



2011

## A Case Study: Understanding the Bridges Program Through the Lens of Stakeholders

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LOYOLA UNIVERSITY CHICAGO

A CASE STUDY: UNDERSTANDING THE BRIDGES PROGRAM THROUGH THE  
LENS OF STAKEHOLDERS

A DISSERTATION SUBMITTED TO  
THE FACULTY OF THE GRADUATE SCHOOL OF EDUCATION  
IN CANDIDACY FOR THE DEGREE OF  
DOCTOR OF EDUCATION

PROGRAM IN CURRICULUM AND INSTRUCTION

BY

MARION PLATT

CHICAGO, ILLINOIS

MAY 2011

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## ACKNOWLEDGEMENTS

I want to acknowledge those stakeholders who participated so candidly in this study; especially those students, parents and all Bridges faculty who allowed me to interview and observe them in the natural setting. They provided the incentive to accurately report their experiences and understandings. Additionally I acknowledge the support and rigorous discipline provided by my committee chair, Dr. David Ensminger.

## DEDICATION

This inquiry is dedicated to my husband for his support in everything I do and my father who always understood the value of education.

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## ABSTRACT

This study is intended to provide the reader with a comprehensive understanding of a school based mental health program, Bridges, from the perspective of stakeholders; those invested in the continuation of the program. Bridges was developed in 2005 in response to a growing need to provide transitioning services for adolescents returning to a public high school subsequent to a psychiatric hospitalization or prolonged absence. The program was designed for a very specific population in a specific high school on the North Shore of Chicago. Because of the uniqueness of the population and programming, qualitative case study analysis was employed to understand the perceptions and understandings of students enrolled in the program, their parents, Bridges faculty and the greater school faculty of this high school. Humanistic psychology provides the theoretical foundation for the study while R.E. Stake's Responsive Evaluation provides a methodological guide for understanding the program through the lens of stakeholders.

## CHAPTER I

### INTRODUCTION

#### **The Prevalence and Incidence of Childhood and Adolescent Health Care Needs**

The literature on health care reform is abundant with documentation indicating the health care needs of adolescents are not being addressed properly or sufficiently (Weist, 2005). According to the National Coordinating Committee on School Health (2004), estimates of youth requiring mental health interventions range from a conservative estimation of 20% to other approximations indicating as much as 38% according to the National Coordinating Committee on School Health in 2004. These numbers become even more significant in that they do not include youth who are “at risk” for mental disorders and who do not receive any services. It is estimated that as few as one-sixth to one-third of adolescents with diagnosable disorders receive treatment. Of those who do, less than half receive adequate treatment.

The 2001 Youth Risk Behavior Survey which is coordinated by the Centers for Disease Control and Prevention provides additional data of concern to the mental health picture of American children and adolescents. In the Youth Risk and Behavior Survey, 30% of youth reported episodic heavy drinking, 14% reported frequent cigarette usage, 24% reported using marijuana within the last month and nine percent reported a suicide

attempt within the past 12 months. In the United States suicide is the third leading cause of death in youth from 10 to 19 years of age.

Pediatric health care professionals have become increasingly aware of the high level of mental health care needs of children and adolescents. It is known that mental health disorders lead to higher rates of juvenile incarcerations, school drop-out, family dysfunction, drug abuse and unemployment. Data derived from the Methodology for Epidemiology of Mental Disorders in Children and Adolescents study (2006) indicates that 13% of children and adolescents have anxiety disorders, over 6% have mood disorders, over 10% have disruptive behaviors and 2% have substance abuse disorders. Combined statistics indicate almost 21% of children and adolescents have one or more diagnosable mental disorders. In the past 20 years that represents a significant increase from 7% to the current statistics of 21%. Additionally, according to the 2001 U.S. Surgeon General's Report on children's mental health, 20% of children and adolescents require mental health interventions with 11% having a significant functional impairment and 5% having an extreme functional impairment.

Experts in children's mental health are in agreement that children with acute mental health care needs can be found in abundance in all public schools where their needs are not being met. Hoagwood (2003a, 2003b) claims the unmet need for child mental health services has remained unchanged in the last 20 years and that only 20% of children with the most severe mental health needs are receiving services. Data on adults with a primary mental disorder and a co-occurring substance abuse problem indicates that in over 90% of the cases studied, the age of onset is prior to age 20 with the mental

disorder typically preceding the substance abuse problem (Kessler, Bergland, Demler, Jin, & Walters, 2005). For the small percentage of adolescents who do receive mental health service, most actually receive it within the school setting (Greenberg et al., 2003, Paternite & Johnston, 2005; Roncs & Hoagwood, 2000, U.S. Department of Health and Human Services, 1999; U.S. Public Health Care Service, 2000). These statistics highlight the need for a continuum of comprehensive school-based mental health programming utilizing the skills of both clinical providers and educators (Atkins, Adil, Jackson, McKay, & Bell, 2001; Flaherty & Weist, 1999).

The outstanding societal issue is how to provide mental health services and interventions to adolescents that will effectively reach those most in need. Community-based interventions reach only a segment of the population and may be viewed as stigmatizing by families. There is promise that school-based mental health facilities can be integrated into the greater school facility by utilizing trained clinicians who form an alliance with school personnel. The studies explored in Chapter II suggest comprehensive mental health interventions can be successfully integrated into schools with effective results using conventional parameters of validity and reliability. Further, the categories of mental health disorders being addressed in the academic setting have expanded from those identified as aggressive and conduct disordered to those for whom attention has been minimal-clinically anxious and depressed adolescents. These studies provide a baseline of what exists and offers possibilities for future research to practical application in school-based mental health.

### **The Evolution of School-Based Mental Health Care**

The inception of school-based mental health services in the United States can be traced to the late 1800s (Adelman & Taylor, 1998). The first mental health services provided counseling to children who had been placed in adult jails or who were experiencing problems in school. These services in conjunction with juvenile courts provided incentive for the emergence of child guidance clinics in the 1920s. The clinics were predominantly staffed by social workers and were the foundation for what is currently known as community health care centers (Pumariega & Vance, 1999). The clinics were non-hospital based and often created to work specifically with school districts. In the 1970s and 1980s, a medical model for child mental health and psychiatric services emerged resulting in a split between the community based model and the hospital based model of care. Hospitals were able to absorb the majority of mental health funding resulting in a significant financial loss for community based care.

In 1975 the first public law addressing the education of students with disabilities was passed, P.L. 94-142. The Education of All Handicapped Children Act was later reauthorized as the Individuals with Disabilities Act, otherwise known as IDEA. This legislation was significant for schools as it placed responsibility on the educational system for addressing mental health needs of students with emotional disturbances. Though schools were mandated to provide support services for students with disabilities, the accompanying funding has repeatedly been criticized as inadequate (Paternite & Johnston, 2005).



Since the 1980s the United States has seen a significant growth of mental health programming options provided within public schools (Adelman & Taylor, 1998). Health care professionals currently acknowledge the significant mental health care needs of children and adolescents and are examining the impediments to mental health care services, often in tandem with educators. Some of the acknowledged barriers to health care services include inadequate health care insurance, lack of transportation to health care facilities, financial constraints of family and agencies, a shortage of child mental health professionals and stigma related to mental health care problems (Leaf, Alegria, Cohen, Goodman, Horwitz, & Hoven, 1996). School- based mental health care programs evolved from a need to minimize the barriers to accessibility of mental health care services. School- based mental health, SBMH, programs are services provided within schools through the collaboration and coordination of mental health care providers and educators.

Federal initiatives have been partially responsible for the growth of SBMH programs and services in the United States. Reports of the U.S. Surgeon General on mental health (U.S. Department of Health and Human Services, 1999) and children's mental health (U.S. Public Health Service, 2000), both focused on the youth mental health crisis and the importance of school- based approaches in improved mental health care. The National Institute of Mental Health (2001) in its report, *Blueprint for Change: Research on Child and Adolescent Mental Health* emphasized that effective programs need to be readily available in schools. The President's Commission on Mental Health (2003) highlights the shortcomings of SBMH services- primarily fragmentation and gaps

in services. From the commission comes a clear recommendation for expansion and improvement in existing SBMH programs.

It is currently recognized that schools are the primary providers of mental health services for many children and adolescents (Paternite & Johnston, 2005). School-based mental health programs vary dramatically in the scope and depth of services from minimal support services to comprehensive, integrated programs of prevention, identification and treatment within the school community.

### **The Value of School-Based Mental Health Programs**

The value of school-based mental health programs has been acknowledged by mental health care providers and educators alike (Flaherty & Weist, 1999). School-based mental health programs have been examined as preventative measures and therapeutic interventions for adolescents with at risk behaviors (Adelman & Taylor, 1998). Schools are capable of playing a powerful role in influencing health-related behaviors (Paternite & Johnston, 2005). The Education Development Center in 1994 indicated that schools can provide the nurture and support needed to facilitate student adoption of health-enhancing behaviors. According to researchers, a comprehensive, well-coordinated school health program can promote optimal physical, emotional, social and educational development of students (Hawkins, Catalano, Kosterman, Abbot, & Hill, 1999).

Much of the programming pertaining to school-based mental health services has been supported by educators, health care professionals, child advocates, welfare providers and social- policy makers. Schools facing demographic changes and social

challenges have encouraged the development of a variety of school-based mental health services unique to the communities in which that are embedded. The expansion of school-based mental health services has resulted in clinics that are administratively controlled by school districts, government agencies or both. Staffing of clinics also varies widely but frequently recognizes school nurses, social workers and counselors as primary participants in programming. Less often included in the administration of programming are clinical psychologists and psychiatrists (Werthamer-Larsson, 1994).

Studies reveal the positive aspects of school-based mental health programs including the following: SBMH programs offer accessible programming for adolescents (Diala et al., 2002), reduced stigma attached to seeking mental health care (Nabors, Weist & Reynolds, 2000), increased opportunities to promote generalization and maintenance of treatment gains (Evans, 1999), enhanced capacity for promotion of mental health and prevention of problems (Weare, 2000). In a study conducted by Catron, Harris and Weiss (1998), it was reported that 96% of individuals referred for school-based counseling followed through on the referral as compared to only thirteen percent of individuals referred for community-based treatment.

As school based mental health programs continue to increase and expand, The Center for School Mental Health Assistance (2003) has reviewed numerous studies of SBMH programs and compiled a list of documented outcomes resulting from interventions provided by SBMH programming and services. A causal link is strongly suggested between SBMH programs and academic, behavioral and emotional outcomes of students. Students who receive support from school-based mental health clinicians

improve academic performance. Schools with mental health care services report fewer course failures and higher grade point averages among students receiving services.

According to this meta-analysis, students receiving support from school-based mental health clinicians learn positive coping skills and exhibit fewer disruptive behaviors.

Positive effects have been evidenced in attendance, truancy and discipline referrals.

Students receiving support from school-based mental health providers reported satisfaction with services, decrease in depression and an increase in self-esteem.

Charles Soule (2007), a Director of a School-Based Mental Health Program in New York, summarizes the advantages of mental health care in local schools as follows. SBMH increases the number of mental health care openings for needy individuals by augmenting what is offered in the community. It decreases common barriers of distance to clinics and lack of insurance for children and adolescents. SBMH provides increased comfort with accessing mental health care services and diminishes stigma associated with seeking assistance. It increases participation in the care of school aged children by mental health care providers. It provides better coordination of services between external and internal mental health care providers and the academic faculty and administration in schools. With decreased behavioral issues exhibited by students, the social and learning environment is more positive for everyone. And finally, SBMH provides the opportunity to introduce classroom and school-wide changes that support the mental health of everyone in that environment.

### **Models of School-Based Mental Health Programs**

School-based mental health service is commonly understood to be any mental health service delivered in the school setting. Currently school settings can mean a variety of placements – neighborhood schools, traditional public schools or programs administered in a variety of “school” settings such as hospitals and juvenile justice facilities. Mental health programming is, to some extent, provided by special education services in public schools. Since the mid-1970s, public schools have been mandated to provide mental health services and manage challenging behaviors of students identified as severely emotionally disturbed. This provision has limited the scope of programming to some degree to those who are found eligible for special education services. However, it is clear there are students with substantial mental health issues that are unable to access services intended specifically for special education students.

Many mental health programs focus on preventive measures rather than treatment approaches. There are three main models for preventive programs as defined by the Commission on Chronic Illness (1957) and revised by Gordon in 1987. Universal prevention programs are provided for all students through school-wide implementation. Selective or secondary prevention programs identify children or adolescents who are “at risk” for development of emotional or behavioral disorders based on documented familial or environmental conditions. Secondary programs focus on individual students but also combine students with similar risk factors for group interventions. Tertiary or indicated prevention programs employ mental health treatment for individual children or adolescents with an identified disorder.

There are three primary models of school-based mental health programs recognized in the literature. The Spectrum of Mental Health Interventions and Treatments (Mrazek & Haggerty, 1994; Weisz et al., 2005) combines traditional mental health interventions within a school setting. This approach may include prevention strategies, psychotherapy, psychopharmacology, and maintenance and recovery methods. For the purposes of this paper, this model will be referred to as The MH Spectrum.

Interconnected Systems for Meeting the Needs of all Children (Adelman & Taylor, 2006; National Institute for Health Care Management, 2005) include three systems of care including prevention, early intervention and systems of care for children with the most severe impairments. These three systems act as a continuum of services. This model is designated the Interconnected Systems.

The third model is The Application of Positive Behavior Supports to Reduce Challenging Behaviors in Schools (Horner et al., 1999). This model introduces the use of functional behavioral assessments – a strategy to understand the function of a particular behavior to effectively provide a decrease in or a replacement for the offending behavior. Positive behavioral supports are introduced to prevent and intervene with challenging behaviors. This model will be referred to as PBS. Of significance when selecting a conceptual model for implementation is consideration of the demographics, resources and stage of development in delivery of the school-based mental health services. Any program will be strengthened when embedded in a system-wide model (Kutash, Duchnowski & Lynn, 2006).

With attention focused on social and emotional development and the perceived relationship to academic achievement, numerous school-based mental health programs have emerged. The professionals who develop and implement these programs represent multiple professional disciplines with often conflicting orientations and perspectives. These systems may differ in primary goals of programming, eligibility for services, conceptual frameworks, theoretical variances and focus of intervention. Despite vastly different frames of reference the literature is replete with efforts to co-exist and share resources to support SBMH efforts.

With the acknowledged difficulties of blending the best of multiple disciplines, there is a new agenda emerging – scrutinizing programs for identification and implementation of evidence- based mental health interventions. Zins, Weissberg, Wang and Walberg (2004) indicate most school-based programs are not empirically-based. Furthermore, the vast majority of programs emerged in response to immediate needs or pressures. There are multiple measures of effective empirically supported strategies such as those provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) detailed in the National Registry of Evidence-Based Programs and Practices (NRREPP, 2005). References will be made in this study specifically to those supported by Rones and Hoagwood in 2000 and Hoagwood in 2006.

### **The Bridges Program**

During the spring of 2005 a group of educators and mental health professionals from an affluent, suburban high school district north of Chicago met to discuss how to assist an emerging and troubled group of adolescent students exhibiting clinical anxiety

and depression. Clinical anxiety and/or depression were manifested in substance abuse, suicidal ideation, eating disorders and school refusal. The emerging population consisted of adolescents who were returning to public high school subsequent to a psychiatric hospitalization and/or prolonged absence. The population of adolescents was historically, and currently, laden with bright, high achieving students – frequently student leaders in academics, government, athletics, theater and the arts. To compound the problem, these students were “regular education” or mainstream students – ineligible for the array of services provided for identified special education services within this district.

The 2005 Committee identified existing services that could be accessed by students returning from a psychiatric hospitalization or prolonged absence. They were minimal at best – including time limited assistance from a school social worker and liaison support and communication between nurses in the health care office with outside physicians and therapists, and traditional nursing services available to all segments of the school population. The social work department, sometimes with representation from the special education department, facilitated the reentrance of students to public school from psychiatric hospitalizations. In addition to time limited counseling services provided by social work, students who had been hospitalized were occasionally provided tutoring services to assist with make-up work. Students returning from significant and sustained periods of absenteeism were afforded even fewer services. Reentry to school was provided by the assistance of a school advisory program, an advocacy program for all students, and the Dean’s office often in concert with truancy officers. These were the



sole structures in existence at this suburban school for adolescents in need of reintegration services.

Returning students often expressed feelings of being overwhelmed by academic expectations upon reentry. Absent a formal advocacy system, students were left to negotiate their return with individual staff members, often with very different expectations. Students, reportedly, were reluctant to explain their initial departure from school and lacked those skills required to ensure a satisfactory and reasonably paced reentry. As a result, returning students floundered between academic expectations and the social/emotional issues related to the reentry process. Student grades and absenteeism rates were indicators of difficulty with the reintegration process. Interviews with social workers reflected the struggles students were experiencing and the absence of a coordinated effort to enlist services to assist these students. Out of the need to provide assistance to adolescents with the reintegration process, the Bridges program was born. The Bridges brochure (2007) describes the program as follows, “Bridges is an intensive regular education program designed to provide individualized education and social emotional support in a time-limited manner.”

The primary goal of Bridges is to provide transitional services for students reentering public school subsequent to a psychiatric hospitalization or prolonged absence that will magnify opportunities for successful reintegration. The program has been in existence for five years and there is a presumed historical value attributed to the program. Limited data collection including a singular survey of staff and informal comments collected from students previously enrolled in Bridges, have provided some indicators of

worth to the school community. However, the value of the Bridges program has not been explored from the perspective of its stakeholders- students enrolled in Bridges, their families, and the faculty of the Bridges program and the greater school community.

### **Current Approaches to Studies of School-Based Mental Health Programs**

There is a preponderance of mixed methods studies of school-based mental health programs (Cohen, 2006; Steiner et al., 2004). Frequently these studies employ large populations for purposes of validity. Replication of studies and pretest/posttest with control group and treatment group are common approaches.

Many of the current studies of school-based mental health programs rely on treatment outcomes of pilot programs for assessment of the efficacy of interventions (Weist et al., 1996). Pilot programs are assessed for the purposes of generalization from one program to future, additional programs. This approach minimizes the significance of a study conducted in isolation with its unique characteristics and qualities. In other words, qualitative case study would not be an appropriate approach for programs that are reviewed and evaluated specifically for treatment outcomes.

There has been a substantial growth of research- based knowledge in child mental health that addresses what is called the science-to-service dilemma (Hoagwood, 2002). Science-to-service practice creates an information loop between research and clinical practice and provides an integration of evidence-based practice and research activities. Currently there is a disconnect between research-based knowledge and application to school-based mental health interventions (Hoagwood, Burns, & Weisz, 2002). Much of

the SBMH literature is focused on how to better integrate research knowledge with current practice.

There are minimal case studies designed to understand the significance and value of a program in isolation with its unique characteristics and qualities. This study overcomes this gap in the literature through the use of an intrinsic case study approach based on the theoretical framework of humanistic psychology and the methodology of R.E. Stake's responsive evaluation. The merits and shortcomings of the program from the perspectives of the Bridges program will be explored from the perspectives of stakeholders.

The focus of this inquiry is to better understand the program with its unique qualities and attributes rather to understand it in the context of comparison or generalization to other programs. It is unique onto itself. Case studies are not suitable for generalizations but are appropriate for exploration of a singular program or case. Stake believes in the value of gaining a deep understanding of a particular case through contextual, cultural, organizational, curricular and collegial details. There is no intent to duplicate this program for other populations in other environments.

My expectation is that I will gain a deep understanding of the Bridges program that will contribute to the essential understandings of stakeholders. New insights may allow stakeholders to refine personal understandings and consider opportunities for program modification, evolution and improvement. My role is to facilitate the process of discovery.

## **Theoretical Framework and Methodological Foundation for this Study**

### **The Externalizing Theory of Humanistic Psychology**

Humanistic psychology evolved in response to psychoanalysis and behaviorism in the 1950s primarily through the works of Abraham Maslow and Carl Rogers. Humanistic psychology focuses on an individual's potential and stresses the importance of growth and self-actualization. The fundamental belief of humanistic psychology is that people are innately good and that mental and social problems result from deviations from this natural tendency (Cherry, 2010). Focal points of humanistic psychology include the following: an emphasis on the role of the individual, an understanding of the role of environment in influencing individual experiences and a venue for exploring individual ability and potential. Humanistic psychology is a value orientation that emphasizes a constructive view of human beings and the capacity for self-determination. It stresses the independent dignity and worth of human beings and a conscious capacity to develop competency and self-respect. Additionally the individual has responsibility for one another and to society. Social change is integral to sustaining human development and organizational efficacy (Simond, 2009).

According to humanistic psychology, values clarification is thought to be internal and relative to the individual. There exists no uniform set of values that is deemed appropriate for all individuals (Huitt, 2004). Like humanistic psychology and integral to Robert E. Stake's responsive evaluation is the belief that the individual determines the value or worth of a particular program, approach or process. By understanding multiple perspectives, one recognizes the worth of individual thought and opinion. Therefore,

when one attempts to understand the value of a program such as Bridges, humanistic psychology and Stake's responsive evaluation would focus on the value an individual attributes to the program. Stake has even adopted an emotive language in responsive evaluation reflective of humanistic psychology. Common terminology focuses on values, the individual, goodness and worth.

Carl Rogers is best known for his contribution to humanistic psychology in the development and promotion of client-centered therapy. This approach places much of the responsibility for the treatment process on the client and redefines the therapist's role as non-directive. Rogers believed, "that within the client resides constructive forces whose strength and uniformity have been either entirely unrecognized or grossly underestimated" (Rogers, 1951). Rogers believed that the constructive forces of an individual can be trusted. The client can achieve sensitive and accurate insights that can be translated into constructive behavior if the proper condition exists of an appropriate relationship and atmosphere between the client and therapist. Client-centered therapy differs markedly from other therapeutic approaches in that it recognizes the strength and capacity of the client or individual.

There are noticeable parallels between client-centered therapy and Stake's responsive evaluation. As previously cited in this study, responsive evaluation employs an intrinsic case study approach that relies on the specific expertise of practitioners in the local setting. This is analogous to reliance on the strength and expertise of the client or individual. Like client-centered therapy, responsive evaluation remains tied to personal experience and explores quality as perceived by the individual. Both acknowledge the

expertise of stakeholders, clients, and the value of their multiple perceptions as there are no universally accepted values. Like client-centered therapy, responsive evaluation is an empirical study of human activity, interactions and thought. Stakeholders or clients assign value and assess the quality of programming or issues as it relates to them personally. Stake extends this thought in a quote from 2004, “Quality is related to cherishing, an intellectual emotion. It can be felt by groups but remains tied to personal experience.” The focus in both methodologies is on personal understanding, personal valuing and personal experience. Interpretation and understanding by stakeholders or clients, not the researcher or therapist, is the primary outcome of client-centered therapy and responsive evaluation.

R.E. Stake indicated in 1994 that programs developed for a specific population within the specific context of a school environment are most effective in meeting the needs of that particular community. The Bridges program is a specific program designed for a very specific population – adolescents returning to a public high school subsequent to a psychiatric hospitalization or prolonged absence. This study will be modeled after the work of Robert Stake using responsive evaluation as a methodological guide. Responsive evaluation employs an intrinsic case study approach that relies on the specific expertise of practitioners in the local setting. The intrinsic case study approach will allow me to serve as facilitator, concerned with understanding a particular program (Stake, 1995) already in existence for the purpose of providing information to Bridges stakeholders. This approach assumes those who carry out the program, the service providers and participants in the program, have much more knowledge than the

researcher. For the purposes of this study, the Bridges faculty and assigned administrator have the expertise that will allow me to understand the uniqueness of the Bridges program. The quality or goodness of the program will be explored while valuing pluralistic understandings. Stake assumes a program has no one single value; its value will be determined by different people for different purposes as there are multiple realities. Stake emphasizes the value of discovery learning through thick description; the practice of collecting personal experiences through stories and portrayals of people that can evoke a vicarious experience in the audience, and facilitate a better understanding of the program. This study will represent the beliefs, values and cultural plurality of its stakeholders as gleaned from personal interviews as well as describe the quality and limitations of the Bridges program from itself. Case studies are not suitable for generalizations but are appropriate for exploration of a singular program or case. Stake believes in the value of gaining a deep understanding of a particular case through contextual, cultural, organizational, curricular and collegial details. There is no intent to duplicate this program for other populations in other environments.

My expectation is that I will gain a deep understanding of the Bridges program that will contribute to the essential understanding of stakeholders. New insights may allow stakeholders to refine personal understandings and consider opportunities for program modification, evolution and improvement. My role is to facilitate the process of discovery.

### **Purpose of Study**

The purpose of this study is to explore and interpret the value of the Bridges program from the multiple perspectives of stakeholders through thick description. I am interested in understanding the Bridges program and its unique attributes in an intrinsic, exploratory, case study. This will be an internal, formative analysis of the value of the Bridges program, as determined by stakeholders, which may be used for program improvement. Additionally, this study is intended to overcome some of the deficiencies in the literature that result from the lack of intrinsic case studies of school-based mental health programs. As such, it will contribute to the fund of knowledge currently available in the literature which is dominated by quantitative studies designed to research the generalization or reproducibility of SBMH programs.

### **Research Questions**

Research questions have been developed subsequent to meetings with concerned stakeholders including Bridges service providers and the primary administrator responsible for oversight and programming. I will be exploring the following questions in depth:

1. How do stakeholders perceive the impact of the Bridges program in facilitating the reentry of students into a specific public high school in a northern suburb of Chicago?
2. In what ways does the Bridges program support successful reintegration of students to a public school subsequent to a prolonged absence or psychiatric hospitalization?



3. What are the stakeholders' perceptions of the Bridges program as a means to assisting students with mental health care concerns?

### **Sources of Data for Study**

In this study the Bridges program is the evaluand and the description of experiences reported by informants during the interview process will serve as my primary data. These will be shared with stakeholders to check for accuracy. Interviews will serve as the primary basis for determining the program's contribution to the well-being of students enrolled in Bridges and its value as a reintegration model. Interviews of students previously enrolled in Bridges, and those who are currently in the program will explore their opinions and recommendations. Parent interviews, including both past and current parents, will provide understanding of the perceived value of Bridges to students and their families. The researcher will conduct face-to-face structured interviews with additional stakeholders – the Bridges staff, oversight administrator, students and parents of enrolled students. Observation and field notes will provide an extensive record and thick description of student and staff behaviors, interactions, and activities.

Structured questionnaires will provide reports of the attitudes, opinions and behaviors of specified stakeholders – the greater school community. Review of existing documentation including minutes of staff meetings and the Bridges brochure will provide a better understanding of the evolution of the program over a four year period of time. Additional sources of data that have been identified for this study include existing public documents that have not been used in this context before including student attendance prior to Bridges, while enrolled in Bridges and subsequent to Bridges. Other sources of

information will include official student records of quarterly and semester grades for comparison for pre Bridges, during Bridges and post Bridges academic achievement. These will be indicators of the value of the program to participants. Personal products including student work samples and journal notations will be reviewed absent student names for purposes of confidentiality. The researcher will maintain a daily journal to record feelings, impressions, prejudices and reflections that arise.

Data will be triangulated to generate a comprehensive and accurate description of Bridges from stakeholders' perceptions. Data including interviews, observations, questionnaires and documents will be reviewed for the purpose of understanding trends and assertions that evolve from the triangulation process. Ethical considerations require substantive efforts to minimize misrepresentations and misunderstandings. I will deliberately search for validation of data through the triangulation process. In this particular case study, triangulation will result in a number of interpretations rather than confirmation of a singular interpretation as I am representing four stakeholder groups.

### **Significance of Study**

Despite substantial interest in school-based mental health programs, the literature does not address the specific population that I am studying – adolescents reintegrating to a public high school. Though studies include school-based mental health programs that provide services for students exhibiting clinical anxiety and depression, there is an absence of programs that combine the transitional dilemma of adolescents returning to public school subsequent to a psychiatric hospitalization and/or prolonged absence with the mental health component. The Bridges program was born out of a need to provide

individualized academic assistance and social and emotional support for a very specific population of students.

This district, like others in its geographic and socio-economic locale, discovered a flaw in its programming for *all* students. While an array of specialized services existed within the school district, regular education students, also referred to as mainstream students, could not access these services unless identified as eligible for special education services. Legislation provided by the All Handicapped Act of 1976 and subsequent reauthorizations of the Individuals with Disabilities Act in 1990 and 1997 and the Individuals with Disabilities Education Improvement Act (IDEIA) of 2004 have resulted in mandated programming for students requiring special education services. Funding for programming has enhanced school districts' abilities to meet the demands of legislation to varying degrees. During the advent and evolution of school-based mental health programs, a parallel structure was emerging in response to the mandate to provide a free, appropriate public education in the least restrictive environment for all special education students. So while districts may have developed programming options for students returning from a psychiatric hospitalization or prolonged absence they, like this district, may have found significant barriers to accessing services for regular education students.

The program being studied is, therefore, unique in its population and unique in its mission – to provide transitional services for regular education students re-entering public high school that maximize successful reintegration. Of the studies reviewed of school-based mental health programs, none reflected the attitudes, concerns, opinions or suggestions for improvement by the adolescents in the SBMH programs. This inquiry

will provide a voice for students formerly and currently enrolled in the Bridges program, thereby expanding understandings and interpretations. Viewed through the lens of student participants, a more comprehensive perspective may emerge of the programming, relationships and experiences of those affiliated with Bridges. I believe there is a great opportunity to examine this program in depth, to understand it as a solitary contribution to the literature on school-based mental health programs.

### **Delimitation of Study**

This research project is limited to a single program in a single public school district. This study is contextually bound and, therefore, not intended to be the basis for generalization and replication in other districts. The focus of this study is on particularization; gaining a comprehensive understanding of a singular project in existence for five years.

### **Limitations of the Study**

As this is an internal study, the researcher is familiar with the Bridges faculty and, to a limited degree, familiar with the program. This familiarity can result in the researcher making erroneous assumptions with regard to the reader's understandings. To address this limitation I will be vigilant to explain terminology and common understandings that exist within the school community.

There is a presumed level of bias on the part of the researcher that could be reflected in the research and analysis of this study. To counteract the possibility of bias, the researcher will take copious notes reflecting the perceptions and opinions of

stakeholders. These understandings will be verified through member checking with stakeholders for accuracy before formally reporting them as part of the analysis.

As the researcher in this study, I will be vigilant to the limitations that may arise from observations including the following: the need to maintain confidential information not relevant to the scope of this study and that may emerge with observation of participants in Bridges and, secondly, the possibility of my presence as a deterrent to candid, authentic participant interactions.

CHAPTER II  
LITERATURE REVIEW

**Introduction**

The question being addressed in this study is as follows; how do stakeholders perceive the impact of the Bridges program in facilitating the reentry of students into a specific high school in a northern suburb of Chicago? Sub questions will explore multiple realities including the following. In what ways does the Bridges program support successful reintegration of students to a public high school subsequent to a prolonged absence or psychiatric hospitalization? What are the stakeholders' perceptions of the Bridges program as a means to assisting students with mental health care concerns? I have identified potential indicators of reintegration to be explored with the four stakeholder groups - students, parents and faculty in the Bridges program and the greater school community. Indicators include student outcomes (regular school attendance and reintegration to classes), academic factors (grades and changes in levels from higher to lower ranked classes), social and emotional factors (reentry into peer groups and the greater school community, participation in school- based therapy including individual and group interventions) and case management (advocacy and liaison functions provided by Bridges staff on behalf of students enrolled in the program). The historical evolution of school-based mental health services as described in Chapter I provide the back-drop and context for the emergence of the Bridges program, first conceived in 2005.

Legislation and funding sources including P.L. 94-142 (1975) and IDEA (1997) have greatly impacted the historical evolution and expansion of special education service mandated for public schools- often to the exclusion of programming options for regular or mainstream students. While many initial programs focused on the needs of the aggressive, conduct-disordered adolescent (Hendren & Birrell, 2002), current research indicates a more comprehensive approach to school-based mental health programs that are designed for students with multiple impairments including clinical depression and anxiety, suicidal ideation and substance abuse is required (Cohen, 2006). The population of my study is unique in the literature as they are adolescents with diagnosed anxiety and depression transitioning back to public school subsequent to a prolonged absence or psychiatric hospitalization. The Bridges population is comprised primarily of mainstream, high functioning adolescents, leaders in every venue of their school environment, who exhibit clinical anxiety and/or depression as manifested in substance abuse, suicidal ideation, eating disorders and/or school refusal. The Bridges program addresses the challenge proposed by Cohen (2006) to develop progressive and comprehensive programs that focus on the complex needs of adolescents in public schools. Consistent with the need to assist an emerging population of youth, the 2005 Bridges committee sought ways to better assist transitioning adolescents with the reintegration process to public school subsequent to a prolonged absence or psychiatric hospitalization.

### **Historical Roots of the Bridges Program**

During the course of gathering data I discussed my research with colleagues. One faculty member shared some rather startling information with me. There had been a concerted effort by some school personnel to develop a program for transitioning students with similar goals to Bridges since 1983. Memos and proposals dating back to 1983 indicate a need for the school to provide transitional services for students returning from a psychiatric or substance abuse hospitalization. During 1984 and 1985, administration and support services personnel investigated the needs of this population by speaking with the sender hospitals and treatment centers and returning students. In 1985, an After Care program was developed by the social work department at this public high school. Its goals were as follows:

1. To facilitate as smooth a transition back into as normalized program as needed.
2. To provide some consistency and continuity between a highly structured hospital program and high school. Specific focus was to be on the unique academic, social and emotional needs of individuals.
3. To provide coordination and enhanced communication between family, school and community resources and to assess the needs of the individual student.
4. To minimize the interruption to the student's educational program and provide additional supportive networks and sponsorship for students attempting to stabilize and reintegrate.



5. To provide a process in which students can, through adult sponsorship and peer group support, address their feelings and deal with issues that directly impact their learning.

The goals of the After Care program of 1985 are very much aligned with the goals of the Bridges program in 2010. What differs markedly is the approach taken at the inception of each program. During the 1985-1986 school year, the social work department initiated weekly transitional group services for returning students. The groups were named the Post Hospital group for those returning from a psychiatric hospitalization and People out of Treatment or the P.O.T. group. Referrals to the two groups were made when a returning student was scheduled to reenter high school. Participation was voluntary and the groups met once weekly for six weeks on a rotating class schedule.

A primary objective of the groups was to help the returning student function adequately within the school environment. To accomplish this, the groups focused on adaptive coping strategies, interpersonal relationships and functional learning behaviors. Documents detailing the transition groups describe returning students as fearful of their return, exhibiting feelings of emotional assault, difficulty dealing with stigma or feelings of embarrassment, and struggling with issues of adequacy and confidence. The groups were planned to assist students in coping with academic pressures and improved school functioning. The two transition groups were intended to enhance student ability to manage stress.

Five years after the groups were introduced by social work services the program was evaluated with input from health care providers from sending institutions, faculty at the public school and students who had participated in the groups. Each of the groups was assessed through anonymous survey. What was learned through the evaluation was that a support group in school for returning students is very important. The groups provide a process for returning students through adult leadership and peer support to address issues relating to self-esteem, relationships in the school environment and management of school responsibilities. The following recommendations were made as a result of the program evaluation:

1. There is a need for in service opportunities for school personnel to better understand the unique needs of returning students.
2. There is a need for tutorial services to assist returning students with make- up work.
3. There is a need for parent involvement and support.
4. There is a need for a designated contact person to coordinate hospital/school issues.
5. There is a need for careful class selection and assignment upon reentry. Some classes might need to be dropped.

The final recommendation of the evaluation was to form a committee to study the identified needs and consider ways to implement change. Documents and memos subsequent to this recommendation do not indicate any change or enhancement of programming. I have since found that space and staffing issues precluded any possibility

of the program evolving into something more comprehensive in nature. In a memo dated November of 1993 to the then superintendent of the school district by the district's coordinator of hospital instruction, a recommendation is made to consider adding a more structured academic component to the reentry program rather than diverting student placement to special education. Apparently special education was the only avenue for access to academic supports. From the time the groups for returning students were initiated until 2005, no significant programming options were introduced for students reintegrating to this public school.

### **Structure of the Literature Review**

This chapter will provide an overview of community based services from which school-based mental health programs emerged. The historical evolution of community based services will be explored primarily through perspectives provided by the World Health Organization (WHO) (2003). This will be followed by a section on legislation-significant to this literature review as it has greatly impacted the evolution of school-based mental health programs. Also significant to the progression of SBMH is the discrepant legislation and resulting funding that exists for students identified as eligible for special education services versus non- identified, mainstream students (Demers & Bricklin, 1995). My study will contribute to the fund of programming options. Bridges was designed specifically for regular education students reintegrating to public school subsequent to a prolonged absence or psychiatric hospitalization. The programming that emerged from this original design eventually incorporated some identified special education students who required assistance with the reentry process. The Bridges

program was developed specifically to address the challenges confronting adolescents in the process of reintegration to public high school.

Following the section on legislation, I will review the existing models and formats of school-based mental health programs. They are numerous and diverse in design though those that incorporate a whole school or universal approach are frequently cited as effective service delivery models (Markham & Aveyard, 2003; Weare, 2000). Evidence-based approaches are currently amongst the most prominent programs that appear in the literature (Kutash, Duchnowski & Lynn, 2006). The overview of SBMH models provides a context from which the Bridges program evolved- mirroring some components of various program models while reflecting the needs of the specific population in a specific public high school. The Bridges program model will be discussed at the conclusion of the SBMH models section.

The next section of my literature review will focus on studies that have been conducted on school-based mental health programs. They provide the historical basis for the most common inquiry methods used to examine SBMH programs. The vast majority of studies conducted on school-based mental health programs have used either a quantitative or mixed methodology research design that focuses on outcomes (Weist, Paskewitz, Warner & Flaherty, 1996). I will be employing a qualitative, case study approach to examine the stakeholders' perceptions of a specific and singular school-based mental health program, Bridges. A case study of the Bridges program will afford me the best opportunity to understand and represent the values and beliefs of stakeholders while reporting evaluation results (Stake, 1975).

