An Investigation of Student Mental Health Supports in Florida Public School Districts

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AN INVESTIGATION OF STUDENT MENTAL HEALTH SUPPORTS IN FLORIDA PUBLIC SCHOOL DISTRICTS

By

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Education in the Department of Educational Leadership and Higher Education in the College of Community Innovation and Education at the University of Central Florida Orlando, Florida

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Major Professor: Thomas Vitale
ABSTRACT

The purpose of this study was to determine the mental health services being provided to students in the state of Florida, specifically the identification of mental health concerns among students, prevention strategies, and interventions utilized. This study consisted of a document analysis of the Mental Health Assistance Allocation Plans submitted to, and posted by, the Florida Department of Education, for the purpose of developing a grounded theory to standardize the recommended practices in serving the mental health needs of students. Standardized recommended practices that emerged from the analysis included (a) universal screening to identify students demonstrating or developing mental health concerns, (b) establishing consistency within the school/school district and a positive school culture, (c) training faculty, staff, and students regarding mental health concerns and how to support/connect with resources connecting with the community to coordinate care, (d) involving families and parents and collaborate with outside or community mental health agencies; (e) keeping ratios between students and mental health professionals as low as possible in order to maximize direct contact between students and their mental health providers, and (f) information sharing between school districts and community or outside mental health partners and providers, while protecting student information.
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CHAPTER 1- INTRODUCTION

Background of the Study

As a result of a series of deadly school shootings, and in an effort to support student mental health, a collaboration between the United States Department of Health and Human Services, the United States Department of Education, and the United States Department of Justice launched the Safe Schools/Healthy Students (SS/HS) Initiative in 1999 (Substance Abuse and Mental Health Services Administration, 2013). A major focus of the SS/HS Initiative was the integration of school-based and community-based mental health supports for students (Substance Abuse and Mental Health Services Administration, 2013). Following the school shooting at Sandy Hook Elementary in 2013, several professional entities (American School Counseling Association, National Association of Elementary School Principals, National Association of School Psychologists, National Association of School Resource Officers, National Association of Secondary School Principals, and School Social Work Association of America) authored the Framework for Successful and Safe Schools with policy recommendations and best practices to support school safety while acknowledging the lack of any universal approach to creating safe and successful schools (Cowan, Vaillancourt, Rossen, & Pollitt, 2013).

Federal legislation has also focused on mental health, specifically through Every Student Succeeds Act (ESSA) and the Individuals with Disabilities Education Act (IDEA). The public law, ESSA, was renewed in 2015 and explicitly suggested mental health interventions. The first suggestion listed for schools with low-income students working to address the needs of all...
students, and especially at-risk students, was to include counseling and school-based mental health programs (ESSA, 2015). When appropriate, ESSA (2015) also encouraged schools to coordinate with IDEA, which was refined in 2004. School districts are currently permitted to use up to 15% of funds allocated through IDEA for interventions towards students with disabilities who are not placed in a formal special education program (Alexander & Alexander, 2019). ESSA (2015) also emphasized safety as a school condition for learning and suggests including mental health awareness programs for faculty regarding resources and de-escalation to achieve this goal.

In 2016, the 21st Century Cures Act passed at the federal level, which outlined grant requirements for increasing community crisis response systems including developing crisis response teams for school officials, plus developing and maintaining programs for mental health promotion, intervention, and treatment. Both mental health crises and substance abuse crises were covered within the 21st Century Cures Act (2016). Crisis response systems are not proactive, and tragedies leading to crises still occur. In 2018, 17 people were killed in the school shooting at Marjory Stoneman Douglas High School in Florida. In response to the tragedy, Florida worked on state legislation to further provide supports. Florida Senate Bill 7026, also known as the “Marjory Stoneman Douglas High School Public Safety Act,” created both the Marjory Stoneman Douglas Public Safety Commission within the Department of Law Enforcement and the Mental Health Assistance Allocation. In 2019, the Florida legislature passed Senate Bill 7030, implementing the legislative recommendations of the Marjory Stoneman Douglas High School Public Safety Commission. Among the school site security information, SB 7030 (2019) also outlined the minimum requirements for each school district to
include Mental Health Assistance Allocation Plans. These minimum requirements include strategies or programs to:

reduce the likelihood of at-risk students developing social, emotional, or behavioral health problems, depression, anxiety disorders, suicidal tendencies, or substance use disorders…to improve the early identification of social, emotional, or behavioral problems…to improve the provision of early intervention services… (SB 7030, 2019, p.48)

**Statement of the Problem**

Only the minimum expectations were recommended for the Mental Health Assistance Allocation Plans, and individual school districts in Florida are not held accountable for surpassing the minimum requirements in supporting the mental health concerns of students. There was a gap in the research, as there was no unified and evidence-based recommended strategy to guide the early identification, prevention, and intervention strategies used by school districts to serve the mental health needs of students. Therefore, the problem to be studied was how to standardize recommended practices for school districts to provide student mental health supports.

**Purpose of the Study**

The purpose of this study was to determine the mental health services being provided to students in the state of Florida, specifically the identification of mental health concerns among students, prevention strategies, and interventions utilized. This study consisted of a document analysis of the Mental Health Assistance Allocation Plans submitted to, and posted by, the
Florida Department of Education, for the purpose of developing a grounded theory to standardize recommended practices in serving the mental health needs of students. Kutcher, Wei, and Weist (2015) emphasized the value of local culture and characteristics in schools serving student mental health needs. The researchers described a building-by-building partnership for mental health supports in schools, but also indicated that initiatives should move towards a more consistent and uniform approach (Kutcher, Wei, & Weist, 2015). This study was conducted through multiple readings of the selected sample school district Mental Health Assistance Allocation Plans. Multiple readings enabled the identification and coding of themes and concepts.

**Significance of the Study**

Research supports the concern(s) of mental health among youth. For example, the Youth Risk Behavior Surveillance Survey is conducted by the Center for Disease Control, and measures behaviors related to leading causes of death, including measuring feelings of hopelessness, suicide attempts, and injury during attempts. From 2007 to 2017, there was a trend toward a higher percentage of students who reported they were experiencing persistent feelings of sadness or hopelessness, in seriously considering attempting suicide, in making a plan, and being injured in a suicide attempt (Centers for Disease Control and Prevention, 2017). Secretary Azar of the Department of Health and Human Services indicated that suicide is the second leading cause of death among youths, while Dr. Kataoka of the UCLA Division of Child and Adolescent Psychiatry indicated that one in five youths have a mental health disorder, and less than half receive needed treatment (Federal Commission on School Safety, 2018).
Mental health is impactful to schools because of its relationship to school safety and climate, but also to individual student achievement. The United States Department of Homeland Security Secretary, Kristen Neilson, has acknowledged both mental and behavioral health as components of school safety (Federal Commission on School Safety, 2018). Positive student perception of school climate has been associated with lower risk behaviors for students (Denny et al., 2011). Students with mental health concerns are more likely to have lower grades, higher absenteeism, and a higher chance of dropping out (Federal Commission on School Safety, 2018).

Schools serve as the center of the community and promoting mental health can decrease stigma around mental health in addition to removing barriers to access (Federal Commission on School Safety, 2018). Barriers to mental health treatment can include recognizing the need for care and seeking out care, but other barriers include shortages of mental health professionals serving youth (especially in rural areas) as well as socio-economic limitations (Federal Commission on School Safety, 2018). Student presence at schools increases the access and availability of interventions, making them a practical setting for these services (Denny et al., 2011). Strengthening the mental health supports provided to students in schools can help the community.

This study developed a grounded theory to further explore the identification of mental health concerns among students, prevention strategies, and interventions utilized, resulting in a standard recommendation for school districts to use in creating evidence based mental health plans. Schools and school districts can use these results as a framework to guide their mental health supports for students.
Definition of Terms

Corbin and Strauss (2012) indicated grounded theory as differing from quantitative research in that the variables emerge in the study rather than being structured traditionally. The overall population of the study consisted of the school districts within the state of Florida. The independent variables included district demographic data such as size, number of students, and socioeconomic status. The dependent variables included the mental health identification processes, interventions, and prevention supports. The extraneous variables included resources and training provided to faculty and staff, as well as ratios of students to mental health professionals. Operational definitions follow:

**Category:** stands by itself as a conceptual element of the theory (Glaser and Strauss, 2017, p. 36).

**Coding:** Deriving and developing concepts from data (Corbin & Strauss, 2012, p.65)

**Concepts:** Words that stand for groups or classes of objects, events, and actions that share some major common property(ies), though the property(ies) can vary dimensionally (Corbin & Strauss, 2012, p.45)

**Dimensions:** Variations of property along a range (Corbin & Strauss, 2012, p. 45)

**Properties:** Characteristics or components of an object, event, or action. The characteristics give specificity to and define an object, event, and/or action (Corbin & Strauss, 2012, p. 45)

**Intervention:** designed to be specific actions to deal with specific problems (Piotrowski, 2019)
Mental health: how people interact with others, handle stress related to life situations, work through problems, and cope with daily living in an appropriate manner (Edens, 2019)

Multi-Tiered System of Supports (MTSS): “is a term used to describe an evidence-based model of schooling that uses data-based problem-solving to integrate academic and behavioral instruction and intervention… delivered to students in varying intensities (multiple tiers) based on student need… to ensure that district resources reach the appropriate students (schools) at the appropriate levels to accelerate the performance of ALL students to achieve and/or exceed proficiency” (Florida’s Positive Behavior Support Project, & Florida Problem Solving & Response to Intervention Project, p.2 )

Prevention: ranges from deterring diseases and behaviors that foster them to slowing the onset and severity of illnesses when they do arise (SAMHSA, 2017).

School Based Mental Health Services Provider: includes a state-licensed or state-certified school counselor, school psychologist, school social worker, or other State licensed or certified mental professional qualified under State law to provide mental health services to children and adolescents (Every Student Succeeds Act, 2015, p. 170)

These definitions were included in order to establish the meanings of these terms for the purpose of this study.

**Conceptual Framework**

This study used a phenomenological philosophy for the conceptual framework. Glaser and Strauss (2017) described grounded theory as a phenomenological position, based on using data to generate a theory. In grounded theory, the researcher evaluates how a concept is similar
to or different from the existing literature (Corbin & Strauss, 2012). Relevant educational theories include phenomenological counseling theories, which allow for consideration of context in meeting mental health needs. These theories also fall under a constructivist lens; in constructivism, “meaning is constructed by an individual” (Day, 2008). Additionally, developmental theory guided this study.

Research Questions

1. How are Florida school districts identifying students who present with mental health concerns?
2. How are Florida school districts providing preventative mental health support for students?
3. How are Florida school districts providing mental health interventions for students?
4. How are Florida school districts connecting evidence-based approaches in their delivery of mental health supports for students?

Limitations

The primary limitation in this study was the isolation to Florida; the Mental Health Assistance Allocation Plans are used in the state of Florida, while mental health supports in schools are a global phenomenon. The Florida Department of Education posts all Mental Health Assistance Allocation Plans online. The plans accessed were from the 2019-2020 school year, which were written prior to the COVID-19 pandemic. Therefore, the plans did not include mention of any mental health supports designed specifically for the pandemic.
Delimitations

While the entire population was available, a delimitation of this study was the use of a sample. The sample contained fifteen school districts of varying geographic sizes, quantity of students, and socioeconomic groups in an effort to expand the scope of the study. Glaser and Strauss (2017) suggested that comparing groups of varying regions can increase generality. These delimitations of the sample aided in avoiding blind spots in the research study regarding factors which may impact resources, and therefore district mental health approaches. Additionally, triangulation was achieved through including School Board discussions of the Mental Health Assistance plans through meeting note documents.

Assumptions

This study assumed that districts are providing the supports that they list. Senate Bill 7030 required school districts to submit data regarding the number of students served, and this study assumed that this data will be made available in the future to demonstrate the quantity of students impacted and to what degree schools have supported student mental health using their Mental Health Assistance Allocation Plans. Additionally, the study assumed that the school districts have a thorough understanding of what occurs at the school-building level for student mental health concerns, and that those needs are represented within the submitted plan.

Organization of the Study

The second chapter will consist of a literature review, including an analysis of existing theory, mental health practice in schools, state recommendations and legislation, and an overview of grounded theory. Chapter three will discuss the methodology, grounded theory, in
more detail and describe the sampling, data collection, and data analysis process. Chapter 4 will describe the results of the research, and Chapter 5 will consist of a discussion of the findings including implications for practice.

**Summary**

Mental health support for students in schools has largely evolved in reaction to school shootings and crises. Legislation continues to pass regarding the mental health supports that students receive in school, including funding in the state of Florida through the Mental Health Assistance Allocation. The current legislative stance does not provide specific directives, but school districts are submitting their plans to the Florida Department of Education. These plans were evaluated through document analysis to standardize specific recommended strategies for mental health promotion, specifically through identification of mental health concerns among students, prevention strategies, and interventions utilized.
CHAPTER 2: LITERATURE REVIEW

Introduction

The literature, using a macro lens, begins with phenomenological theories of counseling and learning. After establishing these theories, the existing circumstances of mental health in schools can be evaluated, particularly the processes of identification of mental health concerns among students, prevention strategies, and interventions utilized. Within the state of Florida, specific legislation has expanded upon global and national expectations. Individual students present with externalizing and internalizing mental health factors, and students with a history of trauma may also present with a need for mental health supports. Finally, this study used grounded theory to standardize current recommended practices within the state of Florida, as indicated by the Mental Health Assistance Allocation Plans, and an understanding of grounded theory must be established.

This chapter is organized to provide a foundation of existing research which has informed this study. In order to account for students learning and living with circumstances unique to themselves, phenomenological theories which honor the experiences of each individual are appropriate in the school setting. After descriptions of each of these theories, this chapter provides more information regarding the identification and prevention of mental health concerns, including the involvement of schools and the community in serving student needs. This study specifically examines school districts within the state of Florida based on plans established through the legislature, therefore both state and national recommendations and legislation are clarified. The baseline of mental health provisions through existing theory, current steps, and
regulations allow for the exploration of student need and the impact of trauma. Finally, this chapter provides an overview of grounded theory as the methodology for this study.

Phenomenological Theories

Phenomenological theories account for the context of individual circumstances, honoring the perception differences of individuals on varying experiences (Day, 2008). Within this section, several counseling theories are described, including humanistic/person-centered, Adlerian, Existentialism, and Gestalt Psychotherapy. A brief history of behaviorism is provided, connecting the learning elements of behavioral therapies to cognitive-behavioral therapies.

Each of these theories focus on the individual experience, environment, perception, behaviors, or a combination of these characteristics. These theories were not developed specifically for implementation within the school system. However, the phenomenological approach of each theory allows for adaptation to implement or integrate the theory into school and school district use. Therefore, the basis of each theory is established, then the connection to the school system is explained.

Humanistic/Person-Centered

Humanistic approaches honor the context of circumstances for individuals as they develop meaning in their lives. Person-Centered Counseling, developed by Carl Rogers, consists of three facilitative conditions: congruence (authenticity); unconditional positive regard; and accurate empathy (Granello & Young, 2009; Day, 2008). The cornerstone of person-centered counseling is the therapeutic relationship, which can be accomplished in the school setting through meeting consistently to determine what is happening with a student (Ray &
Schottelkorb, 2009). The warmth shown by a counselor allows for an emotional connection as a component of expressing the unconditional regard for the client (Granello & Young, 2009). Rogers believed that individuals possess a “formative tendency” to grow and are intrinsically motivated to reach their potential (Sullivan & Stulmaker, 2013; Day, 2008). Person-centered counseling is non-directive, with the client selecting issues they identify to be important to them (Granello & Young, 2009). Ray and Schottelkorb (2009) suggested incorporating person-centered techniques into the school setting by providing professional development to teachers and staff, including reflective listening, returning responsibility to the student, and choice-giving. Slaten, Elison, Hughes, Yough, and Shemwell (2015) found a preference for these basic tenets of person-centered counseling among academically at-risk students. Rogers’ focus on the individual being in control, paired with his emphasis on the relationship and unconditional positive regard for the client, qualify his theory as being both humanistic and phenomenological in nature.

Adlerian

Alfred Adler also emphasized the concept of what he called a “style of life,” where a person’s experiences impact internal values and goals (Day, 2008). In Adlerian counseling, the counseling relationship is a collaborative alliance between counselor and client, with a sense of shared power and responsibility (Kottman, Bryant, Alexander, & Kroger, 2009). In addition to the collaborative therapeutic relationship, conceptualizing the individual’s lifestyle, facilitating insight gains, and reorienting the individual are core concepts of Adlerian therapy (Kottman, Bryant, Alexander, & Kroger, 2009; Day, 2008). A significant element of the Adlerian approach is the emphasis on the family, including birth order. Adler’s family systems approach highlights
the impact of the family where an individual defines himself (Guardia & Banner, 2012). Adler highlighted the social role of the school setting in orienting children to successful group activity (Day, 2008). The Adlerian collaboration allows higher agency of the student while acknowledging their individual journey, including the emphasis of the family background, and providing an opportunity through school for students to learn about functioning within society in addition to academic content.

