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Quality of School-Based Mental Health Services and Student Well-Being

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Abstract

Schools are essential in providing both students who struggle with mental health problems as well as the overall student population with services that improve well-being. Previous research has shown that, among other factors, the involvement of caregivers is important for the effectiveness of such programs, thus improving their quality. However, there is little evidence about the relationship between the quality of these mental health services and student well-being. This study aimed to fill this gap in literature. It was predicted that high quality mental health services and high caregiver involvement would be associated with increased student well-being, as indicated by low symptoms of psychopathology and negative emotions and high levels of life satisfaction, positive affect, and mindfulness. Participants included 19 caregivers, 5 middle school students, and 5 mental health professionals from two school districts in Massachusetts, who completed questionnaires that assessed the study variables. The correlations between quality of mental health services and student outcomes were not statistically significant, however, were all in the expected direction. The correlation between caregiver involvement and psychopathology was also in the right direction, but parental involvement seemed to increase negative affect and decrease life satisfaction. However, none were statistically significant. The trends in the current findings point to the need to evaluate the quality of school services, encourage caregiver involvement, educate caregivers and students about common problems and mental health illnesses, and provide ongoing training to school mental health professionals.

Quality of School-Based Mental Health Services and Student Well-Being

According to the United Nations Children's Fund (UNICEF), one in seven adolescents experience psychological disorders, such as depressive and anxiety disorders, attention-deficit/hyperactivity disorder, and conduct disorder (UNICEF, 2021). However, children do not typically receive services for these mental health problems, and approximately three-fourths of children who receive services for their mental health do so through their school (Langley et al., 2010). Mental health professionals within schools tend to be the first ones to deliver care to children because they are typically the first ones to notice when students struggle (Hanchon & Fernald, 2013). The school is a favorable place to provide preventative programs as well as programs that promote students' well-being since most children attend school (Copeland et al., 2010).

The importance of accessible and quality mental health services to adolescents is acknowledged at the federal level through various initiatives. Executive Order 13263 (President's New Freedom Commission on Mental Health, n.d.), the No Child Left Behind Act (U.S. Department of Education Office of Elementary and Secondary Education, 2002), and the Mental Health in Schools Act of 2015 (Congress.gov, 2015) all stress the importance of the integration of the school system and the mental health system. These initiatives call upon schools to provide quality mental health services that are accessible to all students. They also state that the federal government shall provide funding for schools to support such services.

The need for quality mental health services in schools is important, but especially today during the COVID-19 pandemic. The pandemic has forced schools to shut down and students to learn remotely from home. For many students, however, school is a social hub, a place to receive food, and a home away from home. School closures have impacted the social and educational

development, nutrition, and well-being of many students (Ghosh et al., 2020). Surveys show that one in seven parents believe that their child's overall mental health has become worse since the beginning of the pandemic (Patrick et al., 2020). Students with preexisting mental health problems have been especially affected by the shutdown of schools as they experienced interruptions in the mental health services provided by the schools. Furthermore, social isolation may worsen students' mental health. Those with depression, for example, may experience a relapse of symptoms due to social isolation (Khan et al., 2020).

School psychologists, guidance counselors, therapists, social workers, and other mental health professionals are employed by schools to provide students with mental health services. The need for high quality mental health professionals is essential to effectively meet not only the needs of students who struggle with mental illnesses, but also promoting the general well-being of all students.

In the following sections, the author discusses the types of mental health services that schools can provide and offers evidence that such programs support student mental health and well-being. Because caregivers play an important role in ensuring compliance with any mental health intervention, the author presents research on how caregiver involvement is related to the success of school-based programs. Lastly, a review of the various factors that threaten the quality of these services is discussed along with related evidence.

Types of Mental Health Services Provided by Schools

Schools can provide an abundance of mental health services that promote well-being when there is proper funding, staffing, and support from administration and families. Assessment, behavioral management, counseling, and crisis intervention are mental health

services that schools often provide to students (Teich et al., 2007). Mindfulness-based activities, such as meditation, are also mental health services many schools offer (Singh & Singh, 2021).

Some schools actively screen for signs of mental health disorders to determine the mental health needs of their students and to tailor their services and programs to them (Atkins et al., 2010). For example, the Developmental Pathways Screening Program (DPSP) is designed to identify students who experience emotional difficulties as they enter middle school. The transition from elementary to middle school is often a time of susceptibility and vulnerability that can impact students' self-esteem, academic performance, and psychological adjustment. Students who are identified as being emotionally distressed are provided further assessment and services to support their well-being (Stoep et al., 2005).

Behavioral management interventions are often applied within the school to promote positive behaviors and improve functioning of the students. Positive Behavior Supports (PBS) is often implemented within schools to improve social behavior among students and the overall school climate, and to prevent or change nonadaptive behavioral patterns among all students within the school. Intervention programs that target the whole school population have great potential in promoting the well-being of all students and not just those with mental health problems (Tome et al., 2021; O'Reilly et al., 2018). Other programs that target behavioral changes amongst students include the Fast Track, the Child Life and Attention Skills (CLAS), and the Coping Power Programs. The Fast Track program is designed to prevent anti-social behavior and externalizing disorders among students who have been identified as exhibiting these behaviors by teachers and/or caregivers. The CLAS program is designed to improve attention, organizational, and social skills among students with attention-deficit hyperactivity disorder (Johnson et al., 2014). The Coping Power Program targets four factors that have been

found to be predictive of adolescent substance abuse and mental health disorders: children's social capacity, children's self-regulation and self-control, children's social connection with their school, and the caregiver's consistent discipline and involvement with their children (Lochman et al., 2007).

Counseling can be offered by several staff within schools, including school psychologists, counselors, social workers, administration, and teachers (Ehly & Dustin, 1989). Counseling services can include group/family therapy, individual counseling, and cognitive behavior therapy. Counseling can be used to help individual students cope with mental health problems, such as mood disorders, anxiety, and depression. The onset of many psychological disorders occurs during adolescence (Kessler et al., 2007); therefore, counseling is essential for students with developing mental health problems.

Schools are called to provide services to all students during crises that affect the whole student population, such as the death of a classmate or staff member, school shootings, and health threats. Crisis interventions are usually provided in three levels. The first level involves teaching students about safety before a crisis occurs. These can include conflict resolution, alcohol and drug awareness programs, driving and weapon safety, and suicide prevention programs. The second level includes steps taken following a crisis to help reduce the number of effects the situation has. This includes addressing the safety of those students involved, notification to caregivers, and media response to inform the community. The third level includes long-term counseling and other services for students who are involved and have been psychologically impacted by the crisis. Crisis interventions within schools' support students following a traumatic event that occurred within the school or in the individual's personal life (Knox & Robert, 2005). Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is an

example of a third level crisis intervention. This intervention involves ten group sessions with multiple students experiencing similar outcomes to a traumatic experience, aiming to help them understand and manage the traumatic event (Allison & Ferreria, 2017). In addition to learning about their trauma, the students engage in relaxation practice, trauma exposure, cognitive therapy, and social problem-solving. The intervention also involves caregivers, who in two sessions learn about their child's processing of the traumatic event and the skills the students practiced during their group sessions (Santiago et al., 2013).

School-wide interventions can be implemented to promote the well-being of all students, not just those with mental disorders. This is often done through mindfulness-based programs (MBP) and exercises. MBP's are applied to help individuals cope with anxiety, depression, stress, substance use, and externalizing behaviors (Singh & Singh, 2021). When meditation interventions, a type of MBP, are implemented in schools, students report having a significant reduction in levels of anxiety and stress, which impact the overall students' functioning (Water et al., 2014). Among the most frequently used programs in schools are the Integrative Contemplative Pedagogy (ICP), Group Mindfulness Therapy (GMT), and Mindfulness in Schools Programme (MISP). Through ICP, students learn how to perform meditation practices: breath awareness, awareness of thoughts, sensations and feelings, and body sweep. Body sweep is paying attention to various sensations within the body. GMT teaches students to experience moment awareness, body scanning, loving practices, and mindful breathing, walking, and eating. This program includes after-school sessions that are either in school or at-home practices. GMT is intended to reduce anxiety, relieve stress, and improve attention. Lastly, MISP is a program that is implemented by schoolteachers who teach their students mindful practices that originate from mindfulness-based cognitive therapy and stress reduction. This program is intended to help

all students, but especially those who experience stress and have mental health problems (Singh & Singh, 2021).

The Role of School-Based Interventions in Students Well-Being

Screening, behavioral management, counseling, crisis interventions, and mindfulness-based practices are all mental health services that schools may provide. These services can be further broken up into four categories: those that provide screening, programs that target the whole student population, interventions that target students who present symptoms of poor mental health, and services that target students with diagnosed mental health disorders (Hoover & Bostic, 2021).

Screening is important for identifying students who show symptoms of mental health disorders and especially so during adolescence because this is the time of onset for common mental health disorders. The impulse-control disorders have the earliest median age of onset. These being 8 years for attention-deficit hyperactivity disorder, 11 for conduct disorder, and 16.5 for intermittent explosive disorder. Phobias and separation anxiety disorder have a median age of onset of 12 years. Substance use disorders are rare before the mid-teen years but show a rapid increase in onset in adolescence and early adulthood. Psychotic disorders have a median age of onset of 16 (Kessler et al., 2007). Screening in schools can help identify students who are at risk of developing these various mental health disorders and provide them with preventative services.

School-wide interventions can be used to promote positive well-being of all students within the school. School-based programs have been found to be effective at decreasing anxiety and other mental health problems that may occur in the student population (Tome et al., 2021). The mindfulness programs previously discussed are examples of school-wide interventions that positively impact all students' mental health and well-being. When students who participated in

an ICP program were compared to students who did not participate, the results suggested that ICP improved students' externalizing and internalizing problems, increased attention, decreased rates of suicidality, enhanced attention and awareness, and promoted more flexible coping strategies (Singh & Singh, 2021).