Subsequent to the review of studies conducted on school-based mental health programs, I will examine the classic symptoms of anxiety and depression as these represent the primary, clinical manifestations of behaviors exhibited by the adolescents for whom Bridges was designed. The Diagnostic and Statistical Manual of Mental Health (revised 4<sup>th</sup> Edition) with text revisions, studies of anxiety from C.D. Spielberger and depression studies from Aaron Beck will provide a deeper understanding of these classic symptoms and how programming, specific to Bridges, may contribute to mental health in adolescence.

The final section of this literature review will highlight some of the major findings of my research of school-based mental health programs. I will summarize the basis for my selection of case study and, specifically, Robert Stake's Responsive Evaluation as a methodological guide to better understand the Bridges program. Unlike other philosophical approaches that emphasize outcome based results, this study will reflect the values and understandings of its stakeholders rather than perceived successes or failures of the Bridges program. A study of the Bridges program will augment the body of research currently available on school-based mental health programs.

### **Community Based Services**

Community based mental health systems are the parent to the emergence of school-based mental health programs. The World Health Organization (2001) defines mental health as, "A state of complete physical, mental and social well being and not merely the absence of disease and infirmity. Mental health is a state of well being in which the individual realizes his or her own abilities, can cope with normal stressors of

life, can work productively and fruitfully, and is able to make a contribution to his or her own community.” Mental, social and behavioral health problems are believed to interact in such a way as to intensify the effects on behavior and well being.

The historical development of mental health care systems, as represented by WHO (2003), has three major periods of development. Period one occurred approximately between 1880 and 1950 and was notable for the rise of the asylum model. Large facilities were constructed to provide basic, custodial care- often remote from the populations served. Evidence today indicates the asylum model provided very low levels of treatment and exists today in some countries having extremely limited economic resources (WHO, 2005).

Period two occurred primarily in economically developed countries after 1950 and has been characterized by the decline of the asylum model. During the asylum model patients were found to have a progressive loss of life skills and, subsequently, accumulation of negative and inappropriate behaviors reflective of their environment (Wing & Brown, 1970). Other concerns noted during this era were repeated cases of ill treatment to patients, geographical and professional isolation of the institutions and their staffs, ineffective management and resource allocation, ineffective staff training and measures of quality control. In response to these shortcomings (WHO, 2003), deinstitutionalization became the norm and was characterized by three components: provision of community facilities to prevent inappropriate mental hospital admissions, the discharge of long term institutional patients into the community and the establishment of community support systems for patients not institutionalized (WHO, 2003).

Period three reflects what is referred to as a balanced care of community based services within local settings. The balanced care approach incorporates hospital care into the range of services provided. Balanced care seeks to provide services close to home that include modern hospitals for acute and long term placement, mobile services including home treatment that address disabilities and symptoms, services that provide treatment and care specific to the diagnosis and needs of individuals, adherence to international conventions on human rights, a reflection of priorities as identified by service users themselves and coordination among health care providers and health care agencies.

The progression from community based supports to school based mental health programs evolved because schools are recognized as the major institution for providing the instruction and experiences that prepare adolescents for healthy, productive adults (Education Development Center, 1994). Accessibility to services for children and adolescents is a primary reason for the focus on school- based mental health programs. In 2007 99% of children aged 5 through 18 were enrolled in school in the United States (National Center for Educational Statistics). Studies have shown that health and success in school are inextricably intertwined. Good health contributes to growth, development and optimal learning while education promotes knowledge about being healthy (U.S. Department of Health and Human Services, 1999).

The Bridges program, initiated in 2005, is representative of period three as defined by the World Health Organization and research provided by the Department of Education. It is a program developed in response to an emerging population of students

in a public school for whom no programming had previously been provided. The unique needs of students returning from a prolonged absence or psychiatric hospitalization required that staff garner support and create programming options to assist with the reintegration process. The program emerged simply out of necessity.

### **Legislation**

The topic for my dissertation is rooted in the historical evolution of school- based mental health programs. For this reason, I provide an overview of legislation that has significantly impacted the development of SBMH programs in the United States and, ultimately, the Bridges program. Some legislation, i.e., P.L.94-142, has notably resulted in discretionary spending that can limit access to some programming for some populations of students. As was realized during the investigative stage of the Bridges program, students not identified as eligible for special education services were initially denied access to programming options deemed routine for identified students. During the investigative stage the 2005 Committee consisting of a local group of educators and mental health providers within the district, compiled a comprehensive list of all resources that were currently available within the district and detailed what populations were accessing which resources and services. This analysis informed the 2005 Committee that substantial supports and program options already existed within this public high school but were not being accessed by some student populations. It is believed that some of these inequities evolved from legislation intended to protect special education students. The 2005 Committee was able to reallocate some resources, extend services to additional populations not being wholly served and blend programming options through the



development of the Bridges program while retaining the intent of state and federal legislation.

At the end of the nineteenth century, provision for mental health services for children in public schools emerged. School-based mental health programs evolved from the confluence of four factors during the progressive era (Weist, 2005). They include compulsory education and laws limiting child labor, immigration concerns about social order, urbanization, and concerns about public health and professional and scientific development in psychology, social work and special education. From these factors evolved the development of core disciplines seen in public schools today – nurses, school psychologists, school counselors, social workers and, in some institutions, psychiatrists as consultants to schools. Numerous models of school-based mental health programs have emerged since the 1980s including simple expansions of the traditional services provided by the nurse's office to multi-disciplinary, comprehensive and collaborative approaches.

With legislation impacting the role and responsibilities of public schools, [The Community Mental Health Centers Act of 1963, P.L. 94- 142, The Education of All Handicapped Children Act of 1975 – later reauthorized as the Individuals with Disabilities Education Act (IDEA) and the Comprehensive Mental Health Services for Children and Their Families Program Systems of Care instituted in 1992], schools were increasingly expected to provide a wide range of expanded health services. The Community Mental Health Centers Act of 1963, P.L. 88-164, introduced during the Kennedy presidency was a national initiative that was intended to provide prompt and effective treatment to patients within the geographic area of their home. The focus of this

Act was on comprehensive services and continuity of care (Grohol, 2006). The Education of All Handicapped Children Act, P.L. 94-142, required that children between the ages of 3 and 21 with serious emotional disturbances be provided a free and appropriate public education or FAPE with mental health services needed to promote learning (NIMH, 1999). The Comprehensive Community Mental Health Services Program for Children and Their Families, P.L. 102- 321, is a grant program that supports the development of comprehensive, coordinated, community-based and culturally competent systems of care for children and adolescents with serious emotional disturbances and their families (Adelman, 1996). Largely due to the introduction of these acts in concert with funding of reforms in education and health care, school-based mental health programs emerged in the 1980s. School-based clinics expanded the range and array of health services for students and families based on the traditions of school nursing and public health clinics. The underlying assumption was that marginalized populations would benefit from treatments that were readily accessible. The intent was to provide services to those who would not otherwise seek resources in the greater community (Weist, 2005).

Schools have been identified as underused facilities that can provide a variety of services (Holtzman, 1992) that are school-based or school- linked and are cost-effective (Safeguarding Our Future, 1994). There are approximately one hundred thousand public schools in the United States with about fifty million students in attendance (Kutash, Duchnowski, & Lynn, 2006). No other social structure exists in which youth are so readily available for services. Catron and Weiss (1994) found that when mental health

services were provided in schools, 98% of referred students participated in services while only 17% of similarly referred students entered treatment in traditional, clinic-based programs. Programs have emerged that are both school-based and school-linked in response to social and demographic changes in our nation.

National policy initiatives have addressed the interconnectedness of children's health and educational experience and supported the placement of health- service programs in schools (Dryfoos, 1994). National policies regarding the health needs of children in the school setting have been significantly shaped by the following: the Child and Adolescent Service System Program (CASSP) developed by the National Institute of Mental Health (NIMH, 1984), The Omnibus Budget Reconciliation Act of 1989, the National Health Objectives for Health Promotion and Disease Prevention as outlined in Healthy People 2000 (U.S. Department of Health and Human Services, 1990), and the National Education Goals, outlined in the Goals 2000: Educate America Act (Talley & Short, 1996). These policies have resulted in a link between children's health and their educational experience and supported the placement of health service programs in schools (Dryfoos, 1994). Each of these initiatives has influenced services to children and adolescents in school. According to Adelman and Taylor (2006) national policy targets schools as an ideal location for comprehensive, accessible health, psychological and social services for American youth. Housing mental health services in schools greatly increases accessibility and service utilization.

CASSP was developed in 1984 in response to findings by the Joint Commission on the Mental Health of Children (1969) and the President's Commission on Mental

Health (1978). Both studies documented the lack of adequate children's mental health care services. CASSP was assigned the following tasks: delineate the components of an ideal service delivery system for seriously emotionally disturbed children and youth, improve access to these services, increase the priority of budget allocation for child and adolescent mental health services, improve agency coordination and include family participation in services, ensure culturally competent services and evaluate the progress of states and communities in accomplishing these goals. The guiding principles of CASSP include the following: children's services should be provided in the most normalized environment possible for the child, services should be driven by consumer needs rather than typical agency configurations, and services should be community-based.

Passage of the Omnibus Budget Reconciliation Act of 1989 required states to expand Medicare coverage for children. Additionally the Act of 1989 put a focus on improved prevention services that includes early periodic screening and treatment diagnoses (EPSTD) for children and youth. The requirements of the Omnibus Act further focused on accessibility to services by the development of outreach and EPSTD programs and provision for health care in school-based or school-linked clinical settings.

The National Health Objectives published in Healthy People 2000 (U.S. Department of Health & Human Services, 2000) explains the federal policy goals regarding national health. This report was considered especially significant in that it emphasized health promotion, protection and preventative services. The report's objectives stipulated the need for comprehensive kindergarten through grade 12 health

education in a variety of areas including nutrition, sexuality and substance abuse. The National Health Objectives Report emphasized the need for federally supported, school based mental health clinics to address outstanding health care needs.

The National Education Goals 2000: Educate America Act promoted primarily educational goals. However, the goals reflect an understanding that, “Children’s learning is related to their health status and a healthy school climate.” The goals support the provision for a broad spectrum of support services including health services, social skills training, substance abuse training and mental health services in public schools.

Additional federal initiatives impacting SBMH programming have evolved from more recent publications including the National Institute of Mental Health Report (2001) *Blueprint for Change: Research on Child and Adolescent Mental Health*. This report highlighted the need to provide effective interventions for adolescents where they frequent- schools and other places they access daily. In 2003 the President’s New Freedom Commission on Mental Health ([www.mentalhealthcommission.gov](http://www.mentalhealthcommission.gov)) highlighted the fragmentation of services to youth nation-wide and advocated for improved and expanded SBMH programs. Additionally the American Academy of Pediatrics in its Policy Statement on SBMH services (2004) states, “School-based mental health programs offer the promise of improving access to diagnosis of and treatment for the mental health care problems of children and adolescents.” In response to the specific recommendations of the New Freedom Commission and the Academy of Pediatrics SBMH programs have emerged in cities and states and in national and international cooperative networks (Weist, 2005).

Concurrent with mental health legislation was the emergence of significant special education legislation, Section 504 of the Rehabilitation Act of 1973, mandating schools to provide students with a free, appropriate public education in the least restrictive environment (FAPE). Faced with the dilemma of providing appropriate education for a population of students who previously would have been placed in alternative programs outside of their home schools, resources and funding were sometimes diverted to programming for special education students exhibiting emotional and/ or behavioral issues. Funding allocation and distribution has created barriers for effective use (DeMers & Bricklin, 1995). For example, funding under IDEA is considered educational funding and is restricted to children and adolescents requiring special education services. Therefore, adolescents with substantial health care needs, not identified in need of special education services, are precluded from accessing funding under IDEA. Students who are eligible for special education services can access the full array of services provided by a school district. Minimal programming options exist for regular education students experiencing mental illness issues commonly observed in public schools – clinical depression and anxiety (Weist, Evans, & Lever, 2003). As legislation and funding have made services to special education students mandatory, those not meeting the criteria for eligibility have been exempt from multiple services. The Bridges Program was developed in direct response to this dilemma - multiple services in existence for identified special education students experiencing clinical anxiety and/or depression but a dearth of comparable services for non- identified peers experiencing clinical anxiety and/or depression.

To summarize, all of the legislative policies reviewed in this chapter have facilitated the development of child and adolescent health care programming and services. The acts acknowledge a broad definition of health, an emphasis on prevention, a demand for child-focused, family centered and community based comprehensive service delivery systems (Dryfoos, 1994). Funding sources, while contributing to the advancement of SBMH programs, have sometimes limited access to a comprehensive array of services (Demers & Bricklin, 1995). Dryfoos (1994) maintains schools are optimal settings for expansive services in that they provide easy access to populations in need, are generally stable institutions in neighborhoods familiar to clients, and provide opportunities for coordination of services. Dryfoos envisions schools of the twenty-first century as “full service schools” that can address the comprehensive health care needs of children, adolescents and their families.

### **Existing Models and Formats of School-Based Mental Health Programs**

Numerous models of school-based mental health programs have emerged since their inception in the 1980s. Those that repeatedly appear in the literature as exemplary models, as reviewed by Rhones and Hoagwood, (2000) and Hoagwood (2006), will be explored in this paper. This section of my review will further examine accessibility issues resulting from discretionary funding-resources provided exclusively for special education students. My study of Bridges will provide a unique perspective that focuses on accessibility to existing services and development of additional programming options for a little recognized population of students that emerged in 2005. The Bridges program developers tackled some of the most difficult funding and legal issues that other models

have experienced. In this respect, my study will contribute to the fund of knowledge available on school-based mental health programs. It addresses issues of accessibility for a unique population of students while examining how more inclusive visioning can result in meaningful reallocation of resources.

Adelman and Taylor (2000) developed a continuum of services for school-based mental health programs with a focus on primary prevention at one end of a comprehensive continuum of interventions. Included within the domain of preventative interventions are support and assistance to enhance health and psychosocial development for preschoolers and during early schooling. Supports include cross-disciplinary teaming, education and social support for parents, quality day care and early education and enhanced curricular and extra-curricular enrichment and recreational programs.

Adelman and Taylor (2000) view early-after-onset intervention as the next intervention on the continuum of services. Included within this level of intervention are appropriate screening procedures and amelioration of physical, mental health and psychosocial problems. Supports for learning include specific remediation of learning problems. Adjustment problems are addressed at this level through comprehensive and accessible psychosocial, physical and mental health interventions with school-wide and cross-disciplinary assistance. Emergency and crisis prevention and response mechanisms allow for immediate availability of services required.

The final stage of intervention in Adelman and Taylor's (2000) continuum is treatment for severe and/or chronic problems. Intensive treatments include referral, triage, placement, resource coordination, special education, dropout recovery, services for



severe psychosocial/mental or physical health problems and systems care. The three stage continuum is dependent on the implementation of school *and* community resources with thoughtful implementation of resource allocation through integrated systems. Marginalization of services and resources has been a deterrent to coordinated, comprehensive school- based programming (Adelman, 1996a, 1996b; Adelman & Taylor, 1994, 1997, 1998). Adelman and Taylor (1997) believe the absence of structural mechanisms to support comprehensive and multi-faceted approaches to school- based mental health programs create barriers to learning and efficient allocation of resources. Services for adolescents displaying severe and chronic symptoms of anxiety and depression, in the absence of programming options for *all* students, are accessed through public school special education programs as mandated by state and federal legislation. This is significant in understanding the conceptual framework of the Bridges program- designed specifically for regular education students returning to public school subsequent to a prolonged absence or psychiatric hospitalization. As this population emerged, it became evident that scant resources were being provided to assist in the reintegration process. The 2005 Committee, comprised of district personnel including educators, administrators and mental health care providers, was convened to explore better ways to assist re-entering mainstream students to public high school.

The initial charge of the 2005 Committee was to identify all of the existing resources and services within the district. Then the committee reviewed what populations of students accessed those services. When the tally of resources and populations of use was compiled, it became apparent that significantly more services

were provided for identified special education students to the exclusion of mainstream students. Due to comprehensive legislation including the Individuals with Disabilities Education Act, originally passed in 1975 as the Education of all Handicapped Children's Act (IDEA), instructional programs were developed for students with specific learning disabilities and behavioral programs were developed for students identified with emotional disabilities. IDEA is narrowly focused on students who have an identifiable disability that may affect various life domains and interferes with a student's educational achievement. To access those services a student needs to be identified as requiring special education services. Many returning students did not qualify for the existing services.

Additionally, the 2005 Committee discovered that routine procedures for reentry of special education students subsequent to a prolonged absence or hospitalization were already in place. Services included a re-entry meeting with the student, family and staff, tutoring to assist with instruction, adjustments to schedules as needed, emotional support services through social work and coordination of health care services between the district health care program and outside providers. Many of those routine procedures for special education students were not extended to mainstream students despite the fact that this would not violate any legislation or funding requirements. Therefore, the 2005 Committee sought ways to reallocate existing resources and augment those services already in existence with development of a more integrated and comprehensive model that allowed mainstream students access to existing and developing programs. What emerged from these efforts was the Bridges program.

Ghuman, Weist and Sarles (2002) researched the organization of mental health services in schools and identified five categories for the delivery of services. The first of the delivery mechanisms is school-financed student support systems - commonly referred to as pupil services personnel and includes psychologists, social workers and counselors. These personnel perform services associated with mental health and psychosocial problems including related services designated for special education students. This delivery system is supported by state and federal funding in all public schools. One third of school districts surveyed in this study reported using this model exclusively.

Secondly, some school districts provide mental health units that encompass clinic facilities. This model involves an agreement between schools and community agencies. The clinics provide services and consultation to schools within the district and tend to be centralized with outreach capabilities to schools. The second model can result in enhanced service coordination. Of the schools surveyed, 55% contracted with an outside agency to provide mental health services.

A third delivery model allows schools to create a more formalized connection with community mental health services. This model is frequently referred to as school-linked services in the literature with additional designations such as full-service schools, family resource centers or wrap-around services for special education students. Multiple formats have emerged including a co-location of community personnel and services at schools, formal linkages such as a satellite clinic, formal partnerships to expand school-based mental health facilities and contractual arrangements with community providers to

provide required services for students. Seventeen percent of schools reported participation in this model.

The fourth delivery format identified by Ghuman, Weist and Sarles (2002) is the classroom based curriculum and special “pull out” interventions provided by special education programming. The instruction may be integrated as part of the regular classroom content or a specific curriculum or intervention implemented by specifically trained personnel or, finally, a curriculum approach that is part of a multi-faceted set of interventions designed to enhance positive development and prevent problems. Of the schools surveyed, 59% reported use of curriculum based programs to enhance social and emotional functioning and reduce barriers to learning.

The fifth and final delivery mechanism identified by Ghuman, Weist and Sarles (2002) is a comprehensive and integrated approach that provides a full continuum of programs and services that promote positive development, prevent problems, respond as early after onset as is feasible, and offer treatment regimens. Mental health and psychosocial concerns are the focal point of this delivery system. This approach allows school districts to re-conceptualize what may be fragmented service options and consider integrating schools into systems of care or the creation of a community school. Of schools surveyed 40% had monthly or weekly interdisciplinary meetings and planning sessions.

The Bridges program has taken pieces from these models to suit the particular needs and resources of the students for whom it was designed. The program makes use of school-financed student support systems already in existence but extended the model

by increasing the number of staff available to support students. The number of school psychologists increased from two to five and a social work position became reassigned specifically to Bridges. Additionally, the Bridges program was supplemented by community youth resources to work in tandem with school personnel. Consultation with a recognized adolescent psychiatrist was formalized for assessing student needs and treatment options. School-wide curriculum called Teaching Tolerance was already in existence through initiatives supported by the Anti-Defamation League working in concert with the high school district's administration. Scheduled interdisciplinary meetings have been the norm since the inception of Bridges.

Dryfoos (1994) attributes the development of state school-based mental health programs to the absence of national standards or models. This may explain the wide variance in models that evolved. Dryfoos identifies three models for the provision of health services in schools as follows: school-based, school-linked and community-based. They are defined by location, governance and funding. School-based services like those previously described by Ghuman, Weist and Sarles (2002) are those delivered in school buildings that are comprehensive structures and are school-governed and school-funded. Given the fiscal restraints of public schools, this model is a rarity in public schools.

School-linked services are provided near schools with an administrative structure linking the school system to provider agencies. Community-based services are those administered by community agencies but also serve as a source of referral for school personnel. Support for school-based mental health programs comes from a variety of disciplines.

As with previous models, Bridges has embraced components of Dryfoos's (1994) model. From its inception Bridges has been funded solely through district resources with a focus on asset reallocation. Additionally, community based resources were partnered with Bridges to provide more intensive services required for some enrolled students. Community resources also served as a consultation resource for the Bridges staff. An adolescent psychiatrist from the district community was contracted to provide expertise to the Bridges staff and to evaluate students when more extensive testing was indicated. Contracting is assigned on a case by case needs- based agreement. Support was garnered from administration and the local school Board because minimal additional resources were required to initiate, develop and sustain the program.

Funding for management of SBMH programs can cause divisiveness rather than unity amongst stakeholders. Coordination of services is continually cited as absent from thoughtful administration of services (Illback, 1993). A lack of coordination in funding and reimbursement creates additional confusion for fiscal planning with school districts. The funding for school-based mental health services often occurs through piecemeal, categorical and often duplicative mechanisms (Illback, 1993). Funds provided by IDEA, Social Security, Medicaid, Head Start, the Juvenile Justice System and the Public Services Act provide insufficient funding for needed services. Additionally, the manner in which the funds are allocated and dispersed create major barriers to effective use (DeMers & Bricklin, 1995). While national and state policy reform initiatives have advocated for the integration of education and health resources in the adoption of coordinated, comprehensive, customer-oriented service delivery models, emerging

services are hampered by inadequate funding, complex legal and regulatory mechanisms and professional turf disputes (Paavola, 1995). It would seem that some of the legislation and funding sources have, in effect, limited accessibility to services for all populations of students. As the Bridges Committee discovered, legislation and funding sources can preclude access to existing services- what some might view as a reverse discrimination policy.

There is growing evidence that a whole school approach, also known as a universal approach, to mental health in schools is the most effective delivery model for services (Markham, 2003; Weare, 2000). The whole school approach includes the following features: a holistic model of health that recognizes the physical, social, mental and emotional environmental dimensions and a comprehensive inclusion of many aspects of the school including curriculum, management, ethos, relationships, communication, policies, the physical environment and, finally, relations with parents, community and pedagogical practice. The whole school approach investigates underlying environmental determinants of emotional well being and competence rather than simply learning or behavioral outcomes. The universal approach works with all relevant parties at all levels in the school community including government and education authorities and everyone in the school community rather than simply those students or families who are identified “at risk.”

Mounting evidence exists as to the efficacy of the whole school approach versus a one dimensional approach as documented in controlled studies to review mental health services. A one dimensional approach may focus on an initiative such as curriculum

review and revision. Initiatives that use a wide range of contexts, opportunities, agencies and approaches are more effective than limited one dimensional approach (Wells, Barlow & Stewart-Brown, 2003). A systematic review concluded that whole school approaches can be extremely instrumental in addressing a wide range of health issues including emotional and social issues (Lister-Sharp, Chapman, Stewart-Brown, & Sowden, 1999; Wells, Barlow, Stewart-Brown, 2003). The review by Wells (2003) provides evidence that whole school approaches are effective in changing the attitudes and behaviors of both mainstream students and special education students exhibiting emotional and behavioral problems. It has been proposed that the universal approach maybe particularly effective as it does not target a certain element of the population- thereby eliminating the barrier of stigma or discrimination while simultaneously addressing anxiety, depression, suicide, positive health and well-being. The universal or whole school approach is considered to be a long term, developmental approach that recognizes mental health as a goal for all and is linked with fundamental activities that incorporate social and educational agencies. Though universal programming serves a documented purpose, it fails to target the specific needs of a specific population that is the focus of this study- adolescents transitioning back to public high school subsequent to a psychiatric hospitalization or prolonged absence.

Prior to the Bridges program, a whole school approach to mental health programming was already in existence. A focus on student responsibility and well being was supported through anti- bullying campaigns and membership in programs designed to educate and celebrate differences (Teaching Tolerance, 2003). These initiatives



continued to develop and engage more and more of the entire school population, students and staff, even as the Bridges program evolved. Though there was no effort to coordinate programming with the general population and the specific Bridges population, some staff members have suggested that tolerance for differences may positively impact all of the current mental health initiatives in this district.

Kutash, Duchnowski and Lynn (2006) identify three primary models of school-based mental health programs that provide evidence-based approaches. The MH Spectrum model (The Spectrum of Mental Health Interventions and Treatments as reported by Mrazak & Haggerty, 1994; Weisz et al., 2005) is a traditional mental health approach implemented in schools. It includes prevention strategies, psychotherapy, psychopharmacology, and maintenance and recovery supports. The Interconnected Systems model (Interconnected Systems for Meeting the Needs of All Children as presented by Adelman & Taylor, 2006; National Institute for Health Care Management, 2005) includes a continuum of services from prevention to early intervention to systems of care for seriously impaired individuals. PBS (The Application of Positive Behavior Supports to Reduce Challenging Behaviors in School as reported by Horner et al., 1999) implements positive behavioral supports at the level of prevention and intervention. Additionally, functional behavioral assessments provide valuable information as to antecedents of behavior to address the function of the behavior and develop appropriate strategies for remediation. This model addresses behavior at all levels of the school environment- focus is on the individual, specific classrooms and the entire school community. The Bridges program lacks the resources to support some of the suggested

models but the school district, as has been previously cited was able to implement a program similar to PBS (Teaching Tolerance, 2003) to enlist all students in promotion of mental health.

Trillium Family Services is a private, non-profit family mental health service that provides an array of mental health services to emotionally disturbed children and their families in the state of Oregon. Working in concert with the Oregon Office of Mental Health the agencies explored models of school-based mental health interventions and identified three programs of national significance. Multi-systematic therapy (MST) was developed principally by Scott Henggeler at the Department of Psychiatry and Behavioral Sciences at the Medical Center of South Carolina (Henggeler & Lee, 2003; Henggeler, Schoenwald, Bourdin, Rowland, & Cunningham, 1998). Treatment Foster Care (TFC) was developed by Patricia Chamberlain and colleagues at the Oregon Social Learning Center (Chamberlain, 2002, 2003; Chamberlain & Reid, 1998) and Wraparound Treatment was developed and evaluated primarily by John Burchard, former Professor of Clinical Psychology at the University of Vermont (Burchard, Bruns, & Bouchard, 2002).

All three of these models have attracted considerable attention in the field of children's mental health. They share the following characteristics: all three interventions adhere to systems of care values, all are delivered in a public school setting and have operated in multiple service sectors in the past including mental health, juvenile justice and child welfare. Additionally all three models were developed in real world community settings and all claim to be less expensive than a provision for institutional care.

The Bridges model is unique unto itself as it was created for a specific population that is noticeably absent from the literature. However, the model has mirrored many of the components of Adelman and Taylor's (2006) final stage and the first three stages of Ghuman, Weist and Sarles' (2002) delivery models. Bridges employs a cross-disciplinary model that extends into the broader community by partnering with local physicians, psychiatrists, psychologists and mental health agencies. It offers adolescents emotional and academic support through advocacy, case management, individualized academic assistance and counseling. Bridges resembles a short term triage model intended for acute, rather than chronic, interventions. Diagnostic observations can lead to additional assessments and possible referral to more long term programming options. Though a universal approach to mental health is evidenced in this public school, it is incidental to Bridges rather than part of the original Bridges design. Maintenance and recovery programming is beyond the scope of the Bridges model.

### **Studies of School-Based Mental Health Programs**

In 2002 Dr. Robert Hendren with colleagues (Hendren, Birrell et al. 2002) reviewed existing school-based mental health programs worldwide. The models described were an extension of current, school health offices or the traditional nurses' office rather than the ideal models previously described in this study. Included in the "Characteristics of Effective School Mental Health Programs," was the involvement of community health care professionals partnering with schools. In more recent studies the involvement of community health care professionals has been determined to be a critical component (Pearson, 1999) of SBMH programs. These findings indicate the severe

limitations of worldwide programming as reviewed by Hendren, Birrell et al. (2002) and Pearson (1999). While the broader limitations of programming worldwide have been noted, efforts were made to delineate best practices of evidence based studies.

Six strategic activities are attributed to the creation of conditions within an agency to the full integration of evidence-based practice. They include the following: a full commitment to systems-of-care principles throughout the entire organization, logic modeling of all agency clinical programs, formation of strategic partnerships with regional, local universities for the provision of institute-based researchers, prioritization and implementation of comprehensive evaluations of programs, critical examination of current agency programs against evidence-based models of national significance and the initiation of internal and external dissemination activities around the theme of evidence-based practice. Realistically there are considerable barriers to conducting research within mental health agencies that are historical, funding-related with accompanying ethical and expertise issues. However, models for research are beginning to emerge through the work of Weisz, Sandler, Durlak and Antio (2005) who employ a clinic-based treatment development model and Burns' and Hoagwood's (2003) proposal to develop empirically validated interventions. Studies of school-based mental health programs that claim to be evidence-based rely on treatment outcomes with control groups. They dominate the literature as described in the following sections of this study.

Science-to-service practice creates an information loop between research and clinical practice (APA, 2006). It clarifies the partnership between researchers and practitioners by recognition of the value of both and makes roles transparent. Science-to-

service practice provides for the integration of evidence-based practice and research activities. This, in turn, serves as an integrative and transformative function within the setting of the service agency. Day to day decision making is dependent on employment of the methods and findings of current child mental health research. There are studies, some cited in the following section of this literature review, that implement a science-to-service model – using research to determine appropriate practice. While these efforts may contribute to the success of SBMH programming, limitations are also evidenced in the studies that follow.

A number of studies of school-based mental health services rely on treatment outcomes of pilot programs for the assessment of the efficacy of interventions (Weist et al., 1996). In the study reviewed by Weist et al., adolescents were assigned to a treatment or control group. Students in the treatment group received between four and twelve individual therapy sessions in a ten-month period of time. No rationale was provided for the discrepancy between the numbers of sessions some students received versus others. Students in the control group received no therapy. Researchers justified this approach by stating that the students in the control group had not been identified as having significant need for intervention services. The research indicates there is adequate reason to support systematic school-based treatment services though there were clear limitations to the study. Limitations included a lack of resources and time, minimal measures of success including only self-reporting, and a need for continued studies to assess reliability.

In a similar pilot program using similar methodology of a treatment and control group approach to mental health programming, Owens reports on a study conducted in

2005. The treatment group was represented by an entire school population, as was the “wait-list” control group. The treatment group was eligible for school-based intervention while the control group was eligible only for community-based services. Scales including the Disruptive Behavior Disorder Rating Scale, DBD Rating Scale (Pelham, Gnagy, Greenslade, & Milich, 1992) and the Child Behavior Checklist, CBCL (Achenbach, 1991) – both recognized for validity and reliability with adolescents, were used in pretest and posttest of participants. Students in the treatment group demonstrated growth on variable measures while students in the control group actually demonstrated a marked decline in functioning on measured domains. Owens (2005) concludes the results indicate “cautious optimism” for transporting evidence-based treatment options from community to school settings. Limitations of this study include recognition of practical challenges such as enlistment of teachers and time constraints. This method is comparable to a universal approach previously cited in the work of Weare (2000) and Markham and Aveyard (2003). It is consistent with the application of research-based knowledge to school-based mental health programs as described by Hoagwood and colleagues (2002).

In one of the studies reviewed, a comprehensive school-wide behavioral intervention program (Pelham, Wilson & Standley, 2005) was implemented. The Academic and Behavioral Competencies Program, hereafter referred to as the ABC Program, was introduced into schools with populations of students considered to be “high risk.” Prevention and intervention strategies were implemented at multiple levels of intensity. This programming highlights an integrated approach. The methodology

included multiple year training and on-going consultation services with prescriptive responses to asocial and socially appropriate student behaviors. Documentation of effectiveness is noted in multiple replications of interventions. The program is based on a set of procedures that are evidence-based. Intervention protocols and measures of effectiveness were documented with Likert scales and “unobtrusive measures” were reviewed for consistency with measured outcomes. This suggests a theoretical model can be applied to an entire school population. From a purely practical standpoint, the allocation of resources can be concentrated and address multiple levels of need. This study highlights science-to-service methodology.

Many of the studies reviewed are subsets of broader methodologies as has been described in treatment/control groups, pretest and posttest design, treatment outcome based interventions and specific therapeutic interventions. A study reported in the *Journal of the American Medical Association* (Stein, Jaycox, Katoaka, Wong, Tu, Elliott, Fink, 2002) used a unique approach to mental health intervention for schoolchildren exposed to violence – a randomized controlled trial. The objective of the study was to evaluate the effectiveness of a collaboratively designed school-based intervention for reducing symptoms of posttraumatic stress disorder in children who had witnessed or been exposed to violence. All subjects had clinical levels of PTSD. Participants were randomly assigned to a ten session standardized cognitive-behavioral therapy intervention group or, as in previous studies, wait-listed for delayed intervention- the comparison group.

At three months and again at six months, the early intervention group had significantly reduced symptoms of PTSD as measured by adjusted mean difference between groups. The results of this study suggest that a standardized ten-session cognitive-behavioral group intervention can significantly reduce symptoms of PTSD and depression in students exposed to violence. Perhaps of even greater significance, from a practical position, this study suggests that the intervention can be effectively introduced on school campuses when trained school-based mental health clinicians deliver the treatment. Of concern in this trial is the ethical consideration of delay of treatment to an identified group with clinical levels of posttraumatic stress disorder. Replication of this methodology using delay of treatment in public schools would be ethically prohibitive. This study and the others cited delineate the importance of combined efforts to utilize research in development of interventions. While the studies cited in this literature review recognize the science-to-service model as best practices for SBMH programming, there are researchers who question whether this approach is in fact being employed extensively in the field.

According to Hoagwood (Hoagwood, Burns & Weisz, 2002), there has been a substantial growth of research-based knowledge in child mental health that is not being utilized or properly disseminated. Kimberly Hoagwood, Director of Child and Adolescent Research in the New York Office of Mental Health and formerly Associate Director for Child and Adolescent Research at the National Institute for Mental Health refers to this problem as the science-to-service problem. A number of explanations have been cited as potential reasons why research-based knowledge is not being widely used.



Those most frequently cited by Hoagwood (2002) include a lack of consensus as to what constitutes evidenced-based practice, minimal research on effective service solutions for children with severe and co-occurring mental health problems and the fragmented current service system of funding, administration and organizational features referenced earlier in this paper. According to Kazdin and Weisz (2003), the growth of managed care and managed revenue initiatives in behavioral health have underscored the need for testing of clinical interventions in more real world settings. They note that, “Testing treatments under conditions more and more like those of actual practice in mental health service settings may be a way to build especially robust treatments and a way to build an evidence base that supports their use in everyday clinical care” (Kazdin & Weisz, 2003).

A review of the literature by Rones and Hoagwood (2000) examined the empirical literature published between 1985 and 1999 on school-based mental health programs. The literature search uncovered over 5,100 entries using the term school-based mental health services. Of those entries, only 47 of the described programs met the criteria for rigorously evaluated and researched treatment approaches. The factors they associated with program effectiveness include consistent implementation, multi- component programs for children, parents and teachers, the use of multiple approaches, targeting specific skills and behaviors, developmentally appropriate strategies and strategies integrated into the classroom curriculum (Rones & Hoagwood, 2000). Of the 47 programs that were identified, 36x articles described randomized controlled trials, nine described quasi-experimental designs, and two studies used a multiple baseline design.

More recently in 2006, Hoagwood conducted another review of the literature and examined over 2,000 articles on SBMH produced between 1990 and 2004. Her research concluded that 63 of the articles met her criteria of a rigorously tested intervention focused on mental health in children. Twenty-three of these studies tested the effects of the program on academic and mental health outcomes and fourteen of these found an impact on both domains. The remaining 40 studies examined only mental health outcomes with 38 of these demonstrating effectiveness in mental health. So, questions remain. In actuality, is evidence-based practice being employed effectively in SBMH programming? Are treatment outcomes the most effective means of determining success of programming? Is there clear consensus as to what constitutes evidence-based practice? Are there other valid approaches to studying SBMH programming?

It can be assumed from these studies that while evidence-based practice would seem to suggest significant positive implications for SBMH programming, standardized criteria for determining what constitutes science-to-service, or evidence-based practice, is lacking. Additionally, measures of success are based primarily on treatment outcomes and replication capacity. While this may constitute an appropriate evaluative design, it does not diminish the value of researching school-based mental health programming from a remarkably different perspective as will be applied in the Bridges study and discussed later in this chapter.

Programs that provide systems of care, a comprehensive array of services incorporating a universal approach with a prescribed continuum of services, appear most favorably in the literature. Systems of care studies have been evaluated by specific

parameters approved by the American Academy of Child and Adolescent Psychiatry (2006) and can be replicated nationally while appropriately embedded in the intended culture and community with adaptations. In the next section I include those studies of systems of care most frequently cited in the literature as best practice.

The Mental Health Spectrum (MH) (Mrazek & Haggerty, 1994; Weisz et al., 2005) refers to a continuum of services and interventions designed for children who have a mental illness, emotional disturbance or are considered at risk. The MH Spectrum provides a broad array of service components ranging from universal prevention strategies to in-patient care. These SBMH programs have traditionally targeted diagnostic groups or those considered at risk for developing a mental health disorders. Consequently, many of these programs were developed with a particular population in mind – frequently aggressive, conduct-disordered students. Empirically validated programs that prevent these behaviors include Promoting Alternative Thinking Strategies (PATHS) and The Good Behavior Game (Kellum, Rebok, Ialongo & Mayer, 1994). At the selective or indicated levels of prevention are programs including the Coping with Stress Course (Clarke et al., 1995). This program has been rigorously tested and found to significantly reduce instances of major depression in participants.