Existentialism

An existential approach to counseling deals with the intersection of the concerns of life and an individual’s concept of being (Henrikson, 2013). The four pillars, or major concerns, of existentialism include death, freedom, isolation, and meaninglessness (Henrikson, 2013; Day, 2008; Yalom & Leszcz, 2015). In existentialism, anxiety is a result of conflicts with any of the major concerns (Yalom & Leszcz, 2015). An existential counseling relationship is collaborative to help the client identify their beliefs about life (Henrikson, 2013; Day, 2008). Existentialism operates within four synchronous dimensions: the self (including awareness); the natural world and environment; relationships; and spiritual dynamics (Day, 2008). Yalom and Leszcz (2015) described the humanistic Americanization of existentialism which focuses on potential instead of limits, and awareness instead of acceptance. Within schools, an existential approach can strengthen a group setting in addition to individual counseling, as a group would overlap the relationship between self and an environment of peers (Yalom & Leszcz, 2015). Existentialism combines the phenomenological individual concept of being with the general human experience. In the school setting, this includes relating the self and the surrounding environment, to include social relationships.
Gestalt Psychotherapy

Gestalt psychotherapy, established by Fritz Perls, is based on existential roots (Yalom & Leszcz, 2015). This approach relates to a phenomenological conceptual approach by emphasizing the environment. Perls used the idea of a figure and ground to separate important and unimportant elements of the environment (Day, 2008). The two essential concepts of Gestalt Psychotherapy include an awareness and polarities, with awareness serving as the key to personal integration and polarities representing the conflicts within the individual (Day, 2008, Yalom & Leszcz, 2015). Contacts, boundaries, and support are also significant concepts within Gestalt Psychotherapy (Day, 2008). These boundaries and supports can be integrated by accessing students through the school setting to provide Gestalt psychotherapy and increase awareness to enhance sense of self and perception.

Behavioral Therapies

Behavioral therapies are based on learning theory, interrelating the actions, feelings, and thoughts of an individual (Day, 2008). Behavioral therapies begin with assessment, with a goal of behavior change (Granello & Young, 2012). Within behaviorism, a critique is the lack of control an individual has over his own development (Berk, 2010). Phenomenologically, behaviorism views behavior as “the result of what the environment rewards and punishes (Granello & Young, 2012).” Behavior therapy emphasizes learning as causing and changing behavior (Granello & Young, 2012). Ivan Pavlov discovered classical conditioning by experimenting with stimulus and response in his work with dogs (Berk, 2010; Day, 2008). John
B. Watson expanded Pavlov’s work and connected the ability to alter child behavior through the use of stimulus and response (Berk, 2010; Day, 2008; Granello & Young, 2012).

Later, Edward Thorndike researched operant conditioning and developed the two laws of learning. The law of exercise suggests that a higher frequency of connection between behavior and consequence leads to stronger connection, while the law of effect refers to a connection that leads to positive experience strengthens the connection (Day, 2008). B. F. Skinner applied behavioral therapies to humans and focused on the observable, especially controlling the frequency of behavior by using positive and negative reinforcement (Berk, 2010; Day, 2008; Granello & Young, 2012). Albert Bandura expanded this with his social learning theory, suggesting that modeling and thought process impact learning (Day, 2008). Bandura’s work with thought process and learning use cognition as a bridge, connecting his theory to cognitive behavioral therapies. The emphasis on assessment and goal setting to achieve behavior change aligns with schools and the concept of learning, teachers can manage student behaviors through conditioning and modeling. These approaches can be expanded through behavioral counseling approaches within the school setting.

Cognitive-Behavioral Therapies

Cognitive-Behavioral Therapies expanded to connect the power of thinking in overriding the impulses of emotions and behavior (Day, 2008). Aaron Beck developed cognitive therapy, with a cognitive triad consisting of negative views of self, others, and the world (Granello & Young, 2012). Beck’s Cognitive Therapy focuses on identifying and challenging dysfunctional thought patterns and emphasizes collaborative empiricism (Day, 2008). Albert Ellis
incorporated behavior into Beck’s work, creating Rational-Emotive Behavior Therapy (REBT) (Granello & Young, 2012). Ellis’ REBT identifies humans as inherently rational, with internal messages determining emotions and behaviors (Day, 2008). In using REBT, errors and faults in information processing are identified, and core schemas represent the belief systems in a network (Day, 2008). In both Cognitive Therapy and REBT, individuals interpret life events and treatment includes discovering and changing dysfunctional belief systems (Granello & Young, 2012).

Additionally, Reality Therapy is relevant in the schools. Wubbolding (2013) describes Glasser’s Reality Therapy as using an operative framework of behavioral self-control and a corrective behavioral intervention program. Reality Therapy identifies two vital human needs: relatedness and respect (Wubbolding, 2013). Choice theory, a component of Reality Therapy, outlines human behavior as an attempt to satisfy human needs (Wubbolding, 2013). M. M. Linehan’s Dialectical Behavior Theory was originally designed for people with borderline personality disorder, and emphasizes self-acceptance and change (Day, 2008). While schools may not be conventional places of DBT practice, Linehan also introduced mindfulness, the idea of accepting things that cannot easily be changed, which can be implemented into various educational settings (Day, 2008).

Also popular in the school settings is Solution Focused Therapy (SFT), which is goal driven. Within SFT, each session is seen as if it could be the final session, therefore the therapy is brief (Day, 2008). SFT emphasizes exceptions to the problem being presented, enabling the student to experience the problem in a new way and discover how it can be changed (Litrell, 2009). A criticism of SFT is that occasionally a problem may be beyond the scope of the brief
limits (Litrell, 2009). Phenomenologically, SFT is individualized to the presenting concern and experience of the student, and works well within the time constraints of schools.

**School Mental Health in Action**

Mental health is a concern across the globe (Bährer-Kohler & Carod-Artal, 2017; Kutcher, Wei, & Weist, 2015). Involving mental health services in schools is suggested globally to integrate the promotion of mental health appropriately and effectively, especially in developing countries (Bährer-Kohler & Carod-Artal, 2017). In Brazil, an estimated minimum of six million young people would need at least one mental health evaluation during their teenage years, with a ratio of less than 500 specialized professionals in the country (Estanislau et al., 2015). AlObaidi (2015) described Iraq’s shortage of mental health professionals (AlObaidi, 2015). In Iraq, children and youth are exposed to violence, trauma, and instability while the country undergoes civil unrest and economic difficulty, but there is no mental health strategy in the school system (AlObaidi, 2015). Ghana also lacks a national child and adolescent mental health policy, and both poverty and stigma are barriers to mental health (Lee et al., 2015).

However, in more developed countries such as Canada, comprehensive mental health programs are incorporated into the school systems and communities. The British Columbia School Centered Mental Health Coalition (Coalition)’s goals include improving mental health through commitments and school connectedness, viewing schools as a defining center of the community (Coniglio et al., 2015). In British Columbia, the Coalition provides access to resources and supports, including a Summer Institute for educators and community stakeholders, as well as events for family mental health alignment, provincial professional development, and
student voice including the goal of decreasing mental health stigma (Coniglio et al., 2015). In Novia Scotia, the School-Based Integrated Pathway to Care model integrates mental health promotion through a mental health curriculum and increasing mental health literacy within the school and the community with constant feedback and consultation within the community (Wei et al., 2015).

In school mental health, resources are a barrier to serving students (Kutcher, Wei, & Weist, 2015). School districts can access their resources in order to promote student mental health (Kendziora & Osher, 2016). Florida’s Mental Health Assistance Allocation provides an increase in the funding to districts, which is earmarked for mental health promotion, allowing for additional resources to be provided for students. These resources are used for mental health promotion through identification of mental health concerns among students, prevention strategies, and interventions utilized. This section explores existing identification and prevention practices, as well as examining school and community involvement as partners within mental health promotion.

**Identification**

Mental health interventions occur in schools universally and at the individual level, and these interventions must be targeted appropriately to meet the specific need presented by each student based on the resources available within the school district. For the purpose of this study, identification refers to the process of determining which students need what level of mental health care. Identification of mental health concerns among students allows for appropriate mental health supports to be provided in response to detected concerns. Universal mental health screenings equate to broader scale identification where no student is missed, a baseline is
established, and money can be saved over time (Humphrey & Wigelsworth, 2016). However, screenings should only be conducted when there is an adequate capacity to provide intervention (Moore, Mayworm, Stein, Sharkey, & Dowdy, 2019). Barriers to feasibility include cost and time, as well as training for faculty and staff (Soneson et al., 2020).

**Screening Inventories**

There are many options for mental health screening inventories, ranging from broad scope to specific disorders, either available for purchase or free inventories, but selected screening approaches should be culturally competent (Humphrey & Wigelsworth 2016). Students and/or their parents may complete inventories, or teachers can be a contributing source for screening, but a multi-informant approach is recommended (Humphrey & Wigelsworth, 2016). While universal screening assesses all students, selective screening assesses only those students with identifiable risk factors (Soneson at al., 2020). Teacher nomination can also be incorporated as a method of identifying students at risk for mental health concerns when universal screening is not being implemented (Humphrey & Wigelsworth, 2016). Additionally, a curriculum-based model educates students regarding mental health concerns, relying on student self-identification and self-advocacy in communicating concerns (Soneson et al., 2020).

Mental health screenings in schools can be focused exclusively on deficits or exposure to risk factors, but contemporary screenings focus on both deficits and strengths; screening for distress and strength factors allows for supports to also be provided to students who may demonstrate low strengths with low distress, these languishing students can face similar low outcomes to those with high distress (Moore et al., 2019).
Prevention

The Substance Abuse and Mental Health Services Administration described prevention as a range between deterring diseases and related behaviors to slowing those diseases and limiting their severity (SAMHSA, 2017). Protective factors and risk factors should be considered when planning prevention supports, as well as the influence of the environment (Domitrovich et al., 2010). Promoting protective factors helps with prevention when students face risk factors by limiting the impact of risk factors (Domitrovich et al. 2010; Greenberg et al., 2001). Mental health prevention can be delivered across three scales: universal prevention for an entire population, selective prevention for a subpopulation with known risk factors, and indicated prevention for those members of a population with elevated symptoms (Stormont, Reinke, & Herman, 2009).

Using these three tiers, the entire population gains support regardless of need, a full deterrent on the range of prevention measures. The members of the population with known risk factors may receive interventions which aim both to deter the development of mental health concerns and lower the severity, while the members with elevated symptoms may receive interventions specifically designed to minimize the severity of their concerns. While universal prevention may prevent many problems, a disadvantage is the potential lack of sufficient impact for students needing prevention methods compared to the cost of implementing to all students, including many who do not need prevention supports (Greenberg et al., 2001). Integrated models of prevention apply multiple strategies or programs, and maximizes exposure to intervention (Domitrovich et al., 2010).
School and Community Involvement

The literature suggests that community involvement is critical in serving student mental health needs (Derzon et al., 2011; Kendziora & Osher, 2016). Brofenbrenner’s Bioecological Model supports the partnership between school, family, and community. Within the Bioecological Model, an individual develops among the complex relationships of multiple levels of surrounding environment (Berk, 2010). Indeed, Kendziora and Osher (2016) referred to a successful mental health promotion framework that is child-centered/family focused, community based, and provides culturally competent care to enhance recovery and resilience.

One challenge of community partnerships is maximizing effectiveness, because they are based on relationships and require resources (Derzon et al., 2011). The hierarchy of decision making, with variation across school buildings, causes additional difficulty in creating a coherent program (Weist et al. 2015). Kendziora and Osher (2016) suggest that this fragmentation can be avoided by shifting to a whole-district approach, where the district system instead adopts social-emotional learning practices in an integrative approach.

Recommendations and Legislation

The state of Florida promoted an outline of implementing multi-tiered approaches to student mental health. State legislation created the Mental Health Assistance Allocation Plans and outlined the minimum requirements for school districts to meet. Additionally, federal legislation influenced mental health promotion, including regulations to protect confidentiality of student records pertaining to education and mental health.
Framework for Safe and Successful Schools

The Framework for Safe and Successful Schools provided recommendations for integrating services and was recognized by the Florida Department of Education (FLDOE). The Framework suggested an expansion of the Multi-Tiered System of Supports in using “MPHAT” for crisis response and intervention: Multi-Phase, including prevention, preparedness, response, and recovery; Multi-Hazard, covering dangerous activities that could occur at schools; Multi-Agency, including collaboration between schools, fire, police, mental health, etc.; and Multi-Tiered, including the MTSS approach to identify students who are experiencing barriers to learning (Cowan et al., 2013). Additionally, there is an emphasis on balancing the physical and psychological safety of the school, especially through integrating mental health into the learning process and improving ratios of mental health staff to students (Cowan et al., 2013).

Every Student Succeeds Act

The Every Student Succeeds Act (ESSA) (2015) outlined recommendations for serving students with disabilities, and suggested that funding be used in developing or expanding programs to serve students with disabilities, such as a Multi-Tiered System of Supports (MTSS) or Positive Behavior Intervention System (PBIS). Supporting student mental health through a tiered support system was included within the directives of SB 7030 (2019). Additionally, ESSA (2015) encouraged training in forming partnerships between school and community based mental health programs. School mental health includes both early identification of students in need of services, and also school-based partnership programs (Every Student Succeeds Act, 2015).

Protections for Sensitive Information
Mental health in schools creates an overlap between education and health. A professional responsibility of both fields is documentation, and there are federal protections for this sensitive information. While the Health Insurance Portability and Accountability Act (HIPAA) set the privacy protections for health records, including mental health, the Family Educational Rights and Privacy Act (FERPA) was more relevant for schools because notes kept by schools are regarded as components of a student’s educational record (Strauss, 2016). Confidentiality refers to the legal and ethical duty to keep client information private (Granello & Young, 2009).

Privacy of information increases the likelihood of an individual seeking help, and the privacy protections increase the level of trust (Federal Commission on School Safety, 2018). Exceptions to confidentiality include circumstances where a client is presenting as a danger to himself or others, when abuse is occurring, or when the client waives confidentiality (Granello & Young, 2009). In addition to federal laws and national ethical guidelines, privacy and confidentiality are regulated at the state level. Chapter 1002 of Florida’s K-20 Education Code echoes the expectation of protecting educational records according to federal law.

**Florida Senate Bill 7026**

Florida Senate Bill 7026 (2018), is also referred to as the Marjory Stoneman Douglas High School Public Safety Act. SB 7026 (2018) created the Marjory Stoneman Douglas High School Public Safety Commission within the Department of Law Enforcement. The bill and act provided the purpose for the Mental Health Assistance Allocation, which was to assist in establishing or expanding comprehensive mental health programs, training educators and staff in supporting mental health of students, and connecting students and families to appropriate
services. Minimum expectations of Mental Health Assistance Allocation Plans, according to SB 7026 (2019), include information about at least one community mental health partnership, training for Mental Health First Aid or similar programs, and a mental health crisis intervention strategy.

**Florida Senate Bill 7030**

Senate Bill 7030 (2019) outlined the funding for Mental Health Assistance Allocations, the requirement for each district to submit a Mental Health Assistance Allocation Plan, and outlined the minimum elements for these plans including:

- Strategies or programs to reduce the likelihood of at risk students developing social, emotional, or behavioral health problems; depression; anxiety disorders or substance use disorders; strategies to improve the early identification of social, emotional, or behavioral problems or substance use disorders; to improve the provision of early identification services… (SB 7030, 2019, p. 48).

These minimum expectations outline the identification, prevention, and intervention services for mental health supports for students. The framework suggested contextual factors as significant, but did not identify specific strategies that could be used to guide the process of completing the Mental Health Assistance Allocation Plan.

**Students and Schools**

Children spend much of their time in schools, offering an opportunity to positively impact them through the school setting. The National Academies of Sciences, Engineering, and
Medicine (2019) deemed this a feasible and beneficial task, although they acknowledged the challenge of integrating evidence-based approaches to span varying levels of development and risk/protective factors. Teachers must balance student need and academic content, despite some students may present with mental health related behavioral, social, or academic challenges (Morton & Berardi, 2018). Individual factors such as sleep and nutrition influence mental health in addition to family and community characteristics (National Academies of Sciences, Engineering, and Medicine, 2019).

Youth Mental Health Statistics

The Youth Risk Behavior Surveillance Survey (YRBSS) questioned students within 38 states about prevalence of risk behaviors within the twelve-month period of time prior to the survey. The YRBSS identifies five suicide-related risk behaviors as (a) having felt sad or hopeless, (b) having seriously considered attempting suicide, (c) having made a suicide plan, (d) having attempted suicide, and (e) having made a suicide attempt resulting in an injury, poisoning, or overdoes that had to be treated by a doctor or nurse (Kann et al., 2017). The prevalence of suicide related behaviors was higher among female students than male students and also among students who were gay, lesbian, or bisexual (Kann et al., 2017).

These mental health concerns can be related to traumatic experiences, which are also prevalent. Based on an analysis of the National Comorbidity Study-Replication Survey, almost 40% of adults reported having at least one traumatic experience by age 13 (Koenen, Roberts, Stone, & Dunn, 2010). Within Florida, the National Association on Mental Illness (n.d.) reported more than six million people living in a mental health professional shortage area.
In 2018, states were ranked based on low rates of mental health concerns combined with high access to care across both adult and youth populations. Despite ranking only 9th in low prevalence of mental illness, Florida was ranked 43rd in access to care, resulting in an overall ranking of 32nd among all states, as well as 32nd in overall youth rankings (Hellebuyck, Halpern, & Nguyen, 2018). In this same study, Florida youth showed higher access to care than adults, ranking 28th in that category, but ranking 42nd in mental health work force availability (Hellebuyck, Halpern, & Nguyen, 2018).