Mental health services that are provided to those with symptoms of psychopathology are also called preventative services. Preventative services have been found to significantly reduce problems, such as depressive symptoms, anxiety, aggression, noncompliance, and disruptive behaviors, and increase competencies in academic performance and social relations (Durlak & Wells, 1998). Services that target behavioral management have been found to lower antisocial behavior, decrease rates of externalizing disorders, increase attention, improve organizational skills (Johnson et al., 2014), lessen aggressive behaviors, and reduce delinquency among students (Lochman et al., 2007).

Mental health services are primarily provided to those who have been diagnosed with a mental health disorder. School-based mental health services have been found to be effective in treating behavior disorders, substance use problems, and mood disorders. One common school-based mental health service that was discussed earlier is CBITS. This group therapy intervention that targets post-traumatic stress disorder (PTSD) in children has yielded significant results. For example, Allison and Ferreria (2017) applied this intervention to Latino students from a school in New Orleans, Louisiana who were identified as having PTSD by completing the Child Posttraumatic Symptom Scale (CPSS). Following the intervention, the mean number of trauma symptoms decreased by 6.09 and the mean number of depressive symptoms decreased by 9.91; both of which were shown to be statistically significant. Therefore, CBITS has been shown to decrease levels of depression symptoms and PTSD in those with a previous diagnosis of PTSD.

Research supports that various school-based therapy interventions can effectively support students with diagnosed mental health disorders. One hundred righty-one middle and high school students who were receiving school-based therapy participated in a study by Nabors and Reynolds (2000). A comparison group of 113 middle and high school students was also recruited. Clinicians providing these services identified behavior problems, family problems, poor social skills, anger problems, low self-esteem, depression, anxiety, experiences of abuse or violence, grief from the death of a loved one, sexually transmitted diseases, substance abuse, and hyperactivity and attention problems as the most common reasons for those receiving services. Clinicians completed the Child and Adolescent Functional Assessment (CAFAS) to assess outcomes for students receiving the services. CAFAS scores decreased over time, with significant differences at the 3- and 6-month marks. Students also completed the Youth Self-Report Form (YSR) to assess their perceptions of their behavioral and emotional functioning. YSR scores decreased over six months, showing an improvement in functioning, although this decrease was smaller in magnitude than the one observed in the CAFAS. The researchers were able to conclude that school-based mental health services and therapy improve behavioral and emotional functioning for students presenting a range of psychopathology.

Furthermore, school-based interventions that target the well-being of all students, such as mindfulness programs, are shown to improve indices of positive functioning, such as higher life satisfaction, happiness, academic performance, and social competence in all students (Copeland et al., 2010). Students with high life satisfaction and happiness, tend to find a greater interest and value in their learning. They are also more likely to have higher perceived academic self-efficacy and engage in more educational activities, all of which can have a positive impact on overall academic performance (Wu et al., 2020). On the other hand, students with psychopathological

symptoms, such as depression, are more likely to experience lower academic success (Monzonis-Cardia et al., 2021). Thus, addressing the well-being of all students can help improve the academic success of students (Baskin et al., 2010). Mental health and social relationships have also been found to be positively correlated with one another (Kiecolt et al., 2008). Positive relationships and support from teachers and caregivers significantly improve the mental health and well-being of adolescents. Students who reported feeling connected to peers in school environments also reported higher levels of life satisfaction and lower internalizing symptoms (Moore et al., 2018). Addressing mental health problems in adolescents can improve their relationships with others and ameliorating adolescents' relationships with others can enhance their mental health.

Caregiver Involvement in School-Based Interventions

Mental health services for students work best when the caregivers are actively involved in the interventions (Rones & Hoagwood, 2000). When the caregivers are involved, the intervention produces positive changes quickly and shows improvements in the child's behavior and mental health (Olvera & Olvera., 2012; Vanderbleek, 2004). An example of a school-based mental health program that includes caregiver sessions is CBITS, where caregivers learn how to help their child process and cope with their experienced trauma. Caregivers who participate in CBITS sessions often report wanting to learn how to better communicate with their child to help them with their trauma (Santiago et al., 2013). This creates a closer relationship between caregiver and child, helping to improve the outcome of CBITS (Santiago et al., 2015).

Caregiver involvement in child mental health interventions has been found to be associated with more positive caregiving and an improved relationship between the two. The child's behavior also tends to improve because of this improved relationship with their

caregivers (Shucksmith et al., 2010). The Incredible Years Parent Program is a program that is designed to train and teach caregivers to promote more positive parenting. The program is especially targeted for caregivers whose child has oppositional defiant disorder (ODD), conduct disorder (CD), or attention-deficit hyperactivity disorder (ADHD). After completion of the program, caregivers use less harsh discipline, increase their praise, and apply more appropriate discipline, such as verbal discipline. This program significantly improved the interactions and relationship between caregiver and child, thus improving the child's well-being (Letarte et al., 2010).

The Incredible Years Program and other interventions that involve the caregiver help to improve parental warmth toward their child. Overall parental warmth and involvement have a positive relationship with their child's capability of problem-focused coping strategies in adulthood. Moreover, children who experienced warmth from their caregiver are more likely to report higher positive affect, lower negative affect, and increased sense of purpose in life as adults (Moran et al., 2018). In a study conducted by Wenk et al. (1994), 2000 children who had both a maternal and paternal figure completed a questionnaire to assess their relationship with their caregivers and their level of well-being. The results revealed that both behavioral and emotional involvement from both parents were positively related with increased levels of well-being.

Caregiver involvement also helps to foster a more positive climate within the school. Highly involved caregivers may help to create a caring and supportive community within schools, which helps to promote positive mental health in students (Wang et al., 2019). Some ways schools can expand involvement of caregivers is through specialized outreach programs for caregivers with children with mental health needs or through family support techniques, such as

including the caregiver in their child's counseling services (Atkins et al., 2010) or asking for their feedback and suggestions on how to improve the mental health services that are offered.

Caregivers play a critical role in their child's well-being and overall success even outside of school-based mental health services (Wang et al., 2019). Caregiver involvement in their child's academics has not only been found to positively predict their mental health, but also their overall academic success. The most effective way has been found to be academic socialization, in which the caregiver discusses educational and future career goals with their child. Through these discussions and active involvement, the children know that they have their caregivers' support. These discussions also help the child understand the importance of their education, thus increasing their appreciation of the education they receive which in turn predicts positive well-being (Wang & Shiekh-Khalil, 2014).

Quality of Mental Health Services in Schools

Although caregiver involvement supports the effectiveness of school-based mental health services and the overall emotional, social, and academic adjustment of students in the school setting, there are other factors that threaten the efficacy of these services. One of these factors is the number of mental health professionals employed by the school. The lack of mental health professionals in schools throughout the United States, especially school psychologists, is concerning. The National Association of School Psychology (NASP) recommends there be one school psychologist per every 500 students. However, the national ratio is 1:1211 and in some states this ratio is approaching 1:5000 (NASP, 2021). The shortage of school psychologists creates an overwhelming workload leading to burnout. Boccio et al. (2016) identified three dimensions of burnout: emotional exhaustion, depersonalization, and personal achievement. Emotional exhaustion is when one becomes emotionally drained or overextended by the

occupational demands. Depersonalization refers to having detached attitudes from one's clients. A diminished sense of personal achievement occurs when one holds a negative outlook regarding their personal effort, skills, and achievements. Moreover, Boccio et al. (2016) investigated these dimensions in a sample of school psychologists who filled out the School Psychology Occupational Well-Being Survey (SPOWS). The researchers found that 36.8% of school psychologists reported having high levels of emotional exhaustion, 4.8% reported having high levels of depersonalization, and 53.3% reported having high levels of personal achievement. Burnout was also associated with lower work quality and quality of services that they provided to students, greater dissatisfaction with their occupation, and a greater number of workdays absent. In addition, many school psychologists are not able to provide as many students as they would like to with mental health services. School psychologists spend on average two-thirds of their time involved in the assessment and placement of students into special education programs, even though they have a desire to provide counseling services to students. When a sample of school psychologists was asked if they believed that providing counseling services should be a role of school psychologists, the average score was a 4.46 out of 5, indicating a high desire to engage in counseling with students (Hanchon & Fernald, 2013).

Another factor that affects the quality of mental health services provided by schools is funding. With limited funding, the amount and types of services decline. Striving to meet the needs of the current students, there is great hesitancy in approving educational plans for additional students. School psychologists often feel the pressure to deny services to keep costs down. Additionally, improper funding leads to inadequate materials, interventions, and assessments. Boccio et al. (2016) found that one-third of participants reported having received

administrative pressures to perform unethically in their career. Approximately half said that these unethical practices were due to cost-related reasons.

The quality of mental health services also depends on the schooling that mental health professionals received during their graduate programs. In a study conducted by Hanchon and Fernald (2013), school psychologists completed a questionnaire about their training in counseling while they were in graduate school. Although 92% of respondents said that they received some training in providing counseling services, 40% said that they were insufficiently prepared by their program. When asked about their perceived confidence in providing school-based counseling services to students, the average score was a 3.2 out of 5, suggesting an average level of perceived preparedness.

Not only is the counseling education provided by school psychology programs lacking, there is also a lack of training programs in general for school psychologists. There are currently only 191 NASP-accredited school psychology programs in the United States and some states, such as Hawaii, have no accredited school psychology programs. The enrollment in these programs is low as of the 2020-2021 academic school year due to a low number of applicants and high selectivity (NASP, 2021). There are, however, other graduate programs throughout the United States that prepare individuals for other mental health related careers in school settings, such as social work and guidance counseling.

The Present Study

Most students who receive mental health services receive them through school (Langley et al., 2010). There are many types of school-based mental health services. These include assessment, behavioral management, counseling, crisis interventions (Teich et al., 2007), and mindfulness-based practices (Singh & Singh, 2021). These services fall into four categories:

those that provide screening, interventions that target the whole student population, programs that target those with symptoms of poor mental health, and services that target those with diagnosed mental health disorders (Hoover & Bostic, 2021).