The Interconnected Systems model, previously mentioned in the research (Kutash, Duchnowski & Lynn, 2006), emerged from some of the barriers mental health services encountered while implementing school-based mental health programs. The Interconnected Systems model offers a continuum of services intended to provide a balance between mental health promotion, prevention programs, early detection and

treatment and intensive intervention, maintenance and recovery programs (National Institute for Health Care Management, 2005). Systems of prevention are universal interventions aimed at students in a kindergarten through grade 12. Systems of intervention may include drop out programs for high risk adolescents or programs aimed at pregnancy prevention. Systems of Care (SOC), was proposed by Stroul and Friedman in 1994. At this level, problems are severe and long standing. Multiple domains of functioning are impaired and intensive treatment is required. Often special education students are exhibiting severe behavioral and emotional problems are served by Systems of Care.

In the last 20 years, a number of school- based mental health programs have adopted the Positive Behavior Support Program based on applied behavioral analysis (Horner et al., 1999). The program was originally designed to eradicate very serious and dangerous behaviors of people who were developmentally disabled. It has since been adapted for use with students with and without disabilities in a variety of settings including homes, schools and the community. Today PBS addresses a broad range of academic and social/behavioral challenges and has evolved into a systems level implementation that engages entire schools and districts in the process. There is now literature that describes the integration of PBS with systems of care principles and wraparound services at the selected and indicated levels (Eber et al., 2002; Robbins & Armstrong, 2005). The universal application of PBS is to create a positive school environment for all students. The success of a school-wide implementation of PBS requires the commitment of its staff to the process, not just an isolated intervention.

Teaching Recess is a school-wide program implemented at an elementary school subsequent to a multitude of office referrals originating at recess (Todd et al., 2002). An instructional plan was developed that involved the participation of all staff and students before implementation of the program. At the end of the first year of implementation, recess-related referrals were reduced by 80%. This program can be considered as universal prevention in that it demanded consistent, behavioral expectations in the school staff.

“Improving Classroom Behavior by Modifying Task Difficulty” (Umbreit, Lane, & Dejud, 2004) is an example of a selective intervention in PBS. Using a functional behavioral assessment to determine the antecedent of off task and distracted behavior, it was found that students react negatively to tasks that are either too difficult or too simple. In either case, off task, distracted behavior increased when tasks were not appropriately geared to the student’s level of understanding. Engagement in on task behavior is cited as increasing from 50% to 90% when the intervention was appropriately leveled to the student’s level of understanding.

Many school districts have introduced PBS to address challenging behaviors and psychosocial barriers to learning. PBS has been evaluated with single-subject design studies though many researchers would argue that single-subject designs lack commonly accepted criteria for establishing evidence. Forness (2005) urged the use of experimental designs, especially random-controlled trials, to demonstrate the effectiveness of behavioral interventions at the level of evidence based practice. Dunlap (2006) suggests while PBS is in its infancy stage of development, it holds promise for addressing

emotional and behavioral problems.

An accepted System of Care is Wraparound Services (Adelman & Taylor, 2006). This is a service delivery that is most frequently associated with children and adolescents presenting with very substantial needs who might otherwise be placed in restrictive facilities such as group homes. The dominant philosophy of wraparound services is to bring resources to the individual rather than placing an individual in a particular program. The California Department of Social Services (1997) defines wraparound services as encompassing the following components of services delivery: family centered, individualized, culturally relevant and strength based planning, team driven with reliance on natural community supports, monitoring evaluating outcomes while complying with federal legislation requiring services be provided in the least restrictive environment (LRE). Adelman and Taylor in 2006 advocated for a major restructuring of schools and communities to develop a comprehensive, interconnected system of wraparound services for effective school-based mental health programming.

In recent years a new model, Response to Intervention (RTI), has emerged that is an early intervention model that uses research validated practices and technology, redefines identification of students with a specific learning disability and maintains a focus on improved academic results for all students (In Case, 2009). As this is an evidence-based practice it is mentioned briefly here. However, RTI is primarily concerned with providing instructional resources that support student achievement and improved outcomes. Though instructional practices adopted by RTI may support students in school-based mental health care programs, its goal is not to provide mental

health care services. Therefore, it has limited application for this study.

The significance of all these studies suggests that treatment options for adolescents can be effective when delivered in a school-based milieu with trained clinicians working in collaboration with educators. The traditional nurses' office assumes a much greater role as mental health facility. Kristin Robinson (2005) reports that 20% of American youth have a diagnosable mental health disorder. She further cites in her research that 25% of school-aged children have experienced suicidal ideation or have used drugs and only 20% of adolescents in need of mental health services currently receive them.

The U.S. Surgeon General's Report on Mental Health estimates that, "Up to 21% of children in the United States aged 0 to 17 have a diagnosable mental or addictive disorder and is in need of mental health services. Estimates of those with significant and extreme functional impairment were 11% and 5% respectively" (U.S. Department of Health & Human Services, 2000).

Studies of school-based mental health programs provide the historical basis for the most common inquiry methods. The vast majority of studies conducted on school-based mental health programs have used either a quantitative or mixed methodology research design (Hoagwood, 2001, 2002, 2006). The quantitative design has been useful in examining the variables of a program that impact outcomes. More specifically, this objective approach has allowed researchers to identify causal relationships between program variables and student outcomes. Data is collected on instruments based on measures completed by participants or by observations recorded by the researcher

(Creswell, 2005). Mixed methodology has been helpful in collecting diverse types of data, quantitative and qualitative, to identify successful SBMH programs and the characteristics that make them successful. Both the quantitative and mixed methodology research designs lend themselves to generalization and development of programs for the purposes of replication (Creswell, 2005). Quantitative and mixed methodology research designs have limitations when understanding the value of an individual program to its stakeholders.

Case study is another methodology that can be applied to understanding school-based mental health programming. Though not frequently appearing in the literature of SBMH programming, case study lends itself to research questions that seek to better understand a particular program or issue. R. E. Stake (1995) indicates, “We study a case when it itself is of very special interest. We look for detail of interaction with its contexts. Case study is the study of particularity and complexity of a single case, coming to understand its activity within important circumstances. It is a disciplined, qualitative mode of inquiry into a single case. The qualitative researcher emphasizes episodes of nuance, the sequence of happenings in context, the wholeness of the individual.”

Case study is characterized by focus on the particular, use of multiple data sources, explanation of the how and why of a particular program within a specific environment, and use of thick description. It is a bounded system. Case study research takes place in the natural environment and requires humanistic and interactive methodology – sometimes referred to as an unfolding research model. Fred Erikson (1986) indicates the single most distinctive characteristic of qualitative case study is its



emphasis on interpretation. More specifically, the key interpretations are not the researcher's but the participants or stakeholders in the study.

The research questions proposed in this study have led me to qualitative case study design as the most appropriate means for exploring and better understanding the Bridges program. This research approach naturally allows for interpretation and focus on a particular program within the context and setting of its participants. This study will be modeled after the work of Robert E. Stake using responsive evaluation as a methodological guide (Stake, 2004). The essential components of Stakes' responsive evaluation are the following: the belief that there is no true value to anything (knowledge is context bound), the belief that stakeholder perspectives are integral elements in evaluations and the belief that case studies are the best method for representing the beliefs and values of stakeholders and of reporting evaluation results (Stake, 1975). Responsive evaluation according to Stake is based on what people naturally do to evaluate things- they observe and react. Responsive evaluation portrays the complexity of programming while it conveys holistic impressions – often in the format of portrayals or story-telling. Stake's responsive evaluation is issue focused – reflecting the complexity of programming and the valuing of stakeholders.

The quality of the Bridges program will be explored while valuing pluralistic understandings. Knowledge will be gained from an intrinsic case study approach while using personal observation and interpretation. Thick description of personal experience will allow the audience, those reading this study, to better understand the quality of a program already in existence through vicarious experience. Stakeholders will be able to

identify what aspects of the program to protect when considering program improvement. This study will represent the beliefs and values of the stakeholders – students, parents and faculty enrolled in or associated with Bridges, as gleaned from observation, personal interviews and faculty surveys. The researcher will consider the uniqueness of Bridges in tandem with the cultural plurality of stakeholders. Stake (1995) writes: “The real business of case study is particularization, not generalization.” As in this case study, the stakeholders and researcher are interested in the unique attributes of this program, not in relationship to others but as a solitary program.

Prior to this proposed study, there has been no organized attempt to understand the perceptions of the Bridges program through the lens of the primary stakeholders. Also unique to this study is the population of adolescents for whom programming was initiated in 2005 – specifically, youth not identified as special education students experiencing clinical anxiety and/or depression reintegrating into public high school subsequent to a psychiatric hospitalization and/ or prolonged absence. This proposed study will provide feedback to the program providers of Bridges concerning the perceptions of the program as it currently exists.

This study will represent the beliefs and values of identified stakeholders and be formative in nature. It is novel in population and intent. Most unique to this study, is the population of adolescents integral to the Bridges program- adolescents, not identified as special education students, reintegrating to a specific public school subsequent to a psychiatric hospitalization or prolonged absence. A review of the literature indicates an absence of programming designed for this specific population of adolescents. This

research will provide insight to an existing school- based mental health program specifically designed to assist adolescents with the process of reintegration to a public high school. I will explore the value of planned reentry strategies and mental health interventions from the lens of stakeholders.

### **Presenting Symptoms of Anxiety and Depression and the Relationship to Programming**

Students referred to the Bridges program have two major presenting symptoms – anxiety and depression that may be manifested in a variety of behaviors. Because they are consistently the identifiers for enrollment in the Bridges program, I believe a section on anxiety and depression and their relationship to specific programming is warranted in this literature review. While it is acknowledged that many people experience mental health problems at some time during their lives, it is estimated that one in ten adolescents may suffer from mental illness severe enough to cause some level of impairment. It is estimated that less than two of those ten will receive needed treatment (Center et al., 2003). In the same study it was revealed that academic success in school could serve as a preventative and intervention strategy for protecting the mental health of adolescents. Research supported by the National Institute of Mental Health (National Institute et al., 1999; National Institute et al., 2000) suggests academic success, or lack thereof, as a key factor in anxiety and depression in youth.

The American Psychiatric Association publishes the Diagnostic and Statistical Manual of Mental Health Disorders, more commonly referred to as the DSM-IV Revised 4<sup>th</sup> Edition, text revision (2000) as a guide to mental health disorders in children and

adults. The DSM-IV is typically used by professionals to diagnose mental disorders. It uses a multidimensional approach to diagnose disorders in a comprehensive evaluation of five informational domains. Critical to this study are those domains that focus on the presenting symptoms of anxiety and depression exhibited by students in the Bridges program. Axis I diagnoses clinical syndromes and other conditions that may be a focus of clinical attention. Axis IV addresses the severity of psychosocial and environmental stressors that may impact disorders in Axis I and II. Axis V is the global assessment of functioning that delineates a person's functioning at the present time and the highest functioning rate within the previous year. In the current study, students in the Bridges program are impacted by anxiety and/or depression – both sub-categories of clinical symptoms as identified by the DSM IV Revised 4<sup>th</sup> Edition with text revisions.

The DSM-IV provides descriptions of diagnostic categories to assist with the diagnosis and treatment of disorders. Additionally it provides a common language for the clinicians who use the manual. According to the DSM IV, anxiety disorders include the following: panic disorders without agoraphobia, panic disorder with agoraphobia, agoraphobia without history of panic disorder, social anxiety disorder, obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder, generalized anxiety disorders, anxiety disorder due to a medical condition, substance- induced anxiety disorder and anxiety disorder not otherwise specified. Depressive disorders are a sub category of mood disorders and include the following: major depressive disorder with a single episode, major depressive disorder that is recurrent, dysthymic disorder and depressive disorder not otherwise specified which may indicate an adjustment disorder

with mixed anxiety and depressed mood. An example of an anxiety disorder not otherwise specified is a mixed anxiety and depressive disorder with clinically significant symptoms of both present.

Understanding the etiology of emotion, specifically anxiety and depression, can contribute to the structural foundation of a program designed for students exhibiting those emotions. Early writings from Darwin (1872/1965) indicate fear or anxiety is an adaptive characteristic varying in intensity that evolved over generations through a process of natural selection. Freud (1924) understood fear and anxiety as something felt – a specific, unpleasant emotional state or condition that included experiential, physiological and behavioral components. Freud explained objective anxiety as an emotional reaction proportional in intensity to a real danger in the external world. He coined the term neurotic anxiety to describe emotional reactions that are greater in intensity than might be expected on the basis of objective danger. The source of the danger, according to Freud, is the individual's repressed sexual or aggressive impulses. Freud (1936) regarded anxiety as the "fundamental phenomenon and central problem of neurosis" (p. 217).

There was little research on human anxiety prior to 1950. Since then, human anxiety research has been promoted on two fronts – the nature of anxiety was redefined as a theoretical construct and a variety of measurement scales were created to measure anxiety. Based on Cattell's (1966) research there are two anxiety constructs. The first is State Anxiety (S-Anxiety) and is similar to the early conception of fear and objective anxiety formulated by Darwin (1965/1872) and Freud (1936). S-Anxiety consists of unpleasant feelings of tension, apprehension and worry that are accompanied by

activation of the autonomic nervous system. Trait Anxiety (T- Anxiety) is the acquired behavioral tendency of individuals to perceive a wide range of situations as dangerous or threatening with variations in intensity and frequency of experiences. With a new way of defining anxiety, multiple instruments for measuring anxiety evolved including The Hamilton Rating Scale (1959), projective testing, but most notably self- report psychometric questionnaires. Some of the more utilized questionnaires in experimental research include The Taylor Manifest Anxiety Scale, MAS (1953), The Anxiety Scale Questionnaire, ASQ, developed by Cattell and Scheier (1963) and the STAI, State-Trait Anxiety Inventory, developed by Spielberger, Gorsuch and Lushene (1970).

To summarize, anxiety research has evolved from two separate traditions and two disciplines of mental health providers. Anxiety viewed as a mental disorder or illness is defined by psychiatrists who have developed categories of illness reflected in the DSM. Often the categories have evolved from research of case studies. Anxiety as viewed as a personality construct is research conducted primarily by psychologists employing psychometric instruments often focusing on individual differences. Regardless of the historical lineage of anxiety research or the source of diagnosis, be it psychiatrist or psychologist, students entering the Bridges program frequently come with a clinical diagnosis of anxiety and/or depression and are being treated by a mental health care professional in the community. Understanding the etiology of anxiety and accompanying interventions is essential for providing appropriate programming for students in school and cooperative planning with community health care providers.

Early understandings of depression are rooted in Freud's (1936) psychodynamic

perspective to more recent understandings (Beck et al., 1961) that depression is guided by the patient's own thoughts or cognitions. Cognitive-behavioral theorists such as Aaron Beck suggest that depression results from maladaptive or irrational cognitions that manifest as distorted thoughts and judgments. Dr. Beck indicates negative thoughts, generated by dysfunctional beliefs are the primary cause of depression. There are three main dysfunctional beliefs or themes that dominate depressed peoples' thinking that include the following: I am defective or inadequate, all of my experiences result in failure, and the future is hopeless. This is the Negative Cognitive Triad as defined by Beck (1979). In recent years Beck indicates that depression results from an interplay of genetic, developmental and stress factors and the contribution of each factor will vary between individuals.

Dr Albert Ellis (1962) further explains the presence of irrational beliefs as an evolution into absolute statements. Ellis believes depressed people make unqualified demands on others and convince themselves that they have overwhelming needs that absolutely must be met. They ignore positive information and pay exaggerated attention to negative information. They also have a tendency to over generalize - assuming failure in one isolated event will result in failure in any future events.

As with anxiety, self-report rating scales have evolved to measure the intensity of depression symptoms. The Beck Depression Inventory originally developed in 1961 is an instrument widely used in research. Though originally designed as a screening device, it is now used as a diagnostic tool by health care providers. The BDI assesses the intensity of depression, can monitor changes over time and is an objective measure for

judging improvement or effectiveness of treatment. Numerous other self-report inventories have been developed but the BDI has been used in over two thousand empirical studies and translated into multiple languages (Nemade, Reiss & Dombeck, 2007).

Psychological treatment of depression can assist depressed individuals in several ways – supportive counseling can ease the pain of depression and address feelings of helplessness. Secondly cognitive therapy, a component of psychotherapy can change pessimistic perspectives that sustain depression. Thirdly, problem solving therapy assists with changing aspects of an individual's life that create stress and contribute to depression. Aaron Beck and Albert Ellis, both previously mentioned, suggested the cognitive components of depression could be instrumental in therapy for depression. Cognitive Therapy or Cognitive-Behavioral Therapy (CBT) is an empirically-supported treatment that focuses on altering existing, maladaptive patterns of thinking (Beck & Beck, 1995). CBT has been used for a variety of mood disorders, anxiety disorders, substance abuse disorders and eating disorders. It can be very effectively combined with anti-depressant medication for treatment of individuals with depression (Beck et al., 2003).

Students in the Bridges program typically present with symptoms indicative of clinical anxiety and depression – including suicidal ideation, eating disorders, substance abuse and school refusal. Frequently they have acquired maladaptive behaviors and understandings and may respond to school as an aversive stimulus. Mineka (2000) notes that emotional states, particularly negative ones such as anxiety and depression, distort



human cognitive processing. They have a powerful, often reciprocal effect on cognitive processing and social relationships. Taken within the context of public school, a student experiencing anxiety and/or depression may not possess the cognitive faculties to problem solve the simplistic tasks necessary to navigate the school day. Consider the student returning from a psychiatric hospitalization or prolonged absence who is expected to resume a normal schedule of academics, make up missed assignments from the absence, explain the absence to staff and peers, resume extracurricular activities and make, what the student considers to be, satisfactory grades. The 2005 Bridges committee cited these specific expectations as typical expectations for reintegration to this public high school. It was assumed by the 2005 Committee that by understanding the etiology of anxiety and depression and how it relates to treatment and programming options for adolescents, those students who would later participate in Bridges would be positively impacted by the interventions employed by both clinical and academic staff.

### **Summation of Findings**

School-based mental health programs are recognized as a valuable resource to the communities they serve for the following reasons. They provide services for children and adolescents in a natural environment and what many consider to be the ideal location. SBMH programming is cost effective for the community and clients being served. It reduces the stigma posed by accessing services in community-based mental health clinics and encourages marginalized populations to utilize existing resources. SBMH programming recognizes the vast array of services and resources that can be provided based on need. School-based mental health programs may provide any one or all of the

following: a universal approach intended to impact an entire school community, a targeted approach to address an identified segment of the school population, and interventions and triage as deemed necessary for individual students. Additionally, SBMH programming has proven effective in addressing the mental health concerns of “at risk” populations of students. Though the literature acknowledges the difficulties of collaboration between disciplines, the studies uniformly support a partnership between researchers, educators, and mental health care providers. School-based mental health programs recognize the interconnection between education and mental health and the need to advance both simultaneously to promote healthy lifestyles in children and adolescents.

Legislation has been instrumental in advancing the development of school-based mental health programs. Federal legislation has been particularly influential in this capacity. However, as has been noted previously, legislation particular to special education may have actually served as a deterrent to extending services to non-identified mainstream students. The literature acknowledges the challenges posed by fragmentation in the delivery of services and funding of services that is causally linked to legislation. Additionally, one of the primary understandings emerging from school legislation is acknowledgment of the changing roles and responsibilities of schools; some refer to public schools now in the context of full service schools. The expectations for public schools have expanded to include functions previously fulfilled by families or community service providers.

Multiple models of school- based mental health have emerged over the last 20

years. The range is extensive from basic referral to comprehensive multi-dimensional systems of care. Of significance in planning within individual communities are the realities of resource coordination and reallocation. Program design can be limited or extended based on the cooperation between service providers and the creativity planners bring to the partnership. The efficacy of many programs has been based on quantitative measures that allow for duplication of programming to other sites. This is both an advantage and a limitation to this approach.

Many studies of school-based mental health programs cite the importance of evidence-based models reflective of the best science-to-service alliance. These studies emphasize the importance of a partnership between researcher, educator and mental health care provider. While this integrative approach is favored in the literature, there is concern that research-based knowledge is not being effectively utilized or disseminated for the purposes of program development. Additionally controversy exists as to what actually constitutes evidence-based practice though measures of success are routinely associated with treatment outcomes and replication capacity.

Systems of care are well regarded in SBMH literature for the array and continuum of services provided. They routinely provide a balance between promotion of mental health, prevention programs, early detection and treatment, intensive interventions and maintenance and recovery programs. Systems of care have been adapted for a variety of settings and successfully so when planners are consciously sensitive to the unique culture of the community it serves.

Studies of adolescent anxiety and depression are of particular significance to this

proposed study. The students participating in the Bridges program have been diagnosed as having clinical anxiety and/ or depression prior to their entry to Bridges. Bridges faculty work in tandem with mental health care providers in the greater community to better address individual student needs. Understanding the etiology and treatment options for anxiety and depression has assisted the staff in providing appropriate programming for Bridges students. The alliance between mental health care providers and educators is closely aligned with what is considered best practices for SBMH programming.

I now refer back to my research questions that have led me to this point in time. I will be exploring the following questions in depth:

1. How do stakeholders perceive the impact of the Bridges program in facilitating the reentry of students into a specific public high school in a northern suburb of Chicago?
2. In what ways does the Bridges program support successful reintegration of students to a public school subsequent to a prolonged absence or psychiatric hospitalization?
3. What are the stakeholders' perceptions of the Bridges program as a means to assisting students with mental health care concerns?

These questions cannot be properly addressed in a quantitative study. These questions lend themselves to a qualitative, case study approach whereby the program can be studied for its uniqueness and complexities. Unlike other design methods, there is no intent to evaluate the program based on standardized measures. Nor is there any intent to duplicate Bridges in any other setting. The purpose of this study is simply to better

understand the program from the lens of invested stakeholders. To best address the research questions and value the uniqueness of the Bridges program I will be conducting a qualitative case study.

I have selected Humanistic Psychology as my theoretical framework and Robert E. Stake's Responsive Evaluation as the methodological guide for understanding the Bridges program from the perspective of its stakeholders. According to R. E. Stake (2004), "Responsive evaluation is a search for and documentation of program quality. The essential feature of the approach is responsiveness to key issues or problems. It is responsive to stakeholder concerns. The purpose of the evaluation is mainly to understand" (p. 86).

Since the inception of Responsive Evaluation in 1974, Stake has supported the premise that the definition of RE is continuously evolving. However, the primary components of RE are a constant. Consistent with Responsive Evaluation, the purpose of my study is to understand the complexities of the evaluation; the Bridges program, from the perspective of four stakeholder groups – the students enrolled in the program, their parents, Bridges staff and the greater school community. Additionally, Responsive Evaluation targets individual programs to examine their "goodness," as termed by Stake, as stand-alone programs. Interest in a particular program is exactly that – an effort to better understand its many complexities and perspectives not in comparison to others but to determine its own unique qualities or value.

Responsive Evaluation is largely interpretive, relying on human experience to give meaning and value to the study of any program. The researcher becomes acquainted

with the program by observing its activities, interviewing those who have a stake in the program and examining relevant documents. Stake (2004) refers to the process of refining the study as “progressive focusing” (p. 90) as the evaluator comes to understand with increasing precision and confidence what is happening and what is its’ value. Additionally, individuals in the study are viewed as informants or participants rather than subjects.

R.E. Stake (1995) has stated that, “The real business of case study is particularization, not generalization” (p. 8). Case study designs are intended to examine distinctive characteristics of programs through interpretation. There is an emphasis on the uniqueness of the program while trying to understand the multiple realities of its stakeholders. Because of my desire to understand the Bridges program and study the perspectives of the primary stakeholders, I have selected R. E. Stake’s Responsive Evaluation with case study design as the methodology and process for study. Of particular importance to me will be accurately representing the multiple realities of stakeholders so that readers of this study may vicariously experience understandings and values of stakeholders through rich description and interpretation.

Qualitative case study is in many ways highly personal, allowing for personal perspectives in the interpretation of programming. The quality of the research may be examined from how effectively the researcher portrays the program issues, personal relationships and performances that actually reveal the program quality. Qualitative case study includes a well developed context, is field oriented with an emphasis on the observable, employs natural language description and is interpretive (Stake, 1995). Study

of the Bridges program will be consistent with these qualitative attributes.

CHAPTER III  
METHODOLOGY

**Introduction and Foundation for Study**

This is a formative study of a program, Bridges, in existence for five years. The purpose of the study is to understand the perceptions of stakeholders enrolled in and associated with the Bridges program. I explore the following questions in depth:

1. How do stakeholders perceive the impact of the Bridges program in facilitating the reentry of students into a specific public high school in a northern suburb of Chicago?
2. In what ways does the Bridges program support successful reintegration of students to a public school subsequent to a prolonged absence or psychiatric hospitalization?
3. What are the stakeholders' perceptions of the Bridges program as a means to assisting students with mental health care concerns?

The public high school in this study is composed of two campuses: freshmen attend one campus while sophomores through seniors attend a separate campus. For the purposes of this study, the research is focused on the multi-grade campus as this is where the original program was developed. Programming for Bridges on the freshman campus is not a replication of Bridges as it exists on the multi-grade campus. It is less developed in terms of staffing, procedures, interventions, design and use. As a result, it presents as



a very different program than Bridges at the multi-grade campus and will not be addressed in the study.

The first year Bridges was in existence, 2005-2006, only a handful of students were serviced. This was partially due to the fact that the program was being developed even as student referrals arose. Additionally, at the inception of Bridges, it was staffed primarily through volunteers from the special education staff who were willing to devote their non-scheduled periods to assisting students in Bridges. No uniform procedures had been established at that time and statistics on students being served were not documented. By the beginning of the 2006- 2007 school year routines, procedures, staffing, interventions, and interdisciplinary participation became well established. Provisions for maintaining accurate statistical data on attending Bridges students also became an important focal point of the Bridges faculty. Data included referral source, gender, student grade level, incidence of regular education students versus special education, entry and exit dates and disposition or exit placement. Interestingly, the staff concluded by the 2008-2009 school year statistics describing specific exit placements had become so highly individualized that including the disposition in the statistical data did not reveal pertinent information.

Analysis of the data clearly indicates a steady increase of student participants yearly from 2006 to the conclusion of the 2009- 2010 school year. This is illustrated in Table 1.

Table 1

*Bridges Monthly Tally of Enrolled Students*

| <b>Month</b> | <b>2006-2007</b> | <b>2007-2008</b> | <b>2008-2009</b> | <b>2009-2010</b> |
|--------------|------------------|------------------|------------------|------------------|
| August       | 1                | 0                | 1                | 2                |
| September    | 8                | 9                | 7                | 6                |
| October      | 6                | 8                | 13               | 17               |
| November     | 5                | 6                | 9                | 12               |
| December     | 2                | 6                | 5                | 8                |
| January      | 7                | 3                | 3                | 8                |
| February     | 5                | 4                | 11               | 6                |
| March        | 3                | 9                | 13               | 17               |
| April        | 10               | 8                | 10               | 8                |
| May          | 12               | 8                | 6                | 5                |
| June         | 0                | 0                | 0                | 2                |
| Totals       | 58               | 63               | 78               | 91               |

Statistical data also consistently indicates that females outnumber males each year. In 2006-2007 females outnumbered males 34 to 24, in 2007-2008 35 to 28, in 2008-2009 50 to 28, and in 2009-2010 62 to 29. The specific reason for the substantial increase in females most recently is not known, though Bridges faculty speculate that female members of the school advisory system may be more inclined to refer female students to the program than their male counterparts and, in turn, female students may be more inclined to accept enrollment in Bridges.

Accurate data delineating the exact number of daily participants in the program is unavailable though monthly figures show trends when more students are enrolled than others. Bridges faculty estimate that, on average, they see approximately fifteen to twenty students daily- some for as little as one period daily while others are in the program virtually all or most of their school day.

This study is modeled after the work of Robert E. Stake (2004) using responsive

evaluation as a methodological guide. The quality or value of the program is explored while revealing stakeholder, pluralistic understandings. Knowledge is gained from an intrinsic case study approach using personal observation and interpretation. Thick description of personal experience allows the audience, the readers of this study, to better understand the quality of the program already in existence through vicarious experience. My research reflects the beliefs and values of its stakeholders as gleaned from multiple observations and personal interviews. I consider the uniqueness of Bridges in tandem with the cultural plurality of stakeholders. Stake (1995) writes: “The real business of case study is particularization, not generalization” (p. 8). As in this case study, the stakeholders and researcher are interested in understanding the unique attributes of this program, not in relationship to others, but as a solitary program representing the unique perspectives of its stakeholders. Results of the study will be shared with service providers including the assigned Bridges teachers, social worker and administrator responsible for oversight of the program. These findings may be used when considering program improvement.

### **Evolution of the Researcher’s Role and the 2005 Committee**

My role as researcher in this study has evolved over the last four years. Prior to initiation of the 2005 Committee (referenced in Chapters I and II), I was one of approximately 20 staff members who were becoming increasingly aware of a growing population of students reintegrating to public school subsequent to a psychiatric hospitalization or prolonged absence. Concerns arose about the limitations of services extended to this population and the lack of a standardized, district approach. Of the

approximate 20 faculty members, there was representation from many disciplines including special education, health services, social work services, the school's advisory system, student assistance services (which, at that time, was primarily involved with issues relating to substance abuse), psychological services and administration. At that time I served as Special Education Department Chair for the district.

The group of 20 evolved into the 2005 Committee. The Committee agreed to serve an investigative function to determine the following: the incidence of the problem (how many students actually were, or had been, engaged in the reintegration process), what resources already existed within the district that might be extended to students reentering the high school, what populations actually accessed those identified resources and services and, finally, identification of other public school programs in the same geographical area that supported similar populations of students.

The Committee identified approximately five percent of the high school population as requiring assistance with reintegration to this public school. This percentage was assumed to be lower than the actual percentage as there had been no prior organized attempt to track and maintain reliable data. The 2005 Committee generated a fairly substantial list of known resources and services within the district and then identified populations of students accessing them. From this information it became apparent that there was a great disparity between resources allocated for special education services versus non-identified mainstream students. Non-identified students were afforded very few of the services available within the district. The Committee sought ways to better organize and reallocate what appeared to be fragmented and isolated

services for students.

The 2005 Committee contacted public high schools in the geographical area with very similar socio-economic populations. It was hoped that there would be a program in existence that we could model and mold to our particular needs. This research resulted in only one program that was developed for a similar high school population. That program served a more generalized population though it included students returning from psychiatric hospitalizations and prolonged absences. It was designed as a drop in center for students to request tutorial assistance or counseling services. This program had bundled existing resources to be available to students upon request. There was no formalized referral, exit procedures or uniform protocol for programming.

In lieu of other programs to model, the 2005 Committee was charged with developing an internal program for designated students with existing resources. With the spring and summer as a planning period for the Committee, Bridges emerged in the fall of 2005 with a staff of two part time special education teachers, one part time social worker and an administrator committed to program development. Several students were referred to the program in September of that year. Since that time, Bridges has evolved into a comprehensive, multidisciplinary program serving a unique population of students.

I became disassociated from the Committee and Bridges during the 2005-2006 school year; having resigned my position to pursue other professional interests. I was not in a position of authority for the staffing of Bridges; nor for execution of the program. However, my interest in program development, particularly involving mental health issues, was piqued; stemming from my earlier experiences with Bridges. During that

period of time I focused my research on school-based mental health programming. Though there is extensive research and programming options available on SBMH, I was unable to locate a single program in the literature designed specifically for adolescents reintegrating to public school subsequent to a psychiatric hospitalization or prolonged absence. It occurred to me that Bridges was a unique program serving a unique population of adolescents.

Simultaneously I was introduced through doctoral coursework to the research studies and methodologies of Robert E. Stake. His focus on qualitative case study as a means to understanding a singular program from the perspectives of stakeholders was intriguing. Through a long process I have come to understand Bridges as a unique program worthy of being studied and understood. Bridges has never been formally reviewed nor have stakeholders been afforded the opportunity to voice their perceptions of the program. This study represents the confluence of my experiences, interests and doctoral research. It will add to the body of existing research on school-based mental health programs.

### **Program Description**

The program being studied is called Bridges; so named with the intent to provide a bridge back to a public high school subsequent to a psychiatric hospitalization or prolonged absence. This is an intensive, school-based mental health program developed in 2005 in response to an emerging population of students exhibiting clinical anxiety and/or depression as manifested in substance abuse, suicidal ideation, eating disorders and school refusal. The population of adolescents was historically, and currently, laden with

bright, high achieving students; frequently identified as student leaders in academics, government, athletics, theater and the arts. The Bridges brochure describes the program as follows, “Bridges is an intensive regular education support designed to provide individualized education and social emotional support in a time- limited manner.

Students who are typically referred are those returning from hospitalizations or treatment settings, students with significant school refusal/ phobias, students experiencing acute and/or significant emotional distress and students who have missed a significant amount of school due to medical illness” (Bridges Brochure, 2007). The population being served has been expanded from its inception to include students with medical illnesses and identified special education students.

The primary goal of the program is to provide transitional services for students re-entering public high school that will magnify opportunities for successful reintegration. “The program can offer a safe, comfortable environment in an effort to ease the transition back to classes, emotional and academic support through advocacy, case management, academic assistance and counseling, individualized academic programs in collaboration with teachers, parents, students and outside medical providers and the Bridges staff” (Bridges Brochure, 2007).

Services that were previously provided in isolation for select students have been bundled into a more comprehensive approach including adult advocacy on behalf of students, liaison services between student and school staff, individual and group counseling, daily tutoring, extension of assignment deadlines, enlistment of internal and external health care services, support for affected parents, and gradual, individualized

transitioning into academic classrooms and the greater school environment. The Bridges teachers assume the role of case manager reflective of case management of special education students – serving as the primary adult responsible for securing and communicating appropriate services for the student within the school and greater school community. Academic support is provided to students through one on one tutoring in areas of academic need with the two special education teachers assigned to the program. The two Bridges teachers are still assigned to the program for only part of their day with one covering morning students and one covering afternoon students. These teachers collaborate with classroom teachers to prioritize student assignments and negotiate new timelines for completion. Classroom teachers are consistently updated, verbally or in writing at least once weekly, on student progress to assist with student reintegration into classes.

The Bridges social worker provides social and emotional support through daily counseling for affected students. Counseling services consist of individual and group therapy and are determined by assessed need. The social worker and Bridges teachers frequently work in concert with community psychologists and psychiatrists who have Bridges students engaged in therapy. Additionally, Bridges faculty, including the social worker and teachers, provide support to affected families through frequent telephone calls, e-mail and monthly parent meetings.

The oversight administrator is responsible for programming, support and evaluation of Bridges staff. She is the primary spokesperson for soliciting appropriate financing and resources for programming. Additionally the administrator is the liaison to



district decision makers, the greater school community, and mental health services accessed on behalf of students. She frequently serves as a resource to families and the greater school faculty influenced by Bridges. She has served a vital role in advocacy and education surrounding the initiation and continuance of Bridges.

New to the program this year, 2009-2010, is an instructional assistant who is assigned full time to the program. He is the one constant in the program and is vital for communicating updated information to the rest of the Bridges staff. He also is responsible for assisting students academically, listening to student concerns and referring students to appropriate personnel when discussion is beyond his level of expertise. The instructional assistant was selected for the program by the Bridges faculty for his expertise in many high school subjects and his documented ability to work with students often in crisis.

The Bridges program description, goals and activities have remained consistent since its inception in 2005. However, protocols and school-wide educational programs have been expanded to elicit understanding and support from the entire school community. The oversight administrator and Bridges faculty have made several public presentations to district administration, the local school board and the greater school community to educate and garner support for the program.

### **Program Theory and Need for Study**

Bridges has several guiding principles as agreed upon by the 2005 Committee. Having identified the emerging population of concern, the Committee concluded that reentrance procedures were inadequate for assisting students with the process. It was agreed that the Committee would explore ways to provide transitioning students with an

integrated system of supports. The agreed upon model was a multidisciplinary approach that could be accessed by all students reintegrating to public school subsequent to a prolonged absence or psychiatric hospitalization. As previously mentioned, mainstream students had been exempt from comparable services afforded special education students.

The 2005 Committee agreed that there was a need to involve the resources provided by the various disciplines in the school. Prior to this agreement, departments sometimes provided services in isolation while others duplicated services – a wasteful allocation of resources at best. It was agreed that utilizing the supports provided by the various departments in an integrated, comprehensive approach would magnify chances of successful interventions. The following departments were elicited for input and services: social work, special education, health services, the school advisory program, psychological services, student assistance services and administration. It was believed that a comprehensive program should involve community services; specifically, health care agencies and providers so they were enlisted.

One of the original premises that emerged from the Committee was the belief that there should be some standardized procedures for assisting students. These included but were not limited to the following: a referral and exit process, a template of services and interventions that routinely could be enlisted as supports, a communication chain between disciplines and outside providers, a communication network for parents to involve them as part of the integrative team approach and channels of communication to involve staff in the greater school community.

The 2005 Committee identified the following as minimal supports required for a

comprehensive approach: individual academic support, social/ emotional support, coordination of generalized health care needs including monitoring of medication and providing assistance for substance abuse. It was also understood that, initially, staffing for the program would be minimal as there was no funding allocated for program development.

Bridges emerged from the initial understanding that an integrated system with dedicated resources and minimal uniform procedures could more appropriately assist reentering students than what had previously been provided. This philosophy is supported by the research of Adelman and Taylor's (1994) final stage of interventions to treat severe or chronic problems in adolescents. Adelman and Taylor's continuum of services includes the minimal components of referral, triage, placement and resource allocation. Similarly, the initial components of Bridges addressed the same concerns.

