma informed system of delivery such as the Sanctuary Model that takes a "whole system approach designed to facilitate the development of structures, processes, and behaviors on the part of staff, children, and the community-as-a-whole that counteract the...wounds suffered by the children in care" (Bloom, 2005, p. 65). Consequently, adopting a trauma informed care system would assist in the conceptualization of a philosophy and framework for staff selection, training, consultation and coaching, staff performance evaluation, organization-level assessment of implementation success and continuous quality improvement, administrative support, and supportive interactions with external systems (Glisson, Landsverk, Schoenwald, Kelleher,

Eaton, Hoagwood, et al., 2008). Trauma informed care assists in creating a common language among a variety of agency professionals serving traumatized individuals.

Beyond creating improved training standards, it is the hope that, at a macro level, policies are put in place to ensure statewide core competencies across both private and community mental health TDT providers, such as the creation of specialized certification standards. In other words, in order for a clinician to meet the qualifications of a QMHP (Qualified Mental Health Practitioner/Provider) specific defined training criterions and competency must be met in addition to specific educational and experience standards. These standards should be supported and reinforced through the state, licensing and funding agencies.

Social Work Implications. School social workers are in a unique position to serve as liaisons and advocates in bridging the gaps between community mental health and the school systems. They can serve as an intermediary between the school and the community mental health organizations. School social workers can assist in negotiating and clarifying roles as well as creating new ways of thinking and approaches that acknowledge both systems.

Additionally, school social workers can proactively promote a collaborative approach by engaging families, schools, TDT service providers and other professionals/agencies. Social workers are better equipped to expand their "clinical roles and responsibilities with macro-level practice involving other school-serving agencies, families, and communities" (Anderson-Butcher et al., 2010, p. 161). In doing so, service benefits are enhanced particularly as research has linked the benefits of collaboration with creating an environment of mutuality, reducing learning and system barriers,

improving treatment planning, intervention fidelity, and team decision making (D'Agostino, 2013; Dimmitt, Carey, & Hatch, 2007; Greenberg et al., 2003; Minke & Anderson, 2005).

At a macro-level, social workers can advocate to key stakeholders and policy makers for increased funding for the effective training of direct care providers as well as the creation of uniform training standards across community mental health and private providers alike.

Future Research

Future research should expand and examine the different types of didactic and field-based experiences (i.e. supervision, in-service) that would contribute to competency in providing school based mental health services by community TDT clinicians. Future research is merited to explore supervisory relationships and styles in the dissemination and delivery of training. Research on dissemination, implementation and fidelity of evidenced based practices should be expanded in regards to school based mental health programs as well as its real-world application, given the limitations outlined by study participants. It is the hope of the researcher that this and future studies will provide the impetus for the establishment of an effective training model that acknowledges the diverse skills and complex conceptual understandings needed for TDT providers to effectively fulfill their roles in school based settings.

Future research should also explore the ethnic, racial and religious cultures of the clients, settings, and clinicians and the impact to service access and delivery.

Chapter 7

CONCLUSION

As schools have become the ideal and likely place for the provision of mental health services for its strategic setting and assessibility, more children and adolescents receive services for behavioral and emotional concerns by school-based mental health providers. Virginia established the Therapeutic Day Treatment Program to increase access to mental health services for children and families from disadvantaged backgrounds. Unfortunately, little is understood about the trainings needs of providers in this setting. This study represents a critical first step in developing a measure to best understand the training needs of community school based providers.

All clinicians in this study endorsed the belief that TDT service delivery modality is the most effective way to deliver mental health services to SED children within a school setting; however, their concerns centered on their lack of preparation and ongoing training to effectively deliver such a highly intensive service. Results from this study emphasizes how service delivery for children cannot occur without attention to context, including the family, schools, the child mental health care system, and the community mental health system. Although the findings from this study support prior research, this study examines and further expands on the unique challenges that TDT clinicians face. Additionally, this study provides information on treatment providers, evidence-based preparation, barriers to provision of services, impact of organizational culture and climate, collaboration, family implication, program structure and content that will be important to training development and dissemination.

The goal of most training for health care professionals is to impact behavior change in recipients of the training and, ultimately, impact the mental health outcomes for clients. Given that therapeutic day treatment is generally short-term, having knowledgeable and trained providers in the delivery of TDT treatment as well as effective interventions/strategies that incorporate the unique needs of the identified students within the context in which service provision occurs, may optimize school-based mental health treatment.