Because many mental health disorders have an onset during the school years, screening is vital in identifying students with symptoms of poor mental health (Kessler et al., 2007). These students can then receive preventative supports to reduce depressive behaviors, anxiety, aggression, noncompliance, disruptive behaviors (Darlak & Wells, 1998), antisocial behavior, attention, and organizational difficulties (Johnson et al., 2014), and delinquency (Lochman et al., 2007). Most school-based mental health services, however, target those with diagnosed mental health disorders. These often decrease the severity of symptoms (Allison & Ferreria, 2017) and improve behavioral and emotional functioning (Nabors & Reynolds, 2000). Overall, school-based interventions and preventative programs can help improve life satisfaction, happiness, academic performance, and social competence, all of which are components of positive well-being and support mental health (Monzonia-Cardia et al., 2021; Wu et al., 2020; Moore et al., 2018; Baskin et al., 2010; Copeland et al., 2010; Kiecolt et al., 2008).

The factors that support the success of these programs include caregiver involvement and various characteristics of services provided by schools. Mental health services for students work best when the caregiver is actively involved in the intervention (Olvera & Olvera, 2012; Vanderbleek, 2004; Rones & Hoagwood, 2000). For example, when caregivers are involved in the parent sessions of their child's CBITS intervention, the relationship between caregiver and child and the understanding of their child's problems both improve. This has a positive impact on the student's overall well-being (Santiago et al., 2015; Santiago et al., 2013; Shucksmith et al., 2010). Moreover, teaching positive parenting skills to caregivers whose children have behavioral

problems has improved children's positive functioning (Letarte et al., 2010). When both caregivers are actively involved in their education and exhibit high levels of warmth, their children report higher levels of well-being (Moran et al., 2018; Wang & Sheikh-Khalil, 2014; Wenk et al., 1994).

There are also risk factors for the effectiveness of school-based mental health services. These include shortages of mental health professionals in the school, burnout amongst mental health professionals, lack of funding (Boccio et al., 2016), insufficient training in counseling students (Hanchon & Fernald, 2013), and limited school psychology programs offered in the United States (NASP, 2021).

Although school-based programs bring about positive effects on children's well-being and mental health, schools often suffer from limited resources to either offer such programs or have them implemented effectively. Currently, there is limited evidence to demonstrate the link between the quality of services and student mental health outcomes. The goal of this study was to address this gap in the literature by investigating how caregivers and mental health professionals perceive the quality of mental health services provided by schools and how this related to the levels of well-being among students. Students' mental health and overall well-being were assessed by asking students to self-report on symptoms of psychopathology (e.g., internalizing and externalizing symptoms), as well as their emotions, and life satisfaction. Because mindfulness has been shown to be related to positive emotional, social, and academic adjustment (Singh & Singh, 2021; Water et al., 2014), students also reported their mindfulness as another index of positive well-being. The levels of perceived caregiver involvement within the school were taken into consideration. It was predicted that the perceived quality of school-based mental health services would be positively associated with positive indices of well-being (e.g.,

life satisfaction, positive emotions, mindfulness) and negatively associated with symptoms of psychopathology (e.g., anxiety). It was also expected that caregiver involvement would be positively associated with children's positive outcomes and improved mental health (e.g., lower symptoms of psychopathology).

Method

Participants

Participants included five mental health professionals, five middle school students, and 19 caregivers from two public middle schools in Northern and Central Massachusetts. Students (male, 40%; female, 40%; non-binary, 20%) were in grades 6 (20%), 7 (40%), and 8 (40%). Students came from a variety of ethnic backgrounds (40% white, 40% Asian American, 20% Latinx). Most students and their caregivers came from intact families (50%; 25% coparents, 25% other). Families came from a variety of income levels (25% <$49,999, 25% $50,000-$74,999, 25% $100,000-$124,999, 25% $150,000-$174,999). Half of the respondents were mothers of the children and 50% were fathers. The average age of the parents was 43.5. The majority reported having a graduate degree (75%) and the remaining had a college education. Due to technical difficulties, only 21% of caregiver participants were able to provide demographic information. Participants were recruited through an invitation letter and a consent form via email that was sent to the families by the principal of the middle school. Parents consented for both them and their child, however, the child also had the opportunity to consent for themselves. Data collection took place during the spring of 2022 and the fall of 2023.

Measures

Mental health professionals, students, and their caregivers completed several questionnaires to measure the study variables. Students and caregivers completed surveys about demographic information. Students completed questionnaires about their mental health and well-being (i.e., psychopathology, life satisfaction, positive and negative affect, mindfulness). Caregivers assessed the quality of the school-based mental health services and their involvement in the services provided by schools. Mental health professionals completed questionnaires about the quality of mental health services within the school.

Student Well-Being

Psychopathology. Students completed the Pediatric Symptom Checklist Youth Report (Y-PSC) to assess symptoms of psychopathology (Jellinek et al., 1986). This is a 35-item self-report. This scale consists of 35 statements that are rated on a 3-point scale (0 = "Never", 1 = "Sometimes", and 2 = "Often"). The scores for each statement were added together to get the final score. If the final score was 28 or above, then the participant was considered to have "psychological impairment" and further evaluation may be needed. In addition to the total score, the scale reveals the child's level of attention difficulties (e.g., "fidgety, unable to sit still"), internalizing problems (e.g., "feel sad, unhappy"), and externalizing problems (e.g., "fight with other children"). The scale has been used for research and initial diagnostic purposes and has high reliability and validity (Pagano et al., 2000; Appendix B).

Life Satisfaction. Students completed the Multidimensional Student Life Satisfaction Scale (MSLSS) to measure their overall life satisfaction (Huebner, 1991a; Huebner, 1991b). This scale consists of 40 items, each rated on a 5-point Likert scale ranging from "strongly disagree" to "strongly agree". The statements are categorized under five domains measuring satisfaction in different areas of life: family (e.g., "I like spending time with my parents"), friends (e.g., "My

friends are nice to me"), school (e.g., "I learn a lot at school"), living environment (e.g., "There are lots of fun things to do where I live"), and self (e.g., "I am fun to be around"). The total score was the sum of all responses. Higher scores indicate higher levels of life satisfaction; however, some items are reverse scored due to negative wording (e.g., "I feel bad at school"). The scale has been used for research to assess life satisfaction and has high reliability and validity (Gilman & Huebner, 2000; Appendix C).

Positive and Negative Affect. Students completed the Positive and Negative Affect Scale for Children (PANAS-C) to measure subjective well-being (Ebesutani, et al., 2012). The scale consists of 10 words that described either their positive (happy, cheerful, proud, joyful, and lively) or negative emotions (sad, scared, miserable, afraid, and mad). The participants were asked to rate the extent to which they experienced each emotion during the last week using a 5-point scale, ranging from "very slightly" to "extremely". The scale has been used for research to assess subjective happiness and has high reliability and validity (Smees et al., 2020; Appendix D).

Mindfulness. Students completed the Mindful Attention Awareness Scale for Children (MAAS-C) to measure their mindfulness (Brown & Ryan, 2003). This is a 15-item self-report (e.g., "I can't stop thinking about the past of the future"). These questions fall under five domains: cognitive (e.g., "I forget a person's name almost as soon as I've been told it for the first time"), emotional (e.g., "I could be feeling a certain way and not realize it until later"), physical (e.g., "Usually, I do not notice if my body feels tense of uncomfortable until it gets really bad"), interpersonal (e.g., "I focus so much on a future goal I want to achieve that I don't pay attention to what I am doing right now to reach it"), and general (e.g., "I snack without being aware that I'm eating"). Each question was answered with a 5-point Likert scale, ranging from "strongly

disagree" to "strongly agree". Items were reversed scored and the average was used in calculations, with higher total scores indicating higher levels of mindfulness. This scale has been widely used for research purposes to assess the effectiveness of mindfulness-based programs in schools and has high reliability and validity (Goodman et al., 2017;)pendix E).

Quality of School-Based Mental Health Services

Mental health professionals completed questions selected from the School Mental Health Quality Assessment Questionnaire (SMHQAQ) to assess the quality of the mental health services within the school (Weist et al., 2006). These questions were rephrased into statements (e.g., the question "Do you have services in place to help students contend with common risk and stress factors?" was changed to the statement "The school has services in place to help students contend with common risk and stress factors"). Furthermore, some questions were broken up into two separate statements to facilitate the process of rating. Participants used a 5-point Likert scale ranging from "strongly disagree" to "strongly agree" to rate their agreement with each statement. The option of "do not know" was also added to accommodate participants who did not have sufficient information to rate the statement. The statements target different aspects of school-based services (e.g., screening) to caseload of school mental health professionals and connections with families (Appendix F).

Caregivers also evaluated the quality of mental health services provided by the school by answering questions also adapted from the SMHQAQ (Weist et al., 2006). These questions were also rephrased into statements, and some were broken into separate statements. In general, the statements assessed the caregivers' knowledge of the types of services provided by the school, their perception of the effectiveness of such services, and their level of participation in school-based initiatives aiming to improve children's well-being (Appendix G).

Caregivers whose children receive services from the school additionally completed the Youth Services Survey for Families (YSS-F) to assess their appraisal of the quality of such services (Mental Health Statistics Improvement Plan, 1999). The YSS-F is a 25-item self-report that assesses caregivers' satisfaction in several domains: cultural sensitivity (e.g., "Staff understood my family's cultural traditions"), access (e.g., "The location was convenient for us"), participation in treatment (e.g., "I helped to choose my child's services"), appropriateness (e.g., "The services were right for us"), and outcome (e.g., "My family and child got the help we wanted"; Riley et al., 2005). These statements are rated using a 5-point Likert scale ranging from "strongly agree" to "strongly disagree". There was also an option that reads "do not know" for participants who do not have an answer. Scores to answers in a single domain were added together and divided by the total number of questions to retrieve the score. Scores greater than 3.5 were in the positive range for that domain. The scale has been used for research and has high reliability and validity (Shafer & Temple, 2013; Appendix H).