Currently there is an understanding amongst program providers and the greater school community of the assumed, historical success of the Bridges program in providing services that support reintegration to school for students. There is also a generalized understanding that the program provides mental health services, academic supports and comprehensive, multidisciplinary, integrated resources that contribute substantially to the presumed success of the program. The program has never been studied to understand if Bridges is perceived as successful from the perspectives of stakeholders in achieving the goals of the program. In the past, the only information derived from stakeholders is anecdotal data volunteered by student enrollees and their parents. Though these may be helpful in understanding stakeholder perceptions, a more comprehensive inquiry can now

provide a voice for stakeholders. Their participation in the study has provided insight to best practices for reintegration to public school subsequent to a psychiatric hospitalization or prolonged absence. Ultimately this study will provide program providers a better understanding of the presumed success of Bridges and may contribute to program improvement.

### **Program Context**

The context into which Bridges originated was based on an identified need; to provide transition services for affected students with research into the historical roots of school-based mental health programs. Research and staff documentation of the identified population led to a rather startling understanding. Students identified as eligible for special education services had access to a wide array of school-based services as part of a reintegration process. This is largely due to mandated programming for special education students as represented in legislation and funding sources now in existence for more than 30 years. Access to those same services had been denied, unintentionally, to “regular” education students. Thus, the dilemma; how to provide appropriate services for all students to ensure a successful transition subsequent to a psychiatric hospitalization or prolonged absence?

With this explanation of program context, the study might lend itself to a participatory approach. Michael Patton (2002) describes participatory evaluation in *Qualitative Evaluation Methods* this way; “One of the negative connotations often associated with evaluation is that it is something done to people. One is evaluated. Participatory evaluation, in contrast, is a process controlled by the people in the program

or the community. It is something they undertake as a formal, reflective process for their own development and empowerment.”

However, R.E. Stake (1975) believes in the value of pluralism and multiple realities. He distinguishes his approach from his colleagues by keeping the locus of control with the evaluator. So while stakeholder expertise is recognized, the evaluator sets the design and breadth of the study. According to Stake (2004), “The role of evaluator is a singular task of inquiry” (p. 51). Consistent with Stake’s responsive evaluation, the researcher maintained the locus of control in this research study.

Stake (2004) indicates that the purpose of evaluation is to better understand the quality of a program already in existence. The evaluator provides an in depth description of the evaluation by looking at the activity, personal relationships and performances that reveal the program quality. Stake believes that value stems from the stakeholders and the context. Further, Stake indicates that case studies are the best method for representing the beliefs and values of stakeholders and the best method for reporting evaluation results. This study will model Stake’s responsive evaluation approach.

### **Stakeholder Participants**

The primary stakeholders in this program include the following: the students served through the program, their parents, Bridges faculty and, separately, faculty members in the greater school community. The focus of this study is to better understand the quality of the program from the perspectives of the four stakeholder groups. The majority of original program developers in 2005 have been absorbed into current stakeholder groups- primarily the certified faculty supporting Bridges either directly as

Bridges staff or indirectly as members of the greater school community who initiate referrals to the program. They provide a unique perspective of the program as members of stakeholder groups.

The student group includes students currently enrolled in Bridges and graduates of Bridges. Together, they provide a unique perspective of Bridges as they are, or have been, the recipients of mental health and transition services. As previously described, these are adolescents returning to public high school subsequent to a prolonged absence or psychiatric hospitalization. As a collective group they exhibit clinical anxiety and/ or depression as manifested in substance abuse, suicidal ideation, eating disorders and school refusal. Additionally they tend to be regular education students, not identified for special education services, who are leaders in the school community- through academics, government, athletics, theater and the arts.

The second group of stakeholders consists of parents of students currently enrolled in Bridges and parents of students who have exited the program. Their perspective of the quality of the program is explored through interview and questionnaire. Parent perspective is considered vital to understanding Bridges. Having first experienced the dilemma of removal of their adolescent from public school either voluntarily or at the discretion of others, parents now assume a new concern at the onset of placement in Bridges. How does one successfully reintegrate a student to the environment from which they've been removed? Parents have a unique perspective as to how the process has impacted their adolescent and what supports have proven valuable in the reintegration process. They offer substantive recommendations that may better integrate parents in the

reentry process. I believe their perspective may also assist future parents of Bridges students in understanding the program and assisting in the reintegration process.

The third stakeholder group includes the primary service providers; the Bridges teachers, social worker, instructional assistant and, to a lesser degree, the oversight administrator. The fourth and final stakeholder group is represented by the general school population. This grouping may be the most diverse in that they represent varying levels of engagement in the program. Some members share students with Bridges faculty and, therefore, are more personally invested in the program.

### **Design**

The design of this study is an internal, intrinsic case study using primarily qualitative data supplemented by quantitative data provided in existing documentation including informational and organizational reports. The design of the study is intended to be formative and exploratory to understand the multiple perspectives of stakeholders regarding the quality of the Bridges program. This inquiry is modeled after a sequential exploratory model. This model requires two sources of evidence. They are direct observation of the events being studied and interviews of the persons involved in the events. Yin (2003), cites the following; “The case study’s unique strength is its ability to deal with a variety of evidence- documents, artifacts, interviews, observations” (p. 18). These four represent design components of the study of Bridges.

I am using R.E. Stake’s methodology as a guide for studying Bridges. Much of his work has involved evaluation of singular programs for the purpose of better understanding the program for its uniqueness. That is exactly my intention in studying

Bridge as a singular, unique program.

The Bridges program has been in existence for five years and there is a presumed level of success for students engaged in the program. Bridges has never been explored from the perspectives of its multiple stakeholders. The focus of research is on the participants' perceptions and experiences; including student participants and their parents, Bridges faculty, and the greater school community. The research question being explored clarifies the perceptions of stakeholders as to how the Bridges program facilitates the reentry of students into a specific public school in a northern suburb of Chicago. It is the intent of the researcher to gain an in depth understanding of Bridges as a unique program through case study analysis and interpretation.

Consistent with Stake's responsive evaluation, the researcher maintains the locus of control in the Bridges study. Additionally the role of researcher is described by Eisner and Merriam (1991, 1998) as follows: "The researcher is the primary instrument in data collection rather than some inanimate mechanism" (p. 14).

In my role as researcher I acknowledge that I bring my own values and biases to the study. I served as a member of the original committee in 2005 that identified the need for an additional programming option for the designated population of adolescents. I assisted in the development of the program during the initial phases of implementation. Since 2006, I have not been in any way affiliated with the program, nor do I serve in a supervisory capacity for the program or student participants. This is an internal, formative inquiry-making some aspects of research such as accessibility to documents easier but issues concerning bias more pronounced. My familiarity with the program



presents some challenges. The possibility exists that information has been overlooked as inconsequential or that terminology may not be adequately defined for the reader. To address these concerns I have elicited comments from a reader unfamiliar with the Bridges program to determine if what is being described is comprehensive and understandable.

### **Instruments (Sources of Data)**

The researcher's primary role in this study is to understand perceptions of stakeholders. Therefore I have been looking for common themes or issues that arise in each of the four participant groups. From my perspective I have prioritized the participant groups based on level of personal experience and investment. The most invested group is represented by the clientele Bridges serves, students. Second to them are the parents of the students, followed by the Bridges faculty and, finally, the greater school faculty.

Consistent with qualitative case study I have used multiple sources of data collection including interview, observation, archival information, and document examination. Research case studies are concerned with rigorous and fair presentation of data (Yin, 2003). Stake recognizes interview as the primary source for understanding and interpreting multiple perspectives. Interviews are central to this study. Additionally, as the researcher, I have been looking for convergence of data for the purposes of triangulation and validity. This has assisted me in accurately generating comprehensive descriptions and interpretations. A description of the instruments follows.

### **Student Interview**

The student interview protocol is intended to elicit the perceptions of enrollees in the Bridges program from the time of their placement in the program to their intended or completed dismissal from Bridges. Questions are designed for students to articulate their experiences and make recommendations that may positively impact programming for future students. The interview protocol was administered to five students currently in Bridges and five graduates of Bridges. The ideal number of students for interview was determined by reviewing statistical data from the months of April and May over the course of the previous four years. The number five reflects, as a minimum, half or more of all new referrals during the period of time in which the interviews took place; the months of April and May. Selection of students was random to attain a representative sampling of student participants. The interviews were open-ended and face to face. They were designed to be conversational; allowing participants to reflect on areas of programming the researcher may not have considered relevant. Participation was voluntary and student confidentiality and anonymity was strictly adhered to as prescribed by the Institutional Review Board. Subsequent to each interview, the researcher reconstructed a written account and submitted it to the student participant for accuracy and stylistic improvement, consistent with Stake's approach to personal interview. The reader is referred to Appendix A for the Student Interview Protocol.

### **Parent Interview**

The parent interview was intended to elicit the understandings and perceptions of Bridges as it personally impacted the lives of their adolescent and themselves as parents of a Bridges student. Their perceptions were particularly useful in understanding the value of supports offered to assist in the reintegration process. Parents revealed specific recommendations that likely may assist future parents of Bridges students. The interview protocol was administered to parents of five students currently in Bridges and five parents of Bridges graduates. The ideal number of parents for interview was determined by reviewing statistical data from the months of April and May over the course of the previous four years. The number five reflects, as a minimum, half or more of all new referrals during the period of time in which the interviews took place – the months of April and May. Selection was based on the return rate of parent consent. Those that consented to participate first were those that were interviewed. The interviews were open-ended and face to face. Interviews were conducted in the researcher's office and parents were provided several suggested times from which to choose. Subsequent to the interview the researcher prepared a written account of the interview which was submitted to parents for verification of accuracy. The reader is referred to Appendix B for the Parent Interview Protocol.

### **Service Provider's Interview**

The interview protocol for service providers was developed specifically to better understand the historical origins of Bridges and to reveal answers to the primary research questions. It also was intended to provide data as to what constitutes successful

reintegration of students and to determine what social/emotional and academic supports contribute to the reintegration process as perceived by Bridges faculty.

The same interview protocol was administered to all four service providers including the two teachers, social worker and oversight administrator to determine if there is a consistency of shared beliefs and understandings amongst staff. The interviews were conducted face to face with the exception of one of the teachers with whom time became a determining factor. The interviewer prepared a written facsimile of the interview which was submitted to the participant for review of accuracy. The reader is referred to Appendix C for the Service Providers' Interview Protocol.

### **Questionnaires**

Questionnaires reveal major themes that have been compared to staff interpretation of program functioning and supports as defined in personal interviews. Existing documents including the program brochure and notes from observations provided critical information about student programming and levels of interventions required for student reintegration. All data has been analyzed to better inform the researcher and stakeholders about whether actual programming is consistent with the described purpose, methodology and process of reintegration from non- school attendance to the Bridges program and, eventually into the greater school community. The composite information, quantitative and qualitative data, has been integrated to understand the multiple perspectives of stakeholders with regard to program quality.

**Student Questionnaire**

The student questionnaire was administered to current and former participants in Bridges subsequent to parent consent. The purpose of the questionnaire was to understand what aspects of programming have served to assist with reintegration to school from the student perspective. Focus was directed on mental health and academic interventions and their influence on the reentry process. Student questionnaires were administered by Bridges faculty to current students and were mailed to former students in a self-addressed, stamped envelope for return to the researcher. Participation was voluntary. The number of returned questionnaires was minimal. The researcher surmises this was due to the prescribed sequence of obtaining parent consent prior to student participation. This resulted in multiple mailings that were less than timely. A more comprehensive analysis of the minimal rate of return of student questionnaires will be addressed in Chapter V of this study. Student confidentiality and anonymity were strictly adhered to as prescribed by the Institutional Review Board. The reader is referred to Appendix D and E, respectively, for the present and former Student Questionnaires.

**Parent Questionnaire**

The parent questionnaire was mailed to the parents of current and former participants in Bridges during the 2009-2010 school year. The purpose of the questionnaire was to understand what aspects of the program have served to assist with reintegration to school from the parent perspective. As with the student questionnaire, focus was on mental health and academic interventions. Additionally, the questionnaire was intended to clarify parent participation in the reintegration process as they are, or

were, invested stakeholders. The questionnaire expanded the researcher's understandings gleaned from parent interviews. Participation was voluntary with prescribed anonymity. The reader is referred to Appendix F and G for, respectively, the Parent Questionnaires.

### **Faculty Questionnaire**

The faculty representing the larger school community was surveyed for the purpose of understanding their perspectives of the Bridges program. The questionnaire was administered to certified staff only as they represent the larger school community having some level of engagement with the program. The questionnaire distinguished between faculty members that "share" Bridges students and those who have had no direct involvement in the program. Distinct perceptions of Bridges based on direct interaction with the program through students or an absence of direct involvement will be discussed in Chapter V. The questionnaire was provided to all certified staff on the multi-grade campus and returned anonymously to the researcher. The reader is referred to Appendix H for the Faculty Questionnaire.

### **Observations**

The researcher observed ten times in the natural setting of Bridges gathering information, observing, taking extensive field notes that reflected participant behavior and interactions. I made use of a narrative design. The role of the researcher was known and the purpose of the study disclosed. It is a study of a program, not of students. Observation allowed the researcher to understand the program, its activities and the relationship of participants in their natural setting. It has confirmed and negated some of the findings expressed through personal interview or questionnaire. The researcher

strove to become part of the environment through repeated observations and thereby gain an authentic understanding of the setting and participants. This may have facilitated valid responses from student participants. The researcher used a protocol developed to address multiple aspects of the program including descriptive notes, reflective notes and demographic information. The reader is referred to Appendix I for the Observation Protocol.

### **Quantitative Data from Public Documents**

Public and informational documents served a role in this research. Quantitative data concerning academics and mental health interventions reflect information obtained about the interviewed student population prior to, during and subsequent to Bridges placement. This data consists of academic grades- quarterly and semester and any changes initiated within levels; the school tracking system with level one classes being the lowest and level five representing advanced placement classes. Data sources also included daily attendance information, promotion to the next grade level and/or graduation from high school “on time” for seniors. Social and emotional factors contributing to successful reintegration included the same tri-fold schedule of pre, during and post Bridges participation and engagement in therapy, compliance with medication and diminishment of anxiety and/or depression symptoms as reported by Bridges faculty and parents. Social and emotional factors were further assessed through reintegration and participation in school activities including clubs and extracurricular activities as reported by students.

### **Researcher's Journal**

Consistent with qualitative inquiries, I maintained a journal of reflections that may offer perspectives and insight not provided by previously mentioned instruments. Use of a journal has allowed me to assess the reliability of responses from study participants to observed behaviors. It also has contributed to the validation and triangulation of different sources of information representing the four separate communities of thought; those of the student participants, their parents, the Bridges faculty and those of the greater school community. This information has been compared with the researcher's personal observations and reflection.

### **Procedures**

Recruitment of Bridges faculty was obtained with the understanding that this study will provide substantive information for understanding multiple perspectives that may assist in program improvement. Recruitment of students required strong ethical and confidentiality considerations. I complied with all Institutional Review Board guidelines by making student participants and their parents aware of the purpose of the study through written disclosure statements and verbal conversations with students and families. The focus of this study has always been on the program- not the students. Their participation afforded me an opportunity to reflect on student perception of Bridges. It also provided students a venue in which to make programmatic recommendations that could impact change for current and future Bridges enrollees. Written permission was solicited for participation in the study by students currently and previously in Bridges and their parents. Participation in the study was strictly voluntary



and participants understood they could withdraw at anytime without penalty. The reader is referred to Appendix J for Parent Consent for Student Participation and Appendix K for Student Consent for Participation.

### **Phase One**

Prior to initiation of Phase One, administrative approval was obtained for release of information of student names. Subsequent to administrative approval, the Bridges faculty provided the researcher with a list of students previously enrolled in Bridges and those currently participating in Bridges. I contacted parents of students currently and previously in Bridges during the 2009-2010 school year through a comprehensive written explanation of the proposed study which was mailed home. The mailing explained in detail that the focus of the questionnaire was on perceptions of the program and would be devoid of any questions regarding student need for placement in Bridges. Informed consent forms for all parents of adolescents formerly or currently in Bridges were included in the initial mailing. See Appendix L for details. Parents were asked if they would be willing to participate in an enclosed questionnaire, Appendix F or G and if they would be receptive to a personal interview with the researcher. Mailings included self addressed stamped envelopes for ease of return to the researcher.

A second mailing to parents by the researcher then asked for parent consent for their student to participate in an anonymous questionnaire, be observed in class by the researcher and/ or be interviewed by the researcher (see Appendix J). Mailings included self addressed stamped envelopes for ease of return to the researcher. Once parent permission was obtained, students were similarly contacted by mail with documentation

indicating their parent had approved participation but with the caveat that their consent, as the student, was also required for participation. They were asked if they would consent to participate in an anonymous questionnaire, be observed in class and/ or be interviewed by the researcher (see Appendix K). Questionnaires were then provided by Bridges teachers to those responding affirmatively and returned to the researcher anonymously (see Appendix D for the Current Student Questionnaire). Dismissed students who had given approval for completion of a questionnaire were mailed the survey with a self-addressed, stamped envelope for ease of return (see Appendix F for Former Student Questionnaire). Choice of participants for interview was random and reflected the first five students both current and former who responded positively. Students were reminded that participation was voluntary and could be withdrawn at any time.

During the initial phase of study the researcher reviewed all existing organizational and informational documents relevant to the Bridges program. The program providers recommended documents and literature relevant to the study of Bridges. The researcher used multiple sources of data collection including a review of attendance and grades; accessible to the researcher as this was an internal study. Quantitative data such as the grades of students who were interviewed was monitored throughout the course of the study.

Review of existing organizational documents, with informed consent from administration (see Appendix M), i.e., the Bridges brochure and selected documents provided a better understanding of the development of the program over a five year period and an in depth understanding of the unique individual plans developed to address

student academic and social/emotional needs. These records provide documentation of individual student progression and introduction of specific interventions during critical events in student programming. All information reviewed contributed to understanding stakeholder experiences.

During the month of April, and subsequent to administrative informed consent (see Appendix M), the greater faculty questionnaire was distributed to the mailboxes of all certified staff on the multi-grade campus for anonymous completion. The purpose of the questionnaire was to provide an avenue in which this population could freely express their opinions and perceptions about the Bridges program. The greater school faculty afforded me a unique opportunity to understand the perceived value or lack thereof attributed to the Bridges program for students reintegrating to this public high school. Questionnaires were returned to the researcher anonymously through placement in my school mailbox.

For a richer understanding of the program, the researcher conducted structured interviews with the primary program providers including the two teachers, the social worker assigned to Bridges and the program administrator. These were conducted personally and individually for comparison of attitudes, understanding of program function and perceived stakeholders' impression of the quality of the program. These interviews were initiated during the month of April but all were not completed until June. Due to time constraints one of these interviews took place through phone conference. All others were face to face. A written account of the interview was prepared the same day as the interview and submitted the following day for the program provider to review and

check for accuracy. The amended account of the interview was returned to the interviewer with clarification changes or emphasis. As interview was the primary instrument used by Stake to understand stakeholder perceptions, this process was expected to provide a comprehensive understanding of this invested group of participants. The process did just that.

The researcher observed in the natural setting to understand the details of the program and be involved with the actual experiences of the participants. This commenced upon receipt of informed consent from students and parents and continued until the conclusion of the school year in early June. The researcher employed methods that were both interactive and humanistic reflective of Dr. Stake (1995). I attempted to accurately report the feelings, emotions and preferences of stakeholders as a reporter/facilitator, not as an expert. Data was recorded on the observation sheet found in Appendix I. Interpretation, characteristic of qualitative case study, requires the researcher to be thoroughly immersed in the program to better understand the activities and interactions stakeholders participate in. For me, the process included cycling back and forth between data collection, analysis and formulation of understanding of various stakeholder groups as the study progressed. As indicated by Merriam (1988) and Marshall and Rossman (1989) data collection and analysis was viewed as a simultaneous, linked process. Consistent with qualitative case study, I questioned my understandings with those observed to ensure accuracy of understanding and reporting.

Copious field notes provide a record of the observations. Thick description allows the researcher and, potentially, stakeholders to analyze current practices, identify

what to protect and cherish, and understand the quality of the program as it currently exists. Observations included participants interacting in one on one tutorial sessions, daily activities and procedures, case management, therapy and liaison activities. The observation protocol was developed using strategies proposed by Miles and Huberman (1994) and is listed as Appendix I.

### **Phase Two**

During phase two the researcher conducted all student interviews face to face and subsequent to informed consent. Students were selected randomly and on a first come first serve basis. They were notified in writing (see Appendix N) of the impending interview and timelines. Students were given two suggested times for personal interviews. The researcher made every effort to accommodate student requests for time and did not intrude on student academic schedules. Each interview took approximately half an hour. A total of forty five minutes was allotted to review the purpose of the interview and reiterate student rights to withdraw participation at any time; followed by the actual interview. Rapport was established with current students during periods of program observation or during the interview itself. Former students were notified in the same way and procedures were duplicated. I had concerns about establishing rapport with students with whom I had no previous contact. This concern never proved to be an issue.

Parent interviews were completed during phase two of data collection. Parents were notified by telephone that they had been randomly selected to participate in the interview process. Time constraints required phone contact rather than the invitation letter that appears in Appendix O. Interviews took place either in my office at the school

or in a designated conference room. Several times for interview were suggested to parents who then selected the best time for their personal schedule. The interview was expected to take approximately half an hour. Additional time was allotted for review of parental rights and to establish rapport. I compiled an account of my understandings of the interview which were then forwarded to the parent for review of accuracy. Parents were asked to make changes to the document if it had inaccuracies in tone or content and return the amended document to the researcher.

To assist in all phases of the data collection process I maintained a journal to provide a detailed account of my personal experiences and reflections. This has been compared to my field notes during observations and the results of interviews and questionnaires to better understand multiple interpretations. The journal reflects my perceptions and is instrumental in the analysis phase of the investigation.

### **Analysis of Data**

Stake (1995) and Wolcott (1994) indicate case study involves a detailed description of the setting or individuals followed by analysis of emerging themes or issues. That is the framework from which my analysis evolved. Additionally I implemented the generic process described by Creswell (2003) of sequenced activities as follows: organization and preparation of the data for analysis including transcription of interviews and sorting and arranging information into meaningful topics, a comprehensive review and reflection of all existing data, coding of data into logical categories, development of a detailed description of the Bridges program and emerging themes including major findings reflective of multiple perspectives, development of a

process and framework for representation of the qualitative narrative and, finally, interpretation of data through the lens of the researcher and participants in the study.

Issues of research validity have been addressed by utilization of procedural strategies including triangulation of evidence obtained from student participants and their parents, staff assigned to Bridges and the greater faculty community. Additionally, field notes of observations and journal entries by the researcher have enhanced the understanding of multiple perspectives. Member checking was employed by encouraging interviewees to review and determine the accuracy of the researcher's findings. A rich, thick description as described by Stake (1995) has assisted with accurate representation of findings and support shared understandings. The researcher's reflections served as self disclosure for understood biases that influenced reported findings. Contrary or discrepant information has been reported candidly through the lens of multiple perspectives. The researcher developed an in depth understanding of the program and perspectives of participants through observations over a sustained period of two months to bring credibility to this study.

## CHAPTER IV

### RESULTS

#### **Introduction**

In Chapter IV, I review the results of my findings through the multiple sources of data collection as they relate to the three specific research questions in my study. Themes evolve that typify stakeholder needs and program responses to identified needs. As might be expected in a study of this kind, there is overlap in responses that frequently address more than one research question. The components of the program are purposely integrated to present a comprehensive school based mental health care model.

Through the examination of responses to the research questions, themes emerge that are indicative of the values and deficiencies stakeholders assign to Bridges and Bridges faculty. Many of the findings are predictable but some were unexpected. Due to the nature of qualitative case study analysis, emergent themes cannot be anticipated or planned in the design of the study. Of most importance, this chapter provides the reader with personal experiences and reflections of stakeholders that detail their progression through the reintegration process. Consistent with responsive evaluation, the reader has the opportunity to meet the stakeholders and walk in their shoes through vicarious experience.



### **Process for Analysis of Data**

The process of data collection and analysis in this study is an interactive and cyclical process as illustrated in Figure 1 (Miles & Huberman, 1994). As I was collecting data, the analysis process began simultaneously. Initially I read through all of the data as it became available. With interviews, the process was almost immediate as I transcribed my notes the same day for clarity and member checking. Students were coded numerically and referred to in the study as student one, student two and so on. The same is true for coding of the ten interviewed parents and Bridges faculty. They were coded numerically in the order in which they were interviewed. As I reread each of the interviews I made notations in the margins for possible coding. I had not developed a master code prior to the data collection stage.

With the return of faculty questionnaires I developed a coding method for displaying and analyzing the results of the survey. Because I was interested in responses by disciplines I developed a spread sheet for each department so I could analyze data within departments and across disciplines. The spread sheet tallied the frequency of responses to each question. This proved to be an effective tool in organizing and understanding faculty responses. I developed a similar spreadsheet for parent responses to the questionnaire noting the frequency of same responses. As there was a minimal return of student questionnaires, I simply made notes in my journal about student responses. They were then reviewed for frequency of response within and across groups.

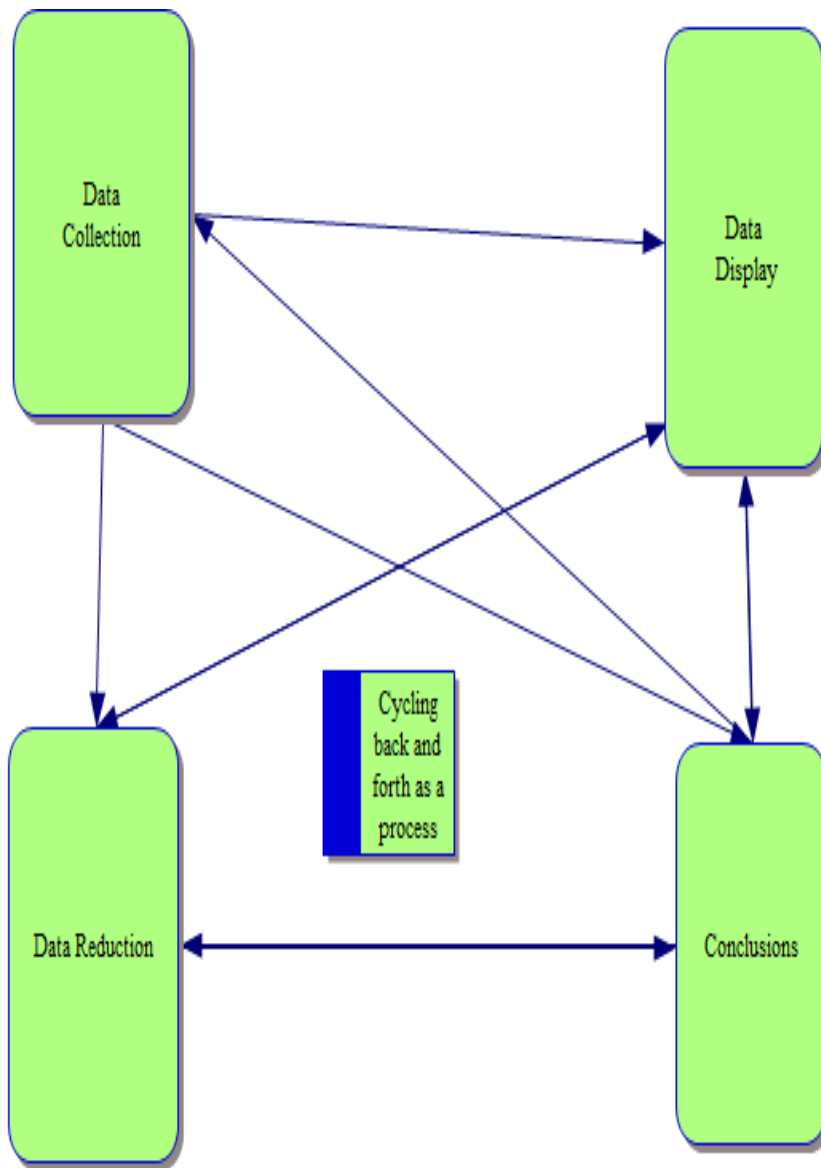


Figure 1. Interactive Data Analysis Model

From: Miles and Huberman, 1994

Figure 1. Interactive Data Analysis Model

Daily observations were recorded with notations using the observation protocol (see Appendix I). Self-reflection journaling through note taking and memos allowed me to examine my own perceptions and biases as they evolved during the data collection and analysis processes. A review of documents including the Bridges brochure and the attendance and grade patterns of interviewed students concluded the process of actual data collection and initial analysis.

Following the initial phase of reviewing the data as it became available; I followed a more structured approach. I organized the data into a manageable filing system based on stakeholder groups with subsections for relevant documents. With questionnaires there was an opportunity for participants to write in personal comments and reflections. I separated these out from the more objective portions of the questionnaires. Sub groups were further separated by positive and negative comments. An observation section was developed by date of the observation. A section for documents included any literature I obtained about the program. This included the Bridges brochure and excerpts from the Bridges website. The data for attendance and grades of the ten interviewed students required separate sections for each. My filing system includes a section for humanistic psychology and a separate section for R. E. Stake and responsive evaluation. Finally I developed a section for miscellaneous data that I couldn't easily catalog any place else. Eventually the data in this section was either refiled with one of the major sections or removed as irrelevant to the study.

My next step was to read through all of the data and begin to develop a coding system by writing notations as I processed the information. I looked for similarities

within stakeholder groups and across groups. Initially I organized the data by relevancy to research questions and membership in one of four stakeholder groups. This data was then clustered for commonalities using descriptive codes like “anxiety response” and color coding of like or similar responses. I developed a master list of codes that reflected codes within stakeholder groups and codes that expanded across stakeholder groups. The codes were again clustered according to relevancy to each research question. Pattern coding was the preferred approach for understanding the local setting, actors, events and processes. Naming codes that closely reflect the concept being described allowed easy and timely access to the original concept. The codebook is listed as Appendix P.

Perhaps one of the most difficult issues I faced in the analysis was the reduction of data. This was a struggle as every story or quotation from students and parents reflect the emotive character of humanistic psychology and responsive evaluation. Every story and quotation seemed vital to understanding the value stakeholders attribute to Bridges. I was extremely moved by the candor, vulnerability and strength of the interviewees. Their stories were incredible tales of true survival for some and ongoing struggles for others. I elected to include as many quotes from the interviewees as possible without being redundant. Many stories reflect similar experiences from an emotional perspective so I consciously tried not to be repetitive.

Qualitative analysis is an intricate and subjective process. To insure internal validity a number of strategies were employed. In the tradition of qualitative research, the conclusions I reached in this analysis were consistently subjected to triangulation of data primarily through observation and review of documents for reliability. Additionally,

member checking was consistently employed to insure my understandings were accurate portrayals of information shared with me. I transcribed responses to interviews and submitted them to interviewees for verification. In most cases I was able to transcribe the interview the same day and submit the transcription to the interviewee the next day for verification and accuracy. Transcriptions were member checked by half of student interviewees, five of ten, and half of parent interviewees, also five of ten participants. Member checking of Bridges faculty was completed by all four participants. A total of 14 of the 24 interviewees were asked to participate in the member checking process. Email proved to be a time conserving and cost effective method for collecting precise, verbatim responses regarding the accuracy of the interview transcripts. All transcripts were edited to remove any identifying information and given a numerical identification code. The conclusions reached in this study are believed to be an accurate representation of stakeholder perceptions.

### **Format for Presentation of Results**

I am addressing the results of this study as they relate to each of the three research questions posed in this inquiry. Data collection for this study includes student interview, student questionnaire, parent interview, parent questionnaire, service provider (Bridges faculty) interview, the greater school faculty questionnaire, relevant documents to this study including the Bridges brochure, observation in the Bridges program and analysis of relevant quantitative data (grades and attendance). The presenting needs and perceptions of the stakeholder groups are documented as are the program responses to identified needs. The four stakeholder groups include students formerly or currently (at the time of

data collection) in the Bridges program, their parents, Bridges faculty and the greater school faculty. Responses from each stakeholder group are presented in the order of importance from the most intimately involved group, students, to the distal group least impacted by the program, the greater school faculty. The sequence is as follows: current and former students of Bridges, their parents, Bridges faculty and faculty in the greater school community. Evidence of significant findings by the researcher provides additional data reflective of outcomes to the research questions.

*How do stakeholders perceive the impact of the Bridges program in facilitating the re-entry of students into a specific high school in a northern suburb of Chicago?*

*(RQ1)*

My research indicates that each stakeholder group singularly and collectively, attributes substantial importance to the Bridges program in facilitating student reintegration to this public high school. More specifically, each stakeholder group identifies safety as a perceived outcome of Bridges; though identifiers of safety are distinct within stakeholder groups. Impact of the program can be analyzed as promoting both positive and negative outcomes for students.

Research Question 1, (*How do stakeholders perceive the impact of the Bridges program in facilitating the reentry of students into a specific high school in a northern suburb of Chicago?*), can be analyzed through R.E. Stakes' responsive evaluation. Stake defines the quality of programs in terms of perceived outcomes by multiple stakeholders including observations that provide authentic understandings and field notes that confirm understandings. Students being considered for enrollment in Bridges present with a

unique set of needs including substantive academic and emotional needs. Students self identify feelings of being overwhelmed or anxious at the prospect of returning to school, a need to have a manageable workload established early in the reentry process, a process by which grades and schedules could be adjusted based on individual need and provision for a safe environment when initiating the reintegration process. These perceptions of needs are being addressed in the interim phase of reentry to school through the Bridges program according to shared perceptions from students, parents, service providers and researcher observations and review of documents. More specifically, parents and service providers identify Bridges as an interim step in the process of full reintegration to the greater school community. Additionally parents cite specific needs of their own including understanding and coping with the reentry process and relinquishing some or all responsibility for their adolescent's needs during the reintegration phase. This is substantiated by parent interview and questionnaire, service provider's interview and observations.

Bridges faculty define one of the populations served through Bridges for whom there were limited outcomes for engagement in school; this being students who were chronically absent. Alternatives to staying home with or without tutoring or placement in therapeutic day school have been provided through Bridges. A review of documents reveals that students can attend with greater regularity when they participate in Bridges though attendance post Bridges again drops off indicating the need for continued, individualized programming. Part of the impetus to develop the Bridges program was to create an environment in which it was possible to engage chronically absent students in

school. As such, when looking at supports it's important to review attendance patterns of those students enrolled in Bridges. Consistent with review of grades, the attendance patterns of the students interviewed is what is reported in this study. Of the ten students interviewed in this study all had attendance issues prior to placement in Bridges. The reasons for attendance issues varied enormously including truancy, surgery, chronic and life threatening illness, treatment in a drug and alcohol facility and a psychiatric hospitalization. Attendance while in Bridges was consistently better for all ten individuals though post Bridges attendance was as varied as pre Bridges attendance. The reasons for this will be explored in Chapter V.

Students, parents and Bridges faculty all identify the need for full reintegration to the greater school through incremental programming. Perceptions of stakeholders indicate an understanding for this to occur as a natural process towards self-determination reflective of humanistic psychology and Maslow's Hierarchy of Needs. However, this process is also defined as difficult for students to accept and perhaps indicating a tendency for over reliance on Bridges program and staff.

The greater school faculty, while identifying Bridges as a positive program that should be continued, also expressed some misconceptions about the purpose of the program and the population being served. Lack of understanding about the existence of the program from parents, combined with misconceptions by faculty, indicates that past and current efforts to educate stakeholders about the program have been unsuccessful. This perceived outcome is repeatedly expressed by two stakeholder groups through interview and questionnaire and is supported, though less so, through students responses.



A perception expressed by three stakeholder groups including students, parents, and service providers, places significant importance on the need for a safe environment with safe people. This is an outcome of the Bridges program as expressed by so many and confirmed through observation. Safety is cited as critical for initiation of the reintegration process regardless of the reason for a sustained absence.

And lastly, outcomes of participation in Bridges are perceived as both a positive and negative outcome for students. Though the majority of stakeholders identified Bridges as a critical and positive step in the reintegration process, some individual students cited a reluctance to extend reentry to the greater school community. Additionally some faculty questioned the value of the program when viewed as an enabling intervention. Observations and interviews with parents and students verify a comfort with Bridges that could evolve into reliance on the program and staff. Service providers are aware of this issue and actively work with students to gradually reintroduce them to classes while still providing counseling and tutoring supports. Implications will be explored in Chapter V.

*Essential Understanding: As the researcher and reporter of stakeholder perceptions it is my understanding that the value and impact of Bridges is defined by program response to individual and stakeholder needs.*

### **Theme 1: Students Needs**

This theme refers to the comprehensive set of needs presented by students who are part of the Bridges program. These needs include extensive psychological, emotional, academic and social needs. Students referred to Bridges present with complex

profiles with any number of outstanding needs. One of the students (Student 3) I spoke with detailed her journey to Bridges and eventual graduation from high school. I paraphrase her story. I made a suicide threat and was placed in a psychiatric hospital for a week. I wasn't all that serious but the school and hospital thought I was. My parents wanted me to go back into regular classes when I returned to school. I felt fine doing that but I think I made a lot of people nervous because they had me escorted everywhere throughout the day by an instructional assistant. It was horrible. My parents complained and then we were offered Bridges as an alternative. I read about it on the website. I didn't think I needed it and my parents didn't either but we thought it was better than being followed all day. At first I felt like I was being punished but then I started to make new friends in the program. I had a lot of support from the kids in Bridges because they were pretty much in the same situation even though the reasons we were placed in Bridges were very different. I learned about people and problems I didn't know existed. I got caught up in my classes and had to leave Bridges. I miss the people and the environment but I've kept the friends I made in Bridges. This student finished out second semester with less than stellar grades but graduated that same year.