TDT clinicians need to continually update their knowledge and skills throughout their careers, just as professionals in any field must do; consequently a training model that is more appropriate to the mental health care realities of TDT is necessary. Several factors that impact TDT service delivery is the necessity for ongoing, intensive training and support for clinicians as well as attention to clinician and school climate factors. The training model should be comprehensive, meet specific needs of the population as well as take into account the social, economic, cultural, racial, and political systems of school and mental health environments.

As such it is the hope that this study and future studies will serve as the push to develop a comprehensive training curriculum that will address the formidable challenges of their day-to-day jobs, and incorporate diagnosis, evidenced based practices, developmental theory and trauma informed treatment approaches that recognizes the pervasive impact of trauma, the context of the environment with its agency cultures, multiple levels, and diverse priorities and goals, and aims to ameliorate rather than exacerbate the effects of SED children's symptomatology.

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Appendix A

Glossary of Key Terms and Associated Acronyms

Term	Definition
Community Services Board (CSB)	Community Services Boards are the single point of entry for the Virginia public mental health system. CSBs are responsible for assuring, with resources, the delivery of community-based mental health, developmental, and substance abuse services to individuals with mental health or substance use disorders, intellectual disability, or co-occurring disorders (Virginia Association of Community Services Boards, 2015).
Department of Behavioral Health and Developmental Services (DBHDS)	Virginia's public mental health, developmental disability and substance-use disorder services system is comprised of 15 state facilities and 40 locally-run community services boards (CSBs) (DBHDS, 2014b).
Department of Medical Assistance Services (DMAS)	The Department of Medical Assistance Services is the State Agency designated by the General Assembly of Virginia, under the provision of Title XIX of the Social Security Act, to administer Virginia's Medical Assistance Program.
Individuals with Disabilities Education Act (IDEA)	A federal law enacted in 1990 and reauthorized in 1997 and 2004. It mandates that all children who qualify under IDEA are provided with free services and accommodations individualized to their needs in a least restrictive setting as possible (Judge, 2011, p. 804-806).
No Child Left Behind (NCLB)	Act passed in 2001 that ensures that all children have a fair, equal, and significant opportunity to obtain a high-quality education and reach, at a minimum, proficiency on challenging State academic achievement standards and state academic assessments (U.S. Department of Education, 2008)
Qualified Mental Health Practitioner-Child (QMHP-C)	A person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. It includes at least a bachelor's degree in a human services field or in special education and at least one year of clinical experience with children and adolescents.
Severe Emotional Disturbance (SED)	A serious mental health problem diagnosed in children (birth-17) and that must exhibit problems in personality development and social functioning; problems are disabling upon the social functioning and becoming more disabling over time; and requires significant intervention by more than one agency (DBHDS, 2014, p. 32).

TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS

Appendix B

TDT Eligibility Requirements (DMAS, 2011, p. 16-17)

Children and adolescents must demonstrate a clinical necessity for the service arising from a condition due to a mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. The disability must have become more disabling over time (within the past 30 days) and must require significant intervention through services that are supportive, intensive, and offered over a period of time in order to provide therapeutic intervention.

Individuals **must meet at least two of the following** on a continuing or intermittent basis (within the past 6 months) and the support for this must be clearly documented in the medical record with child-specific examples:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement (see definition below) because of conflicts with family or community.

2. Exhibit such inappropriate behavior that recent repeated interventions by the mental health, social services, educational system, or judicial system are necessary. For example, crisis intervention services have been provided, outside intervention for truancy have been made, or there have been repeated in school and out of school suspensions that must be addressed as a part of the TDT Individual Service Plan.

3. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. For example the youth exhibits acting out in such a fashion that will cause harm to themselves or others.

In addition to meeting two of three criteria listed above, children and adolescents **must meet one of the following** that must be supported by child-specific documentation in the medical record:

1. Have deficits in social skills, peer relations, or dealing with authority; are hyperactive; have poor impulse control; or are experiencing a diagnosed behavioral issue. The deficits or problem behaviors must be documented in the medical record and must be to the level that they significantly impact the child's abilities to participate in activities of daily living compared to most children who are the same age.

2. Would otherwise be placed on homebound instruction because of severe emotional or behavioral problems, or both, that interfere with learning. The medical record must contain documentation from the school that supports this criterion.

3. Require year-round (9-12 months) treatment in order to sustain behavioral or emotional gains. The medical record must document the need for year-round treatment and any periods when service has been decreased and behavioral or emotional gains have been lost.

4. Behavioral and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without this programming during the school day or as a supplement to the school day or school year. The medical record must document the type of classroom programming that is unable to meet the child's needs, and why the needs are not able to be met and how the problem behaviors are exhibited.

TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS

Appendix C

Description of Therapeutic Day Treatment Services

A minimum of two hours per day programming with a minimum of two therapeutic activities daily

- Completing diagnostic evaluations, assessing treatment needs;

- Consultation with teachers and others involved in the child/adolescent's treatment and observation in the classroom.

- Planning and implementing individualized pro-social skills curriculums and interventions; e.g., problem-solving, anger management, community responsibility, increased impulse control, appropriate peer relations, etc.),

- Monitoring progress in demonstrating the acquisition of pro-social skills (anger management, problem-solving skills, identification and appropriate verbalization of feelings, conflict resolution, etc.);

- Implementing cognitive-behavioral programming;

- Planning and implementing individualized behavior modification programs and monitoring progress through collaboration with school personnel, family, and others involved in the child/adolescent's treatment; (Family contacts, either in person or by telephone, occurs at least once per week).

- Responding to and providing on-site crisis response during the school day and behavior management interventions throughout the school day;

- Providing individual, group, and family counseling based on specific treatment objectives;

- Collaborating with all other community practitioners providing services to the child/adolescent, including scheduling appointments and meetings, and

- If the child or adolescent is on medication, education about side effects, monitoring of compliance and referrals for routine physician follow up must be provided to the child/adolescent and parent/ guardian and documented. Response to medication and education, as well as compliance must also be documented (DMAS, 2011, p. 20).

Appendix D

Institutional Review Board Approval

University of Pennsylvania
Office of Regulatory Affairs
3624 Market St., Suite 301 S
Philadelphia, PA 19104-6006
Ph: 215-573-2540/ Fax: 215-573-9438
INSTITUTIONAL REVIEW BOARD
(Federalwide Assurance # 00004028)

25-Mar-2015

Joretha Bourjolly
jerri@sp2.upenn.edu
creamon@sp2.upenn.edu

PRINCIPAL INVESTIGATOR : Joretha Bourjolly
TITLE : The Training Needs of Community Service Providers of an Intensive Mental
Health Program in Virginias Public School Settings
SPONSORING AGENCY : NO SPONSOR NUMBER
PROTOCOL # : 822169
REVIEW BOARD : IRB #8

Dear Dr. Bourjolly:

The above referenced protocol and was reviewed and approved by the Executive Chair (or her authorized designee) using the expedited procedure set forth in 45 CFR 46.110, category 7, on 23-Mar-2015. This study will be due for continuing review on or before 22-Mar-2016.

Approval by the IRB does not necessarily constitute authorization to initiate the conduct of a human subject research study. Principal investigators are responsible for assuring final approval from other applicable school, department, center or institute review committee(s) or boards has been obtained. If any of these committees require changes to the IRB-approved protocol and informed consent/assent document(s), the changes must be submitted to and approved by the IRB prior to beginning the research study.

If this protocol involves cancer research with human subjects, biospecimens, or data, you may not begin the research until you have obtained approval or proof of exemption from the Cancer Center's Clinical Trials Review and Monitoring Committee.

The following documents were included in this review:
-HS ERA Initial Application, confirmation code: bhheddab, submitted 3.17.15
-Electronic Recruitment Script, uploaded 2.25.15
-Semi-Structured Interview Questions and Prompts, uploaded 3.8.15
-Informed Consent & HIPAA Authorization Form, uploaded 3.17.15
-Cover Letter, dated 3.17.15

When enrolling subjects at a site covered by the University of Pennsylvania's IRB, a copy of the IRB approved informed consent form with the IRB approved from/to stamp must be used unless a waiver of written documentation of consent has been granted.

If you have any questions about the information in this letter, please contact the IRB administrative staff. Contact information is available at our website: http://www.upenn.edu/IRB/directory.

Thank you for your cooperation.

Sincerely,

Stephanie Lesage

Digitally signed by Stephanie Lesage
DN: cn=Stephanie Lesage, o=ORA, ou=IRB,
email=lesages@upenn.edu, c=US
Reason: I attest to the accuracy and integrity of
this document
Date: 2015.03.25 16:29:50 -04'00'

IRB Administrator

TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS

Appendix E

Research Subject Information and Consent Form

TITLE: *The Training Needs of Community Service Providers of an*
Intensive Mental Health Program in Virginia's Public School Settings

Principal Investigator:
Joretha N. Bourjolly*,* MSW, PhD
Associate Professor/Clinician Educator
Associate Dean for Academic Affairs
Director, MSW Program
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Office of Regulatory Affairs at the University of Pennsylvania:
3624 Market Street, Suite 301 S.
Philadelphia, PA 19104-6006
Office: (215) 898-2614
Fax: (215) 573-9438

Introduction and Purpose of Study
I am conducting a qualitative research study as part of the requirements for my doctoral
degree in social work at The School of Social Policy and Practice at the University of
Pennsylvania. I am studying the training needs of community mental health providers of
Therapeutic Day Treatment (TDT) services in public school settings. I am inviting you to
participate in this interview.