Caregiver Involvement

Select questions from both the SMHQAQ and the YSS-F asked about the caregiver's involvement in the mental health programs in the school were used (Weist et al., 2006; Mental Health Statistics Improvement Plan, 1999).

Procedure

Participants were emailed a link to Qualtrics in which they completed their surveys. Caregivers and children used the same link. After the caregivers completed their part, they invited their child to read the consent form and choose to either participate or not. The caregivers were instructed to allow children privacy to complete the questionnaires.

Results

The statistical analyses that were performed were limited to descriptive and correlational analyses due to the small sample size. The main outcome variables of the study included the total psychopathology scores of the students as rated by both them and their caregivers, life satisfaction, positive and negative emotions, and mindfulness, as rated by the children. Furthermore, the analyses did not include sub-variables of psychopathology (i.e., attention, internalizing behaviors, externalizing behaviors) and life satisfaction (i.e., family, friends, school, living environment, self) because such analyses were not considered meaningful beyond what the analyses with total scores would reveal. The predictor variables of the study included the total score of the SMHSQAQ. Since only one caregiver completed the YSS-F, the author calculated the variable of caregiver involvement by averaging the score of three items from the SMHSQAQ that was completed by the caregivers (Q6, Q7, and Q8). The items included questions about how well the school educates caregivers about the mental health of their children as well as involves them in the mental health services that are offered by the school (e.g., "the school offers opportunities that educate caregivers about children's mental health"). The Cronbach's alpha for the quality of mental health services as rated by caregivers was 0.96, the quality of mental health services as rated by mental health professionals was 0.92, and for caregiver involvement was 0.92. Lastly, a qualitative analysis of the caregivers' suggestions on how to improve the quality of mental health services at schools was also conducted.

Descriptive analyses of the outcome variables showed that the caregivers rated their child's psychopathology (M = 16.11, SD = 8.37) lower than the children rated their own (M = 21.20, SD = 17.51; Table 1). Students rated their levels of life satisfaction an average of 168.60 (SD = 41.49), which was above average (maximum possible score = 200). Students rated their

levels of positive emotions 3.16 out of 5 (*SD* = 1.60) and their levels of negative emotions 2.04 out of 5 (*SD* = 1.56). Mindfulness in students was also scored above average (*M* = 3.72, *SD* = 1.13). Therefore, the children did not exhibit high levels of psychopathology and reported being happy and mindful.

Descriptive analyses of the predictor variables indicate that both caregivers and mental health professionals rated the services quality to be above the average (Table 1). However, the caregivers rated the quality of the services (*M* = 3.25, *SD* = 0.18) slightly higher than the mental health professionals (*M* = 3.14, *SD* = 0.54). Examining specific items indicate that caregivers rated questions regarding the delivery of treatment by schools and their involvement in treatment below average. They rated questions pertaining to inclusion, confidentiality, and assessment above the average (Table 5). Mental health professionals rated questions about training, the use of input from families and other individuals, the evaluation of current programs, and family involvement as below average, and questions pertaining to inclusion and collaboration above average. However, the lowest rating was regarding the existence of an advisory board responsible for supersizing all school services to students (Table 6).

In addition, the author analyzed the suggestions that caregivers provided regarding how schools can improve the mental health services that they offer to students (Table 7). Caregivers wanted to see more educational opportunities for both themselves and students regarding bullying and the use of online platforms, such as social media. Caregivers also noted that more staff and the use of more SEL practices would be helpful in improving the mental health services for students.

To address the hypothesis that increased quality of mental health services would be associated with decreased symptoms of psychopathology and increased positive student

outcomes, the author conducted correlational analyses between caregiver-rated quality of mental health services and the variables of caregiver-rated child psychopathology, child-rated psychopathology, life satisfaction, positive affect, negative affect, and mindfulness. Results showed non-significant correlations, but all the associations were in the expected direction (Table 2). There was a negative correlation between quality of services and psychopathology as rated by both the caregivers, $r(3) = -0.22$, $p = 0.19$, and children, $r(3) = -0.74$, $\underline{p} = 0.08$, as well as between quality of services and negative emotions, $r(3) = -0.63$, $p = 0.13$. There was a positive correlation between quality of services and life satisfaction, $r(3) = 0.61$, $p = 0.14$, positive emotions, $r(3) = 0.08$, $p = 0.45$, and mindfulness, $r(3) = 0.59$, $p = 0.15$.

To investigate the hypothesis that increased caregiver involvement would also be associated with decreased symptoms of psychopathology and increased positive student outcomes, correlational analyses were conducted between caregiver involvement with caregiver-rated psychopathology, child-rated psychopathology, life satisfaction, positive and negative emotion, and mindfulness (Table 3). Results again showed non-significant correlations (Table 3). There was a negative correlation between caregiver involvement and psychopathology as scored by both caregivers, $r(3) = -0.20$, $p = 0.23$, and children, $r(3) = -0.17$, $p = 0.42$, as expected. However, the negative correlation between caregiver involvement and life satisfaction, $r(3) = -0.29$, $p = 0.36$, and positive emotions, $r(3) = -0.73$, $p = 0.13$ were contrary to expectation. Also unexpected was the positive correlation between the quality of services and negative emotions, $r(3) = 0.20$, $p = 0.40$. Lastly, the positive correlation between caregiver involvement and mindfulness, $r(3) = 0.49$, $p = 0.25$, was in the predicted direction.

Moreover, the author investigated the intercorrelations between the outcome variables. As shown in Table 4, there were two significant correlations. Most of the correlations were in the

expected direction and many were close to being significant. There was a significant positive correlation between child-rated psychopathology and negative emotions, $r(3) = 0.89$, $p = 0.04$, and a significant negative correlation between life satisfaction and negative emotions, $r(3) = -0.97$, $p = 0.01$.

Discussion

The aim of the present study was to establish the associations between the quality of mental health services that are offered by schools and the well-being of students. The well-being of students was assessed by symptoms of psychopathology, life satisfaction, positive and negative emotions, and mindfulness. This was the first study to attempt to find a direct relationship between quality of services and student outcomes. The associations between the level of caregiver involvement with student well-being were also considered, as caregiver involvement has been found to be critical for the improvement of children who receive services (Olvera & Olvera, 2012; Rones & Hoagwood, 2009; Vanderbleek, 2004). It was hypothesized that higher quality of mental health services and greater involvement by the caregiver would predict decreased symptoms of psychopathology and increased levels of positive well-being (life satisfaction, positive emotion, mindfulness). Although the results did not successfully support these hypotheses, they were mostly in the predicted direction.

The association between the quality of mental health services and the variables of student well-being were not statistically significant, but all correlations were as expected. Higher quality mental health services were associated with lower symptoms of psychopathology. Prior research has shown that preventative and intervention programs offered at schools often improve the well-being and mental health of students (Tome et al., 2021; Allison & Ferreria, 2017; Johnson et al.,

2014; Nabors & Reynolds, 2000; Durlak & Wells, 1998). The current results imply that there is a linear relationship between quality of these programs and psychopathology. Moreover, this is the first study to expand this relationship to positive outcomes in students. Previous literature has shown the connection between mindfulness programs and well-being and the current results highlight the importance of using quality programs that increase children's life satisfaction and happiness in the school setting (Singh & Singh, 2021; Copeland et al., 2010).

Furthermore, these results reflect the importance of quality and accessible mental health services in schools for all students, not just for those with mental health issues. According to Hoover and Bostic (2021), there is a need for universal mental health screening and interventions for all students. In fact, the parents in this study recommended services that help all students deal with daily challenges not just students who have a mental illness. Parents specifically reported the need to support students dealing with bullying and the effects of social media, which can often have a negative impact on student's mental health (Arslan, Allen, & Tanhan, 2021; O'Reilly et al., 2018). Parents also requested programs that educate them about mental health and programs for children at this age. Finally, parents wanted more information about services that are offered by schools.

It is interesting that caregivers and mental health professionals rated the quality of mental health services slightly above average and showed similar trends. Both caregivers and mental health professionals pointed out the lack of an advisory board in schools, which invites caregivers to provide their suggestions and feedback for the mental health services that are offered. However, both caregivers and mental health professionals rated the schools as having high levels of confidentially and inclusion, revealing the high levels of ethical practice within the schools.

Intercorrelations between outcome variables were also consistent with previous literature. The significant positive correlation between negative emotions with child-rated psychopathology reveals that as children experience increased symptoms of psychopathology, their levels of negative emotions and feelings also increase. This makes sense as many individuals with mental health issues typically have more negative than positive emotions. The significant positive correlation between negative emotions and life satisfaction reveals that as children experience increased negative emotions, they also experience lower levels of life satisfaction. Previous literature has reflected that negative affect is a predictor of poor life satisfaction (Diener, 1984). Although not significant, positive correlations between mindfulness with life satisfaction and positive affect were reported. Copeland et al. (2010) found that mindfulness-based programs that are provided by schools improved student life satisfaction and happiness, consistent with the results of the present study. Another important finding, even though not significant, was the strong correlation between child-rated psychopathology and caregiver-rated psychopathology. This reveals that both children and caregivers rated the child's psychological well-being similarly to one another. This suggests that caregivers are aware of the psychological state and well-being of their child.