Another student (Student 1) shared her story with me. Again, I paraphrase. I was in and out of Bridges for two and a half years. I became very ill with a chronic condition sophomore year. I was out of school for two months and was terrified of going back. There were all the expectations, missed work and I was still quite ill. Gradually I worked my way back into school through Bridges and they [Bridges staff] helped me get caught up and finish out the year. During my junior year I was sick almost all the time and

became completely overwhelmed. Bridges teachers helped me sort through everything, prioritize, and lay out a recovery plan step by step. Then during my senior year I was out of school a substantial amount of time for three surgeries. Each time I was ready to come back the teachers worked out a plan with me to get back on track. My experience with Bridges and the kids I met through Bridges have led me to strongly consider a career in child and adolescent psychology or psychiatry with a focus on those with chronic illnesses. This remarkable young woman graduated, on time, having earned almost straight A's in very demanding, high level courses. Her doctors were able to time the surgeries so she could be treatment free and strong enough to enter a very competitive college as a healthy young woman this fall.

One of the postulates of humanistic psychology is the belief that one is influenced by one's experiences. From the students involved in this study I have a sense they would note this period of time in their high school years as influential in their experiences and ultimately who they became as individuals.

### **Student Need, Anxious and Overwhelmed**

One of the earliest and most surprising findings of this study was that all students, regardless of reason for a prolonged absence were subject to the same concerns of reentry. The Bridges program was developed for the initial population which included students returning from psychiatric hospitalizations and a prolonged absence.

Consideration was given for students with their stated anxiety concerns of reentry to school. "I felt lost and over whelmed." (Student 7) However, as other populations of students emerged, primarily "medical" students; the staff began to recognize the

unanticipated finding that these students too required a tailored reentry plan due to the accompanying anxiety. Student comments in interview and questionnaire state that returning to school subsequent to prolonged absence produced emotions of anxiety and feeling overwhelmed. Expressions of anxiety seem to be two-fold and are coded as such.

**Emotional Anxiety.** The first is what I refer to as an emotional anxiety response to the actual reintegration process. The subsequent quotes reflect the emotional response to reintegration of students. “I was completely lost and overwhelmed with the process of returning to school.” (Student 1) “Bridges provides a relief from the anxiety I was feeling at the thought of reentering high school.” (Student 5). Students describe feelings of anxiety specifically with the reentry process. Other students target academic expectations as anxiety provoking.

**Anxiety Relating to Academics.** Anxiety relating to workload and academic expectation is a subset of the code anxiety and overwhelmed. Another student communicated his anxiety through feelings of fear about returning to school and having to address the academic demands of getting caught up with assignments. It seems that some of the reluctance to reengage in school is related to work avoidance. “I had been out of school for a while with emotional problems and the work was piling up. I was terrified of going back to school and trying to get caught up.” (Student 6)

### **Program Response to Student Need: Making the Workload Manageable**

Bridges faculty alleviated some of that anxiety through thoughtful reintroduction of work. Student questionnaires and interviews identified a primary outcome of participation in Bridges is to make the academic workload manageable. This finding is

very consistent with Student 7 who reported, “The Bridges teachers negotiated the workload for me. They talked with each of my teachers and negotiated a manageable workload. They helped me make up work. It would have been impossible otherwise.”

Students consistently report that the Bridges teachers effectively serve as a liaison to the greater school community, advocating for and communicating on behalf of Bridges students. “Bridges teachers talked to my teachers to find out what I needed to make up and helped negotiate work extensions.” (Student 2) Student 1 reported that, “Making up the work would have been impossible but Bridges teachers talked and negotiated the workload and timelines with my teachers.” The actual process of how Bridges teachers make the workloads more manageable will be addressed through research question 2 (RQ2).

### **Program Response to Student Need: Grades and Adjustments to Schedules**

Review of documents is significant in understanding the impact of the program from the stakeholders’ perspectives of a manageable workload and triangulating that data with student responses. This is most evidenced when reviewing the grades, level changes (movement from higher level classes to less rigorous classes) and use of IP grades. An IP grade is an individual progress grade that can be assigned in lieu of a traditional grade to struggling students with approval from department chairs and administration. The grade is issued as pass or fail; thereby allowing a student to receive credit for a course without a specific grade. As with a move down in the school’s level system, the IP grade reflects a conscious effort to assist a student experiencing great difficulty transitioning back to school while maintaining credits toward graduation.

I reviewed the grades of the ten interviewed students pre Bridges, while in Bridges and post Bridges. The data indicates that there was no uniform approach to assist students with maintaining grades reflective of previous grades achieved. Instead, when the data was reviewed, it indicated that use of IP grades and dropping down in course levels was infrequently used with this population. Though there is evidence of a slight decrease in some student grades during the time in Bridges, the vast majority maintained grades commensurate with previous grades. Post Bridges grades remained constant as well. In some cases students were granted an extension to complete work not finished at the end of the semester. When this was implemented and the work was fully completed, students were awarded grades consistent with prior performance. Perhaps the most surprising finding in this population was the consistency of grades maintained by students' pre, during and post Bridges. This may reflect that supports during the reintegration and transition period allowed students to address academic requirements while acclimating to the high school environment first as a Bridges student, and then as a student in the greater school community. Table 2 reflects the grade point averages and modifications to schedules of the ten students pre, during, and post Bridges.

The grades students receive while in Bridges reflect the impact of Bridges as a stabilizing factor and individualized approach to academic achievement. The workload was viewed as anxiety producing to the process of reentry by students. Careful planning and negotiation by Bridges staff allows students to function academically commensurate with pre Bridges performance as reflected in Table 2.

Table 2

*Grade Point Averages and Modifications to Schedules of Interviewed Students*

| <b>Interviewed Students</b> | <b>GPA pre Bridges</b> | <b>GPA during Bridges</b>  | <b>GPA post Bridges</b>                                 |
|-----------------------------|------------------------|--|---|
| Student one                 | 4.93                   | 4.22<br>2 IP grades given  | 4.95<br>Increase in AP classes                          |
| Student two                 | 2.75                   | 3.23<br>No schedule change                                       | 2.5   |
| Student three               | 3.67                   | 3.84<br>Incomplete & extension given<br>No IP or schedule change | 3.92  |
| Student four                | 2.75                   | 3.22<br>Incomplete & extension given                             | 3.0   |
| Student five                | 2.25                   | 1.42<br>Dropped a class  | 2.17  |
| Student six                 | 5.08                   | 4.5<br>No modification to schedule or classes.                   | 4.42  |
| Student seven               | 3.75                   | 3.75<br>Two IP grades assigned                                   | Remained in Bridges through the end of the school year. |
| Student eight               | 3.58                   | 3.56<br>Dropped a class  | 3.78  |
| Student nine                | 2.66                   | 2.5<br>Dropped 2 classes   | Remained in Bridges through the end of the school year. |
| Student ten                 | 3.73                   | 3.73<br>No modification to schedule.                             | 3.73  |

**Program Response to Student Need: Safe Environment**

Students frequently cite Bridges as a safe place to get caught up with work, readjust to being in school again and develop a daily routine. Students consistently report a respectful and supportive environment and a pervasive feeling of comfort during what they describe as an extremely stressful time in their lives. “They [Bridges staff] gave me

emotional and academic support and quiet time to make up missed work. I felt really safe.” (Student 3) Students indicate that while feeling supported, they were expected to progress sufficiently to eventually reenter classes and be dismissed from Bridges. “It was a safe environment and we [students] all had a common goal, to get back into school successfully. It was a very safe feeling.” (Student 5)

My observations in Bridges are supportive of the code safe environment. The primary staff is deliberately balanced between male and female. Both teachers are female and the social worker and instructional assistant are male. The reason for the intended balance is to reach each adolescent in his or her own comfort zone to communicate individual needs. During one observation the instructional assistant who is a male was present with one of the female teachers. There were eight students in the program at that time, five girls and three boys. Though it was obvious some students gravitated toward one of the adults based on his or her particular area of academic expertise, it was also evident that some students felt more comfortable with a male or female adult; often dependent on the content of the conversation. One male student cites his experience in the following excerpt; “I loved working with Mr. C. He helped me get through the day. He’d help me with my work but he’d also talk hockey with me.” (Student 4) When I observed him in Bridges he was right by Mr. C.’s side the entire time. This observation can be interpreted in several ways. From a positive perspective the student is expressing his comfort in working with a particular staff member in Bridges. It can also be looked at from a different perspective. Implications for this statement will be reviewed as a possible negative outcome of Bridges when paired with comments from the greater



school faculty.

Student reflections, grades and observations collectively identify issues of anxiety for returning students; anxiety as an emotional response to the reentry and academic anxiety to the seemingly overwhelming workload. The process of addressing the workload is achieved by Bridges teachers negotiating manageable workloads with faculty and making adjustments to grading procedures and level changes. Table 2 reflects the individual planning that is entailed for each student. Safety is an overarching code defined on multiple levels through the physical setting observed, the reduction in student anxiety as expressed by students, observed communication between staff and students and the greater school faculty. Students have assigned value to the program for the following reasons: alleviation of stress/anxiety, communication by Bridges faculty with other faculty regarding academic expectations, creating individual and manageable workloads and providing a safe environment as an initial step in the reentry process. The expertise of this stakeholder group is valued for the individuality of responses and the multiple perspectives presented.

### **Theme 2: Parent Needs**

Parents present with some similar needs as their students; specifically around the issue of safety. However, parents as a stakeholder group also reflect concerns and needs that are uniquely their own. These will be explored in this section of the chapter.

**Program Response to Parent Need: Safety**

The code of safety is reflected in parent concerns as well. Their experience with program response to their concerns is reflected in positive comments shared with the researcher. Bridges is frequently referred to as a “safe haven” and “a life saver” by parents. The following comment reflects statements made by parent 5 to the researcher. “The staff was supportive of my child and very positive about everything that could be done to reach my child’s goals. This program was a life saver for my child and I am not sure she would have been able to get caught up and graduate on time without the Bridges program.”

Parents frequently cite Bridges as a safe and supportive environment that allows students to acclimate to being back in the actual facility while establishing school routines. As described by Parent 1, her daughter’s reentry was successful because of the supportive environment provided by everyone in the program including both the Bridges staff and the peers in the program. Parent 1 describes how the program was individualized for her daughter’s unique reentry. “There was no cookie cutter approach. There was no formula or template. Everyone was there for her and she knew it and felt it.” Parent 5 indicates that even after her daughter returned to all of her classes she could still go to Bridges during free periods for “the safe haven.”

**Parent Need: Families in Crisis**

I interviewed parents of students returning from psychiatric hospitalizations, substance abuse treatment centers, medical crises and other traumatizing events. Parents of Bridges students through interview and questionnaire describe their child’s transition

back to high school as an extraordinarily difficult time for the family, and the student.

“This was a very difficult family time. My husband was very ill, my kids lost their grandparents, my stepson was in trouble with the law, my daughter was so anxious she developed school refusal issues. We were in absolute crisis.” (Parent 3)

### **Program Response to Parent Need: Interim Step to Full Reintegration**

Parents report the difficulty of the transition is moderated by the introduction of Bridges as an interim step to full reentry to classes. Parents attribute significant success to the Bridges staff in assisting and mediating the reentry process. “Our experience with Bridges during the reentry to school was wonderful. My daughter would never have been able to make it back into school without their (Bridges’ staff) interventions. They prioritized the assignments, negotiated compacting the curriculum with her teachers and taught her how to self advocate over time.” (Parent 5) A parent, with two adolescents in Bridges, remarked on the initial reintegration process through the parent questionnaire. “Both my kids were extremely anxious when returning to high school. Neither was prepared to reenter classes. Bridges staff helped get them back into school through the program. They could not have been more helpful or understanding.”

### **Parent Need: Relinquishing Responsibility**

Parents through interview and questionnaire expressed the very real need to alleviate themselves of some of the day to day planning and the actual execution of the reintegration process. They often expressed the real need to “hand over” some of the stress and problems to the Bridges staff. When this occurred, parents expressed great satisfaction with programming. Bridges staff appears to understand and recognize the

very real need of parents to alleviate themselves of some of the day to day planning and actual execution of the reintegration process.

I'll share a story from a mother's perspective. "My daughter was diagnosed with a very large cancerous tumor and was in surgery in another state within three days time. She has a very rare and aggressive form of cancer that can be cured but it's tenacious. Her departure from school was so abrupt. All of us were extremely stressed by the diagnosis and required treatments. B.'s advisor recommended Bridges to us when my daughter was strong enough to return to school. They [Bridges staff] helped her develop an individualized program to get her through the chemo and her classes with the least stress possible for both of us. She was in Bridges in March through June of 2009. Then in 2010 she had to have another round of chemo and went back into Bridges when she was strong enough to return to school. Bridges has been a god sent to us. I couldn't have managed the stress of her school expectations while attending to her health needs. You have to trust the expertise of the staff. They focused very intently on my daughter's individual needs. There was no formula; it was all about what she needed. B. never would have graduated this year if it hadn't been for the Bridges staff. I never could have handled the constant anxiety without the support of Bridges staff. I am so grateful to them." The follow up to this story is that the student elected to take a GAP year to address another required surgery and, likely, more chemo. While deferring college for one year to hopefully resolve the health issues, she has been accepted to a well known school on the east coast that she plans to attend in the 2011-2012 school year.

## **Program Response: Bridges Faculty Assume Responsibility for the Reintegration Process**

Parent 3 was referenced earlier, citing the extraordinary family issues that had evolved prior and during the reentry process for her daughter. The multiple issues the family was coping with seemed overwhelming to her. She describes her experience with the reentry process in terms of relief. “The Bridges staff coordinated everything and took a huge load off of me. I felt so happy and relieved. It was wonderful.” Parent 2 describes similar feelings of relief during her daughter’s reintegration to school through Bridges. “Our experience was extraordinary. The staff [Bridges] provides a safe environment. The program took much of the burden off my family.”

The primary question of Stake’s responsive evaluation is what is the quality of a program as defined by stakeholder groups? Secondly, what are the perceptions of quality? Parents attribute value to the Bridges program in several ways. Their perceptions, as detailed in questionnaire and interview, are that Bridges can greatly assist in the process of reentry to school through interventions made by staff on behalf of their adolescents. They acknowledge the importance of Bridges as an initial step in reintegration to this public high school. Sources of data including interview and questionnaire reflect a feeling of safety that extends beyond the realm of students. Safety for parents means relinquishing some control over the reentry process for their son or daughter. Safety for students means individual planning for reintegration, anxiety reduction, manageable workload, and adjustment to schedules and classes.

### **Bridges Faculty Response to Safety Needs of Students and Parents**

Bridges faculty indicates they understand the obstacles students face and try to ease the reintegration process. Sometimes that may mean a referral to additional agencies or mental health professionals outside of school. However, the primary component of a successful reentry consistently cited by service providers is the atmosphere of the program. Bridges faculty acknowledge the environment as the primary and most positive contribution of Bridges; providing a safe place with safe people. This is reflective of the code of safety as suggested by both students and parents.

Observation in the Bridges program supported the opinion of Bridges staff that environment is vital to the program and the impact it has on students. The room and office spaces, while very cramped, are arranged for comfort, unlike a traditional classroom. There are comfy lounge chairs and tables rather than traditional student desks. The room is decorated with bright colors and there are some comforts of home; food and drinks have been purchased for students to access when they choose. All of the textbooks and novels a student might need have been purchased for the program; again for easy access. The physical environment is warm and inviting.

While the physical environment is vital to creating the appropriate atmosphere, it is the dialogue and non-verbal communications that offer insight into the basic beliefs of Bridges staff. As with client centered therapy, Bridges staff are nonjudgmental and respectful of students. This is further reflected in conversation between students who help and support each other academically and emotionally. During observations a significant amount of time was allotted to individual academic need and tutoring, but

balanced with active listening by the adults. Problem solving was evidenced in every observation. Students were encouraged to offer solutions to their own issues and given a clear message that they were competent, capable individuals; again reflective of client centered therapy.

Maslow's Hierarchy of Needs identifies safety as a necessary precursor to higher level thinking and development. Safety needs are second only to basic physiological needs that are requirements for human survival. Maslow (1970) defines safety as an individual's need for personal security and health and general well being. Students and families who are initially introduced to Bridges are lacking in basic feelings of security. The students may pose a safety threat to themselves or others, or feel paralyzed by anxiety and fear. The school building may represent an insurmountable fortress to feelings of safety and self worth. The primary function of Bridges is to begin the process of instituting safety factors that allow an individual and his family to negotiate the road back to school and confront feelings of incompetency. It is a complex and highly individualized process that builds on the trust of faculty and families and the belief in the expertise of the Bridges staff.

### **Theme 3: Shift in Programmatic Approach**

Bridges faculty consistently report that the program was and is intended to provide assistance to students transitioning back to high school. The intended outcome is an eventual and successful reentry to mainstream classes. While the purpose of Bridges remains the same, all four interviewees explained that the original population targeted students returning from psychiatric hospitalizations and students with extraordinary poor

school attendance. This population has been expanded to include students with medical and physical disabilities that range in severity from broken legs to Crohn's disease, cancer and autoimmune deficiency diseases. Other students have been placed in Bridges because they are reportedly in a dangerous home environment with an alcoholic parent or returning from drug and alcohol treatment centers.

### **Old Outcomes for Chronically Truant Students**

During the planning stage of Bridges, there was focus on the perceived negative outcomes for students with significant attendance issues. Bridges faculty 3 indicated that, "Prior to Bridges we had been placing kids in therapeutic placements for non- attendance issues. We also had kids who wandered throughout the day and we just couldn't seem to contain them. Historically we had no effective means of encouraging chronically absentee students with any level of reengagement in school. We received some training from Chris Kearney in 2005 about using a cognitive- behavioral therapeutic approach to address issues of school refusal and reintegration to school" (Kearney, 2000). According to Bridges faculty 1, another outcome for students prior to Bridges was for non attendance students to simply stay home in bed either with real or perceived, somatic complaints. All stakeholder groups have a need for students to attend school with regularity. This need was not being met by the existing avenues provided.

### **New Outcomes for Chronically Truant Students**

Given there were the only two outcomes for chronically absent students, the introduction of Bridges provided a third and more desirable option of reentering school through an interim program, Bridges. By all accounts from Bridges faculty, the



reintegration program was always intended to be individualized based on the unique presenting problems of the individual student. Additionally, as specified in the Bridges brochure, the program was intended to be time limited with the final outcome being a return to the greater school community with or without a modified schedule. The Brochure published in 2007 indicated it was the intent of the Bridges faculty to return the student to his original course load as soon as possible. Now the more expansive outcome as shared by Bridges faculty 2 is as follows. “Successful reintegration means helping a student find the right path for him or her. It does not necessarily mean reintegrating to a student’s original academic schedule.”

### **Reintegration to the Greater School Community is a Student, Parent and School Expectation**

Subsequent to reentry to high school through Bridges there is an expectation that reintegration is not completed until the student is reintegrated to the greater school community. Bridges staff place importance on gently pushing students back into some kind of school routine. Using clinical judgment and gauging student progression with academics and emotional stability, the staff initiate a gradual return to the greater school community. “The clearest barometer for me of successful reintegration is when a student has the ability to attend school consistently, absent huge anxiety.” (Bridges faculty 1) “When a student is back in all mainstream classes and doesn’t need us anymore is when we understand the impact of Bridges.” (Bridges faculty 2)

#### **Theme 4: There are Multiple Perceptions of Bridges and the Function of Service Providers [Bridges Faculty]**

The ability of Bridges faculty to effectively reintegrate students into the school community requires an understanding by all stakeholders of the role of Bridges and the faculty providing services. Though the role of Bridges staff will be investigated more thoroughly in Research Question 2, it is significant to understand whether the more distal stakeholder group represented by the greater school faculty has a clear and realistic perspective of the function of Bridges. As faculty are partners in the process of referring students to Bridges and accepting students as they are dismissed from Bridges, student reintegration is influenced by the understanding and actions of the entire school community.

#### **Perceptions of Bridges Through the Lens of Bridges Faculty**

Service providers reflect on the impact of Bridges through the eyes of the greater school community. Each of the four faculty interviewed agree that Bridges reaches into all departments in the school community and beyond. They believe that support for the program has grown over the years as faculty has become more aware of the programming as a transition option for students requiring reentry services. This is significant as the success of the program is dependent on an awareness and understanding of the function of Bridges by all stakeholders.

“Our services are so integrated into the community that we have become part of the fabric and culture of the school. We’ve started meeting with sophomore advisories, student guidance and support groups of which all students are enrolled, at the beginning of the school year to tell them about the program and the changes that evolve with the sheer number of students we see annually.

We've also received grants from the school's foundation to buy textbooks and we've been asked to present to the Board of Education and parent groups about the services provided by Bridges. Some faculty members volunteer their free time to work with their Bridges student in their area of expertise. All of this serves to make our work better known and Bridges better understood." (Bridges faculty 2)

## **Perceptions and Understandings of Bridges Through the Lens of the Greater School**

### **Faculty**

The faculty questionnaire was distributed to all certified staff at the multi-grade campus. One third of the questionnaires were completed and returned to the researcher. Every department within the school was represented indicating the faculty is aware of the Bridges program and, in many cases, have had some first-hand experience with the program through "shared" students. No questionnaires were returned indicating no knowledge of the program. Therefore, it appears that the Bridges program has reached into all departments and disciplines within the school it serves. The lowest participation rate was administration with only one questionnaire returned.

Results of the faculty questionnaire reflect the impact of Bridges in facilitation of reentry for students to this school from the perspective of the greater school community. Members of every department in the school indicated that they had recommended students to the Bridges program which would seem to reflect some understanding of how the program impacts students. Respondents to the questionnaire further indicated that approximately half understand the purpose of the program while better than two-thirds understand the diverse population Bridges currently serves. The purpose of Bridges is to provide tutorial, mental health services, transition services and support for students

through advocacy and case management. It serves regular education and special education students experiencing acute emotional distress, students returning from hospitalization and treatment centers, students with school refusal and students who have missed a significant amount of school due to medical illness. Table 3 provides the percentages of faculty respondents who understand the purpose of the program and the population Bridges serves by department.

Table 3

*Percentage of Faculty by Discipline who Understand the Purpose of Bridges and the Population it Serves*

| <b>Department</b>  | <b>Number of Respondents</b> | <b>Percentage understanding purpose of Bridges program</b> | <b>Percentage understanding population served by Bridges</b> |
|--------------------|------------------------------|--|--|
| Administration     | 1                            | 100 %  | 100%   |
| Department unknown | 3                            | 0%   | 66%  |
| English            | 7                            | 71 %   | 86%  |
| Fine Arts          | 6                            | 100 %  | 83 %   |
| Kinetic Wellness   | 9                            | 100 %  | 100 %  |
| Mathematics        | 14                           | 43 %   | 50 %   |
| MCL                | 10                           | 60 %   | 90 %   |
| Post HS Counseling | 3                            | 100 %  | 100%   |
| Practical Arts     | 5                            | 60 %   | 80 %   |
| Science            | 12                           | 50 %   | 75 %   |
| Social Studies     | 6                            | 50 %   | 66 %   |
| Special Education  | 16                           | 75 %   | 68 %   |
| SW & Student Serv. | 6                            | 83 %   | 83 %   |

### **Misconceptions of Bridges**

The results of Table 3 reflect misunderstandings of program purpose and populations being served. This may be viewed as a communication issue between Bridges staff and the greater school faculty. A substantial percentage of the respondents were unclear as to the purpose of Bridges and the population it serves. While those statistics are indisputable, it is also the understanding by faculty that Bridges represents a safe place for some students to reenter high school and get caught up in work. Misconceptions by faculty have the power to inadvertently impact reintegration of students particularly during the referral and dismissal stages.

The greater school faculty claims to understand the population Bridges serves but there were two misconceptions occurring in their responses. The faculty expressed confusion as to whether the program is intended to serve special education students or general education, mainstream students. Although the program was intended to serve general education services initially, there are some students in special education who have benefited from the program. The source of the confusion I believe stems from the staffing of Bridges. Though the original intent was to staff the program with general education teachers representing the humanities and math/sciences, the program was initiated with special education teachers. This staffing continues to this day; partially due to the expertise required specifically around the task of case management of which special education teachers are explicitly trained in. Additionally, the oversight administrator oversees all special education programming. There is an ongoing dialogue about replacing the special education teachers in Bridges with general education teachers

and replacing the oversight administrator with one of the assistant superintendent's positions. As of now, there is no definitive resolution or time line to affect this change in staffing.

The second misconception about the population Bridges serves involves students with chronic attendance issues. Students with school refusal were not routinely identified by faculty as a qualifier for the Bridges program. This may be attributed to misconceptions about the actual nature of school refusal in general. This population is frequently relegated to truancy status and legal interventions as opposed to remediation and reconditioning interventions. The term school refusal evokes a negative stereotype of students who are defiant and disinterested in academic achievement. Regardless of the reasons for confusion regarding the population being served in Bridges, some students in this public school might never be identified for assistance through Bridges. A more comprehensive understanding of the multiple presenting symptoms of students in the program may elicit additional and appropriate referrals to the program. Students with school refusal were in fact one of the two original populations identified by the 2005 committee as requiring alternative programming. The challenge for Bridges faculty is to extend understandings of the program and minimize misconceptions for all stakeholder groups. Some measures to address this issue have been instituted on the Bridges website. The referral process and roles of referring staff are a recent addition. However redundant it may seem to Bridges faculty, the information they provide is not currently reaching many of its intended recipients.

Table 4 reflects the misunderstandings by the greater school faculty in

understanding the goals of Bridges and most significantly, how to implement the referral process for a student or where to learn about the process. This is significant as many referrals are initiated by this population. Bridges personnel have responded to a request for more information by faculty by developing a Bridges Manual for Teachers. The manual provides information in the following areas: Bridges contacts, attendance, assignments, deadlines, communication, blackboard, grading options and curriculum exemptions. The manual does not address the referral and enrollment process or the specific role classroom teachers have as source referrals. As there remains much confusion as cited in Table 4, Bridges staff have an opportunity to expand understandings of the process by inclusion of this information in the Teacher's Manual.

### **Positive Understandings of Bridges**

Responses to individual questions on the survey support the assumed understanding that Bridges has had a positive impact on the school population. A high percentage of the faculty respondents indicate they view Bridges as a positive addition to services for students with an equal percentage indicating the program should continue. Table 5 indicates the percentage of faculty respondents who view Bridges as a positive addition to student services and believe the program should continue. Positive perspectives of the Bridges allow the program to initiate, continue and bring the process to successful closure through completed reintegration with the support of classroom teachers. Absent this, full reintegration could be compromised.

Table 4

*Faculty Misconceptions*

| <b>Department</b>  | <b>Number of Respondents</b> | <b>Percentage understanding goals of Bridges</b> | <b>Percentage understanding referral and enrollment process</b> | <b>Percentage understanding where and how to access information about Bridges</b> |
|--------------------|------------------------------|--|---|---|
| Administration     | 1                            | 100 %  | 0%  | 100 %   |
| Department unknown | 3                            | 66 %   | 66 %  | 0 %   |
| English            | 7                            | 43 %   | 14 %  | 29 %  |
| Fine Arts          | 6                            | 66 %   | 6 %   | 50 %  |
| Kinetic Wellness   | 9                            | 56 %   | 11 %  | 66%   |
| Mathematics        | 14                           | 57 %   | 21 %  | 66 %  |
| MCL                | 10                           | 60 %   | 30 %  | 50 %  |
| Post HS Counseling | 3                            | 33 %   | 0 %   | 66 %  |
| Practical Arts     | 5                            | 80 %   | 20 %  | 60 %  |
| Science            | 12                           | 50 %   | 25 %  | 50 %  |
| Social Studies     | 6                            | 66 %   | 50 %  | 100 %   |
| Special Education  | 16                           | 88 %   | 75 %  | 75 %  |

**Negative Perceptions (Reliance on Program)**

While Bridges is acknowledged as having a positive impact on students as illustrated in Table 5, some of the comments in the narrative section of the faculty questionnaire and responses from student interview support the notion that Bridges can also have a negative impact on students. A science teacher expressed the following; “It [Bridges] sometimes seems to be more of an enabling process.” This position is



supported by others who question if the time in Bridges is appropriate for the amount of academic work actually completed. “The work returned to me was minimal for the amount of time spent in Bridges.” (Science teacher) Time spent in Bridges versus classroom instruction poses other difficulties for faculty in grading procedures. “It is difficult to figure out how to assess/grade students who have missed a significant amount of classroom time.” (Modern and Classical Languages teacher) Given these comments from faculty, there is difficulty reconciling whether time spent in Bridges can be viewed as equivalent to participation in classroom instruction, and perhaps more importantly, the program is being questioned for its enabling properties.

When this information from faculty is compared with student responses, a similar concern evolves. Referenced earlier was student 4 who became attached to a Bridges faculty member and was observed shadowing the staff member during observations. It may be possible for some students to become overly reliant on the program and Bridges faculty. During interviews student 6 indicated, “The program can be very addictive. On the last day I was sad I had to go.” Student 3 described her experience in Bridges. “It is truly a heaven on earth; easily one of the most important and beneficial programs in the school. The teachers are absolutely unbelievable in everything they do.” While the student intended this comment to be a positive appraisal of the program and faculty, it evokes concern that students could become too comfortable in Bridges and dependent on the faculty and program. During an observation one student speaking with the instructional assistant said he felt he could be more productive staying in Bridges the entire day. The instructional assistant countered with, “You’ve worked your way back

into chemistry and your teacher will expect you to be there. I know you can handle it or we wouldn't have made the decision with you to return to the class." The student reluctantly agreed to go to that class in the afternoon. This discussion reflects the concern about over dependence on the program and staff.

Table 5

*Percentage of Faculty by Discipline who View Bridges as a Positive Program and Believe it Should Continue*

| <b>Department</b>  | <b>Number of Respondents</b> | <b>Percentage identifying Bridges as a positive student service</b> | <b>Percentage indicating Bridges should continue</b> |
|--------------------|------------------------------|---|--|
| Administration     | 1                            | 100 %   | 100 %  |
| Department Unknown | 3                            | 100 %   | 100 %  |
| English            | 7                            | 71 %  | 71 %   |
| Fine Arts          | 6                            | 86 %  | 100 %  |
| Kinetic Wellness   | 9                            | 78 %  | 89 %   |
| Mathematics        | 14                           | 100 %   | 100 %  |
| MCL                | 10                           | 100 %   | 90 %   |
| Post HS Counseling | 3                            | 100 %   | 100 %  |
| Practical Arts     | 5                            | 100 %   | 100 %  |
| Science            | 12                           | 75 %  | 75 %   |
| Social Studies     | 6                            | 83 %  | 100 %  |
| Special Education  | 16                           | 100 %   | 100 %  |
| SW & Student Serv. | 6                            | 100 %   | 100 %  |

### **Program Response to Reliance on Bridges as a Negative Concern**

Bridges staff is aware of the potential negative outcome of becoming overly reliant on the program and staff. As expressed by Bridges faculty 1, “We’re careful not to foster dependence as this could do more damage than good.” Bridges staff place importance on gently pushing students back into some kind of school routine. As stated previously staff use clinical judgment to gauge student progression with academics and emotional stability, prior to initiating a gradual return to the greater school community. The process is addressed through attempts to quantify readiness for reentry to classes. Readiness includes being caught up academically in classes and demonstrating consistent attendance in school. There is currently no additional strategy employed by Bridges faculty to insure students are progressing towards full reintegration to school absent reliance on Bridges. While reintegration is a stated goal of Bridges faculty, student reluctance and faculty understanding may undermine the intended outcome for certain individuals.

Students and parents present with immediate needs that require a proactive response during the reentry meeting and introduction of Bridges. Bridges faculty respond to these needs by alleviating stressors associated with anxiety by making recommendations for grading procedures and alternative scheduling options. They provide a safe environment as defined by both students and parents.

Additionally Bridges faculty are proactive in assisting families in crisis and assuming a primary role in the initial reintegration of the adolescent. They provide a process, a program and an individualized plan to assist the transitioning student. Through

this process and the extension of services to students deemed truant, Bridges faculty have programmed for students formerly placed in alternative therapeutic schools by the district. The greater school faculty has many positive perspectives of the Bridges program but some question the possible outcome of over reliance on the program and staff.

Research Question 2 is designed to provide the reader with specific procedures and interventions employed by Bridges faculty to insure successful outcomes for transitioning students.

*In what ways does the Bridges program support successful reintegration of students to a public high school subsequent to a prolonged absence or psychiatric hospitalization?*

I distinguish between Research Question 1 and Research Question 2 by utilizing the following criteria: research question 1 reflects the process and perceived impact of reintegration of students to public high school while Research Question 2 describes the “nuts and bolts” or the “how to” of the reentry process. There are inevitably overlapping themes that evolve from each research question as reflected in responses from all stakeholder groups. Each stakeholder group identified a number of supports provided in Bridges that they believe results in successful reintegration to the high school. There was a variance between groups as to what supports were acknowledged as primary in the process though the overriding theme that emerged from all stakeholder groups was that Bridges provides a supportive environment with safe people. Observation and review of documents further identified specific supports that contribute to successful reintegration.

These have been triangulated with stakeholder groups.

There is a convergence of data supported by all four stakeholder groups regarding the importance of Bridges in providing returning students with a supportive community. Staff and students note specifically a reduction in stress for both students and their parents as critical to the theme of supportive community. I was not able to observe meetings between staff and parents as observations took place at the end of the school year when there are few if any new referrals to the program. However, through parent questionnaire and interview, it is apparent that a supportive community includes the elements of safety and trust as critical to the environment.

The roles of teachers in the program are defined by all stakeholders as academic. While this is accepted as appropriate, the role of advocate/ communicator is controversial. Results of the faculty questionnaire indicate there are some issues regarding the appropriateness of Bridges teachers acting as negotiators for the scope, amount of work and deadlines students are required to address. Additionally, the questionnaire indicates that communication with faculty has not been achieved to the degree Bridges faculty would like. This is supported by parent interview and questionnaire.

There are critical periods in the reintegration process as identified by stakeholder groups that include the reentry to school through Bridges, reentry to classes and dismissal from Bridges. A customized approach with individualized student plans is identified as an essential component of the program by students, parents and Bridges faculty. This is supported through a review of documents relating specifically to attendance and

questionnaires. The customized approach enhances the reintegration process.

Results pertaining to this research question can be analyzed in tandem with outcomes as described in research question one. They can be further analyzed in regard to positive and negative outcomes. The theme of supportive community is interpreted as one that provides adult and peer support, alleviates anxiety, advances school routines and positive attendance patterns, and assists individuals with specific plans to augment complete reintegration. The role of the Bridges teachers results in manageable workloads for students so reintegration is possible. The role of teachers, according to students and parents extends beyond academics. They are recognized as emotional supports both for students and their parents.

The theme of negative impact of Bridges is identified by some participants in the faculty questionnaire and, frequently and inadvertently in students' responses. There is an underlying theme of reluctance to rejoin the school community for complete reintegration. Students express a dual understanding of Bridges as an initial response to reentry but a desire to have the program be an end in and of itself. Parents also reflect on their son or daughter's comfort with the program and their hesitancy to reengage in the general school community. Bridges faculty communicate through deed and action that the process is not complete until full reintegration has occurred as depicted in customized plans. However, they are sometimes hindered by the hesitancy of students to advance beyond the initial stage of reintegration.

As discussed in the literature review, school based mental health programs are recognized as a valuable resource to communities when they are tailored to the individual

needs of the community. A school based mental health program needs to reflect the unique population for which it is intended. The program needs to be responsive to the stakeholder groups for which it was designed. Bridges is valued by all stakeholder groups for its supportive community and customized approach to the reintegration process. R.E. Stake (1995) indicates that stakeholder groups assign particular value to the human experience and interactions between individuals and groups. Reflective of this is the identified positive interactions in the program and the success of reintegrating individual students to this high school through the supportive efforts of Bridges staff. Stake (2004) indicates that the quality of a program is determined by individual stakeholders and personal reflection. Emerging from all stakeholder groups are positive reflections on the program, the process and the staff.

### **Theme 5: Supportive Community**

Students identify a number of factors that contribute to their successful reintegration to high school. Many of them can be grouped under the theme of a supportive community. They include the role of Bridges faculty, the support offered by peers in the program and the general, calming atmosphere experienced by students in Bridges. Student perception is that the reintegration process can be very successful when a supportive community initiates, assists and guides the process.

#### **Tutoring Role of Bridges Faculty**

Central to a supportive community is the roles assigned to Bridges staff. Bridges students, past and present (at the time of data collection), attribute successful reintegration to the academic and emotional support they receive from Bridges staff.

Specifically they cite the individual academic tutoring as particularly helpful when they have been absent for a sustained period of time without the traditional instruction provided in the classroom. Students report that the staff collectively has expertise in all subject areas. Student 4 indicates that the faculty “helped me find out what my assignments were and then helped me with the assignments.” Student 4 stated the faculty also helped her find out what her make- up work was and “helped me mostly with math.” My observations in Bridges confirmed the tutoring component of the program in Bridges. As students in the program are representative of the greater school population, the assignments were from multiple disciplines and representative of the multiple levels of difficulty. During an interview with Bridges faculty 2, similar understandings were reported. “We get all the assignments a student owes, help students prioritize assignments and create a time line for work completion on a calendar. We provide tutoring in all subjects and at all levels from the lowest to the advanced placements.” I observed a staff that recognizes their own strengths and limitations in academics. Students were logically directed toward the adult having the most expertise in a particular subject. As student 5 indicated to me in an interview, “Ms. P. was the math lady, Ms. Z. the organization lady and Mr. C. was the science guy.” Three of the four faculty members participate in tutoring students. The social worker does not provide tutoring as evidenced in observations and through faculty interview.