What is involved?
The interview itself will last about an hour. We will go over the consent and answer any
questions you may have. I will make an audio recording of the interview and may take written
notes.

The purpose of this interview will be to examine more intensively the experience and the
professional training needs of Qualified Mental Health Practitioners (QMHP) in their
provision of Therapeutic Day Treatment Program (TDT). I will ask you questions about
your experience(s) with serving TDT population, working within the context of a school
setting and training needs and prior training experiences.

TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS

To be eligible for this study, you must be: a Qualified Mental Health Practitioners (QMHP) with an undergraduate degree and providing TDT services in an elementary public school setting for a minimum of 6 months. I am not interviewing QMHP's who have a graduate degree or have less than 6 months experience providing TDT services.

Confidentiality:
The information you share will be kept strictly confidential. I will not share information about whether or not you participate in this project with anyone. I will never use your name, personal information or information about where you live or work in my write-up of the interview.

All records will be kept confidential in the secure possession of the researcher. Nothing with your name or other identifying information (names and places mentioned in the interview) will be turned in. Consent forms will be securely stored in a different locked cabinet from the interview data. Once the interview has been transcribed I will destroy the audio recording. I will remove anything from the transcript that might serve to identify you in the transcript, including geographic locations and names of particular individuals you might mention, in the final paper.

Risks of participating: There are no foreseeable risks in participating in this interview. The ways that confidentiality will be protected have already been described.

Benefits of participating:
Although being interviewed will not help you directly, it is also possible that having a chance to share your story will be an interesting and possibly even a rewarding experience for you. In addition the information learned from participants in this study may help build a deeper knowledge base about therapeutic day treatment training needs in the Commonwealth of Virginia, which could impact therapeutic day treatment training policies and practice. Furthermore, the findings from this study will contribute to the scholarly literature in the area of community and school-based mental health treatment and policy.

Payment
If you decide to participate you will be given a gift card in the amount of $30 when the interview is completed. You will also be reimbursed for any money you spend to travel to the interview site.

If you have questions about the project after the interview is over, please feel free to contact myself, the Principal Investigator, or the Office of Regulatory Affairs at the University of Pennsylvania.

Your participation is completely voluntary:
You do not have to participate in this project. There will be no negative consequences if you decide not to participate. Any program or agency that you work with will not know whether you participate or not. If you don't participate, it will not affect your job or anything else.

TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS

If you do decide to be interviewed today, you can stop the interview at any time. You can also refuse to answer any questions that you don't want to answer.

By signing this consent form, you are indicating that you have had all of your questions about the interview answered to your satisfaction and that you have been given a copy of this consent form.

Participant signature: _____

Participant printed name: _____

Date: _____

Interviewer signature: _____

Interviewer printed name: _____

Date: _____

Appendix F

Electronic Mail Script

Date:

Dear Directors/Supervisors of Therapeutic Day Treatment Programs,

I am conducting a qualitative research study as part of the requirements for my doctoral degree in social work at The School of Social Policy and Practice at the University of Pennsylvania. I am studying the training needs of community mental health providers of Therapeutic Day Treatment (TDT) services in public school settings. I am sending this email to ask for your help recruiting participants for this study.

I am looking for Qualified Mental Health Practitioners (QMHP) with an undergraduate degree that are currently providing TDT services in an elementary public school setting. QMHP's must have a minimum of six months experience providing TDT services. I am not interviewing QMHP's who have a graduate degree or have less than 6 months experience providing TDT services. I will be conducting in-person interviews lasting 60 minutes.

All participants will be given $30 compensation at the conclusion of the interview. Please forward this email to anyone whom you think might be eligible and interested. I am available to answer any questions you may have.

I have attached a consent form that briefly explains the study as well as your rights if you chose to participate in the study. Participation in this study is completely voluntary. You can choose not to participate in this study. If you are interested in participating in the study please contact me via e-mail or telephone so a meeting can be set up where I personally review the consent with you. Thank you for your consideration and support!