Development

National Academies of Sciences, Engineering, and Medicine (2019) found student mental, emotional, and behavioral health to be a complex process influenced by many physical and social factors, including genetics, brain development, parenting, and school climate. Experiences shape neural connections, and early experiences particularly influence basic regulatory structures of the brain (Siegel, 2020). While early childhood presents a limited attention span with typical social/emotional conflicts emerging from egocentric thinking, more complex emotions emerge in middle childhood when school-related stressors are most common (Vernon, 2009). During childhood, negative interpersonal experiences or traumatic events are more likely to be related to decreased impulse regulation and conflicted sense of self (Van der Kolk & d’Andrea, 2010).

Teicher et al. (2010) suggested varying regions of the brain displayed different levels of vulnerability to stress. Early adolescents can struggle to deal with emotions, and relationships with others are a common struggle (Vernon, 2009). Meanwhile, mid-adolescents are more able
to express themselves, and face planning for postsecondary life (Vernon, 2009). Child and adolescent development relate directly to mental health concerns. The National Alliance on Mental Illness (n.d.) reported 50% of mental illness beginning by age 14, and 75% of mental illness beginning by age 24.

Funding

A portion of school funding comes from the state level, and the legislature established the Florida Education Finance Program (FEFP) in 1973 to equalize funding for students (Escue, 2012; Florida Department of Education [FLDOE], 2020a). The FEFP acknowledges factors relevant to equalizing school funding, including varying (a) local property tax, (b) education program costs, (c) costs of living, and (d) cost for equal programming based on disbursement of student population (FLDOE, 2020a). Public school district funding comes from federal, state, and local government sources.

In 2018, school districts received 39.9% of their funding from state sources, 48.79% from local sources, and 11.31% from federal sources (FLDOE, 2020a). In the final calculation for the 2019-2020 school year, the total FEFP for the state was $17,115,511,54; the Mental Health Assistance Allocation comprised $75,000,000 of those total funds (FLDOE, 2020b). Each of the 67 school districts in the state was allocated $100,000 and remaining balance was distributed based on student enrollment (FLDOE, 2020a). Prior to the development of Mental Health Assistance Allocation Plans, Kutash, Duchnowski, & Lynn (2006) estimated that Medicaid funded more than half of public health services provided at the state level, with schools providing majority of mental health services to children.
Trauma

Childhood trauma research has developed from the physical impacts to the psychological ramifications, and developments in technology allow for analysis of the influence of traumatic experiences on brain development. In the mid-1800’s, Ambrose Tardieu published the first paper about child abuse, primarily focusing on physical abuse, while Jean Martin Charcot acknowledged traumatizing events in many of his patients being treated for hysteria (Dorahy, van der Hart, & Middleton, 2010). Even earlier, Charles Darwin researched the connection between the body and mind, which today is monitored through the vagus, an element of the autonomic nervous system (Porges, 2003; van der Kolk, 2015). The influence on the brain can impact present experiences, self-awareness and expression, and both emotional and physical regulation. Therefore, traumatic experiences have the power to shape a student experience, and educators have a responsibility to remain informed regarding trauma sensitive practices.

Neurobiology of Trauma

Trauma can impact the way that the brain processes information, and viscerally the body reacts to this new interpretation. Van der Kolk (2015) explained being traumatized as the past continuing to impact the present as if the trauma were still occurring. The effects of reliving trauma include shutting off access to various parts of the brain such as Broca’s area, responsible for language, as well as rekindling Brodmann’s area 19 in the visual cortex (van der Kolk, 2015). In addition to communication and sensory difficulty impacting learning, students may also face challenges engaging socially. When an individual perceives a situation as dangerous their social engagement become more primitive, similar to a fight-flight reaction (Porges, 2003). The stress
hormones released in response to trauma limit the effectiveness of these structures relevant to cognitive processing (Morton & Berardi, 2018).

Van der Kolk (2015, p. 56-59) explained the structure of the triune, or three-part brain, including (a) the brainstem, or reptilian brain, which organizes basic life-sustaining functions; (b) the mammalian brain, or limbic system, which is shaped in response to experience and controls emotions; and (c) the neocortex, the center of reason. In addition to basic function, emotion, and reason, trauma can also impact the physical systems of the body. Teicher et al. (2010) found exposure to trauma influenced the sensory systems of the brain, and Siegel (2020) emphasized negative impact of trauma on the regulatory features of the body. Van der Kolk (2015) also described the midline structures as the Mohawk of self-awareness, which connects sense of self but which can be shut down by trauma.

Childhood Trauma

While much trauma research has been centered around veterans, Van der Kolk (2015) indicated that for each soldier who served in a war zone abroad, there are ten children enduring trauma at home. Childhood experiences and trauma are impactful to mental health, and the Adverse Childhood Experiences (ACEs) are used to measure childhood adversity. The three categories of ACEs include child abuse, neglect, and household challenges (Ports, Ford, Merrick & Guinn, 2020). ACEs impact brain development, and subsequently the ability to regulate emotions and influence coping strategies (Sheffler, Stanley, & Sachs-Ericsson, 2020). Higher ACEs create higher levels of disruption in youth development (Báez et al., 219). Community level ACEs and adverse conditions can also put children at risk (Ports, Ford, Merrick, & Guinn,
Children enduring or reliving trauma may appear distracted, disengaged, and defiant, and these trauma responses can be misinterpreted by educators (Morton & Berardi, 2018).

Trauma Sensitive Schools and Trauma Informed Care

Báez et al. (2019) described the universal benefit of implementing a trauma-informed framework, allowing students to receive support regardless of the level of intervention they were targeted to receive. The transition from specific trauma treatment for individual students to a school-wide trauma-sensitive approach promotes resilience for all students (Gherardi, Flinn, & Jaure, 2020).

In creating a trauma sensitive school, Gherardi, Flinn, & Jaure (2020) described professional development as a first step. Meanwhile, Morton and Berardi (2018) called for extensive training in the community-wide effort of caring for children with trauma; for educators they suggested incorporating trauma-informed specializations into teacher training programs rather than brief professional development sessions, and for mental health professionals they called for trauma-informed expertise. Experience shapes the way the brain process information, but relationships have the power to influence the way children interpret their experiences (Siegel, 2020).

Grounded Theory

Corbin and Strauss (2012) identified grounded theory as a humanistic approach. Grounded theory is developed from Chicago interactionism, concerning developing definitions, and pragmatism, assuming that knowledge is created through action and interaction (Corbin & Strauss, 2012). As a component of grounded theory, Corbin and Strauss (2012) acknowledged
the analytic strategy of considering the meanings of the words. Within grounded theory, the researcher discovers categories and their properties through data analysis, evaluates conditions and consequences of these categories, develops them at varying conceptual levels, forms a hypothesis based on the data, and integrates the information within a theoretical framework (Glaser and Strauss, 2017).

**Summary**

The literature consists of a combining force of humanistic theories, including counseling theories and grounded theory, which can be operationalized in practices seen today. Mental health promotion in school is not limited to reactive interactions, instead identification measures can be taken in addition to preventative supports. Mental health is not isolated to the individual, and both family and community factors can influence a student. Additionally, trauma may influence the brain, mind, and body of a student.

Schools are uniquely positioned to provide support in promoting mental health due to the amount of time that students spend within the school environment. Still, mental health promotion consists of many stakeholders, including students, families, and teachers in addition to school based mental health services providers and community partnerships. The current legislative stance does not provide specific directives, but districts are contributing their plans which will be evaluated to identify and analyze specific strategies.
CHAPTER 3-METHODOLOGY

Introduction

Corbin and Strauss (2012) suggested that conceptual ordering is a way to classify information, and theorizing is a way to explain relationships. The approach used in this study is to conduct a document analysis of Mental Health Assistance Allocation Plans from a sample of school districts in the state of Florida, collecting and analyzing data regarding the strategies described for identifying, preventing, and intervening with mental health concerns for students. This chapter consists of an overview of the purpose of the study, the process for selecting the sample, and descriptions of the instrumentation, data collection, and data analysis.

Purpose of the Study

The purpose of this study was to determine the mental health services being provided to students in the state of Florida, specifically the identification of mental health concerns among students, prevention strategies, and interventions utilized. This study consisted of a document analysis of the Mental Health Assistance Allocation Plans submitted to, and posted by, the Florida Department of Education, for the purpose of developing a grounded theory to standardize recommended practices in serving the mental health needs of students.

Selection of Sample

The population consists of school districts in Florida. Florida Senate Bill 7030 (2019) outlined the minimum requirements which school districts must include in Mental Health Assistance Allocation Plans, to include identification, prevention, and intervention of mental
health concerns in supporting students. Funding is provided from the state to each school district based on the MHAAP (SB 7030, 2019). Corbin and Strauss (2012) suggested that theoretical sampling is an acceptable and appropriate for Grounded Theory to expand upon the initial sample based upon concepts and themes revealed within the data. Fraenkel, Wallen and Hyun (2015) defined theoretical sampling as a type of purposive sampling typically used within qualitative research. Theoretical sampling calls for the continued sampling of groups until saturation occurs, or no additional data emerge to develop the properties of a category, and core categories emerge to inform the development of theory (Glaser & Strauss, 2017). Purposive sampling is non-random, and school districts were selected to represent the population.

Within qualitative studies, the sample size typically consists of between one and twenty participants (Fraenkel, Wallen & Hyun, 2015). While the entire population is accessible, the feasible sample size is limited, and therefore began with ten districts. Glaser and Strauss (2017) indicated that theoretical sampling and data collection occur simultaneously, as a category is continually sampled until it reaches saturation and no new ideas or data emerge. The selection of school districts aligned with the recommendation of Glaser and Strauss (2017) to select comparison groups based on theoretical relevance, different groups aid in establishing as many categories as possible and broaden the scope.

Dan Siegel (2020) emphasized the importance of environment on brain development and mental health, particularly the difference between a supportive environment and a stressful environment. The factors of a school district, representing a student environment in this study, which were used as a baseline for the original sample included geographic setting, number of students by enrollment, and rate of poverty within the school district. Level of poverty within
the household and community influences mental health (National Academies of Sciences, Engineering, and Medicine, 2019; Koenen, Roberts, Stone, & Dunn, 2010). Additionally, setting is an influential factor: a rural setting may have less access to mental health resources (Federal Commission on School Safety, 2018), while a more urban setting is more likely to introduce victimization and trauma (Koenen, Roberts, Stone, & Dunn, 2010).

School districts selected for the theoretical sample included (a) the most rural school district and the most urban school district (b) two largest and two smallest school districts by student enrollment numbers, and (c) the two school districts with lowest poverty rate and the two school districts with the highest poverty rate (Table 1). The selection of the districts representing these categories was informed through the American Community Survey and the National Center for Education Statistics.

Table 1

School Districts in Original Sample

<table>
<thead>
<tr>
<th>School District</th>
<th>Poverty Rate</th>
<th>Students Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>7.4</td>
<td>41897</td>
</tr>
<tr>
<td>C</td>
<td>8.2</td>
<td>38284</td>
</tr>
<tr>
<td>B</td>
<td>11.7</td>
<td>270978</td>
</tr>
<tr>
<td>E</td>
<td>13.3</td>
<td>130229</td>
</tr>
<tr>
<td>D</td>
<td>16.9</td>
<td>350434</td>
</tr>
<tr>
<td>J</td>
<td>18</td>
<td>1228</td>
</tr>
<tr>
<td>I</td>
<td>20.4</td>
<td>769</td>
</tr>
<tr>
<td>F</td>
<td>23.8</td>
<td>1315</td>
</tr>
<tr>
<td>G</td>
<td>24.6</td>
<td>5237</td>
</tr>
<tr>
<td>H</td>
<td>26.4</td>
<td>7266</td>
</tr>
</tbody>
</table>
The use of theoretical sampling in this study expanded the sample after the initial round of coding. In instances of overlap when expanding the sample, when a school district was next to be included in two categories, that school district was included and the following two sequential school districts in each category were also included to avoid bias. Due to small representation in the geographic spectrum, the sample was expanded after the first reading based on the next levels of urban and rural school districts. Out of those eight school districts, five were included to represent the extremes among the other two categories of school districts included in this sample. Within the first expansion of the sample, there was overlap in two categories (e.g., as shown in Table 2; School District N had the lowest level of poverty and highest number of students) and therefore that school district was included in addition with the next sequential school districts in each of those categories, expanding the sample by five schools.

Table 2

<table>
<thead>
<tr>
<th>School District</th>
<th>Poverty Rate</th>
<th>Students Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>12</td>
<td>41409</td>
</tr>
<tr>
<td>O</td>
<td>13.1</td>
<td>5057</td>
</tr>
<tr>
<td>K</td>
<td>21.5</td>
<td>33974</td>
</tr>
<tr>
<td>L</td>
<td>22.8</td>
<td>1318</td>
</tr>
<tr>
<td>A</td>
<td>24.1</td>
<td>29845</td>
</tr>
</tbody>
</table>

Instrumentation

Instrumentation refers to the whole process of preparing to collect data, including the location of data, time of collection, frequency of collection, and who will be collecting the data (Fraenkel, Wallen, & Hyun, 2015). In this study, the data are publicly accessible on the Florida
Department of Education website. Fraenkel, Wallen, and Hyun (2015) suggested that in qualitative studies, the researcher can serve as the primary data collection instrument. For the purpose of this study, the data was collected throughout the fall of 2020 by the researcher. This study used grounded theory, which can lead to description, conceptual ordering, and theory, based on existing data (Corbin & Strauss, 2012). The existing data consists of the Mental Health Assistance Allocation Plans of sample school districts in Florida from the 2019-2020 school year. As an element of grounded theory, data collection and sampling can occur simultaneously (Glaser & Strauss, 2017).

When one researcher is conducting the content analysis, reliability can be increased through reevaluating categories after a meaningful amount of time (Fraenkel, Wallen, & Hyun, 2015). Therefore, no less than three readings occurred for each district plan. Context is significant in grounding concepts and putting them into perspective (Corbin & Strauss, 2012). In respect to validity, coding the content for manifest and latent content strengthen the validity of the research (Fraenkel, Wallen, & Hyun, 2015). Triangulation occurred through reading and analyzing the School Board discussion of the Mental Health Assistance Plans, via meeting note documents posted online.

**Data Collection**

Concepts are identified within the data and guide the organization process (Corbin & Strauss, 2012). As part of grounded theory, the documents for the sample were read and coded. Collected data were managed systematically, with notes kept regarding the sample demographics in order to manage the relationship between documents (Gross, 2018). The data were publicly
available, easing the collection process. The American Community Survey organized school districts by poverty level, and the information was retrieved from proximityone.com/sd_fl.htm. The school district information regarding number of student enrollments and categorizing districts on a spectrum of rural to urban was retrieved from the National Center for Education Statistics School and District Navigator, at nces.ed.gov/ccd/schoolmap. The Mental Health Assistance Allocation Plans for the 2019-2020 School Year were retrieved from fldoe.org/safe-schools/mental-health.stml.

Once the data were initially collected, a second reading was conducted to analyze trends within the data. Glaser and Strauss (2017) described the process of continuous, simultaneous data collection and analysis until theoretical saturation occurs, or when there is no further data being found to develop properties or a category. Saturation was determined based on code saturation, where no further categories emerged. The scope of the research also leaned to saturation in that the sample was focused. Additionally, triangulation through school board meeting notes supported determination of saturation. Categorizing data by coding occurs as data collection begins and continues as data continues to be collected (Thornberg, 2017). Therefore, data collection continued within the study both in terms of expanding the sample and repeated readings of the plans to code and process information until saturation occurs. Glaser and Strauss (2017) suggested flexibility in theoretical sampling, allowing for theoretical questions to impact the selection of groups as the sample expands.
**Data Analysis**

Data analysis is conducted in grounded theory when the researcher disaggregates the components to identify properties and dimensions, then forms inferences to give meaning to the data (Corbin & Strauss, 2012). A concern of the literature (Cowan et al., 2013), regards a disconnect between the context and the mental health supports, but grounded theory considers the context and how this context shapes the nature of circumstances from a macro to micro level (Corbin & Strauss, 2012).

As data were collected, they were coded, or labeled, and higher-level codes that emerged formed categories (Thornberg, 2017). Joint coding and analysis allowed for the developing theory to be integrated, and a researcher should code the same content three to four times (Glaser & Strauss, 2017). With each of the three rounds of reading for this study, the coding process developed to accommodate the joint coding and analysis process. These coding types implemented included (a) open or initial coding, (b) focused coding, and (c) axial coding. Finally, the coded data was thematically analyzed.