According to students, Bridges teachers tend to focus on one class at a time so the work seems manageable. One of the primary tools to assist with tutoring and reintegration cited by students is the use of “to do lists” generated by the Bridges



teachers. Lists are reportedly developed daily for individual students. As work is completed, it is crossed off the list. This allows the student to experience daily accomplishment of tasks without the accompanying anxiety of having an exorbitant amount of work to complete. Student 3 reports the process of making up work as follows; “I was able to catch up on work without feeling like I was drowning. I wouldn’t have been able to do it without Bridges.” Once a student is caught up in a particular subject area, the reentry process to that class is discussed and agreed upon with input from staff and student. Student 9 shared the following role of faculty during the interview. “They talked to my teachers, made lists of missing work which made it easier to check things off as I finished them.”

### **Advocacy and Communication Role of Bridges Faculty**

All of the students interviewed indicated they felt supported by Bridges staff with a particular focus on the role of the teachers as negotiators with the greater school faculty. “They talked with my teachers, got work extensions when I needed them, got the tests when I ready to take them and communicated with my teachers. They gave me extra attention and help in all subjects.” (Student 10) According to student 2, “They [Bridges staff] were there to help me whenever I needed it. They got work extensions for me and had all my tests there [in Bridges] when I was ready to take them.” The impression students have of the faculty as negotiators is consistent with previous findings that the staff actively work to make the workload manageable. It is also consistent with comments from a science teacher who wrote, “I do not agree with Bridges staff members asking teachers to excuse or drop assignments for students.” Though this type of

comment was infrequent it may reflect the opinions of some staff who declined to complete the survey.

Further, students consistently indicate the communication provided by Bridges staff on their behalf was especially comforting. When emailing students' teachers, Bridges staff ask students what they want shared. As student 1 noted, "They [Bridges staff] were aware of everything going on with me and they shared information with others only with my approval. They had a real willingness to work with me especially when I was overwhelmed. They helped me to figure out what to say when people asked me why I was gone."

Student 3 relates her experience in the following comments. "They [Bridges faculty] hooked me up with social work, talked with my teachers, and helped me catch up on missed work. They kept me going by being supportive academically and emotionally. They gave me the support and push I needed."

Bridges faculty view themselves as advocates and primary communicators for students enrolled in the program. The case manager, one of the two Bridges teachers, notifies all relevant staff of a student's enrollment in Bridges. Bridges faculty 2 describes her role as case manager as the primary communicator and liaison for students, faculty members, service providers and parents. She chronicles what the student accomplishes daily on a software program, Blackboard, which can be accessed by appropriate staff. Blackboard also provides Bridges staff with a written log of individual student progression and can be used to chart student attendance. Case managers provide academic and emotional support and serve as a liaison to the greater school faculty. They

facilitate student/teacher dialogue to assist faculty with understanding and empathizing with students. They provide reasonable routines for students to acclimate to the school environment; eventually expanding into the greater school community as the student progresses. Bridges faculty recognize advocacy and communication as a means to facilitate full reintegration. Students view advocacy as a positive outcome of the program from which they benefit. Parents recognize advocacy more frequently as a means to address and alleviate issues of severe anxiety and school refusal for their adolescent. Collectively these three stakeholder groups attribute value to the advocacy provided in the program. While advocacy is a shared value, they originate from different perspectives as indicated by the three stakeholder groups.

Providers stress and teach the importance of organizational skills while evaluating the appropriateness of a student's schedule or program. Bridges faculty member 1 shared the following insight; "Students may be overscheduled. This happens a lot. We work to get them into a regular program that is not necessarily the original schedule. That's a sign of success." Consistent with student reports, Bridges faculty intervene to make school manageable for students. The administrator for Bridges describes the case managers' roles as, "Generalists in academics and specialists in case management." This is also consistent with student reports of personal experience.

The greater school faculty tends to view Bridges faculty in a more one dimensional role according to the faculty survey. The majority of faculty indicates they understand the role of the teachers and social worker in the Bridges program. They identify the role of teacher as the academic component of the program. Teachers are

understood to assist students with getting caught up on prior assignments and, subsequently, focusing on current assignments to prepare the student for reentry to classes. The social worker is understood to provide services to alleviate anxiety and stress that interfere with the individual's capacity to reenter classes. There is minimal understanding of the complexity of services provided by Bridges staff including the coordination of multi-disciplinary services within the school community and enlistment of mental health providers extending beyond the school community.

### **Peer Support in Bridges**

Bridges students indicate that part of their successful reintegration can be attributed to other students in the program. Student 1 reports peers in Bridges as being "friendly and warm when welcoming new members to the program." Student 5 shared her experience with me during an interview. I paraphrase her reflections. At first I didn't want to be part of the program and felt like I was just being pushed into it. But once I was there, "I got a lot of support from the group [peers]. There were others in the same situation as me. We all had a common goal; to get back into school successfully." The translation for me is that despite feeling somewhat coerced into becoming part of Bridges, she felt supported by others in the program with whom she could relate.

During my observations in Bridges I viewed students on multiple occasions supporting each other through dialogue and non-verbal communication. Student 9 who had returned from a psychiatric hospitalization due to suicidal ideation said to a student sitting beside her, "I feel like we're all in the same situation. The group support is great."

Student 4 was observed saying, "I wish I could stay in Bridges all year. The kids

here just accepted me when I came into the program. They didn't really care about why I was gone. They just welcomed me." Comments like these reflect the intent of the programming developed in the 1980's to positively engage the support of peers through similar experience and empathy. However, these comments present a double edged sword in that the issues of over dependence on the program and staff can be the result of the supportive environment.

### **Atmosphere**

Bridges faculty 1 indicated during an interview that, "Some of the students we see don't require any specific emotional support through therapy, but they rely heavily on the atmosphere of the program. It's a safe place with safe people."

A teacher in fine arts stated, "We are so fortunate to have this program [Bridges]. It's always in the best interest and well being of the student. Until a student is in an atmosphere where they feel safe they cannot function productively. Bridges fills that role."

Humanistic psychology indicates that environment influences and shapes one's experiences. Students frequently referred to the atmosphere of Bridges as supporting reentry. Student 8 says, "The best thing about Bridges is the environment. It feels safe to talk about anything." As will be discussed in this chapter, atmosphere is also defined by two other stakeholder groups, parents and Bridges faculty, as critical to the program. Aside from the physical attractiveness and comfort of the space as discussed by students in interviews (Student 5, 2 and 8), one code that repeatedly emerges is the reduction of pressure experienced by students while in Bridges. Student 5 reflecting on her

experience; “It was a relaxed atmosphere, free from stress and pressures and everyone (faculty and students) had good communication. No one ever made me feel like I was on my own. The other kids in the program understood how hard it was getting back into school.” Other descriptors students used when citing the atmosphere of Bridges were “calm” (Student 9), “safe” (Student 9), “relaxing” (Student 1) and “comfortable” (Student 7). The atmosphere of Bridges is consistently cited by students as positive and supportive of the reintegration process. As previously stated, while the atmosphere is supportive of the reentry process, it can have a negative impact of deterring students to regain full reintegration to the greater school community. Student 6 reflects on her experience. “I think a student should be allowed to stay as long as she’s making progress.”

During observation in Bridges, the words that repeatedly come to mind are safety and trust. Students indicate their sense of safety and trust in the staff through conversation and non- verbal indicators. As students enter the room they are routinely greeted individually and with a positive comment such as. “I’m glad you’re here.” Likewise, personal messages are shared with students as they exit the classroom. While in Bridges the staff works to engage each student in conversation. I often observed students sharing with staff their perceived needs and concerns. The general atmosphere in the program is supportive and non- judgmental. Students are encouraged to problem solve and are verbally rewarded for their efforts. At the same time, I observed students sleeping and not engaged when they were feeling overwhelmed and exhausted with the sheer effort of “showing up.”

On another occasion I observed a student being aggressively argumentative to which the teacher (Bridges faculty 4) replied, “You don’t always get to choose what you want to do. Sometimes you just have to do what you’re supposed to do.” Her tone of voice was flat and modulated but the message was clear; you need to do what you need to do. Reflecting on these interactions, I am aware of the expertise of the Bridges staff and their critical understanding of students as individuals. Bridges faculty clearly distinguishes between a stated need and an attempt to manipulate a situation. This versatility of thinking stems from a thorough understanding of each student as an individual.

### **Theme 6: Customized Plans for Students**

As previously suggested there is a concerted effort by Bridges staff to individualize the Bridges experience through to do lists, calendars and academic expectations. As will be discussed in more detail with research question 3, individualized plans were developed for therapeutic purposes as well. Students, parents and faculty identify critical periods of time in the Bridges experience for thoughtful attention to customized planning. These critical periods of time are during the initial reentry to school through Bridges, dismissal from Bridges and reintegration to the greater school community.

Student 9 shared her story with me which I paraphrase. I had been out of school for a long time with all kinds of emotional problems. Things at home were awful and I felt like everyone was criticizing me. I didn’t want to go anywhere or do anything. I just withdrew from people, everything. I’d lost some friends during this time because I was

so depressed and scared of what would happen to me. The work was piling up and I just couldn't do anything. I was scared staying at home because I kept getting further behind and I was scared to go back to school because I figured people would ask me all kinds of questions and treat me like a freak. My social worker convinced me to try Bridges. Eventually I did. It was very hard going into school that day but the teachers and everyone were so nice in Bridges. I felt safe. I stayed in Bridges for quite a while before I felt comfortable being part of the bigger school. I gradually started to get some confidence back and felt satisfaction that I was actually getting things done. The social worker was in contact with my therapist so I felt like everyone knew what I needed. It was a secure feeling of being taken care of while they (Bridges staff) encouraged me back into classes. They prepped me ahead of time so that I wouldn't stumble over the awkward questions like where have you been? I was very sad when I had to go.

When questioned about a dismissal plan from Bridges and full reintegration to classes students consistently report having an individual dismissal and reentry plan but with some similarities. Reminiscent of Client Centered Therapy, students are participants in determining the plan and approximate time line but frequently commented that the plan could be flexible according to need and the unexpected that can occur. Most students report a similar experience such as, "I stayed until everything was checked off the list (the to-do lists) and I was caught up and ready, and then I was dismissed." (Student 5) Student 6 expressed her dismissal this way, "It's very situational. You're phased out of the program as you're ready."

There were exceptions to the standard process of dismissal and full reentry as



explained by several students with chronic illnesses that required multiple reentries to school through Bridges. For those students it became apparent that Bridges could serve students in a different capacity. There were times as reported by students that they were too sick to go to classes but felt they could accomplish something, even with a shortened day, if they could simply work in Bridges. This was accommodated with a number of students I interviewed. As with students with more conventional dismissal and reentry plans, students report missing the comfort, the constant care and support of teachers, the atmosphere and minimal pressure and, mostly, the feeling of safety. One former student, student 3, quoted earlier as saying, “It is truly a heaven on earth; easily one of the most important and beneficial programs in the school. The teachers are absolutely unbelievable in everything they do.” This student resumed her normal schedule successfully after two months in Bridges through a gradual phase out dismissal plan.

One parent characterized her daughter’s reentry as follows. “My daughter experienced serious cyber bullying that left her incapacitated. She was absolutely overwhelmed at the thought of returning to school and seeing the girls who victimized her. We used the Bridges program to get her back into school, twice. She didn’t have to go to the lunchroom or places in the school that made her uncomfortable. She never would have made it without Bridges.” (Parent 4)

Another parent reports the following experience. “My daughter had been hospitalized and had been very sick. Bridges was suggested to us at her reentry meeting. My daughter was traumatized by the idea of returning to school and her anxiety was huge. It was extremely difficult for her to reenter the building at all. The first day I

walked her to Bridges and she was able to stay only an hour. The time in Bridges was gradually increased until she could tolerate a full day.”(Parent 2)

These stories from parents of Bridges students are typical of the responses I gleaned through interview and questionnaire. The reentry meeting is a critical time for parents and students to learn about the program and tailor a reintegration plan that’s suitable for the individual student. The majority of students entering the program have experienced a traumatic event. At the reentry meeting, the focus is on devising a plan that allows the student to feel safe and supported. As expressed by Parent 4 and 2, getting the student back into the actual building can be difficult. Parent 1 reports she became part of a team at the reentry meeting and helped design the actual program for her daughter. Parents attribute significant importance to the reentry meeting in determining what the student feels is tolerable and how actual reentry to the building can be accomplished while minimizing stress. Parent 9 indicates at the reentry meeting, “Trust the experience of the staff. Be open to their input. They really want to work with you to make the process successful.” Parents expressed tremendous satisfaction with the individual plans that were drafted at the reentry meetings for their son or daughter. As previously mentioned, some students require repeated reentries due to chronic illnesses and hospitalizations. Parents indicate that their adolescent found each successive reentry to be a little easier as they understood the process actually can work.

Gradual transition back into the greater school community is another time that parents indicate as critical for their child’s successful reintegration. Parent 1 indicates the dismissal plan from Bridges and reentry to classes was excellent. “It was designed with

her in mind, no one else.” Exit requirements from Bridges are generally twofold: the student is caught up in classes and is emotionally stable, enough so that regular attendance has been achieved. The dismissal plan always involves Bridges staff, the student and his or her advisor. Ancillary staff may include parents, a grade level adviser chair, health care practitioners, school psychologists, mainstream teachers and community agencies. One parent describes her son’s dismissal plan as follows, “This was handled between my son and Bridges staff. I left it up to them. He gradually transitioned back into each class as he was ready. He also dropped a level in one class and I trusted their judgment in that decision. Initially my son felt that was punitive but he came to agree with that option to alleviate stress.” (Parent 8)

Parent 3 referred to the continued planning for Bridges students as, “Devising and revising the game plan.” This speaks to the continuous need to reassess the student’s progress in the reintegration process and consider viable options supportive to that end.

All four stakeholders groups acknowledge the importance of a supportive community to assist transitioning students with reengagement with school. Critical periods of time for reengagement are identified as initial reentry, reintegration to the greater school community and dismissal from Bridges. The factors that create a supportive community include the role of Bridges faculty as academics, advocates and communicators on behalf of Bridges students. Additionally the staff attend to factors that may contribute to student stress by reassessing schedules through individualized plans. Identified primarily by students and, secondarily, by parents is the positive role peers in the program have in establishing a supportive community. They are attributed with

fostering a caring and nurturing environment in tandem with staff.

Lastly, responses to this question acknowledge the possibility of over dependence on Bridges and program faculty. Of the four stakeholder groups Bridges faculty are most aware of this as a negative outcome. Some greater school faculty also acknowledge this as a possibility and students, almost unconsciously, frequently express desire to remain in the supportive environment beyond the required actual need for the program.

An observation from my perspective is that there is a convergence of factors that foster the calming, supportive environment. Customized programming is integral to academic supports and emotional supports. Mental health is also primary in customized planning and a supportive environment. The interaction of these factors addressed simultaneously insures the supportive environment. Emotional support is explored in the next research question; again through the lens of stakeholders.

*What are the stakeholders' perceptions of the Bridges program as a means to assisting students with mental health care concerns?*

Each of the stakeholders groups recognize mental health supports as a vital component of Bridges. However, students, parents and Bridges staff view this role as a primary component of the program while the greater school faculty tends to assign the role of academics as the primary component of the program with mental health supports being secondary. Observation in the program and a review of documents supports the perception that mental health care is a critical component of Bridges.

Mental health supports provided in Bridges are reflective of humanistic psychology and Stake's responsive evaluation; both of which have a constructionist view

of human beings and their basic goodness. Stake (2004) says that, “Responsive evaluation is responsive to stakeholder concerns. The understanding of goodness rather than the creation of goodness is its aim” (p. 89). When addressing the mental health supports required by individuals in Bridges, the focus is on the present and the capacity of individuals to make choices, accept ownership for personal actions; be they positive or negative. Personal growth and understanding can be achieved by individual effort to continuously seek opportunities for self improvement.

The language of humanistic psychology, responsive evaluation and Bridges is emotive. Each of these approaches acknowledges the goodness, value, worth and positivity of individuals and the free will to make changes. Perceptions of stakeholders provide the lens for understanding the quality of a program. Just as works of art do not hold a singular true value, a program has no single true value. Its value is reflected in the many responses of different stakeholders with different perspectives.

The role of mental health supports in Bridges is intended to provide the necessary therapies for students to reengage in academic and social/ emotional, personal growth. The outcome of successful mental health interventions is personal availability for the reintegration process to occur. With appropriate supports the individual is able to affect change, engage in continuous self improvement and recognize the internal power of self determination.

### **Theme 7: Emotional Support is Provided by All Bridges**

#### **Staff and Ancillary Staff**

Interestingly, students identified all of the Bridges personnel including the social

worker, teachers and instructional assistant as contributing to mental health. They did not distinguish the roles of the staff as instructional or therapeutic but identified all staff as contributing to overall mental health. Student 10 identified all Bridges faculty as mental health supports. “If you need someone to talk to, they [Bridges staff] are always available to you.” Most often students identified the program as safe with safe staff; meaning there was someone who would listen to individual needs, was aware of individual struggles, and who actively worked to deescalate pressures and feelings of becoming overwhelmed. Student 3 identified mental health supports as, “Therapy through social work and teacher support.”

In some cases the certified staff, social worker and teachers, worked collaboratively with outside therapists or made referrals to therapists and agencies as the need arose. For that reason, the district contracted with a child and adolescent psychiatrist well known in the community. He became an auxiliary staff member to whom referrals for additional evaluations and recommendations could be directed.

Reaffirming what students report through interview and questionnaire, parents attribute emotional support to all Bridges faculty. They do not make a distinction between staff members in the mental health supports offered in Bridges. Parent 1 reflects on the supports. “They [Bridges staff] provide an extremely supportive environment. My daughter worked with the social worker but seemed most comfortable with the teacher she was assigned to her. When she needed to return to Bridges she worked with the same teacher again by choice.”

Parent 3 described her personal experience with Bridges. “My primary contact

was the social worker. I trusted the staff to make good decisions. The kids are under so much pressure when they enter the program. They're feeling like everything is hopeless. The social work services and counseling were wonderful. We had been very frustrated with the outside mental health services we were receiving. Our experience with the mental health supports was extremely positive. You know, I think it's good therapeutically for the kids to get together and share their problems and hopes. My daughter learned one of the girls enrolled in the program had cancer. Another had just had a baby. She said I didn't know there were those kinds of problems in school. I think it helped her put her own serious issues in some kind of perspective." The daughter of this parent graduated this year and was accepted to the college of her choice.

Choice is an important component of a student and parent's experience in Bridges. Parent 4 reflects on her experience with mental health supports in Bridges. "My daughter chose not to access the mental health supports offered as she was seeing an outside therapist who was helping her cope with social issues. That was her decision and everyone in Bridges respected and honored it." This was not a singular decision. Parent 2 shared her reflections in an interview. "We received a lot of support through the social worker. Other than that, B. rejected all offers of emotional support."

Parent 6 describes the mental health supports offered to his adolescent favorably. "She met regularly with the social worker and student assistance coordinator about issues with drugs. They were very helpful and the social worker really guided her through the entire process of reentering school and classes. She's done fine; is back in all her classes and is working a part time job."

Parent 8 reflects on the mental health supports provided by Bridges staff. “My perception of the staff is that they are skilled and educated in my daughter’s condition of acute anxiety. She says she loves Bridges and the staff. They’ve [Bridges staff] supported her through some pretty intense anxiety attacks.”

Parents uniformly believe that Bridges staff provides the adolescent with guidance to navigate the larger school system. Parent 1 commented as follows during an interview. “They [Bridges staff] relieved a huge amount of my daughter’s anxiety about returning to school after a major medical crisis. They offered counseling that included concrete solutions to very real problems.”

Often cited by parents is the understanding that this particular high school is academically rigorous, intense and competitive. This understanding is pervasive amongst parent respondents on questionnaires and interview. While they did not cite this as a negative aspect of the school or programming, they did see the resulting pressures on their own adolescent as detrimental to mental health and the transition process. “I think the program and the staff are unbelievable. They are incredibly supportive to students going through a difficult time and helping them get back on their feet. My daughter would never have made it through this public high school without them [Bridges staff] and the program.”

As previously stated, the faculty assigns importance to the role of Bridges and staff as a means to address mental health care concerns. The majority of faculty believe they understand the role of Bridges staff. They identify provision for mental health care supports as one function of that role. The comments that follow reflect the majority of



opinions expressed by respondents from various departments on the faculty questionnaire. One physical education teacher commented on the mental health supports in Bridges this way; “Bridges is essential, not a frill, for a number of our students. It is the compassion part of what we do. Matriculation should not be survival of the fittest.”

An English teacher comments on the mental health supports of the program as, “Supports I am not capable or trained to do.”

A social worker determines that, “Bridges is an invaluable program that allows an option to work with students experiencing very difficult circumstances.”

A fine arts teacher recognizes the program as, “An important service to the overall well being of kids.”

A teacher in the modern and classical languages department indicates that, “Bridges has served as a lifeline for some of my students.”

A social worker comments; “Bridges is a vital component to our school. It provides a great place for students to receive emotional support.”

A special education teacher comments, “Bridges has been very helpful to two of my students. It takes some of the emotional pressure off the students when they have missed school and are trying to return.”

Though the vast majority of faculty respondents indicated mental health supports provided in Bridges as positive, there were a few respondents who expressed negative perceptions of the program. A science teacher indicates that the program has become, “A catch all for any student who falls behind in work. Further, the program can be very enabling for students.”

A special education teacher expresses concern about a student's dependency on the program and staff. "It's not clear to me when Bridges supports end. A student of mine was not technically in the program but would continue to go to Bridges for emotional support. I'm not sure if this is common."

The greater school faculty view counseling and advocacy as primary to the mental health of students and the success of Bridges. Respondents did not recognize inclusion of other supports within the school such as nurses, the student services coordinator who works with students experiencing alcohol and drug addiction and school psychologists. Additionally respondents did not cite collaboration with outside therapists and agencies as a component of the program. The more expansive nature of the program and the role Bridges staff serve appears to be an unknown to the greater faculty.

### **Theme 8: Peer Support, Tolerance and Friendships**

Students also identified their peers in Bridges as contributing to mental health support. This was a significant component of the 1985 After Care program. Student 5 responded in an interview; "I got a lot of support from the group." [peers in Bridges] Students describe their experience as an opportunity to make new friends who were working toward the same goal of successful reintegration to high school. One student elaborated on the many kinds of issues others were struggling with including a recent pregnancy, a life threatening illness, drug addiction and extreme depression and anxiety that had paralyzed a student from attending school. These interactions with students appear to have positively affected the growth of friendships amongst students who might never have met in such a large school. As reported by Bridges students, the interaction

with peers in the program also appears to have, inadvertently, promoted tolerance and respect for differences. Student 6 summarizes her feelings about being grouped with students from diverse backgrounds with diverse needs. “There were some people with very serious illnesses and problems. I thought I had difficulties but being in Bridges I became aware of the need to be really conscious of germs as it could be life threatening to some of the kids. Others had emotional problems like me but it didn’t seem so bad knowing others shared your experience. There’s always someone who seems to have a tougher situation than what you’re dealing with. We never criticized each other and we learned our problems were manageable.”

“My daughter had a great experience interacting with other kids having many different issues. She sometimes was grouped with a student who had suffered a stroke and others with serious issues of depression and anxiety. It was very revealing for her.”  
(Parent 2)

### **Theme 9: The Evolution of Therapy in Bridges**

#### **Original Therapy in Bridges**

The Bridges staff reports that the social/ emotional support was originally intended to be intense and immediate. It was assumed that group therapy would be clinically appropriate for students enrolled in Bridges. As the population expanded to include students with more varied needs, Bridges faculty 1 recalls that, “group therapy no longer seemed appropriate to address individual, outstanding needs so we discontinued it.” According to Bridges faculty 3, “The staff started to see students who were overwhelmed with numerous therapies and interventions including psychiatrists for

medications, psychologists for family therapy, and social workers for individual and small group therapy. Some students presented as fairly intact and did not requiring specific emotional support other than reliance on the positive environment of the program.”

Bridges faculty 1 reflected in an interview on the evolving approach to mental health. “Originally we thought addressing the mental health issues were the primary focus and academics of enrolled students secondary. Now it’s the reverse. We try to have students understand they can do the academics while addressing the mental health issues.”

### **Current Therapy in Bridges**

All students have an intake meeting prior to enrollment in Bridges. The team determines what level of support is initially required to address mental health issues. This is continuously reviewed as the student progresses through the program. The ability to draw upon additional resources and make individual determination of needs appears to provide the foundation for flexible programming that parents and students cite as critical to a successful transition. According to Bridges faculty 2, “Students are staffed into Bridges at the reentry meeting and at that time we decide if a student requires more intense therapy from an existing social worker or if the student requires one [social worker] and needs to be appropriately assigned. With many students we have frequent communication with the hospitals they’ve come from and outside therapists to coordinate our services and efforts.”

Bridges faculty 1 describes current therapy as follows. “Now we monitor and

take stock of individual student needs and provide individual counseling through myself and the rest of the social work department. Since many of the students already have an established relationship with a counselor we encourage that to continue.”

### **Role of the Social Worker**

On occasions when I observed, the social worker spoke quietly with students while they were working. During those times conversations were focused on generalities. “How is your day going? What’s your anxiety level on a scale from one to ten?” For more in depth, personal conversations the social worker was observed speaking with one or two students in the office area located off of the main classroom. While small, the space provides privacy and a door. On those occasions students discussed personal concerns including issues of safety for self and others, medication changes and evolving social and familial relationships. Much of the therapy centers on problem solving and empowerment consistent with humanistic psychology. Bridges staff encourages student independence and self advocacy by acknowledging their abilities.

The role of staff, in particular the social worker, continues to evolve. The social worker provides individual therapy to students and serves as a liaison to other services in the school community including, but not limited to, additional social workers, nurses and a consulting psychiatrist. When appropriate, students are referred to social groups conducted by school social workers or school psychologists. Bridges staff and most frequently, the social worker, communicate with outside clinicians to coordinate comprehensive services for students. This may include individual therapists or representatives from the sending hospitals.

As is consistent with humanistic psychology and responsive evaluation, the mental health supports provided by Bridges are intended to acknowledge the ability of the student to affect positive change through personal growth and understanding. Further, the student is capable and encouraged to make choices in their quest for personal growth. Therapy is recognized by all stakeholder groups as an essential component of reengagement with school. All Bridges faculty and peers in Bridges are acknowledged as instrumental in the therapeutic support afforded to students. As has been demonstrated in previous examples, Bridges faculty continue to be responsive to the changing needs of the primary stakeholders, students, by focusing therapy on presenting needs rather than an established, historical approach.

### **Researcher Reflections**

Observations in Bridges took place at the end of the school year. As such, the majority of students had been in the program for some time and had learned the routines and expectations of staff and peers. This relates back to the essential understandings of the program including provision for a respectful learning environment where individuals are valued and encouraged to progress out of the program. This was evidenced in the engagement between students and staff and students with peers. Additionally, the social worker assigned to the program was observed counseling individual students on a daily basis. As has previously been documented, all members of the Bridges staff including the instructional assistant provide counseling to students on some level. The staff attributes this component as essential to the safety of students. My observation of interactions between individuals and small groups are consistent with the stated focus on

safety for all.

The entire school community experienced a tragedy two weeks before the end of school. To cope with the tragedy, many staff members were assigned additional duties that took them away from their primary positions. The Bridges social worker was reassigned to a grief support group and had limited opportunity to meet with Bridges students. The two teachers were also assigned additional duties that limited their time and interaction with Bridges students. The instructional assistant became the primary staff member by default. Because of his year long experience in Bridges he appeared to maintain the consistency and safety vital to the program. Students wanted to discuss the tragic incident in detail and some were extremely critical of the student who had allegedly caused the tragedy. The instructional assistant encouraged the students to reflect on a time when they had been incredibly scared and not demonstrated the best judgment. Although two of the six involved in the conversation were unable to get past the negative thoughts toward the individual, the others started to reflect on the very difficult times they had experienced that didn't result in the best decisions. There was clearly an effort to have students consider individual limitations and flaws while also experiencing empathy for others. It was a good conversation with the adult modeling thoughtful consideration of what had transpired from a different perspective than the students' initial understandings. Though the three certified faculty members were abruptly and simultaneously removed from Bridges, the instructional assistant assumed the primary role of both academic and mental health care provider for Bridges students. Surprisingly, there were no discernable negative outcomes for Bridges students from an

observable vantage point.

The Bridges brochure gives a description of students typical for referral to the program. It includes students who are experiencing acute and/ or significant emotional distress. It describes what the program can offer students including the following: emotional support through advocacy, case management, counseling and coordination with outside medical and therapeutic providers. The informational brochure has been made available to faculty in the greater school community, parents of students enrolled in the program, the Board of Education and various parent groups within the community. The brochure is also posted on the school website. Given the distribution list just reviewed, one would expect a pervasive community understanding of the program and the appropriateness for certain types of students. Repeatedly, it has been brought to my attention by all stakeholder groups that Bridges is a well kept secret. This was particularly prevalent amongst parent respondents. This understanding will be explored further in Chapter V.

Responses to the three research questions at times seem redundant and overlapping. I believe that is attributable to the nature of the program being examined. The Bridges program was designed to be intensive with multipurpose components. The program attributes are interactive and contribute to a supportive environment and a successful reintegration to public school. Each component in and of itself is inadequate to address the numerous problems students confront during the reentry process. Therefore the academic component would not be effective absent the therapeutic component that allows a student to be available to learn. The reverse is also true; a



student could not reengage in school with simply therapeutic supports as the academics would still pose an enormous hindrance to the reintegration process. The services are intentionally intertwined to address issues simultaneously. The most outstanding characteristic as defined by all stakeholder groups is the necessity to provide a supportive environment where an individual automatically is recognized as worthy and capable. Bridges has been very successful in this capacity from the perspective of all stakeholder groups.

Chapter V provides my analysis of the accumulated data including some of the unexpected findings. These findings will be explored through both responsive evaluation and humanistic psychology. My reflections include the outcomes that resulted from a qualitative case study approach and offer a new perspective on how to examine a unique program developed for a unique population.

CHAPTER V  
ANALYSIS AND DISCUSSION

**Introduction**

The format for Chapter V begins with a discussion of barriers overcome that ultimately allowed for the emergence of the Bridges program in 2005. This section relates back to the historical efforts in the 1980s and 1990s to develop a program for a similar population of students with similar goals to the current Bridges program. Following the introductory section of barriers overcome is an examination of the similar and divergent perceptions of stakeholders with a particular focus on how this examination is aligned with Stake's responsive evaluation.

At the conclusion of my research I developed a logic model that depicts the intended progression of a student reintegrating to high school through Bridges and culminating in the expected outcome of reentry to the greater school community and dismissal from Bridges. The logic model is examined through the principles of responsive evaluation. Program attributes are then discussed based on the constructs and practices of humanistic psychology. This section is followed by specific examples highlighting how qualitative case study analysis has addressed some of the gaps in literature pertaining to school based mental health programs. Concluding this chapter, I discuss the significance of my findings and proposed next steps for research of school based mental health programs.

Historically school based mental health programs have been researched using quantitative data and comparative analysis for duplication of programming. The study of Bridges was intentionally designed to be a case study of a unique program designed for a unique population of adolescents. The research and resulting documentation is a reflection of the stakeholders' perceptions and understandings. It is intended to be case specific with a focus on its unique qualities as defined by stakeholders, not the researcher. The program is intended to result in full inclusion in the school community with the outcome satisfying the needs of students, parents and the public school. The progression is detailed later in Figure 2.

### **Barriers from the 1980's Overcome in the Design and Implementation of Bridges**

As was described in Chapter II, there was a concerted effort on the part of social work services and some administrators to develop a program that currently parallels many of the goals of Bridges. The program focus was on after care and was delivered through student participation in one of two transition groups, the post hospital group or the people out of treatment group. Both were intended to provide transitioning students with adult leadership and peer support to better navigate the school environment. These groups were developed with guidance from sending hospitals and institutions. Documents (Agenda from the Third Annual Post Hospital Planning Luncheon) detailing this history indicates that a study group was recommended in 1993 to make further recommendations for expansion of the program. That, in fact, did not effectively evolve until the district undertook a comprehensive Strategic Planning process in 2004.

With student, community, Board of Education and faculty representation, various committees were formed to develop specific action plans based on accepted priorities and principles. One of those committees was titled Climate of Exploration. Members of that committee included representatives from the social work department and student assistance program whose function is to provide prevention, intervention and support services for students struggling with alcohol and drug dependency. The committee wanted to insure a physically and emotionally safe environment so each student can grow and learn. Written into the strategic planning action plan is a specific reference to transitioning students. It is documented in the Strategic Action Plan (2004) as follows; “Provide a safety net of services that addresses the needs of vulnerable students, the most critical of whom include post hospital reentry, students returning from crisis intervention and/ or psychiatric hospitalization” (p. 4).

Specific steps cited in the document include development and implementation of a wrap around program that provides academic and social support for transitions, assistance with academic and classroom issues, student support groups and provision for a designated space for students to receive these services on a drop in basis. The committee recommended coordination and integration of services and resources both internally and within the community. Having a specific reference to the needs of this particular population in the strategic planning document contributed to community awareness of an existing problem first noted by faculty in 1983. Committee recommendations were then aligned with the Illinois Social/ Emotional Development Standards of the Illinois Learning Standards. The standards were developed in

accordance with Section 15 (a) of Public Act 93-0495. The Act requires the State Board of Education to develop and implement a plan to incorporate social and emotional development standards as part of the Illinois Learning Standards. Strategic planning within the district effectively removed the first barrier to development of Bridges by acknowledging the need for the program publicly.

The 2005 Committee was chaired by the Director of Special Education Services. At the time the committee commenced its work no resources had been made available to initiate the development of a program for transitioning students. As such, the committee looked at options for reallocating existing resources. Eventually the chair of this committee committed both staff and classroom space to begin the process of developing the Bridges program. In the past, these two vital resources were unavailable and funding was nonexistent. The commitment made by the special education department allowed the process to effectively move forward. Today there is mixed opinion as to whether special education should continue to staff Bridges as it is intended to be a regular education initiative. How that proceeds will be partially determined by supervision assignment of the program. Currently the Director of Special Education continues to be the oversight administrator.

With public recognition of a need for a program responsive to vulnerable students transitioning to public high school and allocation of staff and resources, barriers to the development of Bridges were effectively removed. Originally the program design was intended to be a drop in center for students. What evolved was a much more structured approach to reentry to school, reentry to the greater school community and dismissal

from Bridges. This is a defining characteristic of the program.

From its initiation, Bridges was developed to address the needs of a unique population. Because Bridges was developed with a very specific population in mind, I determined the appropriate method to explore the program would be by case study analysis from the perspective of those stakeholders directly involved in the Bridges program. Their perspectives and understandings provide the foundational data in this study.

### **Similar and Divergent Perceptions of Stakeholders**

Responsive evaluation is the empirical study of human activity and documentation of program quality. The quality of the program [Bridges] is examined from the perspectives of those most intimately engaged with the program; the stakeholders. Responsive evaluation acknowledges the role of the stakeholders as program experts and places the evaluator in the role of presenting and interpreting the information presented by the stakeholders. For this study my role as researcher was to accurately represent the information provided by my participants and to make an accurate interpretation of the meaning of the data. Stake (2004) stated, “Quality is related to cherishing, an intellectual emotion. It can be felt by groups but remains tied to personal experience” (p. 287). For that reason, much of this study chronicles the personal experiences and reflections of individuals in all stakeholder groups.

### **Awareness, Understanding and Misconceptions of Bridges**

According to R. E. Stake (2004), “The essential feature of responsive evaluation is the responsiveness to key issues or problems. It is responsive to stakeholder concerns.” (p. 89). Stake has indicated that the primary intent of responsive evaluation is to look at the merit or value of a program and the many perceptions of that value. As such, it is also important to note the deficiencies in a program from the perspectives of stakeholders. One such deficiency involves the lack of program awareness, despite efforts to educate students, the greater school faculty, the Board of Education, and parent groups, awareness of Bridges and understanding its function remain unfulfilled goals.

Students participating in the student survey presented with a variety of responses about program awareness. One student indicated, “A friend told me about it.” Another student says he learned about Bridges, “Through my best friend’s sister.” Besides informal word of mouth, Bridges faculty have tried to access better modes of communication including speaking to sophomore advisee groups at the beginning of each school year. There is evidence by all student accounts of some level of awareness of the program though there doesn’t appear to be a comprehensive approach to make the program known to the entire student body.

Parents in particular, often learn about the program at the reentry meeting for their son or daughter. The general consensus amongst parents is that this is a “well kept secret” (Parent 1) from which others would benefit. They encourage the Bridges faculty to continue in their efforts to educate all possible sources of referrals. One parent (Parent 10) commented, when learning about Bridges.

“At the reentry meeting is when I learned about Bridges. It was such a difficult time that I neglected to get the information I really needed. The staff seemed to have my child’s best interest at heart but I needed a detailed account of the program. It would help enormously if the staff developed a detailed and complete written description of how the program works, what the student does during Bridges, how specifically they are supported, the expectations for the student, the implications of time spent in Bridges with regard to other classes and, most importantly, the timeline for reentry to regular classes. This would have been extremely helpful at the time of the reentry meeting, but more so, prior to that, so parents have the opportunity to understand the program when they’re not in a state of crisis.”

Parents, in general, from all sources of data, reiterate that the reentry meeting is the first time they’re made aware of the program. To rectify this situation, parents of students currently and formerly in the program work collaboratively with Bridges faculty. Parent 2 specifically requested that Bridges staff meet with several parent groups to, as she puts it, “To get the word out.”

The greater school faculty has indicated some confusion about Bridges through their responses to the faculty questionnaire. A social worker wrote the following; “Despite being told about Bridges, given pamphlets about Bridges, many teachers are unaware. People just don’t pay enough attention.” A science teacher shares the following perspective; “I have heard about this program. However, I don’t know the details. I am returning to this public high school after nine years away and we didn’t have this program when I was here before. I am definitely not clear on the goals or even if I’ve had a Bridges student.”