Correlations between caregiver involvement in mental health services and children's outcomes were interesting, as not all were found to be in the expected direction. Previous research has shown that mental health services work best when the caregiver is actively involved (Rones & Hoagwood, 2000). Previous literature has also demonstrated that when caregivers were involved more in their child's life and provided their child with more warmth, the child experienced fewer mental health difficulties and suicidal thoughts and behaviors (Wang et al., 2019). Therefore, the negative correlations between caregiver involvement with both child- and

caregiver-rated psychopathology and the positive correlation between caregiver involvement and mindfulness were expected and were reflected by the results. However, the negative correlations between caregiver involvement with positive emotions and life satisfaction and the positive correlation with negative emotions were unexpected and contrary to previous literature showing that caregiver involvement improves the well-being of the child. However, these results may simply imply that children of this age do not wish their caregivers to be heavily involved in the mental health services they receive because such involvement may infringe upon their need for privacy and independence. For example, adolescents may be concerned about confidentiality in relation to sexuality and health-related problems (Holder, 2008). It is important that student-directed services protect the child's privacy and allow for a non-invasive but supportive role for the caregiver.

Limitations, Future Research, and Clinical Implications

There were few shortcomings in this study. The small sample size did not hold enough power for the statistical analyses to be meaningful. However, it is promising that most of the correlations were in the expected direction. Another shortcoming of this study is the limited generalizability of the findings to other school districts. Districts vary in how many resources they have, the variety of the services they offer, and the size and demographic characteristics of the student population. Lastly, the study did not account for the types of services provided by the schools and the factors that affect the quality of the services such as funding, the ratio between mental health professionals employed by the school and students, and the education and training of mental health professionals. Future research may utilize the same measure to assess the quality of mental health services, as the Cronbach's alpha based on both the mental health professionals and caregivers were high, making the measure valid and reliable. Moreover, other

measures for well-being could be added. Academic success (i.e., GPA) and loneliness are also predictors of well-being (Heredia Jr. et al., 2017; Steinmayr et al., 2016). Therefore, surveys that assess these variables could be included in future research to further measure the overall well-being of students. Lastly, future research could examine whether subjective or objective measures (e.g., numbers of students per counselor, funds) are better predictors of children's well-being.

The present findings, although falling short in statistical significance, could potentially have clinical implications. Actively involving caregivers, while protecting the privacy of students, in designing, implementing, and evaluating school services is associated with positive outcomes for the students (Santiago et al., 2015; Santiago et al., 2013; Shucksmith et al., 2010). Both mental health professionals and caregivers included in the study acknowledged the lack of an advisory board within the district, whose primary role would be to evaluate the effectiveness of all services offered by the schools. Additionally, schools could ask for input from caregivers regarding the services by distributing surveys that assess the quality of mental health services. The parent version of the SMHSQAQ could be a useful tool for seeking families' feedback in order to improve the mental health programs for all students.

Moreover, the current findings suggest the desire or need for more opportunities that educate students and caregivers about the effective and safe use of social media and how to address bullying. Continuing education for caregivers and children about mental health and mental illness regardless of whether the children suffer from mental health problems is also important. Lastly, based on the comments made by the mental health professionals who participated in the study, more training is desirable and therefore schools should monitor the needs of the counselors and other staff who directly provide services to students. Previous

research has acknowledged that the training mental health professionals receive through their graduate studies, does not adequately prepare them to provide services, such as counseling (Hanchon & Fernald, 2013). However, schools can fill this gap by providing ongoing training.

Conclusions

Despite the shortcomings, this study is the first to demonstrate that it is worth examining the relationship between the quality of mental health services that are offered by schools and the student's well-being. The present findings provide a framework for future research to expand in order to gain a better understanding of this relationship. A larger sample size would allow for more statistically significant results as well as applications to other schools. As children continue to have mental health problems, it is important to acknowledge the critical role schools play in offering mental health services. The trends in the current findings point to the need to evaluate the quality of school services, encourage caregiver involvement, educate caregivers and students about common problems and mental health illnesses, and provide ongoing training to school mental health professionals. More discussions and efforts need to take place to improve the quality of mental health services in schools, so more students can have access to effective mental health services.

References

Allison, A. & Ferreira, R. (2017). Implementing cognitive behavioral intervention for trauma in schools (CBITS) with Latino youth. *Child and Adolescent Social Work Journal, 34*(2), 181-189. https://doi.org/10.1007/s10560-016-0486-9.

Arslan, G., Allen, K., & Tanhan, A. (2021). School bullying, mental health, and wellbeing in adolescents: mediating impact of positive psychological orientations. *Child Indicators Research, 14,* 1007-1026. https://doi.org/10.1007/s12187-020-09780-2.

Atkins, M., Hoagwood, K., Kutash, K., & Seidman, E. (2010). Toward the integration of education and mental health in schools. *Administration and Policy in Mental Health and Mental Health Services Research, 37,* 40-47. https://doi.org/10.1007/s10488-010-0299-7.

Baskin, Y., Slaten, C., Sorenson, C., & Glover-Russel, J. (2010). Does youth psychotherapy improve academically related outcomes? A meta-analysis. *Journal of Counseling Psychology, 57*(2), 290-296. https://doi.org/10.1037/a0019652.

Boccio, D., Weisz, G., & Lefkowitz, R. (2016). Administrative pressure to practice unethically and burnout within the profession of school psychology. *Psychology in the Schools, 53*(6), 659-672. https://doi.org/10.1002/pits.21931.

Brown, K. & Ryan, R. (2003). The benefits of being present: mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology, 84,* 822-848. https://doi.org/10.1037/0022-3514.84.4.822

Congress.gov (2015). H.R. 1211 Mental Health in Schools Act of 2015. Retrieved from https://www.congress.gov/bill/114th-congress/house-bill/1211#:~:text=Mental%20Health%20in%20Schools%20Act%20of%202015.%20Am

ends,culturally%20and%20linguistically%20appropriate%2C%20trauma-informed%2C%20and%20age%20appropriate.

Copeland, E., Nelson, R., & Traughber, M. (2010). Wellness dimensions relate to happiness in children and adolescents. *Advances in School Mental Health Promotion, 3*(4), 25-37. https://doi.org/10.1080/1754730X.2010.9715689

Diener, E. (1984). Subjective well-being. *Psychological Bulletin, 95,* 542-575. Https://doi.org/10.1037/0033-2909.95.3.542.

Durlak, J. & Wells, A. (1998). Evaluation of indicated preventative intervention (secondary prevention) mental health programs for children and adolescents. *American Journal of Community Psychology, 26*(5), 775-802. https://doi.org/10.1023/A:1022162015815

Ebesutani, C., Regan, J., Smith, A., Reise, S., Higa-McMillan, H., & Chorpita, B. (2012). The 10-item positive and negative affect schedule for children, child and parent shortened versions: application of item response theory for more efficient assessment. *Journal of Psychopathology and Behavior Assessment, 34*, 191-203. https://doi.org/10.1007/s10862-011-9273-2.

Ehly, S. & Dustin, R. (1989). *Individual and Group Counseling in Schools.* Guilford Publications. https://doi.org/10.1002/1520-6807(199401)31:1<85::AID-PITS2310310117>3.0.CO;2-P

Ghosh, R., Dubey, M., Chatterjee, S., & Dubey, S. (2020). Impact of COVID-19 on children: special focus on the psychosocial aspect. *Minerva Pediatrica, 72*(3), 226-235. https://doi.org/10.23736/S0026-4946.20.05887-9.

Gilman, R. & Huebner E. (2000). Review of life satisfaction measures for adolescents. *Behavior*

Change, *17*, 178-195. https://www.proquest.com/docview/219361066?accountid=36120&cid=CID:20230214021013690:425409&fromOL=true&fromopenview=true&parentSessionId=Isvv3cbfulcTo%2Fl3%2Fw9BWOM0llrw5jtx%2BZTTf%2F1lIHA%3D&pq-origsite=gscholar

Goodman, M., Madni, L., & Semple, R. (2017). Measuring mindfulness in youth: review of current assessments, challenges, and future directions. *Mindfulness*, *8*(6), 1409-1420. https://doi.org/10.1007/ss12671-017-0719-9.

Hanchon, T. & Fernald, L. (2013). The provision of counseling services among school psychologists: an exploration of training, current practice, and perceptions. *Psychology in the Schools, 50*(7), 651-671. https://doi.org/10.1002/pits.21700.

Holder, A. (2008). Research with adolescents: parental involvement required? *Journal of Adolescent Health, 42*(1), https://doi.org/10.1016/j.jadohealth.2007.10.014.

Heredia Jr., D., Gonzalez, M., Rosner, C., He, X., Castillo, L., & Ojeda, L. (2017). The influence of loneliness and interpersonal relations on Latina/o middle school students' wellbeing. *Journal of Latinos and Education, 16*(4), 338, 348. https://doi.org/10.1080/15348431.2016.1257428.

Hoover, S. & Bostic, J. (2021). Schools as a vital component of the child and adolescent mental health system. *Psychiatric Services*, *72*(1), 37-48. https://doi.org/10.1176/appi.ps.201900575

Huebner, E. (1991a). Initial development of the Students' Life Satisfaction Scale. *School Psychology International*, *12*, 231-240. https://doi.org/10.1177/0143034391123010

Huebner, E. (1991b). Further validation of the Students' Life Satisfaction Scale: the

independence of satisfaction and affect rating. *Journal of Psychoeducational Assessment, 9,* 363-359. https://doi.org/10.1177/073428299100900408

Jellinek, M., Murphy, J., & Burns, B. (1986). Brief psychosocial screening in outpatient pediatric practice. *Journal of Pediatrics, 109,* 371-378. https://doi.org/10.1016/S0022-3476(86)80408-5

Johnson, M. et al. (2014). Behavioral management for children and adolescents: assessing the evidence. *Psychiatric Services 65*(5), 580-590. https://doi.org/10.1176/appi.ps.201300253

Kessler, R., Amminger, P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. (2007). Age of onset of mental disorders: a review of recent literature. *Current Opinion in Psychiatry, 20*(4), 359-364. https://doi.org/10.1097/YCO.0b013e32816ebc8c

Khan, K., Mamun, M., Griffiths, M., & Ullah, I. (2020). The mental health impact of the COVID- 19 pandemic across different cohorts. *International Journal of Mental Health and Addiction.* https://doi.org/10.1007/s11469-020-00367-0.