Open, or initial coding, consists of exploring and defining the data (Thornberg, 2017). Saldaña (2016) described initial coding as an elemental type of coding, which breaks data into discrete parts and allows for comparison of similarities and differences, although all codes developed during the initial coding will be tentative. The second reading used focused coding, where data categories were coded based on thematic or conceptual similarity to find the most significant or frequent codes and elevate them as the most salient categories (Saldaña, 2016; Thornberg, 2017). Within the third reading, axial coding described the category properties and
dimensions, and explores the relationship between categories (Saldaña, 2016; Thornberg, 2017). Thematic analysis of codes, categories, and written memos will assist with linking major concepts and integrating the grounded theory (Gross, 2018; Thornberg, 2017).

**Summary**

Corbin and Strauss (2012) described the humanistic nature of grounded theory as it develops a theory to provide meaning to the interrelationships of the processes in practice. This approach considers the context of the data as analysis occurs and a theory emerges through the trends identified. The purposive sample initially selected may be expanded until data saturation occurs, data collection and coding will occur simultaneously. Multiple readings allowed for plans to be coded several times and strengthen the reliability of the research. Meanwhile, the coding covered both manifest and latent content to enhance validity. Categories were developed from the coding and enabled the emerging theory to be fully integrated.

**Conclusion**

Grounded theory is generated through the discovery of important categories and their properties, conditions, and consequences (Glaser & Strauss, 2017). The conclusion of this research consists of a grounded theory recommending standard practices for the identification of mental health concerns among students, prevention strategies, and interventions utilized.
CHAPTER 4- RESULTS

Introduction

This chapter consists of a report of the results from this research study which mirrors the coding process. First, the research questions are revisited, as the data are organized by research question. Each research question has a dedicated section, which includes an introduction to the research question with an overview of the original codes which emerged from round one. Each subsection of the research question sections represents the primary categories which emerged from the second round of coding. The subsections contain details about the categories, including the properties, dimensions, and relationships, having emerged from the third round of coding. Within the first round of reading, three primary codes emerged including personnel, practices, and procedures. Personnel referred to the individuals providing mental health supports, practices referred to what the specific supports were, and procedures referred to how these supports were delivered. After the research questions, this chapter contains a section on the triangulation process prior to the chapter summary. The population consisted of fifteen public school districts in Florida, representing demographics including urban and rural settings, plus high and low rates of both poverty and student enrollment (Table 3).
Table 3

Overview of Sample of Study

<table>
<thead>
<tr>
<th>School District</th>
<th>Students Enrolled</th>
<th>Poverty Rate</th>
<th>Geography</th>
<th>Original Sample/Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>7266</td>
<td>26.4</td>
<td>Town: Remote</td>
<td>Original</td>
</tr>
<tr>
<td>G</td>
<td>5237</td>
<td>24.6</td>
<td>Rural: Fringe</td>
<td>Original</td>
</tr>
<tr>
<td>A</td>
<td>29845</td>
<td>24.1</td>
<td>City: Mid-size</td>
<td>Expansion</td>
</tr>
<tr>
<td>F</td>
<td>1315</td>
<td>23.8</td>
<td>Rural: Fringe</td>
<td>Original</td>
</tr>
<tr>
<td>L</td>
<td>1318</td>
<td>22.8</td>
<td>Rural: Distant</td>
<td>Expansion</td>
</tr>
<tr>
<td>K</td>
<td>33974</td>
<td>21.5</td>
<td>City: Mid-size</td>
<td>Expansion</td>
</tr>
<tr>
<td>I</td>
<td>769</td>
<td>20.4</td>
<td>Rural: Distant</td>
<td>Original</td>
</tr>
<tr>
<td>J</td>
<td>1228</td>
<td>18</td>
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</tr>
<tr>
<td>D</td>
<td>350434</td>
<td>16.9</td>
<td>Suburb: Large</td>
<td>Original</td>
</tr>
<tr>
<td>E</td>
<td>130229</td>
<td>13.3</td>
<td>City: Large</td>
<td>Original</td>
</tr>
<tr>
<td>O</td>
<td>5057</td>
<td>13.1</td>
<td>Rural: Distant</td>
<td>Expansion</td>
</tr>
<tr>
<td>N</td>
<td>41409</td>
<td>12</td>
<td>City: Mid-size</td>
<td>Expansion</td>
</tr>
<tr>
<td>B</td>
<td>270978</td>
<td>11.7</td>
<td>Suburb: Large</td>
<td>Original</td>
</tr>
<tr>
<td>C</td>
<td>38284</td>
<td>8.2</td>
<td>Suburb: Large</td>
<td>Original</td>
</tr>
<tr>
<td>M</td>
<td>41897</td>
<td>7.4</td>
<td>Rural: Fringe</td>
<td>Original</td>
</tr>
</tbody>
</table>

Research Question 1

1. How are Florida school districts identifying students who present with mental health concerns?

In identifying student mental health concerns, the categories which emerged included determining the level of need, information, and actions or steps. Each category is explored including the properties or characteristics, and dimensions or variations. The category of determining level of need consisted of indicators and self-identification, screenings and surveys, and crisis evaluation. The category of information consisted of parental consent, information
sharing, and information management. The category of actions or steps consisted of student programs, faculty identification, and referral processes.

**Determining Level of Need**

Within the category of determining level of need, school districts described methods of identifying student need, including the use of screenings and surveys as well as the professional administering those assessments. Additional sources for identification included self-report questions on registration forms, where school districts ask families to provide input regarding mental health concerns. Students in crisis may be evaluated for suicidal or homicidal ideation, and a psychiatric evaluation is a component of a Baker Act, which can occur on school property or outside of school; some school districts emphasize coordinating care in the event of a student returning to school after hospitalization and/or psychiatric care. Regardless of crisis, school districts described determining the appropriate level of care for the students identified with mental health concerns.

**Indicators and Self-Identification**

Early Warning System Indicators included attendance, grade, and discipline data. Eighty percent (80%) of school districts in this study (the exceptions being School Districts B, E, and I) included a description in their Mental Health Plan for utilizing an Early Warning System to identify students expressing mental health needs or concerns. In addition to the Early Warning System, School Districts H, I, J, and M included descriptions of their students using FortifyFlorida, a website/application where students may anonymously report suspicious activity and concerning behavior to school officials and law enforcement. School districts ask families to disclose existing mental health concerns via the enrollment and registration process. School
Districts F, L and O each highlighted this attempt to identify students with mental health concerns within their MHAAP documents.

Table 4

Indicators and Identification

<table>
<thead>
<tr>
<th>School District</th>
<th>Early Warning System</th>
<th>Self-Report</th>
<th>FortifyFl</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Screenings and Surveys

Additional assessments were used by school districts, including surveys and screenings, as well as self-report information on school registration. Specific screenings included: Behavior Intervention Monitoring Assessment System (BIMAS-2); Biopsychosocial and Children’s Functional Assessment Rating Scales (CFARS); Brief Multidimensional Students’ Life Satisfaction Scale (BMSLSS) screener; Children’s Depression Inventory; Externalizing Screening Scale (Drummond); Internalizing Screening Scale (Cook); Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSD); Neurosequential Model of Therapeutics
as an assessment tool; Panorama Education Survey; Strength and Difficulties Questionnaire; Student Risk Screening Scale (SRSS-IE); and Suicide Risk Assessment and Threat Assessment instruments. School District G indicated that providers have specific assessment tools which they use, while School District N indicated an intention to investigate the potential implementing a mental health screener in the future. One third of school districts (School Districts D, H, I, J, M, and O) did not indicate specific survey/screening assessments or plans for utilizing these tools in the future as elements of their identification process.

Within each school district, different groups of students receive different administrations of the varying assessments identified. In School Districts A, K, and L, all students receive the selected screening instrument(s) universally. Within School District E, the selected screening instrument is administered in grades 3, 6, and 9, as well as to students with violent infractions of the student code of conduct. Additionally, school districts identified the mental health professional administering the screening instrument(s) and assessment(s) including school district employees, specific school employees, and outside/community agency providers.
### Table 5

**Screenings and Surveys**

<table>
<thead>
<tr>
<th>School District</th>
<th>Instrument</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Strength and Difficulties Questionnaire and/or Student Risk Screening Scale</td>
<td>Universal administration to all students</td>
</tr>
<tr>
<td>B</td>
<td>Neurosequential Model of Therapeutics</td>
<td>Unspecified</td>
</tr>
<tr>
<td>C</td>
<td>AllHere: Assessment and intervention</td>
<td>Unspecified</td>
</tr>
<tr>
<td></td>
<td>Biopsychosocial and Children's Functional Assessment Rating Scales (PRE and POST Test); BIMAS</td>
<td>Grades 3, 6, and 9, plus violent infractions of student code of conduct</td>
</tr>
<tr>
<td>E</td>
<td>Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS) Internalizing Screening Scale (Cook) and Externalizing Screening Scale (Drummond); Suicide Risk and Threat Assessment screening</td>
<td>Unspecified</td>
</tr>
<tr>
<td>F</td>
<td>SIBSS- Drummond)</td>
<td>Universal administration to all students</td>
</tr>
</tbody>
</table>

### Crises and Evaluation

At times, student need is identified as part of a crisis intervention or Baker Act where a student receives psychiatric evaluation and subsequent mental health care. Seven school districts provided information directly related to the crisis management and Baker Act process. School districts did not indicate that they were directly initiating any Baker Act. Rather, consultative services were referenced in partnership with local sheriff offices or outside/community agency Licensed Mental Health Counselors when a student expressed intention to harm themselves or others, and school districts provided information regarding the impact on identifying student need and responding accordingly.

In School District E, when a student may pose threat to themselves or others, the school contacts a school district hotline, then a school district advisor is sent the assessment and
contacts the Child Guidance Rapid Response Team, who sends a Licensed Mental Health Counselor to the school to assess the student. In School District I, a Designated Mental Health Employee conducts the Risk Assessment. In each of these school districts, if no Baker Act is initiated then there is still therapeutic follow up with either resources provided or a meeting held to determine appropriate interventions.

Other individuals may initiate the Baker Act: in School District L, the local sheriff’s office conducts the Baker Act while in School District M, a Mobile Crisis Response Team is utilized. After determination and transport, School District B receives support from the local health system’s Youth Emergency Services Team. A key component of supporting students who have been hospitalized is to coordinate care and build upon their supports, and the process for re-entry to the school must consider these factors. The Multiagency Network for Students with Emotional/Behavioral Disabilities (SEDNET) has a coordinator in two different school districts (B and D), who is involved in communicating with the facilities and school districts when a student returns from a Baker Act. In School District M, the School Social Workers have worked to build relationships with Baker Act receiving facilities in order to encourage parents to share information with the school district after an at-home-initiated hospitalization. In School District E, a Crisis Team uses a Discharge Plan in partnership with the School Social Worker and School Counselor in order to continue the care plan. School District O refers students with more than two psychiatric evaluations to the Community Action Team and shares information with the Threat Assessment Team to coordinate care and supports.

Regardless of whether a student is in crisis, varying levels of mental health need must be determined in order to match appropriate level of care when a student presents with mental
health concerns. Within this study, only one school district contains steps in the MHAAP to provide a diagnosis to students with mental health concerns. School District E includes Full Service Schools, and the Therapist uses the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) to diagnose mental illness. Both School Districts A and O evaluate the student for Exceptional Student Education services, reviewing data as part of an Individual Education Plan team to determine student eligibility under IDEA. The Problem-Solving Team (also Multi-Tiered System of Success Teams and Student Study Teams) also meet to identify level of need and determine the appropriate intervention based on data collected, especially in School Districts A, B, G, I, M, and N.

Table 6

### Crisis and Evaluation

<table>
<thead>
<tr>
<th>School District</th>
<th>Threat/Risk Assessment</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Youth Emergency Services Team; SEDNET</td>
<td>Evaluate for Exceptional Student Education services/interventions</td>
</tr>
<tr>
<td>B</td>
<td>Youth Emergency Services Team; SEDNET</td>
<td>MTSS/PST</td>
</tr>
<tr>
<td>D</td>
<td>Child Guidance Rapid Response Team</td>
<td>SEDNET support</td>
</tr>
<tr>
<td>E</td>
<td>Child Guidance Rapid Response Team</td>
<td>Crisis Team Discharge Plan; Diagnosis possible</td>
</tr>
<tr>
<td>G</td>
<td>Designated Mental Health Employee Conducts Risk Assessment</td>
<td>MTSS/PST</td>
</tr>
<tr>
<td>I</td>
<td>Local Sheriff’s office conducts assessment</td>
<td>MTSS/PST</td>
</tr>
<tr>
<td>M</td>
<td>Mobile Crisis Response Team</td>
<td>School Social Worker builds relationship; MTSS/PST</td>
</tr>
<tr>
<td>N</td>
<td>Evaluate for Exceptional Student Education services</td>
<td>Referral to Community Action Team after 2+ evaluations; MTSS/PST</td>
</tr>
<tr>
<td>O</td>
<td></td>
<td>Evaluate for Exceptional Student Education services</td>
</tr>
</tbody>
</table>
Information

Once a student has been identified with a mental health concern, data driven decisions are made regarding the mental health care of the student. School districts described gaining parent consent for providing mental health services, sharing information with outside community agencies to coordinate continuous care for the student, and managing all collected information both securely and effectively.

Parental Consent

School Districts indicated the importance of gaining parental consent for screening students for mental health concerns after concern is raised. School District F emphasized the importance of gaining parental consent for additional assessments as student mental health concerns are identified. Similarly, School District G indicated that parental consent was required to administer screenings based on Early Warning System Indicators or teacher/parent referral for mental health concerns. In contrast, in School District E, a Full Service Schools Therapist may assess a student one time without parental consent, allowing for potential crisis intervention as necessary. After need has been identified, consent must also be obtained in order to provide mental health care to students. Both in-school services and referrals to outside community agencies require parental consent for mental health care. School Districts A and N emphasized the requirement for parental consent prior to making referrals for outside care as an element of the identification process.
Table 7

Parental Consent

<table>
<thead>
<tr>
<th>School District</th>
<th>Use of Requests to Release Information</th>
<th>Existing Agreements</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Request Release of Information</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Request Release of Information</td>
<td>Agreement with Baker Act receiving Facilities</td>
</tr>
<tr>
<td>G</td>
<td>Request Release of Information</td>
<td>Mutual Exchange of Information Agreements</td>
</tr>
<tr>
<td>H</td>
<td>Request Release of Information</td>
<td>Mutual Exchange of Information Agreements</td>
</tr>
<tr>
<td>I</td>
<td>Request Release of Information</td>
<td>Mutual Exchange of Information Agreements</td>
</tr>
<tr>
<td>K</td>
<td>Request Release of Information</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Developing Request Release of Information</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Request Release of Information</td>
<td>Mutual Exchange of Information Agreements</td>
</tr>
<tr>
<td>N</td>
<td>Request Release of Information</td>
<td></td>
</tr>
</tbody>
</table>

Information Sharing

In coordinating care, sharing information allows the school, outside mental health provider, and family to support the student’s mental health with continuity. However, this information is protected and school districts described the process for gaining permission to share and receive information from outside community agencies regarding student mental health. School District E requested that parents share the Discharge Plan after a Baker Act. School Districts A, G, H, M, and N included descriptions for requesting releases of information in order to consult, communicate, and coordinate with outside community agencies regarding student mental health care. School District L indicated they were developing a process for requesting parent or guardian release to share information.
Some school districts described existing agreements in their Mental Health Assistance Allocation Plans for sharing information with outside/community agencies. School District E specified an agreement with local Baker Act receiving facilities to coordinate the re-entry plan. School Districts H, I, K, and N explained mutual exchange of information agreements with outside/community agencies.

Table 8

Information Sharing

<table>
<thead>
<tr>
<th>School District</th>
<th>Use of Requests to Release Information</th>
<th>Existing Agreements</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Request Release of Information</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Request Release of Information</td>
<td>Agreement with Baker Act receiving Facilities</td>
</tr>
<tr>
<td>G</td>
<td>Request Release of Information</td>
<td>Mutual Exchange of Information Agreements</td>
</tr>
<tr>
<td>H</td>
<td>Request Release of Information</td>
<td>Mutual Exchange of Information Agreements</td>
</tr>
<tr>
<td>I</td>
<td>Request Release of Information</td>
<td>Mutual Exchange of Information Agreements</td>
</tr>
<tr>
<td>K</td>
<td>Request Release of Information</td>
<td>Mutual Exchange of Information Agreements</td>
</tr>
<tr>
<td>L</td>
<td>Developing Request Release of Information</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Request Release of Information</td>
<td>Mutual Exchange of Information Agreements</td>
</tr>
<tr>
<td>N</td>
<td>Request Release of Information</td>
<td>Mutual Exchange of Information Agreements</td>
</tr>
</tbody>
</table>

Information Management

Mental health information falls under the category of health information, and has specific protections in addition to the educational records which schools must already keep protected. Three school districts (E, I, and N) specifically mentioned honoring the Health Insurance Portability and Accountability Act (HIPAA) and/or the Family Education Rights and Privacy Act (FERPA) in their plans.
In addition to protecting the mental health records, school districts manage this information in order to effectively identify students so they may receive appropriate services. Three separate electronic databases specifically emerged within the school district plans for the purpose of managing student mental health information in relation to identifying student mental health needs: Behavior and Academic Support Intervention Services (BASES) database, District Student Case Management System (SCMS), and Behavior Intervention Monitoring Assessment System.

