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Abstract

We report on a program that aimed to deliver evidence-based mental healthcare services to disadvantaged adolescents experiencing symptoms of emotional disorders in an inner-city high school in the southeastern United States. This program had two main components: in-person group counseling, and individual cognitive behavioral therapy via a telehealth platform. The goals of this paper are to: (1) describe the design, implementation, and efficacy of a school-based mental health program, (2) summarize self-reported behavioral health issues and themes generated from participant responses, and (3) assess the implications of the use of telehealth platforms in school-based behavioral health systems. Preliminary assessment of the program confirmed that this combined group counselling/teletherapy approach was acceptable by participants and a strategic and effective way to provide behavioral health services on a school campus.

Introduction:

In the United States, 10-20% of adolescents experience one or more mental health conditions (CITE Bird et al., 1988; Bitsko et al., 2018; Ghandour et al., 2019). Emotional disorders (e.g., depression, anxiety, and anger) commonly emerge during adolescence (Kessler et al., 2005) affecting as many as 10-15% of youth (AACAP Practice Parameters, 2007) with the risk of depression increasing by a factor of 2 to 4 after puberty, especially among females. Approximately 28% of adolescents will have experienced an episode of major depression by age 19, with higher rates among women (35% versus 19% for young men) (Lewinsohn et al., 1998). Data from community-based, epidemiological surveys also suggest that nearly 30% of a sample of adolescents aged 14 to 18 had a least one current symptom of major depression (Roberts et al., 1995). Furthermore, AACAP Practice Parameters (2007) cite studies in adults and one study in adolescents which suggest that each successive generation since 1940 is at greater risk for developing depressive disorders. The authors also suggest that the onset of these conditions,

even among adolescents, has begun earlier.

Suicide is also a contemporarily significant issue for youth. The recent Youth Risk Behavioral Surveillance Survey (YRBSS, 2017) reported adolescent suicide and suicidal ideation were a noteworthy and worrisome trend. More specifically, while YRBSS included only one measure (persistent feelings of sadness or hopelessness) as a proxy for suicide risk, it reflected increasing levels of suicide ideation and action. Moreover, the incidence for 4 of the 5 identifiable predictor measures increased in the negative direction. These predictors included the following: The percentage of high school students who felt sad or hopeless almost every day for two weeks or more in the past year (31.5%); percentage of high school students who seriously considered suicide in the past year (17.2%); percentage of high school students who made a suicide plan in the past year (13.6%); percentage of high school students whose suicide attempt in the past year resulted in an injury, poisoning, or overdose that had to be treated by a behavioral professional (2.4%). Only the percentage of high school students who attempted suicide (7.4%) in 2017 saw no change. Adolescents that experience these disorders, even at severe levels, are unlikely to seek services (Gulliver et al., 2010; Martínez-Hernáez et al., 2014; Rickwood et al., 2007).

Evidence-based practices, such as Cognitive Behavioral Therapy (CBT) and pharmacotherapy, are effective treatments for emotional disorders such as anxiety and depression (Ginsburg et al., 2012; Huey & Polo, 2008; Weisz et al., 2009). However, 80% of adolescents with depression and anxiety do not have access to clinicians equipped to provide CBT (Forman et al., 2009; Kilbourne et al., 2018; Zins et al., 2007). Adolescents tend to have low treatment adherence, an essential component of effective CBT. School-based mental health services are a practical option for adolescents and their parents, as they are easily accessed, low cost, and often require minimal parent involvement (Farmer et al., 2003; Kataoka et al., 2002; Rones & Hoagwood, 2000; Zins et al., 2007). The majority of adolescents that do receive

mental health services, especially non-white adolescents, enter into that care through the education system (Cummings et al., 2010; Farmer et al., 2003). School settings also can increase treatment adherence, as they remove some of the typical barriers in clinical settings (e.g., taking off work/class to attend, cost, or transportation). These factors make school-based clinics the ideal location for CBT implementation with adolescents. While school-based services are ideal for students, many schools have difficulty attracting qualified providers to deliver evidence-based care for on-site services due to budgetary limitations or lack of providers in the area. To combat this, particularly in harder-hit rural areas, many schools are implementing telehealth programs, both for physical and mental healthcare (Miller et al., 2003; Stamm, 1998; Young & Ireson, 2003).