Sincerely,

Cristina Vanessa Reamon, LCSW
Doctoral Candidate
University of Pennsylvania School of Social Policy and Practice
creamon@sp2.upenn.edu
757-803-7786

TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS

Appendix G

Face Sheet

1. With which gender do you identify? ___ male ___ female ___

2. Age: _____

3. Race/Ethnicity: _____

4. Occupation and Title: _____

5. Length at current agency: _____

      a) Length of time in mental health field: _____

      b) Length of time in child/adolescent mental health: _____

      c) Length of time in TDT department: _____

6. Highest education attained, please check all that apply

    _____ High School

    _____Bachelors (BA or BS)

    _____Masters

7. What was your concentration? Please check.

    _____Counseling   _____Psychology

    _____Social Work   _____Other (please specify _____)

8. What is your current caseload? _____

TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS

Appendix H

Semi-Structured Interview Questions and Prompts

Introduction/Rapport Building

Can you tell me a little bit of the type of work you do?
        Probes
                Challenges?
                Training Preparation?

Knowledge of Population

Tell me about your experiences working with the children that you serve

What are the biggest challenges when working this population?
        With their families?
        With the school personnel (teachers, administrations, counselors/school
        social workers)?

From your perspective, what are the presenting problems and needs of the population
being served?

What was your experience with working with SED population prior to working for TDT?
        Prompts: Are there any ways that you could have been better prepared

In terms of your interventions with the families you work with, what skills have been
beneficial?
        In what ways can you better serve these families?
        Describe how the agency and/or school better enable your work with families?

Context

What kind of support systems are in place that enable to do your job as QMHP?
        Prompt: School? Agency wise? Department wise?

How are your interventions/work impacted by"
        The school?
        The agency?
        TDT licensing requirements?

How would you describe your experience providing services in the context of a school
setting?
        Any differences from other settings?
        Advantages?
        Disadvantages/Challenges?

TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS

How prepared were you in terms of knowledge of the school environment?

Please describe how to best to deliver mental health services in school setting? (in or out of school, individual, family or group therapy, more sessions etc)

How has agency training prepared you for the provision of services in the school setting?
 Describe school policies/norms/rules that were different and/or posed a challenge to your work?

Theoretical Perspectives

Trauma/Trauma Informed practices

What role do you think issues like trauma play in the issues that you see on display?

Tell me about your experiences with trauma in relation to your work with the children and/or families on your caseload.

What are your thoughts on your preparedness to deal with issues relating to trauma?
 Prompts: Please explain, Please share an example

What is your knowledge in regards to secondary trauma and self-care?

Attachment Theory

What role do you think attachment plays in the development and maintenance of relationships of the children you serve?
 Probes: In family relationships, with peers, authority figures, and TDT clinicians

Child Development

From your perspective, do you think issues related to child development are important in the delivery of TDT services? Prompt: Please explain

What other kinds of issues or contexts do you feel are important to capture in terms of your provision of services with SED children?

Training/Preparation

What type of trainings did you receive prior to providing services?
 Probes
  On an ongoing basis?
  How many hours of training
  Over what period of time?
  How many were relevant to the work that you do?

TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS

Any training related to evidence based practice?

Who delivered the training?
    Probes
        What are their qualifications and experiences?
        Related to specifically the provision of TDT services?

How useful was the training for you (i.e. are you using the knowledge and skills acquired through training at work)?

How could that training be strengthened (e.g. practical tools, theoretical knowledge, etc.)?

Please think back to your first month on the job, describe your preparation to perform the duties of a TDT clinician.
    Probes
        What things did you believe you were prepared for?
        What areas did you feel you weren't?
        What about now?

Describe a situation related to your work in which you felt the most unprepared?
    Probes
        What or whom did you wish you had available at that moment?

Have you either sought or wanted outside training/education related to your current work?
    Why or why would you?

In your opinion, how can training help TDT clinicians to feel more confident and better equipped in their delivery of TDT services?

In this next section, I will call out several training content areas. On a scale from 1 (least) to 8 (highest), please rate your preference in terms of need and/or interest:

    ____Cognitive Behavioral   _____Trauma Informed Care

    ____Assessment/Evaluation   _____Developmental Theory

    ____Trauma Theory   _____Assessment/Diagnosis

    ____Attachment Theory   _____Evidenced Based Practices

Debriefing

What advice would you give to someone who is just beginning his or her work in TDT?

Is there anything I didn't ask that I should have asked to help better understand your experience?

TRAINING NEEDS OF COMMUNITY SERVICE PROVIDERS