In addition, some school districts used electronic spreadsheets to monitor student information. In School District B, school psychologists used Accelify to document mental health services they provided to students. Student data was also coded within the student information systems (e.g., Skyward, FOCUS) with unique codes to identify the mental health concern and/or services within School Districts B, D, G, I, and N. Manual records were also mentioned within the school district plans. In School District G, service providers were expected to maintain manual documentation, while School District I kept a specific folder on campus for documenting mental health services.

School districts maintained and protected this information, and utilized it in providing mental health services to students. In School District D, principals accessed the dashboard to monitor student mental health concerns, while School District A maintained a school-based case manager for each student receiving mental health supports. In some school districts, a specific department was established to support student mental health promotion, including data monitoring and management, while other school districts tasked district staff from unspecified departments to monitor student mental health data. These included School Districts A, C, and D.
Within each school district, specific actions and steps contributed to the identification process. Some school districts implemented programs or trainings to increase student, faculty, and staff awareness and recognition of mental health concerns to strengthen the identification process. Other school districts specified their referral process and the relationship between outside/community agency referrals and the school-based identification process for mental health concerns.
Student Programs

Some school districts provide programs specifically to increase student awareness of mental illness and subsequent ability to identify mental health concerns. School District D implemented the Sandy Hook Promise Programs “Know the Signs” and “Say Something” which train youth and adults to identify mental health concerns and connect to resources before an individual causes harm to either self or others. School District L implemented the Sanford Harmony program, teaching social skills and mental health curriculum to students to increase awareness and identification of mental health concerns. School District G implemented the Signs of Suicide (SOS) Program to raise awareness of mental health concerns. Students would report the mental health concerns they identified amongst themselves and their peers. School District H provided training to students in using an electronic reporting site specific to their school district, and also in using the reporting website/application FortifyFlorida. Other school districts (I, J, and M) described students using FortifyFlorida in reporting concern for bullying, threat of violence, and threat of harm to self or others.

Table 10

Student Programs

<table>
<thead>
<tr>
<th>School District</th>
<th>Prevention Curriculum</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Sandy Hook Promise Program</td>
</tr>
<tr>
<td>G</td>
<td>Signs of Suicide Program</td>
</tr>
<tr>
<td>H</td>
<td>Student training for electronic reporting</td>
</tr>
<tr>
<td>L</td>
<td>Sanford Harmony Program</td>
</tr>
</tbody>
</table>
Faculty Identification

Faculty may also identify students with potential mental health concerns. In School Districts A, B, G, I, M, and N, Problem-Solving Teams work to identify student mental health concerns and connect to appropriate screenings, interventions, and referrals. School District G provided specific MTSS training, while School District I provided training for faculty regarding identifying warning signs and the procedures for school referrals for mental health concerns. School District D established a Progression of Mental Health Support process regimenting the steps for assessing and supporting student mental health needs. School Districts H, I, and M described training faculty in threat assessments. While school districts identified specific mental health professionals who worked with student mental health, professional development was an element described for both general faculty and staff, as well as specific mental health professionals within the school district.

Each of the school districts other than School District B directly described the implementation of Youth Mental Health First Aid Training (YMHFA) for faculty and staff. Additionally, all but three school districts described specific trauma trainings for either general faculty or specific training for mental health professionals. School District B described training for Trauma Focused Cognitive Behavioral Therapy to be provided to mental health professionals, while School District D also described trauma training for mental health professionals. School District A described training specific to trauma for faculty and staff. School Districts C, E, G, H, K, L, N, and O described Trauma Informed Care training for faculty and staff.
Some school districts offered trainings which were neither unique to their district nor mentioned in the majority of plans. School Districts A, D, and I described implementation of Kognito K-12 At-Risk for Educators Training. School Districts K and L described implementation of Child Safety Matters and Teen Safety Matters Trainings. School Districts G and N described PREPaRE for school psychologists. School Districts A, D, E, G, K, L, and N described restorative practices training, a related element to identifying student mental health concerns. School Districts G and H described Crisis Prevention Intervention Training for faculty.

Some school districts described trainings which were unique to their plan. School District D’s Department of Mental Health Services provided a mental health awareness program to all stakeholders, including parents and the community through presentations, and also coordinated other training offered by the school district. School District G described Compassion Fatigue Training for mental health professionals. School District H described Zones of Regulation Training. School District O described training in mandatory reporting for faculty and staff.
### Table 11

**Faculty Identification**

<table>
<thead>
<tr>
<th>School District</th>
<th>Team Training</th>
<th>Trauma Specific Training</th>
<th>Procedural Trainings</th>
<th>Other Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>PST training</td>
<td></td>
<td>Restorative Practices Training</td>
<td>Kognito</td>
</tr>
<tr>
<td>B</td>
<td>PST training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>PST training</td>
<td>Trauma Informed Care</td>
<td>Restorative Practices Training</td>
<td>Kognito</td>
</tr>
<tr>
<td>D</td>
<td>PST/MTSS training</td>
<td>Trauma Informed Care</td>
<td>Restorative Practices Training</td>
<td>PREPaRE</td>
</tr>
<tr>
<td>E</td>
<td>PST/MTSS training</td>
<td>Trauma Informed Care</td>
<td>Assessment Training Threat</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>PST/MTSS training</td>
<td>Trauma Informed Care</td>
<td>Assessment Training Threat</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>PST/MTSS training</td>
<td>Trauma Informed Care</td>
<td>Restorative Practices Training</td>
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</tr>
<tr>
<td>H</td>
<td>PST/MTSS training</td>
<td>Trauma Informed Care</td>
<td>Restorative Practices Training</td>
<td>Child Safety/Teen Safety Matters</td>
</tr>
<tr>
<td>I</td>
<td>PST/MTSS training</td>
<td>Trauma Informed Care</td>
<td>Assessment Training Threat</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>PST/MTSS training</td>
<td>Trauma Informed Care</td>
<td>Assessment Training Threat</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>PST/MTSS training</td>
<td>Trauma Informed Care</td>
<td>Restorative Practices Training</td>
<td>Child Safety/Teen Safety Matters</td>
</tr>
<tr>
<td>L</td>
<td>PST/MTSS training</td>
<td>Trauma Informed Care</td>
<td>Restorative Practices Training</td>
<td>Child Safety/Teen Safety Matters</td>
</tr>
<tr>
<td>M</td>
<td>PST/MTSS training</td>
<td>Trauma Informed Care</td>
<td>Assessment Training Threat</td>
<td>PREPaRE</td>
</tr>
</tbody>
</table>
Referral Processes

Two school districts described their progress in developing their identification, referral, and intervention process. School District C planned for district work groups to evaluate and work to improve identification of student mental health concerns as well as access to mental health care for students. School District L was developing a universal referral form to streamline the referral process. School District L also emphasized access in their plan, focused on overcoming economic, logistic, and cultural barriers through the referral process.

As an element of identifying student mental health concerns, some school districts described circumstances where referrals would be made for assessment or evaluation, either school based or community based. In School District A, school district staff made referrals while honoring parent preference for mental health providers. In School District M, the school-based MTSS team made referrals to the District Mental Health Counselor for screenings, while the School Counselor or School Social Worker made referrals to outside/community agencies. In School District E, Full Service School referrals for therapists could be made by faculty, staff, administration, students, or parents. In both School Districts D and K, school-based teams made referrals for screenings or assessments as part of the identification process.
Table 12

Referrals

<table>
<thead>
<tr>
<th>School District</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Staff made referrals</td>
</tr>
<tr>
<td>C</td>
<td>District Work Groups</td>
</tr>
<tr>
<td>D</td>
<td>School-based teams make referrals</td>
</tr>
<tr>
<td>E</td>
<td>Full Service School referrals can be made by faculty, students, or parents</td>
</tr>
<tr>
<td>K</td>
<td>School-based teams make referrals</td>
</tr>
<tr>
<td>L</td>
<td>Focus on overcoming barriers through referral process</td>
</tr>
<tr>
<td>M</td>
<td>Referrals for in school district or outside/community agency partnerships</td>
</tr>
</tbody>
</table>

**Research Question 2**

2. How are Florida school districts providing preventative mental health support for students?

In providing student mental health concern prevention, the categories which emerged included universal mental health and adjacent services. Each category is explored including the properties or characteristics, and dimensions or variations. The category of universal mental health consisted of awareness programs, social-emotional learning programs, and school culture. The category of adjacent services consisted of substance abuse and violence prevention.

**Universal Mental Health**

Florida public school districts implemented multiple prevention strategies in order to provide preventative mental health care promotion for students. Some school districts partnered with outside/community agencies or purchased curriculums from organizations to provide mental health prevention for students, while others strengthened their school-based offerings through universal lessons implemented via existing classes. Programs focused on student or faculty
awareness of mental health and reporting strategies for their own concerns. Preventative services were focused on Tier 1, provided universally to all students, although some school districts enhanced Tier 2, the targeted interventions, based on student need. Specific Tier 1 interventions emphasized Social-Emotional Learning lessons delivered to all students. Additionally, some school districts described strategies to enhance the culture and environment of the schools within their school district as methods of preventing student mental health concerns from developing.

**Awareness Programs**

Three student programs overlapped between multiple school districts within this study. Sanford Harmony, a social skills and mental health curriculum, was implemented by School Districts F, H, K, L, and O. Two suicide prevention programs were implemented by multiple school districts in this study. Sources of Strength was implemented by School Districts K and M, while Signs of Suicide (SOS) Prevention Program was implemented by School Districts G and N. Additionally, School District K implemented the Jason Foundation Suicide Prevention Curriculum. School District C also indicated the use of suicide prevention programs for awareness and prevention, although the program remained unspecified.

Other unspecified programs included: student training regarding mental health awareness and classroom instruction by school counselors in School District A; free counseling services to reduce likelihood of students developing mental health concerns in School District B; lessons for student success skills, a parenting academy, and mental awareness education in School District E; and a character education programs in School Districts G, J, and L.

Some school districts specified programs which were not utilized elsewhere as part of their prevention element of mental health promotion for students. School District B
implemented two components of the Sandy Hook Promise Program, Start with Hello to teach students about connections, and Say Something to teach students about recognizing and reporting mental health concerns. School District F developed a leadership program for students and also implemented the You’re Not Alone program. School District H implemented The Leader in Me, Skill Streaming, and Words of Wisdom programs to support prevention of mental health concerns for students. School District J implemented Mental Health Awareness and Prevention Training, while School District L described their approach for providing five hours of mental/emotional health instruction to secondary students each year. Two school districts described implementing mental health concern prevention strategies within their physical education classes. School District L incorporated mental health topics into their personal fitness course. School District M provided mental health awareness within their Health Opportunities through Physical Education (HOPE) classes.

In addition to student programs and trainings, faculty programs and trainings also support mental health concern prevention. Six school districts (A, E, G, H, K, and M) described MTSS or Problem-Solving team training for faculty. Each of the school districts other than School District B directly described the implementation of Youth Mental Health First Aid Training (YMHFA) for faculty and staff. As elements of mental health concern prevention, eight school districts (A, E, G, H, K, L, N, and O) emphasized trauma informed or trauma sensitive training for faculty. School District A identified Kognito K-12 At Risk for Educators as a training supporting overall mental health concern prevention. School District D sent school leadership teams to 3-day summer learning institutes regarding mental health concerns. School Districts G and H described Crisis Prevention Intervention Training for faculty.
School districts also incorporated outside/community agencies in promoting mental health through prevention measures. School District B utilized the local youth coalition for mental health prevention, while School District D implemented a local Values Matter initiative. Both School Districts D and K collaborated with outside/community agencies, while School District M partnered with their outside/community agencies to provide training to staff, students, and parents. School District E shared a Quarterly Mental Wellness newsletter, hosted events, encouraged students to create public service announcements and posters regarding mental health, and distributed resources to students and families.

Table 13

Awareness Programs

<table>
<thead>
<tr>
<th>School District</th>
<th>Sanford Harmony</th>
<th>Suicide Prevention Program(s)</th>
<th>Character/Values Education Programs</th>
<th>Trauma Informed/Sensitive Training for Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
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<tr>
<td>D</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td></td>
<td>Y</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>F</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
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<tr>
<td>J</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
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<tr>
<td>L</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
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<tr>
<td>M</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
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<tr>
<td>N</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social Emotional Learning Programs

Prevention is primarily delivered to students universally (Table 14). Seven school districts (A, B, C, I, L, N, and O) described delivering universal social-emotional learning curriculum as a concern prevention strategy in promoting student mental health. School District J described implementing the Ripple Effects social emotional learning program in Tier 2 as a targeted intervention, in contrast to School District H where it was a universal program. Other specific social-emotional learning program and curricula included the Seven Mindsets in School District C, and Social Emotional Learning Program in School District I. School Resource Officers in School District J implemented social-emotional learning in student lessons on anti-bullying and also resilience training through archery lessons. School District M utilized American School Counselor Association Mindsets and Behaviors for Student Success Standards in classroom lessons, and also met the Collaborative for Academic, Social, and Emotional Learning (CASEL) Social Emotional Competencies through the Being a Reader, Being a Writer, and/or Making Meaning programs. School District O also used CASEL approved programs in small groups, in addition to implementing the Good Behavior Game. School districts G and H implemented Cloud9, a social-emotional learning program integrated with technology.
School District | Social Emotional Learning
---|---
A | Universal SEL curriculum
B | Universal SEL curriculum
C | 7 Mindsets Program
H | Ripple Effects (universal)
I | Universal SEL curriculum
J | Ripple Effects (targeted)
L | Universal SEL curriculum
M | ASCA Mindsets and Behaviors; CASEL programs
N | Universal SEL curriculum
O | CASEL programs

School Culture

While these structured programs increased prevention, school districts also attempted to create a culture and environment which promoted mental health and served to prevent mental health concerns. School District L described strategies for consistent routines and procedures, which were provided to all school administration. School District J emphasized creating a positive school culture as part of preventing mental health concerns. School District D implemented the Framework of Effective School Culture, identifying opportunities to improve the school culture as an element of preventing mental health concerns. School District N implemented the Single School Culture Model, where consistency in practices is created through shared norms and procedures. In addition to school culture, the environment within the school contributed to the prevention efforts combatting mental health concerns. School district L described their Community Eligibility Provision for Free Breakfast and Lunch for all students, as well as a partnership with the local Department of Health providing comprehensive health
services to all students in grades K-8, as supporting prevention efforts based on the relationship between physical and mental wellness.

Five school districts (E, G, I, K, and N) described the Positive Behavior Interventions and Supports (PBIS) system as supporting mental health concern prevention within their schools. School District N implemented the Kids at Hope Philosophy across all schools. Instructional and classroom management practices were also attributed to mental health concern prevention. Both School Districts E and N described teachers using the Conversation, Help, Activity, Participation, Success (CHAMPS) classroom management model. School Districts L and O highlighted relationship building in using Kagan strategies, and School District L emphasized relationship building in using the Danielson framework.

Table 15

<table>
<thead>
<tr>
<th>School District</th>
<th>School Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Framework of Effective School Culture</td>
</tr>
<tr>
<td>E</td>
<td>PBIS; CHAMPS</td>
</tr>
<tr>
<td>G</td>
<td>PBIS</td>
</tr>
<tr>
<td>I</td>
<td>PBIS</td>
</tr>
<tr>
<td>J</td>
<td>Positive School Culture</td>
</tr>
<tr>
<td>K</td>
<td>PBIS</td>
</tr>
<tr>
<td>L</td>
<td>Consistency; free breakfast and lunch for students; comprehensive health services; Kagan strategies; Danielson framework</td>
</tr>
<tr>
<td>N</td>
<td>PBIS; Single School Model; CHAMPS</td>
</tr>
<tr>
<td>O</td>
<td>Kagan strategies</td>
</tr>
</tbody>
</table>
Adjacent Services

While school districts described the universal mental health supports to prevent mental health concerns arising for students, there are other concerns also covered within the Mental Health Assistance Allocation Plans. These include: substance abuse or misuse, violence, and discipline. Each of these concerns is adjacent to mental health and can relate to or influence a student’s mental health.

Substance Abuse

Substance abuse and misuse prevention is emphasized more than any other adjacent service in the school district Mental Health Assistance Allocation Plans. School Districts K, L, and N utilize the Too Good for Drugs Program for substance prevention. School Districts H, I, and M incorporated school wide substance abuse prevention programs. School District K had a Safe and Drug-Free champion at each school.

Outside/community agencies and providers were also involved in the substance prevention process. School Districts B and N partnered with local associations for substance abuse and mental health prevention, while School Districts K and N both incorporated specific substance abuse counselors into their substance prevention process. Two school districts (E and G) indicated that their Student Code of Conduct provided prevention supports, and two school districts (A and E) described peer mediation as a preventative mental health related strategy.

Violence Prevention

Additionally, violence prevention was involved in the mental health concern prevention process. Both School Districts K and N utilized the Too Good for Violence program. School District L incorporated the Green Dot Program for violence prevention, while School District M
provided a school-wide dating violence prevention program. In School District J, the school resource officer implements Gang Resistance Education and Training universally for students. School District B works with a grant for their collaborative STOPS (School Teachers, Organizations, Parents and Students) Violence program. In regards to discipline, School Districts A, D, E, G, K, L, and N described implementing restorative justice practices

**Research Question 3**

3. How are Florida school districts providing mental health interventions for students?

In providing mental health interventions for students, the categories which emerged included Curricula, Providers, and Tiers. Each category is explored including the properties or characteristics, and dimensions or variations. The category of curricula consisted of professional development and student programs. The category of provider consisted of school district employees and outside or community agency partnerships. The category of tiered interventions consisted of targeted interventions and intensified interventions.