In response to evidence-based findings, a variety of legislative initiatives in several states have attempted to provide statutes to encourage and reimburse electronic platforms for medical services. This recent legislation has encouraged the expansion of electronic interventional platforms to include but not limited to the support of intrastate services, FQHC and rural settings, as well as qualifying Medicaid patients for electronic care and electronic-based medical homes. In addition, electronic-based primary care drug treatment and behavioral health services have also benefited from laws enabling provider reimbursement for such care. These statutes have also supported behavioral health electronic interventions via the internet to expand to high school settings and have encouraged innovative pilot initiatives to bring telehealth and teletherapy platforms to these settings.

With the backdrop of expanding electronic platforms in the delivery of health care in general (Donelan et al., 2019) and in urgent health delivery (Harvey et al., 2017) in particular, the objectives of this qualitative assessment are threefold. First, it will describe the components of a mental health program in an inner-city secondary school, coupling group, and individual teletherapy to address student behavioral health issues. Second, it will summarize self-reported

behavioral health issues and themes generated from the responses of students who participated in group and individual sessions. Finally, it will discuss the implications of this approach to behavioral health that uses teletherapy in school settings as a possible portal for a vulnerable youth to receive early behavioral health services. It is hoped such applications of these behavioral health electronic platforms can provide timely intervention as well as mitigation in the increasing incidence of mental health problems between immigrant and traumatized youth.

Program Description

The theoretical models that guided this program were the Social Determinants of Health (Braveman et al., 2011) and Resiliency theories (Rutter, 1999). These approaches suggest that behavioral health concerns experienced by youth are also modulated in part by the ability to respond appropriately to a variety of internal and external non-medical pressures and/or forces that affect an individual's mental wellness. These theories also suggest that understanding the way youth experience and manage life and its stressors can suggest subsequent impact on health, especially behavioral health, and is fundamental to developing effective interventions. The pilot behavioral health initiative was embedded in a clinic under the auspices of medical school and was located at a large secondary public high school in an inner city in the southwest United States. The collaborating high school was selected for the program because youth in this area were defined as high-risk based on health disparities, federal poverty status guidelines, or immigrant status. The clinic provided healthcare to underserved populations 13-24 years of age. The school had roughly 1,800 students at any given time, but this number was constantly changing because the school experienced high turnover rates throughout the year due in part to some of the challenges the school's unique population faces. Over half of the school's students were refugees or immigrants, 97% were economically disadvantaged, and 56% had limited English proficiency. The large number of students and their behavioral needs often overwhelmed the school's counselling staff. The Institutional Review Board of the affiliated medical school

approved the protocol for the program.

Methods

The pilot program had two components. The first component consisted of a voluntary group counseling setting where behavioral health issues were discussed, and topics were identified that could require a more intense or one-on-one intervention. The groups were conducted by a licensed psychotherapist affiliated with a school-based clinic. As part of this group counseling component, students were also offered the opportunity to participate in one-on one sessions for more in-depth issues. A masters-trained psychotherapist under licensed clinical psychologist supervision conducted the individual therapy sessions via a secure, HIPAA compliant, telemedicine platform.

Participants

For the group-counseling component, 40 adolescents 15 to 19 years of age volunteered to participate. Of this initial group, 33 completed the group counselling program and participated in two groups per month during January, February, March, and April of 2019, The eight individuals who did not complete the eight-week series either did not like the format or felt that participation interfered with their classes. The second component was a one-on-one teletherapy program in which an additional eight students received individual therapy via telemedicine. The sample generated the two parts. In the first part, students volunteered to participate in the group counseling component. The second part consisted of either youth who initially participated in group counseling sessions and self-selected this option or who were recommended by the school administration for more intense care. From the group component, one female requested one-on-one teletherapy, and the seven other students (two males and five females) were recommended by the school counselor or Wraparound specialist. Teletherapy participants on average completed four sessions. Participants in the two components consisted of a variety races and nationalities and were

African American, Hispanic, Middle Eastern, and Central Asian students that reflected the diverse makeup of the school. No Anglo clients chose to be in the program. The mean participant age at entry across both program components was 17. Responses from individuals in both group and individual sessions generated themes that described the student issues and the usefulness of project participation in addressing those concerns.