As revealed in Chapter IV, there are many misconceptions about Bridges emerging from the greater school faculty. There is a lack of clarity by faculty regarding the purpose of the program, the population it serves and procedures for referral,



enrollment and dismissal from Bridges. Despite inaccuracies in understandings as reported in Tables 3 and 5, the overwhelming majority of faculty view Bridges in a positive light and indicate the program should continue as referenced in Table 4.

These perceptions and comments from stakeholders indicate that past attempts to make the program known have not been successful for some stakeholders and that training in the program needs to be ongoing and cyclical to reach all newcomers to the public high school; students and staff alike. Given the attempt to “advertise” the program has been unsuccessful, using an alternative approach seems warranted. Parents of students who have been enrolled in Bridges could be a powerful spokesperson group. Sharing of personal stories can be a highly effective and memorable means of disseminating information from a very personal and humanistic perspective. R.E. Stake would acknowledge the expertise of the parent group as significantly engaged stakeholders. So it is clear there is a lack of knowledge about the program in general by some stakeholder groups but there are also misconceptions about Bridges as detailed in the faculty questionnaire. There is substantial confusion regarding the entire referral process, goals of the program and how to access information about Bridges.

### **Bridges Perceptions are Fluid**

There is an old proverb cited by Diogenes Laertius in the third century, author unknown that states; “Change is the only constant in life.” So too with the Bridges program; understandings and practices change as the need becomes apparent. Stake (2004) indicates that, “Evaluating responsibly is particularly respectful of multiple standards, sometimes contradictory standards, standards held by different individuals and

groups, or even held by the same individual that change over time” (p. 93).

When Bridges was first developed there was an understanding that students who had substantial attendance issues or had been psychiatrically hospitalized would require strategies to alleviate anxiety and reintegrate to the public high school. Initially Bridges faculty believed students with mental health issues and/or prolonged absence required assistance with the reentry process. However, as the program and population evolved, the “medical” students referred to the program expressed very similar needs. Students, parents and Bridges staff indicate they recognized this trend as the population in Bridges became more expansive to include students with significant medical problems or drug and alcohol addictions. Expansion of the original population necessitated new understandings and perceptions. Three of the stakeholder groups including students, parents and Bridges faculty indicate that all students, regardless of the reason for a prolonged absence, require assistance with the reintegration process. The greater school faculty, if they do recognize this as a similar need, did not express so, on the questionnaire.

Bridges faculty responded to this need by applying the same principles of the reintegration process to all returnees. This includes gradual reintegration into the school and academic routines based on the individual student’s tolerance, eventually leading to the gradual phase out of the program and total reentry into the greater school community. This development implies a commitment amongst Bridges staff to adapt and fashion programming based on student need. It also reflects a need to provide faculty in the greater school community additional information and data about returnees in general.

The complexities of issues that arise during the reintegration process may not be understood by faculty, particularly as it relates to “medical” students. Formerly, students returning from surgery or medical crises were afforded options for tutoring, extended deadlines and sometimes adjustments in grades. The consequences of an extended absence for medical students were never examined from the perspective that these students might require an extensive reentry plan to quell feelings of anxiety and helplessness expressed by students returning from psychiatric hospitalizations. It was only after Bridges was initiated and the population of transitioning students expanded to include medical students that the Bridges staff recognized all returnees required some assistance with reintegration reflective of the original population. While awareness of need for individualized reentry is facilitated by Bridges staff, the greater school population remains uninformed that medical students share the same fears and need for a comprehensive reintegration plan. There is not a school wide understanding that students experiencing medical crises or a prolonged absence resulting from medical issues require comprehensive supports reflective of the original population of Bridges. This needs to be clarified and better understood by all faculty in this public school.

As previously stated, students, parents and Bridges faculty assign great importance to the mental health care aspect of the program. Of interest to me was the staff’s ability to adjust therapeutic interventions to the clinical needs of an evolving population. The original intent of Bridges staff was to provide immediate and intense supports similar to those provided in acute health care facilities. The assumed treatment of choice was individual and group therapy combined with cross disciplinary services

within the school and coordination of services with community resources including psychologists, psychiatrists, counselors and mental health care agencies. Students requiring longer term maintenance of mental health supports were to be diverted to other programming. What actually occurred was a shift in the mind set regarding appropriateness of treatment options given the expanding and evolving Bridges population. Bridges faculty responded to the change in population and the intensely varied needs of the student population by extending services to assist those with chronic mental health conditions, in addition to those with acute mental health care needs. As Bridges represents the only comprehensive programming option for general education students experiencing significant mental health concerns within the district, it is likely Bridges will continue to accommodate a wide variety of students in need of both acute and chronic supports.

The original expectations of what students required emotionally were adjusted as the population expanded and evolved. A more thoughtful and individualized approach was instituted to address the varying needs of students. Cognitive behavioral therapy principles are applied to the individual therapy sessions. This is consistent with a client centered therapy approach whereby the client, in this case the student, is empowered to affect change in himself and his community. Stake (1995) describes case study research as, “Empathic, emergent and responsive. It is through reflective practice that one can effectively understand a case and its stakeholders” (p. 48). So, too, is the approach exhibited by Bridges staff when examining and responding to the needs of their clients [Bridges students].

### **Obstacles for Faculty**

Stake (1995) indicates that to understand the uniqueness and complexity of a program a researcher needs to delve into the nature of people and their challenges by observing people [stakeholders] during their struggles. Stake indicates, “It is not a fixation on failure, but rather a belief that the nature of people and systems becomes most transparent during their struggles” (p. 16). What follows is an accounting of the challenges stakeholders, primarily Bridges faculty, continues to struggle with.

As referenced in Chapter IV, Blackboard is the primary means of providing current, daily information on individual students to the greater school faculty. Blackboard was implemented to streamline the process of communication. The greater school faculty indicates that communication with Bridges staff could be improved. They identify the issue as one that communication flows in one direction; from Bridges faculty to general education teachers. It is not known how many teachers actually access Blackboard to seek information. From the faculty’s perspective Blackboard is not meeting their needs for communication. From the perspective of Bridges faculty, Blackboard provides a method by which progress of individual students can be chronicled and managed daily. It can be accessed daily by the greater school faculty to read progress reports on their students presently in Bridges. Consistent with my observations and as expressed by Bridges faculty there is a daily struggle to provide individualized service to students while simultaneously communicating with stakeholders in a consistent, relevant manner. To me, this dilemma is a time issue reminiscent of staff making the workload manageable for students. They need to do the same for themselves

while providing current and relevant communication to the greater school faculty. In the Teacher's Guide, Bridges teachers encourage faculty to augment communication by using the Blackboard blog and, ideally, visiting the program. Faculty are welcomed to the program anytime, any day and encouraged to maintain personal contact with shared students.

The greater school faculty indicates they do not receive adequate communication to assist the student when reintegrating to mainstream classes. They would like more specific information regarding the historical reason for placement in Bridges and current, presenting issues. The greater school faculty cite this as an obstacle to effective and useful information to support reintegrating students. The true issue is one of student confidentiality as governed by federal statutes that include FERPA (Family Education Rights and Privacy Act of 1974, U.S.P.L.93- 579/ and HIPAA (Health Insurance Portability and Accountability Act of 1996 Privacy and Security Rules). Bridges faculty are cognizant of these laws and actively strive to maintain the confidentiality of students in program. While it appears to be an obstacle for faculty to better understand the student being reintegrated to their classroom, the statutes are clear in their protective capacity for students.

A number of parents expressed a need for more consistent, predictable communication about their adolescent's progress in the program and scheduled dismissal from Bridges. It was noted that parents frequently rely on their adolescent to keep them apprised of progress. When this was the case, parents indicated it was inadequate at best. Parent 5 suggested Bridges faculty provide parents with, "Either a weekly call or email

about where the student stands with the work that needs to be completed.” Parent 6 confirmed the concern expressed by other parents. “The staff guided our daughter through the process. It was good for her but we [parents] had real issues with the lack of communication with us.”

The reverse side of communication struggles was frequently expressed by the parents of “medical” students whose circumstances required multiple reentries; thereby necessitating more frequent contact and, often, more parent engagement in the development of customized plans. Parents of those students expressed clear satisfaction with the level of communication provided by Bridges staff. They noted who was the primary contact with the program by name; most often it is one of the two teachers but the social worker was also referenced at times as the liaison between home and Bridges. For these parents their Bridges contact was positive and transparent.

### **Bridges Can Be Addictive**

Qualitative research is exploratory and employs a technique of progressive focusing which results in unanticipated understandings. Stake (1995) indicates that qualitative researchers are engaged in the process of, “Understanding the complex interrelationships between stakeholders” (p. 37). A pattern of concern for over reliance on Bridges and Bridges staff emerged almost immediately during the data collection stage. It continued to emerge as a focus in all stakeholder groups through interview, observation and questionnaire. There is agreement, though on varying levels, by all stakeholder groups that Bridges has the potential to be addictive for the students it serves. I became aware of this concern during my first interview with Bridges faculty 1. Bridges

staff recognized in the early stages of the program that once students have been in the program and have developed a comfort level with Bridges and the services they're receiving, they may be reticent to leave all that behind. "We're careful not to foster dependence as this could do more damage than good. "We gently push them back into school routines and classes."

However, student 1 shared with me that; "Some kids felt rushed getting back into the school community and classes."

Student 3 indicates, "I really felt I could have stayed in Bridges a few more weeks and done better in school when I had to go back to classes."

Student 6 indicated that, "Although we all knew we were there [Bridges] to help us get back into school successfully I really miss it and I know others do as well. It can be highly addictive."

Another student shared his story through the student questionnaire. I paraphrase. I had been out of school for a really long time. I was having trouble with my girlfriend and my parents were on my back about my grades. I avoided school constantly. Even if I got to school I skipped classes. I had been using since last year but mostly just on weekends. I started using everyday to get away from my problems. The school was aware I was using for some time but my parents didn't believe it was true until I had a car accident and I was charged with DUI. Then I got put in a treatment center for a month. When it was time to return to high school I knew I'd have the same issues to deal with. The kids I hung out with all were users so I felt like I was going right back into the same environment. Bridges gave me an alternative to the same old, same old. I felt protected



from some of the negative influences in the school. There were I was doing so well they encouraged me to gradually return to classes. I didn't feel at all ready. I wish I could have stayed for the rest of the year.

Only one parent out of the ten interviewed and of the many parents returning the questionnaire indicated that it was possible that her "daughter was using the program as a crutch." That being the singular parent response indicating an over reliance on the program and staff is not significant.

Faculty questionnaire as cited earlier in chapter 4 referred to Bridges and Bridges faculty as "enabling." Of the faculty returning the narrative portion of the questionnaire, referencing the potential negatives of the program in this context were minimal; in fact these comments represent less than 2% of the total. Interestingly, parent and the greater school faculty seem aligned in that over reliance is not a significant outcome of the program.

Bridges faculty are well attuned to the probability of over reliance as cited in the four interviews. Fortunately, this stakeholder group also has the ability and the daily commitment required to minimize the negative risk to students. Students, for the most part, reference the many positives of the program and staff that encourage them to feel safe and invested in Bridges. The concern for students is that when praising the program they also indicate, mostly inadvertently, that the best attributes of the program may ultimately inhibit complete reintegration.

### **Reflections on Attendance and Grades**

Stake (1995) indicates that, “Qualitative case study is highly personal research. Persons are studied in depth. Researchers are encouraged to include their own personal perspectives in the interpretation. The quality and utility of the research is not based on its reproducibility but on whether or not the meanings generated by the researcher or the reader are valued” (p. 135). I placed considerable focus on the ten interviewed students as we had candid, personal conversations and I had the opportunity to observe some of the students in the Bridges program. I was able to review the data regarding attendance and grades as it related specifically to individuals which made the quantitative data all the more meaningful for me.

Interviewed students represent a fairly typical cross section of students served through Bridges. Interviewees included students labeled chronically truant, recovering from surgery, living with a life threatening illness, returnees from drug and alcohol treatment centers or psychiatric hospitalizations. These students all exhibited major attendance issues prior to Bridges which may be attributable to the many disabling conditions reviewed. All students maintained a better attendance pattern while in the program which may indicate they were able to attend with greater frequency because of tailored individual schedules and customized plans. This was evidenced in the chronically ill who were welcomed to attend any part of the day the student deemed as feasible. On the other hand, attendance patterns amongst the interviewees after dismissal from Bridges did not reflect consistent school attendance. This may again reflect the inability of a student to sustain regular attendance without the support of an individual

plan or it may simply reflect the nature of the disabling conditions experienced by students. I do believe the results of this study reflect success in engaging chronically absent students in a school program. Attendance data indicates students with chronic truancy issues were able to attend school with greater regularity while enrolled in Bridges. In the past, truancy was frequently addressed through the legal system or through placement in therapeutic day schools. Provision for an alternative to those options was an individualized program with academic and emotional supports in a safe environment. Chronically absent students have responded positively to this option and their attendance patterns validate that Bridges is effective in that capacity. However, subsequent to dismissal from Bridges there is tendency to revert to old behaviors. This may reflect a need to extend individualized plans for some students into the mainstream environment post Bridges.

I compared grades with attendance patterns within the interviewed population. I would have anticipated grades and attendance patterns to be more closely aligned regardless of whether the pattern moved in a positive or negative direction. However, a review of documents indicates grades were consistent before, during and after Bridges while attendance patterns were much more varied in the before and after phases. It may be that students did not maintain the same level of investment in attending school after dismissal from Bridges but were still committed to maintaining grades commensurate with previous performance. There have been numerous discussions between faculty and administration in this school concerning students who rarely appear in classes but maintain a solid grade point average. This disparity between attendance and grades that

seems counterintuitive is part of the culture of the school rather than simply symptomatic of students in Bridges.

### **Success of Bridges is Confirmed**

According to R.E. Stake (2004), “Program evaluation is usually a clear departure from building scientific theory. The question of science may be, “Do programs of this kind succeed?” But the question of evaluation is, “Is this particular program succeeding?” (p. 91). This study validates the “presumed success” of the Bridges program from the perspectives of the most intimately involved group of students to the distal stakeholder group of faculty. This is evidenced repeatedly in written disclosure through questionnaire, interview and spontaneous conversation. The value of the program to its recipients is also evident in observations and dialogue between staff and students. Stakeholders individually and collectively voice satisfaction with the program. From the perspective of stakeholders responding in this study, Bridges is successful in its mission to assist transitioning students back to public school. Students and their parents praise the efforts of Bridges faculty and repeatedly refer to the program as a life saver.

Adolescents grouped together through similar experiences and goals gain insight and tolerance. As was repeatedly shared with me, students in Bridges were exposed to problems they didn’t know existed at this school. They also met students with whom they never would have been grouped with either academically and socially. The result was in some cases new friendships. Almost all of the Bridges students found a way either verbally, in writing or through nuances I observed to express this as a positive outcome of Bridges. Awareness of others’ problems often assisted individuals with

placing their own concerns in a different and more favorable light. Knowing others were struggling with similar issues seemed to bring comfort to many. The group model first discussed in 1983 acknowledged the support of peers as vital to mental health.

Students praised the staff with comments such as, “They’re awesome in everything they say and do. I never could have made it back into school without them.” That typifies the generally response of students who had been or were in Bridges at the time of this study. There was a clear message of gratitude for the staff that had provided them with the transitioning services that allowed for successful outcomes. Of the ten interviewed students, all either successfully reintegrated to the greater school community or graduated from high school.

Parents are extremely aware of the positive effects of Bridges programming for their adolescent and often cite the expertise of Bridges staff. Parent 9 reflected on her experience. “We experienced genuine care and concern. The tutoring, advocacy and counseling aspects of the program worked in tandem to provide a very successful transition for our daughter. The program allowed her to get up to date on assignments and not have to deal with stresses of the classrooms for a while. It’s a great program and much needed in an intense and competitive public school.”

Parents and students almost unanimously indicate Bridges has been a huge success from their personal experience. Consistently both stakeholder groups cite the caring, supportive staff, their level of expertise in the reintegration process, their academic versatility and the therapeutic components of the program as excellent. Further, parents and students alike, cite the individualized approach to treatment as

critical to an adolescent's success in the program.

With almost unanimous consensus the greater school faculty acknowledges the positive impact of Bridges in the reintegration of students to this public school. There were no discernable differences between faculty members who had a student previously in Bridges versus those who did not. This may be attributable to the population that elected to complete the questionnaire; the vast majority of whom had personal experience with the program through "shared" students. They defined the purpose of the program as much more narrow in scope than the actual services provided. Tutorial and transitioning services were almost uniformly cited as services in Bridges; mental health services and support for students through advocacy and case management were less so. This may be reflective of personal experience with a student in Bridges or may simply reflect their academic orientation. Regardless, the faculty would benefit from understanding the array of services provided in house and coordination of services with outside therapists, hospitals and agencies. The program plays a more expansive role than what is currently understood. Despite some differing perspectives, individuals and all four stakeholder groups collectively present a clear assertion. Bridges is a success for the individuals it serves.

### **Logic Model**

Qualitative research places emphasis on interpretation as a focal characteristic of case study analysis. The logic model (see Figure 2), represents my interpretation and understanding of the complex interrelationships of primary stakeholders in the Bridges program. Consistent with responsive evaluation the needs of the students and their

parents direct the program response by Bridges faculty. The process of reintegration to this public school is prompted by the reentry meeting. At that time, student and parent need is assessed by Bridges faculty. Typically student needs require an immediate response that can alleviate anxiety in a nurturing, safe environment. Parents' initial needs typically center on finding a process or program that can assist their adolescent while relieving them of some of their own anxiety and responsibility. Both stakeholder groups have a need for reengagement with the school community in some capacity. Students don't often acknowledge this as a primary need at that time, but it has to be addressed and woven into any reentrance plan. The program response is determined by individual needs and results in a customized plan for students.

While parents remain part of the process, their role often shifts from direct involvement in the planning process to that of monitoring the progression of their adolescent. The student is at the center of the treatment plan. Bridges faculty, having assessed presenting, individual needs, tailor a response that results in academic and emotional support in a supportive community [Bridges]. This entails coordination of internal services and frequently with community mental health care providers. Academically, the staff initiates contact with the greater school faculty and assume the role of advocate and communicator. Specific steps to alleviate academic needs are addressed at this time. The intent of these interventions is to provide a successful reintegration to the Bridges program.

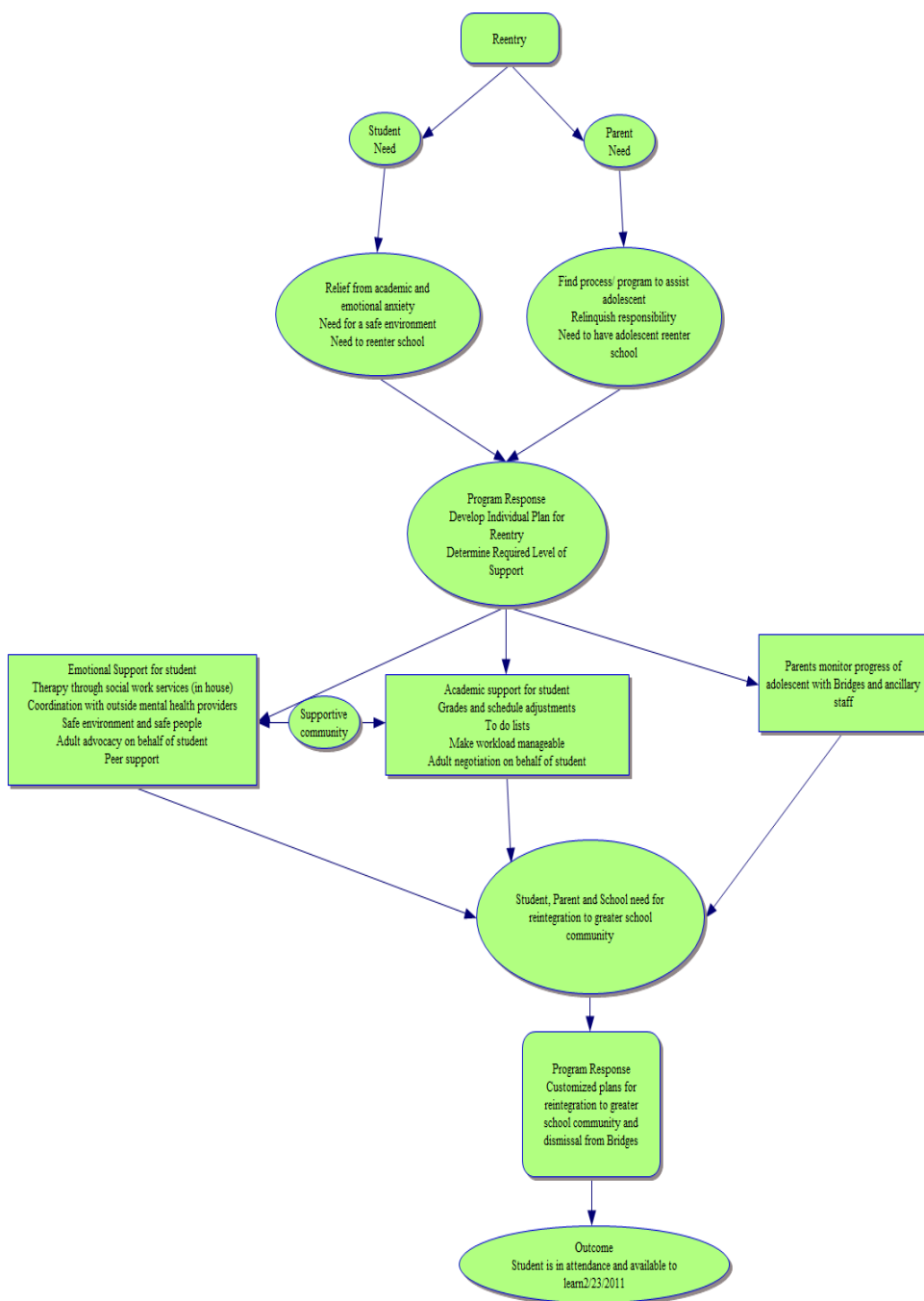


Figure 2. The Logic Model

Once that process has been achieved the evaluation for readiness into the greater school community is initiated. Criteria for readiness include academic readiness, being



caught up in subject areas, and consistent attendance absent huge anxiety. At this juncture in the process there is a specific need for reintegration by all stakeholders; students, parents and school. It is at this time that some students tend to balk at the process having gained success and comfort in the safe, supportive environment.

However, successful reintegration in this program requires complete reentry to the greater school community. As previously referenced, this may not be the student's original schedule but always should reflect a customized plan that allows and encourages a student to find their own path in the larger community. The student is gradually reintroduced to the greater school community while Bridges faculty monitor and adjust the process as needed. Those with chronic health needs demand a great deal of sensitive and responsive evaluation of the process. The intended outcome of Bridges is to provide the student with supports that will allow him or her to be in attendance and be emotionally secure and available to learn. When the intended outcome of Bridges is achieved, the needs of all stakeholder groups have been met.

### **Humanistic Psychology Program Attributes**

Abraham Maslow's (1970) best known contribution to humanistic psychology is his Needs Pyramid. The fundamental premise of his hierarchy is that humans are born with basic needs. The lowest stratum in the hierarchy is our most base needs; those required for survival like food, drink, oxygen and sleep. Maslow indicated once the base needs have been met, it is then possible to focus on the next stratum which is the need for safety and security. Unless a person's goal of a safe environment is actualized, the individual is stifled in any attempt to consider higher order needs. Humanistic

psychology indicates that nourishing environments can make an important contribution to the development of healthy individuals. Obvious parallels exist between humanistic psychology and Bridges' commitment to provide students with a safe environment and safe people.

Humanistic psychology is so named for its core belief in the basic goodness of and respect for humanity. It assumes an individual will seek to understand one's own existence and, ultimately, role in social responsibility. It assumes that the quest for understanding will result in personal growth and satisfaction. Humanistic psychology is founded on four core beliefs.

1. The present is the most significant aspect of individuals.
2. To be mentally healthy, individuals must take responsibility for their actions, regardless if those actions are positive or negative.
3. Each person, simply by being, is inherently worthy.
4. The ultimate goal of life is to attain personal growth and understanding.

These core beliefs are reflected in specific characteristics of the Bridges program. Humanistic psychology views the present as the most significant aspect of an individual's life. What happened in the past is simply the past. It is the present state that allows an individual to achieve personal growth and understanding through constant self improvement. The Bridges staff came to the conclusion that regardless of what had happened in the past, all students reintegrating required assistance with the process. That need for assistance with reentry spread across all populations regardless of the reason for absence. Therefore, the critical component of any customized plan is to initially address

the current, outstanding need of reintegration. The process of self improvement and understanding cannot be actualized until the immediate needs of the present are properly attended to. Regardless of the history that brings a student to the program, the initial need for all students is reengagement in some capacity with the school community.

Therapy in Bridges parallels many of the postulates of humanistic psychology. Because all individuals are valued they receive unconditional positive regard from staff. That is innately woven into the program. Like client centered therapy, the individual has the capacity to develop emotionally and with greater understanding through introspection. Through therapy the individual can realize his actions and develop strategies to respond in a healthy and responsible manner to challenges. Humanistic psychology also acknowledges that for an individual to be mentally healthy, one must take personal responsibility for their actions, be it positive or negative. While the Bridges staff is using clinical judgment to ascertain the appropriateness of reentry into the greater school community, some students may be saying I'm simply not ready to assume responsibility for myself and my actions. To me this is reminiscent of those students who desire to stay in the program because they have attained a comfort level and success within the supportive community. It also is reflective of the possible addictive quality of the program for students that Bridges faculty discourage.

Humanistic psychologists stress the importance of social change and development of institutions that sustain human growth and organizational efficacy. The stakeholder groups in this study clearly value Bridges as an institution that is capable of supporting individual determination and social change. The challenge of Bridges is to extend

understandings of the program and minimize misconceptions to all stakeholder groups. The impact of the program can never be fully actualized until there is a pervasive understanding of Bridges in all stakeholder groups. Some measures to address this issue have been instituted on the Bridges website. The referral process and roles of referring staff are a recent addition. However redundant it may seem to Bridges faculty, the information they currently provide is not reaching many of the intended recipients.

### **School-Based Mental Health Models and Bridges Supports**

Bridges represents an amalgamation of school based mental programs. There are many similarities between Bridges and the final stage of intervention as described by Adelman and Taylor (1997). Intensive treatment according to Adelman and Taylor includes referral, triage, placement, resource coordination, special education, dropout recovery and services for severe psychosocial/mental or physical health problems. This approach is dependent on implementation of school and community resources. Interestingly, as has been pointed out through this study, the original population of Bridges did not include students with physical health problems. However, as the need to address the health care issues of “medical” students ballooned, so did the efforts of Bridges staff to accommodate a whole new population of students. Ironically, Adelman and Taylor’s design addresses two critical populations; those with significant social and emotional issues and those with significant physical health issues. Bridges has, unexpectedly, become more aligned with Adelman and Taylor’s SBMH model with the response to an identified need of a growing population not previously served through Bridges.

Some elements of Dryfoos's model (1994) can be found in Bridges. In particular, Bridges was initially funded through district resources that had already been committed. Asset reallocation made the progression of Bridges possible. Additionally, similar to the Dryfoos model, Bridges has partnered with community agencies and health care providers to more appropriately and comprehensively care for its students.

As referenced earlier in this study a universal approach to mental health has been promoted district wide through a variety of activities, groups and campaigns. It would have to be said that this is incidental to Bridges as it existed prior to Bridges and continues to expand without any specific guidance or input from Bridges. However, I would have to say they complement each other in this district's efforts to provide a safe and respectful environment for all its members.

Lastly I have found Bridges to be unique onto itself as it was created for a specific population that is noticeably absent from the literature; students reintegrating to public school subsequent to a prolonged absence or psychiatric hospitalization. Originally Bridges resembled a short term triage model intended for acute interventions. With the passage of time and the identification of need, this has expanded to include a model for students requiring chronic care. The clinical focus has been adjusted to address individual needs rather than an earlier assumption of the need and value of group therapy. I believe it's reasonable to say the Bridges model is still evolving as roles within the program change, approaches to therapy are altered and the needs of students continue to expand the resources currently available.

### **Benefits of Qualitative Research**

As determined early in my research of school based mental health programs there are numerous studies of programs using a quantitative approach in the literature. This is especially useful when looking at programs with the intent to duplicate them. I elected to follow a qualitative approach as the data I wanted to obtain could not be accessed through quantitative measures. I selected a case study for the following reasons:

- \*I wanted to explore and interpret the value of the Bridges program from the multiple perspectives of stakeholders.

- \*I wanted to understand a unique program developed for a unique population.

- \*I wanted to understand the unique attributes of this program as a solitary program.

- \*I wanted to add to the body of literature on SBMH using a qualitative approach.

Just as humanistic psychology acknowledges the constructive forces of an individual, humanistic psychology also values individual introspection and human dignity. Stake's responsive evaluation acknowledges the expertise of stakeholders and the value of multiple perspectives. As with humanistic psychology it is not the role of any individual to define what is of value to another. The individual determines worth or value for himself and himself alone. The individual stakeholders' perspectives of the Bridges program are the most significant element to my study.

I used multiple sources of data collection to understand the perspectives of stakeholders. Qualitative research takes place in the natural setting thereby allowing the researcher to understand individuals in detail and be involved in the actual experiences of

stakeholders. Observation in the natural setting allows emergent themes to evolve rather than assuming the existence or value of preexisting assertions. The multiple methods of data collection are interactive and humanistic. Interviews provide an in depth understanding of an individual's experience and perceptions not attainable through quantitative analysis. While the questionnaires used in this study present a broad understanding of stakeholder groups, they cannot define the experiences, nuances and perceptions of individuals and their interactions. This requires a comprehensive commitment to collect data and interpret the findings while bringing meaning to individual struggles and understanding the implications for programming. Reflective thinking by the researcher and member checking with stakeholders insure an accurate understanding and reporting of the perceptions of individuals. Quantitative data can be integrated into the more comprehensive frame of reference provided by qualitative analysis for a deeper understanding of individuals and the program. Qualitative case study research provides the reader with an opportunity to vicariously experience the understandings and actions of stakeholders in the Bridges program. There is a sensitivity and involvement with individuals that cannot be attained through quantitative research.

Some specific findings from the qualitative case study analysis present surprising results. Who knew that "medical" students would need the same types of supports for reintegration as psychiatrically hospitalized students required? Without the emergence of the medical population being paired with an existing program, Bridges, the clinical needs of those students would have likely gone unmet. Who knew that the program could become addictive even for a student who balked at the initial placement? This occurred

despite staff efforts to ease students gently and gradually back into the greater school community. How could we understand the evolution of the program from its roots in the 1980s to the present without exhaustive narrative? This information and a comprehensive understanding of Bridges could not be gleaned from quantitative data. The stories shared with me through students and parents are the most memorable part of the whole experience for me. They spoke from the heart about their personal experiences and their extreme gratitude to the school and particularly the Bridges staff for providing them with a lifeline. They were willing to elaborate on some of their most intimately painful and victorious moments in their lives. I was moved by their stories and in awe of some of the struggles they had overcome. For some, their struggles continue. Those individuals, for the most part, are approaching their next hurdle optimistically knowing they have made it this far. So whether it's the struggle to maintain sobriety or enter into another round of chemo, they share a common experience. They have had the experience of surviving and reentering a "normal" environment. Put to the test, I believe this will bring added strength to their continuing battles. Certainly this information could not have been extracted or interpreted from quantitative data.

### **Considerations for the Future**

Administrators, with the exception of the Bridges oversight administrator, have not traditionally spent time observing in Bridges or assessing the daily function of the staff and program. If knowledge within this public school is generated at least partially from the top down, then a better understanding by administration of Bridges would enhance general understandings amongst all stakeholders. It might also bring greater



recognition to a program and staff believed by all stakeholder groups to be of value to individuals and the greater school community.

Growth of the program is evidenced through the increasing numbers of students being served yearly in Bridges. Had I employed an experimental design focused on the impact of the program as measured in outcomes, I would not have comprehensive understanding of program growth. This is a benefit of the qualitative case study analysis. Expansion of Bridges faculty has occurred incrementally. Many would argue the expansion of faculty is not commensurate with the increasing population of need. Stakeholders routinely acknowledge the current space for the program is inadequate and limits the effectiveness of academic and mental health interventions. In fact Bridges has gained space from its original location but is consistently cited as inadequate by all stakeholder groups. Issues of increased staffing and space will require a financial commitment by the district to support the increasing numbers and diverse needs of the Bridges population.

Repeatedly parents discussed their personal experience with Bridges as “amazing” but just as vehemently stated, “We need to get the word out.” Bridges was basically an unknown to the parents participating in this study until there was a personal need for involvement. One parent, referenced earlier, solicited the Bridges staff to share their perspectives with several parent groups. They did so but the requests to publicize the program continue. From the perspective of Bridges faculty they believe this effort has been made repeatedly though, apparently, not effectively. This is where the parent stakeholders can make a substantial contribution to a program they hold in high regard.

Sharing personal stories is a powerful means of truly engaging an audience in the message being shared. I believe this stakeholder group can effectively disseminate information through personal stories in a way no other stakeholder group can. Their understandings and experiences with Bridges are powerful. This district also employs an individual to relay information to the greater community through news releases and pamphlets. Perhaps the expertise of a public relations individual can more effectively disseminate information to the public.

Bridges faculty need to address the misconceptions held by the greater school faculty particularly with regard to the purpose of the program, the population it serves and the referral and dismissal process. Even faculty who “shared” students in Bridges had erroneous understandings. As the demands on Bridges faculty are extensive and as faculty 2 reports, “Physically and emotionally draining,” perhaps some of the needed education of staff needs to, again, come from the top down with administration taking a lead position.

As my data collection occurred at the end of a school year, innate variables reflective of public schools influenced the daily operation of the program. As has been mentioned, the end of the school year presents unique problems for public schools with many expectations not required during other times of the year. It is typical in this public school to assign teachers to additional duties to maintain an orderly conclusion to the school year. Teachers in the Bridges program were assigned additional duties consistent with other faculty. The social worker was also assigned additional duties during the same period of time. It seems like an obvious recommendation emerging from this study that

Careful consideration should be given prior to altering the daily staffing of Bridges. At the very least, all three certified staff should not be required to absent the program simultaneously. I compiled a list of recommendations I intend to share with Bridges faculty. These recommendations may prove valuable for future programming and sustainability of Bridges.

### **Recommendations for Bridges Faculty**

- Now that Bridges has become a Tier 3 intervention for Response to Intervention, this might be the appropriate time to consider moving Bridges to the Curriculum and Instruction Department under the supervision of the Assistant Superintendent for Curriculum and Instruction.
- Consider having the Assistant Superintendent of Curriculum and Instruction provide literature and presentations on the Bridges program, similar to the March, 2011 Board of Education presentation. The school faculty and greater school community are in need of this information.
- Consider training other teachers in the role of Bridges teachers, especially as it pertains to case management.
- Consider forming a parent group of “Parents of Prior Enrollees in Bridges” to disseminate information and personal experiences to other parent groups regarding the Bridges program.
- Consider extending the Bridges web site to be more prominent with very specific information detailing the population served, process for referral, enrollment, reintegration transitions and dismissal form Bridges.

- Consider using a logic model to explain to families and staff the intended progression of a student from initial reentry to dismissal.
- Review the current communication model and the use of Blackboard as it relates specifically to parents of students enrolled in Bridges and the greater school faculty.
- Consider extending customized plans into the mainstream community post Bridges. The data indicates attendance patterns declined for the interviewed students, reflective of, and more consistent with, pre Bridges enrollment.
- The current study did not review the incidence or prevalence of recidivism in Bridges. This information could be instrumental in planning and future programming.
- Females outnumber males each year in enrollment in Bridges. Understanding the reasons why may assist the Bridges staff in determining whether this is symptomatic of referrals or simply an increased compliance from females to participate. This may assist with the referral process or result in programming indicators.
- The greater school faculty does not have a clear understanding of students with school refusal. This may impact why some students are not referred by mainstream teachers. Though in-servicing staff may be beyond the scope of Bridges faculty, consideration should be given to educate the greater school faculty on the appropriateness of school avoidant student referrals to Bridges.

- Though this program was developed for a very specific population in a specific community, Bridges might serve as a model to other districts developing comprehensive RTI programming design.

### **Limitations of the Study**

In the planning stages of this study, I elected to seek information about adolescent perceptions only after having received informed written consent from parents. While this proved to be appropriate for observation and interview of students, this procedure greatly inhibited the number of respondents to the student survey. The process was unwieldy as it required a mailing to parents, a return of consent to the researcher, forwarding the survey to students via Bridges teachers or, in some cases, another mailing and return of survey to the researcher. The design was flawed. As there were so many steps to be followed, the result was an inadequate sample size. This could have been resolved had the researcher approached the student survey in the same manner as the faculty questionnaire; as both were to be completed anonymously. Had I sought permission to include a disclaimer at the end of the survey similar to that of the faculty, I am confident I would have received many more returns and a much more expansive understanding of student perceptions.

Recidivism has been addressed in this study only as it relates to students with chronic, disabling medical conditions. While the Bridges faculty is aware of students who represent program repeaters, there has been no analysis through this study that would assist with understanding the specific reasons a student may require enrollment in Bridges twice or even several times. However, Bridges faculty frequently state that they

work with students to avoid dependence on the program. This, again, may be why some students felt rushed to return to mainstream classes. Questions that could extend understanding would be to simply begin by assessing the actual rate of recidivism amongst the population followed by exploratory questions that clarify why that might happen. Is an individual simply more prone than peers to gravitate to the source of comfort and safety? Is the recidivism an inadvertent function of the program? Is there a way to identify and program for identified students suspected as particularly vulnerable in an aftercare program upon reentrance to mainstream classes? There are many questions outside of the realm of my current research that could expand understandings by implementing qualitative case study analysis when designing or reviewing School based mental health programs.