**Curricula**

Both students and adults received formal preparation in working with interventions. School districts provided formal trainings and professional development opportunities to their faculty, administration and staff. These trainings enabled the school-based and school district personnel to support student mental health concerns. Students receiving interventions were, at times, exposed to structured programs obtained or developed by their school district.
Professional Development

Nine school districts (A, H, I, J, K, L, M, N, and O) identified Youth Mental Health First Aid (YMHFA) training for faculty and staff as an intervention support for students. Additionally, both School Districts A and I identified Kognito K-12 At-Risk for Educators as a training supporting mental health interventions. School Districts H, I, and M identified the intervention benefit of training faculty and staff in Threat Assessment processes. School Districts A and L also connected restorative justice practices training to their mental health interventions for students. Overlap also existed between school districts providing trauma related trainings to employees, including School Districts A, C, H, K, L, and O. Both School Districts H and L identified Child Safety Matters and Teen Safety Matters Trainings as elements of their intervention supports for student mental health.

Table 16

<table>
<thead>
<tr>
<th>School District</th>
<th>YMHFA</th>
<th>Threat Assessment Training</th>
<th>Trauma Related Trainings</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Y</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>H</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>I</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>J</td>
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</tr>
<tr>
<td>K</td>
<td>Y</td>
<td></td>
<td>Y</td>
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<tr>
<td>L</td>
<td>Y</td>
<td></td>
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<tr>
<td>M</td>
<td>Y</td>
<td></td>
<td>Y</td>
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<td>N</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
</tbody>
</table>

Some school districts outlined trainings and professional development opportunities which did not emerge in other plans as elements of intervention support. School district H
included Crisis Prevention Training and Zones of Regulation training for faculty and staff, while School District L described progress monitoring support for district and school-based staff. School District O identified the mandatory reporting training as a mental health intervention support for students. School District K indicated the anticipated expenditures including professional development and program facilitation.

**Student Programs**

Programs provided to students provided structures in which interventions could occur. School District C identified a Student Assistance Program, as well as the Stop Now and Plan Program. School District D established a Progression of Mental Health Support to offer structured steps outlining interventions. While some school districts utilized Sanford Harmony as a preventative program, School District E implemented this program as an intervention, in addition to Calm Classroom, School-Connect, MindUp, Morning Meeting, and Second Step programs. School District G utilized the Overcoming Obstacles Life Skills Program as a mental health support intervention for students. School District H indicated the use of the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidence-Based Programs and Practices in selecting mental health support interventions for students. School District I indicated the implementation of a Social Emotional Learning Curriculum to support mental health interventions for students. School District N indicated the use of curriculum reviewed by the Collaboration for Academic, Social and Emotional Learning (CASEL) in providing mental health support interventions to students.
Table 17

Student Curricula

<table>
<thead>
<tr>
<th>School District</th>
<th>Student Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Student Assistance Program; Stop Now and Plan Program</td>
</tr>
<tr>
<td>D</td>
<td>Progression of Mental Health Support</td>
</tr>
<tr>
<td>E</td>
<td>Sanford Harmony; Calm Classroom; School Connect; MindUp; Morning Meeting; Second Step</td>
</tr>
<tr>
<td>G</td>
<td>Overcoming Obstacles Life Skills Program</td>
</tr>
<tr>
<td>H</td>
<td>SAMHSA Programs</td>
</tr>
<tr>
<td>I</td>
<td>SEL Curriculum</td>
</tr>
<tr>
<td>N</td>
<td>CASEL Curriculum</td>
</tr>
</tbody>
</table>

Provider

Mental health providers can be employed by the school district of contracted providers. School district employed mental health providers may be school based or work within the entire school district. The contracted partners include mental health providers from outside/community agencies. Any combination of these providers may meet with students to support mental health interventions on school campuses, in addition to referrals and wrap-around services.

School District Employees

School District A regarded school district provided mental health supports as quickest and most efficient approach to supporting student mental health, and described school based mental health providers as including school counselors, school social workers, and school psychologists, alongside two district based Mental Health Specialists (Table 18). School District C described a school District Mental Health Professional as the school district employed mental health provider. School District D created a Department of Mental Health Services, and at the school level described the Student Support Team members as including the principal, school
counselor, teacher(s), Exceptional Student Education staff, a licensed social worker and/or licensed psychologist, plus the parent and student. School District E described school social workers and school counselors as the school district employed mental health providers. School District F described school district personnel as the school district employed mental health providers. School District H described district-wide coordination of mental health services. School District I described school counselors and the Designated Mental Health Employee as the school district employed mental health providers. School District J described the school counselor and/or District Mental Health Coordinator as the school district employed mental health providers. School District L described guidance counselors, licensed clinical social workers, and licensed clinical social work interns as the school-based mental health providers. School district M described the school counselor, school social worker, or school psychologist as the school district employed mental health providers. School district O described a licensed mental health professional as the school district employed mental health provider.
### Table 18

**School District Employees**

<table>
<thead>
<tr>
<th>School District</th>
<th>School Based</th>
<th>School District Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Include school counselors, school social workers, and school psychologists</td>
<td>Mental Health Specialists</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td>Mental Health Professional</td>
</tr>
<tr>
<td>D</td>
<td>Student Support Team</td>
<td>Department of Mental Health Services</td>
</tr>
<tr>
<td>E</td>
<td>School Social Workers and School Counselors</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td>Mental Health Providers</td>
</tr>
<tr>
<td>H</td>
<td></td>
<td>District-wide coordination of mental health services</td>
</tr>
<tr>
<td>I</td>
<td>School Counselors</td>
<td>Designated Mental Health Employee</td>
</tr>
<tr>
<td>J</td>
<td>School Counselors</td>
<td>District Mental Health Coordinator</td>
</tr>
<tr>
<td>L</td>
<td>Guidance Counselors, Licensed Clinical Social Workers/Interns</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>School Counselor, School Social Worker, or School Psychologist</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td></td>
<td>Licensed Mental Health Professional</td>
</tr>
</tbody>
</table>

**Outside/Community Agency Partnerships**

Each school district provided a description in their Mental Health Assistance Allocation Plans (MHAAP) of the outside/community agency partnerships (Table 19). 90% of school districts described partnerships with three or more outside agencies. School District A coordinated three contracts through MHAAP funds, and maintained four additional agreements at no cost to the school district. In addition, School District A coordinated wrap-around services for students both on-site at schools and at home. School District B described three partnerships with outside/community agencies. School District C described five agreements with outside/community agencies. School District D described twelve agreements with outside/community agencies. School District E described two agreements with
outside/community agencies in addition to working with outside mental health providers. School District F described eleven agreements with outside/community agencies, in addition to two more developing agreements. School District G described seven agreements with outside/community agencies. School District H described zero agreements, indicating that no mental health agency was available to meet with all students, instead partnering with each student’s primary health or mental health provider. School District I described one partnership with an outside/community agency, in addition to outside mental health providers being identified by the Designated Mental Health Employee. School District J described a contract with another school district (not included in this study) to access school psychologists, as well as agreements with four outside/community agencies. School district K described eleven agreements with outside/community agencies. School District L described eleven agreements with outside/community agencies. School District M described ten agreements with licensed outside/community agencies. School District N described a formal Mental Health Collaborative, included six outside/community agencies. School District O described four agreements with outside/community agencies.
Table 19

Outside/Community Agency Partnerships

<table>
<thead>
<tr>
<th>School District</th>
<th>Number of Agreements</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>12</td>
</tr>
<tr>
<td>F</td>
<td>11</td>
</tr>
<tr>
<td>K</td>
<td>11</td>
</tr>
<tr>
<td>L</td>
<td>11</td>
</tr>
<tr>
<td>M</td>
<td>10</td>
</tr>
<tr>
<td>A</td>
<td>7</td>
</tr>
<tr>
<td>G</td>
<td>7</td>
</tr>
<tr>
<td>N</td>
<td>6</td>
</tr>
<tr>
<td>C</td>
<td>5</td>
</tr>
<tr>
<td>J</td>
<td>4</td>
</tr>
<tr>
<td>O</td>
<td>4</td>
</tr>
<tr>
<td>B</td>
<td>3</td>
</tr>
<tr>
<td>E</td>
<td>2</td>
</tr>
<tr>
<td>I</td>
<td>1</td>
</tr>
<tr>
<td>H</td>
<td>0</td>
</tr>
</tbody>
</table>

Tiered Interventions

School districts provided mental health interventions to students based on demonstrated mental health concerns. Within the school districts included in this study, all described a tiered approach to interventions. School District O described their approach as Response to Intervention (RtI), while the other districts referred to the process as the Multi-Tiered System of Supports (MTSS). Within the tiered supports, both targeted, or Tier 2, and intensified, or Tier 3, interventions emerged.

Targeted Interventions

Targeted interventions differed based on each school district (Table 20). Four school districts (A, B, C, and I) included both individual and small group counseling as targeted
interventions for mental health supports. School District G included small group counseling as a targeted intervention for mental health supports, while School District M described school-based counseling as a targeted intervention for mental health supports. In addition to small group counseling, social emotional small groups were included as interventions by School Districts E, H, and O. Three school districts described academic supports: School District B described academic advisement, School District J described small groups focused on academic success skills, and School District I described encouraging parents to support both academic and counseling goals at home.

Table 20

Targeted Interventions

<table>
<thead>
<tr>
<th>School District</th>
<th>Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Individual and small group</td>
</tr>
<tr>
<td>B</td>
<td>Individual and small group</td>
</tr>
<tr>
<td>C</td>
<td>Individual and small group</td>
</tr>
<tr>
<td>E</td>
<td>SEL groups</td>
</tr>
<tr>
<td>G</td>
<td>Small group</td>
</tr>
<tr>
<td>H</td>
<td>SEL groups</td>
</tr>
<tr>
<td>I</td>
<td>Individual and small group</td>
</tr>
<tr>
<td>J</td>
<td>SEL groups</td>
</tr>
<tr>
<td>M</td>
<td>School based</td>
</tr>
<tr>
<td>N</td>
<td>SEL groups</td>
</tr>
<tr>
<td>O</td>
<td>SEL groups</td>
</tr>
</tbody>
</table>

School Districts A, B, and C emphasized community partnerships in their targeted interventions. School Districts B, G, and K described mentoring programs as targeted interventions for mental health supports. Both School Districts A and L described behavior supports and interventions in their targeted interventions for mental health supports. School District B described progress monitoring as an element of their targeted interventions for mental
health supports, while School District C described Exceptional Student Education Services as an element of their targeted interventions for mental health supports. School District G described check in/check out, zones of regulation, music therapy, and home visits as their unique targeted mental health interventions. School District L described a teenage parenting program as one of their targeted mental health interventions.

Intensified Interventions

Based on student needs, interventions were intensified, representing a shift from Tier 2 to Tier 3. In School District A, a school social worker provided additional targeted interventions and assists in the referral process for Tier 3. School Districts C, D, and F also emphasized making referrals for more intensified mental health interventions. School Districts B and G both described family counseling in their intensified mental health interventions.

School districts primarily emphasized the individualized nature of intensified mental health interventions. School Districts D, F, G, H, I, J, L, M, N, and O each described the individualization of intensified mental health interventions. School District F described more intense or more frequent individual counseling, as well as possible referral to Exceptional Student Education services. School District I described partnering with parents in conducting a needs assessment as interventions were individualized. School District L described an animal therapy program at their alternative school, which could also be implemented in the event of a tragedy as an intensified mental health intervention. School District M included both individual and group counseling in their intensified interventions. School District N described the Problem-Solving Team determining who was best equipped to deliver evidence-based services to
students. School District O described a contract with an art therapist and a music therapist among their intensified mental health interventions.

School Districts D, E, F, G, and I described Functional Behavior Assessments (FBA) and Behavior Plans in their intensified interventions for mental health supports. While School District E referred to their Behavior Plan, the remaining school districts used different formal names: School District D referred to the behavior plan as Social Emotional/Behavioral Intervention Plan; School District F referred to the behavior plan as a Positive Behavior Improvement Plan, and School Districts G and I both referred to the behavior plan as a Behavior Intervention Plan.

Table 21

<table>
<thead>
<tr>
<th>School District</th>
<th>Referrals</th>
<th>Intensified</th>
<th>Behavioral interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Family counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Referrals</td>
<td>Individualized</td>
<td>Social Emotional/Behavioral Intervention Plan</td>
</tr>
<tr>
<td>E</td>
<td>Referrals</td>
<td></td>
<td>Behavior Plan</td>
</tr>
<tr>
<td>F</td>
<td>Referrals</td>
<td>Individualized</td>
<td>Positive Behavior Improvement Plan</td>
</tr>
<tr>
<td>G</td>
<td>Family counseling</td>
<td>Individualized</td>
<td>Behavior Intervention Plan</td>
</tr>
<tr>
<td>H</td>
<td></td>
<td>Individualized</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td></td>
<td>Individualized</td>
<td>Behavior Intervention Plan</td>
</tr>
<tr>
<td>J</td>
<td></td>
<td>Individualized</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td></td>
<td>Individualized</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td></td>
<td>Individualized</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
<td>Individualized</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Contracted Art Therapist and Music Therapist</td>
<td>Individualized</td>
<td></td>
</tr>
</tbody>
</table>
Research Question 4

4. How are Florida school districts connecting evidence-based approaches in their delivery of mental health supports for students?

In investigating the evidence-based approaches for promoting student mental health, the categories which emerged included Professionals and Strategies. Each category is explored including the properties or characteristics, and dimensions or variations. The category of professionals consisted of ratios of mental health providers to students and also credentials of mental health providers. The category of strategies consisted of theoretical approaches and trainings.

Professionals

Professionals in school district Mental Health Assistance Allocation Plans (MHAAP) include school based and school district-based employees, as well as employees at charter schools who have opted in to the MHAAP. School district employees work with varying professional to student ratios. Based on ratios of mental health providers to students which were listed, averages included: (a) school counselors 1:500, (b) school social workers 1:2500, and (c) school psychologists 1:2100 (Table 22). Additionally, these employees require varying credentials, however a commonality was the expectation for mental health professionals to hold a master’s degree and have or be in pursuit of licensure or certification through the state.

Ratios of Mental Health Providers to Students

The ratio for School District A mental health professionals to students included: school counselors 1:255, school social workers 1:1880, school psychologists 1:2314. Additionally,
School District A employed two Mental Health Specialists and two Licensed Mental Health Professionals. The ratio for School District B mental health professionals to students included: school counselors 1:524, Exceptional Education Counselors 1:795, school psychologists 1:2262, family therapists 1:5777, school social workers 1:1196, and nurses 1:3884. Additionally, in School District B the Employee Assistance Program Counselors ratios were 1:17,500. The ratio for School District D mental health professionals to students included: school counselors 1:473, psychologist 1:1400, school social worker 1:1746. Additionally, School District D created a Department of Mental Health Services. The ratio for School District E mental health professionals to students included: school counselors 1:407, school social workers 1:2053, school psychologists 1:1851. The ratio for School District H mental health professionals to students included: elementary school counselors 1:555, middle school counselors 1:418, high school counselors 1:561, school psychologists 1:2620, Licensed Mental Health Counselors/School Social Workers 1:3930. Additionally, School District H employed 1 Board Certified Behavior Analyst, 2 Behavior technicians, 1 Board Certified Behavior Assistant, Exceptional Student Education specialists, parent liaisons, occupational and physical therapists, and speech pathologists.

The ratio for School District J mental health professionals to students included three full time guidance counselors with a ratio of 1:400, as well as a school district Director of Safety and Mental Health. The ratio for School District L mental health professionals to students included individual breakdowns for each school: 3:126, 3:168, and 2:165. Additionally, School District L has one Exceptional Student Education/Student Services Director, one Director of Instruction/Curriculum, and one School Safety Specialist. School District O included the
approximate ratio of students to certified or licensed mental health providers of 1:340. School District I created a Designated Mental Health Employee position.