Instrument and Procedures

Group counseling previously existed as part of the standard school protocol, and school staff obtained parental consent for student individual counseling teletherapy participation. At program initiation, all students were invited to evaluate various aspects of each format upon completion. All participants were queried using standardized questions of the effectiveness of each counseling platform that helped to generate student themes. In addition to recommendations for future program implementation, student responses detailing their counseling experience allowed the research team to generate five thematic questions.

Data Analysis

Transcribed group comments and subsequent structured program assessment questions provided qualitative information. Thematic analysis techniques were employed to identify emerging themes. Two members of the research team, who were not involved in conducting the individual therapy or group discussions, independently summarized the themes that emerged in the written responses. They then compared the themes and reached a consensus. The research team member who was involved in the group discussion reviewed and verified the themes based on notes taken during the group discussion.

Results

The results were organized around the five identified themes that reflected various social, emotional, and resiliency constructs, and related behavioral health concerns.

Theme 1: Teletherapy as an efficient and easy way to address behavioral health problems

in a school setting. Most of the students who voluntarily participated in the group and one-on-one sessions were pleasantly surprised that the program could also offer behavioral health services in a seamless and supportive way at their school campus. Participants reported that the on-site location provided a level of convenience usually not available to students who attended school during the week. Several comments reflected the dependence on public transportation or the school bus that by default eliminated the opportunity to leave the school to receive any type of care. In addition, for the teletherapy component, the students acknowledged that they actively participated in multiple social media platforms and were comfortable using a computer with visual capacities to interact with a therapist off-site vis-à-vis the web. One student also reported that her family liked this approach and wanted to use the services as well.

Student comment*: "It is a constant problem getting to places; no one can ever pick me up even if I am really sick."*

Student comment: "*I liked using a computer to discuss my problems and my mother also wants to participate in this computer counselling.*"

Theme 2: Group and individual teletherapy as a safe and confidential platform for receiving behavioral health counseling on a school campus. Those youths who selected both the group and individual the counseling formats expressed that they felt safe and secure participating in this counseling initiative provided by staff whom they trusted and knew. This aspect was enhanced as both formats were held in a conference room that provided a confidential space away from the regular classroom location. A surprising student comment alluded to the relative lack of privacy in their homes to discuss their problems and that that both group and one-on-one sessions afforded the participants confidential care. Students also suggested that their personal living conditions were cramped and that adults regularly monitored their phone calls and conversations.

Student comment: "*There is no privacy to discuss problems in my home. Relatives and family members are always listening in. I have issues but I do not want to burden my family*

with my problems."

Theme 3: Group and teletherapy formats can provide practical skills for adolescents who are dealing with present or past difficult situations. Because of school district policy designating this particular school as the primary location for recent immigrants and refugees, a large portion of participating students recently immigrated to the United States and came from countries experiencing active civil conflicts. Our therapists in both group and one on one sessions reported that the emotional consequences of living in these situations emerged in session. Moreover, some students seemed to have developed triggers created from past incidents that caused them to act out. For some, it was a loud and sudden noise that reminded them of the war they fled, or shouting and arguing that is often a trigger for what they see in their family. As a result, they resorted to fight or flight behaviors and most in most cases were more likely to become aggressive. Because of program participation, it appeared that these students developed more awareness of their personal triggers and reported that they learned to respond calmly, not escalate the situation, and to walk away. In addition, supplemented by some teletherapy session counseling, some students were able to identify and understand the triggers of other classmates and not initiate situations that could lead their friends to violence.