The time of year this study took place limits my findings to perceptions of students previously enrolled in Bridges or students who had been a part of the programming for at least several weeks. I didn't have the opportunity to follow a student from the beginning reentry and referral stage, to enrollment and dismissal from the program. Had that been possible, I suspect there would be a more comprehensive understanding of student perceptions while they worked their way through the process.

This study did not focus specifically on frequency of referrals and placement in Bridges by gender. While females outnumbered males both historically and currently, there has been no attempt to analyze why that is the case. It is beyond the scope of this inquiry but would make an interesting study in and of itself. If I were to continue this research I would want to know the reasons females in this program outnumber males. Is

it a function of the referral process? Are female advisors more inclined to refer female students than their male counterparts? Do females simply agree to participate in Bridges? Are they more compliant or possibly accepting of the need for interventions? There are many questions that could be pursued along gender differences that would assist in future programming.

Earlier reflections of Bridges and Response to Intervention, chapter II, indicate there is no relevant application from one program to another. That understanding no longer holds true. As was recognized just prior to closure of this study, the district has embraced Bridges as a significant tier three intervention in the comprehensive district RTI design. There is now a distinct connectivity between Bridges and RTI that was presented to the Board of Education in March of 2011. The inclusion of Bridges in the RTI model may effectively assist with greater community awareness and understanding of a valuable resource intended for all students.

### **Recommendations for Qualitative Research and School-Based Mental Health Programs**

If I were to make recommendations for other districts developing school based mental health programs I would cite three elements as essential components of programming. One of the most interesting findings of this study is reflective of humanistic psychology and client centered therapy. The conscious decision to empower students in their progression through the initial phases of reintegration to dismissal from Bridges is cited by stakeholders as essential to their successful evolution. Provision for immediate and satisfactory response to identified needs is critical for engagement of

students and their parents in the initial stages of reentry. Absent that, engagement in the process is not possible. In designing future school based mental health program these two attributes are critical components of programming. Thirdly and frequently referenced by multiple stakeholders, is the need for a supportive environment with safe people. In order for students and their parents to initiate the reintegration process, there must first be a dedicated provision for a supportive environment that alleviates multiple sources of anxiety and impediments to reentry.

From this study I have come to understand that despite my efforts to focus on a singular program for its unique and complex qualities, there is a possibility for valuable generalization to other communities. This was, in fact, the last expectation I would have anticipated from this inquiry. The reality is that Bridges has become enmeshed with a more comprehensive program, Response to Intervention. The intent was to examine a “stand alone” program with no intent to duplicate. However, I now recognize the potential of Bridges to serve as a model for other districts with similar populations and as a component of a comprehensive RTI design. The value of qualitative case study research in the exploration of school based mental health programs becomes relevant for future program design given the unanticipated outcome of generalization. Unintentionally, this study provides the understanding of the potential generalization of Bridges to other communities and, as an integral component, of a more comprehensive district initiative.



### **Future Directions for the Researcher**

It is my intent to share research findings with Bridges staff and any other school representative interested in this study. It has been determined that the social work and special education departments would be interested as they have historically invested personnel and funding for the program. If in fact Bridges is reassigned to a different oversight administrator, this inquiry may provide that individual with historical data.

Eventually I would like to publish some of my findings from this study. The use of qualitative case study and the logic model may be of interest to other researchers seeking to better understand a particular program or population. My work will contribute to the existing body of research and deficiencies in the research of school based mental health care programs dominated by quantitative analysis. This inquiry explored a program for a very particular population absent from the literature. I employed what Stake refers to as a disciplined qualitative mode of inquiry of a single case study. This is a unique perspective of school based mental health programs. Additionally and collectively I believe this research can improve practice of researching and designing particular programming for specific populations.

The development of a logic model to design school based mental health programs could be particularly effective when the design is for a specific population. My model was developed subsequent to design of the program and therefore serves to explain the progression of a student through Bridges programming. A different approach would be to initiate the process of designing a program by development of a logic map. As such it could serve as a road map from the referral stage of programming to dismissal from the

program. The supports that enable a student to successfully navigate the process are outlined and sequenced to maximize positive progression toward the desired outcome, This approach may extend school based mental health programs as they currently exist and are referred to in Chapter II.

Currently I am involved on multiple levels in the same public school and working with colleagues to understand the impact of race on students and faculty. We have access to much data indicating over representation of African American students in special education classes and in the lower instructional levels in mainstream classes. We have data indicating over representation of Asian American students in higher level classes with minimal participants from this race in special education classes. While the data is interesting and points out some gross inequities, I believe it is the stories shared by individuals that will educate us in this complex problem in public schools and eventually affect change. I was recently given a book entitled *Everyday Anti Racism* (Pollock, 2008) that is a reflection of multiple authors' perspectives. It is comprehensive in scope and rich with description. I think there are many ways to examine issues but a qualitative approach allows individual perceptions to be revealed and valued. It is my perspective that having completed this study, I understand the power of personal experience and narrative more fully. For me, this study has resulted in a transferable skill that can provide a comprehensive understanding of unique issues, programs and individuals. It is my intent to use qualitative case study inquiry to better understand the experience of adolescents in public school.

APPENDIX A  
INTERVIEW PROTOCOL FOR STUDENTS

1. How long have you been (or were you) part of the Bridges program?  
\_\_\_\_\_
2. How did you become aware of the program?  
\_\_\_\_\_
3. Has (did) it changed (change) your schedule and if so how?  
\_\_\_\_\_
4. What services are (were) provided for you through Bridges?  
\_\_\_\_\_
5. What academic supports are (were) offered through Bridges?  
\_\_\_\_\_
6. What mental health supports are (were) offered through Bridges?  
\_\_\_\_\_
7. Tell me what the Bridges staff does (did) to assist you.  
\_\_\_\_\_
8. What are some supports that have been (were) particularly helpful to you?  
\_\_\_\_\_
9. Have there been any supports that you found not to be useful? What are they?  
\_\_\_\_\_
10. Since being (While) enrolled in the Bridges program what has been (was) your connection, if any, to the teachers you used to see daily?  
\_\_\_\_\_
11. How have (did) they assisted (assist) you?  
\_\_\_\_\_
12. What are (were) the advantages to being enrolled in Bridges?  
\_\_\_\_\_
13. What are (were) the limitations to being enrolled in Bridges?  
\_\_\_\_\_
14. Do you know if the Bridges staff has been (were) in touch with your parents? If so, to what extent is (was) their involvement?  
\_\_\_\_\_

15. Do (Did) you have a dismissal plan from Bridges? What does (did) it look like?  
What is (was) the timeline?

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16. Is there any support you would want (wanted) to maintain post Bridges? What and why?

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17. What, if anything, will (did) you miss the most about Bridges?

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18. What are you looking forward to the most when you leave the program? (current students only)

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19. What recommendations would you make to improve Bridges for current and future students?

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20. Is there anything about the program that I've neglected to ask you and you'd like to share with me?

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APPENDIX B  
INTERVIEW PROTOCOL FOR PARENTS

1. Tell me how you became aware of the Bridges program.  

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2. What has been (was) the extent of your involvement in the program?  

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3. What is your understanding of the purpose of the program?  

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4. Can you describe the individual program developed for your child?  

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5. What academic supports have been (were) offered through Bridges?  

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6. What mental health supports have been (were) offered through Bridges?  

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7. How is (did) your child progressing (progress) with the reintegration process?  

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8. What are the exit criteria for dismissal from Bridges?  

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9. How would you rate your overall experience with Bridges and why?  

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10. What suggestions would you offer the Bridges faculty and parents new to the program?  

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11. Is there anything I've neglected to ask you that you feel is important?  

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APPENDIX C  
INTERVIEW PROTOCOL FOR SERVICE PROVIDERS



1. Tell me about the evolution of Bridges and how you came to be part of the Bridges program.  

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2. What is the stated purpose of the program?  

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3. Has this changed with time? If so, how?  

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4. Discuss the academic supports provided in Bridges.  

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5. How do you think the academic supports contribute to successful reintegration of students? Are there measures that support this?  

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6. Can you describe the social/ emotional supports in Bridges? How do they support mental health and successful reintegration?  

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7. What is the role of case manager? How do you see this role supporting successful reintegration?  

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8. How do you currently measure successful reintegration of students?  

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9. What other information would assist you in evaluating successful reintegration of students?  

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10. What impediments, if any, exist for fulfilling your mission of successful reintegration for students?  

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11. Have you received support from the greater school community and, if so, how?  

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12. What recommendations do you have for changing Bridges as it now exists?  

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APPENDIX D  
STUDENT QUESTIONNAIRE (CURRENT)

Directions: These questions are being asked as part of my research study of the Bridges program. I want to better understand the program from several perspectives including that of students participating in the program. The answers to this questionnaire will remain anonymous and be used solely for my research.

For the first part of the questionnaire please check or fill in the answer.

I am a male

I am a female

I am in the \_\_\_\_\_ grade.

I was involved in \_\_\_\_\_ (activities like sports, clubs, theater, student government) before being in Bridges.

I am currently involved in \_\_\_\_\_ (activities like sports, clubs, theater, student government).

I have been in Bridges for \_\_\_\_\_ (how long?)

I expect to leave the program \_\_\_\_\_ (when?)

I have friends who are or were in the program \_\_\_\_\_ (yes or no).

I have a sibling who was or is in the program \_\_\_\_\_ (yes or no).

The best thing about Bridges is....

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If I could change one thing about Bridges it would be.....

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Circle the **one** answer (Letter A, B or C) that best reflects your opinion.

1. I agreed with my placement in the Bridges program.  
A. Very much so      B. Somewhat      C. Not at all
2. I have been part of the planning process for my program in Bridges.  
A. Very much so      B. Somewhat      C. Not at all
3. I feel supported by Bridges staff academically.  
A. Very much so      B. Somewhat      C. Not at all
4. I feel emotionally supported by Bridges staff.  
A. Very much so      B. Somewhat      C. Not at all
5. I am making progress in this program.  
A. Very much so      B. Somewhat      C. Not at all
6. I know what I need to do to be ready to leave Bridges.  
A. Very much so      B. Somewhat      C. Not at all
7. Bridges has helped me get back into classes and activities.  
A. Very much so      B. Somewhat      C. Not at all
8. I expect to return to my former schedule when I leave Bridges.  
A. Yes                      B. No                      C. I'm not sure
9. I would recommend this program to other students.  
A. Yes                      B. No                      C. I'm not sure

Please add any comments that would help me understand your feelings about Bridges. In particular, how did Bridges support you academically and emotionally? What suggestions do you have to support other students?

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APPENDIX E  
STUDENT QUESTIONNAIRE (FORMER)

Directions: These questions are being asked as part of my research study of the Bridges program. I want to understand the program from multiple perspectives including parents of students enrolled in Bridges. The responses to this questionnaire will remain anonymous and be used solely for my research. If you agree to participate in this study please return the questionnaire to me in the stamped, self addressed envelope included with the survey. Thank you for your consideration.

For the first part of this questionnaire please fill in the answer.

I have \_\_\_\_\_ (how many?) children who currently or previously attended the public high school that is part of this study.

I have had \_\_\_\_\_ (how many?) children in the Bridges program.

My son/ daughter who participates in Bridges is in the \_\_\_\_\_ (what?) grade.

He/ she has been part of the program for \_\_\_\_\_ (how many weeks, months?)

Circle the **one** answer that best reflects your opinion.

1. I had a good understanding of the Bridges program when my son/daughter became enrolled.  
A. Very much so      B. Somewhat      C. Not at all
2. I have come to know the Bridges staff working with my son/ daughter.  
A. Very much so      B. Somewhat      C. Not at all
3. I have been part of the planning process for my son/ daughter with the Bridges staff.  
A. Very much so      B. Somewhat      C. Not at all
4. I feel my son/ daughter is making progress in the Bridges program.  
A. Very much so      B. Somewhat      C. Not at all
5. I have a better understanding of my son's/daughter's needs since entering Bridges.  
A. Very much so      B. Somewhat      C. Not at all
6. The planning for my son/ daughter includes a reintegration plan to his/ her former classes.

A. Yes                      B. Possibly                      C. Not at all

7. The planning for my son/ daughter may include additional evaluations.

A. Yes                      B. Possibly                      C. Not at all

8. The planning for my son/ daughter may include a different schedule than his/ her former schedule.

A. Yes                      B. Possibly                      C. Not at all

9. The planning for my son/ daughter may include placement in another program after Bridges.

A. Yes                      B. Possibly                      C. Not at all

10. I am looking forward to the time my son/ daughter leaves the Bridges program.

A. Yes                      B. Somewhat                      C. Not at all

11. I am apprehensive about my son/ daughter leaving the program.

A. Yes                      B. Somewhat                      C. Not at all

12. The supports my son/ daughter have received in Bridges have been positive.

A. Yes                      B. Somewhat                      C. Not at all

13. I believe my son/ daughter has gained skills that will help him/her be successful.

A. Yes                      B. Somewhat                      C. Not at all

14. If asked, I would recommend this program to other parents.

A. Yes                      B. Somewhat                      C. Not at all

Describe how the program has helped your son/ daughter.

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What would you share with parents who have a son/ daughter about to enter the program?

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What recommendations would you make to improve the program?

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What supports were most useful for your son/ daughter? (tutoring, advocacy, counseling, other?)

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Please describe your experience with the staff and program.

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APPENDIX F  
PARENT QUESTIONNAIRE (CURRENT)

Directions: These questions are being asked as part of my research study of the Bridges program. I want to better understand the program from several perspectives including that of students who participated in the program. The answers to this questionnaire will remain anonymous and be used solely for my research.

For the first part of the questionnaire please check or fill in the answer.

I am a male

I am a female

I am in the \_\_\_\_\_ grade or I graduated (when) \_\_\_\_\_.

I was involved in \_\_\_\_\_ (activities like sports, clubs, theater, student government) before being in Bridges.

I am currently or was involved in \_\_\_\_\_ after Bridges (activities like sports, clubs, theater, student government) .

I was in Bridges for \_\_\_\_\_ (how long?)

I had expected to leave the program \_\_\_\_\_ (after how long?)

I have friends who are or were in the program \_\_\_\_\_ (yes or no).

I have a sibling who was or is in the program \_\_\_\_\_ (yes or no).

The best thing about Bridges was....

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If I could change one thing about Bridges it would be.....

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Circle the **one** answer (Letter A, B or C) that best reflects your opinion.

1. I agreed with my placement in the Bridges program.

A. Very much so                      B. Somewhat                      C. Not at all

2. I was part of the planning process for my program in Bridges.  
A. Very much so      B. Somewhat      C. Not at all
3. I felt supported by Bridges staff academically.  
A. Very much so      B. Somewhat      C. Not at all
4. I felt emotionally supported by Bridges staff.  
A. Very much so      B. Somewhat      C. Not at all
5. I made progress in this program.  
A. Very much so      B. Somewhat      C. Not at all
6. I knew what I need to do to be ready to leave Bridges.  
A. Very much so      B. Somewhat      C. Not at all
7. Bridges helped me get back into classes and activities.  
A. Very much so      B. Somewhat      C. Not at all
8. I expected to return to my former schedule when I left Bridges.  
A. Yes      B. No      C. I'm not sure
9. I would recommend this program to other students.  
A. Yes      B. No      C. I'm not sure

Please add any comments that would help me understand your feelings about Bridges. In particular, how did Bridges support you academically and emotionally? What suggestions do you have to support other students?

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APPENDIX G  
PARENT QUESTIONNAIRE (FORMER)

Directions: These questions are being asked as part of my research study of the Bridges program. I want to understand the program from multiple perspectives including parents of students who were enrolled in Bridges. The responses to this questionnaire will remain anonymous and be used solely for my research. If you agree to participate in this study please return the questionnaire to me in the stamped, self addressed envelope included with the survey. Thank you for your consideration.

For the first part of this questionnaire please fill in the answer.

I have \_\_\_\_\_ (how many?) children who currently or previously attended New Trier.

I have had \_\_\_\_\_ (how many?) children in the Bridges program.

My son/ daughter who participated in Bridges is in the \_\_\_\_\_ (what?) grade or graduated high school \_\_\_\_\_ (when?).

He/she was been part of the program for \_\_\_\_\_ (how many weeks, months?)

Circle the **one** answer that best reflects your opinion.

1. I had a good understanding of the Bridges program when my son/daughter became enrolled.

A. Very much so      B. Somewhat      C. Not at all

2. I have come to know the Bridges staff working with my son/ daughter.

A. Very much so      B. Somewhat      C. Not at all

3. I was part of the planning process for my son/ daughter with the Bridges staff.

A. Very much so      B. Somewhat      C. Not at all

4. I felt my son/ daughter made progress in the Bridges program.

A. Very much so      B. Somewhat      C. Not at all

5. I have a better understanding of my son's/ daughter's needs since leaving Bridges.

A. Very much so      B. Somewhat      C. Not at all

6. The planning for my son/ daughter included a reintegration plan to his/her former classes.  
A. Yes                      B. Possibly                      C. Not at all
7. The planning for my son/ daughter included additional evaluations.  
A. Yes                      B. Possibly                      C. Not at all
8. The planning for my son/ daughter included a different schedule than his/her former schedule.  
A. Yes                      B. Possibly                      C. Not at all
9. The planning for my son/ daughter included placement in another program after Bridges.  
A. Yes                      B. Possibly                      C. Not at all
10. I looked forward to the time when my son/ daughter would leave the Bridges program.  
A. Yes                      B. Somewhat                      C. Not at all
11. I was apprehensive about my son/ daughter leaving the program.  
A. Yes                      B. Somewhat                      C. Not at all
12. The supports my son/ daughter received in Bridges were positive.  
A. Yes                      B. Somewhat                      C. Not at all
13. I believe my son/ daughter gained skills that will help him/her be successful.  
A. Yes                      B. Somewhat                      C. Not at all
14. If asked, I would recommend this program to other parents.  
A. Yes                      B. Somewhat                      C. Not at all

Describe how the program helped your son/daughter.

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What would you share with parents who have a son/ daughter about to enter the program?

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What recommendations would you make to improve the program?

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What supports were most useful for your son/daughter? (tutoring, advocacy, counseling, other?)

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Please describe your experience with the staff and program.

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APPENDIX H  
FACULTY QUESTIONNAIRE



Directions: These questions are being asked as part of my graduate study of the Bridges program. I want to better understand the program from multiple perspectives including the New Trier Faculty. Responses to this questionnaire will remain anonymous and be used solely for my research. Please respond frankly to each item and place the completed survey in my mailbox. I am most appreciative of your assistance. Thank you, Marion Platt

Fill in the answer to the best of your knowledge.

1. I have been teaching \_\_\_\_\_ years.
  2. I am currently in administration. Yes \_\_\_ No\_\_\_
  3. For administrators: I have been an administrator at New Trier for \_\_\_\_\_ years.
  4. For teachers: I have been teaching at New Trier for \_\_\_\_\_ years.
  5. I am in the \_\_\_\_\_ department.
  6. The classes I teach are \_\_\_\_\_.
  7. I have had \_\_\_\_\_ students in the Bridges program.
  8. I have recommended students to the Bridges program. Yes \_\_\_ No \_\_\_\_\_.
  9. If yes to # 8, how many and over what period of time?
- 

Circle **all** answers you believe to be true for number 10 and 11.

10. What is the purpose of the Bridges program?
  - A. Tutorial services
  - B. Mental health services
  - C. Transition services
  - D. Support for students through advocacy & case management
  - E. All of the above
  
11. What population of students does the Bridges program serve?
  - A. Regular education students
  - B. Special education students

- C. Students experiencing acute emotional distress
- D. Students returning from hospitalizations or treatment centers
- E. Students with school refusal
- F. Students who have missed a significant amount of school due to  
Medical illness
- G. All of the above

Circle the **one** answer that best reflects your opinion.

12. A student assigned to me has been in the Bridges program.  
A. Yes                      B. No
13. I understand the goals of Bridges.  
A. Yes                      B. Somewhat                      C. Not at all
14. I know the process for enrolling a student in Bridges.  
A. Yes                      B. Somewhat                      C. Not at all
15. I know how to access information about Bridges.  
A. Yes                      B. Somewhat                      C. Not at all
16. I understand the primary role of Bridges staff.  
A. Yes                      B. Somewhat                      C. Not at all
17. I have worked with Bridges staff when we “shared” students.  
A. Yes                      B. Somewhat                      C. Not at all
18. I view Bridges as a positive addition to services for students.  
A. Yes                      B. Somewhat                      C. Not at all
19. I believe the majority of faculty view Bridges positively.  
A. Yes                      B. Somewhat                      C. Not at all
20. I believe this program should continue.  
A. Yes                      B. Somewhat                      C. Not at all

Please feel share to make comments about the program not addressed in this questionnaire.

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Completion and return of this survey to the researcher's mailbox will indicate your consent to participate in this survey.

APPENDIX I  
OBSERVATION PROTOCOL

Setting (date, time, physical description)

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Actors (students, staff, ancillary personnel, dialogue)

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Events (tutoring, advising/ counseling, liaison, preparation for class re-entry/ rehearsal, other)

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Process (what's happening?)

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APPENDIX J  
INFORMED CONSENT BY PARENT FOR  
STUDENT PARTICIPATION IN RESEARCH

**(Parent Consent for Student Participation)**

**Project Title:** Understanding the Bridges program through the lens of stakeholders

**Researcher(s):** Marion Platt

**Faculty Sponsor:** Dr. David Ensminger

**Introduction:**

You are being asked to give permission for your child to take part in a research study being conducted by Marion Platt, for her dissertation on the Bridges program, under the supervision of Dr. David Ensminger in the Department of Education at Loyola University of Chicago, Ph: 312-915-7257 or [densmin@luc.edu](mailto:densmin@luc.edu).

Your child is being asked to participate because he/she is or was a student in the Bridges program. The current study will include students who are or have been enrolled in Bridges, their parents, Bridges staff and the greater school community.

Please read this form carefully and ask any questions you may have before deciding whether to allow your child to participate in the study.

**Purpose:**

The purpose of this study is to understand the Bridges program from the perspectives of students, parents and staff associated with the program.

**Procedures:**

If you agree to allow your child to be in the study, he/she will be asked to:

- Participate in an interview with the researcher of about 30 to 45 minutes. Questions are focused on the program, not the student. The questions are designed to understand the program from the unique perspective of the student. The questions are attached though not all questions will necessarily be used.
- Be observed in the Bridges program or classroom setting.
- Complete a student questionnaire that will be administered and submitted anonymously.

**Risks/Benefits:**

There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life. The focus of the study is on the Bridges program, not the students enrolled in the program. There are no direct benefits to participants but the study will offer a voice for students to explore the value of the program.

**Confidentiality:**

The participants can be assured of the utmost confidentiality. No names of either the school or individual participants will be revealed at any time unless the participants desire to be mentioned. Nevertheless, the official study will under no circumstances reveal the identities of the participants.



**Voluntary Participation:**

Participation in this study is voluntary. If you do not want your child to be in this study, he/she does not have to participate. Even if you decide to allow your child to participate, he/she is free not to answer any question or to withdraw from participation at any time without penalty. Your decision to allow your son/ daughter to participate or not participate in this research study will have no effect on his grades or standing with the school or administration.

**Contacts and Questions:**

If you have any questions about this research study, please feel free to contact Marion Platt at 847-784-6854 or e-mail me at [plattm@newtrier.k12.il.us](mailto:plattm@newtrier.k12.il.us) or Dr David Ensminger at Loyola University at 312-915-7257 or [densmin@luc.edu](mailto:densmin@luc.edu).

If you have questions about your child's rights as a research participant, you may contact the Compliance Manager in Loyola's Office of Research Services at 773-508-2689.

**Statement of Consent:**

Your signature below indicates that you have read and understood the information provided above, have had an opportunity to ask questions, and agree to allow your child to participate in this research study. You will be given a copy of this form to keep for your records. Please check **only** the boxes that you allow your child to participate in.

I allow my child to be observed in Bridges class.

I allow my child to participate in an anonymous survey.

I allow my child to be interviewed by the researcher about his/her experiences in Bridges.



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 Parent's/Guardian's Signature

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 Date

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 Researcher's Signature

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 Date

APPENDIX K  
STUDENT CONSENT FOR PARTICIPATION IN RESEARCH

**(Student)**

**Project Title:** Understanding the Bridges program through the lens of stakeholders

**Researcher(s):** Marion Platt

**Faculty Sponsor:** Dr. David Ensminger

**Introduction:**

I understand that I am being asked to participate in a study of the Bridges program for a dissertation by Marion Platt who is a student at Loyola University of Chicago.

**Purpose:**

The purpose of this study is to gather information about the Bridges program from the perspective of students who have been or are in the program.

**Procedures:**

Information in this study will be collected through observation of the program, interview and questionnaire. Consent from my parent/ guardian has already been obtained. By signing this document I agree to participate in a case study that focuses on my experiences with the Bridges program. Access to this information will be available only to the researcher, Marion Platt.

**Risks/Benefits:**

There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life. There are no direct benefits to you from participation, but this study will provide a better understanding of the Bridges program from the perspective of students.

**Confidentiality:**

I understand the information gathered in this study is only for the purpose of research about the Bridges program and that my identity and the identity of others I might mention will never be revealed. The researcher will maintain complete confidentiality.

**Voluntary Participation:**

I understand that participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

**Contacts and Questions:**

If you have any questions about this research study, please feel free to contact Marion Platt at 847-784-6854 or e-mail me at [plattm@newtrier.k12.il.us](mailto:plattm@newtrier.k12.il.us) or Dr David Ensminger at Loyola University at 312-915-7257 or [densmin@luc.edu](mailto:densmin@luc.edu).

If you have questions about your rights as a research participant, you may contact the Compliance Manager in Loyola's Office of Research Services at 773-508-2689.

**Statement of Consent:**

Your signature below indicates that you have read and understood the information provided above, have had an opportunity to ask questions, and agree to allow your child to participate in this research study. You will be given a copy of this form to keep for your records. Please check **only** the boxes that you allow your child to participate in.

I agree to be observed in Bridges/ class.

I agree to participate in an anonymous survey.

I agree to be interviewed by the researcher  
about my experiences in Bridges.

---

Participant's Signature

---

Date

---

Researcher's Signature

---

Date

APPENDIX L

INFORMED CONSENT FOR PARENT PARTICIPATION IN RESEARCH

**(Parent)**

**Project Title:** Understanding the Bridges program through the lens of stakeholders

**Researcher(s):** Marion Platt

**Faculty Sponsor:** Dr. David Ensminger

**Introduction:**

You are being asked to take part in a research study being conducted by Marion Platt for a dissertation under the supervision of Dr. David Ensminger in the Department of Education Loyola University of Chicago.

As a parent of a student who was, or currently is, in Bridges you can provide a valuable perspective of the program.

**Purpose:**

The purpose of this study is to understand the Bridges program from the perspectives of students, parents, Bridges staff and the greater school community.

**Procedures:**

If you agree to be in the study, you will be asked to complete an anonymous questionnaire regarding the Bridges program. It will be mailed to you with self addressed stamped envelope to be returned to me. Additionally I will be randomly selecting current and former parents to interview regarding their perspectives of the program. Please indicate at the end of this form if you would be interested in participating in either parent activity.

**Risks/Benefits:**

There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life. There are no direct benefits to you from participation, but this study will provide a better understanding of the Bridges program from the perspective of parents.

**Confidentiality:**

The participants can be assured of the utmost confidentiality. No names of either the school or individual participants will be revealed at any time.

**Voluntary Participation:**

Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

**Contacts and Questions:**

If you have questions about this research study, please feel free to contact Marion Platt at 847-784-6854 or [plattm@newtrier.k12.il.us](mailto:plattm@newtrier.k12.il.us) or Dr. David Ensminger, faculty sponsor, at Loyola University at 312-915-7257 or [densmin@luc.edu](mailto:densmin@luc.edu).

If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

**Statement of Consent:**

Your signature below indicates that you have read and understood the information provided above, have had an opportunity to ask questions, and agree to participate in this research study. You will be given a copy of this form to keep for your records. **Only check the boxes of activities you want to participate in.**

I agree to participate in an anonymous survey.

I agree to be interviewed by the researcher about my experiences as a parent of a Bridges student.

Participant's Signature

Date

---

Researcher's Signature

Date

---

APPENDIX M

INFORMED CONSENT BY COOPERATING INSTITUTION



**NEW  
TRIER** TOWNSHIP HIGH SCHOOL  
WINNETKA CAMPUS



*To commit minds to inquiry, hearts to compassion, and lives to the service of humanity.®*

November, 2009

Marion Platt, Researcher  
School of Education  
Loyola University Chicago  
820 North Michigan Avenue  
Chicago, IL 60611

Dear Marion:

I grant approval for you to use New Trier as the site for conducting the proposed study "Understanding the Bridges Program through the Lens of Stakeholders," as outlined in the attached Research Plan. I further grant you access to student records related to the Bridges Program at New Trier High School with the understanding that your research will in no way reflect any identifying information about an individual student. I understand that the proposed study will take place between January and February, 2010 and will directly involve staff and students that choose to participate.

You must coordinate your activities with Laurel Burman, Director of Special Education, and Paul Sally, Assistant Superintendent for Curriculum and Instruction. All activities are expected to be conducted in a manner consistent with the Illinois School Code regarding student confidentiality and student records. Consent forms are to be obtained from participating staff, students and parents/ guardians of students directly involved in the study. During recruitment, it must be made clear that participation is completely voluntary and can be withdrawn at any time without penalty.

I wish you much success with this project and look forward to receiving a copy of the final report.

Sincerely,

Assistant Superintendent for Curriculum and Instruction

APPENDIX N

STUDENT INVITATION TO PARTICIPATE IN RESEARCH

Dear \_\_\_\_\_

I am looking for average representative students to participate in a 30 to 45 minute interview regarding student experiences in Bridges. You have been randomly selected to participate in an interview. I am hoping that the information that I gather will be helpful to the Bridges program and future students.

Your participation in an interview is entirely voluntary and your decision to participate or not will have no effect on your grades or school standing. All responses during the interview will be completely confidential. Your interview will be scheduled during a free period in your schedule or your lunch period. Please check the indicated box below to specify which time is better for you and return the form to a Bridges teacher. Also please read the attached consent forms, one for your parents and one for you giving your consent to participate, have it signed by your parent and return it to your Bridges teacher or bring it to the interview session. You should sign your individual consent form at the time of the interview. You will not be able to participate in the interview without the signed consent form from your parents.

The interview will be held in office 1E, several doors down from Bridges. If you select a lunchtime interview, please plan to bring your lunch. If you select a free period you may wish to bring a snack with you. The first five students to respond will get to participate in the interview. All respondents will be notified at the beginning of next week regarding their inclusion in the interviews.

-----

**I would like to participate in a lunchtime interview.**

**I would like to participate in the interview during a free period.**

**Date:** \_\_\_\_\_ (To be determined as best fits the school schedule)

**Place:** Office 1E (or similar private meeting room as best fits school schedule)

APPENDIX O

PARENT INVITATION TO PARTICIPATE IN RESEARCH

Dear \_\_\_\_\_

My name is Marion Platt. I am a doctoral candidate at Loyola University Chicago. I am conducting case study research regarding some of the unique aspects of the Bridges program from the perspectives of stakeholders. I have identified four stakeholder groups including current and past students in Bridges, parents of current and past students in Bridges, the Bridges staff and the greater school community. I will be conducting research at New Trier in order to understand the unique values and perspectives stakeholder participants attribute to Bridges. During the course of my research I will be observing classes, collecting data through anonymous surveys and interviewing a number of Bridges students- both past and present, parents of students currently or formerly enrolled in Bridges and Bridges staff in order to understand what is special about Bridges as a program. I believe that there are many things that we can learn that will be of significant assistance to the Bridges staff as they continue to plan for and assist our adolescents.

I am looking for parents of 5 to 10 students (current and former Bridges students) to participate in a 30 to 45 minute interview with me regarding your experiences with the Bridges program. I am hoping that the information that I gather will be helpful to Bridges staff and the greater school community.

Your participation in the interview is entirely voluntary and your decision to participate or not will have no effect on your child's grades or school standing. All responses during the interview will be completely confidential. Please check the indicated box below as to what time you would be able attend. Have your son or daughter return it to a Bridges teacher. Also, please read the attached consent form. The university requires that it be signed in the interviewer's presence at the interview. My phone number and e-mail address are included there under Contacts and Questions.

The interview sessions will be held in office 1E, several doors down from Bridges.

I would like to participate in an interview before school.  (Time and date TBD)

I would like to participate in an interview after school.  (Time and date TBD)

**Date:** \_\_\_\_\_ (To be determined as best fits the school schedule)

**Place:** Office 1E (or similar private meeting room as best fits school schedule)

**Please return this form along with the signed parental and individual consent forms to a Bridges teacher.**

APPENDIX P  
CODEBOOK

## Research Question 1: RQ1 Outcomes

| Student Stakeholder Group (SSG)   | Parent Stakeholder Group (PSG)                                  | Bridges Faculty Stakeholder Group (BFSG)   | School Faculty Stakeholder Group (SFSG)                   | Extends to Multiple Groups  |
|---|---|--|---|---|
| Anxious & Overwhelmed<br>Emotional Anxiety<br>Academic Anxiety<br>Emotional R/<br>Academic Expectations | Safety Families in Crisis,<br>Relinquish Responsibility         | Chronically Truant Students (What to do?)  | Safe place (Positive Understandings)                      | Positive Impact Identified<br>Safety/ Safe Haven/<br>Safe People (SSG), (PSG), (BFSG), (SFSG) |
| Manageable Workload (grades, IP grades, level changes)  | Interim Step to full Reintegration                              | Alternative to staying at home with tutoring or in bed or therapeutic placement outside of district                                  | Negative Perceptions (enabling & over reliance qualities) | Negative Impact Identified (BFSG & SFSG)  |
| Safe Environment (physical environment, reduction in anxiety, advocacy, individualized planning)        | Bridges Faculty Assume Responsibility for Reintegration Process | New Outcome through Bridges  |   |   |
| Provide a Process for Reintegration   | Bridges Faculty Respond to Parent Need for Safety               | Safe place with safe people means reestablishment of school routines, regular attendance, anxiety reduction, finding individual path |   |   |
|   |   | Successful reentry to classes  |   |   |

## Question 2: RQ 2 Support Successful Reintegration

| Student Stakeholder Group (SSG)  | Parent Stakeholder Group (PSG) | Bridges Faculty Stakeholder Group (BFSG) | School Faculty Stakeholder Group (SFSG) | Extends to Multiple Groups      |
|--|--------------------------------|--|---|---------------------------------|
| Academic Support<br>Tutoring/<br>Advocacy/<br>Negotiator/Teacher Communication | Atmosphere/Safe                | Roles/ Advocate/<br>Communicator         | Academic Role/<br>One Dimensional       | Supportive & Safe<br>All Groups |
| Making School Manageable/  | Customized Plans/Tutoring      | Supportive Environment                   | Supportive Environment                  | Transitions<br>All Groups       |

|   |  |                                      |                          |                                     |
|---|--|--------------------------------------|--------------------------|-------------------------------------|
| Transitions   |  |                                      |                          |                                     |
| Calm Atmosphere/Trust/Safety  | Critical Periods/ Reentry x 2/Transitions          | Individualized Planning for Students | Communication Inadequate | Individual Plans (SSG) (PSG) (BFSG) |
| Supportive Community/ Staff/ Peer Group                                   | Advocacy/ Alleviate Anxiety/ Remedy School Refusal | Transitions                          | Students in Crisis       |                                     |
| Individualized Plans/ Customized Approach/ To Do Lists/Dismissal/ Reentry | Communication Gaps                                 |                                      | Transitions              |                                     |

Question 3: RQ 3 Mental Health Supports

|   |   |   |   |  |
|---|---|---|---|--|
| Student Stakeholder Group (SSG)         | Parent Stakeholder Group (PSG)          | Bridges Faculty Stakeholder Group (BFSG)        | School Faculty Stakeholder Group (SFSG) | Extends to Multiple Groups                           |
| All Staff Provide Mental Health/Therapy | All Staff Provide Mental Health/Therapy | Collaboration (In School & Community Resources) | Counseling & Advocacy                   | Therapy as Essential Component of Bridges All Groups |
| Personal Choice                         | Personal Choice                         | Therapy & Changes                               | Therapy for Reintegration               | Personalized (SSG, PSG & BFSG)                       |
| Peer Support                            | Anxiety Relief                          | Integrated Approach                             |   | Peer Support (SSG & PSG)                             |
|   | Peer Support                            |   |   | Collaboration (PSG & BFSG)                           |
|   | Collaboration with Community Resources  |   |   |  |
|   | Peer Support                            |   |   |  |
|   |   |   |   |  |



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## VITA

Ms. Marion Platt has been an advocate for special education services for over 35 years serving preschoolers through adults in Connecticut and Illinois as a teacher, administrator, professional development coordinator and consultant. Areas of expertise include special education law and programming for students on the autism spectrum. In the 1990s she received a Fulbright Scholarship to live and work in Russia to develop special education programming in concert with technological advances. Ms. Platt has been instrumental in the development of public school programming for minority populations including specialized training and services for medically fragile/technologically dependent children, pre-kindergarten through age 21 students on the autism spectrum and, most recently, transitional programming for students returning to public school subsequent to a prolonged psychiatric or medical hospitalization.

Ms. Platt received her Bachelor of Science degree in psychology and education, cum laude, Masters in special education and Sixth Year degree in educational leadership and administration, magna cum laude, from the University of Connecticut. Ms. Platt is a life-long member of many special education organizations including the Council for Exceptional Children. She has served on the board of The Center for Medicare Advocacy since its inception in 1986.

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