Kiecolt, K.J., Hughes, M., & Keith, V. (2008). Race, social relationships, and mental health. *Personal Relationships, 15,* 229-245. https://doi.org/10.1111/j.1475-6811.2008.00195.x

Knox, K. & Robert, A. (2005). Crisis intervention and crisis team models in schools. *Children and Schools, 27*(2), 93-100. https://doi.org/10.1093/cs/27.2.93

Langley, A., Nadeem, E., Kataoka, S., Stein, B., & Jaycox, L. (2010). Evidence-based mental health program in schools: barriers and facilitators of successful implementation. *School Mental Health, 2,* 105-113. https://doi.org/10.1007/s12310-010-9038-1.

Letarte, M., Normandeau, S., & Allard, J. (2010). Effectiveness of a parent training program

"Incredible Years' in a child protective service. *Child Abuse and Neglect, 34*, 253-261. https://doi.org/10.1016/j.chiabu.2009.06.003

Lochman, J., Wills, K., & Murray M. (2007). The Coping Power Program: Preventative intervention at the middle school transition. In P. Tolan, J. Szapocznik, & S. Sambrano (Eds.), *Preventing youth substance abuse: Science-based programs for children and adolescents* (pp. 185-210). American Psychological Association. https://doi.org/10.1037/11488-008.

Mental Health Statistics Improvement Plan (1999). Youth Services Survey for Families. Retrieved from https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/2016%20MHSIP%20Report.pdf

Monzonis-Carda, I., Adelantado-Renau, M., Beltran-Valls, M., & Moliner-Urdiales, D. (2021). An examination of the association between risk of depression and academic performance according to weight status in adolescents: DADOS study. *Journal of Affective Disorders, 290*, 157-163. https://doi.org/10.1016/j.jad.2021.04.086.

Moore, G., Cox, R., Evans, R., Hallingberg, B., Hawkins, J., Littlecott, H., Long, S., & Murphy, S., (2018). School, peer and family relationships and adolescent substance use, subjective wellbeing and mental health symptoms in Wales: a cross sectional study. *Child Indicators Research, 11*, 1951-1965. https://doi.org/10.1007/s12187-017-9524-1.

Moran, K., Turiano, N., & Gentzler, A. (2018). Parental warmth during childhood predicts coping and well-being in adulthood. *Journal of Family Psychology, 32*(5), 610-621. https://doi.org/10.1037/fam0000401.

Nabors, L. & Reynolds, M. (2000). Program evaluation activities: outcomes related to treatment

for adolescents receiving school-based mental health services. *Children's Services: Social Policy, Research, and Practice, 3*(3), 175-189. https://doi.org/10.1207/S15326918CS0303_4

National Association of School Psychology (NASP; 2021). *School Psychology Program Information.* Retrieved from https://apps.nasponline.org/standards-and-certification/graduate-education/index.aspx.

National Association of School Psychology (NASPf2021). *Shortages of School Psychologists*. Retrieved from *https://www.nasponline.org/research-and-policy/policy-priorities/critical-policy-issues/shortage-of-school-psychologists*

Olvera, P. & Olvera, V. (2012). Optimizing home-school collaboration: strategies for school psychologists and Latino parent involvement for positive mental health outcomes. *Contemporary School Psychology, 16.* https://doi.org/10.1007/BF03340977

O'Reilly, M., Dogra, N., Whiteman, N., Hughes, J., Eruyar, S., & Reilly, P. (2018). Is social media bad for mental health and wellbeing? Exploring the perspectives of adolescents. *Clinical Child Psychology, 23*(4), 601-613. https://doi.org/10.1177/1359104518775154.

O'Reilly, M., Svirydzenka, N., Adams, S., & Dogra, N. (2018). Review of mental health interventions in schools. *Social Psychiatry and Psychiatric Epidemiology, 53,* 647-662. https://doi.org/10.1007/s00127-018-1530-1.

Pagano, M., Cassidy, L., Little, M., Murphy, J., & Jellinek, M. (2000). Identifying psychosocial dysfunction in school-age children: the pediatric symptom checklist as a self-report measure. *Psychology in the Schools, 37*(2), 91-106. https://doi.org/10.1002/(SICI)1520-6807(200003)37:2<91::AID-PITS1>3.0.CO;2-3.

Patrick, S. et al., (2020). Well-being of parents and children during the COVID-19 pandemic: a

national survey. *Pediatrics, 146*(4). https://doi/org/10.1542/peds/2020-016824.

President's New Commission on Mental Health (n.d.). Achieving the Promise: Transforming Mental Health Care in America. Retrieved from https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport-1.html

Riley, S., Stromberg, A., & Clark, J. (2005). Assessing parental satisfaction with children's mental health services with the Youth Services Survey for Families. *Journal of Child and Family Studies, 14*(1), 87-99. https://doi.org/10.1007/s10826-005-1124-x.

Rones, M. & Hoagwood, K. (2000). School-based mental health services: a research review. *Clinical Child and Family Psychology Review, 3*(4), 223-241. https://doi.org/10.1023/A:1026425104386

Santiago, C., Pears, G., Baweja, S., Vona, P., Tang, J., & Kataoka, S. (2013). Engaging parents in evidence-based treatments in schools: community perspectives from implementing CBITS. *School Mental Health, 5*(4). https://doi.org/10.1007/s12310-012-9100-2.

Santiago, C., Kataoka, S., Hu-Cordova, M., Alvarado-Goldberg, K., Maher, L., E& scudero, P. (2015). Preliminary evaluation of a family treatment component to augment a school-based intervention serving low-income families. *Journal of Emotional and Behavioral Disorders, 23*(1), 28-39. https://doi.org/10.1177//1063426613503497.

Shafer, A. & Temple, J. (2013). Factor structure of the Mental Health Statistics Improvement Program (MHSIP) family and youth satisfaction surveys. *Journal of Behavioral Health and Research, 40*(3), 306-316. https://doi.org/10.1007/s11414-013-9332-4.

Singh, N. & Singh, S. (2021). *Mindfulness-Based Interventions with Children and Adolescents.* Routledge.

Shucksmith, J., Jones, S., & Summerbell, C. (2010). The role of parental involvement in school-based mental health interventions at primary (elementary) school level. *Advances in School Mental Health Promotion, 3*(1), 18-29. https://doi.org/10.1080/1754730X.2010.9715671

Smees, R., Rinaldi, L., & Simner, J. (2020). Well-being measures for younger children. *Psychological Assessment, 32*(2), 154-169. https://doi.org/10.1037/pas0000768.

Steinmayr, R., Crede, J., McElvany, N., & Wirthwein, L. (2016). Subjective well-being, test anxiety, academic achievement: testing for reciprocal effects. *Frontiers in Psychology, 6,* https://doi.org/10.3389/fpsyg.2015.0194.

Stoep, A. et al. (2005). Universal emotional health screening at the middle school transition. *Journal of Emotional and Behavioral Disorders, 13*(4), 213-223. https://doi.org/10.1177/10634266050130040301

Teich, J., Robinson, G., & Weist, M. (2007). What kinds of mental health services do public schools in the United States provide? *Advances in School Mental Health Promotion,* 13-22. https://doi.org/10.1177/10634266050130040301

Tome, G., Almeida, A., Ramiro, L., Gaspar, T., & Gaspar de Matos, M. (2021). Intervention in schools promoting mental health and well-being: a systematic review. *Global Journal of Community Psychology Practice, 12*(1), 1-23. https://www.gjcpp.org/pdfs/Tom___EtAl-FinalFinal.pdf

UNICEF (2021). *Mental health*. Retrieved from https://data.unicef.org/topic/child-health/mental-health/

U.S. Department of Education Office of Elementary and Secondary Education (2002). No child

left behind act. Retrieved from https://www.congress.gov/bill/107th-congress/house-bill/1

Vanderbleek, L. (2004). Engaging families in school-based mental health treatment. *Journal of Mental Health Counseling, 26,* 211-224. https://doi.org/10.17744/mehc.26.3.xbwbr27wqhcptlmk

Wang, C., La Salle, T., Do, K., & Wu, C. (2019). Does parental involvement matter for students' mental health in middle school? *School Psychology, 34*(2), 222-232. http://doi.org/10.1037./spq00003000.

Wang, M. & Sheikj-Khalil, S. (2014). Does parental involvement matter for student achievement and mental health in high school? *Child Development, 85*(2), 610-625. https://doi.org.101111/cdev.12153.

Water, L., Barsky, A., Ridd, A., & Allen, K. (2014). Contemplative education: a systematic, evidence-based review of the effect of meditation interventions in schools. *Educational Psychology Review, 27,* 103-134. https://doi.org/10.1007/s10648-014-9258-2.

Wenk, D., Hardesty, C., Morgan, C., & Blair, S. (1994). The influence of parental involvement on the well-being of sons and daughters. *Journal of Marriage and Family, 56*(1), 229-234. https://doi.org/10.2307/352718

Weist, M. Stephen, S., Lever, N., Moore, E., & Lewis, K. (2006). School Mental Health Quality Assessment Questionnaire. Retrieved from https://somvweb.som.umaryland.edu/Fileshare/SchoolMentalHealth/Resources/Clin/QAIRsrc/QAQ.pdf

Wu, X., Gai, X., & Wang, W. (2020). Subjective well-being and academic performance among

middle schoolers: a two-wave longitudinal study. *Journal of Adolescence, 84,* 11-22. https://doi.org/10.1016/j.adolescence.2020.07.011.