Student comment: "*My experiences as a refugee were difficult. Leaving Turkey, seeing dead bodies and hearing bombs were a problem for me. I am doing better managing how I react after participating in this program."*

Student comment: *"There are always student fights during lunch, it scares me, and I don't like it. I have learned how to avoid those situations."*

Theme 4: Teletherapy as an effective portal to deal with past trauma. Several participants recounted domestic physical abuse and the inability to talk to someone about their experiences. Others described home situations where family members were incarcerated, missing, or died. Often past problems that were revealed by participants were significant and, in some cases, severe.

Student comment: *"I was attacked, stabbed, shot at or hurt badly at home. There was constant fist fighting between my parents, I got jumped and went to the hospital, escaped my dad, and lived in a shelter. I am glad to be able to talk to someone at school."*

Student comment: *"My family was all killed in a hurricane which destroyed our home in the Virgin Islands. (I) was sent to live with my mother in the U.S. but I do not get along or know her."*

Theme 5: Teletherapy as vehicle for continued utilization among high-risk groups. A subtle overarching theme in all five categories was the importance of continued access to behavioral health because of the students' long-term life circumstances. It also appears that in spite of a variety of issues, the school was the safest and only environment afforded to these adolescents to receive behavioral health services. A sense of depression, loss, and the lack of personal control were extrapolated from many of the students' comments. The apparent lack of available resources to resolve these issues is a worrisome concept. Because of such life circumstances, continued services to address these concerns and to mitigate their intensity on the school campus are warranted.

Student comment: "*I have been dealing with so much - I think because I'm not satisfied with myself in general. 10 years ago, my dad left. 5 years ago, my abuser left home. 1 year ago, I met someone I want to grow old with. December 2018, my little brother was born."*

Discussion

This pilot behavioral health initiative coupling group and teletherapy individual counseling suggest several valuable observations. First, student participation demonstrates overall acceptability of the dual platforms in public school settings. One can speculate that this approach, similar to a variety of popular youth oriented visual platforms, had wide student appeal. In

addition, this initiative identified significant need for services based on self-reported, contemporary, behavioral health problems experienced by at-risk or marginalized groups. Finally, this assessment confirmed that this combined group counselling/teletherapy approach is considered by its adolescent users as an acceptable, strategic, and effective way to provide behavioral health services on a school campus. However, based on the observations generated from the project's conceptualization, its thematic analysis and its implementation, several additional aspects deserve comment.

First, legislation cited previously, from several states including Texas, has resolved a variety of structural and internal issues with using electronic platforms that should provide an impetus for this innovative behavioral health approach. Billing and reimbursement opportunities, as well as access to remote counseling at certain venues without an initial face-to-face encounter provided by highly qualified professionals is now a reality. Advanced HIPAA and patient health information firewalls now in place should facilitate these translational efforts. When installed, this technology can provide sufficient protection of sensitive behavioral health information generated from the teletherapy platform and reduce agency liability for unauthorized release.

This new approach also helps to meet the needs of the changing demographics of our educational system. While general immigration trends in the past decade have received more attention, the long-term impact of those immigrant experiences is not routinely evaluated. Our student responses at the conclusion of this counselling/telehealth behavioral health initiative reinforce the conclusion that the significance of any past trauma and the importance of timely and nonjudgmental delivery of the intervention should be part of a holistic approach and the standard of care in education and in other youth servicing venues.

The present approach, however, has several limitations. As a qualitative design in a school setting, participants were not randomly assigned to either component, nor was there a

control population comparison. In addition, the academic calendar limited study length and follow-up opportunities. Additionally, the unique population of this school and the struggles participants faced make it difficult to generalize results to a more typical school environment. Despite these limitations, this innovative approach was effective in providing acceptable and needed behavioral health care to a vulnerable cohort. It also provides an understanding of how social determinants such as immigration, family mobility, and violence experienced by our students impacted their health, in this case their mental health. Subsequent responses are also a testimony to the importance of cultivating resiliency among this population. In conclusion, teletherapy platforms are a cost-effective way to expand such interventions to a variety of youth servicing agencies. Community leaders would be well served to translate this advantage into stepped up applications with multiple youth-serving organizations. Moreover, public/private endeavors as seen in the partnership of a medical school and a school district can provide the next step to accelerate creative responses to behavioral health issues among vulnerable groups.

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