School District C included the number of mental health professionals employed by the school district, but no student ratios. School District C employed 85 school counselors, 17 school social workers, 18 school psychologists, 8 School Mental Health Professionals, and 4 Specialists at the school district level. School District F included the number of mental health professionals employed by the school district, but no student ratios. School District F employed 1 school psychologist, 1 clinical psychologist, 2 counselors, and 3 mental health counselors. School District G included the number of mental health professionals employed by the school district, but no student ratios. School District G employed 5 school psychologists, 10 school counselors, 1 licensed school social worker, and 1.5 licensed mental health counselors. School District K included the number of mental health professionals employed by the school district, but no student ratios. School District K employed 17 school psychologists, 15 social workers, 59 school counselors, and 15.5 program specialists for behavior. School District M included the number of mental health professionals employed by the school district, but no student ratios. School District M employed 80 school counselors, 19 school psychologists, 12 mental health counselors, and 7 school social workers. School District N included the number of mental health professionals employed by the school district and indicated that they have lowered the student to counselor ratios and added a testing coordinator. Additionally, School District N indicated the re-establishment of the Mental Health Task Force. School District N employed 86 school counselors, 2 Social Emotional Learning Specialists, 23 school psychologists, 9 social workers.
Table 22

Professional to Student Ratios

<table>
<thead>
<tr>
<th>School District</th>
<th>School Counselors</th>
<th>School Social Workers</th>
<th>School Psychologists</th>
<th>Specialists</th>
<th>Licensed Mental Health</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1:255</td>
<td>1:1880</td>
<td>1:2314</td>
<td>2 MH Specialists</td>
<td>2 Professionals</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>1:524</td>
<td>1:2262</td>
<td>1:795 Exceptional Education Counselors</td>
<td>1:5777 family therapists</td>
<td>Nurses= 1:3884; Employee Assistance Program Counselors 1:795</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>85 total</td>
<td>17 total</td>
<td>18 total</td>
<td>4 Specialists</td>
<td>8 School MH Professionals</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>1:473</td>
<td>1:1746</td>
<td>1:1400</td>
<td></td>
<td>Department of Mental Health Services</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>1:407</td>
<td>1:2053</td>
<td>1:1851</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>2 total</td>
<td>1 school and 1 clinical</td>
<td>3 mental health counselors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>10 total</td>
<td>1 total</td>
<td>5 total</td>
<td>1.5 LMHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Elem.= 1:555; Mid.= 1:418; High 1:561</td>
<td>1:3930</td>
<td>1:2620</td>
<td>Exceptional Student Education specialists</td>
<td>1 Board Certified Behavior Analyst, 2 Behavior technicians, 1 Board Certified Behavior Assistant, occupational and physical therapists, and speech pathologists</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>1:400</td>
<td></td>
<td></td>
<td></td>
<td>District Mental Health Employee</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>1:400</td>
<td></td>
<td></td>
<td></td>
<td>Director of Safety and Mental Health</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>59 total</td>
<td>15 total</td>
<td>17 total</td>
<td>15.5 for behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>59 total</td>
<td>15 total</td>
<td>17 total</td>
<td></td>
<td>Exceptional Student Education/Student Services Director, Director of Instruction/Curriculum, School Safety Specialist</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>80 school counselors</td>
<td>7 school social workers</td>
<td>19 school psychologists</td>
<td>12 mental health counselors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>86 school counselors</td>
<td>9 social workers</td>
<td>23 school psychologists</td>
<td>2 Social Emotional Learning Specialists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>86 school counselors</td>
<td>9 social workers</td>
<td>23 school psychologists</td>
<td>2 Social Emotional Learning Specialists</td>
<td>Approximate ratio of students to certified or licensed mental health providers of 1:340</td>
<td></td>
</tr>
</tbody>
</table>
Mental Health Provider Credentials

The credentials and licenses of the mental health professionals employed by each school district also vary. School District A indicated that all employed mental health professionals were certified or licensed by the Florida Department of Education. School District B indicated that all employed Family Therapists were Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, or Licensed Mental Health Counselors. School District B indicated other employed mental health professionals, including School Social Workers, School Psychologists, and counselors, had Master’s degrees or higher.

School District F indicated the following certifications: one School Psychologist, one Clinical Psychologist, one Certified School Counselor, one School Counselor out of area, one Licensed Mental Health Counselor, and one Registered Mental Health Intern. School District G indicated school psychologists were certified in school psychology, school counselors were certified by the state, school social workers were Masters of Social Work, and Licensed Mental Health Counselors were licensed by the Florida Department of Health. School District K indicated that school psychologists, social workers, and school counselors each held Master’s degrees as a minimum and were certified, while mental health specialists held either a Bachelor’s or Master’s degree. School District L indicated that half of school counselors were certified, while half were working out of field, and social workers were Licensed Clinical Social Worker Interns. School District O indicated that they employed ten Certified School Counselors, two Licensed Clinical Social Work Interns and one Licensed Clinical Social Worker, in addition to contracting psychology interns.
School District C indicated that school counselors were certified by the Florida Department of Education or Licensed Mental Health Counselors. School District C indicated that school social workers were certified by the Florida Department of Education or Licensed Clinical Social Workers. School District C indicated that school psychologists were certified by the Florida Department of Education. School District C indicated that School Mental Health Professionals were Licensed Clinical Social Workers, Licensed Mental Health Counselors, or registered mental health interns. School District C indicated that specialists were certified by the Florida Department of Education in various areas.

School District M indicated that school counselors and school psychologists were certified by the state. School District M indicated that ten mental health counselors were certified through the Florida Department of Health, while three were certified in school counseling. School District M indicated that social workers were either Licensed Mental Health Counselors, Licensed Clinical Social Workers, or certified as School Social Workers.

Participants also included Charter Schools within the boundaries of each school district. School District A indicated that participating charter schools were provided with consultative services, with both a specialist and social worker assigned to assist in providing needed services. School District B made their Mental Health Assistance Allocation Plan available to charter schools, and those charter schools provided their own services. School District C indicated that charter schools were not participating in their Mental Health Assistance Allocation Plan. School District D indicated that charter schools had the ability to opt in to the plan and receive services and/or referral options. School District K indicated that charter schools followed the same
process as the school district, including sharing contracted services and same exposure to professional development trainings and resources.

School District L indicated there were no charter schools within their school district boundaries. School District M indicated that three charter schools opted into their MHAAP. School District N indicated that school psychologists provided all services for included charter schools. School District O indicated that charter schools used allocated funds to develop their own mental health plan, although the school district and charter schools collaborated to share best practices and informational resources.

Strategies

Evidence based strategies in supporting student mental health included theoretical approaches, professional development trainings offered, and student programs. Specifically, school districts used Cognitive Behavior Therapy, Brief Solution Focused Therapy, and expressive therapies such as Play Therapy, Art Therapy, and Music Therapy. Counseling theories or theoretical approaches were not identified by each school district. Trainings or professional development and student programs mirrored the identification, prevention, and intervention programs.

Theoretical Approaches

Cognitive Behavioral Therapy (CBT) was the most common theoretical approach. Four School Districts (E, J, L, and O) each identified CBT as one of the primary therapeutic modalities. Additionally, three school districts connected CBT to their trauma interventions and trainings: School Districts B and E described Family Therapists trained in Trauma-Focused Cognitive Behavioral Therapy, while School District C described Cognitive Behavioral
Intervention for Trauma in Schools. School District O also identified Behavior Therapy as an evidence-based theory implemented.

Expressive therapies were also identified by school districts. School Districts G and O identified the use of Music Therapy. School Districts L and O identified the use of Art Therapy. School Districts E and L identified the use of Play Therapy. In addition to the expressive therapies, Brief Solution Focused Therapy was identified by School Districts E, M, and O. School District D described providers spending 80% of their time on direct student support. School District J described the use of Functional Family Therapy, and School District L described the use of Animal Therapy.

Table 23

Theoretical Approaches

<table>
<thead>
<tr>
<th>School District</th>
<th>CBT/TFCBT</th>
<th>Expressive</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Trauma Focused Cognitive Behavioral Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Trauma Focused Cognitive Behavioral Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Cognitive Behavioral Therapy</td>
<td>Play Therapy</td>
<td>80% Direct student support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Brief Solution Focused</td>
</tr>
<tr>
<td>E</td>
<td>Cognitive Behavioral Therapy</td>
<td>Music Therapy</td>
<td>Functional Family Therapy</td>
</tr>
<tr>
<td>G</td>
<td>Cognitive Behavioral Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>Cognitive Behavioral Therapy</td>
<td>Art Therapy, Play Therapy</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Cognitive Behavioral Therapy</td>
<td></td>
<td>Animal Therapy</td>
</tr>
<tr>
<td>L</td>
<td>Cognitive Behavioral Therapy</td>
<td></td>
<td>Brief Solution Focused</td>
</tr>
<tr>
<td>M</td>
<td>Cognitive Behavioral Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Cognitive Behavioral Therapy</td>
<td>Music Therapy, Art Therapy</td>
<td>Brief Solution Focused</td>
</tr>
</tbody>
</table>

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Training

In addition to the counseling theories used by mental health professionals, school districts provided training and professional development opportunities to faculty and staff to support student mental health promotion. Each of the school districts other than School District B directly described the implementation of Youth Mental Health First Aid Training (YMHFA) for faculty and staff. School Districts C, E, G, H, K, L, and N provided Trauma Informed Care trainings for faculty and staff, while School District A provided Trauma Sensitive care training.


School districts also provided evidence-based programs for students. Social Emotional Learning Programs were emphasized in School Districts A, C, I, and O. School Districts C, M, N, and O prioritized programs approved by the Collaborative for Academic, Social, and Emotional Learning (CASEL). Meanwhile, School District H prioritized evidence-based interventions from the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidence-Based Programs and Practices. School District D partnered with the National Alliance on Mental Illness to provide students with the Ending the Silence Program. Elements from Sandy Hook Promise were utilized in both School Districts B
and D, while Sanford Harmony was implemented in School Districts E, F, and O. Multiple school districts (G, I, K, L, N, and O) implemented Positive Behavior Interventions and Supports within their schools.

**Triangulation**

Triangulation of this analysis occurred through analysis of School Board meeting agendas and minutes for each School District. Other documents considered for triangulation included the School District Improvement Plans, however these plans were not inherently or directly related to the mental health supports for students. Therefore, School Board meeting agendas and minutes regarding the mental health supports related to the Mental Health Assistance Allocation Plans were selected for triangulation in order to provide maximum insight regarding the intentions and concerns of each school district. Each School District approved the Mental Health Assistance Allocation Plans unanimously, primarily as items on the Consent Agenda. Five school districts included discussion or detailed recommendations in the meeting minutes, either from the School Board Meeting, School Board Workshop, or School Board Business Meeting. The school districts posting discussions or detailed recommendations regarding the Mental Health Assistance Allocation Plans were School Districts B, C, D, E, and K.

School District B unanimously approved the Mental Health Assistance Allocation Plan, and included discussion in their meeting minutes, where audience input was allowed. Discussion included the idea that teachers and guidance counselors should not be solely responsible for student mental health, due to the varying nature of mental health concerns. The discussion also emphasized the goal of building relationships within the community to meet the needs of
families. Additionally, discussion focused on the shortage of school psychologists, and the difficulty the school district had consistently experienced in staffing school psychologists. The discussion closed with an emphasis on proactively identifying student mental health concerns.

School District C also unanimously approved the Mental Health Assistance Allocation Plan, and included a discussion in their meeting minutes. School District C described the expansion of services through additional staff and programming, as well as the ability to assess student needs. The expected outcome reported included higher social emotional functioning among students, fewer behavioral and emotional issues, and higher student academic success. School District C also described the connection to their Strategic Plan Goal of establishing a respectful climate and culture with equity and access for all.

School District D included a detailed recommendation for the School Board to approve the Mental Health Assistance Allocation Plan. School District D emphasized the pre-existing priority of supporting each student as a whole child. School District D also described the creation of the Department of Mental Health Services, which would continue to coordinate mental health services for students.

School District E also unanimously approved the Mental Health Assistance Allocation plan, and included a detailed recommendation for approval with brief discussion in the minutes. School District E described continued partnerships with outside/community agencies, especially with Full Service Schools and the expanding services for all students. School District E described the plan to continue to provide universal screening for students across three grade levels and for any other student as needed based on referrals. School District E connected the Mental Health Assistance Allocation Plan to their Strategic Goal centered around student
achievement and well-being, where resources were effectively and equitably utilized to support student outcomes. School Board Member discussion included an appreciation of the efforts of the Mental Health Assistance Allocation Plan, as well as an emphasis on the importance of this work based on student need for mental health supports.

School District K included detailed discussion in the approval process for the Mental Health Assistance Allocation Plan. The School Board discussed the emphasis on Tier 1 Strategies and Positive Behavior Intervention Supports. The discussion connected mental health to learning and achievement, and the School Board discussed the focus on identifying students with mental health concerns through continued provision of universal screeners. The School Board emphasized behavior modification and mental health for younger students, and the benefit of teaching coping skills. Clarification occurred regarding student needs exceeding the capability of the school, where a referral would be made to an outside/community agency and parents would be requested to sign a release of information. Instead of the school paying for individualized mental health services, school district employees including guidance counselors, behavior specialists, psychologists, and social workers served student mental health needs within the school setting. Additionally, the School Board discussed equipping teachers and other faculty to support student mental health needs, as well as the importance of parental support of student mental health.

Summary

The initial codes which emerged in the first round, during axial coding, included personnel, practices, and procedures. Personnel referred to the individuals providing mental health supports, practices referred to what the specific supports were, and procedures referred to
how these supports were delivered. Within each Research Question, specific categories emerged through the second round, during focused coding. These category properties, or characteristics, and dimensions, or variations emerged through the third round and were refined through the third round, during axial coding. The categories related to identifying student mental health needs included Determining the Level of Need, Information, and Actions or Steps. The categories related to prevention of mental health concerns for students included Universal Mental Health and Adjacent Services. The categories related to mental health interventions for students included Curricula, Provider, and Tier. The categories related to evidence-based approaches in student mental health promotion included Participants and Strategies. Overlap throughout these categories matched the initial codes which emerged. Details regarding thematic analysis will be discussed in Chapter 5.
CHAPTER 5- DISCUSSION

Introduction

This chapter consists of a discussion of the results from this study. First, the Summary consists of an overview of the problem studied within this study, the purpose of the study, and the framework utilized. The Summary also revisits research questions, methodology, and findings. Next, the Discussion of the Findings interprets the meaning of the data, connecting to specific examples within the results in revealing the grounded theory which emerged from this study. The Implications for Practice section suggests ways these results may be applied to practice, while the Recommendations for Future Research section covers questions for future research. Finally, the conclusion summarizes the study.

Summary of the Study

Problem

Only the minimum expectations were recommended for the Mental Health Assistance Allocation Plans, and individual school districts in Florida are not held accountable for surpassing the minimum requirements in supporting the mental health concerns of students. There was a gap in the research, as there was no unified and evidence-based recommended strategy to guide the early identification, prevention, and intervention strategies used by school districts to serve the mental health needs of students. Therefore, the problem to be studied was how to standardize recommended practices for school districts to provide student mental health supports.
Purpose

The purpose of this study is to determine the mental health services being provided to students in the state of Florida, specifically the identification of mental health concerns among students, prevention strategies, and interventions utilized. This study will consist of a document analysis of the Mental Health Assistance Allocation Plans submitted to, and posted by, the Florida Department of Education, for the purpose of developing a grounded theory to standardize recommended practices in serving the mental health needs of students. Kutcher, Wei, and Weist (2015) emphasized the value of local culture and characteristics in schools serving student mental health needs. The researchers described a building-by-building partnership for mental health supports in schools, but also indicated that initiatives should move towards a more consistent and uniform approach (Kutcher, Wei, & Weist, 2015). This study will be conducted through multiple readings of the selected sample school district Mental Health Assistance Allocation Plans. Multiple readings will enable the identification and coding of themes and concepts.

Framework

This study uses a phenomenological philosophy for the conceptual framework. Glaser and Strauss (2017) describe grounded theory as a phenomenological position, based on using data to generate a theory. In grounded theory, the researcher evaluates how a concept is similar to or different from the existing literature (Corbin & Strauss, 2012). Relevant educational theories include phenomenological counseling theories, which allow for consideration of context in meeting mental health needs. These theories also fall under a constructivist lens; in
constructivism, “meaning is constructed by an individual” (Day, 2008). Additionally, developmental theory will guide this study.

Research Questions

1. How are Florida school districts identifying students who present with mental health concerns?
2. How are Florida school districts providing preventative mental health support for students?
3. How are Florida school districts providing mental health interventions for students?
4. How are Florida school districts connecting evidence-based approaches in their delivery of mental health supports for students?

Methodology

Corbin and Strauss (2012) described the humanistic nature of grounded theory as it develops a theory to provide meaning to the interrelationships of the processes in practice. This approach considers the context of the data as analysis occurs and a theory emerges through the trends identified. The purposive sample initially selected was expanded until data saturation occurred, data collection and coding occurred simultaneously. Theoretical sampling allowed for the population to be represented via a total of fifteen school districts within the sample; school districts were selected based on demographic information including level of poverty, number of students enrolled, and rural or urban status. Multiple readings allowed for plans to be coded several times and strengthen the reliability of the research. Meanwhile, the coding covered both manifest and latent content to enhance validity. Categories were developed from the coding and enabled the emerging theory to be fully integrated.
Findings

The initial codes which emerged in the first round, during axial coding, included personnel, practices, and procedures. Personnel referred to the individuals providing mental health supports, practices referred to what the specific supports were, and procedures referred to how these supports were delivered. Within each Research Question, specific categories emerged through the second round, during focused coding. These category properties, or characteristics, and dimensions, or variations were refined through the third round, during axial coding. The categories related to identifying student mental health needs included Determining the Level of Need, Information, and Actions or Steps. The categories related to prevention of mental health concerns for students included Universal Mental Health and Adjacent Services. The categories related to mental health interventions for students included Curricula, Provider, and Tier. The categories related to evidence-based approaches in student mental health promotion included Participants and Strategies. Overlap throughout these categories matched the initial codes which emerged. Details regarding thematic analysis will be discussed throughout this chapter.