Table 1
Descriptive Statistics of Study Variables

Variable	*M*	*SD*	*CI (95%)*
Caregiver-Rated Quality of Services	3.25	0.18	[2.86, 3.64]
Caregiver Involvement	3.16	0.97	[2.66, 3.66]
Mental Health Professionals-Rated Quality of Services	3.14	0.54	[2.47, 3.08]
Caregiver-Rated Child Psychopathology	16.11	8.37	[11.95, 20.27]
Child-Rated Psychopathology	21.20	17.51	[-0.55, 42.95]
Life Satisfaction	168.60	41.49	[117.09, 220.11]
Positive Affect	3.16	1.60	[1.18, 5.14]
Negative Affect	2.04	1.56	[0.10, 3.98]
Mindfulness	3.72	1.13	[2.31, 5.13]

Note. N = 5-19

Table 2
Correlations Between Caregiver-Rated Quality of Services and Children Outcomes

	Caregiver-Rated Quality of Services
Caregiver-Rated Child Psychopathology	-0.22
Child-Rated Psychopathology	-0.74
Life Satisfaction	0.61
Positive Affect	0.08
Negative Affect	-0.63
Mindfulness	0.59

Note. $N = 5$.

Table 3
Correlations Between Caregiver Involvement and Children Outcomes

	Caregiver Involvement
Caregiver-Rated Child Psychopathology	-0.20
Child-Rated Psychopathology	-0.17
Life Satisfaction	-0.29
Positive Affect	-0.73
Negative Affect	0.20
Mindfulness	0.49

Note. $N = 5$.

Table 4
Intercorrelations Between Study Variables

Variable	1	2	3	4	5	6
1.Caregiver-Rated Child Psychopathology	---					
2.Child-Rated Psychopathology	0.72	---				
3.Life Satisfaction	-0.29	-0.81	---			
4.Positive Affect	0.04	-0.57	0.81	---		
5.Negative Affect	0.34	0.89*	-0.97*	-0.82	---	
6.Mindfulness	-0.84	-0.85	0.39	0.21	-0.56	---

Note. $N = 5$; $^*p < 0.05$

Table 5
Descriptive Analysis for Caregiver Responses about the Quality of Services

	M	*SD*
Q1 (assessment)	3.6	0.89
Q2 (seeking input)	3.2	1.11
Q3 (treatment)	3.2	1.08
Q4 (evaluating quality)	3.8	0.87
Q5 (seeking input)	3.0	1.17
Q6 (family involvement)	3.2	1.12
Q7 (family involvement)	3.3	1.10
Q8 (family involvement)	**2.9**	1.07
Q9 (general mental health)	3.3	1.07
Q10 (prevention)	3.0	1.13
Q11 (treatment)	**2.5**	1.05
Q12 (continuing contact)	**2.8**	0.97
Q13 (training)	3.4	1.09
Q14 (delivery of treatment)	**2.8**	1.01
Q15 (inclusion)	3.5	0.95
Q16 (inclusion)	3.0	0.88
Q17 (delivery of treatment)	**2.9**	1.26
Q18 (confidentiality)	3.6	0.75

Note. $N = 16$. Refer to Appendix G for questions. Means below average (3.0) are in bold.

Table 6
Descriptive Analysis for Mental Health Professional Responses about the Quality of Services

	M	*SD*
Q1 (assessment)	3.0	1.41
Q2 (seeking input)	4.0	0.71
Q3 (seeking input)	3.4	0.89
Q4 (treatment)	3.8	0.84
Q5 (training)	**2.0**	1.00
Q6 (training)	**2.4**	0.89
Q7 (training)	**2.4**	0.89
Q8 (screening)	3.4	1.34
Q9 (assessment)	**2.8**	1.10
Q10 (evaluating quality)	**2.8**	0.84
Q11 (evaluating quality)	4.2	0.45
Q12 (prevention/intervention)	3.4	1.14
Q13 (evaluating quality)	**1.6**	0.55
Q14 (seeking input)	**2.8**	1.10
Q15 (seeking input)	2.8	1.10
Q16 (utilizing input)	**2.6**	1.14
Q17 (family involvement)	**2.8**	0.84
Q18 (sharing information)	3.4	0.89
Q19 (general mental health)	3.4	0.89
Q20 (training)	**2.8**	0.84
Q21 (prevention)	3.4	0.89
Q22 (treatment)	**2.6**	1.14
Q23 (continuing contact)	3.6	0.55
Q24 (assessment)	3.6	1.14
Q25 (training)	3.0	1.00
Q26 (inclusion)	3.2	1.10
Q27 (inclusion)	4.0	0.71
Q28 (collaboration)	3.6	1.14
Q29 (collaboration)	4.2	0.45

Note. $N = 5$. Refer to Appendix F for questions. Means below average (3.0) are in bold.

Table 7
Caregiver Suggestions for Improvements for Mental Health Services in Schools

	Suggestion
1	Assistance with therapy/finding therapy, more in school mental health and SEL practices.
2	Educate caregivers about their children's mental health at least twice a year.
3	Fortunately, we have not had to utilize their mental health services, I do know the children are exposed to a lot online with different kinds or pressures than we had as children. I would recommend education for both caregivers and children on the anxiety kids may be facing due to social media.
4	I believe that the school should be more informative towards students about bullying and the effects that social media has towards young children/young adults. Children who bully others should have a consequence. I feel like there are no consequences given to those students who take advantage of the school. There should be programs added to the schools with children who suffer from mental health. My daughter, for example, she just came out from a behavioral facility and is currently terrified to go back to school because of certain students who were targeting her in the past. What services would she receive in order to keep her anxiety in check? Would those who target her be held accountable for their actions?
5	More staff. Caring about kids that appear okay but are not always well liked by peers.
6	Offer them.
7	They may have, but I have not heard of any student teaching about online platforms and bullying.
8	To take it seriously. I have reached out regarding my daughter numerous times and someone else has reached out on her behalf and the school had done nothing except a quick 2-minute chat.

Appendix A

Demographic Questions

Students

1. What is your student ID number issued by the school?
2. What is your current age?
3. What is your preferred gender identity?
4. What grade are you in? (Circle one):

   5th 6th 7th 8th
5. What is your ethnic background? (Circle one):

   Caucasian African American Asian Latino Other
6. What kind of family do you come from? (Circle one)

   Married Single Parent Coparenting Other
7. Do you receive mental health services through the school? Yes No

Parents

1. What is your child's student ID number issued by the school (middle school only; if more than one child in the middle school please list all their student ID numbers)?
2. What is your current age?
3. What is your ethnic background? (Circle one):

   Caucasian African American Asian Latino Other
4. What kind of family do you come from? (Circle one)

   Married Single Parent Coparenting Other
5. What is your education level?

Graduated high school completed some college graduated college completed graduate school

6. What is your income?
7. Does your child receive mental health services through the school (middle school only; if more than one child in the middle school please say yes if any of them receive services)?

   Yes No

Appendix B

Pediatric Symptom Checklist Youth Report (Y-PSC)

	NEVER	SOMETIMES	OFTEN
1. Complain of aches or pains			
2. Spend more time alone			
3. Tired easily, little energy			
4. Fidgety, unable to sit still			
5. Have trouble with teacher			
6. Less interested in school			
7. Act as if driven by motor			
8. Daydream too much			
9. Distract easily			
10. Are afraid of new situations			
11. Feed sad, unhappy			
12. Are irritable, angry			
13. Feel hopeless			
14. Have trouble concentrating			
15. Less interested in friends			
16. Fight with other children			
17. Absent from school			
18. School grades dropping			
19. Down on yourself			
20. Visit doctor with doctor finding nothing wrong			
21. Have trouble sleeping			
22. Worry a lot			
23. Want to be with parent more than before			
24. Feel that you are bad			
25. Take unnecessary risks			
26. Get hurt frequently			
27. Seem to be having less fun			
28. Act younger than children your age			
29. Do not listen to rules			
30. Do not show feelings			
31. Do not understand other people’s feelings			
32. Tease others			
33. Blame others for your troubles			
34. Take things that do not belong to you			
35. Refuse to share			

Appendix C

Multidimensional Student Life Satisfaction Scale (MSLSS)

1 = strongly disagree
2 = disagree
3 = neutral
4 = agree
5 = strongly agree

1. My friends are nice to me	1	2	3	4	5
2. I am fun to be around	1	2	3	4	5
3. I feel bad at school	1	2	3	4	5
4. I have a bad time with my friends	1	2	3	4	5
5. There are lots of things I can do well	1	2	3	4	5
6. I learn a lot at school	1	2	3	4	5
7. I like spending time with my parents	1	2	3	4	5
8. My family is better than most	1	2	3	4	5
9. There are many things about me I don't like	1	2	3	4	5
10. I think I am good looking	1	2	3	4	5
11. My friends are great	1	2	3	4	5
12. My friends will help me if I need it	1	2	3	4	5
13. I wish I didn't have to go to school	1	2	3	4	5
14. I like myself	1	2	3	4	5
15. There are lots of fun things to do where I live	1	2	3	4	5
16. My friends treat me well	1	2	3	4	5
17. Most people like me	1	2	3	4	5
18. I enjoy being at home with my family	1	2	3	4	5
19. My family gets along well	1	2	3	4	5
20. I look forward to going to school	1	2	3	4	5
21. My parents treat me fairly	1	2	3	4	5
22. I like being in school	1	2	3	4	5
23. My friends are mean to me	1	2	3	4	5
24. I wish I had different friends	1	2	3	4	5
25. School is interesting	1	2	3	4	5
26. I enjoy school activities	1	2	3	4	5
27. I wish I lived in a different house	1	2	3	4	5
28. Members of my family talk nicely to one another	1	2	3	4	5
29. I have a lot of fun with my friends	1	2	3	4	5
30. My parents and I do fun things together	1	2	3	4	5
31. I like my neighborhood	1	2	3	4	5
32. I wish I lived somewhere else	1	2	3	4	5
33. I am a nice person	1	2	3	4	5
34. This town is filled with mean people	1	2	3	4	5
35. I like to try new things	1	2	3	4	5
36. My family's house is nice	1	2	3	4	5

37. I like my neighbors	1	2	3	4	5
38. I have enough friends	1	2	3	4	5
39. I wish there were different people in my neighborhood	1	2	3	4	5
40. I like where I live	1	2	3	4	5

Appendix D

Positive and Negative Affect Scale (PANAS)

Instructions: We're going to ask about your feelings and emotions during the last week, like feeling happy or sad. I want you to think about yourself and how much you've had different feelings this week.