Discussion of the Findings

The findings presented abundant information regarding the state of mental health supports provided to students within public school districts in Florida. One commonality within each research question was the training process, which was an expectation of Florida Senate Bill 7026 (2018). In preventing mental health concerns, only three school districts (D, G, and L) from this study provided awareness programs specifically geared to training students about identifying desire to harm self or others. Four school districts (H, I, J, and M) described the use
of Fortify Florida in empowering students to reflect on their own needs and support their peers through reporting their concerns.

Fourteen school districts (A, C, D, E, F, G, H, I, J, K, L, M, N, and O) described the implementation of Youth Mental Health First Aid training for faculty and staff. Senate Bill 7026 (2018) mandated the use of Mental Health First Aid or similar training program. This training increased awareness, and therefore identification of mental health concerns, as well as suggested steps to empower teachers and other faculty to appropriate intervene. Two school districts (D and I) provided additional and more thorough training for faculty and staff regarding the identification and reporting process. School districts from this study incorporated a multi-tiered approach to mental health concern identification, prevention, and intervention, aligned with recommendations from the Framework for Safe and Successful Schools (Cowan et al., 2013). Six school districts (A, E, G, H, K, and M) provided specific training to their faculty regarding the Multi-Tiered System of Supports and problem-solving training for their faculty.

The next most common training provided to faculty, staff, and specifically to mental health professionals was training related to trauma, with ten school districts (A, B, C, E, G, H, K, L, N and O) indicating trauma related training in their Mental Health Assistance Allocation Plans. Extensive training for faculty regarding trauma supports student mental health promotion (Morton & Berardi, 2018). This majority of trauma related training demonstrated school districts acknowledgement of the severe impact which trauma can have on a student, and the prevalence of trauma among children and adolescents (Koenen, Roberts, Stone, & Dunn, 2010). School districts also provided mental health crises preparation training through Crisis Prevention Training (G and H) and PREPaRE (A, G, K, and N). Further mental health concern response
training took place through Threat Assessment Trainings (D, H, I, and M) and Kognito K-12 At-Risk for Educators training (A, D, and I) also prepared faculty and staff to respond to mental health concerns.

Research Question 1

In identifying mental health concerns, 80% of school districts used an Early Warning System in identifying students with potential mental health concerns, deeming it a recommended practice as a component of this grounded theory. Early Warning System indicators included grades, attendance, and disciplinary infractions. Students with mental health concerns are more likely to have lower grades, high absenteeism, and a higher chance of dropping out (Federal Commission on School Safety, 2018). Additionally, identifying student mental health concerns via enrollment or registration forms is a practice in place in school districts (F, L, and O) but only one school district conducts this paperwork annually. Infrequent opportunities to self-report, if used in isolation as a sole identification process, would allow for unmonitored gaps in information to generate.

Multiple unique screening instruments were used, and more than half of school districts (A, B, C, E, F, G, K, L, M, and N) indicated their use of a research-based screening instrument to identify mental health concerns amongst students. Frequency and circumstances for screeners provided disparity in approaches. While School Districts A, K, and L conducted universal screening for mental health concerns, School District E conducted screenings in grades 3, 6, 9, and also as needed based on referrals. Screenings provide broader scale identification, where no student is missed, however school districts must have adequate capacity to provide interventions
based on screening results as well as ample time and training for staff when screenings are conducted (Humphrey & Wigelsworth, 2016; Moore et al., 2019; Soneson et al., 2020). Triangulation through school board meeting minutes supported the priority of screening students (E). In identifying student mental health concerns, school districts had to plan for crisis intervention (SB 7026, 2018). School districts were not initiating Baker Acts, but nearly half of them included information related to Baker Acts in their Mental Health Assistance Allocation Plans.

In School Districts E and I, school-based personnel reached out to a district-based employee to conduct a risk or threat assessment and evaluate the level of concern. The Sheriff conducted the assessment and made the determination in School District L. In school district M, a Mobile Crisis Response Team was dispatched to the school to evaluate the student crisis, while a community agency provider conducted this evaluation in School District B. A coordinator for re-entry after a Baker Act, either from school campus or from home, was uncommon: only two school districts (B and D) had a specific coordinator to bridge the gap between Baker Act receiving facilities and schools, while two others (M and E) focused on building the relationship between these facilities and the schools to obtain information and coordinate care. Sharing this information assists with supporting mental health promotion.

Information may also be shared outside of crisis situations. More than half of the school districts in this study (A, G, H, I, K, L, M, and N) had processes for outside or community agencies to release information, or had mutual information sharing agreements. School districts included policies for information sharing which aligned with the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA),
which outlined privacy protections for health records and educational records (Strauss, 2016). In addition to parental consent for sharing information, school districts (A, E, F, G, and N) described obtaining parental consent prior to making a referral or providing mental health services. Some school districts (A, D, K, and M) generated referrals to outside or community agencies to conduct their screening process, while School District E made referrals to the Full Service Schools Therapist. School based generation of referrals for identification were sent to outside or community agencies or to the Full Service Schools Therapist in School District E. Only one school district (E) described providing a mental health diagnosis for students, although two school districts (A and O) evaluated students for Exceptional Student Education eligibility based on mental health concerns, related to federal legislation for supporting student mental health through Every Student Succeeds Act and Individuals with Disabilities Education Act (Alexander & Alexander, 2019). A more common practice was meeting with Multi-Tiered System of Supports teams, also referred to as Problem Solving Teams (A, B, G, I, M, and N), to determine the level of need and appropriate intervention based on student mental health concerns. Managing this information was primarily done digitally, with only one school district (I) using a physical folder, and a student information database being the most common method of information management.

Research Question 2

In providing preventative mental health supports, implementing programmatic curricula for students emerged from several school districts. School districts (C, G, K, M, and N) specified multiple suicide prevention programs, including Sources of Strength, the Jason Program, and Signs of Suicide. This emphasis on suicide prevention connects to the prevalence
and trend of higher percentage of youth suicidal ideation, planning, and attempts (Centers for Disease Control and Prevention, 2017).

Nearly one half of school districts (A, B, C, I, L, N, and O) in this study identified universal Social Emotional Learning curriculum as an element of their preventative efforts supporting student mental health. Adopting social emotional learning practices allows for an integrative approach to avoid fragmentation of interventions across various schools (Kendziora & Osher, 2016). Some school districts (C, M, N, and O) specified using curriculum reviewed by the Collaboration for Academic, Social and Emotional Learning (CASEL), while School District H prioritized programs from the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidence-Based Programs and Practices, and School District D implemented programing from the National Alliance on Mental Illness.

A common method for strengthening mental health promotion was Positive Behavior Interventions and Supports (E, G, I, K, L, N, and O). Additionally, multiple school districts (D, A, L, and N) emphasized the goal of a consistent and positive school culture in promoting positive mental health. School culture and subsequent positive student perception of the school climate has been associated with lower risk behaviors for students (Denny et al., 2011). Finally, school districts (E, L, N, and O) emphasized the incorporation of their philosophy and instructional strategies in supporting student mental health. In addition to programming for mental health prevention, school districts provided information regarding drug prevention programs (B, H, I, K, L, M, and N), violence prevention programs (B, L, K, L, M, and N), and incorporation of restorative justice practices (A, D, E, G, K, and L) in disciplinary processes.
Research Question 3

In providing mental health interventions, mental health professionals were both school district employees and outside or community agency mental health providers. School or school district based mental health professionals included school counselors, school social workers, school psychologists, District Mental Health Professional or Designated Mental Health Employee/District Mental Health Coordinator, and Licensed Mental Health Counselors, who worked with principals, teachers, Exceptional Student Education staff, parents, and the student to provide school-based services. School districts maintained agreements and partnerships with community agencies. Resources are a barrier to serving students and supporting their mental health (Kutcher, Wei, & Weist, 2015). School District H had the fewest agreements, zero, and had the highest level of poverty out of any school district within this study. School District D had the most agreements, twelve, out of any school district in this study as well as the highest number of students enrolled.

Interventions were provided to students through a tiered approach. Targeted interventions included individual and/or group counseling (A, B, C, I, G, and M), Social Emotional Learning Groups (E, H, J, N, and O), academic supports (B, J, and I) and community partnerships (B, G, and K). Community involvement is critical in supporting serving student mental health needs (Derzon et al., 2011; Kendziora & Osher, 2016). Intensified interventions included referrals to outside or community agencies (C, D, and F), family counseling (B and G), individualized versions of targeted interventions (D, F, G, H, I, J, M, N, and O), and Functional Behavior Assessments and Behavior Plans (D, E, F, G, and I).
Research Question 4

The ratios of mental health professionals to students varied within the school districts included in this study. Cowan et al. (2013) suggested improving, or lowering, ratios of mental health staff to students in order to enhance the physical and psychological safety of the school. Several school districts (C, F, G, K, M, and N) did not include ratios, instead listing only the number of each type of professional employed within the school district. School counselor ratios varied from 255 (A) to 561 (H) students per school counselor. School psychologist ratios varied from 1400 (D) to 2620 (H) students per school psychologist. School social worker ratios varied from 1196 (B) to 2053 (E) students per social worker. The credentials for mental health professionals included a master’s degree and certificate or licensure. Many school districts utilized interns for social work (L and O), Mental Health Counselors (C and F), and school psychology (L). The shortage for mental health professionals, particularly school psychologists (B), was emphasized in the triangulation through school board meeting minute analysis.

Theories implemented in providing mental health supports to students were primarily behavioral/cognitive, or expressive. School districts (E, J, L, and O) used Cognitive Behavioral Therapy, while School Districts B, E, and O connected trauma and behavior therapy. Cognitive Behavioral Therapy allows individuals to interpret life events, identifying and challenging dysfunctional belief systems (Day, 2008; Granello & Young, 2012). Art therapy (L and O), Play therapy (EL), and Brief-Solution Focused (E, M, and O) were also common. Brief-Solution Focused Therapy is goal driven and enables students to experience problems in new ways to discover how the concern can be changed (Litrell, 2009). Some school districts (A, C, and D) provided support through creating specific mental health support departments within the
organizational structure. Each school district in this study had the Mental Health Assistance Allocation Plan unanimously approved by their school board, with only five (B, C, D, E, and K) publishing a discussion in their meeting minutes. Two school district (C and E) boards connected their discussions specifically to school district strategic plans. Within the plans, two school districts (C and L) emphasized conducting school district work groups to improve services and help students overcome barriers.

**Implications for Practice**

These findings have implications for practice. The grounded theory emerging from this study supports universal screening to identify students demonstrating or developing mental health concerns. The commonalities which emerged among the plans provide a baseline of mental health promotion in schools, which can be continuously improved upon by individual schools, their school districts, and within policy.

**Implications for Schools**

Training all stakeholders can strengthen the identification, prevention, and intervention of mental health concerns. Training for faculty and staff should include identifying mental health concerns, their individual and relevant role in supporting mental health concerns, school and school district processes for referrals, signs of trauma and how to support those impacted, and appropriate relationship building. Teachers are tasked with balancing student need and academic content despite any mental health challenges among the students (Morton & Berardi, 2018). Training for students should include recognizing the signs of mental health concerns and how to
connect to resources and support, especially in instances where an individual is considering
harming themselves or others.

Implications for School Districts

Establishing consistency within the school/school district and a positive school culture
are recommended in order to support universal mental health promotion for students. In addition
to training faculty, staff, and students, connecting with the community is advised in order to
coordinate care. Community involvement is critical in serving student mental health needs, and
this involvement can provide culturally competent care to enhance recovery and resilience
(Derzon et al., 2011; Kendziora & Osher, 2016). Keeping parents and families involved supports
efforts made at the school, and collaborating with outside or community mental health agencies
and providers enables a broader reach of services. The various Mental Health Assistance
Allocation Plans analyzed ranged from four pages to twenty-eight pages, however length did not
necessarily indicate detail or quality of the plan; some shorter plans provided concise detail,
while some longer plans restated identical content within different sections. While the Mental
Health Assistance Allocation Plans are mandatory, school districts would benefit from
examining their plans to ensure they are maximizing these meaningful opportunities to promote
student mental health.

Implications for Policy

Ratios between students and mental health professionals should be kept as low as
possible in order to maximize direct contact between students and their mental health providers.
Additionally, policy may encourage or require additional information in educator preparation
programs regarding mental health and trauma. Childhood trauma is more prevalent than trauma among war veterans (Van der Kolk, 2015). Professional development is a first step, however more specialized teacher training is appropriate in light of the relevance of trauma among youth (Morton & Berardi, 2018; Gherardi, Flinn, & Jaure, 2020). While not all students have or will endure trauma, a trauma-informed framework allows students to receive support regardless of their intended level of intervention (Báez et al., 2019). Finally, information sharing supports mental health care coordination, but this information must be protected. Privacy of information increases the likelihood of an individual seeking help (Federal Commission on School Safety, 2018). As legislation is renewed or developed, privacy must be honored in balance with information sharing to coordinate mental health care.

**Recommendations for Future Research**

This study brings to light questions which guide recommendations for future research. School districts reported their data regarding the number of students served, and methods for those mental health services, in order to measure the efficiency of the Mental Health Assistance Allocation Plan. While this data was beyond the scope of this study, establishing a baseline for those efficiency reports and measuring any changes in subsequent years would be appropriate for further research. Additionally, evaluating the efficiency of the trainings and programs is an area for future research.

The sample for this study included school districts representing both rural and urban school districts, high and low levels of poverty, and high and low levels of student enrollment. While no apparent trend emerged during this study between these demographic details, they do
pose opportunities for further study, including: exploring the relationship between rural or urban schools and mental health supports in school districts, exploring the relationship between poverty and mental health supports in school districts, and exploring the number of students and mental health supports in school districts. Additionally, further research can explore any relationship between the number of students and actual ratios, as compared to recommended ratios by professional organizations. Further research could also explore the impact of differences of ratios within different schools in a school district in terms of constancy and grade level of school and in schools performing at varying academic levels. No virtual education school district had a Mental Health Assistance Allocation Plan submitted for the school year analyzed, however students did pursue virtual and at-home options for education even prior to the changes of the COVID 19 pandemic. Future research could investigate virtual platforms as well as traditional school districts meeting the mental health needs of students digitally.

Finally, further research could be conducted in regards to the referral process. When referrals are made, families are not required to consent to mental health services for their students. Further research could explore how often families follow through with mental health referrals, as well as what barriers stop them in the instance that mental health care is not obtained after a referral. Schools may or may not be able to impact those barriers, and further research could explore the possible roles and responsibilities of the school in that process.

**Conclusions**

Mental health matters, as demonstrated both through tragedies such as school shootings, and also through trends of mental health concerns among youth. One in five youths have a
mental health disorder, and less than half receive needed treatment (Federal Commission on School Safety, 2018). Schools serve as the center of the community, and student presence at schools increases the access and availability of interventions, making them a practical setting for these services (Denny et al., 2011). Student mental health is a global concern, represented in both federal and state legislation.

This study consisted of a document analysis of the Mental Health Assistance Allocation Plans produced by fifteen public school districts in Florida to explore the identification of mental health concerns among students, prevention strategies, and interventions utilized in promoting student mental health. Multiple readings implemented initial coding, focused coding, and axial coding. The study culminated in a grounded theory of standardized recommended practices for supporting student mental health, including (a) universal screening supported through ample resources for interventions, (b) establishing consistency within the school or school district and a positive school culture, (c) training for faculty, staff, students, and community members regarding mental health concerns and how to support or connect with resources, (d) connecting and collaborating with the community to coordinate mental health care while protecting privacy and confidential information, and (e) maintaining low ratios of students to mental health professionals in order to maximize direct contact between students and their mental health providers.
APPENDIX: INSTITUTIONAL REVIEW BOARD EXEMPTION
NOT HUMAN RESEARCH DETERMINATION

November 12, 2020

Dear Rebecca Carter:

On 11/12/2020, the IRB reviewed the following protocol:

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Initial Study</th>
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<tbody>
<tr>
<td>Title of Study</td>
<td>An investigation of student mental health supports in Florida public school districts</td>
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<tr>
<td>Investigator</td>
<td>Rebecca Carter</td>
</tr>
<tr>
<td>IRB ID</td>
<td>STUDY00002439</td>
</tr>
<tr>
<td>Funding</td>
<td>None</td>
</tr>
<tr>
<td>Grant ID</td>
<td>None</td>
</tr>
</tbody>
</table>
| Documents Reviewed | • HRP-251 - FORM - Faculty Advisor Scientific-Scholarly Review fillable form R.Carter 10.1.2020.pdf, Category: Faculty Research Approval;  
• Clarification Documentation.docx, Category: Other;  

The IRB determined that the proposed activity is not research involving human subjects as defined by DHHS and FDA regulations.

IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities are research involving human in which the organization is engaged, please submit a new request to the IRB for a determination. You can create a modification by clicking Create Modification / CR within the study.

If you have any questions, please contact the UCF IRB at 407-823-2901 or irb@ucf.edu. Please include your project title and IRB number in all correspondence with this office.

Sincerely,
Institutional Review Board
FWA0000351
IRB00001138, IRB00012110
Office of Research
12201 Research Parkway
Orlando, FL 32826-3246

Racine Jacques, Ph.D.
Designated Reviewer
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