	Very slightly	**A little**	**Moderately**	**Quite a bit**	**Extremely**
Sad					
Happy					
Scared					
Cheerful					
Miserable					
Proud					
Afraid					
Joyful					
Mad					
Lively					

Appendix E

Mindful Attention Awareness Scale for Children (MAAS-C)

1 = strongly disagree
2 = disagree
3 = neutral
4 = agree
5 = strongly agree

1. I could be feeling a certain way and not realize it until later	1	2	3	4	5
2. I break or spill things because of carelessness, not paying attention, or thinking of something else	1	2	3	4	5
3. I find it hard to stay focused on what's happening in the present moment	1	2	3	4	5
4. Usually, I walk quickly to get where I'm going without paying attention to what I experience along the way	1	2	3	4	5
5. Usually, I do not notice if my body feels tense or uncomfortable until it gets really bad	1	2	3	4	5
6. I forget a person's name almost as soon as I've been told it for the first time	1	2	3	4	5
7. It seems that I am doing things automatically without really being aware of what I am doing	1	2	3	4	5
8. I rush through activities without being attentive to them	1	2	3	4	5
9. I focus so much on a future goal I want to achieve that I don't pay attention to what I am doing right now to reach it	1	2	3	4	5
10. I do jobs, chores, or schoolwork automatically without being aware of what I'm doing	1	2	3	4	5
11. I find myself listening to someone with one ear, doing something else at the same time	1	2	3	4	5
12. I walk into a room, and then wonder why I went there.	1	2	3	4	5
13. I can't stop thinking about the past or the future	1	2	3	4	5
14. I find myself doing things without paying attention	1	2	3	4	5
15. I snack without being aware that I'm eating	1	2	3	4	5

Appendix F

Adapted School Mental Health Services Quality Assessment Questionnaire (SMHSQAQ)

for mental health professionals

1 = strongly disagree
2 = disagree
3 = neutral
4 = agree
5 = strongly agree
DK = no answer (don't know)

1. The school conducts assessments on common risk and stress factors (e.g., exposure to crime, violence, substance abuse).	1	2	3	4	5	DK
2. The school holds meetings with students, parents, and teaching staff to ask them about their needs.	1	2	3	4	5	DK
3. The school holds meetings with students, parents, and teaching staff to ask them for their recommendations for actions by school mental health staff.	1	2	3	4	5	DK
4. The school matches services to the presenting needs and strengths of students/families after initial assessment.	1	2	3	4	5	DK
5. The school provides ongoing training and supervision on effective diagnosis.	1	2	3	4	5	DK
6. The school provides ongoing treatment and supervision on treatment planning.	1	2	3	4	5	DK
7. The school provides ongoing treatment and supervision on clinical decision-making.	1	2	3	4	5	DK
8. The school conducts screening to assist in the identification of mental health problems.	1	2	3	4	5	DK
9. The school conducts follow-up assessments.	1	2	3	4	5	DK
10. The school continually assess whether ongoing services provided are appropriate and help to address presenting problems.	1	2	3	4	5	DK
11. There is clear and affective protocol to assist clinical decision making and care for more serious decisions (e.g., abuse and neglect reports, self-reporting of suicidal/homicidal ideation).	1	2	3	4	5	DK
12. The school actively uses evidence-based (practices and programs) of what works in student mental health to guide school	1	2	3	4	5	DK

counselor's preventive and clinical interventions.						
13. The school has an advisory board (including youth, families, administrators, educators, school health staff, community leaders) for its mental health programs.	1	2	3	4	5	DK
14. The school provides opportunities for school administration to provide recommendations, feedback, and involvement in program development and implementation.	1	2	3	4	5	DK
15. The school offers methods and activities (e.g., meeting, focus groups, surveys) to obtain feedback on an ongoing basis from key stakeholders on how programs are functioning and how they can be improved.	1	2	3	4	5	DK
16. The school provides training and educational activities for families, teachers, and other stakeholder groups based on their recommendations and feedback.	1	2	3	4	5	DK
17. The school ensures that families are meaningfully involved mental health programs.	1	2	3	4	5	DK
18. The school shares positive and negative findings from evaluation of services with youth, families, school staff, and other stakeholders.	1	2	3	4	5	DK
19. The school offers activities promoting school-wide mental health.	1	2	3	4	5	DK
20. The school implements training and educational activities for educators on the identification, referral, and behavioral management of social, emotional, and behavioral problems in students.	1	2	3	4	5	DK
21. The school offers group, classroom, and school-wide prevention activities.	1	2	3	4	5	DK
22. The school offers intensive treatment services to youth and families including individual, group, and family therapy.	1	2	3	4	5	DK
23. School counselors continue to have a mentoring relationship with students who no longer present serious problems.	1	2	3	4	5	Dk
24. The school promptly screens/assesses all students who have been referred for services.	1	2	3	4	5	DK
25. The school provides sufficient training to handle unique demands of school-based practices in an ethical and effective manner.	1	2	3	4	5	DK

26. The school's caseload reflects the diversity of the school population.	1	2	3	4	5	DK
27. The school makes the effort to ensure that the school mental health programs and services are welcoming and respect the students and families served.	1	2	3	4	5	DK
28. The school coordinates mental health efforts to ensure that youth who need services receive them, while avoiding service duplication.	1	2	3	4	5	DK
29. School counselors, educators, administrators, and other professionals actively collaborate.	1	2	3	4	5	DK

Appendix G

Adapted School Mental Health Services Quality Assessment Questionnaire (SMHSQAQ) for Parents

1 = strongly disagree
2 = disagree
3 = neutral
4 = agree
5 = strongly agree
DK = no answer (don't know)

1. The school provides assessments for common risks and stress factors faced by students (e.g., exposure to crime, violence, substance abuse).	1	2	3	4	5	DK
2. The school holds meetings with students, parents, and teaching staff to ask them about their needs and to ask them for their recommendations for actions by school mental health staff.	1	2	3	4	5	DK
3. The school provides services to help students contend with common risk and stress factors.	1	2	3	4	5	DK
4. The school has an advisory board (including youth, families, administrators, educators, school health staff, community leaders) for its mental health programs.	1	2	3	4	5	DK
5. Parents are offered numerous opportunities for recommendations, feedback, and involvement in program development and implementation that benefit all students.	1	2	3	4	5	DK
6. The school offers opportunities that educate parents about children's mental health (e.g., anxiety).	1	2	3	4	5	DK
7. The school offers opportunities that educate parents about their children's well-being (e.g., sleep, eating, social relationships).	1	2	3	4	5	DK
8. The school ensures that families are meaningfully involved in treatment planning and ongoing therapy efforts.	1	2	3	4	5	DK
9. The school offers activities that promote school-wide mental health.	1	2	3	4	5	DK
10. The school offers group, classroom, and school-wide prevention activities.	1	2	3	4	5	DK

11. The school offers intensive treatment services to youth and families including individual, group, and family therapy.	1	2	3	4	5	DK
12. The school continues to offer mentoring relationships with students who no longer present serious problems.	1	2	3	4	5	DK
13. The school staff is sufficiently trained, supported, and supervised to handle the unique demands of school-based practices in an ethical and effective manner.	1	2	3	4	5	DK
14. The school services allow youth and families in need to be served as rapidly as possible.	1	2	3	4	5	DK
15. The school provides care for students and families who present diverse development, cultural, ethnic, and personal backgrounds.	1	2	3	4	5	DK
16. The school makes efforts to ensure that school-based mental health and services are welcoming and respect the students and families served.	1	2	3	4	5	DK
17. The school ensures that youth who need services receive them.	1	2	3	4	5	DK
18. The school ensures that student information is appropriately shared and that students and families confidentiality is protected.	1	2	3	4	5	DK

Appendix H

Youth Services Survey for Families (YSS-F)

1 = strongly disagree
2 = disagree
3 = neutral
4 = agree
5 = strongly agree
DK = no answer (don't know)

1. Overall, I am satisfied with the services my child received.	1	2	3	4	5	DK
2. My child is better at handling daily life.	1	2	3	4	5	DK
3. My child gets along better with family members.	1	2	3	4	5	DK
4. My child gets along better with others.	1	2	3	4	5	DK
5. My child is doing better in school and/or work.	1	2	3	4	5	DK
6. My child is better able to cope when things go wrong.	1	2	3	4	5	DK
7. I am satisfied with our family life right now.	1	2	3	4	5	DK
8. I helped to choose my child's services.	1	2	3	4	5	DK
9. I helped to choose my child's treatment goals.	1	2	3	4	5	DK
10. The people helping us stuck with us no matter what.	1	2	3	4	5	DK
11. I felt my child had someone to talk to.	1	2	3	4	5	DK
12. The people helping listened to what they had to say.	1	2	3	4	5	DK
13. I was frequently involved in my child's treatment.	1	2	3	4	5	DK
14. The services were right for us.	1	2	3	4	5	DK
15. The location was convenient for us.	1	2	3	4	5	DK
16. Services were available at convenient times.	1	2	3	4	5	DK
17. If my child needs services in the future, we will use these again.	1	2	3	4	5	DK
18. My child got the help they wanted.	1	2	3	4	5	DK
19. My child got as much helped as they needed.	1	2	3	4	5	DK
20. My child needs determined treatment goals.	1	2	3	4	5	DK
21. Staff treated us with respect.	1	2	3	4	5	DK
22. Staff understood my family's cultural traditions.	1	2	3	4	5	DK

23. Staff respected my family's religious/spiritual beliefs.	1	2	3	4	5	DK
24. Staff spoke with me in a way that I understood.	1	2	3	4	5	DK
25. Staff were sensitive to my family's cultural/ethnic background.	1	2	3	4	5	DK